

## MEN'S SEXUAL HEALTH

# Impact of Childhood Sexual Assault on Sexual Function in the Czech Male Population



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## ABSTRACT

**Introduction:** This study explores the impact of childhood sexual assault (CSA) on men's sexual function. There is limited understanding on the impact of CSA perpetrated against boys on later adult male sexual function, as there is a dearth of research on this topic. It was hypothesized that men reporting a history of CSA were more likely to report sexual function issues than men with no history of CSA.

**Material and methods:** A cross-sectional survey study of 1,004 Czech men aged between 15 and 85 years ( $M = 42.8$  years; Standard deviation = 17.6 years) have been conducted. The participants anonymously answered a questionnaire on multiple aspects of their life and sexuality. This questionnaire included sought data on history of CSA and self-reported intravaginal ejaculation latency time and the 5-item International Index of Erectile Function.

**Results:** 25 men (2.5%) indicated a history of CSA. 71% of the perpetrators were known by the victims, with a minority declaring the crime to authorities (37.5%). Half of those reporting assault also reported sexual function issues in the present or at some time in their life. Significant correlations were recorded between a history of CSA and erectile dysfunction but not significantly with premature ejaculation.

**Conclusions:** Men who reported a history of CSA are more likely to report sexual function issues than those who do not. The identified association between CSA and sexual function issues in adult life contributes to the small body of literature on the topic. When taking a sexual history, it is recommended to practitioner to include questions about CSA, considering its correlation with erectile dysfunction. An understanding of the relationship between CSA and adult sexual function helps practitioner to improve his patient's well-being and life satisfaction. **Kamnerdsiri WA, Fox C, Weiss P, et al. Impact of Childhood Sexual Assault on Sexual Function in the Czech Male Population. J Sex Med 2020;8:446–453.**

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**Key Words:** Male Sexual Function; Childhood Sexual Assault; Sexual Dysfunction; Erectile Dysfunction

## INTRODUCTION

Childhood sexual assault (CSA) can be defined as any sexual contact between a child and an adult or older person. It can include

oral, vaginal or anal fondling or penetration with a penis, digit, tongue, or foreign object and non-contact sexual assault/abuse (eg, exhibitionism or voyeurism).<sup>1,2</sup> Prevalence of CSA against boys is

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Ethical responsibilities: The ethics of this study was approved by the ethics committee of the First Faculty of Medicine of Charles University in Prague, Czech Republic. This study was carried out according to the World Medical Association's principles and the research protocol meets the requirements of the Ethical IRB and the Helsinki Declaration on Responsible Research. Protection of people and animals: Authors declare that neither

human nor animal testing have been carried out under this study. Data confidentiality: Authors declare that no participant's data appear in this article. Privacy Rights and Informed Consent: Authors declare that no participant's data appear in this article and informed consent was obtained from all participants. The study participants were properly informed gave their explicit consent and completed the questionnaires anonymously and privately. Note: Participants aged 15 years and above can participate in research without parental consent. Therefore, the interviewees' rights to data privacy, confidentiality, and informed consent remained guaranteed.

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reported between 3% and 31%.<sup>3</sup> Globally, it is suggested that 1 in 6 boys are sexually assaulted.<sup>4,5</sup> This statistic is most likely underestimated as many incidences of CSA are not detected or not reported.<sup>6</sup> CSA against girls is reported at higher rates than for boys.<sup>7</sup> The reasons for this gendered difference are contested, not clear, and probably multiple. This discussion is beyond the scope of this article. The reported incidence rates of CSA are impacted by the sociocultural context and local jurisdictions, legal definitions of CSA offenses, and measures of and/or collection of data.<sup>8</sup> CSA is a violation of a child's sexual rights and therefore human rights<sup>9</sup> and can have a lasting impact on the survivors' well-being.<sup>10,11</sup>

