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Childhood and Adolescent/Adult Sexual Abuse in Relation to Sexual Function and Distress: Findings from a Cross-Cultural Study of 42 Countries

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Abstract

Childhood sexual abuse (CSA) and adolescent/adult sexual assault (AASA) are significant public health issues that profoundly impact sexual well-being. This study examined the associations between CSA, AASA, and sexual function and distress across diverse demographic groups and cultural contexts. A cross-sectional, self-report study was conducted using the International Sex Survey with 82,243 participants from 42 countries. Data were analyzed using 3D association analyses and structural equation modeling to assess the impact of CSA and AASA on sexual function problems and sexual distress. Findings revealed significant associations between both CSA and AASA with higher levels of sexual distress and sexual function problems. Gender differences showed that men and gender-diverse individuals exhibited similar levels of sexual function problems and distress as women. Significant variations were observed across sexual orientations, with heterosexual and bisexual individuals reporting more sexual function problems and distress compared to queer, asexual, and pansexual individuals. These results emphasize the lasting impact of CSA and AASA on sexual well-being, highlighting the

importance of trauma-informed and culturally sensitive interventions. Tailored approaches in trauma-informed sex therapy are critical, with particular attention to gender, sexual orientation, and cultural factors to effectively address the effects of abuse on sexual health.

Keywords
childhood sexual abuse, adolescent/adult sexual assault, sexual function, sexual distress

Introduction

Childhood sexual abuse (CSA) and adolescent/adult sexual assault (AASA) are significant public health concerns with profound implications for sexual well-being. While previous research has established general links between sexual abuse and sexual function and distress, our study offers several novel contributions. First, existing research predominantly focused on female survivors, neglecting the experiences of men and sexually diverse individuals (Bigras et al., 2021; Gewirtz-Meydan & Opuda, 2022; Pulverman et al., 2018; Wang et al., 2023). This study included underrepresented groups, such as men, gender-diverse individuals, and people of diverse sexual orientations. Second, most research relies on Western, Educated, Industrialized, Rich, and Democratic (WEIRD) samples, limiting generalizability across cultures

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(Klein et al., 2022). Cultural norms around sexuality, gender roles, and family honor can shape survivors' psychological responses (Fontes & Plummer, 2010; Sanjeevi et al., 2018; Sawrikar & Katz, 2017a). In many cultures, stigma and taboos hinder disclosure and delay help-seeking, intensifying psychological harm (Mensah et al., 2024). By including participants from 42 countries, our study offers a unique opportunity to examine these associations in a broader, culturally diverse context and to identify how patterns of sexual function and distress may vary across different cultural and sociopolitical settings. These additions offer a more nuanced and intersectional understanding of how sexual victimization relates to sexual outcomes globally.

CSA and Sexual Function and Distress

CSA is a significant public health problem that affects the lives of millions of people every year (Barth et al., 2013). It is broadly defined as any sexual activity involving a child who is developmentally unprepared for, unable to provide informed consent to, or coerced into participation due to an age-based or relational power differential (Centers for Disease Control and Prevention [CDC], 2018; World Health Organization, 1999). Such abuse may be perpetrated by adults or older youth and frequently occurs in the context of a relationship marked by trust, authority, or dependency. In the current global study, CSA was assessed using a standardized definition aligned with international frameworks (CDC, 2018; World Health Organization, 1999). However, we also recognize that participants' subjective experiences and the cultural context in which they live may influence how sexual abuse is understood, labeled, and reported.

Estimates of CSA prevalence range from 8% to 31% for girls and 3% to 17% for boys (Barth et al., 2013). In their meta-analysis of the worldwide prevalence of CSA, Pereda et al. (2009) found a mean prevalence of 7.9% in men and 19.7% in women. This variation may be due to different definitions and methodologies used in the studies. A recent meta-analysis highlighted the broad spectrum of mental and physical health issues associated with CSA, including post-traumatic stress disorder (PTSD), depression, anxiety, suicide, substance use, poor physical health, eating disorders, and psychosomatic complaints (Hailes et al., 2019; Irish et al., 2010; Nagtegaal & Boonmann, 2022).

CSA often impacts a survivor's overall sexual well-being and specifically sexual function and distress (Bigras et al., 2021; Gewirtz-Meydan & Opuda, 2022; Pulverman et al., 2018; Wang et al., 2023). Sexual function problems encompass a spectrum of persistent concerns in an individual's capacity to engage in gratifying sexual experiences. These disruptions include sexual interest/arousal disorder, characterized by a lack of sexual interest or arousal,

diminished sexual excitement, and challenges in maintaining arousal during sexual activity (such as vaginal lubrication and erectile functioning); orgasmic disorder, which involves difficulties in achieving orgasm or significant delays in orgasm despite adequate sexual stimulation; and genito-pelvic pain/penetration disorder, which encompasses conditions where individuals experience pain during sexual intercourse or encounter difficulties with vaginal penetration (American Psychiatric Association, 2013; Ishak & Tobia, 2013). These issues can persist over a long period and lead to clinically significant distress or impairment in an individual's life (Hendrickx et al., 2013).

Previous research has demonstrated the association between CSA and sexual function problems such as reduced sexual desire, arousal, orgasm, and increased genito-pelvic pain (Harlow & Stewart, 2005; Leclerc et al., 2010; Pulverman et al., 2018; Swaby & Morgan, 2009). The prevalence of sexual function problems among women who experienced CSA was found to range from 25% to 59% in random probability studies, and from 63% to 94% in clinical samples of women (Pulverman et al., 2018). In a recent systematic review, the prevalence of sexual function problems among male survivors of CSA was found to range up to 80% (Gewirtz-Meydan & Opuda, 2022).

These empirical patterns can be better understood through several theoretical frameworks. The Traumagenic Dynamics Model (Finkelhor & Browne, 1985) identifies four core dynamics related to CSA: traumatic sexualization, betrayal, powerlessness, and stigmatization—all of which disrupt a child's psychological and sexual development. The Self-Trauma Model (Briere, 2002) explains how early interpersonal trauma impacts emotional regulation, identity formation, and cognitive schemas, with lasting effects on sexual well-being. Finally, embodiment theory (B. van der Kolk, 1994; B. A. Van der Kolk, 2014) offers a somatic perspective, suggesting that trauma is stored and expressed in the body, often manifesting in disconnection, dissociation, or confusion between pleasure and threat during sexual activity. Together, these models help frame the deep and multifaceted consequences of CSA across psychological, relational, and embodied domains that may all contribute to its influence on sexuality.

AASA and Sexual Function and Distress

AASA refers to a nonconsensual sexual act or sexual contact that occurs when an adolescent or adult engages in sexual activity with another adolescent/adult without the explicit and voluntary consent of the other party. It involves unwanted sexual penetration, touching, or any form of sexual activity forced upon an individual against their will or in the context of being unable to give informed and voluntary consent due to factors such as

intoxication, coercion, threats, or incapacitation (CDC, 2018). In a recent review of 22 studies examining the prevalence of AASA, reported rates varied widely, ranging from up to 59.2% for women, 0.3% to 55.5% for men, and 1.5% to 18.2% for LGBT samples (Dworkin et al., 2021).

The repercussions of AASA extend beyond the immediate impact, significantly affecting sexual well-being and contributing to both immediate and enduring psychological challenges. Studies have indicated that individuals who have experienced AASA often exhibit higher levels of sexual dissatisfaction and lower sensuality than non-victims (DiMauro et al., 2018; McCall-Hosenfeld et al., 2009). Research has shown that individuals who have experienced AASA also often suffer from impaired sexual function, including pain during sex, lower sexual desire, arousal problems, and difficulties achieving orgasm, as well as lower sexual satisfaction (Högbeck & Möller, 2022; Kelley & Gidycz, 2018; Pulverman & Creech, 2021; Pulverman et al., 2019). Moreover, AASA is frequently associated with PTSD, which can have a significant impact on sexual function (Yehuda et al., 2015).

Despite cross-sectional work and systematic reviews exploring the links between CSA and AASA and their repercussions for sexual function and distress, critical gaps persist in our understanding of the role of sexual violence in individuals' sexual well-being. We identified three gaps in the existing literature that we aim to address in this paper. First, although much attention has been given to CSA and sexual function and distress (Bigras et al., 2021; Buczó et al., 2025; Gewirtz-Meydan & Opuda, 2022; Pulverman et al., 2018; Wang et al., 2023), there is a paucity of comprehensive research specifically focusing on the potential impact of AASA on sexual function and distress. Understanding the nuances and consequences of AASA is crucial for bridging this gap and gaining a more holistic understanding of the broader spectrum of sexual assault experiences across different life stages and their associations with sexual function and distress. Existing research has predominantly focused on cisgender women survivors, resulting in a lack of understanding regarding the experiences and consequences of CSA and AASA for men and gender-diverse individuals (Gewirtz-Meydan & Opuda, 2022).

