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Sexual Anxiety and Eroticism Predict the Development of Sexual Problems in Youth With a History of Sexual Abuse

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Abstract

Youth with confirmed histories of sexual abuse ($N = 118$) were followed longitudinally to examine associations between their initial sexual reactions to abuse and subsequent sexual functioning. Participants were interviewed at abuse discovery (ages 8 through 15) and again 1 and 6 years later. Eroticism and sexual anxiety emerged as distinct indices of abuse-specific sexual reactions and predicted subsequent sexual functioning. Eroticism was associated with indicators of heightened sexuality, including more sexual risk behavior and views of sexual intimacy focused on partners' needs. Sexual anxiety was associated with indicators of diminished sexuality, including few sexual partners and avoidant views of sexual intimacy. Age at abuse discovery moderated some associations, suggesting that the timing of abuse-specific reactions affects trajectories of sexual development. Findings point to the need for a developmental approach to understanding how abuse-specific sexual reactions disrupt sexual development and the need for early interventions promoting healthy sexual development.

Keywords

sexual abuse; sexual risk taking; sexual development; eroticism; adolescence

Sexual problems are among the most reliably identified outcomes of childhood sexual abuse (CSA). Such problems are complex, involving distortions of healthy behavior, cognitions, and emotions about sexuality and intimacy (Bukowski, 1992). Although not all individuals with CSA histories experience sexual problems, those who do tend to exhibit either heightened or diminished patterns of dysfunction (Finkelhor & Browne, 1985; Merrill, Guimond, Thomsen, & Milner, 2003; Noll, Trickett, & Putnam, 2003). Sexual problems related to heightened sexuality include early age of voluntary coitus, more sexual partners, lower birth control efficacy, early pregnancy, sexual preoccupation, and using sex as a means of achieving nonsexual goals (Beitchman, Zucker, Hood, & DaCosta, 1992; Brown, Kessel, Lourie, & Ford 1997; Einbender, & Friedrich, 1989; Fiscella, Kitzman, Cole, Sidora, &

Olds, 1998; Noll, Trickett, et al., 2003; Wyatt, 1988). Problems of diminished sexuality include fear of sex, sexual avoidance, sexual aversion, negative reactions to sex, low sexual arousal, and sexual anxiety (Beitchman, Zucker, Hood, DaCosta, 1991; Briere, 2000; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Johnsen & Harlow, 1996; Merrill et al., 2003; Noll, Trickett, et al., 2003; Stein, Golding, Siegel, Burnam, & Sorenson, 1988; Trickett, Kurtz, & Noll, 2005; Tsun-yin, 1998; Wenninger & Heiman, 1998). Both patterns of dysfunction disrupt individuals' capacities to form and maintain close and satisfying intimate relationships with romantic partners.

Although sexual problems are consistently found among CSA survivors of various ages, little is known about the course of these problems over time. With few exceptions, research on adolescent and adult sexual outcomes is limited by the use of cross-sectional designs and retrospective reports of abuse from adults. Longitudinal research is needed to understand how initial sex-specific reactions to CSA are related to later sexual problems and whether particular kinds of initial reactions predict heightened or diminished sexuality.

The purpose of the current study was to examine how individual differences in sex-specific reactions to CSA help to explain which youth with CSA histories are likely to develop later sexual problems, such as sexual concerns, dysfunctional sexual behavior (e.g., using sex as a means to obtain nonsexual goals), sexual risk taking, and unhealthy views of sexual intimacy. Our focus on sex-specific reactions to CSA as predictors of these problems is rooted in the pressing need to better understand how traumatic sexualization affects the development of sexuality (Finkelhor & Browne, 1985). Traumatic sexualization concerns the aspects of the CSA that put victims at risk for developing inappropriate and dysfunctional views, motivations, and behaviors related to sexual functioning (Finkelhor & Brown, 1985). It entails learning to use sex as a means to manipulate others, misconceptions about sexual behavior and morality, and fear of sexual activity, as well as compulsive sexual behaviors. CSA experiences vary in terms of the amount and kind of traumatic sexualization (Finkelhor & Browne, 1985). Sex-specific reactions to CSA, such as sexual anxiety and eroticism, represent initial indicators of individual differences in traumatic sexualization. Individual differences in initial reactions of sexual anxiety and eroticism may be important to understanding subsequent difficulties in sexual development.

SEX-SPECIFIC REACTIONS TO ABUSE AND SEXUAL BEHAVIOR PROBLEMS

Eroticism and sexual anxiety are distinct reactions to CSA (Crouch, Smith, Ezzell, & Saunders, 1999). According to Yates (1982), children who are eroticized by CSA develop a hypermature sexual responsiveness that is self-reinforcing and sometimes difficult to break. Signs of eroticism include heightened levels of sexual feelings, preoccupation with sexual thoughts, and inability to differentiate sensual from affectionate touch (Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991; Yates, 1982). Children who have been sexually abused display higher levels of eroticism or sexual preoccupation than either nonabused or physically abused peers (Briere et al., 2001; Einbender & Friedrich, 1989). To the extent that eroticized reactions to CSA reflect initial disturbances in sexual development, we expected

that youth who initially respond to CSA in an eroticized way would be more likely to develop sexual problems related to heightened sexuality.

In contrast to eroticism, sexual anxiety in response to CSA includes fear, worry, and distress connected to sexual thoughts and feelings. Conceptualized as an index of traumatic sexualization among sexually abused children (Wolfe et al., 1991), the construct is reminiscent of descriptions of sexual aversion reported among adolescents and adults (Beitchman et al., 1992; Loeb et al., 2002; Tsun-yin, 1998). Indeed, 35% of adults with a history of CSA from a community sample report a fear of sex at some point in their lives (Stein et al., 1988). Women with a history of sexual abuse also report more negative reactions to sex (Charmoli & Athelstan, 1988; Meston, Rellini, & Heiman, 2006) as compared to nonabused women, and those who use avoidant strategies to cope with CSA report fewer sexual partners (Merrill et al., 2003). Little is known about the incidence of sexual anxiety among abused versus nonabused children. However, findings with adults support the prediction that individual differences in a sexually anxious response to CSA would be linked to later indicators of diminished sexuality.

