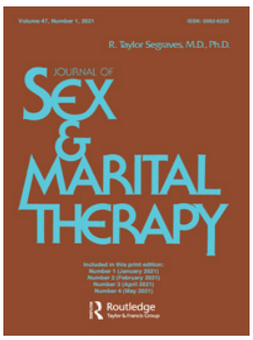

Journal of Sex & Marital Therapy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/usmt20

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To cite this article: Mathilde Baumann, Noémie Bigras, Alison Paradis & Natacha Godbout (2021) It's Good to Have You: The Moderator Role of Relationship Satisfaction in the Link Between Child Sexual Abuse and Sexual Difficulties, Journal of Sex & Marital Therapy, 47:1, 1-15, DOI: 10.1080/0092623X.2020.1797965

To link to this article: https://doi.org/10.1080/0092623X.2020.1797965

Published online: 24 Jul 2020.

JOURNAL OF SEX & MARITAL THERAPY
2021, VOL. 47, NO. 1, 1–15
https://doi.org/10.1080/0092623X.2020.1797965

It's Good to Have You: The Moderator Role of Relationship Satisfaction in the Link Between Child Sexual Abuse and Sexual Difficulties

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ABSTRACT

Research has revealed a significant prevalence of sexual problems in adulthood among child sexual abuse (CSA) survivors, yet many survivors do not report such difficulties. This study examined the moderator role of relationship satisfaction in the association between CSA and sexual difficulties in adulthood. Questionnaires assessing history of CSA, sexual difficulties, and relationship satisfaction were completed by 320 adults in intimate relationships. Analyses indicated that CSA survivors who were highly dissatisfied with their relationships reported more sexual difficulties than those who were satisfied with their relationships. Results highlight the importance of positive intimate relationships when working with CSA survivors.

Child sexual abuse (CSA) is an important social and public health issue. An international meta-analysis suggests that 18% of women and 8% of men report having experienced CSA before the age of 18 (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). Empirical research on this topic indicates that CSA has numerous long-term effects on adult functioning, with an important variability among survivors (Murray, Nguyen, & Cohen, 2014). Considering the magnitude of CSA and the heterogeneous patterns of symptomatology in survivors, it is essential to better understand the factors that might influence the impacts of CSA on adult functioning. This is specifically important in terms of the numerous impacts of CSA on adult sexual functioning, which in this study refers to the sexual difficulties (i.e., sexual concerns and behaviors related to potentially negative outcomes) that can be found in CSA survivors.

Considering the relational nature of CSA, which is often endured in the context of an attachment relationship (e.g., parental figure), and given its occurrence during a vulnerable developmental period in which victims do not have mature strategies to cope with adverse events, CSA survivors can be particularly prone to sexual difficulties in adulthood; this also involves a violation of human intimate connection (Herman, 1992). Finkelhor and Browne's four traumagenic dynamics (1985) offer a framework to understand the negative long-term CSA repercussions on sexuality. Specifically, one of the four dynamics, traumatic sexualization, emphasizes that the developmentally inappropriate context in which a child was introduced to sexuality can potentially lead to numerous sexual difficulties in addition to long-lasting confusion and misconceptions of one's own sexual self-concept. CSA is also found to be especially harmful because it is usually committed by a person who knows the child, often within an intimate or trustful relationship context (Quebec Ministry of Public Security, 2014; Statistics Canada, 2017; Vaillancourt-Morel et al., 2016). Some studies have highlighted the influence of intimate relationship dynamics

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in the association between CSA and sexual difficulties. For example, CSA is related to sexual risk behaviors in adult women and influence's relationship satisfaction (Testa, VanZile-Tamsen, & Livingston, 2005). Furthermore, sexual compulsivity was found to be a mediator that influences extradyadic sexual behaviors (Vaillancourt-Morel et al., 2015). In addition, levels of intimacy were identified as a mediator of relationship and sexual satisfaction (Vaillancourt-Morel, Rellini, Godbout, Sabourin, & Bergeron, 2019), and the partner's response to disclosure of CSA was found to have a moderating role on sexual and relationship satisfaction (de Montigny Gauthier et al., 2019). Moreover, some authors have hypothesized that a satisfying intimate relationship could have a protective effect on trauma survivors' sexual adjustment (e.g., Godbout, Runtz, MacIntosh, & Briere, 2013; MacIntosh & Johnson, 2008) but to our knowledge this has never been tested. As a satisfactory intimate adult relationship may be a particularly beneficial and even restorative experience for CSA survivors. It seems important to examine the moderating role that relationship satisfaction can play in attenuating the impacts of CSA on survivors' sexualities, as it represents a particularly vulnerable and intimate sphere of life.

