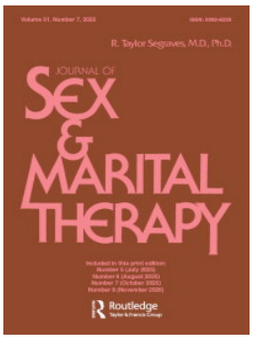

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Profiles of Traumatic Sexuality in Sex Therapy Patients: A Comparison of Interpersonal Trauma History and Sexual Well-Being

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ABSTRACT

This study explored profiles of traumatic sexuality (including six sex-related dimensions—dissociation, intrusiveness, shame and guilt, pleasing the other, interpersonal distress, and hypervigilance) and compared differences in sexual well-being and interpersonal trauma among the profiles. A latent profile analysis was performed on a clinical sample of 484 sex therapy patients consulting for sex and relationship related issues. Results identified three distinct profiles: Low Traumatic Sexuality (characterized by low to moderate scores, 87.8% of the sample), High Traumatic Sexuality (marked by elevated scores across all dimensions, 2.5%), and Dissociative-Pleasing Traumatic Sexuality (exhibiting a mixed score pattern, 9.7%). Comparative analyses indicated that these profiles were further distinguished by key variables, such as sexual well-being and interpersonal trauma. These findings underscore the complex ways in which interpersonal trauma shapes sexual experiences, highlighting the importance of individualized therapeutic approaches tailored to address specific trauma histories and support the restoration of healthy sexual functioning and overall well-being.

Introduction

The notion of "traumatic sexuality" introduced by Gewirtz-Meydan and Lassri (2023) was developed to capture the repercussions of endured interpersonal trauma such as childhood sexual abuse (CSA), on adult sexual experiences. Also referred to in the literature as "post-traumatic sexuality" or "traumatized sexuality," this concept specifically refers to sexual-related post-traumatic stress symptoms (PTSS) that emerge in sexual contexts (Gewirtz-Meydan & Lassri, 2023). Grounded in the DSM-5 framework, which classifies post-traumatic stress into four clusters: intrusions (e.g., flashbacks), avoidance (e.g., steering clear of trauma-related thoughts and emotions), alterations in cognition and mood (e.g., excessively negative self-perceptions), and hyperarousal symptoms (e.g., irritability, aggression)—traumatic sexuality further explores how trauma becomes ingrained in sexual behaviors and experiences (Gewirtz-Meydan et al., 2023; Gewirtz-Meydan & Godbout, 2023; Gewirtz-Meydan & Lassri, 2023).

Gewirtz-Meydan and Lassri (2023) concept of post-traumatic sexuality draws from clinical studies and established frameworks of post-traumatic symptoms to suggest an integrative

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presentation of how trauma-related symptoms manifest during sexual activities. Traumatic sexuality is also deeply informed by embodiment theories, which propose that traumatic experiences are not only psychologically encoded but also somatically stored within the body (Van der Kolk, 2014). These embodied memories could manifest through a range of physical and emotional experiences, including unexplained bodily sensations, emotional dysregulation, involuntary physical responses, and sexual difficulties (Giotakos, 2020; Invitto & Moselli, 2024; Laricchiuta et al., 2023; Van der Kolk, 2014). Such manifestations are implicit, bypassing conscious awareness, and may resurface during moments of physical intimacy. This perspective underscores the importance of considering the body as a site of both trauma and healing in clinical work with survivors.

Traumatic sexuality comprises six dimensions: dissociation during sex, intrusiveness during sexual activity, shame and guilt regarding sexual aspects, pleasing the other during sex, interpersonal distress, and hypervigilance in sexual contexts (Gewirtz-Meydan & Lassri, 2023). These dimensions can serve as adaptive mechanisms, offering short-term protection by helping survivors manage trauma-related distress during sexual activities. However, over time, they often interfere with sexual and relational well-being, as they disrupt self-awareness, embodiment, and a healthy connection to one's sexuality, thereby impeding post-traumatic recovery (Leonard & Follette, 2002).

Traumatic sexuality in survivors of CSA

Traumatic sexuality manifests in complex and multifaceted ways, reflecting the interplay between post-traumatic symptoms and the sexual domain. The six key dimensions, while distinct, often interact and amplify one another (Gewirtz-Meydan and Lassri, 2023). Examining these dimensions allows for a deeper understanding of the diverse experiences of survivors and enables the tailoring of therapeutic interventions to meet individual needs.

Dissociation is a prominent experience among CSA survivors. Approximately 30% of women survivors of CSA report severe dissociative symptoms (Bird et al., 2014; Mulder et al., 1998; Sanders & Giolas, 1991). Dissociation can present as depersonalization, where the individual feels detached from their body, or derealization, in which surroundings feel unreal or distant (Bird et al., 2014; Maercker et al., 2000). These symptoms, often triggered by sexual cues that echo past trauma, can impair sexual arousal and contribute to significant sexual dysfunctions (Bird et al., 2014; Gewirtz-Meydan & Godbout, 2023; Hansen et al., 2012). In this case, survivors of sexual trauma may disconnect from their bodies to avoid reliving the abuse and to manage overwhelming emotions or physical sensations, leading to sensory and emotional numbness during sexual activity (Bird et al., 2014; Gewirtz-Meydan, 2022a; Rellini, 2008).

Intrusive thoughts and flashbacks represent another manifestation of post-traumatic symptoms that can be triggered during sexual activity, leading to distressing reeexperiences of the trauma (Kristensen & Lau, 2011). These intrusive experiences may cause some survivors to avoid sexuality altogether to prevent exposure to triggers (Kristensen & Lau, 2011). Others may continue engaging in sexual activity but experience intense hypervigilance—an exhausting state of heightened alertness that is difficult to escape. To cope with these overwhelming feelings, survivors may attempt to control sexual interactions by restricting touch and avoiding forms of contact that could provoke a flashback (Kristensen & Lau, 2011). The frequency and intensity of these flashbacks are considered clinical indicators of sexual difficulties and their severity, particularly when they occur during sexual activity (Buehler, 2008; Kristensen & Lau, 2011; Maltz, 2002).