SEX-SPECIFIC REACTIONS TO ABUSE AND VIEWS OF SEXUAL INTIMACY

Disturbances in the self are believed to play an important role in the persistence of abuse-related problems (Putnam, 1990). As such, reactions to CSA may affect not only sexual behavior but also the way youth conceive their sexual identities, including cognitive representations of the sexual aspects of the self (i.e., sexual self-schema) and of sexual relationships. Regarding sexual self-schemas, CSA is associated with negative schemas and distortions in processing self-relevant sexual information (Meston & Heiman, 2000; Meston et al., 2006). Disturbances in sexual self-schemas may also contribute to sexual behavior problems (Cyranski, Aarestad, & Andersen, 1999; Meston et al., 2006).

Less is known about how CSA affects representations of the nature and function of sexuality in relationships. From a developmental perspective, views of sexual intimacy are a critical aspect of sexual identity that may influence information processing of sexually relevant information and guide sexual behavior (Cassidy, 2000; Furman & Simon, 1999; Shaver & Mikulincer, 2006). For youth without disruptions to sexual development, the sexual behavioral system first becomes prominent in adolescent romantic relationships, and it plays an important role in the shift from intimate friendships to intimate romance, both of which highlight egalitarian intimacy (Furman & Simon, 1999). Views of sexual intimacy include beliefs about the functions of sex, its relation to broader intimacy goals, and how the self and others relate. These views are rooted in representations of nonsexual intimacy (Cassidy, 2000; Collins & Sroufe, 1999; Furman & Simon, 1999). For sexually abused youth, the sexual behavioral system is prematurely activated in a way that may connect sex to overwhelming emotions, nonsexual goals, recreational rather than relational aspects of sexual behavior, or concerns about dominance and submission rather than egalitarian reciprocity (Meston et al., 2006; Wekerle et al., 2001). Accordingly, views of sexual intimacy may be less oriented around mutual concern and intimacy and more focused on fulfilling partners' needs, obtaining physical gratification, or avoiding intimate involvement.

In the current study, individual differences in youths' initial sex-specific reactions were expected to predict differences in later views of sexual intimacy. More eroticized reactions to CSA were expected to predict views of sexual intimacy that emphasize either physical gratification or the fulfillment of partners' needs. When eroticized reactions to CSA emerge from feelings of physical pleasure or enjoyment of special attention connected with the abuse or from being eroticized for the perpetrator's pleasure, sexual intimacy may become primarily viewed as an opportunity for physical gratification or as a means to fulfill partners' needs. In contrast, more sexually anxious responses to CSA would predict views reflecting dislike and avoidance of sexual intimacy. Persistent worries and fears in connection to sex may make it difficult to develop an intimate, related sexuality and may result in discomfort with the vulnerability and closeness required in sexual intimacy.

DEVELOPMENTAL LEVEL, SEXUAL ABUSE, AND SEXUAL PROBLEMS

An important challenge for understanding developmental effects of sexual trauma is to examine how they are manifest within and across developmental periods (Cole & Putnam, 1992; Feiring, Taska, & Lewis, 1999). Yet most empirical studies of CSA use participants who vary widely in age without examining age-related effects (for a review, see Trickett & McBride-Chang, 1995). Those studies that have considered age-related effects have not examined age differences in sex-specific reactions to abuse.

Sexual abuse during adolescence coincides with prominent psychosexual developments, including the emergence of romantic relationships, pubertal development, and cognitive changes in self-concept, including the sexual self-concept (Crouter & Booth, 2006; Furman, Brown, & Feiring, 1999; Halpern, 2003; Savin-Williams & Diamond, 2004). Age-related developments in sexual knowledge, self-concept, and social perspective taking allow adolescents to contemplate the implications of CSA for their own sexuality and how they might relate sexually with partners. Adolescents may be especially likely to interpret CSA in a highly sexualized manner. Emerging sexual interest, at least among one's peer group, along with pubertal increases in sexual responsiveness and a normative press to construct a sexual identity may predispose adolescents to becoming sexually preoccupied in response to CSA and its public discovery.

In contrast, children's experience of sexual abuse occurs at a time when sexuality is not a particularly prominent aspect of their social, biological, or cognitive lives. Although mutual, exploratory sexual behaviors are not uncommon among children, sexual experiences are not a central aspect of their interpersonal relationships or social identity. Children's experiences of sexual abuse may be more likely to evoke distress and anxiety about sexual matters. Compared to adolescents, children are relatively lacking in sexual knowledge and have a more limited repertoire of cognitive and emotional skills for assimilating CSA experiences into their self-concept or ways of relating to others. Compared to adolescents, CSA experiences may render children more worried about their sexual feelings and more fearful of sexual matters.

The developmental differences described above suggest that children and adolescents would differ in their initial reactions to CSA as a function of their age group. Children were

expected to experience more sexual anxiety than adolescents and adolescents to experience more eroticism than children at abuse discovery and a year later. Developmental differences also were expected in subsequent sexual functioning such that adolescents would be more likely to report heightened sexuality and children more diminished sexuality. Unlike abuse-specific reactions, these differences in sexual functioning may be related to developmental differences in sexual experiences rather than developmental differences in the effects of CSA. To examine abuse-related effects of developmental period on subsequent sexual functioning, we examined how initial sex-specific abuse reactions (eroticism, sexual anxiety) interacted with age group at the time of abuse discovery to predict subsequent sexual functioning. Such interaction or moderation effects address the issue of whether being in a particular age group exacerbates or diminishes the relations between initial abuse reactions and later sexual functioning. We expected that the association between initial sexual anxiety and later indicators of diminished sexuality would be stronger for those who were children at the time of abuse discovery. We also anticipated that the association between initial eroticism and later indicators of heightened sexuality would be stronger for adolescents than children.

To summarize, the purpose of the current study was to examine abuse-specific processes that help explain variations in sexual behavior within youth with a history of CSA. We used a within-group design to examine how individual differences in abuse-specific sexual reactions are related to subsequent sexual behavior and views. The basic question addressed in this research was the extent to which differences in sexual anxiety and eroticism in response to CSA at discovery and a year later were related to subsequent sexual functioning. Understanding how CSA-specific reactions are related to adjustment cannot be assessed in a comparison group without such a history. Initial reactions of eroticism were expected to predict indicators of heightened sexuality, including more sexual risk behavior, more dysfunctional sexual behavior, more sexual partners, expectations of more quickly engaging in sexual activity with potential sexual partners, and views of sexual intimacy that emphasized recreation or partners' needs. These associations were expected to be stronger for those who were adolescents at the time of abuse discovery. Initial reactions of sexual anxiety were expected to predict later indicators of diminished sexuality, including more sexual concerns, less sexual risk behavior, fewer sexual partners, expectations of waiting longer to engage in sexual activity with potential sexual partners, and avoidant views of sexual intimacy. These relations were expected to be stronger for those who were children at the time of abuse discovery.