Child sexual abuse and sexual difficulties

Multiple empirical studies have confirmed the theoretical standpoint that CSA can alter a survivor's ability to approach sex in a healthy manner (for review, see Aaron, 2012). Indeed, CSA is related to numerous sexual difficulties including issues with identifying and expressing one's sexual needs and desires, lower sexual satisfaction, aversion to sex and intimacy, and sexual anxiety (Bigras, Godbout, & Briere, 2015; Vaillancourt-Morel et al., 2015). Other results also support the association between CSA and an increase of unwanted sexual thoughts and feelings (e.g., guilt and avoidance; Easton, Coohey, O'leary, Zhang, & Hua, 2011), as well as sexual dysfunctions (e.g., inability to orgasm, reaching orgasm too quickly; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005). Researchers also found that CSA is linked to an increased frequency of behaviors which have potentially negative sexual outcomes, including risky sexual behaviors (e.g., unprotected sex), a higher number of sexual partners, a heightened risk of infidelity and increased compulsive sexual behaviors (Blain, Muench, Morgenstern, & Parsons, 2012; Vaillancourt-Morel et al., 2015). A 23-year longitudinal study corroborates previous results by highlighting additional links between CSA, higher risks of unwanted pregnancies, and an increased number of sexually transmitted infections in survivors (Trickett, Noll, & Putnam, 2011).

While the relation between CSA and sexual sequelae in adulthood is widespread, not all survivors report experiencing such outcomes (e.g., Lemieux & Byers, 2008; Murray et al., 2014; Rellini & Meston, 2007). This indicates heterogeneity among CSA survivors in addition to the presence of potential protective factors that need to be more thoroughly examined. For instance, a recent study conducted on 324 male and female CSA survivors revealed a variation in sexual difficulties among survivors that was associated with romantic attachment (Labadie, Godbout, Vaillancourt-Morel, & Sabourin, 2018). More specifically, Labadie and colleagues' study (2018) discerned a first group of CSA survivors who reported high levels of attachment avoidance and sexual compulsivity, and a second group who reported levels of attachment avoidance and sexual compulsivity similar to non-survivors. The variation in sexual repercussions among CSA survivors can also be explained in terms of relationship status. Indeed, Vaillancourt-Morel and colleagues (2016) found that sexual compulsivity was higher in single participants whereas sexual avoidance was higher in married participants, suggesting that CSA repercussions on adult sexuality can unfold in distinct patterns depending on the relationship status of the survivor. Another recent study looked at the effect of CSA disclosure on sexual satisfaction and found that the disclosure of CSA to their partner and the partner's response (i.e., positive or negative), influences the sexual satisfaction of both survivor and partner (de Montigny Gauthier et al., 2019). These results also suggest that the

quality of the intimate relationship may have an influence on the sexual difficulties experienced by CSA survivors.

The variation of sexual repercussions between survivors may also be associated with the wide assortment of questionnaires specific to non-traumatic sexuality, which are used in research to assess sexual difficulties in the aftermath of CSA. In response to the paucity of validated and standardized measures, Briere developed the Trauma Symptom Inventory-2 (TSI-2, Briere, 2011), which assesses the full range of potential posttraumatic outcomes in the general population. Two specific subscales from the sexual difficulties dimension of the TSI-2 measure trauma-related sexual outcomes. First, the sexual concerns subscale refers to sexual distress or dysfunctions, and taps into anxiety, negative thoughts and feelings during sex, shame regarding sexual activities, and sexual problems (e.g., lack of interest in sex, anxiety about sexual performance). Second, the problematic sexual behavior subscale (Briere, 2011) measures sexual behaviors that are related to potentially negative outcomes. Items assess sexual behaviors that are self-perceived as having potentially negative repercussions, including behaviors used to meet non-sexual needs or ones perceived as harmful or involuntary by the individual (e.g., sexual attraction to potentially dangerous partners, engaging in sex even when the individual thought it was not a good idea). With the exception of a few studies that used the TSI-2 with female CSA survivors and non-victims (Banyard, Williams, & Siegel, 2001; Van Bruggen, Runtz, & Kadlec, 2006), or with survivors of adult sexual assault (Elliott, Mok, & Briere, 2004; Therriault, Bigras, Hébert, & Godbout, 2020), the specific associations between traumatic events and trauma-related sexual symptoms have been scarcely examined. Therefore, it seems essential to examine the protective role of a satisfying intimate relationship in the association between CSA and sexual difficulties (i.e., sexual concerns and sexual behaviors related to potentially negative outcomes), which in this study are considered to be interrelated to trauma.

In sum, a corpus of empirical data suggests that CSA survivors form a heterogeneous population and highlights the importance of examining factors that may moderate the effects of CSA on sexual difficulties in adulthood (both in terms of sexual concerns and sexual behaviors related to potentially negative outcomes). Even still, while some of the factors influencing sexual concerns and difficulties in CSA survivors have been identified (e.g., relationship status, Vaillancourt-Morel et al., 2015; disclosure, de Montigny Gauthier et al., 2019), the protective factors affecting the sexuality of CSA survivors remain overlooked.