Little is known or understood about the impact of CSA perpetrated against boys, on their later sexuality as adult men. A search for articles using the search string "sexual assault" AND "sexual function" AND "men" of PubMed database returned zero articles and 2 articles in a similar search of PsycINFO database.<sup>12,13</sup> Both the articles considered the impact of adulthood sexual assault. A third article was also located in a Spanish-language journal with a focus on the impact of CSA on Chilean men.<sup>14</sup> The number of studies focused on the post-traumatic effects of CSA among men is much lower than the number of those on women.<sup>15</sup>

The impact of CSA on adult women's sexual function is better documented. Women who reported CSA histories also reported issues with sexual function and satisfaction.<sup>1,16,17</sup> Desire and arousal dysfunctions were most frequently reported.<sup>1</sup> Sexual arousal disorders were reported as high as 84% in a treatment-seeking sample<sup>1,18</sup> and between 49% and 62% in clinical samples.<sup>1,19–21</sup> Desire-related difficulties were also high ranging from 51% to 59% of reported samples.<sup>1,18–22</sup> Orgasmic difficulties were also found to be high in women who reported CSA histories.<sup>1,23</sup>

Sexual dysfunction in men can range from erectile function issues to ejaculatory control issues (premature ejaculation [PE] or delayed ejaculation). Population studies suggest erectile dysfunction (ED) can affect approximately 52% of men. It is estimated that between 5% to 20% of men report moderate-to-severe symptoms of ED.<sup>24–26</sup> ED is influenced by a man's level of psychologic well-being.<sup>27</sup> Psychologic issues with known association to ED include anxiety,<sup>28</sup> depression,<sup>29</sup> and panic attacks.<sup>30</sup> Level of education and age are associated with ED, with ED increasing with age and more prevalent in men who report lower levels of education. The absence of spouse or stable partner is also positively associated with ED.<sup>31–33</sup> Pathophysiological factors such as diabetes, hypertension, hypercholesterolemia, cardiovascular disease, and renal failure are also well-documented causes of ED.<sup>34,35</sup> PE is the most commonly reported sexual dysfunction in men, with reported prevalence rates between 3% and 30%.<sup>36,37</sup> Psychologic distress including performance anxiety has been found to be associated with PE.<sup>38,39</sup> A comorbidity of sexual dysfunction (PE and ED) has also been observed.<sup>40</sup> A history of CSA is also associated with higher levels of psychologic distress, including depression and anxiety.<sup>16,41</sup> In the context of this study, the cognitive processes associated with ED and PE are important to acknowledge. The traumatic experience of CSA

may result in traumatic flashbacks at the moment of sexual encounter. These flashbacks can either activate the adrenergic system, resulting in a PE, or the intrusive memories will interrupt the erotic focus necessary to maintain an erection.<sup>42,43</sup>

The limited research focusing on men reporting CSA histories displays results similar to research with women who report a CSA history. A study reports that North Chilean men with a CSA history were more likely to report sexual difficulties than men without CSA histories.<sup>14</sup> Another study reported impact of CSA histories on 3 aspects of sexual function: emotional (fear of touch; sexual guilt), behavioral (issues with [being] touched; issues with arousal), and evaluative (sexual satisfaction).<sup>16</sup> The authors reported that approximately one-third of respondents indicated sexual fear (37.5%) and sexual guilt (31.3%). Sexual touch was reported by 43.8% of the sample. A similar result was reported for sexual dissatisfaction (40.6%). Approximately 1 in 5 men reported issues with arousal (21.9%).<sup>16</sup> A study explored in more detail a range of sexual dysfunctions in men, yet it does not report frequency data.<sup>13</sup> It concluded that sexual victimization did impact on men's sexual functioning. Masters argued parallels could be drawn between male and female survivors.<sup>12</sup>

The small volume of research on women's experiences and even smaller volume on men suggest CSA later impacts on sexual well-being affecting desire, arousal (erections), and satisfaction. No data were found on the relationship between a history of CSA and ejaculatory control. The aim of the present study is to add to the body of knowledge on the relationship between a history of CSA and sexual function in men and by informing practitioners of the relationship assist them to improve survivors' overall well-being. The small volume data on men who report CSA history also suggest they experience sexual function issues at a higher rate than men without a history of CSA. It is hypothesized that men who report a history of CSA will also report sexual function issues (eg, ED and PE) at rates higher than men who report no history of CSA. This is an exploratory study identifying the relationships between sexual assault histories and sexual function issues to inform practice and future research.