While there are many studies showing prevalence estimates of sexual assault victimization among sexually diverse individuals, the reasons for their elevated exposure to AASA need further investigation. An analysis by Rothman et al. (2011) systematically reviewed 75 studies on sexual assault victimization among gay or bisexual men and lesbian or bisexual women in the United States. The findings revealed a wide range of prevalence estimates, from 15.6% to 85.0% for lesbian or bisexual women and 11.8% to 54.0% for gay or bisexual men. This variation may be due to the different definitions and methodologies used in the studies. These findings underscore

the need for more inclusive research among these populations so that professionals can provide tailored support and intervention approaches. Finally, there is a lack of cross-cultural perspectives. Most research in this domain has been conducted in WEIRD countries, raising concerns about the generalizability of findings to diverse cultural and socioeconomic contexts (Klein et al., 2022). Addressing these gaps is thus essential for a more inclusive, informed, and culturally sensitive approach to treating the aftermath of sexual abuse and assault on a broader scale.

Objectives and Hypotheses

In this study, we examined the association between CSA and sexual function and distress, and between AASA and sexual function and distress. Our primary focus was to examine the underrepresentation of men and sexually diverse individuals in previous studies by investigating how CSA and AASA are associated with sexual function problems and sexual distress among men, women, and gender-diverse individuals, as well as among those with different sexual orientations. Second, we also sought to broaden the scope of the research by examining how CSA and AASA are associated with sexual function problems and sexual distress in WEIRD and non-WEIRD countries, in order to generalize the findings to more diverse cultural and socioeconomic contexts. Specifically, we hypothesized that: (a) CSA (without AASA), AASA (without CSA), and CSA + AASA (both CSA + AASA present) would positively associate with sexual function problems/sexual distress; and (b) the associations between CSA, AASA, and CSA + AASA and sexual function problems/sexual distress would differ across categorical moderators, including gender, sexual orientation, and country of residence. Based on previous research findings, we expected to observe higher sexual function problems and sexual distress in women, as well as within the LGBTQ+ community. Women have historically been identified as more vulnerable to these adverse effects, and individuals on the LGBTQ+ spectrum may face additional stressors related to societal stigma and discrimination that could amplify their sexual difficulties and distress. In the case of country-based differences, our approach is exploratory.

Method

Procedure and Participants

This study was conducted using the International Sex Survey (ISS) study sample, a cross-sectional, self-report study in 42 countries[1] (see the preregistered study design: https://osf.io/fht8p). The English survey battery was

translated into an additional 25 other languages, following a preestablished translation procedure for cross-cultural studies (Beaton et al., 2000). Data were collected between October 2021 and May 2022. Participants who responded to the study advertisements completed an anonymous survey on Qualtrics International Inc., which took approximately 25 to 45 minutes. The list of all collaborating countries, the detailed description of the translation and data collection procedures, and the eligibility criteria are described in the study protocol (Bőthe et al., 2021).

After data cleaning (see detailed data cleaning procedure: https://osf.io/csyjq?view_only=dadcfc82666140a6ab5a1c3f63b679be), a total of 82,243 participants (M_{age} = 32.39 years, SD = 12.52) were included in the final dataset. Concerning participants' gender, 32,549 (39.6%) identified as men, 46,874 (57.0%) as women, and 2,783 (3.4%) as gender-diverse individuals. Most participants (n = 56,125; 68.2%) were heterosexual, and 31.5% (n = 25,777) of the participants were sexually diverse. Most participants had a tertiary education (e.g., college or university; n = 60,896; 74.0%), worked full-time (n = 42,981; 52.3%), and lived in a city or metropolis (i.e., in a city with a population greater than 100,000; n = 56,361; 68.5%). Regarding relationship status, more than half of the participants were in a romantic relationship (n = 51,778; 63.0%). Detailed sociodemographic characteristics of participants by country can be found at: https://osf.io/n3k2c/files/osfstorage/6352e69c6e71e8121a9cb66d.

Ethical Considerations

The study was approved by all collaborating countries' national/institutional ethics review boards (https://osf.io/n3k2c/files/osfstorage/636974c6f490ee001cfe45f) and was conducted in accordance with the Declaration of Helsinki.

Measures

Sexual abuse and assault were assessed using the Sexual Abuse History Questionnaire (SAHQ; Leserman et al., 1995). This scale measures participants' experiences of different types of sexual abuse during their childhood (CSA), adolescence, and adulthood (AASA), with 12 dichotomous (i.e., "no" and "yes") questions (e.g., "Has anyone ever forced you to have sex when you did not want this?"). Six of the questions addressed CSA (≤13 years old), and six questions addressed AASA (≥14 years old). In this study, the SAHQ was translated and validated in all languages (Nagy et al., 2025). Respondents provided their answers on a 2-point scale (0 = *no*; 1 = *yes*). A higher sum score indicated a greater exposure to sexual abuse at that age. Internal consistency was acceptable for both scales (CSA: α = .73; AASA: α = .75).

Sexual function was assessed using the Arizona Sexual Experiences Scale (ASEX; McGahuey et al., 2000). This five-item self-report instrument asks participants to report on core elements of sexual function, including sex drive, arousal, vaginal lubrication, ability to reach orgasm, and satisfaction with orgasm, for example: "How strong is your sex drive?" and "How easily are you sexually aroused (turned on)?" Each ASEX item is rated from 1 to 6 and the score is summed into a total score, with a higher score indicating a greater number of sexual function problems. In this study, the ASEX was translated and validated in all languages ASEX (Ballester-Arnal et al., 2025). The internal consistency of the ASEX was excellent ($\alpha = .91$).

Sexual distress was assessed using a three-item version of the Sexual Distress Scale (SDS-3; Derogatis et al., 2002; Pâquet et al., 2018) to measure the frequency of experiencing distress due to sexual difficulties in the past month (e.g., "How often did you feel distressed about your sex life?"). Participants indicate their answers on a 5-point scale ranging from 0 (*never*) to 4 (*always*), and higher scores indicate more sexual distress. In this study, the SDS-3 was translated and validated in all languages (Lin et al., 2024). The internal consistency of the SDS-3 was good ($\alpha = .83$).

Other relevant demographic information was assessed with single items, as described in the study protocol (Bőthe et al., 2021).

Data Analysis

Hypotheses and statistical analyses were preregistered for transparency and bias reduction; see details at https://osf.io/t8hzn/metadata/osf. Before the primary analyses, we examined whether participants' countries (nested within 42 countries), sexual orientations (nested within 8 orientations), and genders (nested within three genders) accounted for a significant portion of the variance in sexual function problems and sexual distress. To do so, we compared the fit (by the *anova* function in R) of intercept-only linear models (i.e., not nested; *lm* function) with intercept-only mixed effect models (i.e., with participants nested within countries; lmer function of lme4 R package; Bates et al., 2019). A significant deviation test would support a nested design. All tests were highly significant (lowest p-value $<2.2e{-}16$), supporting the need for multilevel analyses. First, to examine the hypothesis that CSA, AASA, and CSA + AASA would predict the severity of sexual function problems and sexual distress, we conducted 3D association analyses. Three-dimensional association analyses plot the joint effects of CSA and AASA on the outcome in three-dimensional space, allowing direct visualization of both main and interaction effects across the full abuse-severity continuum—capturing complex, potentially nonlinear patterns that two-dimensional plots cannot.

Specifically, we appraised the dependent contribution of CSA, AASA, and CSA + AASA on participants' sexual function problems and sexual distress. A regression plane was estimated to capture the prediction trend, and the borders of significance were appraised using the Johnson–Neyman technique.

Next, to test whether the effects of CSA, AASA, and their interaction varied by participants' country, sexual orientation, or gender, we employed multigroup structural equation modeling in Mplus 8.8 (Muthén & Muthén, 2023). We selected this method because it enables the simultaneous estimation and comparison of complex regression paths across numerous moderator levels—42 countries, 8 sexual orientation categories, and 3 gender groups—within a single coherent framework. We began by fitting *unconstrained models*, in which the paths from CSA, AASA, and their interaction to sexual function problems and sexual distress were freely estimated within each group, allowing for natural heterogeneity in effects. We then constructed a series of *constrained models*, in which each focal path (CSA, AASA, or CSA × AASA) was successively fixed to be equal across all groups. This approach avoids the cumbersome and error-prone proliferation of dummy-coded interaction terms required in standard regression models, yields more efficient and interpretable parameter estimates, and accommodates group-specific variation without inflating model complexity. We used the Satorra–Bentler scaled χ^2 difference test, applied under robust MLR estimation with full-information maximum likelihood to handle missing data, to compare constrained and unconstrained models. A significant χ^2 difference indicates that the constrained effect differs across groups, providing a statistically rigorous and scalable test of moderation, even when moderators span many levels.