The role of relationship satisfaction

Relationship satisfaction is typically evaluated as the perception of a positive dyadic adjustment, referring to the feeling of sharing a healthy and fulfilling relationship with a stable partner (Sabourin, Valois, & Lussier, 2005; Spanier, 1976). The protective role of relationship satisfaction is empirically recognized (for a review, see Kielcolt-Glaser & Wilson, 2017) and has been mostly studied in relation to psychological well-being and physical health. For instance, a recent study indicated a protective effect of relationship satisfaction on body image perceptions in female survivors of breast cancer (Cairo Notari, Notari, Favez, Delaloye, & Ghisletta, 2017). In addition, findings from another study found that a stable and satisfactory couple relationship was prospectively predictive of lower levels of depression in parents who reported physical, sexual, and emotional abuse in childhood (Henry, Thornberry, & Lee, 2015).

Previous studies also suggest that being involved in a satisfactory relationship may have beneficial effects on sexuality. For example, a study conducted within a sample of women with fibromyalgia demonstrated that women who had lower relationship satisfaction reported lower sexual arousal and more pain during sexual activities when compared to women who reported higher relationship satisfaction (Kool, Woertman, Prins, Van Middendorp, & Geenen, 2006). Thus, it is possible to infer that the opposite may also be true; higher relationship satisfaction may be

associated with less sexual difficulties. While no study has specifically tested this hypothesis, there are empirical data that support this line of thought. For example, Péloquin, Bigras, Brassard, and Godbout (2014) found that within a sample of 214 heterosexual adults, the perception of a partner as supportive acted as a moderator that tempered the negative impacts of insecure romantic attachment on sexual self-esteem, sexual anxiety, and sexual assertiveness. Another study on a sample of 372 newlywed couple used the TSI-2 to examine associations between several types of child maltreatment and various trauma-related symptoms, including sexual difficulties. Furthermore, the authors of this study also examined the role of social and family support on the link between child maltreatment and sexual trauma-related symptoms. However, they neglected to consider the role of relationship satisfaction in this association (Evans, Steel, & DiLillo, 2013). Another longitudinal study on 80 women suggests the existence of a protective effect in which social support (including the relationship satisfaction of married women) reduces the risk of undergoing sexual revictimization in adulthood (Banyard, Williams, & Siegel, 2003). Yet, this study was conducted solely on women and does not specifically look at relationship satisfaction and sexual difficulties.

The Current study

Based on the empirical literature and the scientific gap that still exists regarding the factors that moderate the effects of CSA on sexuality, the aim of this study was to explore the moderating role of relationship satisfaction in the association between CSA and sexual difficulties. This objective is separated into two hypotheses. First, considering the impact of CSA on sexual functioning (e.g., Bigras, Godbout, & Briere, 2015; Easton et al., 2011; Vaillancourt-Morel et al., 2015), it was hypothesized that the experience of CSA would be associated with more sexual difficulties in adulthood, as measured by the TSI-2. Second, taking into account the protective effect of relationship satisfaction on several aspects of adult functioning (e.g., Cairo Notari et al., 2016; Péloquin et al., 2014), it was hypothesized that a higher level of relationship satisfaction would buffer the negative effects of CSA on sexual functioning. In other words, CSA survivors with a higher level of relationship satisfaction would report less sexual difficulties than CSA survivors with lower levels of relationship satisfaction. This hypothesis proposes relationship satisfaction as a potential reparative factor for survivors (e.g., Godbout et al., 2013; MacIntosh & Johnson, 2008). Results may highlight relationship satisfaction as a variable of interest in research and inform clinical practice by identifying a potentially key variable in actions aiming to improve the sexual health of CSA survivors.

Method

Procedure and participants

Participants were adults recruited online (through social media platforms, such as Facebook, and the use of electronic mailing list software) from the general population of Canada. Participants were asked to complete an online questionnaire hosted on the platform *SurveyMonkey*. The survey required 30 to 45 minutes to complete. To be eligible, participants had to currently be in an intimate relationship (for at least six months) and be 18 years or older. They were offered the opportunity to enter in a drawing for $50 CAN. The study was approved by the [LEAVE BLANK FOR REVIEW] Institutional Review Board.

The final sample consisted of 320 adults (70.6%, $n = 226$ women and 29.1%, $n = 94$ men) aged 18 to 75 ($M = 29.58$; $SD = 10.9$). The majority of participants were Canadian citizens (90.3%, $n = 289$) who spoke French as their primary language (93.4%, $n = 299$). More than half of the sample had a university education (69.3%, $n = 222$) and most were students (48.8%, $n = 156$) or

full-time workers (37.8%, $n = 121$). Most reported an income of less than $40,000 CAN a year (66.3%, $n = 212$) and identified as heterosexual (91.6%, $n = 293$). Regarding their relationship status, 35% ($n = 112$) were in a relationship with a regular partner without cohabiting, 49.1% ($n = 157$) were in a common-law relationship or cohabiting and 15.9% ($n = 51$) were married.

