

Child Sexual Abuse, Sexual Anxiety, and Sexual Satisfaction: The Role of Self-Capacities

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Research indicates that child sexual abuse produces lasting alterations in interpersonal relatedness, identity, and affect regulation, often referred to as self-capacity disturbance. Child sexual abuse also has been shown to negatively impact sexual functioning. This study examined the role of altered self-capacities in mediating the relationship between child sexual abuse and sexual responses. Path analysis revealed that child sexual abuse was related to sexual anxiety and decreased sexual satisfaction through its association with reduced self-awareness and a propensity to be involved in difficult interpersonal relationships.

KEYWORDS affect dysregulation, child maltreatment, identity, interpersonal conflicts, sexual adjustment

Childhood abuse has been linked to an array of psychosocial difficulties. These include anxiety, depression, posttraumatic stress, cognitive distortions, somatic preoccupation, bulimia, substance abuse, and suicidality (see reviews by Arata, Langhinrichsen-Rohling, Bowers, & O’Farrill-Swails, 2005; Briere & Jordan, 2009; Cook et al., 2005). Child maltreatment, especially

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sexual abuse, has also been associated with a range of sexual difficulties in survivors, including reduced sexual satisfaction and sexual distress, although the literature suggests that this relationship may be complex. For example, Rellini and Meston (2011) found lower levels of sexual satisfaction among child sexual abuse (CSA) survivors as compared to nonvictims, and Mullen and colleagues (1994) reported that sexual abuse survivors in a community sample were more likely to report sexual dissatisfaction and to experience at least one sexual problem as compared to nonvictims. On the other hand, Schloretdt and Heiman (2003) compared three groups of women (CSA survivors, survivors of both CSA and physical abuse, and nonvictims) and found no direct link between CSA and impaired sexual functioning (e.g., sexual desire, arousal/orgasm, sexual pain) but an increased negative sexual perception in CSA survivors. In another study, Lacelle, Hébert, Lavoie, Vitaro, and Tremblay (2012b) found that it was not CSA, per se, that was related to sexual problems. Instead, women who had endured CSA as well as cumulative trauma were more likely to report sexual problems as compared to nonvictims, whereas women reporting CSA only did not differ from nonvictims. Finally, in sample of 272 female community students, Lemieux (2008) found no significant associations between CSA and sexual anxiety or satisfaction.

Beyond effects on sexual response, child maltreatment appears to impact what are described as *self-capacities* (Briere & Runtz, 2002; McCann & Pearlman, 1990). Thought to develop in the context of positive parent-child attachment experiences (Alexander, 1992; Bowlby, 1969; Cole & Putnam, 1992), self-capacities refer to the extent to which an individual is able to accomplish three tasks: maintain a sense of personal identity and self-awareness across various experiences; tolerate and control strong negative emotions without resorting to avoidance, sometimes referred to as *affect regulation*; and develop and maintain meaningful relationships with others that are not disturbed by dysfunctional behavior or excessive preoccupation with interpersonal danger, rejection, or abandonment (Briere & Runtz, 2002; Elliott, 1994; McCann & Pearlman, 1990).

IDENTITY

Childhood sexual abuse may specifically lead to identity disturbance (Briere, 1996; Elliott, 1994). As noted by Finkelhor and Browne (1985), CSA-related stigmatization, involving perceptions of being bad, guilty, and responsible for the abuse, can affect survivors' self-image, self-worth, and perception of control over their lives. In addition, sexual abuse survivors may suffer from a less-consistent sense of personal existence or identity (Briere, 2002; Cole & Putnam, 1992), leading to reduced internal self-monitoring and self-awareness.

AFFECT REGULATION

Child sexual abuse and other forms of severe maltreatment have also been linked to problems in the regulation of negative emotional states (e.g., Briere & Rickards, 2007; Messman-Moore, Walsh, & DiLillo, 2010). Such difficulties, in turn, may lead to the compensatory use of behavioral, emotional, or cognitive avoidance strategies, including “acting out” in relationships, substance abuse, deliberate self-injury, dissociation, excessive or inappropriate sexual behavior, and aggression (Arata et al., 2005; Briere, Hodges, & Godbout, 2010; Briere & Runtz, 2002; Cloitre et al., 2009).

