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Symptomatologie conjugale et sexuelle chez des survivants d'agression sexuelle à l'enfance

Thèse

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Québec, Canada

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Résumé

La présente thèse a pour objectif d'examiner le caractère dynamique des rapports entre l'agression sexuelle à l'enfance (ASE) et les répercussions sexuelles et conjugales à l'âge adulte. Plus spécifiquement, la première étude examine la validité d'un modèle médiationnel de l'association entre l'ASE, les séquelles sexuelles (c.-à-d., compulsion sexuelle et évitement sexuel) et l'ajustement conjugal. Les analyses acheminatoires menées à l'aide d'un échantillon de 686 adultes en relation de couple révèlent une association positive entre l'ASE, la compulsion sexuelle et l'évitement sexuel qui sont reliés, à leur tour, à une plus faible satisfaction conjugale. La deuxième étude tente de reproduire ce modèle médiationnel en modifiant l'indicateur du fonctionnement conjugal. Ainsi, elle a pour objectif d'examiner le lien entre l'ASE, la compulsion sexuelle et les relations sexuelles extradyadiques. Les résultats d'analyses d'équations structurelles effectuées auprès de 669 adultes en relation de couple font état d'une association positive entre la sévérité de l'ASE et la compulsion sexuelle qui augmente ensuite la probabilité de s'engager dans des relations sexuelles extradyadiques. Afin de mieux comprendre l'interdépendance entre le fonctionnement sexuel et conjugal des survivants d'ASE, la troisième étude examine le rôle du contexte relationnel sous-jacent aux répercussions sexuelles. L'objectif principal est d'analyser l'invariance des associations entre l'ASE, la compulsion sexuelle et l'évitement sexuel selon le statut conjugal. Les résultats d'analyses acheminatoires réalisées auprès de 1033 adultes démontrent que la sévérité de l'ASE est associée à la compulsion sexuelle chez les individus non-mariés tandis que la sévérité de l'ASE est associée à l'évitement sexuel chez les individus mariés. Ces trois études confirment l'absence de différences de genre quant aux répercussions sexuelles et conjugales ce qui soutient l'hypothèse de similarité entre les hommes et les femmes. Cette série d'études démontre également l'importance de deux patrons de réponses sexuelles, la compulsion sexuelle et l'évitement sexuel, dans le développement de difficultés conjugales tout en soulignant l'émergence de l'évitement sexuel suite à l'ASE précisément au sein des relations de couple où l'engagement et l'intimité sont élevés. Ainsi, la thèse souligne l'importance de tenir compte de la dynamique entre les facteurs relationnels et sexuels pour comprendre les liens complexes qui expliquent les difficultés autant sexuelles que conjugales chez les survivants d'ASE.

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ASE……...Agression sexuelle à l'enfance ou à l'adolescence
CSA……... Child sexual abuse
ESI……..……..Extradyadic sexual involvement
DAS……Dyadic adjustment scale
ANOVA……Analysis of variance
SEM……Structural equation model
RMSEA……Root mean square error of approximation
CFI……...Comparative fit index
χ^2/df……Ratio of chi-square to degrees of freedom
WLSMV……..Weighted least squares mean- and variance-adjusted

Remerciements

Tout au long de mon parcours doctoral, j'ai eu la chance d'être entourée d'une équipe de superviseurs et de collaborateurs m'ayant permis de progresser rapidement et me dépasser ainsi que d'un réseau de soutien inestimable composé d'amies et de proches qui me sont chers. Je profite donc de cette occasion pour remercier tous les gens qui m'ont aidée de près ou de loin à mener ce projet à terme.