Measures

Child sexual abuse

The questions used to measure CSA were in accordance with the definition of CSA presented in the Canadian Criminal Code (1985) and measures the presence of CSA before the age of 18 (age of majority in Canada). A question asked participants "if they had experienced any unwanted sexual contact or any sexual experiences for which they could not provide consent (e.g., someone five years older, authority position) before the age of 18." CSA was scored as a dichotomous variable as absent (0) if participants answered "no," or present (1) if they answered "yes" to this question. Then, participants were invited to respond to a series of questions detailing the characteristics of sexual abuse, such as the type of sexual contact (e.g., showed genitals, oral or anal sex, vaginal penetration), and their relationship with the abuser (i.e., parent, brother or sister, other family members, friends or acquaintance, boy or girl of the same age, teacher or unknown).

Sexual difficulties

Sexual difficulties were assessed using the 10-item sexual scale of the Trauma Symptom Inventory-2 (TSI-2; Briere, 2011), which measures two types of sexual difficulties, namely, sexual concerns (5 items) and problematic sexual behaviors (5 items). Sexual concerns refer to negative thoughts and emotions related to sexuality (e.g., shame), while problematic sexual behaviors examine sexual behaviors self-perceived as having potentially negative outcomes (e.g., engaging in sex when the individual thought it was not a good idea, unprotected sex). Participants were invited to respond to each item based on their experiences in last six months, using a Likert scale ranging from 0 = never to 3 = always. The total continuous score of sexual difficulties was obtained through a sum of the items, ranging from 0 to 30. A higher score indicated a greater level of sexual difficulties, in terms of both sexual behaviors and concerns. The internal consistency in the validation study ranged from $\alpha = .84$ to $\alpha = .96$ (Briere, 2011). In this study $\alpha = .71$.

Relationship satisfaction

Relationship satisfaction was assessed using the short version of the Dyadic Adjustment Scale (DAS-4: Sabourin et al., 2005; Spanier, 1976). Three items, scored on a six-point Likert scale ranging from 0 = *never* to 5 = *always* (e.g., "In general, can you say that things are going well between you and your partner?"). The fourth item is a general indicator of relational happiness and is answered on a seven-point Likert scale ranging from 0 = *extremely unhappy* to 7 = *perfectly happy*. The total possible score ranges from 0 to 21, where higher scores reflect a higher level of relational satisfaction. A score of 13 represents the threshold used to differentiate clinically dissatisfied individuals from those who are satisfied with their relationship (Sabourin et al., 2005). Internal consistency was judged as good in previous studies (values of α ranging from .76 to .96; Sabourin et al., 2005) and in the current sample ($\alpha = .81$).

Data analysis

In order to confirm the sample size required to achieve sufficient statistical power, a power analysis was conducted with G*Power (Faul, Erdfelder, Buchner, & Lang, 2009) for a small effect size of $d = .15$ and an alpha of $p < .05$. Results showed that a minimum of 83 participants was

Table 1. Descriptive variables for childhood sexual abuse.

Variables	*n*	%
Childhood sexual abuse survivors	83	25.9
Gender		
Women	58	69.9
Men	25	30.1
Childhood sexual abuse type		
Missing data	10	12
Without contact	6	7.2
Touching	46	55.4
Penetration (oral, anal, vaginal)	21	25.3
Relationship with abuser		
Intra-familial		
Parent	4	4.8
Brother / Sister	9	10.8
Other family members (uncle, aunt, cousin, grandparent, etc.)	20	24.1
Extra-familial		
Friend of the family or acquaintance	5	6
Boy or girl of the same age without consent	25	30.1
Teacher	3	3.6
Unknown men or women	16	19.3

Note: In Canada and other countries, the threshold of adulthood, is 18 years old so we measured CSA occurring before 18.

needed to detect small to moderate effect sizes with a statistical power of .80. First, descriptive correlational analyses and group comparison analyses were performed using SPSS v24 to document sociodemographic characteristics in the sample. Examination of the data revealed that scores for relationship satisfaction and sexual difficulties were not normally distributed. Since the relationship satisfaction variable had extreme data, it was winzorized to a value of 3 standard deviations from the mean in order to eliminate outliers and correct normality (Ruppert, 2006). Despite a log transformation, the sexual concerns and difficulties variable remained non-normal. To overcome non-normality, regression analyses were conducted in M*plus* version 7 (Muthén & Muthén, 1998–2015), to test the moderating role of relationship satisfaction by using the Maximum Likelihood Robust method of estimation, which is robust to the non-normality of observations (MLR; Yuan & Bentler, 2000). Gender, age, and relationship status were entered as covariates in the final model.

Results

Descriptive and bivariate analyses

Child sexual abuse

As reported in Table 1, 26% of participants in the current sample reported a history of CSA, respectively 18% of women and 8% of men. Among CSA survivors, a total of 62.6% ($n = 52$) reported having experienced CSA without penetration, and 25.3% reported CSA with penetration ($n = 21$). Data was unavailable for 10 participants. Finally, 39.7% ($n = 33$) reported intrafamilial CSA, and 59% ($n = 49$) extrafamilial CSA.