## MATERIALS AND METHODS

### Sample

The sample was 1,004 Czech men aged between 15 and 84 years, with a mean age of 42.8 years (Standard deviation = 17.6). Less than half of the sample reported as being in a relationship (42.6%) with approximately one-third of the sample, single (38.1%), divorced (13.1%), or widowed (6.2%). The sample was well educated with 39.1% of men with completed secondary studies, 30% with completed vocational studies, and 19.1% with a university-level education. One in 10 men reported a primary education (11.8%). Heterosexuality was reported by 88% of the sample, with 1.4% indicating same-sex attraction and 10.7% identifying as bisexual.

## Procedure

Participants were recruited through a social research agency, CEGEDIM, in the Czech Republic. A nationally representative sample of non-institutionalized men of the Czech Republic aged 15–88 years was collected by CEGEDIM in 2013, under the supervision of First Faculty of Medicine, Charles University, Prague. The agency reported an 82% participation rate of persons approached. The sample is representative of the national census with regard to size of municipality, region, age, and education level. After participants provided informed consent (which included a statement of confidentiality of responses and the right to discontinue at any time) and received answers to any questions regarding survey item meaning, participants anonymously completed the paper-based survey instrument and returned it to the social research agency.

The survey instrument consisted of demographic questions (eg, age, relationship status, highest level of education completed, and sexual identity), a sexual history (including history of CSA; these questions can be found in [Appendix A](#)), the International Index of Erectile Function 5-item version (IIEF-5),<sup>44,45</sup> and the Index of Premature Ejaculation (IPE).<sup>46</sup> The IPE was not used in analysis of these data owing to small sample of participants with CSA. This would not allow for meaningful data analyses using the IPE measures. PE is measured using the self-reported intravaginal ejaculation latency times (IELTs). PE was defined as an IELT of 2 minutes or less.<sup>36,38</sup> Ethical approval was granted by the Ethics Committee of the First Faculty of Medicine of Charles University in Prague, Czech Republic.

This is an exploratory study, and a correlational study approach is adopted. The sample of men who reported CSA is small, and detailed analysis using inferential statistics is not justifiable or warranted. The variables under investigation were self-reported sexual assault history and self-reported sexual function issues, as well as calculated IIEF-5 and self-reported IELTs scores. Erectile function was determined based on a score lower than 21 on the IIEF-5.<sup>47</sup> PE was recorded where a participant reports an IELT less than 2 minutes.<sup>48</sup> These data were the basis for the correlations undertaken.

## RESULTS

This Results section first explores the participants' history of CSA to provide a context and understanding of CSA, followed by an exploration of reported sexual function issues (erectile function and PE).

25 men (2.5%) reported a history of CSA. 13 men (1.3%) indicated the CSA was a once-only event, whereas 12 men (1.2%) reported the CSA was repeated more than once. Participants were asked at what age the abuse began, which revealed higher rates during adolescence than childhood (See [Table 1](#)).

The perpetrator was identified as a relative for 5 participants (20.8%). 12 participants (50%) reported their perpetrator was a person known to them. It was a stranger (not known to them) for

**Table 1.** Age at which abuse began

Age (y)	N
8	1
9	1
10	1
11	2
12	0
13	5
14	6
15	9

7 men (29.2%). One participant did not disclose the perpetrator-victim relationship.

Two-thirds of survivors ( $n = 15$ ; 62.5%) did not report the CSA to anybody. 4 men (16.7%) told their parents; 3 participants (12.5%) told friends, 1 survivor reported the CSA to his school, and one reported it to police. Participants were asked why they had not reported the incident to police. Participants were able to select up to 4 responses: shame ( $n = 10$ ; 76.9%), fear of revenge by the perpetrator ( $n = 6$ ; 46.2%), fear of not being believed ( $n = 8$ ; 61.5%), and not wanting to hurt the perpetrator ( $n = 14$ ; 73.7%).