Je remercie mon directeur de thèse, Stéphane Sabourin, puisque sans ses encouragements et ses conseils, je n'aurai pas été en mesure d'effectuer ce travail d'envergure. Merci d'avoir cru en moi et de m'avoir donné le meilleur de vous-même c'est-à-dire votre sens de l'humour, votre franchise et votre écoute. Merci de m'avoir toujours conseillée adéquatement en visant le mieux pour mon développement personnel et professionnel, de m'avoir poussée à donner mon maximum, mais sans jamais dépasser ma limite, de ne jamais m'avoir laissé douter de moi trop longtemps et de m'avoir validée dans mes craintes. Vous êtes un modèle d'équilibre en recherche, un modèle que je vais tenter d'atteindre à ma façon dans ma future carrière professionnelle.

Je remercie ma codirectrice de thèse, Natacha Godbout, puisque sans son enthousiasme et ses nombreux projets, je ne me serais pas lancée aussi rapidement et passionnément dans la recherche. Merci de m'avoir transmis ta passion pour la recherche et d'avoir toujours trouvé les mots justes pour m'encourager et me motiver à me dépasser. Merci pour toutes les opportunités que tu m'as offertes, c'est en partie grâce à toi si j'ai obtenu de beaux succès rapidement dès mes premières années doctorales. Merci d'avoir été un modèle inspirant et stimulant de professeur-chercheur et d'avoir su le demeurer tout au long de mon doctorat.

Je remercie tous les collaborateurs en recherche puisque sans l'encadrement hors pair que j'ai reçu de cette équipe élargie de supervision je n'aurais pas réussi à mettre autant de temps et d'efforts dans nos nombreux projets de recherche. Merci aux membres de mon comité de thèse, Yvan Lussier et Catherine Bégin, pour leur apport à la présente thèse et leurs précieux conseils constructifs. Merci à Yvan pour votre minutie et vos encouragements dans l'élaboration de mes articles, les deux jumelés m'ont permis de persévérer et rendre des articles d'une encore plus grande qualité. Merci aux membres de mon comité de soutenance, Audrey Brassard et Lina Normandin, de m'avoir permis de profiter de leur savoir pour approfondir ma réflexion dans le domaine. I thank two mentors of my supervision team, John Briere and Marsha Runtz, for insisting on a high level of quality in my articles, helping me improve my writing skills and provinding thoughtful and challenging learning opportunities. Je remercie Hélène Paradis et Bei Feng pour leurs précieux conseils statistiques, vous m'avez sauvé des heures incalculables de recherche en étant toujours disponibles pour mes petites questions qui prennent toujours plus de temps que les deux minutes demandées. Je remercie le Fonds de recherche du Québec – Société et culture et le Conseil de recherches en sciences humaines pour leur soutien financier ainsi que le CRIPCAS pour le milieu d'échanges stimulants qu'il m'a offert en plus du soutien financier.

Je remercie tous mes superviseurs cliniques puisqu'en contribuant à ma formation clinique ils m'ont donné accès à des réflexions et approfondissements théoriques qui ont enrichi mes travaux de recherche. Merci à ma première superviseure, Danielle Lefebvre, de m'avoir accueillie à mes débuts et m'avoir permis de développer ma compréhension et mon sens clinique. Merci aux superviseurs subséquents, Delphine Buissières-Genest, Stéphane Sabourin, Julie Larouche, et Alina Kao, d'avoir contribué à différentes facettes de mon développement professionnel, vous faites tous partie de mon identité comme clinicienne. Merci à Julie de m'avoir aidée à me trouver parmi toutes ces théories et avoir travaillé sans relâche sur ma confiance personnelle et professionnelle, je vais continuer ce travail d'envergure.

Je remercie la meilleure équipe de laboratoire, une équipe qui s'entraide et prend le temps de s'écouter, lorsque nécessaire. Merci aux «anciennes» de m'avoir accueillie aussi chaleureusement au sein de leur équipe, particulièrement Marie-Ève, qui a toujours été présente pour me soutenir, me valider et me montrer le chemin le plus facile vers la réussite, comme je marche souvent dans ses traces. Merci à ma collègue de l'UQAM, Noémie, pour sa joie de vivre et ses encouragements dans nos multiples projets communs, même les plus difficiles. Merci à mes deux collègues/amies, Émilie et Sarah, d'avoir été aussi généreuse et présente lors des dernières années. Merci à toute l'équipe pour vos encouragements et votre sens de l'humour, vous allez me manquer!