METHOD

Sample Selection and Characteristics

Participants were recruited from urban and suburban populations in New Jersey. Their sexual abuse was confirmed by at least one of the following criteria: specific medical findings, confession by the offender, abuse validated by an expert such as child protective services (CPS), or conviction of the offender in family or criminal court. The majority of the sample (95%) was referred directly by CPS offices or regional child abuse medical clinics working with CPS. Children between the ages of 8 and 15, who had been brought to the attention of

authorities for sexual abuse within the past 8 weeks, were approached to participate in the study. Project staff reviewed intake logs to identify eligible cases. Caseworkers then contacted 185 families to obtain permission for project staff to contact them to discuss the study. All but three families agreed to be contacted by project staff, and of the 182 families contacted by project staff, 160 families agreed to and did participate in the study.

Children and their families were assessed at abuse discovery (T1) and again 1 year later (T2). At T1, participants included 117 (73%) girls and 43 (27%) boys. Of these, 88 were children aged 12 years and below ($M = 9.5$, $SD = 1.1$) and 72 were adolescents aged 13 years and older ($M = 13.5$, $SD = 1.1$). A third assessment was obtained approximately 6 years following abuse discovery ($M = 6.2$, $SD = 1.2$; range = 4.3 to 10.1). The sample for the current analyses consists of the 118 youth who completed three assessments (T1 through T3). At T3, 54% of the sample were adolescents aged 13 through 17 years and 46% were young adults aged 18 to 23 years. Seventy-six percent of the sample were women. The majority of the participants came from single parent families (70%) and had an income of \$25,000 or less (71%). The ethnicity of the sample was self-reported as African American (39%), White (31%), Hispanic (21%), and Other (9%, including Native American and Asian American). The sample of 118 participants seen for all three T1 through T3 assessments did not differ on demographic, abuse characteristics, or adjustment levels compared to those who were seen for the T1 and T2, but not the T3, assessments.

This study did not provide therapy but made treatment recommendations at T1 and T2 to the agencies from which families were recruited if caregivers and children gave permission. T1 assessments were conducted before any participants received treatment. By the T2 assessment, 68% of youth had received some form of treatment, typically from community-based agencies. Individual therapy was the primary modality and the average length of treatment was 5.4 months ($SD = 4.7$). Between the second and third assessment, 39% of the sample reported having received some form of treatment. Individual therapy was the primary modality and the average length of treatment was 8 months ($SD = 8.5$).

Characteristics of the abuse incidents that qualified participants for inclusion in the study were determined using a checklist designed to systematically collect information about the specifics of the abuse. After children's T1 assessment, project staff members reviewed records from law enforcement and CPS agencies and completed the checklist. The checklist included information on the relationship of the perpetrator to the victim; frequency and duration of the victimization; how the abuse was discovered; types of abusive acts experienced (e.g., fondling, penetration); use of force; medical findings; and how the case was confirmed. Based on the most serious form of contact abuse reported by this sample, 67% experienced genital penetration. Almost all of the perpetrators were known to their victims with 35% being a parent figure, 25% a relative, 37% a familiar person who was not a relative, and 3% a stranger. Forty-three percent of the participants lived with the perpetrator at the time of the abuse. Frequency of the reported abusive events was once for 30% of the sample, 2 through 9 times for 40%, and 10 times or more for 30%. The abuse lasted for a year or longer in 33% of the sample. The use of force was reported in 25% of the sample, the threat of force in 19%, and in 56% of the cases no force or threat were reported. Latency to disclose the abuse; that is, the time lapse from the last abusive act to the time of discovery,

was 2 weeks or less (45%), more than 2 weeks through 6 months (33%), and 7 months or more (22%).

Procedure

All the procedures for this study were approved by the institutional review boards of the academic institutions where the research took place. At each of the three assessment points, when the participant was a minor, written informed assent was obtained from the children and written informed consent from their parents/guardians. At T3, those participants who were 18 or older provided informed consent. Assessment data were gathered via structured interview, standard questionnaire, and computer-assisted methods by a trained clinician in a private office. The administration format for each measure is described below. Abuse-related information was obtained from CPS and law enforcement case records at T1 after the children were interviewed. Participants were reimbursed a total of \$250 for completion of the initial and the two follow-up assessments.

Measures

Initial sex-specific abuse reactions—The Children's Impact of Traumatic Events Scale–Revised (CITES-R) was used to assess sexual anxiety and eroticism at T1 and T2 (Wolfe et al., 1991). Respondents are asked to reflect on what happened during the CSA as they complete the items. The interviewing clinician read the items aloud as participants marked their responses on their own form, which was out of view of the clinician. This administration was followed to make sure children read the questions properly while protecting their privacy.

The items are rated on a 3-point scale where 3 = *very true*, 2 = *somewhat true*, and 1 = *not true*. The sexual anxiety scale uses five items to assess the extent to which children worry and think about sex in a negative way. Sample items include: "Thinking about sex upsets me" and "I get frightened when I think about sex." The alpha coefficients for our sample on this scale are .82 and .81 for T1 and T2, respectively. The four-item eroticism scale taps heightened sexual feelings such as "I have more sexual feelings than my friends" and "I have sexual feelings seeing people kiss" (alpha coefficients for the current sample are .66 and .65 for T1 and T2, respectively). Although there are no published norms for the CITES-R, the means for sexual anxiety and eroticism obtained in the current sample (see Table 1) are comparable to those obtained in a study that examined the measure's psychometric properties (Crouch et al., 1999). Convergent validity for these scales has been demonstrated across two studies in which sexual anxiety was associated with sexual distress as measured by Briere's (1996) Trauma Symptom Checklist for Children (Crouch et al., 1999) and eroticism was related to sexual problems, as measured by Achenbach's (1991) Child Behavior Checklist (Wolfe et al., 1991).

Views of sexual intimacy—The sexual system scales from the Behavioral Systems Questionnaire (BSQ; Furman & Wehner, 1999) were administered in a self-completed questionnaire at T3 to measure views of sexual intimacy. Although romantic relationships and partners vary developmentally, the BSQ has been successfully used among youth as young as 15 years old (W. Furman, personal communication, January 8, 2008). Participants

were instructed to answer questions about physical intimacy broadly defined (e.g., kissing, necking, petting, oral sex, and intercourse), at whatever levels of physical intimacy they have engaged in with partners, defined as boyfriends or girlfriends. The questions were asked in connection to how participants typically feel and act with partners, considering past as well as present relationships.