RELATEDNESS

CSA is also known to impact interpersonal functioning (Cole & Putnam, 1992; DiLillo, 2001). Sexual abuse may easily lead to expectations of betrayal and maltreatment that reduce interpersonal trust and increase the likelihood of relational strife (Finkelhor & Browne, 1985). Sexual abuse may also undermine awareness of the boundaries between the self and others, which can produce problems with significant others (Davis, Petretic-Jackson, & Ting, 2001; Godbout, Lussier, & Sabourin, 2006). These interpersonal difficulties may result in difficult and chaotic relationships or lead the survivor to avoid interpersonal relationships altogether in an attempt to reduce negative thoughts and feelings associated with triggered abuse memories (e.g., Polusny & Follette, 1995).

ADDITIONAL CORRELATES OF SELF-CAPACITY DISTURBANCE

Self-capacity disturbance, in turn, appears to be associated with a range of subsequent negative psychological outcomes, including rejection sensitivity, abandonment concerns, self-injury, impulsivity, indiscriminant sexual behavior, bulimia, “borderline” dynamics with others, substance abuse, suicidality, dissociation, and depression (e.g., Allen, 2011; Alexander, 1992; Briere & Runtz, 2002; Feeney & Noller, 2004; Herpertz, Sass, & Favazza, 1997; Zlotnick, Donaldson, Spirito, & Pearlstein, 1997). Relevant to the current study, several studies also indicate that aspects of self-disturbance (e.g., relational conflicts and use of dysfunctional avoidance strategies) are associated with sexual dissatisfaction and anxiety (Cyranski & Andersen, 1998; Feeney & Noller, 1990; Hazan & Shaver, 1987; Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012a; Meston, Rellini, & Heiman, 2006; Staples, Rellini, & Roberts, 2012).

The literature described suggests that CSA has multiple effects, including impacts on self-capacities that, perhaps irrespective of specific traumatic precursors, are then associated with a range of negative psychological phenomena. Given these findings, a reasonable question is whether at least some of the relationship between CSA and negative outcomes is mediated by self-capacity disturbance; in other words, whether CSA may lead to self-disturbance, which, in turn, influences whether certain psychological difficulties will occur. This mediation has in fact been found for a number of psychosocial problems (Allen, 2011; Briere et al., 2010; Dietrich, 2007; Palesh, Classen, Field, Kraemer, & Spiegel, 2007).

Not yet demonstrated, however, is whether the relationship between CSA and subsequent sexual difficulties may occur in the context of self-capacity disturbance. This is a reasonable hypothesis, since sexual-abuse-related interpersonal conflicts and fears, identity disturbance (including reduced self-awareness), and affect-dysregulation-related avoidance (e.g., substance abuse, dissociation, “acting out”) might easily produce anxiety associated with sexual/intimacy issues and reduced sexual satisfaction. Apropos of this possibility, the current study examined how CSA and self-capacities variables potentially interrelate to produce sexual difficulties, in this case sexual anxiety and sexual dissatisfaction. We hypothesized that (a) CSA would be associated with less sexual satisfaction and increased sexual anxiety in adulthood, (b) CSA would predict alterations in self-capacities, and (c) childhood sexual abuse would exert some of its influence on sexual problems indirectly, through its relationship with impaired self-capacities.