Shame and guilt related to sex are also powerful dimensions that can also influence the sexual experiences of survivors. These emotions are often rooted in internalized stigma and disordered beliefs about sexuality and self-worth, potentially contributing to a deterioration in sexual function, particularly in individuals who feel shame about their experiences or sexual behaviors (Pulverman et al., 2018; Pulverman & Meston, 2020). Research shows that sexual shame plays a key role in the relationship between childhood sexual abuse (CSA) and sexual dysfunction in women (Pulverman & Meston, 2020). In men, shame and guilt can also be amplified by rigid

masculine stereotypes, which may lead to confusion and self-blame, especially when physiological responses occurred during abuse (McMullen, 1990; Rentoul & Appleboom, 1997).

The drive to sexually please others, regardless of one's own desire and needs, is generally rooted in unmet psychological needs for validation, security, or attachment among survivors of CSA, which constitutes a form of betrayal trauma (Gewirtz-Meydan & Ofir-Lavee, 2021). This dynamic can lead survivors to engage in unwanted or unpleasurable sexual activities, thereby reinforcing patterns of self-neglect and revictimization (Brotto et al., 2016; Gewirtz-Meydan & Lahav, 2021). Such people-pleasing behaviors are frequently accompanied by difficulties in sexual assertiveness, as survivors may struggle to articulate boundaries or prioritize their own needs (Hasson & Ginzburg, 2025). This pattern may bear resemblance to the "fawn" trauma response described by Walker (2013), in which submissiveness and compliance are employed to gain approval or avoid conflict. As such, in sexual contexts, compliance may potentially serve an adaptive safety function (e.g., "if I play along, the experience will end more quickly"). In sexual contexts, this manifests as other-directedness, where the partner's needs consistently take precedence over one's own (Briere & Scott, 2015), often replicating earlier toxic relational dynamics and contributing to emotional distress during intimacy (Gewirtz-Meydan & Godbout, 2023).

Interpersonal distress involves significant challenges in establishing emotional connections with one's partner (Bancila & Mittelmark, 2009). Survivors may carry forward negative perceptions of others as unavailable, abusive, insensitive, untrustworthy, dangerous and exploitative. These negative perceptions can be projected by past abuse dynamics onto current partners carried into adult sexual relationships, sometimes even confusing them with their abusers (Hughes, 1994). As a result, survivors may struggle with feeling safe and valued in their relationships, limiting their ability to embrace vulnerability and emotional intimacy with their partners (Finkelhor & Browne, 1985). This interpersonal distress can also be compounded by post-traumatic stress disorder (PTSD)-related hyperarousal, which amplifies perceived threats during sexual contact and be associated with extreme stress regarding every aspect of sexual activity or the actions of the sexual partner (Gewirtz-Meydan & Godbout, 2023).

Finally, sexual hypervigilance manifests as an excessive alertness to perceived threats, discomfort, or unpredictability during sexual activity (Lorenz et al., 2012; Payne et al., 2005). Sexual hypervigilance limits a person's ability to focus on pleasurable sensations during sexual activity, while exacerbating unpleasant sensations, such as sexual pain (Payne et al., 2005). Survivors may feel the need to anticipate their partner's every movement and actions during sexual activity—thereby losing connection to pleasurable sensations (Lorenz et al., 2012; Payne et al., 2005). Hypervigilance is also linked to intrusive trauma-related thoughts, prompting survivors to anticipate certain triggers that may evoke traumatic memories and flashbacks. These experiences can lead to a range of responses, from avoidance and dissociation to anger and hostility toward the partner (Gewirtz-Meydan & Godbout, 2023). In some cases, survivors turn to compulsive or avoidant sexual behaviors, such as excessive use of pornography or masturbation, as a strategy to maintain control and avoid triggers associated with intimate sexual contact and maintain a false sense of control (Gewirtz-Meydan & Godbout, 2023).

Briere's (2015) Pain Paradox provides a compelling conceptual framework for examining the sexuality of individuals who have survived interpersonal trauma, as well as for understanding the experiential avoidance or compulsive behaviors that may emerge in its aftermath. This paradox helps explain why individuals who dissociate, distract themselves, deny or repress their experiences, or engage in maladaptive behaviors (such as sexual compulsivity), are at heightened risk for developing intrusive thoughts and chronic psychological symptoms. Traumatic experiences that are suppressed or dissociated remain inaccessible to conscious processing and thus cannot be meaningfully integrated (Briere, 2015; Briere et al., 2005). Although experiential avoidance and compulsive behaviors are often employed in an effort to mitigate distress, they paradoxically tend to intensify it by increasing the frequency and intensity of intrusive thoughts and aversive emotional states (Briere, 2015). Moreover, as Briere (2015) notes, efforts to avoid trauma-related cues may also hinder individuals' capacity to engage with and derive satisfaction from the

positive aspects of life, thereby constraining their experience of pleasurable emotions. Importantly, the relationship between avoidance and compulsive engagement is neither linear nor straightforward. For instance, in an attempt to escape or diminish intrusive thoughts, flashbacks, and feelings of shame or guilt, survivors of childhood sexual abuse may adopt avoidance strategies such as dissociation (Briere, 2015).

Cumulative interpersonal trauma & sexual well-being in sex therapy patients

Although the *Post Traumatic Sexuality Scale* (Gewirtz-Meydan & Lassri, 2023) was developed using a sample of CSA survivors, individuals who have experienced other forms of cumulative interpersonal trauma may also exhibit patterns of traumatic sexuality. Indeed, cumulative interpersonal trauma experience (i.e., experiencing multiple forms of adverse childhood experiences including physical, psychological, and sexual abuse, physical and psychological neglect, and witnessing violence between parents) has been associated with long-term impacts on sexuality (Bigras et al., 2017a; Dugal et al., 2023; Godbout et al., 2020; Rellini et al., 2012). Similarly, experiencing sexual violence in adulthood (Layh et al., 2020), may also contribute to the development of traumatic sexuality in adulthood. Given these findings, it is plausible that individuals with cumulative interpersonal trauma may also experience difficulties across the six dimensions of traumatic sexuality. This broader application reflects the clinical reality that sexual difficulties often stem from a complex history of interpersonal harm, not limited to CSA.