Of interest for this study were the partner-focused, avoidant, and recreational scales, which tapped problematic views of sexual intimacy. Each scale comprises five items responded to on a 5-point scale ranging from *strongly disagree* to *strongly agree*. The partner-focused scale measures the extent to which individuals view sex as focused on their partners more than their own needs. Sample items include “I get too wrapped up in what my partners want from physical intimacy” and “My partners’ feelings about our physical intimacy are more important than my own” (alpha for the current sample is .79). The avoidant scale measures the extent to which individuals dislike or avoid the perceived entanglements of physical intimacy with items such as “I do not like the way physical intimacy with my partners changes relationships” and “physical intimacy with my partners makes the relationship too serious” (alpha for the current sample is .74). The sex as recreation scale measures the extent to which physical intimacy is viewed as primarily for fun or physical gratification with items such as “Physical intimacy with my partners is mainly for fun” and “Physical intimacy is primarily a chance to try new techniques and explore them with my partners” (alpha for the current sample is .75). These three scales (partner-focused, avoidant, and recreation) are considered problematic because higher scores indicate views of sexual intimacy that operate to the exclusion of other motives (e.g., mutuality, intimacy).

Sexual concerns and dysfunctional sexual behavior—At T3, two subscales of the Trauma Symptom Inventory (TSI) were administered in questionnaire format to index sexual problems during the previous 6 months (Briere, Elliott, Harris, & Cotman, 1995). The Sexual Concerns subscale measures perceptions of sexual problems in relationships, sexual dissatisfaction, and unwanted sexual thoughts and feelings. The Dysfunctional Sexual Behavior subscale measures sexual behavior that is indiscriminant or used to achieve nonsexual goals (e.g., combat loneliness, reduce distress, get love). Each of these subscales is comprised of nine items that are rated on a 4-point Likert-type scale from *never* to *often*. The internal consistency of these subscales in our sample was acceptable (Sexual Concerns alpha = .82; Dysfunctional Sexual Behavior alpha = .78).

Although the TSI was originally developed for use with individuals 18 and older, this measure was administered to all participants at T3 to assess their sexual functioning. The means and standard deviations for our sample on the sexual concerns and dysfunctional behavior scales are comparable to those reported by Briere et al. (1995). Evidence of construct validity is also provided by Briere et al., who reported that individuals who report CSA histories score higher on the sexual concerns and dysfunctional sexual behavior scales than those who deny any CSA history (Briere et al., 1995). In addition, scores on the sexual concerns and dysfunctional sexual behavior scales are significantly related to higher symptomatology (Briere et al., 1995).

Sexual risk behavior—At T3, questions about sexual behaviors were modeled after items from the Sexual Activity Questionnaire for Girls and Boys measure used in several large-scale surveys of adolescent and young adult sexual behavior (Udry, 1993). Similar items have been used in previous studies of individuals with CSA histories (Noll, Trickett, et al., 2003). Participants were asked to report on voluntary, not forced, sexual activity. The items were administered by a computer in which questions were read aloud while also viewed on the screen. Answers were entered directly into the computer. The interviewer was not present during this part of the assessment (although she was available in an adjacent room if questions arose). This method of administration emphasized the anonymity of the assessment and has been shown to promote willingness to report sensitive information to a greater extent than face-to-face interviews (Turner et al., 1998). An index of risky sexual behavior was created to reflect the number of different health risk behaviors participants reported. The index was the sum of participants' affirmative responses to seven items asking whether they had ever engaged in sexual intercourse or oral sex under the following risk conditions: (1) without a condom, (2) with a partner who was an IV drug user, (3) with a partner who is gay, (4) with a partner who is bisexual, (5) with a partner who has had multiple sex partners, (6) in a "one night stand," or (7) while the participant was under the influence of drugs or alcohol.

The number of affirmative responses (1 = *yes*, 0 = *no*) was summed to create a sexual risk score, such that possible scores ranged from 0 to 7 with higher scores reflecting more types of sexual risk behaviors. Our intention was to examine how age group and abuse reactions were related to the safety of sex practices among those who were engaging in behavior with potential health risks. To avoid confounding sexual risk with sexual activity, sexual risk scores were only calculated for participants who reported that they had engaged in oral sex or intercourse. Forty participants reported no experiences with oral sex or intercourse, reducing the sample size to 81 for analyses on sexual risk behavior.

Number of sexual partners and latency to engage in sexual behavior—Two additional scores were created from the T3 computerized assessment of sexual behavior to better understand participants' ways of relating to potential sexual partners. One index was the number of different sexual partners adolescents reported on a sliding scale from 0 to 100+. Responses ranged from 0 to 50, with a median score of 2.00. The mean number of partners was 4.54, with a standard deviation of 8.51. Outliers were identified via box plots. To reduce their influence on the analyses, outliers were recoded with the next lowest score in the distribution that did not reflect an extreme value, which was a score of 15 (Tabachnick & Fidell, 2001). This resulted in a scale with values ranging from 0 through 15 partners.

Youths' latency to engage in sexual behavior with potential sexual partners was assessed by a series of questions that asked about the number of times participants typically go out with a partner before engaging in various types of sexual behaviors. Possible responses were rated on a 12-point scale that ranged from *never* (i.e., have never engaged in that behavior) to *more than 10 times*. Separate items assessed latency to engage in light petting (i.e., feeling above the waist/outside of clothes), heavy petting (i.e., feeling below the waist/inside clothes), oral sex, and intercourse. Scores were averaged across items to create an overall composite score for the latency of youths' engagement in sexual behavior with potential

sexual partners. Higher scores reflected more latency or the expectation of waiting longer before engaging in sexual behavior with a potential sexual partner.

RESULTS

Analytic Plan

In the preliminary analyses, descriptive statistics for all the continuous variables in the subsequent analyses for the entire sample and by age group at discovery (children 8 through 11 years, adolescents 12 through 15 years) are presented. Next, correlations between all these variables within and over time are examined. Finally, hierarchical regressions to examine the effects of initial sexual anxiety and eroticism and the interaction of these sex-specific abuse reactions with age group on subsequent sexual problems and views of sexual intimacy are presented. The regressions were also conducted using age as a continuous variable and the results were similar. The results for age group are presented because we were interested in how the effects might vary as a function of developmental period.