METHOD

Participants and Procedure

Participants were 257 women and 45 men aged 18 years and older. Recruitment was conducted online. A link to the study was shared on the Facebook social network through a page dedicated to the study, and an invitation to participate in the study was sent through a listserv for students, teachers, and other professionals associated with psychology. The online version of the questionnaire was hosted by the SurveyMonkey website. Because not everybody was assumed to be comfortable with the Internet, participants also had the option of receiving the questionnaires by mail. The study was described as a confidential and anonymous survey on past experiences of victimization, intrapersonal processes, relationships, and sexual functioning. Participation required 30 to 40 minutes. Participants were offered the opportunity to be entered in a drawing for \$50. The study was approved by University of Quebec in Montreal's Institutional Review Board. The average participant was 28.6 years of age ($SD = 9.6$, range 19 to 74 years). Most were Canadian citizens (91%), students (54%), and full-time workers (35%). Their primary

language was French (93%), 38% had completed undergraduate studies, and 89% were heterosexual. Forty-four percent of participants were in an intimate relationship, 24% were in a common-law relationship, 12% were married, and 19% were single.

Measures

Child sexual abuse was assessed using gate questions about whether the individual had ever experienced unwanted sexual contact in childhood/adolescence or sexual contact during childhood or adolescence with an adult, someone in authority, or someone five years older. Those who responded positively to any of these items were invited to answer additional questions, including the type of sexual contact experienced (e.g., showed genitals, touching, oral sex, vaginal or anal penetration) and the participant's relationship to the abuser (e.g., father, uncle/aunt, neighbor). Participants were classified as having experienced CSA if the answer to any question indicated physical sexual contact.

Self-capacities were evaluated using the 63-item Inventory of Altered Self-Capacities (IASC; Briere, 2000). The IASC is a standardized, validated test of difficulties in the areas of relatedness, identity, and affect regulation. Each of the 7 IASC scales consists of 9 items, which are rated on a 5-point Likert scale (1 = never; 5 = very often). Scales assess the following domains: Interpersonal Conflicts, Idealization-Disillusionment, Abandonment Concerns, Identity Impairment, Susceptibility to Influence, Affect Dysregulation, and Tension Reduction Activities. Elevated scores on the IASC have been shown to predict insecure attachment style, childhood trauma history, interpersonal problems, suicidality, substance abuse history, posttraumatic stress disorder, and dissociation in various samples (e.g., Allen, 2011; Briere, 2006; Briere & Runtz, 2002; Dietrich, 2007; Messman-Moore et al., 2010).

For the purpose of this study, a French translation of the IASC was created and then back-translated to English—at which point the original English version and the back-translated version were compared by the test publisher and test author and approved as equivalent. Cronbach's alphas in the current study indicated high internal consistency of all scales: Interpersonal Conflicts ($\alpha = .84$), Idealization-Disillusionment ($\alpha = .92$), Abandonment Concerns ($\alpha = .92$), Identity Impairment ($\alpha = .89$), Susceptibility to Influence ($\alpha = .88$), Affect Dysregulation ($\alpha = .90$), and Tension Reduction Activities ($\alpha = .72$).

Sexual anxiety was assessed with the 5-item Sexual Anxiety scale of the Multidimensional Sexuality Questionnaire (MSQ; Snell, Fisher, & Walters, 1993), translated into French by Ravart, Trudel, and Turgeon (2000). Items are rated on a 5-point Likert scale (0 = not at all characteristic of

me; 4 = very characteristic of me) and summed to form subscale scores. Both Cronbach's alpha coefficients for the Sexual Anxiety subscale in Snell, Fisher, and Walters's (1993) sample and the current sample were good, respectively .87 and .85.

Sexual satisfaction was assessed using a French-translated version of the Global Measure of Sexual Satisfaction (GMSEX; Lawrance & Byers, 1995). Participants rate their sexual relationships on 5 7-point bipolar scales: good-bad, pleasant-unpleasant, positive-negative, satisfying-unsatisfying, valuable-worthless. Scores vary from 5 to 35, and higher scores indicate greater sexual satisfaction. The GMSEX internal consistency reported by the authors in their 2 samples was very good (.90—.96). In the current study, the alpha coefficient was .92.