Results

Associations Between Sexual Abuse in Childhood and Adolescence/Adulthood and Sexual Function Problems and Distress

The 3D regression plane associating CSA and AASA with sexual distress revealed a significant linear plane in which the greater the exposure to CSA ($b = 0.15$, $p < .001$) and/or AASA ($b = 0.16$, $p < .001$), the greater the severity of sexual distress (see Figure 1). The Johnson–Neyman technique indicated that there were no borders to the plane; in other words, exposure to CSA predicted sexual distress regardless of exposure to AASA and vice versa.

A more complex regression plane was observed for the association between CSA and AASA and sexual function problems. On the one hand, we found that the greater the exposure to CSA ($b = 0.04$, $p = .020$) and/or AASA

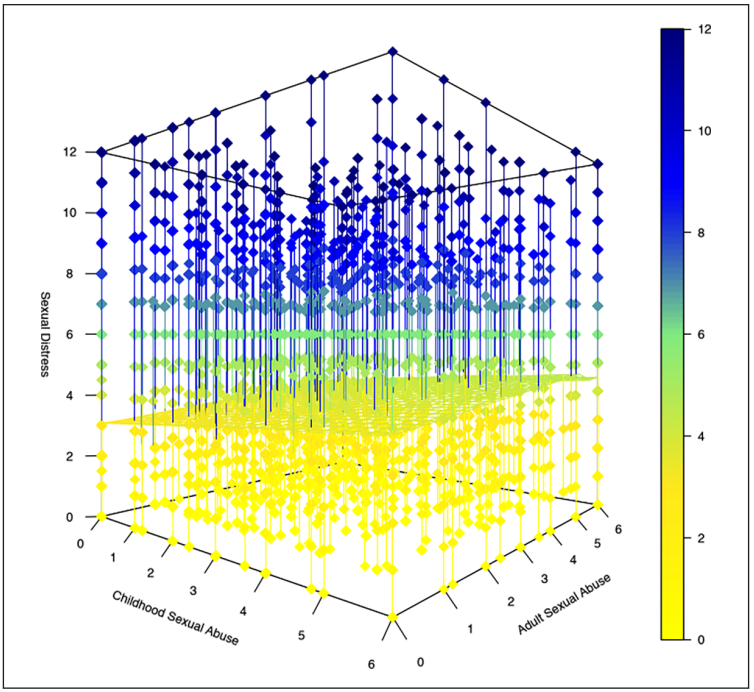

Figure 1. Three-dimensional association between CSA, AASA, and sexual distress.

Note. This plot visualizes the joint effects of CSA and AASA on sexual distress using a regression plane overlaid on observed data points. Color represents the level of sexual distress (yellow = low, blue = high), and the height of each point corresponds to individual scores. The analysis revealed a significant linear trend: both CSA ($b = 0.15$, $p < .001$) and AASA ($b = 0.16$, $p < .001$) were independently associated with greater sexual distress, with no interaction effect. The Johnson–Neyman technique indicated that these effects were consistent across the entire range of the other variable—that is, CSA predicted distress regardless of AASA levels and vice versa. CSA = childhood sexual abuse; AASA = adolescent/adult sexual assault.

($b = 0.18$, $p < .001$), the greater the severity of sexual function problems (see Figure 2). On the other hand, the Johnson–Neyman technique revealed significant borders to these effects. Specifically, higher exposure to CSA predicted greater severity of sexual function problems only among participants with less than average exposure to AASA (i.e., less than a *Z*-score of

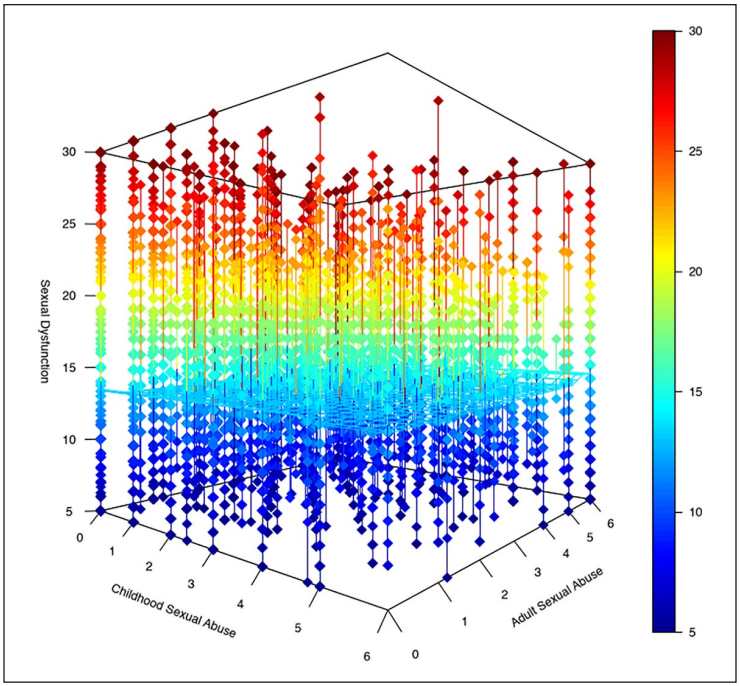

Figure 2. Three-dimensional association between CSA, AASA, and sexual function problems.

Note. This figure shows the complex interaction between CSA and AASA in predicting sexual function problems. Both CSA ($b = 0.04$, $p = .020$) and AASA ($b = 0.18$, $p < .001$) were associated with greater dysfunction, but the relationship was moderated by their interaction. Color intensity and height correspond to the severity of sexual function problems (blue = low, red = high). Johnson–Neyman analysis revealed that CSA predicted increased dysfunction only when AASA exposure was below a *Z*-score of 0.13, and predicted decreased dysfunction when AASA was above 1.27. Similarly, AASA predicted increased dysfunction primarily when CSA was low ($< Z = 2.75$) and predicted decreased dysfunction when CSA was very high ($> Z = 4.50$). Thus, the peak in dysfunction was observed at moderate levels of CSA combined with high levels of AASA. CSA = childhood sexual abuse; AASA = adolescent/adult sexual assault.

0.13). Conversely, the level of exposure to CSA predicted *lower* severity of sexual function problems among participants with relatively high exposure to AASA (i.e., higher than a *Z*-score of 1.27). Similarly, exposure to AASA predicted greater severity of sexual function problems only among

participants with higher exposure to CSA, less than a *Z*-score of 2.75. Conversely, exposure to AASA predicted *lower* severity of sexual function problems among participants with high exposure to CSA (i.e., higher than a *Z*-score of 4.50; $n = 605$, 0.79% of the sample). In other words, the peak of sexual function problems was revealed to be across a plane in which CSA was between *Z*-scores of 0.13 to 1.27 (slightly above the average, which ranges in raw scores between 0.72 and 2), and AASA between *Z*-scores of 2.75 to 4.5 (ranging in raw scores from 5 to almost 6). In simpler terms, the peak of sexual function problems appeared among participants with slightly above-average CSA and high levels of AASA.

Differences by Genders

Slopes of each effect are presented in Supplemental Table 1. Satorra–Bentler chi-square tests revealed differences between genders in the effect of AASA ($\chi^2[2] = 77.72$, $p < .001$, $\chi^2[2] = 10.23$, $p = .006$) for sexual function problems and sexual distress, respectively. No significant differences were observed in CSA ($\chi^2[2] = 4.74$, $p = .093$ and $\chi^2[2] = 5.97$, $p = .051$) or in the interaction between CSA and AASA in terms of problems in sexual function or sexual distress ($\chi^2[2] = 3.06$, $p = .216$, $\chi^2[2] = 2.75$, $p = .253$). The results revealed that whereas among men, there was no significant association between AASA and sexual function problems, there was a significant negative association among women: The higher the exposure to AASA, the fewer the sexual function problems ($b = -0.20$, $p < .001$). Regarding the association between CSA and sexual distress, the model indicated that the magnitude of the positive association was significantly weaker among gender-diverse individuals than among men and women.