Participants were asked about the impact of the CSA on their later life with 8 participants (32%) reporting no impact and 17 participants (68%) indicating the CSA had an impact on later life. 7 of the men reported the impacts of CSA continued at the time of completing the survey. The impacts reported by participants can be found in [Table 2](#).

Participants were also asked about adulthood sexual assault. 27 participants (2.7%) reported being forced into sexual intercourse by violence or threat of violence, and a further of 14 participants (1.4%) reported repeatedly being forced into intercourse. The perpetrator of the adult sexual assault was reported as a man in 13 cases (35.1%) and a woman in 24 cases (64.9%). 11 participants self-reported that the adult sexual assault had an impact later in their lives. Continual, or ongoing, impact of the assault is reported by 6 participants.

Of the 25 participants who reported a CSA history, 15 participants (60%) also reported sexual assault as an adult: 5 men (20%) reporting a single adult sexual assault event, and 10 men (40%) reporting more than a single event of sexual assault.

**Table 2.** Reported impact of CSA on participants

Impact of CSA	N
Fear of women	3
Sexual disorders	1
Mood disorders (anxiety, depression)	4
Lack of self-confidence	4
Relationship issues	2
Had to seek psychiatric or psychologic support	3

CSA = childhood sexual assault.

## Sexual Functioning

126 men (12.5%) reported a life-time history of experiencing sexual function issues, with 133 men reporting current experience of sexual function issues. Sexual function issues and lifetime and current experience are reported in Table 3.

Of those participants who reported a CSA history, 12 men (48%) also reported a sexual function issue at some time in their life, and 11 men (45.8%) reporting a sexual function issue at the time of completing the survey. Lifetime and current experiences of sexual function issues for men with a history of CSA are reported in Table 4.

Current erectile function was assessed using the IIEF-5. The IIEF-5 is validated with a reported Cronbach's alpha scores of 0.98 and 0.88.<sup>47</sup> Lower scores indicate greater severity of ED with men who report scores lower than 21 are considered to be experiencing erection issues. 105 men (10.5%) were scored to have erection issues (ie, scores less than 21). Of these, 3 men (2.9%) also reported a history of CSA.

Current PE was assessed using the self-reported IELT. An IELT less than 2 minutes is considered to be PE.<sup>48</sup> 31 participants (3.1%) reported an IELT of 2 minutes or less. Of these participants, 2 men also reported a history of CSA.

## Correlations

Pearson correlations were performed to explore the relationships between variables. A significant correlation was recorded between *ever suffered a sexual function issue* and *current experience of a sexual function issue* ( $r = 0.506$ ;  $P < .001$ ). A significant association was reported between a history of CSA and *having ever suffered a sexual function issue* ( $r = 0.173$ ;  $P < .001$ ) and *current experience of sexual function issue* ( $r = 0.150$ ;  $P < .001$ ). Significant relationships were also recorded between a life history of sexual function issues and PE ( $r = 0.088$ ;  $P = .006$ ) and erection issues ( $r = 0.116$ ;  $P = .001$ ). The correlations between current experience of sexual function issues and PE ( $r = 0.098$ ;  $P = .002$ ), as well as with erection issues ( $r = 0.269$ ;  $P < .001$ ), were significant. A history of CSA was also found to be

significantly correlated with the presence of erection issues ( $r = 0.079$ ;  $P = .030$ ) and experiences of adult sexual assault ( $r = 0.217$ ;  $P < .001$ ) but not with PE ( $r = 0.004$ ;  $P = .890$ ).