Preliminary Analyses

Table 1 shows the descriptive statistics for sex-specific abuse reactions assessed at T1 and T2 and the indicators of sexual functioning at T3 for the entire sample and by age group at the time of abuse discovery. All the measures demonstrated good variability. In addition to the mean values, consideration of percentage of participants scoring in the high range for sexual anxiety, eroticism, and sexual concerns and dysfunction, provide important information about the degree to which the sample is distressed in regard to sexual functioning. At the time of abuse discovery and a year later higher levels of sexual anxiety are characteristic of youth in this sample (average score of 2 or higher for 64% and 42% at T1 and T2, respectively). Higher levels of eroticism are less common (18% and 14% at T1 and T2, respectively). At T3, only a small percentage of youth report sexual concerns and dysfunction in the clinical range (a *T*-score of 65 or higher for 7% and 9% in sexual concerns and dysfunction, respectively).

Age group differences emerged on abuse reactions over time as well as on sexual problems and views. Specifically, children reported higher sexual anxiety than adolescents, both at the time of discovery and 1 year later. However, the two groups did not differ on eroticism at either time. The only age group difference in T3 sexual behavior was for the number of sexual partners, with those who were children at the time of abuse discovery reporting fewer sexual partners than those who were adolescents at discovery. At T3, those who were children at abuse discovery endorsed higher levels of avoidant views of sexual intimacy than those who were adolescents at discovery. No age group differences were found in recreational or partner-focused views of sexual intimacy.

Table 2 shows the correlations among the primary study variables within and across time.¹ As expected, sex-specific abuse reactions at the time of discovery (T1) were significantly

¹Abuse severity and its relation to subsequent sexual functioning was not the focus of the current study. Such effects have been weak in prior work. More importantly, the focus of this study was on abuse-related processes that may be changed through intervention rather than on static characteristics that are not (Feiring, Taska, & Lewis, 2002). Nevertheless, we did examine bivariate relations

related to reactions 1 year later (T2). However, the two reactions were unrelated to one another at either time point, suggesting that sexual anxiety and eroticism are distinct sex-specific reactions to abuse. These reactions also were differentially related to later sexual functioning. Sexual anxiety at T1 and T2 was primarily associated with fewer sexual partners and more avoidant views of sexual intimacy at T3. T1 eroticism was associated with having more sexual partners, and T2 eroticism was associated with higher levels of sexual concerns, dysfunctional sexual behavior, and greater endorsement of partner-focused and recreational views of sexual intimacy at T3.

Moderate correlations were found among the various T3 indicators of sexual functioning, suggesting that, although related, these measures are indexing different aspects of sexual problems. More sexual concern was related to more dysfunctional sexual behavior. Each of these indicators was associated with higher levels of sexual risk behavior and more sexual partners, but differentially associated with views of sexual intimacy. A more partner-focused view was associated with more avoidant and recreational views of sexual intimacy. However, avoidant views were not associated with recreational views. This pattern of associations suggests that youth who view sex as centered on partners' needs may also be uncomfortable with sexual intimacy or view sex as an opportunity for physical pleasure. Youth who are uncomfortable with sexual intimacy are not likely to view sex as an opportunity for physical pleasure.

Predicting Sexual Functioning From Initial Sex-Specific Abuse Reactions and Age Group

The goal of this study was to examine how sex-specific reactions to sexual abuse were associated with subsequent sexual functioning and whether these associations varied by youths' age group at abuse discovery. Toward this end, we conducted a series of hierarchical regressions in which each of the T3 indicators of sexual functioning was regressed on sexual anxiety and eroticism at T1 and T2 and the interaction of each of these variables with age group at abuse discovery (child or adolescent). Prior to the analyses, all predictors were centered to reduce multicollinearity (Aiken & West, 1991). In each of the regression analyses, age group was entered in the first step because the mean analyses indicated age group was related to T3 sexual functioning. After controlling for age group, the main effects of T1 sexual anxiety and T1 eroticism were entered on the second step, followed by the two-way interactions of T1 sexual anxiety and eroticism by age group on the third step of the regression. The main effects for T2 sexual anxiety and eroticism were entered in the fourth step and the two-way interactions of T2 sexual anxiety and eroticism by age group were entered in the last step. All significant interactions between sex-specific abuse reactions and the moderator of age group were subsequently probed by calculating slope estimates at each level of the moderator (Holmbeck, 2002). Tables 3 (sexual problems) and 4 (views of sexual intimacy) show the standardized beta weights for each predictor variable and the change in

between abuse characteristics and sexual functioning to determine if such variables needed to be controlled for in the regression analyses. Abuse characteristics were mostly unrelated to the T3 measures of sexual functioning. Bivariate correlations were computed for seven abuse characteristics, including frequency, duration, number of abuse events, use or threat of the use of force, whether penetration occurred, whether the perpetrator was a parent figure, whether the perpetrator lived with the child at the time of the abuse, and an overall severity score. Only 2% (2 of 84) of the correlations between abuse characteristics and the T3 measures of sexual functioning were significant, a rate that does not exceed what might be expected by chance. Hence these variables were not included in the primary analyses.

variance accounted for at each step of the regression when predicting each of the T3 indicators of sexual functioning. The results are discussed in relation to the differential pattern of findings predicted for the two sex-specific abuse reactions of eroticism and sexual anxiety. Moderating effects (rather than main effects) of age group are of particular interest because they provide information on how the relation between sex-specific abuse reactions and sexual functioning are affected by developmental period at the time of abuse discovery.

Eroticism and age group at discovery as predictors of T3 sexual functioning—

Eroticism predicted indices of heightened sexual behavior at T3 (see Table 3). Dysfunctional and sexual risk behaviors were each predicted by T2 eroticism, such that more eroticism was significantly associated with higher levels of dysfunctional and risk behavior at T3.

However, the significant effect of T2 eroticism on sexual risk behavior was qualified by a significant age group interaction. Post hoc probing of the interaction indicated that the association between T2 eroticism and T3 sexual risk behavior was significant for those who were adolescents at the time of abuse discovery, $b = 1.42$, $p = .002$, but not for those who were children at the time of discovery, $b = -.183$, $p = .65$. T1 eroticism was a marginally significant predictor of the expected number of dates before engaging in sexual activity with potential partners, with more eroticism relating to fewer dates. Contrary to expectations, T2 eroticism predicted T3 sexual concerns, such that more eroticism was significantly related to more concerns.