Differences by Sexual Orientations

Slopes of each effect are presented in Supplemental Table 2. Satorra–Bentler chi-square tests revealed differences between sexual orientations in the effect of CSA ($\chi^2[7] = 19.66$, $p = .006$ and $\chi^2[7] = 15.07$, $p = .035$), AASA ($\chi^2[7] = 37.86$, $p < .001$, $\chi^2[7] = 24.19$, $p < .001$), and their interactions (CSA + AASA; $\chi^2[7] = 29.48$, $p < .001$, $\chi^2[7] = 23.87$, $p < .001$) on sexual function problems and on sexual distress, respectively. Regarding the effect of both CSA and AASA on sexual function problems, we found that the associations among heterosexual and bisexual individuals were significantly different than among those who defined themselves as asexual or queer individuals. Overall, we found that among heterosexual and bisexual individuals, CSA and AASA were linked with greater sexual function problems.

Conversely, among asexual or queer participants, CSA was related to fewer sexual function problems, whereas AASA was not significantly associated with sexual function problems.

Regarding the effect of CSA on sexual distress, we found that whereas the association between CSA and sexual distress was positive and significant among most sexual orientation groups, there was no association among participants who identified as queers or pansexual ($b = 0.01$, $p = .85$). In addition, there were significant differences in the magnitudes of the associations between CSA and sexual distress. Specifically, the strongest positive association was found among asexual participants; the lowest (yet still significant) association was found among participants who identified as queer, pansexual, homoflexible, and heteroflexible; and an intermediate magnitude was found among participants who were either heterosexual or gay/lesbian.

Differences by Country

Slopes of each effect are presented in Supplemental Table 3. Satorra–Bentler chi-square tests revealed differences between countries in the effect of CSA ($\chi^2[41] = 119.03$, $p < .001$ and $\chi^2[41] = 56.72$, $p = .052$) and AASA ($\chi^2[41] = 156.27$, $p < .001$, $\chi^2[41] = 93.45$, $p < .001$) on problems in sexual function and sexual distress, respectively. Significant differences in the interaction were found for sexual function problems ($\chi^2[41] = 60.16$, $p = .027$), but not for sexual distress ($\chi^2[41] = 47.26$, $p = .232$). The interaction effects are plotted in Figure 3, and the effects of CSA and AASA are presented in Supplemental Figures 1 and 2. The strongest associations between CSA and sexual function problems and sexual distress were found in Algeria. The second strongest association between CSA and sexual distress was found in Iraq. Overall, however, the effects of CSA and/or AASA on sexual function problems and sexual distress tended to be weak in most countries. The detailed interaction effects of CSA and AASA on sexual function problems and sexual distress by gender, sexual orientation, and country are presented in Table 1.

Discussion

In the current study, we addressed existing gaps in scientific literature by examining the associations between CSA, AASA, and sexual function and distress in a large international sample. The findings corroborate previous research demonstrating the robust associations between both CSA and AASA and elevated levels of sexual distress, with each form of sexual violence independently correlating with higher levels of distress regardless of the level of exposure to the other (Bigras et al., 2021; Stephenson et al.,

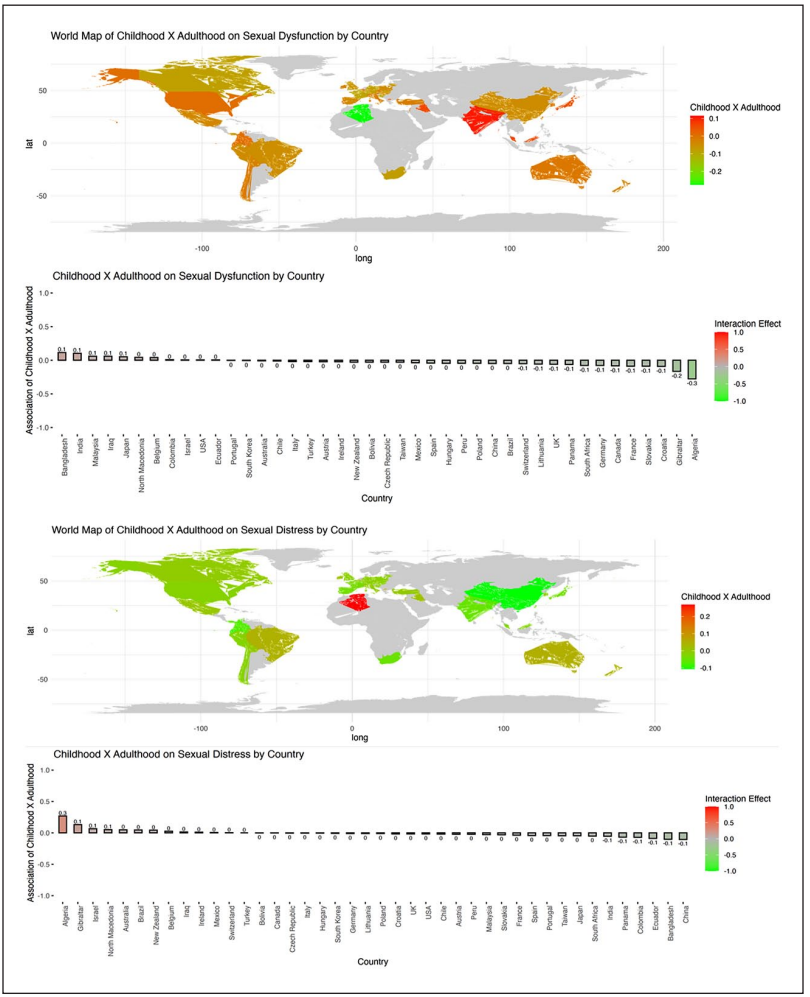

Figure 3. Size and direction of the interaction.

2012). In terms of sexual function, a more intricate relationship emerged: while both CSA and AASA were associated with greater sexual function problems overall—a finding that aligns with previous studies (Gewirtz-Meydan & Opuda, 2022; Pulverman & Creech, 2021; Pulverman et al., 2018; Wang et al., 2023), their effects interacted in complex ways. Specifically, CSA was linked to more sexual function problems primarily

Table 1. The Significant Interaction Effects of CSA and AASA on Sexual Function Problems and Sexual Distress by Gender.

		Sexual Function Problems		Sexual Distress	
Group	Effect	*b*	*p*	*b*	*p*
Gender					
Men	Interaction	−0.01	.206	−0.03	**<.001**
Women	Interaction	0.01	.237	−0.03	**<.001**
Sexual orientation					
Heterosexual	Interaction	−0.06	**<.001**	−0.03	**<.001**
Bisexual	Interaction	−0.07	**<.001**	−0.01	.523
Queer/pansexual	Interaction	0.04	.108	0.05	**.006**
Homo-hetero flexible	Interaction	−0.07	**.001**	−0.01	.388
Asexual	Interaction	0.11	.053	−0.07	**.033**
Country					
Canada	Interaction	−0.08	**.010**	0.00	.913
China	Interaction	−0.08	**.029**	−0.09	**<.001**
Colombia	Interaction	0.01	.778	−0.07	**.015**
Croatia	Interaction	−0.16	**.001**	−0.02	.539
France	Interaction	−0.11	**.014**	−0.03	.272
Germany	Interaction	−0.12	**<.001**	−0.01	.612
Hungary	Interaction	−0.09	**<.001**	−0.01	.650
Lithuania	Interaction	−0.10	**.029**	−0.01	.684
Poland	Interaction	−0.09	**<.001**	−0.02	.328
Slovakia	Interaction	−0.15	**.008**	−0.04	.410
South Africa	Interaction	−0.12	**.009**	−0.05	.142

Note. CSA = child sexual abuse; AASA = adolescent/adult sexual assault. Bold values are statistically significant at $p < .05$.

among those with low to moderate AASA exposure, whereas at high levels of AASA exposure, the association between CSA and function problems weakened or reversed. Similarly, AASA predicted greater sexual function problems, mainly among those with low CSA exposure.

These associations can be better understood through several theoretical lenses. The Traumagenic Dynamics Model (Finkelhor & Browne, 1985) helps explain why both CSA and AASA were independently associated with heightened sexual distress. This model posits that experiences of betrayal, stigmatization, and powerlessness disrupt foundational developmental processes, shaping negative internalized beliefs about sexuality and the self. These dynamics may give rise to persistent emotional discomfort and distress in sexual contexts, even when only one form of abuse occurred, by instilling enduring feelings of shame, distrust, and confusion about intimacy.

Similarly, the Self-Trauma Model (Briere & Scott, 2014) provides a useful lens through which to interpret the complex interaction between CSA and AASA in relation to sexual function. According to this model, early interpersonal trauma impairs emotional regulation, cognitive processing, and the development of a coherent sense of self. These disruptions may help explain why sexual function problems peaked among individuals with moderate CSA and high AASA exposure, as cumulative trauma can overwhelm coping mechanisms, intensify dissociation, or impair sexual responsiveness. In contrast, among those with very high levels of CSA or AASA, numbing or avoidance might attenuate perceived difficulties, offering a potential explanation for the nonlinear patterns observed.