Sexual difficulties

On a possible range of 0 to 24, the total mean score for the sexual difficulties scale was 3.23 ($SD = 3.59$) which is slightly lower than what has been found in validation studies (e.g., between 4.40 and 6.50; Briere, 2011). *T*-test analyses indicated that scores on this scale differed significantly between survivors of CSA and non-victims ($t_{(109,319)} = -3.26$, $p = .002$), with survivors reporting more sexual difficulties ($M = 4.53$, $SD = 4.55$) than non-victims ($M = 2.78$, $SD = 3.07$).

Table 2. Correlations, means and standards deviations among study variables.

Variables	1	2	3	4	5	6	*M*	*SD*
1. Childhood sexual abuse	–	–	–	–		–	N/A	N/A
2. Relationship satisfaction	−.15**	–	–	–		–	16.58	3.31
3. Sexual difficulties	.21**	−.31**	–	–		–	3.22	3.68
4. Age	–	−.16**	–	–	–	–	29.58	10.9
5. Gender	–	–	–	–	.20**	–	–	–
6. Relationship status	–	–	−.13*	−.12**	−.52*	–	–	–

Notes:
*$p < .05$;
**$p < .01$;
***$p < .001$.
Childhood sexual abuse is a dichotomous variable.

Relationship satisfaction

The current sample showed a level of relationship satisfaction that was similar to previous studies on general population samples (e.g., Sabourin et al., 2005), ($M = 16.6$, $SD = 3.27$). A significant difference was found regarding CSA ($t_{(318)} = 2.75$, $p = .006$), with survivors reporting significantly lower relationship satisfaction ($M = 15.76$, $SD = 3.79$) than non-victims ($M = 16.89$, $SD = 3.02$).

Considering that certain studies have highlighted that scores of relationship satisfaction and sexual functioning may be related to relationship status (Vaillancourt-Morel et al., 2016), an ANOVA analysis was conducted to examine whether relationship satisfaction and sexual difficulties scores differed as per relationship status (i.e., in relation to having a regular partner, common-law partner or being married). Results of the current study revealed no significant differences in levels of relationship satisfaction ($F_{(2)} = 0.38$, $p = .686$) and sexual difficulties ($F_{(2)} = 2.85$, $p = .059$) according to relationship status.

Results of correlational analyses (see Table 2), indicated a significant and positive relationship between the experience of CSA and the presence of sexual difficulties in adulthood. The presence of CSA was negatively correlated with relationship satisfaction and the latter was also negatively correlated with sexual difficulties. This means that higher relationship satisfaction was associated with less sexual difficulties.

Moderating effect of relationship satisfaction on the link between CSA and sexual difficulties in adulthood

Regression analyses revealed that CSA was associated with sexual difficulties ($\beta = .174$, $p = .002$). Results of the moderation analysis (see Table 3) indicated that the moderating effect of relationship satisfaction was statistically significant ($\beta = -.183$, $p = .011$) and explained 15.6% of the variance in sexual difficulties. The interaction term remained significant once the covariates were added (i.e., age, gender, and relationship status) ($\beta = -.179$, $p = .011$). The final moderation model explained 18.7% of the variance in sexual difficulties.

The two-way interaction was examined using a follow-up simple slope analysis with the moderator at three values: clinical cutoff (−1 *SD* below the mean), mean, and high (+1 *SD* above the mean). Results of the simple slopes test (see Figure 1), indicated that CSA survivors reported significantly higher scores of sexual difficulties not only when their levels of relationship satisfaction were below the clinical threshold (i.e., DAS score of ≤ 13, $p < .001$) but also when they were below the sample mean score (i.e., mean DAS score of 16.6, $p = .002$). The association between CSA and sexual difficulties became non-significant when relationship satisfaction scores were high. More specifically, the association between CSA and sexual difficulties became nonsignificant ($p = .092$) when the score on the dyadic adjustment scale was larger than 18.

Table 3. Regression analyses: moderating effect of relationship satisfaction in the association between childhood sexual abuse and sexual difficulties.

	Sexual difficulties				
	β	SE	t	p	r^2
Childhood sexual abuse	.169	.052	3.250	.001	
Relationship satisfaction	−.278	.054	−5.116	.001	
Childhood sexual abuse X Relationship satisfaction	−.183	.074	−2.355	.011	.156
Childhood sexual abuse X Relationship satisfaction X Age X Gender X Status	−.179	.070	−2.552	.011	.187

Notes: Childhood sexual abuse is a dichotomous variable.