Je remercie mes quatre belles amies «du doctorat», Audrey, Christine, Mylène et Magalie. Je me sens privilégiée d'avoir partagé ce long parcours laborieux avec vous. Merci d'avoir rendu tout ce travail plus plaisant par nos nombreux diners et fous rires. Merci Magalie pour ton support inconditionnel chaque fois que je me permettais de te demander de l'aide, je t'aime!

Je remercie mes proches qui m'ont accompagnée à leur façon lors de mon doctorat. Merci à ma mère qui m'a encouragée à poursuivre de longues études et s'est montrée fière de moi. Merci à mon père qui a pris soin de moi et m'a soutenue particulièrement dans cette dernière année difficile qu'est l'internat. Merci à mes beaux-parents, Guy et Marina, qui ont su souligner mes réussites et s'intéresser à mes projets.

Je remercie mon mari, Éric, qui a traversé cette grande réalisation à mes côtés et qui a été témoin de tous les efforts que j'y ai mis. Merci d'avoir accepté d'en prendre plus sur tes épaules durant de longues périodes pour me permettre de me consacrer entièrement à mes études tout en sachant quand m'obliger à décrocher. Merci de m'aider à me dépasser et devenir une meilleure personne chaque jour, sans toi jamais je n'aurai complété mon doctorat avec autant de plaisir.

Merci à tous!

Avant-propos

L'auteur de la thèse, Marie-Pier Vaillancourt-Morel, a effectué le recrutement des participants, les analyses statistiques, l'interprétation des résultats et la rédaction des trois articles scientifiques du présent travail avec la collaboration de Stéphane Sabourin, Ph.D., directeur de recherche et professeur à l'École de psychologie de l'Université Laval et de Natacha Godbout, Ph.D., co-directrice de recherche et professeure au département de sexologie de l'Université du Québec à Montréal. En plus de ces deux collaborateurs, les articles scientifiques ont été rédigés en collaboration avec Yvan Lussier, Ph.D., membre du comité de thèse et professeur au département de psychologie de l'Université du Québec à Trois-Rivières pour les trois articles, Marsha Runtz, Ph.D., professeure au département de psychologie de l'Université de Victoria, pour le premier et le troisième article, John Briere, Ph.D., professeur à la Faculté de médecine Keck de l'Université de Californie du Sud, pour le deuxième et le troisième article, Chloé Labadie, étudiante au doctorat en psychologie à l'Université Laval, pour le premier article ainsi que Caroline Dugal et Rébécca Poirier-Stewart, étudiante au baccalauréat en psychologie à l'Université Laval, pour le deuxième article. L'introduction générale de la thèse ainsi que la conclusion ont été rédigées par Marie-Pier Vaillancourt-Morel.

Le premier article de la thèse, intitulé *Avoidant and compulsive sexual behaviors in male and female survivors of childhood sexual abuse* a été publié en février 2015 dans la revue *Child Abuse & Neglect*. Le second article, intitulé *Extradyadic sexual involvement and sexual compulsivity in male and female sexual abuse survivors*, a été publié en septembre 2015 dans le *Journal of Sex Research*. Le troisième article, intitulé *Adult sexual outcomes of child sexual abuse vary according to relationship status* a été publié en janvier 2016 dans le *Journal of Marital and Family Therapy*.