However, surprisingly, we found that the effect of CSA or AASA differed based on exposure to the other type of abuse. Specifically, higher exposure to CSA predicted greater sexual function problems among those with lower exposure to AASA, and vice versa, indicating a nuanced interplay between the two forms of abuse and their associations with sexual function. One possible explanation is that survivors who experienced both CSA and AASA—that is, those revictimized—may navigate a more complicated sexual landscape. Their sexual function may coexist with deep-seated feelings of shame, guilt, or dissociation during sexual activity (Gewirtz-Meydan & Lassri, 2022; Pulverman & Meston, 2020). Additionally, at higher levels of trauma exposure, some individuals may exhibit response saturation, developing dissociative defenses or emotional numbing that dampen subjective reports of distress. These responses can dampen subjective sexual distress as postulated by the embodiment theory, which emphasizes how trauma becomes ingrained in the body and may disrupt interoceptive awareness. As a result, survivors may experience confusion between arousal and threat, or detachment from bodily sensations during intimacy (B. van der Kolk, 1994;

B. A. Van der Kolk, 2014). Moreover, survivors with more extensive trauma histories may also have greater access to therapeutic interventions, which could contribute to reduced self-reported distress (Menschner & Maul, 2016). Lastly, the associations between trauma and sexual function may become nonlinear at extreme exposure levels (Bonanno, 2008), reflecting complex adaptations or redefinitions of sexual identity and experience. These findings underscore the importance of future research that examines mechanisms like coping strategies, trauma-related schemas, and help-seeking behaviors that might explain this attenuation effect.

Significant differences were noted across countries in terms of the associations between CSA and AASA and sexual function and distress. Although the strongest associations between CSA and sexual problems were identified in Algeria, followed by Iraq, it is important to note that these findings are based on very small samples in these countries. Nonetheless, the inclusion of non-WEIRD countries remains crucial for a more comprehensive understanding of these associations (Klein et al., 2022). Cross-cultural variation may play a critical role in shaping how both sexual abuse and sexuality are experienced and reported. In some cultures, values related to shame, silence, and family honor may inhibit the disclosure or recognition of abuse (Mensah et al., 2024; Sawrikar & Katz, 2017a), while sexual beliefs may shape how sexual difficulties are perceived, expressed, and addressed in different cultures (Hall, 2019). Conversely, in countries with more open discussions of sexuality and greater access to trauma-informed care, the psychological impact of CSA and AASA on sexual outcomes may be mitigated (Sanjeevi et al., 2018). Disparities in access to trauma-informed care, sexual health services, and education may further amplify or reduce these associations (Fontes & Plummer, 2010).

Our cross-cultural findings highlight that variations across countries likely reflect these broader cultural dynamics, including stigma, gendered expectations, and the taboo surrounding sexual trauma (Reddock et al., 2022). For example, stronger associations between CSA and sexual distress in countries such as Algeria and Iraq may be linked to cultural norms that limit open discussions of abuse and discourage help-seeking (Mensah et al., 2024). These insights underscore the need for culturally sensitive and contextually informed approaches when interpreting the effects of sexual abuse on sexual health and call for future research that moves beyond WEIRD-centric frameworks to incorporate diverse cultural perspectives (Sawrikar & Katz, 2017b).

The findings showed variations among sexual orientations regarding the potential associations of CSA and AASA with sexual function and distress. Heterosexual and bisexual individuals with greater CSA and AASA exposure experienced a greater number of sexual function problems, whereas asexual

or queer individuals showed different patterns. Despite the exposure to CSA and AASA, these individuals did not show the same increase in sexual function problems. Similar patterns were found for the association between CSA and sexual distress, with the association between CSA and sexual distress being nonsignificant among participants who identified as queer or pansexual. In addition, the magnitudes of associations between CSA and sexual distress varied among different sexual orientation groups, with asexual participants showing the strongest positive association. These disparities may stem from various factors. Individuals identifying as queer, asexual, or pansexual may experience sexual distress and functional issues independent of abuse, due to pervasive stigma and internalized homophobia (Flynn et al., 2017; Grabski et al., 2019; Li et al., 2019). Moreover, they might also endure other forms of victimization, such as significant parental rejection and school-based bullying related to their sexual or gender identity, further obfuscating the role of CSA in their sexual function and distress (Friedman et al., 2011; Wilson & Cariola, 2020).

The lack of significant differences in CSA or its interaction with AASA for either sexual function or distress between men and women is an important finding. This aspect, often overlooked in discussions concerning men (Gewirtz-Meydan & Opuda, 2022), highlights the notion that CSA may be related to lower sexual function and distress for all genders, despite being less examined in among men or gender-diverse individuals. However, gender-related differences became apparent, particularly regarding the association between AASA and sexual function. Among women, higher exposure to AASA correlated with fewer sexual function problems. While counterintuitive, this finding aligns with developmental and trauma-focused models, suggesting that early abuse may have a more profound impact on sexual functioning than abuse experienced later in life. The Traumagenic Dynamics Model (Finkelhor & Browne, 1985) and the Self-Trauma Model (Briere & Scott, 2014) emphasize that childhood abuse can disrupt core developmental processes, leading to lasting impairments in sexuality. When abuse occurs early, individuals may become prematurely sexualized, forming internal working models shaped by trauma that distort how they perceive themselves and others in intimate contexts—undermining healthy relationships and reinforcing a sense of being sexually exploitable (Finkelhor & Browne, 1985). In contrast, AASA may be less developmentally disruptive, particularly if it occurs after a stable sexual self-concept has been established. Embodiment theory (B. van der Kolk, 1994; B. A. Van der Kolk, 2014) similarly suggests that early trauma becomes encoded in the body, potentially resulting in long-term sexual difficulties, whereas adult trauma may be less deeply internalized. Together, these models help contextualize why AASA was not associated

with greater sexual function problems among women and may, in some cases, have had a weaker impact than CSA.

The analysis revealed that the positive association between CSA and sexual distress was notably weaker among gender-diverse individuals than it was among men and women. This finding suggests that gender-diverse individuals may face unique challenges that affect their experience of sexual distress and problems. These challenges may include societal stigmatization, discrimination, and lack of access to affirming healthcare services. One possible explanation for the weaker association is that gender-diverse individuals might already be experiencing heightened levels of sexual distress due to other factors, such as gender dysphoria, minority stress, and lack of adequate support systems (Holt et al., 2023). These preexisting factors could potentially overshadow the impact of CSA on sexual distress, making the association appear weaker. For those who have undergone surgery as part of their transition, there may be significant complications with sexual function (Schardein & Nikolavsky, 2022). Additionally, gender-diverse individuals may develop unique coping mechanisms or resilience strategies to navigate these complex challenges (Gorman et al., 2020), which might also mitigate the direct impact of CSA on their sexual distress. Therefore, the attenuated association between CSA and sexual distress highlights the complex interplay of factors influencing sexual well-being in gender-diverse individuals.

Clinical Implications

The study findings have implications for clinical practice and intervention strategies. Recognizing the complex interplay between CSA, AASA, sexual function, and distress is crucial for clinicians working with survivors. Clinicians in the field of trauma must develop appropriate knowledge of sexual health, and should not assume that resolving trauma alone will lead to sexual well-being (O'Driscoll & Flanagan, 2016). Treatment of sexual abuse must be informed by considerations of sexual health, just as sex therapy must be adapted through a trauma-informed lens. Survivors of sexual abuse often experience arousal-related shame, dissociation, or intrusive memories, particularly when their bodies responded physiologically during nonconsensual encounters (Gewirtz-Meydan & Lassri, 2022). Sex therapy approaches or techniques, such as sensate focus (Gewirtz-Meydan, 2025) or mindfulness-based techniques (Brotto et al., 2012), should be adapted through a trauma-informed lens when working with survivors of sexual abuse, as they may inadvertently trigger distress if not adjusted to account for trauma histories (Gewirtz-Meydan, 2022; MacIntosh et al., 2020). Therapists must therefore incorporate trauma-sensitive sex therapy, blending exposure-based trauma

treatments, such as such as Prolonged Exposure (PE) or Eye Movement Desensitization and Reprocessing (EMDR; Menschner & Maul, 2016) with adapted sexual interventions that foster safety and embodiment (Vechiu, 2019). The PLISSIT (Permission, Limited Information, Specific Suggestions, Intensive Therapy) and EX-PLISSIT (extended) models, which emphasize permission-giving, individualized pacing, and therapist reflexivity, offer a useful framework (Annon, 1976; Cicek Ozdemir et al., 2024; Vechiu, 2019). Equally, trauma-focused therapy should integrate ongoing assessment of sexual function, as it may yield secondary benefits in this domain (Steil et al., 2024). A dual focus—one that simultaneously addresses trauma and sexual well-being—appears to be the most effective and ethical approach for promoting healing in this sensitive intersection.