Data Analyses

The relationships between CSA and self-capacities, sexual satisfaction, and sexual anxiety were first assessed using multivariate analysis of variance (MANOVA). Correlations were conducted to assess the associations between the study variables, and multiple regression was performed to examine the extent to which CSA and self-capacities predicted sexual satisfaction and anxiety. Finally, based on previous results, the hypothesized model was tested using path analysis, with CSA as the predictor, self-capacities identified as significant by multiple regression as potential mediators, and sexual satisfaction and sexual anxiety as outcome variables.

Path analysis is a statistical method that allows testing both direct and indirect relationships among different variables that may be correlated (Kline, 2011). It also has the advantage of estimating relationships among variables, considering all relationships simultaneously. Analyses were conducted using Mplus, version 7 (Muthén & Muthén, 1998–2012). This program accounts for missing data using the full information maximum likelihood estimation (Muthén & Muthén, 1998–2012). The present study used a cross-sectional design, and the causal order of the entry/sequence of variables was determined based on theory and chronology (i.e., CSA is typically experienced before self-capacities have been developed, and current sexual satisfaction and sexual anxiety usually occur later in development, after self-capacities are thought to be in place). Often adopted in the trauma literature (e.g., Briere et al., 2010; Godbout, Dutton, Lussier, & Sabourin, 2009), this theoretically grounded analytic strategy is a routine statistical recommendation for causal analyses (Byrne, 2013).

The following indices were used to assess the overall model fit: the chi-square statistic, the comparative fit index (CFI; Bentler, 1990), the normed fit index (NFI; Bentler & Bonett, 1980), and the root mean square

error of approximation (RMSEA; Steiger, 1990). A nonstatistically significant chi-square value, a CFI and NFI value of .90 or higher, and a RMSEA value below .06 are considered indicators of good fit (Hu & Bentler, 1999). Since chi-square tests are sensitive to sample size (Kline, 2011), we also used the ratio of chi-square to degrees of freedom (X^2/df). Values less than 5 indicate a satisfactory fit, but a more conservative cutoff value of 3 is ideal (Ullman, 2001).

RESULTS

Descriptive Statistics

The prevalence rates of CSA were 19.4% in women ($n = 49$) and 11.1% in men ($n = 5$). The average age at first sexual abuse was 10.37 years ($SD = 4.71$, range = 4 to 17 years). Seventy-eight percent ($n = 42$) reported sexual touching, 24% ($n = 13$) reported oral contact, and 44% ($n = 24$) reported vaginal or anal penetration. A total of 28% ($n = 15$) were abused by a family member, and 32% ($n = 17$) reported abuse by a friend of the family, a neighbor, or an acquaintance.

Comparison Tests Between CSA Survivors and Nonsurvivors and Associations Between Self-Capacities, Sexual Anxiety, and Sexual Satisfaction

A two-level MANOVA was conducted to compare the IASC scales, sexual satisfaction, and sexual anxiety between participants reporting a CSA history and those not reporting CSA. Analysis revealed a statistically significant main effect of CSA (Wilk's $\lambda = .927$; $F(9, 260) = 2.27$; $p = .018$; $\eta^2 = .073$). Post-hoc ANOVAs indicated that CSA was associated with all IASC scales except Abandonment Concerns and Susceptibility to Influence. Means, standard deviations, and ANOVA results are presented in Table 1.

Means, standard deviations, correlated among variables are presented in Table 2. In contrast to our hypotheses, the relationships between CSA and sexual satisfaction and sexual anxiety were nonsignificant. In all cases, sexual anxiety and sexual satisfaction were, as expected, predicted by IASC scales.