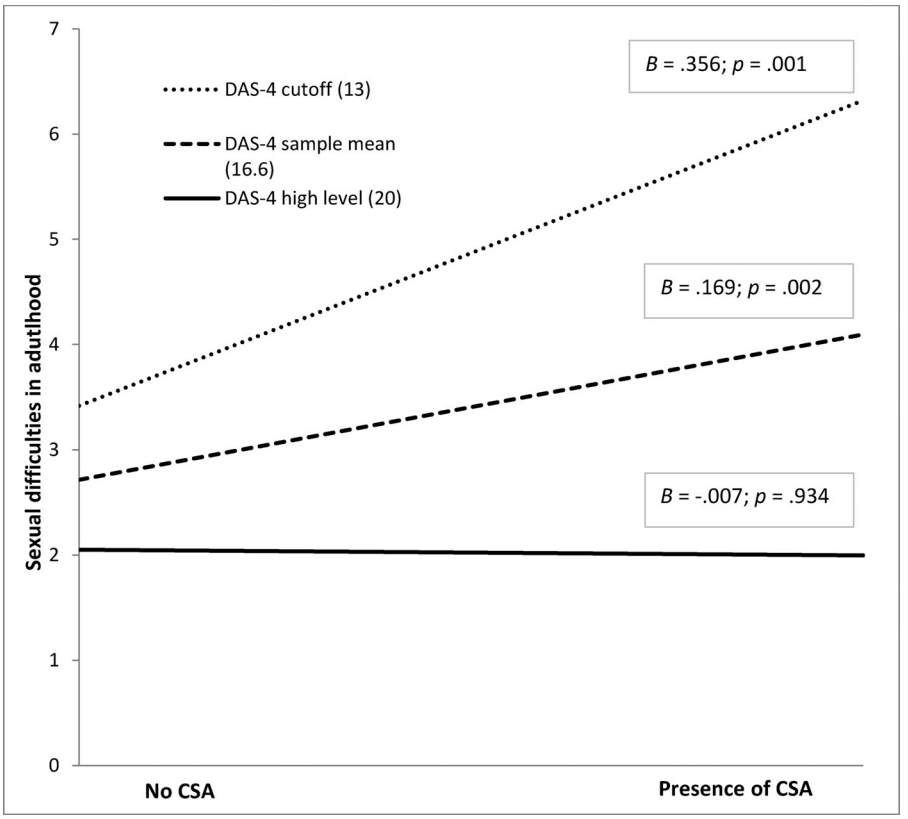

Figure 1. Moderation effect of relationship satisfaction in the association between childhood sexual abuse and sexual difficulties.

Discussion

CSA is known to be associated with long-term interpersonal consequences and the ramifications of such abuse can extend to sexual functioning (for review, see Aaron, 2012). However, individual variations can be found among survivors and some do not report experiencing any sexual difficulties in adulthood (e.g., Lemieux & Byers, 2008; Murray et al., 2014; Rellini & Meston, 2007). The purpose of this study was to examine the potential protective role of relationship satisfaction in the association between CSA and sexual difficulties in adulthood, in a convenience sample of adults involved in an intimate relationship. As expected, findings suggested that CSA was related to more sexual difficulties in adulthood. Also consistent with our hypotheses, this association was moderated by the level of relationship satisfaction.

About a quarter of the sample reported having experienced CSA, which is similar to the prevalence found in a global meta-analysis on CSA (Stoltenborgh et al., 2011) and other empirical studies among the general population (Barth, Bermetz, Heim, Trelle, & Tonia, 2013). As hypothesized, CSA survivors reported on average, lower levels of relationship satisfaction and higher levels of sexual difficulties than non-victims. These results support the trauma-based theoretical conceptualisations (Finkelhor & Browne, 1985; Godbout et al., 2013), explaining the negative repercussions of CSA on relationship and sexual functioning. Our results also add to the body of research regarding the deleterious effects of CSA experiences on sexuality (e.g., Rellini & Meston, 2011; Vaillancourt-Morel et al., 2015, 2016). With the exception of a few studies (e.g., Banyard et al., 2001; Van Bruggen et al., 2006), little research had examined the specific associations between CSA and trauma-related sexual difficulties.

Furthermore, non-traumatic sexuality specific questionnaires such as the Multidimensional Sexual Self-Concept Questionnaire (MSSCQ; Snell, 1995) or the Sexual Satisfaction Scale (SSS; Meston & Trapnell, 2005), which have been used in association with traumatic experiences, do not consider the trauma-related repercussions of CSA in adulthood and are not built in a trauma-informed approach. Indeed, these questionnaires are based on the general population, which can limit generalization to survivors' characteristics, the trauma-sensitivity of their items, and the specific repercussions of traumatic experiences that are evaluated. For these reasons, the current study used a standardized and validated measure of specific trauma-related symptoms to assess sexual difficulties (i.e., TSI-2; Briere, 2011). Considering the use of such a trauma specific questionnaire, it is possible to assume that we effectively targeted the impacts that CSA has on adult sexuality. Thus, our results provide good insights into how traumatic, developmentally inadequate, and deleterious the experience of CSA can be for survivors. As hypothesized, our results showed relationship satisfaction as a protective factor as we observed a non-significant association between CSA and sexual difficulties in individuals who reported higher relationship satisfaction. In contrast, in individuals who reported low or average relationship satisfaction, the experience of CSA was related to greater levels of sexual difficulties. As such, the present study helps to understand why the link between CSA and sexual functioning is not consistently observed and provides unique data on the often overlooked, potential protective factors at play in CSA survivors' sexuality.