Eroticism was a significant predictor of both partner-focused and recreational views of sexual intimacy (see Table 4). T2 eroticism predicted partner-focused views, with more eroticism related to more partner-focused views. For recreational views of sexual intimacy, the interaction of T1 eroticism with age group at discovery was a significant predictor. Post hoc probing of the interaction indicated that the association between T1 eroticism and T3 recreational views was marginally stronger for those who were children at the time of abuse discovery, $b = .39$, $p = .09$, than for those who were adolescents at the time of discovery, $b = -.21$, $p = .32$. After accounting for T1 effects, T2 eroticism predicted additional significant variance, such that more T2 eroticism was associated with stronger recreational views of sexual intimacy.

Sexual anxiety and age group at discovery as predictors of T3 sexual

functioning—Sexual concerns at T3 were predicted by the interaction of T2 sexual anxiety and age group at discovery, although the increase in variance explained was only marginally significant (see Table 3). Post hoc probing of the association for each age group did not produce a significant slope for either age group, $b = -.44$, $p = .80$, and $b = 2.26$, $p = .175$ for the child and adolescent groups, respectively. Sexual anxiety also was associated with diminished levels of sexual behavior at T3. T1 sexual anxiety predicted dysfunctional sexual behavior and T2 sexual anxiety predicted sexual risk behavior, with greater anxiety predicting lower levels of each of these T3 indicators of sexual functioning. T1 sexual anxiety predicted the expectation of waiting longer to engage in sexual behavior with potential partners, even after controlling for the significant effect of age group at discovery (older youth wait less). After accounting for the association between age group at discovery and number of sexual partners (older youth have more partners), T1 sexual anxiety predicted

having fewer sexual partners. However, the amount of variance accounted for was only marginally significant. To clarify whether sexual anxiety was predicting few versus no partners, a logistic regression was conducted predicting the presence of *any* sexual partners. If sexual anxiety predicted the absence of sexual partners, it would provide clearer evidence for sexual aversion. Results indicated that the full model including age group, sexual anxiety (T1 and T2), and eroticism (T1 and T2) significantly predicted whether participants had any versus no sexual partners, $\chi^2 = 28.50$, $p = .000$. After controlling for age group, T1 sexual anxiety was the only additional predictor to approach significance, with more sexual anxiety predicting no sexual partners, $B = -.88$, $p = .08$.

Avoidant views of sexuality were significantly predicted by both sexual anxiety and age group at discovery (see Table 4). Youth with more T2 sexual anxiety reported more avoidant views, after controlling for the significant effect of age of discovery (older youth reported less avoidant views). Although there was a significant age group by T2 sexual anxiety interaction, the increase in variance explained was only marginally significant. Post hoc probing of the association for each age group indicated that the association between T2 sexual anxiety and avoidance was only significant for those who were adolescents at the time of abuse discovery, $b = .55$, $p = .002$ ($b = .07$, $p = .63$ for the child group).

DISCUSSION

Friedrich (1998) advocated a developmental framework for understanding when and how CSA affects salient developmental tasks. The current study adopts this framework by providing a longitudinal perspective on sex-specific effects of CSA over the 6-year period following abuse discovery. The results suggest that, for some youth, initial sexual reactions to CSA may persist over time and interfere with the development of sexual behavior as well as representations of sexual intimacy. In this community-based, CPS-referred sample, sexual anxiety and eroticism emerged as distinct indicators of initial abuse-related disturbances in sexuality. Although the actual levels of these initial sexual reactions were moderate, individual differences in reactions predicted sexual functioning 6 years after abuse discovery. As expected, each of these initial sexual reactions predicted a distinct pattern of sexual functioning. Eroticism was primarily associated with later indicators of heightened sexuality, whereas sexual anxiety was associated with indicators of diminished sexuality.

Differential Patterns of Sexual Development

Findings of both heightened and diminished sexuality among individuals with CSA histories have led some researchers to conjecture that there are multiple pathways of sexual development following CSA (Merrill et al., 2003; Noll, Trickett, et al., 2003). Eroticism has not received much empirical attention as an indicator of early sexual disturbance, but the current findings suggest that youth who are initially more eroticized by CSA may be prone to distortions in sexual development that manifest as over-sexualized ways of relating to others. Behaviorally, this may include using sex as a means to attain nonsexual goals, engaging in sexual behavior early in relationships, or behaving in ways that endanger sexual health. Contrary to expectations, eroticism was unrelated to number of sexual partners. The strong relation between age group and number of sexual partners may have made it difficult

to detect any additional effects of eroticism. Eroticism was also unrelated to latency of engaging in sexual behavior with potential partners. In the current study, latency was assessed across a range of sexual behaviors ranging from kissing to intercourse and oral sex. Eroticism may be a better predictor for latency to engage in more intense (e.g., intercourse) than less intense (e.g., kissing) sexual behavior.

At the representational level, eroticized youth may come to view themselves as objects for partners' sexual pleasure with little value placed on reciprocity and mutual concern. By emphasizing the gratification of sexual needs, greater eroticism in response to CSA may also undermine the emergence of sex as an expression of romantic intimacy, resulting in a view of sex that focuses on recreation and hedonic pleasure. Initial eroticism also appears to be related to increased sexual concerns. This finding was unexpected, and may reflect a persistence in sexual preoccupation that later emerges as worries about sexual matters. To the extent that initial eroticism forecasts a reliance on sex as a way of relating to others, those who experience earlier eroticism may also be more concerned about sex.

In contrast to eroticism, more sexually anxious reactions to CSA may forecast diminished sexuality. Moderate levels of worries and fears about sexuality were common around the time of abuse discovery. Youth who experienced higher levels of sexual anxiety expected to wait longer to engage in sexual behavior and reported having had fewer, and often no, sexual partners. In addition, youth who were more sexually anxious were more likely to develop avoidant views of sexual intimacy, suggesting that increased anxiety about sexuality may create difficulties in developing close sexual relationships. It is unclear whether these findings reflect sexual aversion or sexual caution, as initial sexual anxiety was also associated with lower levels of dysfunctional and risky sexual behavior. Additional longitudinal studies are needed that compare the developmental trajectories of abused and nonabused children as they transition to developmental periods that involve greater opportunities and expectation for sexual experiences. Such work would help to determine whether and when initial sexual anxiety predicts sexually cautious behavior or the types of sexual aversion and avoidance noted in cross-sectional research with adults (Briere, 2000; Matorin, 1999; Stein et al., 1988; Wenninger & Heiman, 1998).

Developmental Effects

There are two major types of developmental effects of sexual abuse on sexual functioning: effects that occur over the course of development and effects that vary as a function of the developmental stage at which the abuse occurred or was discovered. Regarding the former, those who were adolescents at the time of abuse discovery reported more sexual partners at T3 when they were young adults than those who were children at abuse discovery and adolescents at T3. This finding is likely to reflect a developmental difference in sexual experience and may be unrelated to having a CSA history. Comparisons between abused and nonabused samples are needed to examine this issue.