Patients in sex therapy represent a particularly relevant population for exploring profiles of traumatic sexuality, given self-reported experiences of cumulative interpersonal trauma and high rates of sexual problems (Bigras et al., 2017a,2017b; Dugal et al., 2023). Sexual well-being encompasses emotional, physical, mental, and social dimensions of sexual health (World Health Organization, 2010) and is reflected in higher levels of sexual satisfaction (Bigras et al., 2021) and lower levels of sexual distress (Stephenson et al., 2012). Research indicates that adults seeking sex therapy report nearly twice the rate of cumulative interpersonal trauma compared to community samples (Bigras et al., 2017a; Edwards et al., 2003), with 56% of women and 37% of men in this clinical group disclosing CSA. Additionally, studying sex therapy patients is particularly relevant given the high prevalence of sexual distress and dysfunction within this population (Lafortune et al., 2023).

Given the well-established connection between interpersonal trauma such as CSA (Bigras et al., 2021; Wang et al., 2023), childhood physical abuse, childhood emotional abuse, childhood neglect (Wang et al., 2019) and cumulative interpersonal trauma on sexual functioning (Bigras et al., 2017a,2017b), it is equally important to consider how interpersonal trauma is associated with different profiles of traumatic sexuality in patients consulting in sex therapy. Consistent evidence links childhood interpersonal traumas—such as sexual abuse, physical abuse, and neglect—to adult sexual functioning, sexual dysfunction and sexual satisfaction (Norman et al., 2012; Pulverman et al., 2018; Rellini et al., 2010; Voisin et al., 2014). Beyond these effects, cumulative interpersonal trauma has been associated with a range of adult sexual issues, including sexual anxiety, avoidance, compulsive behaviors, lower sexual satisfaction, and risky sexual behaviors (Bigras et al., 2017a; Norman et al., 2012; Rellini et al., 2012; Walsh et al., 2014; Wang et al., 2019).

To better understand, identify and support those affected by traumatic sexuality, it therefore appears essential to examine the different constellations of symptoms in light of individuals' traumatic histories (sexual trauma and cumulative interpersonal trauma) and their overall levels of sexual well-being.

Person-centered analyses

A person-centered approach is essential for capturing the complexity and diversity of sexual responses among trauma survivors—particularly those receiving sex therapy. Rather than assuming a uniform set of symptoms, this method allows for the identification of distinct profiles that reflect

varying patterns of distress, coping, and adaptation (Lanza & Cooper, 2016). Such an approach is especially relevant for understanding traumatic sexuality, as survivors may present with similar symptoms (e.g., sexual dysfunction or distress), but differ in their underlying relational dynamics.

Although studies on traumatic sexuality profiles are limited, studies examining sexual behaviors, PTSD and trauma history reveal diverse patterns among survivors. For example, a study on attachment representations (anxiety and avoidance) and sexuality (i.e., compulsion and avoidance) of CSA survivors (Labadie et al., 2018) identified two profiles. The first profile was defined by a high level of attachment anxiety with low to moderate attachment avoidance, along with low to moderate levels of sexual compulsion and sexual avoidance. In contrast, the second profile exhibited both high scores of attachment anxiety and attachment avoidance, accompanied by elevated levels of sexual compulsion and sexual avoidance (Labadie et al., 2018). Participants in the second profile also reported more experiences of psychological abuse and witnessed parental violence, and they experienced higher levels of personal distress (Labadie et al., 2018). Gewirtz-Meydan (2022b) identified four profiles of sexual behavior in 806 adults from the community: hyposexual individuals, hypersexual porn users, porn users, and within usual range. These four groups differed in terms of childhood abuse, PTSD, anxiety, depression, and sexual motives. Precisely, the "hypersexual porn users" reported the highest levels of childhood trauma (emotional, physical, and sexual) and significantly more PTSD symptoms than the "within usual range" and "hyposexual" groups. They also had higher anxiety and depression scores than all other profiles. The "hyposexual" group reported the lowest levels of sexual motivation, while "hypersexual porn users" and "porn users" were more likely to engage in sex as a coping mechanism or due to peer pressure, compared to the other groups. A recent study by Lipinski and Beck (2025) used latent profile analysis and found four distinct patterns of co-occurring sexual dysfunctions and posttraumatic stress disorder symptoms among women survivors of adolescent and early adulthood sexual assault. Findings highlighted the heterogeneity in symptom presentation, with more severe posttraumatic stress disorder symptoms and sexual dysfunctions associated with greater assault severity and unsupportive social response (Lipinski & Beck, 2025).

These findings emphasize the multifaceted impact of trauma on sexual behavior and the lived experiences of survivors' sexuality. They also suggest the existence of distinct profiles of traumatic sexuality, each characterized by varying levels of sexual and relational well-being. Yet, there remains a significant gap in research on sex therapy patients. Studies are needed to better understand the diverse manifestations of traumatic sexuality in this population and examine how sexual and relational well-being may predict or differentiate these profiles. Addressing this gap could offer valuable insights to guide more effective interventions for sex therapy patients.

The current study

To address the aforementioned limitations of past studies and better capture the diverse expressions of traumatic sexuality, the present study examined a clinical sample of individuals seeking sex therapy, using their responses on the self-reported *Post-Traumatic Sexuality Scale* (PT-SEX; Gewirtz-Meydan & Lassri, 2023). The first aim was to identify distinct profiles of traumatic sexuality using latent profile analysis (LPA). Given the exploratory nature of LPA, no specific hypotheses were made regarding the number of profiles. However, we expected profiles to differ based on varying levels—higher or lower—across the six dimensions of traumatic sexuality: dissociation during sex, intrusive thoughts during sexual activity, shame and guilt regarding sexual aspects, pleasing the other during sex, interpersonal distress, and hypervigilance in sexual contexts. The second aim was to compare the profiles identified on patients' interpersonal trauma history (i.e., sexual trauma and cumulative interpersonal trauma), as well as their sexual well-being (i.e., sexual satisfaction, sexual distress, and sexual function). We anticipated that participants in the profiles characterized by higher levels of traumatic sexuality would be more likely to have experienced interpersonal trauma and would report more sexual dysfunction, higher sexual distress, and lower sexual satisfaction.

Materials and methods

Participants and procedure

The sample consisted of 484 patients seeking sex therapy from clinical sexology interns in different settings (i.e., university, private clinics, hospitals, family medicine clinics, community clinics, specialized clinics) consulting for sex and relationship related issues between Fall 2022 and Winter 2024. Patients were systematically invited by their clinical sexology intern to complete self-reported online questionnaires (approximately 1.5 hours) as part of the assessment phase in their initial sex therapy sessions. Inclusion criteria were being fluent in French or English, being at least 18 years old, and having answered the PT-SEX questionnaire.