Moreover, the study highlights the urgent need for gender- and culture-sensitive interventions. Men and gender-diverse individuals reported similar levels of sexual distress and dysfunction, yet their experiences are often neglected in both research and therapy (Gewirtz-Meydan & Opuda, 2022). Masculinity-based shame, reluctance to seek help, and social stigma may compound the effects of sexual trauma for male survivors. Clinicians must be aware of these barriers and actively address them in treatment. Gender-diverse survivors face additional challenges such as gender dysphoria, discrimination, or inadequate access to affirming care (Schardein & Nikolavsky, 2022), requiring tailored support. Finally, given the cross-cultural nature of this study, clinicians must understand how cultural norms surrounding sexuality can shape disclosure, meaning-making, and symptom expression (Gewirtz-Meydan et al., 2024; Lefevor et al., 2024). Integrating cultural competence into trauma and sex therapy training can foster safer environments for healing and increase access for marginalized populations. By integrating trauma-focused therapies with adapted sex therapy modalities, accounting for gender and cultural differences, and promoting an open, client-centered dialogue around sexuality, clinicians can better support survivors' holistic recovery and sexual well-being.

Strengths, Limitations, and Future Research

Spanning 42 countries, the ISS offers a comprehensive approach to examining the association between sexual violence and sexual well-being. Its substantial sample size and rigorous methodology enhance the reliability and generalizability of its findings, while its commitment to open-science practices ensures transparency and reproducibility. Despite the notable strengths, some general limitations should be considered in all studies using this dataset (for a better overview, see https://osf.io/n3k2c/files/osfstorage).

Study-specific limitations include the conceptual grouping of AASA into a single construct. While this decision reflects the structure of the SAHQ used in the ISS dataset, it may obscure important developmental differences in trauma processing and outcomes (Buczó et al., 2025). Future studies should adopt measures that differentiate between adolescent and adult experiences to better capture these developmental nuances. Another limitation is the inability to directly assess clinical sexual dysfunction according to the formal diagnostic criteria. In other words, the study may not fully capture the nuances of sexual dysfunction experienced by survivors of sexual abuse. Additionally, the absence of some trauma-related measures, such as PTSD assessments, hinders a comprehensive understanding of the mediating effects of trauma on the association between sexual abuse and sexual function and distress. It is important to note that in this study, we did not directly examine traumatized sexuality, which refers to the psychological and emotional impact of trauma on an individual's sexual experiences, desires, and behaviors, particularly trauma embedded within sexual activity (Gewirtz-Meydan & Lassri, 2022).

Furthermore, the study lacks detailed information about the characteristics of the abuse experienced by participants, including the age of the survivor at the time of abuse, the identity and gender of the perpetrator, the frequency and duration of the abuse, the location of the abuse, and whether the abuse was disclosed. These characteristics are crucial for understanding the association between CSA and AASA and sexual function problems and sexual distress, and would provide insights into the nature of the abuse experienced by survivors, as well as the contextual factors that might influence impacts on sexual outcomes. Importantly, given the global scope of the study, our operationalization of CSA, although based on internationally recognized frameworks (i.e., WHO and CDC), may not fully reflect the cultural and legal diversity of definitions across countries. Future research should explore how local norms and legal distinctions shape both the experience and reporting of abuse. On the one hand, the use of a standardized cutoff at age 14 facilitates consistency across the 42 countries included in the study, where definitions of adolescence and legal ages of consent vary considerably. It is also supported by a large study conducted in the United States, indicating that peer-perpetrated sexual violence becomes more common around this age (Gewirtz-Meydan & Finkelhor, 2020). On the other hand, combining adolescent and adult experiences into a single construct may obscure important developmental and psychological distinctions.

The study also did not include information on the various types of sexual function problems, such as erectile dysfunction, orgasmic disorders, and pain

disorders, and their specific associations with CSA. This missing information limits the ability to fully understand the range of sexual dysfunctions that may be linked to CSA. Additionally, there may be biased recall among participants, as survivors of sexual abuse might have varying degrees of memory and willingness to disclose their experiences, which can affect the accuracy of the data collected.

Finally, given that sexual function and distress are often experienced within the context of intimate relationships, it is imperative that future studies be conducted in a dyadic setting. The abovementioned limitations underscore the need for future research to address these gaps and provide a more comprehensive understanding of the impact of sexual abuse on survivors' sexual function and distress.

Conclusion

This study contributes to a deeper understanding of the multifaceted relationship between CSA and AASA and sexual well-being across diverse demographic groups and cultural contexts. Our findings indicate that CSA and AASA are significantly correlated with heightened sexual distress, regardless of exposure to the other form of abuse. Both forms of abuse also relate to greater sexual function problems, with variations seen across countries and sexual orientations. It is important to recognize these complexities and tailor interventions that aim to promote sexual well-being, accordingly, taking into consideration cultural backgrounds, gender identity, sexual orientation, and individual experiences.

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Supplemental Material

Supplemental material for this article is available online.

Note

1. Egypt, Iran, Pakistan, and Romania were included in the study protocol paper as collaborating countries (Bőthe et al., 2021). However, it was not possible to obtain ethical approval for the study in a timely manner from these countries. Chile was not included in the study protocol paper as a collaborating country (Bőthe et al., 2021) as it joined the study after the study protocol was published. Therefore, instead of the planned 45 countries (Bőthe et al., 2021), only 42 individual countries were considered in the present study; see details at https://osf.io/n3k2c/.

References

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. American Psychiatric Association.

Annon, J. S. (1976). The PLISSIT model: A proposed conceptual scheme for the behavioral treatment of sexual problems. *Journal of Sex Education and Therapy*, *2*(1), 1–15. https://doi.org/10.1080/01614576.1976.11074483

Ballester-Arnal, R., Elipe-Miravet, M., Castro-Calvo, J., Beltrán-Martínez, P., Nagy, L., Koós, M., Kraus, S. W., Demetrovics, Z., Potenza, M. N., Batthyány, D., Bergeron, S., Billieux, J., Briken, P., Burkauskas, J., Cárdenas-López, G., Carvalho, J., Chen, J. K., Chen, L., Ciocca, G.,& . . . Bőthe, B. (2025). Cross-cultural validation of the Arizona Sexual Experience Scale (ASEX) in 42 countries and 26 languages. *Sexuality Research and Social Policy*, *22*, 1307–1329. https://doi.org/10.1007/s13178-024-01040-0

Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health*, *58*(3), 469–483. https://doi.org/10.1007/s00038-012-0426-1

Beaton, D. E., Bombardier, C., Guillemin, F., & Ferraz, M. B. (2000). Guidelines for the process of cross-cultural adaptation of self-report measures. *Spine*, *25*(24), 3186–3191.

Bigras, N., Vaillancourt-Morel, M. P., Nolin, M. C., & Bergeron, S. (2021). Associations between childhood sexual abuse and sexual well-being in adulthood: A systematic literature review. *Journal of Child Sexual Abuse*, *30*(3), 332–352. https://doi.org/10.1080/10538712.2020.1825148

Bonanno, G. A. (2008). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *Psychological Trauma: Theory, Research, Practice, and Policy*, S(1), 101–113. https://doi.org/10.1037/1942-9681.s.1.101

Bőthe, B., Koós, M., Nagy, L., Kraus, S. W., Potenza, M. N., & Demetrovics, Z. (2021). International Sex Survey: Study protocol of a large, cross-cultural collaborative study in 45 countries. *Journal of Behavioral Addictions*, *10*, 632–645. https://doi.org/10.1556/2006.2021.00063

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, T. Reid, & C. Jenny (Eds.), *The APSAC handbook on child maltreatment* (2nd ed., pp. 175–202). Sage Publications.

Briere, J., & Scott, C. (2014). Principles of trauma therapy: A guide to symptoms, evaluation, and treatment (2nd ed.). Sage.