Chapitre I : Introduction générale

Au Québec, comme ailleurs, l'agression sexuelle à l'enfance ou à l'adolescence (ASE) constitue une problématique sociale d'importance qui suscite de plus en plus d'intérêt autant dans les médias qu'en clinique et en recherche (Murray, Nguyen, & Cohen, 2014). Malheureusement, il est difficile de tracer un portrait valide de l'ampleur de ce phénomène en partie à cause des tabous, secrets, préjugés et menaces associés à ces gestes sexuels abusifs. Ces enjeux rendent le dévoilement de ces agressions particulièrement difficiles privant parfois les survivants[1] de l'aide et des services appropriés nécessaires (Collin-Vézina, Daigneault, & Hébert, 2013). Ces problèmes de dévoilement rendent d'autant plus préoccupant le consensus actuel dans la documentation scientifique à propos des répercussions délétères de ce trauma sexuel à court et long terme sur diverses sphères du fonctionnement, dont la santé physique, psychologique, sexuelle et relationnelle. En effet, l'examen des données probantes portant sur les répercussions de l'ASE confirme la présence de répercussions négatives à long terme sur le fonctionnement conjugal et sexuel des survivants (Rellini, 2014; Whiffen & Oliver, 2004). Par contre, ces études n'ont pas tenté de modéliser les relations entre l'ASE, les problèmes sexuels et le fonctionnement conjugal examinant, la plupart du temps, séparément ces deux sphères du fonctionnement. Pourtant, dans le domaine de la santé sexuelle et relationnelle, les difficultés sexuelles sont de moins en moins examinées comme un problème purement individuel et la nécessité de prendre en compte le rapport dynamique entre la sexualité et les relations de couple a récemment été soulignée (Dewitte, 2014). L'examen concomitant des difficultés sexuelles et relationnelles des survivants d'ASE permettra d'étudier différents patrons de réponses sexuelles au sein des relations de couple et leurs liens avec le fonctionnement conjugal. Afin de bien comprendre la nature des variables étudiées, il convient d'abord de procéder à un relevé de la documentation pertinente. Il sera donc question des différentes définitions de l'ASE, des taux de prévalence et des modèles théoriques expliquant le développement des séquelles subséquentes à l'ASE. Ensuite, les répercussions à l'âge adulte de l'ASE seront présentées en mettant l'accent sur les répercussions conjugales et sexuelles ainsi que sur le caractère dynamique des rapports entre ces deux sphères. En fin de chapitre, les objectifs de la thèse seront exposés.

Définition de l'agression sexuelle en bas âge

La définition de l'agression sexuelle vécue à l'enfance ou à l'adolescence, aussi appelée abus sexuel, ne fait pas encore l'objet d'un consensus même si plusieurs éléments communs ressortent (Murray et al., 2014). En

[1] Le terme « survivant » est utilisé afin de décrire les personnes qui ont été victime d'ASE. Ce terme reflète mieux l'idée que l'ASE est un événement traumatique incontrôlable, auquel ils ont survécu. Ainsi, il fait davantage référence à la force intérieure et la réappropriation du pouvoir, le survivant ayant maintenant le contrôle.

contexte de protection de l'enfance au Canada, il y a ASE lorsqu'un enfant subit des gestes à caractère sexuel, avec ou sans contact physique, commis par un adulte ou un jeune (Trocmé & Wolfe, 2001). En vertu de l'article 150.1 du Code criminel du Canada, l'âge légal pour consentir à une activité sexuelle est fixé à 16 ans. Ainsi, tout geste à caractère sexuel, avec ou sans contact physique, commis envers un enfant de moins de 16 ans est considéré comme une agression sexuelle, peu importe le consentement du mineur. Il y a toutefois certaines exceptions à cette règle. Par exemple, il est possible pour les jeunes de 12 et 13 ans de consentir à des activités sexuelles avec un autre adolescent de moins de deux ans leur aîné et pareillement pour les adolescents de 14 et 15 ans avec un partenaire qui n'a pas plus de cinq ans qu'eux. De plus, l'âge minimum pour consentir lorsqu'un partenaire est en situation d'autorité, de confiance ou d'exploitation vis-à-vis de l'autre partenaire est de 18 ans.