Participants were on average 35.5 years old ($SD = 10.48$). Participants self-identified as heterosexual (71.1%), bisexual (12.4%), lesbian/gay (4.3%), queer (4.5%), exploring/questioning (5.6%), on the asexual spectrum (1.7%), and 0.4% preferred not to answer. They reported being women (55.8%), men (37.6%), non-binary (2.3%), gender fluid (.8%), gender nonconforming (.2%), exploring/questioning (.8%), and .6% preferred not to answer. Regarding gender identity, the majority reported being cisgender (94.6%), 4.8% were trans, and .6% preferred not to answer. Complete sociodemographic information is presented in Table 1. Chi-square tests revealed

Table 1. Sociodemographic characteristics ($n = 484$).

Characteristics	n	Participants (%)
Gender		
Women	270	55.8
Men	182	37.6
Other (e.g., non-binary, fluid)	32	6.6
Sexual orientation		
Heterosexual	344	71.1
Lesbian	10	2.1
Gay	11	2.3
Bisexual/Pansexual	35	7.3
Flexible	25	5.2
Queer	22	4.5
Asexual	8	1.7
Questioning	27	5.6
Birthplace		
Canada	424	87.6
United States	1	.2
Europe	40	8.2
Central or South America	7	1.4
Asia	5	1.0
Caribbean	1	.2
Africa	6	1.2
First language		
French	435	89.9
English	18	3.7
Spanish	12	2.5
Other (e.g., Creole, German, Arab)	19	3.9
Occupation		
Student	93	19.2
Full- or part-time worker	346	71.5
Retired	14	2.9
Currently unemployed	12	2.5
Other (e.g., stay at home, invalid)	19	3.9
Education		
Primary school	5	1.0
High school	49	10.1
College/professional	159	32.9
Undergraduate	188	38.8
Graduate	89	17.1
Individual annual income		
CAD$19,999 or less	94	19.4
CAD$20,000 - CAD$39,999	73	15.1
CAD$40,000 - CAD$59,999	90	18.6
CAD$60,000 - CAD$79,999	79	16.3
CAD$80,000 or more	144	39.7

significant but modest associations between profile membership and sociodemographic variables, including gender, sexual orientation, occupation, and income. While standardized residuals pointed to specific group differences—such as a higher proportion of non-binary participants, students, or low-income individuals in Profile 3—small effect sizes and low expected counts in some cells suggest these findings should be interpreted with caution (see supplemental material).

The current study was approved by the institutional review board for research involving human subjects of the Université du Québec à Montréal. A consent form was completed by participants before their participation. This form notifies them of their right to decline participation or withdraw from the study at any time without impacting the services they receive. To mitigate distress that may arise from participation in the study, individuals were encouraged to contact their therapist, and a list of emergency references and contact information for the research team was provided.

Measures

Traumatic Sexuality was assessed using the *Post-Traumatic Sexuality Scale* (PT-SEX; Gewirtz-Meydan and Lassri, 2023), translated into French by our team using a back-translation process as our sample was French-speaking in majority (Vallerand, 1989). Precisely, a bilingual individual translated the items from English to French, another bilingual individual retranslated the items from French to English, and the retranslated items were reviewed and approved by the original author to ensure the accuracy of the translation in capturing the meaning of the items. A confirmatory factor analysis (CFA) was performed on the French translation of the instrument. The CFA confirmed the original factorial structure with each item loaded on its designated factor with standardized loadings between .352 and .948 and satisfactory fit (χ^2 = 632.581 (*df* = 259), *p* = .000, RMSEA = .055, 90% CI [.049; .060], CFI = .915, TLI = .902, SRMR = .087). The questionnaire consists of 25 items divided into six dimensions of traumatic sexuality, answered on a 5-point Likert scale ranging from 1 (Not at all) to 5 (Very often), namely: dissociation (7 items: α = .93; "During sex, my mind wanders and I can't focus on the sexual activity"), intrusive thoughts (5 items: α = .92; "I have images (flashbacks) from the traumatic experience"), shame and guilt (5 items: α = .79; "I feel guilty when I am sexually aroused"), the drive to please the other sexually (4 items: α = .79; "I feel obligated to have sex with my partner"), interpersonal distress (2 items: α = .34; "I feel like I am scared of my partner during sex"), hypervigilance during sexual activity (2 items: α = .52; "During sex, I need my partner to always tell me what is going to happen next"). Total scores were obtained by averaging the items for each scale, ranging from higher scores indicating higher levels of traumatic sexuality.

Traumatic experiences

Childhood sexual abuse (CSA) was assessed based on the Canadian Criminal Code definition (Criminal Code of Canada, 1985): "Before the age of 18 (17 and under), did you experience an unwanted sexual act with any of the following individuals?" (yes/no).

Adult sexual victimization was assessed based on the Canadian Criminal Code definition (Criminal Code of Canada, 1985): "Have you experienced any sexual act without your consent after the age of 18?" (yes/no).

Cumulative childhood interpersonal trauma was measured using the *Cumulative Childhood Trauma Questionnaire* (CCTQ; Godbout et al., 2017). This scale consists of 17 self-reported items, assessing experiences of seven forms of childhood trauma, including physical and psychological abuse, physical and psychological neglect, exposure to physical and psychological partner violence, and bullying. Participants reported how often they experienced each form of trauma on a 7-point Likert scale ranging from "never" (0) to "every day" (6), for a typical year before the age of 18. For analysis, each type of trauma was dichotomized as either present (1) or absent (0) if experienced at least once in a typical year before age 18, and summed to form a total score ranging from 0 to 7, with higher scores indicating a greater accumulation of

childhood interpersonal trauma. This cumulative index score demonstrated acceptable internal consistency (α = .74).

Sexual well-being measures. ***Sexual satisfaction*** was assessed using the *Global Measure of Sexual Satisfaction* (GMSS; Lawrance & Byers, 1995), which assesses satisfaction levels regarding one's sexuality using five items on a seven-point bipolar nominal scale, namely: "My sexuality is: good-bad, pleasant-unpleasant, positive-negative, satisfying-unsatisfying, valuable-worthless". Scores were obtained by summing, with higher scores reflecting higher sexual satisfaction. Internal consistency was excellent in the original sample (α = .90; Lawrance & Byers, 1995) and in the French validation (α = 96; Paquette et al., 2025). In this study, the internal consistency was good (α = .88).