Brotto, L. A., Seal, B. N., & Rellini, A. (2012). Pilot study of a brief cognitive behavioral versus mindfulness-based intervention for women with sexual distress and a history of childhood sexual abuse. *Journal of Sex & Marital Therapy*, *38*(1), 1–27. https://doi.org/10.1080/0092623X.2011.569636

Buczó, D., Koós, M., Nagy, L., Demetrovics, Z., & Bőthe, B. (2025). Further investigation on sexual abuse experiences: Revisiting the psychometric properties of the Sexual Abuse History Questionnaire and the content of its open-ended item. *Sexuality Research and Social Policy*, *22*(1), 211–225. https://doi.org/10.1007/s13178-023-00919-8

Centers for Disease Control and Prevention (CDC). (2018). *Sexual Violence: Definitions*. https://www.cdc.gov/sexual-violence/about/index.html

Cicek Ozdemir, S., Dogan Gangal, A., & Senturk Erenel, A. (2024). The effect of sexual counseling based on PLISSIT and EX-PLISSIT models on sexual function, satisfaction, and quality of life: A systematic review and meta-analysis. *Archives of Sexual Behavior*, *53*(9), 3485–3513. https://doi.org/10.1007/s10508-024-02898-2

Derogatis, L. R., Rosen, R., Leiblum, S., Burnett, A., & Heiman, J. (2002). The Female Sexual Distress Scale (FSDS): Initial validation of a standardized scale for assessment of sexually related personal distress in women. *Journal of Sex and Marital Therapy*, *28*(4), 317–330. https://doi.org/10.1080/00926230290001448

DiMauro, J., Renshaw, K. D., & Blais, R. K. (2018). Sexual vs. non-sexual trauma, sexual satisfaction and function, and mental health in female veterans. *Journal of Trauma and Dissociation*, *19*(4), 403–416. https://doi.org/10.1080/15299732.2018.1451975

Dworkin, E. R., Krahé, B., & Zinzow, H. (2021). The global prevalence of sexual assault: A systematic review of international research since 2010. *Psychology of Violence*, *11*(5), 497–508. https://doi.org/10.1037/vio0000374

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A Conceptualization. *American Journal of Orthopsychiatry*, *55*(4), 530–541. https://doi.org/10.1111/j.1939-0025.1985.tb02703.x

Flynn, K. E., Lin, L., & Weinfurt, K. P. (2017). Sexual function and satisfaction among heterosexual and sexual minority U.S. adults: A cross-sectional survey. *PLoS One*, *12*(4), e0174981. https://doi.org/10.1371/journal.pone.0174981

Fontes, L. A., & Plummer, C. (2010). Cultural issues in disclosures of child sexual abuse. *Journal of Child Sexual Abuse*, *19*(5), 491–518. https://doi.org/10.1080/10538712.2010.512520

Friedman, M. S., Marshal, M. P., Guadamuz, T. E., Wei, C., Wong, C. F., Saewyc, E. M., & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health*, *101*(8), 1481–1494. https://doi.org/10.2105/AJPH.2009.190009

Gewirtz-Meydan, A. (2022). Treating sexual dysfunctions among survivors of child sexual abuse: An overview of empirical research. *Trauma, Violence, & Abuse*, *23*(3), 840–853. https://doi.org/https://doi.org/10.1177/1524838020979842

Gewirtz-Meydan, A. (2025). Adapting sensate focus for sexual abuse survivors: A trauma-informed approach to reclaiming body and intimacy. *Sexual Health and Compulsivity*, *32*(3), 205–220. https://doi.org/10.1080/26929953.2025.2479548

Gewirtz-Meydan, A., & Finkelhor, D. (2020). Sexual abuse and assault in a large national sample of children and adolescents. *Child Maltreatment*, *25*(2), 203–214. https://doi.org/10.1177/1077559519873975

Gewirtz-Meydan, A., & Lassri, D. (2022). Sex in the shadow of child sexual abuse: The Development and Psychometric Evaluation of the Post-Traumatic Sexuality (PT-SEX) Scale. *Journal of Interpersonal Violence*, *38*(5–6), 4714–4741. https://doi.org/10.1177/08862605221118969

Gewirtz-Meydan, A., & Opuda, E. (2022). The impact of CSA on men's sexual function: A systematic review. *Trauma, Violence & Abuse*, *23*(1), 265–277. https://doi.org/10.1177/1524838020939134

Gewirtz-Meydan, A., Sowan, W., Estlein, R., & Winstok, Z. (2024). Rights or obligations: The extent to which sexual desire and gender roles determine sexual intimacy in romantic relationships. *Journal of Sex and Marital Therapy*. https://doi.org/10.1080/0092623X.2024.2310693

Gorman, K. R., Shipherd, J. C., Collins, K. M., Gunn, H. A., Rubin, R. O., Rood, B. A., & Pantalone, D. W. (2020). Coping, resilience, and social support among transgender and gender diverse individuals experiencing gender-related stress. *Psychology of Sexual Orientation and Gender Diversity*, *9*(1), 37–48. https://doi.org/10.1037/sgd0000455

Grabski, B., Kasparek, K., Müldner-Nieckowski, Ł., & Iniewicz, G. (2019). Sexual quality of life in homosexual and bisexual men: The relative role of minority stress. *Journal of Sexual Medicine*, *16*(6), 860–871. https://doi.org/10.1016/j.jsxm.2019.03.274

Hailes, H. P., Yu, R., Danese, A., & Fazel, S. (2019). Long-term outcomes of childhood sexual abuse: an umbrella review. *The Lancet Psychiatry*, *6*(10), 830–839. https://doi.org/10.1016/S2215-0366(19)30286-X

Hall, K. S. K. (2019). Cultural differences in the treatment of sex problems. *Current Sexual Health Reports*, *11*(1), 29–34. https://doi.org/10.1007/s11930-019-00189-9

Harlow, B. L., & Stewart, E. G. (2005). Adult-onset vulvodynia in relation to childhood violence victimization. *American Journal of Epidemiology*, *161*(9), 871–880. https://doi.org/10.1093/aje/kwi108

Hendrickx, L., Gijs, L., & Enzlin, P. (2013). Distress, sexual dysfunctions, and DSM: Dialogue at cross purposes? *The Journal of Sexual Medicine*, *10*, 630–641. https://doi.org/10.1111/j.1743-6109.2012.02971.x

Högbeck, I., & Möller, A. (2022). Female sexual function six months after sexual assault: post-traumatic stress disorder strongest risk factor for impaired function. *Journal of Sex and Marital Therapy*, *48*(2), 112–120. https://doi.org/10.1080/0092623X.2021.1958964

Holt, M., Broady, T., Callander, D., Pony, M., Duck-Chong, L., Cook, T., & Rosenberg, S. (2023). Sexual experience, relationships, and factors associated with sexual and romantic satisfaction in the first Australian Trans & Gender Diverse Sexual Health Survey. *International Journal of Transgender Health*, *24*(1), 38–48. https://doi.org/10.1080/26895269.2021.2016540

Irish, L., Kobayashi, I., & Delahanty, D. L. (2010). Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of Pediatric Psychology*, *35*(5), 450–461. https://doi.org/10.1093/jpepsy/jsp118

Ishak, W. W., & Tobia, G. (2013). DSM-5 changes in diagnostic criteria of sexual dysfunctions. *Reproductive System & Sexual Disorders*, *2*(2), 122. https://doi.org/10.4172/2161-038X.1000122

Kelley, E. L., & Gidycz, C. A. (2018). Posttraumatic stress and sexual functioning difficulties in college women with a history of sexual assault victimization. *Psychology of Violence*, *9*(1), 98–107. https://doi.org/10.1037/vio0000162

Klein, V., Savaş, Ö., & Conley, T. D. (2022). How WEIRD and androcentric is sex research? Global inequities in study populations. *Journal of Sex Research*, *59*(7), 810–817. https://doi.org/10.1080/00224499.2021.1918050

Leclerc, B., Bergeron, S., Binik, Y. M., & Khalifé, S. (2010). History of sexual and physical abuse in women with dyspareunia: Association with pain, psychosocial adjustment, and sexual functioning. *The Journal of Sexual Medicine*, *7*(2), 971–980. https://doi.org/10.1111/j.1743-6109.2009.01581.x

Lefevor, G. T., Sorrell, S. A., & Skidmore, S. J. (2024). How and why religiousness influences sexual health: A review. *Current Sexual Health Reports*, *16*(3), 185–194. https://doi.org/10.1007/s11930-024-00390-5

Leserman, J., Drossman, D. A., & Li, Z. (1995). The reliability and validity of a sexual and physical abuse history questionnaire in female patients with gastrointestinal disorders. *Behavioral Medicine*, *21*(3), 141–150. https://doi.org/10.1080/08964289.1995.9933752

Li, D. H., Remble, T. A., Macapagal, K., & Mustanski, B. (2019). Stigma on the streets, dissatisfaction in the sheets: Is minority stress associated with decreased sexual functioning among young men who have sex with men? *Journal of Sexual Medicine*, *16*(2), 267–277. https://doi.org/10.1016/j.jsxm.2018.12.010

Lin, C. Y., Tsai, M. C., Koós, M., Nagy, L., Kraus, S. W., Demetrovics, Z., Potenza, M. N., Ballester-Arnal, R., Batthyány, D., Bergeron, S., Billieux, J., Briken, P., Cárdenas-López, G., Carvalho, J., Castro-Calvo, J., Chen, L., Ciocca, G., Corazza, O., Csako, R. I.,& . . . Bőthe, B. (2024). The short version of the Sexual Distress Scale (SDS-3): Measurement invariance across countries, gender identities, and sexual orientations. *International Journal of Clinical and Health Psychology*, *24*(2), 100461. https://doi.org/10.1016/j.ijchp.2024.100461

MacIntosh, H., Vaillancourt-Morel, M.-P., & Bergeron, S. (2020). Sex and couple therapy with survivors of childhood trauma. In Y. M. Binik & K. Hall (Eds.), *Principles and Practice of Sex Therapy* (6th ed.). The Guilford Press.