Of particular interest in this study was how the effects of CSA on later sexual functioning vary according to the developmental stage when the abuse occurred. The present findings indicate that the developmental stage at which CSA occurs is an important moderator of the associations between initial sex-specific abuse reactions and subsequent sexual functioning.

When abuse or its discovery occurs during adolescence, initial reactions characterized by higher eroticism predict greater subsequent engagement in sexual risk behavior. Adolescents whose initial reactions are characterized by greater sexual anxiety are more likely to develop more avoidant views of sexual intimacy. This particular effect was somewhat surprising, as we had expected that sexual anxiety would predict avoidant views for those who were children at discovery. Because sexual anxiety is less characteristic of adolescents' than children's initial reactions to CSA, its presence may be particularly meaningful for understanding adolescents' sexual functioning.

Being a child at the time of abuse did not moderate links between initial sex-specific reactions to abuse and subsequent sexual functioning. For the child group, initial eroticism predicted more recreational views of sex; however, the persistence of eroticism one year later predicted recreational views regardless of age group. Overall, the stronger effects for those who were adolescents at the time of abuse discovery suggest that this may be a particularly vulnerable time for the development of sexual problems in response to CSA. Developmental tasks associated with puberty, romantic relationships, and differentiation of the self-schema as well as increases in self-consciousness make sexuality particularly salient for adolescents. Intense sexual reactions associated with CSA may be more likely to distort or disrupt healthy sexual development during this period.

Testing for these kinds of developmental effects moves us closer to understanding how the timing of abuse and abuse-specific reactions affect the trajectory of youths' sexual development. There is not a single sexual identity for youth with CSA histories. Understanding developmental variations in the sexual development of CSA youth requires longitudinal studies with sufficiently large samples to detect these moderated effects. It also requires studying samples that focus on a narrow age range and tracking sexual development across critical periods.

As previously noted, understanding developmental effects also requires adopting a developmental approach in which the trajectories of both abused and nonabused youth can be compared. Including nonabused youth in longitudinal studies of CSA would provide sorely needed information about normative sexual development and serve as a reference for interpreting findings for CSA youth. The purpose of this study was to examine abuse-specific processes that help explain variations in sexual behavior within youth with a history of CSA. However, the absence of a comparison group in the current study makes it difficult to discern the extent to which the current findings reflect normative changes in participants' romantic and sexual development versus long-term effects of sexual abuse. Developmental assessments of normative sexuality should be used in concert with those that tap sexual distortions commonly experienced by CSA youth (e.g., sexual anxiety and eroticism). Put simply, linking initial abuse-specific sexual reactions to later sexual functioning is good, but understanding the normative developmental processes that are disrupted by abuse-specific reactions is better. This may be more challenging than it seems because of the paucity of theory and research on the nature and development of healthy, rather than risky, sexual behavior (Bancroft, 2006; Welsh, Rostosky, & Kawaguchi, 2000).

Examination of whether and how youth with and without CSA histories depart from normative trajectories of interpersonal development also is needed. In the current study, eroticism and sexual anxiety were associated with the emergence of different views about the nature of sexual intimacy. For nonabused youth, these views about the functions of sex, its relation to intimacy, and how the self and others relate sexually are rooted in experiences and representations of nonsexual intimate relationships (Collins & Sroufe, 1999; Furman & Simon, 1999). This suggests that examining abuse-specific sexual reactions along with experiences and representations of nonsexual intimacy may help to explain how particular sexual reactions emerge and interact with intimacy in relationships with caregivers and close friends. Examining abuse-specific reactions in the context of the developmental processes believed to be affected by CSA seems critical for understanding whether and how abuse-specific reactions disrupt or distort developmental tasks.

Limitations

Although our results suggest important directions for future research, there also are limits for interpreting the current findings. Our measures of initial sexuality were limited to the presence of two abuse-specific sexual problems that were not indexed by multiple indicators and did not include broader measures of sexual or interpersonal development. A more complete assessment would also include other sexual reactions such as sexual behavior problems, body image, and knowledge of sex. It would also include interpersonal functioning, such as intimacy in parent-child and peer relationships and sexual attitudes/norms in families and peer groups. Likewise, the outcome measures focused on sexual functioning in the absence of information about the relationships in which sexual behavior might occur. These processes may be important moderators of associations between initial abuse-specific reactions and later sexual functioning.

Further limits to these results include the nature of the sample and methodologies. Participants were recruited from social service agencies. Although they reported a range of abuse-related distress, it is unclear whether the current findings would generalize to a clinically referred sample. The external validity of the study is also limited to individuals for whom the abuse was reported to the appropriate authorities. Data collection relied on self-report methods and some measures of sexual behavior partly relied on retrospective recall. Although the data are longitudinal, they are nonexperimental and hence not conclusive with respect to the causal direction. Despite these limitations, the current study is among the few to demonstrate long-term effects of abuse-specific sexual reactions on later sexual functioning using data from multiple time points on confirmed cases of sexual abuse.

Clinical Implications

Sexually abused youth who initially experience higher levels of eroticism or sexual anxiety may be at risk for different types of sexual problems. These findings point to the need for early and developmentally sensitive interventions that address specific disruptions in sexual development. Treating abuse-related distress may be insufficient for reducing the sexual risks associated with CSA (Briere, 2004). Multimodal treatments are needed that include components that address sexuality directly in a way that is sensitive to clients' developmental status, initial abuse-specific reactions, and views of sexual intimacy (Briere,

2004; Lescano, Brown, Puster, & Miller, 2004). Trauma-focused cognitive behavioral therapy emphasizes the importance of providing youth with an emotional and sexual vocabulary they can use to narrate their abuse experiences (Cohen, Mannarino, & Deblinger, 2006). The current findings suggest that providing youth with a means of discussing both healthy and unhealthy sexual experiences may also be useful for constructing a developmentally appropriate understanding of normative sexuality. In this way, abuse experiences can become more clearly disentangled from youths' emergent sexual identity.