Hierarchical multiple regression analyses were conducted to determine the predictive value of CSA and each of the seven self-capacities scales with reference to sexual satisfaction and sexual anxiety. As indicated in Table 3, for both dependent variables, CSA was entered at step 1, whereas at step 2 the stepwise entry method was used to determine which IASC scales were significantly related to outcome variables, controlling for sexual abuse (see Table 3). CSA effects at step 1 confirmed those of the MANOVA. Step 2 results

TABLE 1 Means and Standard Deviations for Self-Capacities and Psychosexual Variables as a Function of CSA Status

Variables	CSA		No CSA		F	η^2
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Interpersonal Conflicts	19.19	5.99	16.35	4.61	13.18***	.05
Idealization-Disillusionment	16.07	8.81	14.10	5.97	3.87*	.01
Abandonment Concerns	18.41	9.37	15.60	7.07	2.08	.01
Identity Impairment	18.28	8.34	15.48	6.41	3.99*	.02
Susceptibility to Influence	14.69	6.83	12.76	4.82	3.36	.01
Affect Dysregulation	17.58	7.76	14.57	5.90	8.01**	.03
Tension Reduction Activities	14.30	5.65	11.91	3.49	9.97**	.04
Sexual Anxiety	5.23	4.54	5.11	4.64	.04	.00
Sexual Satisfaction	27.35	6.56	27.62	6.10	.92	.00

Note: CSA = child sexual abuse.
 $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

indicated that Interpersonal Conflicts and Identity Impairment predicted sexual anxiety, whereas Interpersonal Conflicts and Susceptibility to Influence negatively predicted sexual satisfaction.

Integrative Model

Path analysis was used to confirm the hypothesized integrative model in which CSA was related to altered self-capacities that, in turn, were correlated with sexual anxiety and decreased sexual satisfaction. This analysis tested indirect effects, not mediation; the former involves the same calculations as mediation analyses, but, unlike mediation analyses, indirect effect analyses do not require a direct relationship between two variables in order to explore whether this association may be indirectly affected by a third intermediary variable (Cecil, Barker, Jaffee, & Viding, 2012).

After nonsignificant paths (which included the Susceptibility to Influence scale) were removed, the final adjusted model provided a very good fit to the data: NFI = .99, CFI = .99, RMSEA = .03, CI [.00, .09], $X^2 [4] = 5.18$, $p = .27$, Ratio $X^2/df = 1.29$. As presented in Figure 1, this model indicated that CSA was positively and significantly associated with both interpersonal conflicts and identity impairment which, in turn, were associated with sexual anxiety. Decreased sexual satisfaction, however, was associated with identity impairment but not interpersonal conflicts.

As might be expected, covariances between the self-capacity scales (interpersonal conflicts and identity impairment) and the sexual outcome scales (sexual anxiety and lower sexual satisfaction) were statistically significant in each case, $r = .50$, $p < .001$ and $r = -.31$, $p < .001$,

TABLE 2 Means, Standard Deviations, and Correlations Among Variables Included in Path Analysis

Variables	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9
1. CSA ^a	.18	.38	1								
2. Interpersonal Conflicts	16.87	5.01	.22**	1							
3. Idealization-Disillusionment	14.46	6.61	.12*	.59**	1						
4. Abandonment Concerns	16.12	7.60	.14*	.61**	.70**	1					
5. Identity Impairment	15.99	6.88	.16**	.52**	.55**	.66**	1				
6. Susceptibility to Influence	13.11	5.29	.14*	.50**	.58**	.62**	.75**	1			
7. Affect Dysregulation	15.12	6.37	.18**	.68**	.51**	.65**	.63**	.62**	1		
8. Tension Reduction Activities	12.35	4.07	.23**	.52**	.62**	.63**	.60**	.65**	.68**	1	
9. Sexual Satisfaction	22.57	6.17	-.02	-.24**	-.23**	-.12*	-.23**	-.24**	-.21**	-.17**	1
10. Sexual Anxiety	5.13	4.61	.01	.36**	.31**	.28**	.36**	.34**	.32**	.33**	-.38**

Note: Pearson's *r* correlation was used for continuous variables, and point-biserial correlation was used for associations between dichotomous and continuous variables. CSA = child sexual abuse.

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

^a CSA is a dichotomous variable.