Sexual function was measured using the *Arizona Sexual Experience Scale* (ASEX; McGahuey et al., 2000), assessing low sexual desire or arousal, difficulties with lubrication or erection, premature ejaculation or orgasm, delayed or absence of ejaculation or orgasm, and pain during sex, on a Likert scale ranging from 1 to 6 (1 = extremely easily/strong/satisfying, 6 = very difficult/weak/unsatisfying). To reflect the DSM-5 (APA, 2013) diagnostic of sexual dysfunction, the sexual difficulty had to be present for at least 6 months, and participants were invited to assess their level of distress associated with the difficulty (1 = no distress, 6 = extreme distress). Following the scoring proposed by Lafortune et al. (2023) to reflect the DMS-5 diagnostic criteria (American Psychiatry Association, 2013), participants who obtained high scores on the scales (at least 5 out of 6 on the function items and at least 4 out of 6 on the related distress items) were classified as presenting a sexual dysfunction. Sexual dysfunction was then categorized into two groups: no sexual dysfunction (0 sexual dysfunction) or the presence of one or more sexual dysfunctions (1+ sexual dysfunction). Participants completed the version of the questionnaire that corresponded to their genitalia rather than their gender identity as some of the items were genitalia-specific (vaginal lubrication and erections). In this study, the internal consistency was satisfactory (α = .71).

Sexual distress was assessed using the *Female Sexual Distress Scale-Revised* (FSDS-R; DeRogatis et al., 2008) and its adapted version for men (Bois et al., 2016). This scale measures the level of sexual distress on a 6-point Likert scale ranging from 0 (Never) to 5 (Always), with 13 items (e.g., "I feel stressed about sex"). The score was calculated using the average, where a score ≥ 11 indicates sexual distress. In this study, the internal consistency was excellent (α = .93).

Data analysis

Descriptive analyses were performed using SPSS v.28 (IBM Corp., 2023), while LPA was conducted with Mplus 8.3 (Muthén & Muthén, 2012). LPA is a valuable tool for identifying subgroups or profiles within a population based on patterns of responses to multiple observed variables. To identify profiles based on participants' scores on the six dimensions of traumatic sexuality, LPA was performed using scale scores from the traumatic sexuality (PT-SEX scale): dissociation, intrusive thoughts, shame and guilt, the drive to please the other sexually, interpersonal distress, and hypervigilance during sex. Different models were tested, ranging from one to six latent classes. Missing data were handled using Full Information Maximum Likelihood (FIML) estimation in Mplus. Model fit was evaluated using several fit indices, including the Akaike information criterion (AIC), Bayesian information criterion (BIC), adjusted BIC, Bootstrapped likelihood ratio test (BLRT), and entropy. These indices statistically support in selecting a model with the best balance of fit and parsimony. The selected model was also evaluated based on its theoretical relevance and interpretability, in line with recommendations from Geiser (2013).

Once the optimal model was identified, profile differences on indicators of interpersonal trauma (CSA, adult sexual violence, and cumulative childhood trauma) and outcomes (sexual satisfaction, dysfunction and distress) were examined using the modified Bolck-Croon-Hagenaars

(BCH) method (Bolck et al., 2004) for continuous outcomes and the categorical distal outcome (DCAT) procedure (Asparouhov & Muthén, 2014a; 2014b; Lanza et al., 2013) for categorical indicators in Mplus 8.3. The BCH method examines how continuous covariates differed across latent profiles, while accounting for classification uncertainty (Bolck et al., 2004). This approach allows for comparisons of covariate means across profiles, helping to identify how external variables distinguish and characterize each profile (Asparouhov & Muthén, 2014b). For categorical covariates, we used the DCAT method, which tests for differences in the distribution of categorical variables across profiles (Asparouhov & Muthén, 2014b; Lanza et al., 2013). Together, these procedures provide insight into how both continuous and categorical covariates help differentiate latent profiles in a statistically robust manner.

Results

Identification and description of latent profiles

Across the sample ($n = 484$), 162 participants (33.5%) were survivors of CSA, and 155 (32%) were survivors of adult sexual victimization. Participants reported an average of 3.5 cumulative interpersonal traumas. In terms of sexual dysfunctions, 268 participants (55.4%) presented no sexual dysfunction, and 196 (40.5%) presented one or more sexual dysfunctions. Participants had an average score of 22.5 on the sexual satisfaction scale, which is above clinical average, and 254 participants (52.5%) presented clinical levels of sexual distress.

The LPA model fit indices for the models ranging from 1 to 6 profiles are presented in Table 2. All indices showed the model with three-profile solution as the most optimal model. Although one profile included fewer than 5% of participants, it was theoretically meaningful, representing individuals with elevated levels of traumatic sexuality, aligning with the research focus. The four-profile solution included one class that was uninterpretable and two classes below 5%, weakening its utility.

Table 3 reports the means and standard errors of the traumatic sexuality measures across profiles, with corresponding graphical representations provided in Figure 1. Profile 1 (87.8% of participants) demonstrated low levels of intrusive thoughts, interpersonal distress, and hypervigilance, while maintaining moderate scores in shame and guilt, pleasing others, and dissociation.

Table 2. Fit indices for the LPA.

	Fit indices				*p*	*p*	*p*	*n* of participants in each profile					
	Akaike (AIC)	Bayesian (BIC)	Adjusted BIC	Entropy	BLRT	VLMR	LMR	n 1	n 2	n 3	n 4	n 5	n 6
1 profile	5437.300	5550.217	5464.520	NA	NA	NA	NA	484					
2 profiles	5043.435	5185.625	5077.712	0.992	0.0000	0.0076	0.0084	457	27				
3 profiles	4813.654	4985.120	4854.989	0.989	0.0000	0.2000	0.2074	425	12	47			
4 profiles	4557.624	4758.364	4606.015	0.994	0.0000	0.3647	0.3720	35	21	420	8		
5 profiles	4423.378	4653.392	4478.826	0.993	0.0000	0.3648	0.3577	401	7	34	8	34	
6 profiles	4071.092	4330.381	4133.597	0.998	0.0000	0.2364	0.2425	3	20	51	387	19	4

Table 3. Means and standard errors of the dimensions of the traumatic sexuality measure.