McCall-Hosenfeld, J. S., Liebschutz, J. M., Spiro, A., & Seaver, M. R. (2009). Sexual assault in the military and its impact on sexual satisfaction in women veterans: A proposed model. *Journal of Women's Health*, *18*(6), 901–909. https://doi.org/10.1089/jwh.2008.0987

McGahuey, C. A., Gelenberg, A. J., Laukes, C. A., Moreno, F. A., Delgado, P. L., McKnight, K. M., & Manber, R. (2000). The Arizona Sexual Experience Scale (ASEX): Reliability and validity. *Journal of Sex & Marital Therapy*, *26*(1), 25–40. https://doi.org/10.1080/009262300278623

Mensah, F., Abdullah, A., & Cudjoe, E. (2024). Unpacking norms shaping disclosure of intrafamilial child sexual abuse. *Discover Psychology*, *4*(1), 170. https://doi.org/10.1007/s44202-024-00286-4

Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation*. www.chcs.org

Muthén, L. K., & Muthén, B. O. (2023). Mplus user's guide (8.8 ed.). Muthén & Muthén.

Nagtegaal, M. H., & Boonmann, C. (2022). Child sexual abuse and problems reported by survivors of CSA: A meta-review. *Journal of Child Sexual Abuse*, *31*(2), 147–176. https://doi.org/10.1080/10538712.2021.1985673

Nagy, L., Bergeron, S., Koós, M., Gewirtz-Meydan, A., Vaillancourt-Morel, M. P., Kraus, S. W., Potenza, M. N., Demetrovics, Z., Dupuis-Fortier, F., & Bőthe, B. (2025). A short screen for lifetime sexual victimization experiences: Expanding research on the Sexual Abuse History Questionnaire (SAHQ) across cultures, genders, and sexual identities. *International Journal of Clinical and Health Psychology*, *25*(1), 100535. https://doi.org/10.1016/j.ijchp.2024.100535

O'Driscoll, C., & Flanagan, E. (2016). Sexual problems and post-traumatic stress disorder following sexual trauma: A meta-analytic review. *Psychology and Psychotherapy: Theory, Research and Practice*, *89*(3), 351–367. https://doi.org/10.1111/papt.12077

Pâquet, M., Rosen, N. O., Steben, M., Mayrand, M. H., Santerre-Baillargeon, M., & Bergeron, S. (2018). Daily anxiety and depressive symptoms in couples

coping with vulvodynia: Associations with women's pain, women's sexual function, and both partners' sexual distress. *Journal of Pain*, *19*(5), 552–561. https://doi.org/10.1016/j.jpain.2017.12.264

Pereda, N., Guilera, G., Forns, M., & Gómez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review*, *29*(4), 328–338. https://doi.org/10.1016/j.cpr.2009.02.007

Pulverman, C. S., Christy, A. Y., & Kelly, U. A. (2019). Military sexual trauma and sexual health in women veterans: A systematic review. *Sexual Medicine Reviews*, *7*(3), 393–407. https://doi.org/10.1016/j.sxmr.2019.03.002

Pulverman, C. S., & Creech, S. K. (2021). The impact of sexual trauma on the sexual health of women veterans: A comprehensive review. *Trauma, Violence, & Abuse*, *22*(4), 656–671. https://doi.org/10.1177/1524838019870912

Pulverman, C. S., Kilimnik, C. D., & Meston, C. M. (2018). The impact of childhood sexual abuse on women's sexual health: A comprehensive review. *Sexual Medicine Reviews*, *6*(2), 188–200. https://doi.org/10.1016/j.sxmr.2017.12.002

Pulverman, C. S., & Meston, C. M. (2020). Sexual dysfunction in women with a history of childhood sexual abuse: The role of sexual shame. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(3), 291–299. https://doi.org/10.1037/tra0000506

Reddock, R., Reid, S. D., & Nickenig, T. (2022). Child sexual abuse and the complexities of gender, power, and sexuality. *Journal of Interpersonal Violence*, *37*(1–2), NP176–NP208. https://doi.org/10.1177/0886260520909193

Rothman, E. F., Exner, D., & Baughman, A. L. (2011). The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: A systematic review. *Trauma, Violence, and Abuse*, *12*(2), 55–66. https://doi.org/10.1177/1524838010390707

Sanjeevi, J., Houlihan, D., Bergstrom, K. A., Langley, M. M., & Judkins, J. (2018). A review of child sexual abuse: Impact, risk, and resilience in the context of culture. *Journal of Child Sexual Abuse*, *27*(6), 622–641. https://doi.org/10.1080/10538712.2018.1486934

Sawrikar, P., & Katz, I. (2017a). Barriers to disclosing child sexual abuse (CSA) in ethnic minority communities: A review of the literature and implications for practice in Australia. *Children and Youth Services Review*, *83*, 302–315. https://doi.org/10.1016/j.childyouth.2017.11.011

Sawrikar, P., & Katz, I. (2017b). The treatment needs of victims/survivors of child sexual abuse (CSA) from ethnic minority communities: A literature review and suggestions for practice. *Children and Youth Services Review*, *79*, 166–179. https://doi.org/10.1016/j.childyouth.2017.06.021

Schardein, J. N., & Nikolavsky, D. (2022). Sexual functioning of transgender females post-vaginoplasty: Evaluation, outcomes and treatment strategies for sexual dysfunction. *Sexual Medicine Reviews*, *10*(1), 77–90). https://doi.org/10.1016/j.sxmr.2021.04.001

Steil, R., Weiss, J., Bornefeld-Ettmann, P., Priebe, K., Kleindienst, N., & Müller-Engelmann, M. (2024). A preliminary study on the effect of trauma-focused

therapies on sexual dysfunctions in women with PTSD after childhood abuse. *Journal of Psychiatric Research*, *170*, 340–347. https://doi.org/10.1016/j.jpsychires.2024.01.013

Stephenson, K. R., Hughan, C. P., & Meston, C. M. (2012). Childhood sexual abuse moderates the association between sexual functioning and sexual distress in women. *Child Abuse and Neglect*, *36*(2), 180–189. https://doi.org/10.1016/j.chiabu.2011.09.015

Swaby, A. N., & Morgan, K. A. D. (2009). The relationship between childhood sexual abuse and sexual dysfunction in Jamaican adults. *Journal of Child Sexual Abuse*, *18*(3), 247–266. https://doi.org/10.1080/10538710902902679

van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

Van Der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, *15*(1), 253–265. http://www.tandfonline.com/doi/abs/10.3109/10673229409017088

Vechiu, C. (2019). The impact of sexual assault on sexual function: Strategies for treatment and prevention. In W. T. O'Donohue & P. A. Schewe (Eds.), *Handbook of Sexual Assault and Sexual Assault Prevention* (pp. 353–368). Springer.

Wang, S. J., Chang, J. J., Cao, L. L., Li, Y. H., Yuan, M. Y., Wang, G. F., & Su, P. Y. (2023). The relationship between child sexual abuse and sexual dysfunction in adults: A meta-analysis. *Trauma, Violence, and Abuse*, *24*(4), 2772–2788. https://doi.org/10.1177/15248380221113780

Wilson, C., & Cariola, L. A. (2020). LGBTQI+ Youth and mental health: A systematic review of qualitative research. *Adolescent Research Review*, *5*(2), 187–211. https://doi.org/10.1007/s40894-019-00118-w

World Health Organization. (1999). *Report of the consultation on child abuse prevention, 29-31 March*. https://apps.who.int/iris/handle/10665/65900

Yehuda, R., Lehrner, A., & Rosenbaum, T. Y. (2015). PTSD and sexual dysfunction in men and women. *Journal of Sexual Medicine*, *12*(5), 1107–1119. https://doi.org/10.1111/jsm.12856

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