TABLE 3 Hierarchical Regression Analyses to Predict Psychosexual Adjustment

Predictor	Sexual Anxiety		Sexual Satisfaction	
	R ² change	β	R ² change	β
Step 1	.00		.00	
CSA ^a		-.00		-.01
Step 2	.17***		.07*	
Interpersonal Conflicts		.26***		-.17*
Identity Impairment		.23***		—
Susceptibility to Influence		—		-.16*

^a CSA is a dichotomous variable.

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

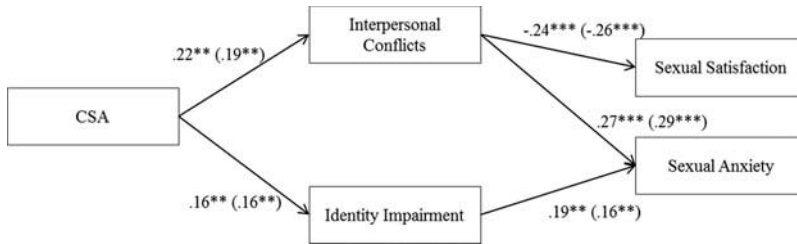


FIGURE 1 Path analysis of CSA, self-capacities, sexual anxiety, and sexual satisfaction.

Note: CSA = child sexual abuse. Coefficients in parentheses are for women only.

respectively. We used the bootstrap confidence intervals method to examine the magnitude and significance of the indirect effects (Shrout & Bolger, 2002). Results indicated that the indirect effects of CSA, through interpersonal conflicts, were significant for decreased sexual satisfaction ($\beta = -.83$, 95% CI -1.49 to $-.41$) and for sexual anxiety ($\beta = .69$, 95% CI $.35$ to 1.25). The indirect effect of CSA on sexual anxiety, via identity impairment, was also significant ($\beta = .34$, 95% CI $.12$ to $.77$). Overall, the final model explained 16% of the variance for sexual anxiety and 6% for the sexual satisfaction. Standardized coefficients are presented in Figure 1.

Given the small number of men in the current sample ($n = 45$), the stability of the current findings for the larger group (women only) was assessed by removing male participants from the analyses. Results indicated that the model remained stable with good adjustment fit (NFI = .98, CFI = 1.00, RMSEA = .00, CI [.00, .09], X^2 [3] = 2.18, $p = .54$, Ratio $X^2/df = .73$) and similar observed links (see Figure 1, in brackets). The effect sizes were also comparable ($R^2 = .16$, $.7$, for sexual anxiety and satisfaction, respectively).

DISCUSSION

The results of this study suggest that CSA has an indirect impact on sexual anxiety and sexual satisfaction through its association with altered self-capacities. Nevertheless, our first hypothesis, that CSA would be directly related to negative sexual outcomes, was not supported. These results are consistent with another study finding no relationship between CSA and sexual anxiety or satisfaction (Lemieux & Byers, 2008) and research indicating that CSA does not predict sexual problems unless cumulative trauma is also present (Lacelle et al., 2012a). The current findings do not agree with other studies linking CSA to sexual difficulties (Mullen et al. 1994; Rellini & Meston, 2011).

It may be that the current sample and/or measures differed in significant ways from those in which the CSA–sexual problems relationship has been found. Mullen and colleagues (1994) used a nonvalidated, study-specific measure of sexual problems, and Rellini and Meston (2011) used a different measure of sexual satisfaction (Sexual Satisfaction Scale–Women; Meston & Trapnell, 2005) than did the current study. The only study to have measured sexual satisfaction with the same instrument (the GMSEX) as the present study also did not find a significant direct relationship between CSA and sexual problems (Lemieux & Byers, 2008). It is also possible that CSA predicts types of sexual outcomes that were not measured in this study, such as sexual schemas or sexual self-concept, in addition to being indirectly related to sexual satisfaction and anxiety as measured in the present study.