Previous research on social, peer or family support has highlighted the significant contribution of these variables on multiple aspects of human functioning, such as global health (Holt-Lundstad & Uchino, 2015). Other studies have suggested that social support (i.e., support from friends and family) moderates the link between different types of childhood traumas (i.e., sexual abuse, emotional abuse, physical neglect) and the presence of trauma-related symptoms in adulthood (e.g., dissociation, sexual difficulties, depression; Evans et al., 2013). Another longitudinal study suggests that relationship satisfaction has a protective effect as it reduces the risk of undergoing sexual revictimization in adulthood (Banyard et al., 2003). Our results add to these conclusions by revealing the specific role of relationship satisfaction, where high levels of relationship satisfaction moderate the impact of CSA on sexual difficulties. More precisely, relationship satisfaction below a score of 18 on the DAS-4 did not have a protective effect on sexual functioning. Therefore, even if the clinical threshold for relationship satisfaction is fixed at 13, average scores were not enough to buffer against the effect of CSA on sexual functioning. Stronger levels of relationship satisfaction (i.e., $\geq$ 18) were in fact deemed necessary to counteract the effects of CSA on sexual functioning.

Different factors not taken into account in the present paper are likely to be important determinants of relationship satisfaction (e.g., insecure attachment; Godbout et al., 2017; identity and relatedness; Bigras, Godbout, & Briere, 2015; received support; Evans et al., 2013). These factors could offer interesting explanations for understanding why some CSA survivors cannot achieve the level of relationship satisfaction needed to benefit from the protective effect on sexuality.

Nevertheless, our results indicate the considerable influence that a satisfactory relationship can have on the sexual functioning of CSA survivors and how such positive relationships can serve as a restorative basis for an individual's vulnerabilities (here CSA experience). Furthermore, our results illustrate that while some CSA survivors may be deeply affected in how they relate to and deal with their partners, some can still find a satisfactory relationship to attenuate past relational injuries.

Practical Implications

First, results confirm the importance of considering the association between CSA and sexual difficulties in adulthood. In agreement with previous studies, it appears necessary for clinicians to routinely assess the presence of CSA in their evaluation protocols, as this traumatic experience may contribute to the presence of sexual difficulties (i.e., sexual concerns and sexual behaviors related to potentially negative outcomes). This study also confirmed the long-defended clinical hypothesis, which suggests that a satisfying intimate relationship may act as a fundamental aspect in promoting CSA survivors' sexual functioning. Indeed, the results of this study shed light on the protective role of relationship satisfaction on CSA survivors' sexual functioning and highlight the importance of taking into account survivors' perception of their relational functioning when engaging in therapeutic work. Since CSA survivors' difficulties in forming and maintaining meaningful intimate relationships are largely acknowledged by both clinicians and researchers (Fournier, Brassard, & Shaver, 2011; Godbout, 2018; Godbout et al., 2013), our results put forward the importance of working more thoroughly and carefully with those limitations when planning clinical work with survivors. Indeed, various elements (e.g., romantic attachment; Fournier et al., 2011) can influence relationship satisfaction. Therefore, it could be highly beneficial to include the intimate relationships dynamic and to work specifically on the individual's or the couple's perception of relationship satisfaction during the therapeutic process with CSA survivors who consult for sexual functioning.

Clinicians should be acutely aware of those intertwined domains when assessing an individual or a couple consulting for sexual or relationship difficulties. This study also confirms ideas established by previous authors, who adapted the original Emotion Focused Couple Therapy (Johnson, 1996) for CSA survivors (MacIntosh, 2019; MacIntosh & Johnson, 2008) by focusing more on the intimate relationship dynamic or on how therapy must be adapted for survivors whose boundaries have been crossed. In addition, while established couple therapy focuses on couple functioning, specificities regarding sexual functioning should also be integrated.

Given the traumatic event they have experienced, CSA survivors may struggle to experience, or even consider, sexuality as a positive, enjoyable, and healthy experience. Based on this idea, Maltz (2012) has developed a therapeutic approach were the focus is on treating the couple rather than the individuals, since sexual difficulties are, in most cases, part of a dyadic dynamic. Here again, our results support this type of approach. Moreover, treatment should first help the couple establish a secure basis from where partners can acquire the necessary skills to then address sexual difficulties and trauma-related issues (Godbout, 2018; Maltz, 2012).

Overall, our results suggest that the intimate relationship dynamic is a potentially important therapeutic target. Results indicated that a highly satisfactory relationship might indeed be restorative for the sexual functioning of CSA survivors. A healthy intimate relationship was found to buffer the negative effects of previously endured relational traumas and promote sexual functioning. Given the far-reaching effects of CSA and the results of this study, involving the partner in treatment seems to be compelling. Moreover, if the relationship between partners is not part of the healing process, it might become part of the problem. Therefore, offering couple therapy anchored in trauma sensitive practices and including both partners in interventions for CSA survivors might be optimal.