Dans la documentation scientifique, certains chercheurs utilisent une définition objective basée sur la loi en vigueur ou des critères établis tandis que d'autres emploient une définition subjective basée sur la perception qu'a l'individu de l'expérience sexuelle vécue (Rellini & Meston, 2007; Senn, Carey, & Coury-Doniger, 2011; Steever, Follette, & Naugle, 2001). Les diverses définitions objectives recensées dans la documentation scientifique varient principalement selon quatre critères; les caractéristiques du contact sexuel (c.-à-d., avec ou sans contact physique), l'âge limite pour être considéré comme un enfant, âge qui varie entre 14 et 18 ans, la relation entre la victime et l'agresseur et la différence d'âge requise entre la victime et l'agresseur (Collin-Vézina et al., 2013; Murray et al., 2014). De plus, certaines définitions objectives ne spécifient pas de différence d'âge critique, mais requièrent que l'expérience sexuelle soit abusive, coercitive ou qu'elle ait lieu sans le consentement de la victime (Meston, Rellini, & Heiman, 2006; Steel, Sanna, Hammond, Whipple, & Cross, 2004). En général, les études utilisant une définition subjective (p. ex., avez-vous été victime d'agression sexuelle en enfance) rapportent des taux de prévalence relativement faibles par rapport à ceux rapportés à partir d'une définition objective (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Valentine & Pantalone, 2013). Ainsi, afin de s'assurer de bien documenter l'ensemble des expériences sexuelles abusives ayant lieu à l'enfance ou à l'adolescence, la présente thèse opte pour une définition objective de l'ASE inspirée des dispositions légales canadiennes pour consentir aux activités sexuelles ainsi que de la documentation scientifique à ce sujet (Godbout, Briere, Sabourin, & Lussier, 2014; Kelly, Wood, Gonzalez, MacDonald, & Waterman, 2002; Meston et al., 2006).

L'ASE est définie comme tout acte à caractère sexuel avec ou sans contact physique, entre un enfant âgé de moins de 16 ans et une personne ayant au moins cinq ans de plus ou en position d'autorité, avec ou sans présence de force physique ou violence, avec ou sans le consentement de l'enfant. L'absence de consentement est considérée comme primordiale dans certaines définitions actuelles (p. ex., Meston et al., 2006). Cependant, certaines situations d'ASE, particulièrement chez l'homme, sont qualifiées par les victimes

de non abusives et consentantes (Easton, Saltzman, & Willis, 2014; Weiss, 2010). L'absence de consentement n'est donc pas retenue dans la présente définition afin d'inclure également les agressions sexuelles perçues comme non abusives et consentantes. Une telle définition ne se limite donc pas à la perception du sujet de l'expérience sexuelle précoce. Le choix de l'âge, soit 16 ans, permet de prendre en considération l'immaturité développementale de l'enfant, son incapacité à consentir à une relation sexuelle selon les lois canadiennes et l'incapacité de prendre en compte l'ensemble des répercussions possibles d'un acte sexuel (Forouzan & Van Gijseghem, 2004).

Prévalence et incidence de l'agression sexuelle en bas âge

Plusieurs chercheurs se sont intéressés au taux de prévalence de l'ASE, mais d'importantes variations subsistent. Les résultats de la méta-analyse de Barth et al. (2013) recensant 55 études précisent bien l'étendue de cette variabilité avec des taux allant de 0% à 69% pour les filles et de 0% à 47% pour les garçons. Ces fluctuations seraient fonction de plusieurs facteurs, tels que la définition de l'ASE, la provenance de l'échantillon, le taux de réponse, la méthode et les outils de recherche utilisés (Barth et al., 2013; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). En dépit de cette variabilité, la consultation de trois méta-analyses récentes, combinant chacune respectivement 55, 331 et 65 études, suggère qu'à l'échelle mondiale le taux de prévalence de l'ASE oscille entre 15.0% et 19.7% chez les femmes et entre 7.6% et 8.0% chez les hommes (Barth et al., 2013; Pereda, Guilera, Forns, & Gomez-Benito, 2009; Stoltenborgh et al., 2011). Deux études québécoises effectuées auprès d'échantillons représentatifs de la province révèlent des taux de prévalence de l'ASE comparables soit 22% pour les filles et 10% pour les garçons (Hébert, Touriguy, Cyr, McDuff, & Joly, 2009; Tourigny, Hébert, Joly, Cyr, & Baril, 2008).