Traumatic sexuality dimensions	Full sample ($n = 484$)	Profile 1 Low PT-SEX ($n = 425$)	Profile 2 High PT-SEX ($n = 12$)	Profile 3 Dissociative-Pleasing PT-SEX ($n = 47$)
Dissociation	2.230 (1.11)	2.115 (.05)	3.182 (.36)	3.050 (.17)
Intrusive thoughts	1.244 (.60)	1.054 (.01)	3.983 (.18)	2.290 (.09)
Shame and guilt	1.256 (.52)	1.209 (.02)	2.052 (.34)	1.488 (.12)
Pleasing others	2.002 (.97)	1.886 (.04)	3.631 (.39)	2.630 (.18)
Interpersonal distress	1.193 (.47)	1.131 (.02)	2.372 (.34)	1.441 (.11)
Hypervigilance	1.555 (.76)	1.440 (.03)	2.749 (.35)	2.286 (.14)

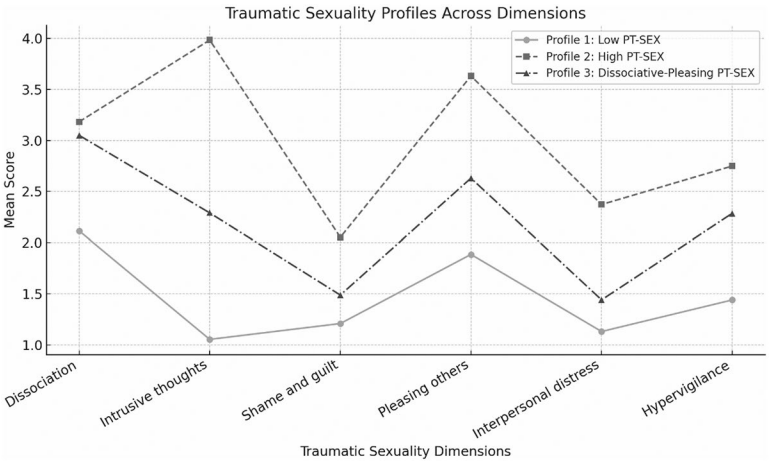

Figure 1. Traumatic sexuality profiles across dimensions.

Table 4. Relations of the three latent profiles to the indicators in the full sample ($n = 484$).

Variable	Profile 1 Low PT-SEX ($n = 425$)	Profile 2 High PT-SEX ($n = 12$)	Profile 3 Dissociative-Pleasing PT-SEX ($n = 47$)	BCH χ^2	1 vs. 2	1 vs. 3	2 vs. 3
Indicators of interpersonal trauma							
Childhood sexual abuse (0 = no, 1 = yes)	30.0% (0.022)	41.2% (0.147)	63.4% (0.074)	0.000	0.571	18.544**	1.755
Sexual abuse in adulthood (0 = no, 1 = yes)	29.2% (0.022)	58.8% (0.144)	51.0% (0.077)	0.004	4.127**	7.359**	0.228
Cumulative trauma (0–8)	3.396 (0.101)	3.914 (0.620)	4.684 (0.280)	0.000	0.680	18.528**	1.280
Outcomes							
Sexual dysfunction (0 = no, 1 = yes)	39.4% (0.024)	71.4% (0.097)	33.6% (0.137)	0.006	10.143**	0.170**	4.732**
Sexual distress (0 = no, 1 = yes)	43.7% (0.024)	66.6% (0.137)	77.8% (0.064)	0.000	2.727	24.495**	0.548
Sexual satisfaction (5–35)	22.802 (0.320)	18.912 (2.643)	20.186 (0.910)	0.010	2.135	7.292**	0.207

Note. Analyses were performed with BCH and DCAT procedures in Mplus 8. *$p < .05$, **$p < .01$. Relations of the three latent profiles to continuous outcomes variables (i.e. sexual satisfaction and cumulative trauma) are presented as *M* (*SE*). Relations of the three latent profiles to categorical outcomes variable (i.e., Childhood sexual abuse, Sexual violence in adulthood, Sexual distress, Sexual dysfunction) are presented as probabilities and standard error (*SE*).

This profile was identified as the Low PT-SEX profile. Profile 2 (2.5% of participants) exhibited elevated scores across all six dimensions of traumatic sexuality and was identified as the High PT-SEX profile. Finally, Profile 3 (9.7% of participants) showed elevated scores in dissociation, intrusive thoughts, and pleasing others, moderate scores in shame and guilt, and hypervigilance, and low scores in interpersonal distress. Consequently, this profile was identified as the Dissociative-Pleasing PT-SEX profile.

Comparisons of profiles on sexual well-being and traumatic experiences

Table 4 presents the results of BCH and DCAT analyses comparing the three profiles ($n = 484$). The three profiles differed significatively based on the overall chi-square tests. For continuous outcomes (e.g., cumulative interpersonal trauma and sexual satisfaction), comparisons were based on mean scores. For categorical outcomes (e.g., CSA, adult sexual victimization, sexual dysfunction, and sexual distress), comparisons were based on probabilities. The following patterns emerged: Participants in Profile 1 (Low PT-SEX) exhibited the highest average sexual satisfaction,

the lowest average cumulative interpersonal trauma (average score: 3), and moderate likelihood of experiencing sexual distress. Profile 2 (High PT-SEX) was characterized by the lowest average score of sexual satisfaction and a higher likelihood of experiencing adult sexual victimization. Participants in Profile 3 (Dissociative-Pleasing PT-SEX) reported the highest average cumulative interpersonal trauma (average score: 5) and the highest probability of reporting a history of CSA.

Discussion

The current study examined profiles of traumatic sexuality in a clinical sample of patients seeking sex therapy, aiming to shed light on the heterogeneous and complex ways in which traumatic sexuality manifests in adults experiencing sexual difficulties. This study contributes to the scientific literature by employing a person-centered approach (LPA) and offering novel insights into how different patterns of traumatic sexuality cluster within a clinical population. Furthermore, it expands existing literature by linking these profiles to sexual well-being—encompassing sexual satisfaction, sexual distress, and sexual function—as well as traumatic experiences, including CSA, adult sexual victimization and cumulative interpersonal trauma.