Above and beyond sexual disturbance, the hypothesis that CSA would be associated with altered self-capacities was confirmed: CSA was linked to all 7 IASC scales. This finding is consistent with Allen (2011) but contrary to Briere and Rickards's (2007) report that CSA was not related to Interpersonal Conflicts or Identity Impairment. However, the Briere and Rickards sample consisted primarily of males (57.8%), and the mean age was 49.7 years ($SD = 15.4$), whereas our sample consisted largely of women who were, on average, 20 years younger. In a study of the psychometric properties of the IASC across general population, clinical, and university samples, women rated themselves as having more self-capacity disturbance than did men, as did younger participants relative to older ones (Briere & Runtz, 2002). Similarly, DiLillo and his colleagues (2007) found that women, but not men, who experienced maltreatment endorse more relationship difficulties compared to nonvictims.

Our third hypothesis, that CSA would have indirect effects on sexual responses via disturbed self-capacities, was also supported. Together, these findings suggest that CSA is associated with relational difficulties and decreased self-awareness, which are then related to problems with sexual anxiety and/or decreased sexual satisfaction. The indirect effect of CSA on

sexual response through interpersonal difficulties and self-awareness problems may be indicative of an increased risk for insecure attachment following traumatic experiences. In this regard, Alexander (1992) suggests that negative relational representations observed in CSA survivors are typical of insecurely attached adults, a relational style that may underline a greater propensity to experience interpersonal conflicts (Godbout et al., 2006; Ruminstein-McKean & Hunsley, 2001). As was also found by Sprecher and Cate (2004), the current results suggest that interpersonal difficulties or emotionally upsetting relationships may lead to sexual anxiety and sexual dissatisfaction, whereas stable and satisfactory relationships may facilitate sexual responses that are more free of anxiety and are more satisfying.

These findings also suggest that negative interpersonal representations may affect how CSA survivors construe their sexual interactions (Feeney & Noller, 2004; Shaver & Mikulincer, 2006), potentially impairing their capacity to experience pleasure from sexual encounters. Along with Zurbriggen and Freyd (2004), our finding suggests that CSA may lead to decreased self-awareness and relational confusion that, in turn, results in problems in freely consenting to sexual activity, in communicating efficiently with intimate others, and in dealing with negative sexual memories that emerge during intimate relations. In response, CSA survivors may fail to understand or relate to others sufficiently to meet their sexual needs and be unable to recognize or experience their own internal states (Elliott, 1994). These difficulties may lead to a number of concerns in adolescence and adulthood, perhaps especially in intimate encounters. As per Finkelhor and Browne's (1985) *stigmatization* dynamic, some CSA survivors may develop a more negative sense of self through a perception of being "bad" or different following victimization, with an expectation that others will reject them if they get to know them. These cognitive representations of the sexual aspects of self and intimate relationships may produce anxiety and decreased sexual satisfaction, as well as, possibly, negative feelings during sexual arousal (Meston et al., 2006) and tension, discomfort, or anxiety when thinking about sexual issues or experiences (Snell et al., 1993).

Several aspects of this study should be taken into account when considering its applicability to the experience of sexual abuse survivors. First, because it is one of the only studies on the role of self-capacities as they influence the relationship between CSA and negative sexual responses, the findings reported here should be replicated in other samples to ensure their reliability and generalizability, perhaps especially to clinically presenting individuals. Second, because this study utilized a cross-sectional, retrospective design, causality cannot be inferred based on these results alone. Not only may recall be a factor, but this study can only speak to correlations, not necessarily cause and effect. We attempted to address this shortcoming by using path analysis, which tested whether the current data support a specific

causal hypothesis (i.e., that CSA leads to self-capacity disturbance in some people, which results in sexual anxiety and decreased sexual satisfaction). The resultant fit indices and associated statistics indicated that this causal hypothesis is strongly consistent with the data. However, other causal orders may also be supported, including the possibility that sexual anxiety and dissatisfaction can impact self-capacities, or that sexual disturbance and self-disturbance are actually a function of additional variables that were not included in the present analyses. The latter may include the role of other forms of maltreatment that are known to co-occur with CSA and have relational impacts, such as parental neglect or psychological abuse (Briere & Jordan, 2009; Briere & Runtz, 1990; Godbout et al., 2009; Godbout, Runtz, MacIntosh, & Briere, 2013), attachment patterns that correlated with impaired self-capacities (Roche, Runtz, & Hunter, 1999), the presence or absence of social support (Godbout, Briere, Sabourin, & Lussier, 2014) and dysfunctional coping strategies that also may occur following CSA and affect self-capacities (Bal, Van Oost, De Bourdeaudhuij, & Crombez, 2003).