Certains chercheurs se sont intéressés au taux d'incidence de l'ASE, c'est-à-dire au nombre de nouveaux cas d'ASE recensé au Québec au cours d'une même année. Les conclusions d'un rapport du Ministère de la sécurité publique (2012) révèlent que 703 garçons et 2524 filles de moins de 18 ans ont été victimes d'ASE en 2012 au Québec. Cependant, MacMillan, Jamieson et Walsh (2003) démontrent qu'au sein d'un échantillon de 809 victimes d'ASE seulement 8.7% ont signalé l'évènement aux services de protection de l'enfance. De plus, les données d'un sondage québécois révèlent que 34.2% des hommes et 15.7% des femmes ayant vécu une ASE rapportent n'avoir jamais révélé l'agression à qui que ce soit avant l'étude (Hébert et al., 2009). Il semble donc que le nombre de cas d'ASE signalé aux services de protection de l'enfance ou aux autorités policières représente seulement une fraction de l'occurrence réelle du phénomène. Il est donc probable que les statistiques basées sur ces rapports soient peu représentatives de la réalité. Malgré les importantes variations au sein des taux de prévalence et la faible représentativité des taux d'incidence, il ne fait aucun doute que la victimisation sexuelle des filles et des garçons est un phénomène d'une ampleur significative. Ainsi, il semble

indispensable d'examiner les répercussions à court et long terme de l'ASE en s'appuyant sur des modèles théoriques intégrateurs et des données scientifiques probantes.

Modèles théoriques généraux

Depuis la parution des premières observations sur les effets potentiels de l'ASE, quelques chercheurs ont proposé des modèles théoriques expliquant le développement des séquelles subséquentes à l'ASE. Ces modèles datent toutefois de plusieurs années, ils n'ont pas fait l'objet de développements récents ou d'applications spécifiques et ils ne guident que très peu, et souvent seulement après coup, les recherches contemporaines en ASE (Liem, O'Toole, & James, 1996; Spaccarelli, 1994). De même bien que de plus en plus de chercheurs s'inspirent des théories de l'attachement pour comprendre les séquelles d'ASE, et même s'il s'agit d'une riche perspective sur le développement humain, il n'existe pas à proprement parler de modèle étiologique de l'ASE et de ses séquelles au long cours fondé sur cette notion. En conséquence, la présente démarche s'appuie principalement sur des analyses récentes de la documentation empirique (Aaron, 2012; Rellini, 2008; Schwartz & Galperin, 2002) et elle propose la vérification de la validité d'un modèle médiationnel fondé sur l'hypothèse que l'ASE se répercute négativement sur le fonctionnement conjugal et sexuel (c.-à-d., la compulsion sexuelle et l'évitement sexuel) des survivants. Ces deux sphères s'inter-influenceraient pour expliquer la diversité de répercussions recensées chez les survivants d'ASE. De plus, au sein de ce modèle général, la sévérité de l'ASE, le genre du survivant et la durée de l'union conjugale ou l'âge du participant sont pris en compte. Il existe trois modèles théoriques pertinents qui ont servi de fondements tout au long de la présente démarche de recherche et particulièrement lors de l'interprétation des résultats obtenus. Nous présentons donc premièrement ces trois conceptions et leurs limites tout comme leur influence respective dans le choix des variables, le développement des hypothèses et l'interprétation des résultats. Nous décrivons ainsi le modèle des dynamiques traumatogéniques de Finkelhor et Browne (1985), le modèle du trauma au soi de Briere (1996, 2002) et les modèles psychodynamiques (Bergner, 2002; Ensink & Normandin, 2011; Ferenczi, 1932; Fonagy & Target, 1997; Freud, 1896, 1920; Terr, 1990).