Profiles of traumatic sexuality and associated characteristics

Participants in Profile 1—Low PT-SEX reported relatively low traumatic sexuality symptoms, particularly in intrusive thoughts, interpersonal distress, and hypervigilance. They reported moderate levels of dissociation during sex, shame and guilt regarding sexual aspects, and a drive to please the other sexually. Notably, they also reported the highest levels of sexual satisfaction among all profiles. However, they were more likely than participants in the Dissociative-Pleasing PT-SEX profile to report at least one sexual dysfunction. The lower cumulative interpersonal trauma scores, coupled with a reduced likelihood of experiences of CSA or adult sexual victimization in this group, align with Gewirtz-Meydan and Lassri (2023) framework on traumatic sexuality as it reinforces the idea that individuals without a history of sexual abuse are less susceptible to experiencing dimensions associated with traumatic sexuality. This profile may reflect a more general or non-trauma-related form of sexual difficulty, where moderate symptoms of dissociation or shame and guilt are present but do not cluster into a full traumatic sexuality profile. Clinically, this group reminds us that not all sexual difficulties in therapy are trauma-based, even if minor trauma-related elements are present. Additionally, participants in this profile may have benefited from certain protective or psychosocial support factors that may have mitigated the detrimental effects of a history of childhood sexual abuse (CSA), thereby reducing their susceptibility to revictimization in adulthood (Austin et al., 2020), although this postulate would need to be tested empirically.

Patients in the High PT-SEX profile displayed elevated scores across all six dimensions of PT-SEX, indicating pronounced traumatic sexuality symptoms. Despite this heightened symptomatology, individuals in this profile were less likely to have experienced CSA but were more likely to have experienced adult sexual victimization compared to those in the Dissociative-Pleasing profile. However, the likelihood to have experienced CSA were still high compared to the general population although it was lower than the Dissociative-Pleasing profile. The substantial trauma experience of the individuals in High PT-SEX profile—averaging four cumulative interpersonal traumatic experiences—further underscores the vulnerability of this group of patients. These patients reported higher levels of sexual distress than those in the Low PT-SEX profile, but lower than those in the Dissociative-Pleasing profile. Additionally, their average level of sexual satisfaction fell below the clinical threshold. This suggests that they face considerable challenges in establishing fulfilling sexual experiences, likely due to the lingering impact of interpersonal trauma on their sense of security and comfort—key elements for healthy sexual functioning (Briere & Jordan, 2004; Briere & Scott, 2015; Nolin et al., 2023).

More specifically, prior studies have demonstrated that women who have experienced sexual violence in adulthood frequently report lower sexual satisfaction, heightened sexual distress, and a greater prevalence of sexual dysfunctions (Kelley & Gidycz, 2019; Nolin et al., 2023; van Berlo & Ensink, 2000). This profile is particularly compelling because it challenges the assumption that traumatic sexuality stems primarily from childhood abuse. Instead, it highlights that adult-onset sexual trauma—especially when coupled with cumulative adversity—can lead to intense and generalized patterns of traumatic sexuality. This adds nuance to theoretical models, suggesting the timing of trauma (childhood vs. adulthood) might shape symptom expression differently.

The Dissociative-Pleasing PT-SEX profile exhibited a distinct pattern of traumatic sexuality symptoms, characterized by high levels of dissociation, intrusive thoughts, and a strong drive to please the other. Patients in this profile reported moderate levels of shame and guilt, and hypervigilance, their interpersonal distress scores were relatively low. They also had the highest probability of experiencing clinical levels of sexual distress. This particular profile regrouped patients with the highest prevalence of CSA and the highest cumulative interpersonal trauma experience among all profiles (average of 5 traumatic experiences). This profile supports the theory that dissociation and compliance (pleasing the other) are hallmark trauma responses rooted in early relational harm (Gewirtz-Meydan & Godbout, 2023; Gewirtz-Meydan & Lahav, 2020). Interestingly, the low interpersonal distress in this group may indicate a dissociative mechanism that shields against becoming emotionally overwhelmed, which raises important questions for treatment—particularly regarding emotional presence and agency during intimacy. Notably, participants in this profile were less likely to report one or more sexual dysfunctions than other profiles. These findings show that early trauma is related to impaired sexual well-being, as demonstrated in previous studies (Bernstein & Freyd, 2014; Brassard et al., 2015; Freyd, 1996) and further support the notion that childhood trauma significantly influences sexuality. They also underscore the importance of considering the multifaceted nature of traumatic sexuality in the assessment of sexual health.

Previous research has explored traumatic sexuality through various frameworks, including embodiment theory (Van der Kolk, 2014), the traumagenic model (Finkelhor & Browne, 1985), and trauma-informed models of sexual functioning (Abu-Raya & Gewirtz-Meydan, 2023; Gewirtz-Meydan et al., 2023; Gewirtz-Meydan & Godbout, 2023; Gewirtz-Meydan & Lassri, 2023). These studies have laid critical groundwork by identifying key dimensions of traumatic sexuality—such as dissociation, guilt, avoidance, and the drive to please—mainly through variable-centered approaches. However, the person-centered approach utilized in this study, particularly through LPA, moves beyond examining isolated dimensions and allows us to explore how these experiences cluster together within individuals. This approach offers novel insights into the diverse and heterogeneous manifestations of traumatic sexuality in a clinical population. Rather than assuming a uniform experience across trauma survivors, LPA identifies meaningful subgroups based on different combinations of symptoms. For example, our findings revealed that individuals with mixed levels of traumatic sexuality (Profile 3)—who do not score consistently high or low across all dimensions—can still experience profound sexual distress and complex trauma histories. These nuanced profiles challenge binary understandings of "healthy" versus "traumatized" sexuality, emphasizing instead the need for individualized therapeutic approaches. Importantly, the emergence of distinct symptom constellations suggests that therapeutic focus may need to shift depending on the profile—toward reclaiming agency and bodily autonomy, addressing dissociative coping, or working through compliance-related dynamics rooted in earlier relational trauma.