## DISCUSSION

The present study aimed to add to the body of knowledge on the relationship between a history of CSA and sexual function. The hypothesis that men who report a history of CSA will also report sexual function issues is supported. The statistically significant associations reported in this study are considered small to moderate. The self-reported rate of CSA is in the lower levels of reported rates with Doyle Peter<sup>49</sup> suggesting between 3% and 31% and well less than the 1:6 ratio.<sup>4</sup> Approximately half of the sample experienced repeated incidences of CSA with age of onset between 8 and 15 years. In approximately 71% of cases, the perpetrator was known to the respondent, either as a family member or another person, a known person associated with the participant. The low levels of reporting are in line with past research.<sup>5,49–53</sup> It has been reported that the low levels of reporting of CSA results from fear of family breakdown (if CSA is reported), fear for personal safety, a sense of responsibility for other children, and fear of not being believed.<sup>54</sup> For male victims of CSA, it has also been suggested that perceptions of being emotionally weak, gay, not masculine, or fear of the victim-cum-perpetrator narrative, all contribute to non-reporting of CSA.<sup>54</sup>

CSA was reported to have later impacted for nearly two-thirds of the participants, with 7 men still experiencing the impact at time of completing the survey. Sexual trauma can impact on individuals throughout life. Sexual trauma can have long and devastating effects on some survivors. It can impact them psychologically and physiologically.<sup>52,53,55–57</sup> For these men, the impacts varied and included sexual and mood disorders as well impacts on sense of self and relationships.

Adult sexual assault was also reported by some participants. These incidence data, such as the CSA incidence data, are at the lower ends of the reporting range when compared with other research.<sup>58–60</sup> The incidence rates of men with CSA also being

**Table 3.** Experiences of sexual function issues—current and life-time experiences

Sexual function issue	Life time experience		Current experience	
	N	N (%)	N	N (%)
Lack of sex drive or desire	29	2.9	40	4.0
Premature ejaculation	43	4.3	12	1.2
Delayed ejaculation	13	1.3	8	0.8
Inability to attain orgasm	19	1.9	32	3.2
Anejaculation/Inability to ejaculate	8	0.8	16	1.6
Erection issues	46	4.6	75	7.5
Hypersex drive	28	2.8	22	2.2
Pain or unpleasant feelings during sex	14	1.4	7	0.7

CSA = childhood sexual assault.

NB Not all participants responded to these questions.



**Table 4.** Experiences of sexual function issues for men with a history of CSA—current and life-time experiences

Sexual function issue	Life-time experience	Current experience
	N	N
Lack of sex drive or desire	2	4
Premature ejaculation	1	6
Delayed ejaculation	4	6
Inability to attain orgasm	2	5
Anejaculation/Inability to ejaculate	3	5
Erection issues	3	2
Hypersex drive	3	5
Pain or unpleasant feelings during sex	4	7

CSA = childhood sexual assault.

subjected to adult sexual assault are within previously reported ranges.<sup>59,60</sup>

Incidence of induced sexual function disorders is not easily compared. There are no data on global rates of sexual function. The current experience of sexual function issues is in line with past research.<sup>24,25,36,37,61</sup> Data comparison and triangulation is also difficult owing to the small numbers in the sample.

The hypothesized relationship between history of CSA and sexual function issues was supported. Men who reported a history of CSA also reported past experience of sexual function issues and/or current experience of sexual function issues. Not surprisingly, men who had suffered a sexual function issue were also likely to be experiencing sexual function issue during the survey period. Associations were also recorded between past experiences and current experiences of sexual function issues and the presence of rapid ejaculation and erectile function issues. This is an expected finding. Erection issues were also reported to be related to a history of CSA and adult sexual assault. The presence of the sexual function issues and the confirmed relationship is noted in past research.<sup>13,14,16</sup> These data on sexual function for men with a history of CSA must be read with caution because of the small size of the sample. Future research could explore these associations in greater detail.