Promoting sexual health among individuals with CSA histories also requires changing dysfunctional patterns of thought and emotion regulation (Brown, Lourie, Zlotnick, & Cohn, 2000; Lescano et al., 2004). Individual differences in views about sexual intimacy provide a way of understanding these dysfunctional patterns as they relate to sex. Views about sex reflect characteristic ways of processing information and emotions about sexual intimacy (Furman & Simon, 1999). Differences in views about the functions of sex are associated with different motivations for sex and specific patterns of sexual behavior and risk (Cooper, Shapiro, & Powers, 1998). For example, individuals motivated by avoidant views of intimacy are likely to have fewer partners and engage in less risky sexual behavior, whereas those motivated by partner approval are likely to have more partners and engage in more sexual risk. Treatments that consider individuals' views of sex and address underlying beliefs and emotions about the functions of sex are likely to be important for promoting healthy sexuality and intimacy.

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TABLE 1
Descriptive Statistics for Primary Study Variables for Entire Sample and by Age of Discovery

	Min.	Max.	Sample M	SD	Child M ^a	SD	Adolescent M ^b	SD	t ^c
Sexual anxiety T1	1.00	3.00	2.13	0.68	2.52	0.51	1.82	0.63	6.52****
Sexual anxiety T2	1.00	3.00	1.79	0.71	2.17	0.69	1.50	0.57	5.76****
Eroticism T1	1.00	2.75	1.42	0.49	1.42	0.49	1.42	0.48	0.04
Eroticism T2	1.00	3.00	1.28	0.41	1.27	0.39	1.28	0.43	-0.15
Sexual concerns T3	42.00	92.00	49.88	9.14	48.65	8.59	50.83	9.39	-1.29
Dysfunctional sex behavior T3	44.00	90.00	51.09	9.95	49.20	7.89	52.56	11.12	-1.83
Cumulative sexual risk ^d T3	0.00	5.00	1.94	1.47	2.05	1.50	2.42	1.61	-0.94
Number of sexual partners T3	0.00	15.00	3.43	4.56	2.32	3.92	4.79	4.74	-2.95****
Number of dates before engaging in sexual behavior T3	0.67	12.20	7.07	2.58	7.40	2.75	6.83	2.45	1.12
Avoidant view T3	1.00	4.40	2.50	0.72	2.72	0.63	2.34	0.75	2.73****
Partner-focused view T3	1.00	5.00	2.46	0.79	2.55	0.85	2.39	0.75	1.02
Recreational view T3	1.20	4.60	2.96	0.79	2.82	0.71	3.06	0.82	-1.51

^aChild group = age 8 to 11 years at time of abuse discovery.

^bAdolescent group = age 12 to 15 years at time of abuse discovery.

^cT-test of mean level differences between the child and adolescent groups.

^dCumulative sex risk calculated only for those who reported engaging in oral sex and/or sexual intercourse.

p .01.

p < .0001.

TABLE 2

Correlations Among Primary Study Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12
1. Sexual anxiety T1	—											
2. Eroticism T1	.11	—										
3. Sexual anxiety T2	.58***	.09	—									
4. Eroticism T2	.03	.30***	.15	—								
5. Sexual concerns T3	-.16	.03	-.03	.30***	—							
6. Dysfunctional sexual behavior T3	-.27***	.01	-.07	.31***	.63***	—						
7. Cumulative sexual risk T3	-.15	.08	-.24**	.21*	.41***	.64***	—					
8. Number of sexual partners T3	-.40***	.04	-.30***	-.01	.32***	.50***	.54***	—				
9. Number of dates before engaging in sexual behavior T3	.12	-.03	.20**	-.21*	.14	-.12	-.22*	-.22**	—			
10. Avoidant view T3	.26***	-.08	.34***	.14	.09	.08	-.13	-.39***	.27***	—		
11. Partner-focused view T3	.06	.05	.03	.23**	.29***	.34***	.09	-.10	.05	.46***	—	
12. Recreational view T3	-.11	.04	-.14	.15	.19	.25***	.16	.21**	-.05	.12	.35***	—

* $p < .10$.

**

 $p < .05$.*** $p < .01$.

TABLE 3
Hierarchical Regressions to Sexual Problems at T3 from Sex-Specific Abuse Reactions at T1 and T2 and Age at Abuse Discovery

Predictor	Sexual Concerns		Dysfunctional Sex Behavior		Cumulative Sexual Risk		Number of Dates before Engaging in Sexual Behavior		Number of Partners	
	Change R^2 for Step	β	Change R^2 for Step	β	Change R^2 for Step	β	Change R^2 for Step	β	Change R^2 for Step	β
Step 1	.03		.02		.01		.19***		.14***	
Age		.15		-.16		.08		-.44***		.37***
Step 2	.02		.07**		.02		.07**		.05*	
T1 sexual anxiety		-.12		-.30**		-.14		.25**		-.27**
T1 eroticism		.05		.04		.10		-.18*		.01
Step 3	.05*		.04		.01		.01		.02	
T1 Anxiety $\times$ Age Group		-.14		-.03		-.05		-.03		.04
T1 Eroticism $\times$ Age Group		-.17*		-.18*		-.05		.11		-.03
Step 4	.12***		.13***		.07**		.03		.00	
T2 sexual anxiety		.01		.05		-.25**		.15		.02
T2 eroticism		.36***		.37***		.24**		-.10		.00
Step 5	.05*		.04*		.09***		.03		.02	
T2 Anxiety $\times$ Age Group		.28**		.13		-.13		.08		-.17
T2 Eroticism $\times$ Age Group		-.09		.15		.32***		-.16		.14

NOTE: Change R^2 and standardized betas are reported for each step.

* $p < .10$.

** $p < .05$.

*** $p < .01$.

TABLE 4

Hierarchical Regressions to Predict Views of Sexual Intimacy at T3 From Sex-Specific Abuse Reactions at T1 and T2 and Age at Abuse Discovery

Predictor	Avoidant View		Partner-Focused View		Recreational View	
	Change R^2	β	Change R^2	β	Change R^2	β
Step 1	.08**		.02		.01	
Age		-.29**		-.15		.09
Step 2	.03		.02		.01	
T1 sexual anxiety		.17		-.07		-.10
T1 eroticism		-.08		.10		.07
Step 3	.00		.01		.07**	
T1 Anxiety $\times$ Age Group		.02		.14		-.01
T1 Eroticism $\times$ Age Group		.04		.12		-.27**
Step 4	.06**		.06		.06*	
T2 sexual anxiety		.37**		-.07		-.20
T2 eroticism		.13		.22**		.22**
Step 5	.04*		.00		.02	
T2 Anxiety $\times$ Age Group		.28**		-.04		.17
T2 Eroticism $\times$ Age Group		-.03		.20		-.02

NOTE: Change R^2 and standardized betas are reported for each step.* $p < .10$.** $p < .05$.*** $p < .01$.