Modèle des dynamiques traumatogéniques

Ce modèle théorique développé par Finkelhor et Browne (1985) propose quatre dynamiques qui s'activent parfois, simultanément ou en séquence, lors de l'agression. Elles expliqueraient la diversité des conséquences sexuelles et conjugales de l'ASE : la *sexualisation traumatique*, la *trahison*, l'*impuissance* et la *stigmatisation*. La *sexualisation traumatique* réfère au processus par lequel l'ASE façonne les croyances et comportements sexuels de l'enfant de manière dysfonctionnelle et inappropriée compte tenu de son stade de développement. En effet, lors de l'agression, l'enfant est confronté à des comportements sexuels et à des réactions émotionnelles et physiologiques qu'il n'est pas préparé à comprendre. La *trahison* renvoie aux sentiments

éprouvés par l'enfant lors de l'agression quand un adulte de confiance lui a causé du tort en profitant de sa vulnérabilité ou lorsqu'un parent non agresseur n'a pas réussi à le protéger ou ne l'a pas cru. Ainsi, la capacité du survivant à faire confiance à une autre personne dans le contexte de relations intimes est compromise par ce sentiment d'avoir été trahi. La dynamique d'*impuissance* tire sa force des émotions vécues par l'enfant lors de l'agression lorsque ses désirs, sa volonté, son sentiment de contrôle et ses frontières corporelles sont niés ou transgressés. Elle prend aussi naissance dans le déséquilibre du pouvoir entre l'agresseur et l'enfant. La *stigmatisation* réfère aux sentiments de culpabilité, de honte et de blâme que l'enfant développe en réaction aux attitudes ou messages négatifs qui lui sont adressés, explicitement ou implicitement, par son entourage ou par l'agresseur en situation de dévoilement partiel et complet de l'expérience vécue. Finkelhor et Browne (1985) suggèrent que ces dynamiques s'activent selon diverses caractéristiques de l'agression et entraînent l'apparition de séquelles distinctes. Par exemple, la sexualisation traumatique serait liée aux relations sexuelles précoces ou à risque tandis que la présence d'une dynamique de trahison s'accompagnerait d'un plus fort sentiment d'isolement, de difficultés à se montrer vulnérable et à tolérer l'intimité, particulièrement l'intimité sexuelle, au sein des relations amoureuses.

Évidemment, la puissance théorique du modèle traumatogénique tient à l'interpénétration de cet ensemble de dynamiques, à des degrés divers, dans certaines situations particulières. Même si ce modèle complexe est à la source de quelques études (Easton, Coohey, O'leary, Zhang, & Hua, 2011; McCallum, Peterson, & Mueller, 2012; Senn et al., 2011), il comporte trois limites significatives : (1) les dynamiques proposées ne sont pas exclusives à l'ASE, mais peuvent être présentes dans le cas d'autres événements traumatiques (Finkelhor & Browne, 1985; Schilling & Christian, 2014) (2) son ancrage profond dans la notion de trouble post-traumatique est critiqué car toutes les victimes d'ASE ne rencontrent pas nécessairement les critères diagnostiques de ce trouble (Kendall-Tackett, Williams, & Finkelhor, 1993; Runyon, Deblinger, & Steer, 2014) et (3) il n'adopte pas systématiquement une perspective développementale donc ne tient pas compte suffisamment du cours évolutif des séquelles typiques de l'ASE (Browning, 2002; Trickett, Noll, & Putnam, 2011). Nous montrerons plus tard que, dans le cadre de cette thèse, toutes ces dynamiques servent de lignes directrices pour comprendre l'association entre la gravité de l'ASE et le fonctionnement sexuel et conjugal à l'âge adulte. En effet, les réactions conjugales et sexuelles à l'ASE doivent être bien sûr interprétées à la lumière du phénomène de la sexualisation traumatique mais aussi en référence aux affects de trahison et d'impuissance fréquemment rapportés par les survivants et aux réponses stigmatisantes des proches et de la société.