It should be noted that this study examined individuals in couple relationships and that not all CSA survivors are interested in such relationships, nor do all CSA survivors have the ability to maintain or have access to a highly satisfactory relationship that may offer a protective effect on their sexuality. While CSA tends to fracture the sexual and relational functioning of survivors, many survivors continue to long for a healthy and vibrant attachment relationship (Godbout, 2018; MacIntosh & Johnson, 2008; Maltz, 2012). Yet, forming and maintaining couple relationships can also be a source of challenges or distress (e.g., loss, re-victimization within the relationship), which may be detrimental. Some CSA survivors may therefore be reluctant to develop intimate relationships, in order to protect themselves emotionally or to decrease the risk of further victimization (Godbout, 2018; Testa et al., 2005). A "one size fits all" intervention encouraging survivors to systematically seek to form an intimate relationship is to be avoided. On the contrary, practitioners are encouraged to tailor their intervention to the needs and trajectories of each survivor, to accompany them at their own rhythm with openness and flexibility, and to keep in mind the constellation of possibilities regarding intimate relationship including choosing to be single.

Limitations and Future Research

This study has some limitations that need to be considered. The use of retrospective self-reported questionnaires may have distorted how participants recalled their experiences and may have also biased some of their responses (Baldwin, Reuben, Newbury, & Danese, 2019). However, according to previous studies (e.g., Vaillancourt-Morel et al., 2016), objective self-reporting measures are a reliable tool to detect traumatic experiences and allow for the documentation of more precise proportions than other, more subjective measures of CSA (e.g., when participants have to self-identify as "victim"). In addition, the correlational design prevents us from inferring any definite direction of causality. It is possible that survivors of CSA who succeeded in establishing highly satisfactory relationships are also those with less sexual difficulties. Moreover, this study included a relatively small sample of CSA survivors which consisted mainly of heterosexual Canadian women. Future studies need to be replicated with larger and more diverse samples, including a wider representation of CSA victims, before they can be generalized to a broader population. Another limitation of this study is related to the fact that we could not control for the potential effect of relationship duration as this data was not available, although it is recognized that relationship satisfaction diminishes over time (McNulty, Wenner, & Fisher, 2016). Moreover, the high level of relationship satisfaction that was necessary to benefit from its protective effect may be affected by different elements that are not examined in our study (e.g., attachment style, conflict resolution, emotion regulation). Replicating and complexifying our model could enable us to better capture the extent of the role of relationship satisfaction, but also to account for other variables that may also protect CSA survivors' sexual functioning, such as attachment, emotional regulation or conflict resolution. Also, this study only considered the experience of CSA. Yet, considering other forms of childhood trauma (e.g., neglect, physical and psychological abuse, etc.) is essential in future studies as they may also influence sexual functioning. In addition, adult sexual assault and revictimization are variables that are likely to influence the risk of experiencing sexual difficulties in adulthood (Briere, Runtz, Rassart, Rodd, & Godbout, 2020; Therriault et al., 2020; Van Bruggen et al., 2006). Therefore, it is essential to consider these variables in future models. Furthermore, since only one of the partners responded to the questionnaire, further studies including both partners could allow us to better capture the overall intimate relationship dynamics and the extent of the effect of relationship satisfaction. This could be particularly important for couples in which both partners have experienced CSA (e.g., dual-trauma couples; Ruhlmann, Gallus, & Durtschi, 2018) and are therefore more likely to experience issues in their relationship and sexuality. Finally, sexual and intimate characteristics (e.g., asexuality, open

relationships, polyamory versus monogamy) and other factors related to a satisfactory sexuality also need to be examined in future studies. Some qualitative studies have begun to document the sexual experiences of survivors of sexual violence and have identified challenges such as being triggered (e.g., flashbacks) or facing union dissolution due to the sexual impacts of this trauma (e.g., O'Callaghan, Shepp, Ullman & Kirkner, 2019). In this same line, future qualitative and mixed-method studies could help to document how survivors discuss their sexuality in association with their relational satisfaction. Future research can also help to further understand how relational satisfaction may promote healthy and positive sexual health.

Conclusion

This study helps to bridge a gap in the current scientific literature regarding the protective factors influencing the sexuality of CSA survivors. Results highlight how relationship satisfaction may act as a shield against the pervasive effects of CSA on sexuality. Even if our model is to be replicated and complexified in future studies, it clearly indicates the protective role of a satisfactory relationship on the presence of sexual difficulties. Clinicians working with CSA survivors who present sexual difficulties should keep in mind that relationship satisfaction is an important element to consider in order to foster positive sexuality. Finally, regardless of the relationship status, the gender, and despite the traumatic experience, the important takeaway is the positive and beneficial effect of satisfying relationships. Thus, a healthy, stable, and satisfying intimate relationship can offer survivors of CSA a space to heal from the long-lasting intimate sequalae of an event as intrusive and relationally damaging as CSA.

Disclosure statement

No potential conflict of interest was reported by the authors.

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