Although the results confirmed the proposed integrative model depicting the links between CSA and sexual outcomes through interpersonal conflicts (sexual anxiety) and identity impairment (sexual anxiety and sexual satisfaction), the effect sizes remain relatively small (see Cohen, 1992). This is common, however, in studies examining the long-term effects of child maltreatment on sexual outcomes or relational intimacy (e.g., Berthelot, Godbout, Hébert, Goulet, & Bergeron, 2014; Godbout et al., 2009, 2006; Lacelle et al., 2012b; Messman-Moore, 2010; Vaillancourt-Morel et al., 2014). The effect sizes observed in the current study suggest that CSA is a distal factor that might, many years later, still indirectly affect the survivors' current sexual functioning depending on their levels of identity impairment and interpersonal deficits. These results also suggest the potential contribution of other key variables not included in the current model (e.g., attachment representations, anxiety, depression) that should be examined in further studies.

Clinical Implications

These findings have several implications for clinical practice. They highlight the need for a systematic, detailed assessment of trauma-related history in individuals consulting for sexual difficulties, including identity impairment and interpersonal conflicts, that might lead to sexual anxiety and dissatisfaction. A better understanding of the intermediate variables related to the sexual adjustment of CSA survivors could facilitate the development of interventions that better fit the specific needs of survivors seeking treatment for sexual problems or dysfunction (Godbout et al.,

2013). In particular, self-capacities may be key targets of intervention for some survivors. Given the current results, treatment that builds or reinforces a sense of self (e.g., Briere & Scott, 2014; Cloitre, Cohen, & Koenen, 2006; Fonagy & Bateman, 2006; Yeomans, Clarkin, & Kernberg, 2015) and enhances relational skills (e.g., Linehan, 1993; Paivio & Pascual-Leone, 2010) might be expected to benefit survivors' sexual adjustment.

Finally, the current results may offer hope for survivors in suggesting that CSA, per se, does not inevitably define the survivors' sexual-relational life in adulthood. On the contrary, internal resources already available to some CSA survivors, or that can be developed through successful psychotherapy, may serve as significant protective or ameliorative factors. In addition, because CSA is often a "high betrayal trauma" (Freyd, 1996), a consistent, nonexploitative, and reliable therapeutic relationship may become a particularly powerful contradiction to the client's internalized assumptions about the need for distrust and avoidance of intimacy.

In this way, therapists who provide empathic human contact, validation, and a safe environment may promote beneficial models of self and others that were not previously possible due to the posttraumatic hypervigilance and dysfunctional avoidance often seen in trauma survivors (Briere et al., 2010; Briere & Scott, 2014). Such a context may gradually allow the restructuring of internalized relational patterns and foster the development of new, positive relationships so that the survivor's interpersonal life can become more fulfilling and less chaotic.

By highlighting the potential role of self-capacities in sexual abuse-related sexual issues, this study encourages clinical attention not only to the classic conditioned response and cognitive models of sexual difficulties (Rosen & Leiblum, 1995) that are typically addressed in cognitive-behavioral therapy (e.g., Barlow, 1986; Jehu, 1989) but also to issues involving self-disturbance and relational dysfunction (e.g., MacIntosh & Johnson, 2008; Pearlman & Courtois, 2005). Such interventions might focus more on attachment dynamics, relational functioning, and internalized schema about self and others rather than on more mechanistic attempts to simply remove sexual symptoms.

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