Clinical implications

These findings highlight the clinical importance of recognizing the heterogeneity of traumatic sexuality in sex therapy patients. Assessing the six dimensions of traumatic sexuality alongside

patients' cumulative interpersonal trauma, and sexual well-being should guide the development of personalized treatment plans and targeted interventions. These profiles offer valuable insights for clinicians, offering guidance to focus therapeutic efforts where they are most likely to be effective. An evidence-based assessment of traumatic sexuality should adopt a life-history approach to capture the complex pathways leading to different patterns of traumatic sexuality, cumulative interpersonal trauma, and variations in sexual well-being. This approach can help clinicians identify key developmental and relational factors that contribute to the persistence or worsening of traumatic sexuality symptoms. A systematic evaluation of traumatic sexuality can also assist professionals in distinguishing specific subgroups among sex therapy patients, enabling more precise and tailored interventions. Despite growing awareness of the prevalence of trauma-related sexual difficulties, there is still no standardized or empirically validated treatment approach specifically designed for traumatic sexuality (Gewirtz-Meydan, 2022c). Clinicians often adopt one of two routes: a trauma-focused intervention that may only indirectly address sexual symptoms, or a traditional sex therapy protocol (e.g., cognitive-behavioral interventions for sexual dysfunctions) that is not trauma-informed and, in some cases, may risk retraumatizing the patient. For example, when addressing sexual pain in women without a known history of abuse, the therapeutic goal is typically symptom reduction or elimination. However, in the context of traumatic sexuality, symptoms such as pain, avoidance, or lack of arousal may serve as protective mechanisms—indicating unmet safety needs, unresolved trauma, or a dissociative response to sexual cues (Gewirtz-Meydan, 2022a). Treating these symptoms solely as dysfunctions risks invalidating their adaptive function, potentially reinforcing shame, resistance, or even clinical rupture. On the other end, a review by O'Driscoll and Flanagan (2016) suggests that while trauma therapy may alleviate core post-traumatic symptoms, it does not consistently improve sexual functioning. This underscores the need for specialized therapeutic approaches that directly target the intersection of trauma and sexuality, rather than assuming improvements in one domain will automatically translate to the other. As such, standardized sex therapy models—such as Sensate Focus—must be adapted for trauma survivors to ensure safety, agency, and attunement to dissociation, hypervigilance, and emotional overwhelm (Almås & Benestad, 2021; Gewirtz-Meydan, 2025; Maltz, 2024). These trauma-informed adaptations might include: preparatory work focused on emotion regulation, establishing a clear sense of bodily autonomy, identifying and avoiding triggered body areas, tracking dissociative states during sessions, reinforcing consent and assertiveness skills, and collaboratively developing sexual scripts that feel safe and empowering to the survivor. Until trauma-specific sexual therapy protocols are developed and empirically tested, clinicians must integrate trauma-informed principles into their practice with flexibility and care—balancing the dual goals of fostering safety and supporting sexual reconnection. Doing so can help ensure that survivors are not retraumatized by well-intentioned interventions and are instead supported in reclaiming a sense of agency, pleasure, and self-compassion in their sexual lives.

Strengths, limitations, and future directions for future studies

One of the major strengths of this study is the use of a clinical sample, consisting of individuals who have experienced traumatic events. This offers a unique and ecologically valid perspective on how traumatic sexuality manifests in real-world therapeutic settings. The use of a person-centered analytic strategy (LPA) further strengthens the study by allowing for the identification of clinically meaningful subgroups that might be obscured in variable-centered approaches.

Despite these strengths, several limitations should be noted. The small sample size, especially for one profile comprising just under 5% of the total sample, limits the representativeness of the findings. While this result was somewhat anticipated, given that high levels of traumatic sexuality across all dimensions mirror those with elevated PTSD levels—diagnosed in only 3.9% of the world population—it still poses limitations for drawing broader conclusions (Koenen et al., 2017). Additionally, LPA assigns participants to profiles based on probabilities, which—though

statistically robust—does not guarantee perfect classification and may obscure individual variability (Weller et al., 2020). Furthermore, while validated self-reported measures are beneficial for their brevity and straightforwardness, they are susceptible to social desirability and memory biases, potentially affecting the accuracy of the data. A further limitation lies in the nature of the trauma data. Although we assessed the presence of childhood sexual abuse, adult sexual victimization experiences, and cumulative interpersonal trauma, further studies could examine the experience of other types of traumas on their characteristics. Moreover, the low alpha scores for interpersonal distress and hypervigilance in the Post-Traumatic Sexuality Scale may reflect the limitations of two-item scales, where even moderate correlations yield low reliability. These results could also be influenced by our clinical sample, differing from the original study's population of women survivors of childhood sexual abuse (Gewirtz-Meydan & Lassri, 2023). Finally, the sample may not be representative of all populations, particularly those with different sociodemographic backgrounds. It is important to reflect on how this sample, which was largely Canadian-born (87.6%), employed (71%), highly educated (88.9% had at least college or professional education), and had higher annual income (74.6% earning $40,000 or more), and who were engaged in treatment, might differ from other samples and other geographic regions. These characteristics may influence generalizability of the findings. Further research is needed to examine whether these results hold across more diverse populations and settings.

Future studies should aim to include larger and more diverse samples to enhance the representativeness and generalizability of the findings. Longitudinal research could offer valuable insights into the stability of these profiles over time, their long-term effects on sexual well-being, and how each profile responds to clinical interventions. Additionally, incorporating qualitative methods could help capture the nuances of traumatic sexuality experiences that quantitative measures might miss. Moreover, we did not examine dyadic data regarding participants' current or past partners. In some cases, the partner may also be the source of current abuse or trauma triggers, which could fundamentally shape a participant's sexual distress and behavior. The absence of this relational context limits our ability to interpret the full interpersonal landscape surrounding traumatic sexuality. Incorporating dyadic designs in future research could help untangle the interactions between personal trauma histories and current partner dynamics—an area especially critical for sex therapy interventions.

Conclusion

This study highlights the complexity of traumatic sexuality and underscores the need for a nuanced, person-centered approach to understand traumatic sexuality and address the sexual well-being and traumatic experiences of individuals. By identifying three distinct profiles, we provide a framework for more targeted and effective clinical interventions. These findings underscore the need to move beyond one-size-fits-all models and to consider both trauma histories and current sexual well-being when supporting survivors. Ultimately, this research contributes to the growing effort to develop trauma-informed, sexuality-sensitive therapeutic approaches that honor the complexity of clients' lived experiences.

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Data availability statement

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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