The dearth of research on the relationship between sexual function and sexual assault makes comparison of the results of this study with past research difficult. Sexual assault, or sexual trauma, is a trauma. The relationship between sexual function and trauma (not necessarily sexual trauma) is documented in the general trauma<sup>62</sup> and post-traumatic stress disorder literature.<sup>42</sup> The impact of trauma may be experienced in different areas of sexual function including desire, arousal, and orgasm (ejaculatory) issues.<sup>42</sup> The perception of severity of trauma appears to be associated with the severity of sexual dysfunction.<sup>62</sup> It is suggested that trauma that results in physical, psychologic, or social limitations can lead to issues with sexual function.<sup>62</sup> The CSA-related trauma can result in psychologic impacts. Therefore,

there is a greater likelihood of sexual function issues for survivors of CSA. The trauma response models applied to sexual function can perturbate any and all of biological, cognitive, and/or affective processes.<sup>42</sup>

## Limitations and Future Research

The sample is reflective of Czech male population but not of broader European population. This study is limited by the small sample size of men reporting a history of CSA. This made comparison between the groups statistically irrelevant. Causation could not be tested, and the results cannot be generalized. Although, given that these results are in line with past research, it can be argued that a relationship is supported and warrants a more detailed exploration.

The reliance on self-report data on sexual function and a lack of objective measures to triangulate these data also limit the strength of the results, although the self-report data was triangulated with more objective measures, at least for erectile function. The use of objective measures of PE (eg, the *Premature Ejaculation Profile*<sup>63</sup> triangulated with self-reported *intravaginal ejaculation latency time*) and sexual satisfaction (for example, *Global Measure of Sexual Satisfaction*<sup>64</sup> or the *New Sexual Satisfaction Scale*)<sup>65</sup> would enhance the reliability, validity, and generalizability of the results.

Given the lack of research investigating this phenomenon, the contribution and support of this study providing to the existing small body of literature is welcome. The need for rigorous research focused specifically on this topic—men who report a history of CSA and the impact on their sexual function—remains necessary.

## Implications for Practice

This research supports the hypothesis and validates past research. Men who report a history of CSA are also likely to experience sexual function issues.

Sexual trauma, or trauma resulting from sexual assault does impact sexual well-being and sexual satisfaction.<sup>66</sup> This may trigger a chain of negative reactions that will impact numerous aspects of a person's life, as sexual well-being and sexual satisfaction are major determinants of quality of life<sup>67</sup> and therefore overall life satisfaction. The intimate relationship may also be negatively impacted as sexual function, and sexual satisfaction are important to relationship satisfaction<sup>68</sup> and overall well-being.<sup>44</sup> Relationship strength (as an outcome of relationship satisfaction) is an indicator of good physical and mental health with healthy relationships a protective factor for better health. A practitioner needs to understand the intricate interrelationship between sexual trauma, sexual function, well-being, and relationship satisfaction to better support men who have experienced CSA.

When screening for sexual function issues, it is important to explore sexual assault history as part of the sexual history. Men who present sexual function issues may report a history of CSA (or

recent sexual assault). When seeking the etiology of a sexual function issue, the use of open-ended and non-judgmental questions would minimize practitioner-informed retraumatization.

Understanding that a history of CSA can impact sexual function (erectile function and ejaculatory control) and the possibility of somatic-oriented trauma suggests the adoption of a trauma-informed approach by practitioners in the sexological field. A trauma-informed approach is strengths based and provides the survivor with an opportunity to tell their story rather than being diagnosed as a problem. There is therapeutic benefit to explore the narrative of a survivor's life.<sup>69,70</sup> With the assistance of an informed practitioner, a survivor may succeed to reauthor the meaning of the traumatic event to a more positive outcome.

## CONCLUSIONS

This study has contributed to the growing knowledge of the impact of CSA on men's sexual functioning in general and specifically for Czech population. The research findings are limited and are congruent with past research. Men who report a history of CSA also reported sexual function issues. The relationship between these 2 variables was moderate and significant. Future research that explores the causal relationship of these phenomena is necessary. A trauma-informed approach to sexual history taking would provide a safe environment for men survivors to disclose their sexual function issues and history of CSA.

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## SUPPLEMENTARY DATA

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.esxm.2020.06.003>.

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