Modèle du trauma au soi

Ce modèle théorique proposé par Briere (1996, 2002) a été mis au point pour comprendre les réactions psychosociales à l'ensemble des formes de maltraitance. Briere soutient que les mauvais traitements à l'endroit des enfants, dont l'ASE, compromettent le développement de l'enfant et entraînent une

symptomatologie parfois persistante via trois principaux mécanismes : des relations interpersonnelles teintées de dynamiques d'attachement altérées, des stratégies de régulation émotionnelle dysfonctionnelles et un développement identitaire comprenant des représentations cognitives distorsionnées de soi, des autres et du futur. Tout d'abord, que ce soit lors de l'ASE ou face aux réactions du parent lors du dévoilement, l'agression tend à perturber les dynamiques d'attachement entre l'enfant et son parent (Godbout et al., 2014). Ainsi, les relations interpersonnelles des survivants sont souvent teintées d'évitement de l'intimité et d'anxiété d'abandon (Aspelmeier, Elliott, & Smith, 2007; Godbout, Lussier, & Sabourin, 2006). Ensuite, face à une détresse importante suscitée par l'ASE et des capacités de régulations émotionnelles altérées, les survivants utiliseraient des stratégies d'évitement inadaptées telles que la dissociation, l'automutilation, les compulsions sexuelles et l'abus de substance. Le recours à ces stratégies d'évitement atténuerait à court terme la détresse émotionnelle, mais empêche la régulation des symptômes traumatiques. Finalement, au plan de l'identité, l'ASE détourne l'attention de l'enfant de son état interne et la dirige vers l'environnement extérieur où la présence de danger est constamment évaluée. Ce contexte d'hypervigilance empêche l'enfant de se concentrer sur son développement identitaire ce qui fait naître un sentiment de vide intérieur. En résumé, des représentations de soi et des autres profondément altérées, des habiletés insuffisantes à gérer les états émotionnels et le recours à des stratégies défensives, particulièrement l'évitement, en contexte intime sont les mécanismes proposés pouvant expliquer les réponses traumatiques à court et long terme dont l'altération du fonctionnement sexuel et conjugal. Même si quelques recherches récentes appuient la validité de ces propositions en matière d'ASE (Bigras, Godbout, & Briere, sous presse; Briere, Hodges, & Godbout, 2010), ce modèle ne traite pas spécifiquement des séquelles d'ASE.

Modèles psychodynamiques

Certaines notions issues des théories psychanalytiques et psychodynamiques peuvent permettre d'expliquer l'émergence et la diversité des conséquences de l'ASE. Tout d'abord, la notion de retour du refoulé (Freud, 1896) pourrait expliquer l'émergence des difficultés au sein des relations intimes. Lors de l'ASE, l'avant-coup, l'enfant subit un événement désorganisateur pour le psychisme infantile immature. Afin de ne pas être submergé par cet événement traumatique, le psychisme va utiliser sa capacité de refoulement pour oublier complètement l'événement ou les émotions associées, mais cet événement laisse des traces inconscientes. Après la puberté, quand le développement sexuel physique est complété, un contexte analogue à l'ASE, tel que le développement d'une relation intime ou une première expérience sexuelle, réactive le souvenir refoulé dans l'inconscient et lui donne sa connotation sexuelle et traumatique, l'après-coup. Le survivant fait alors face à ce retour du refoulé et les symptômes traumatiques peuvent faire surface plusieurs années après l'ASE.

Le concept d'identification à l'agresseur (Ferenczi, 1932) fait référence au mécanisme de défense par lequel l'enfant intègre la culpabilité et l'agression dans ses représentations de soi afin de conserver une image

positive de l'agresseur, fréquemment une figure parentale dont l'enfant dépend pour sa sécurité et de l'affection. Lors de l'ASE, l'incapacité de l'enfant à se défendre face à son agresseur, physiquement et émotionnellement, car il est figé par la peur, l'amènerait à se soumettre à la volonté de son agresseur et à anticiper le moindre de ses désirs. Ainsi, se développe un mécanisme d'identification à l'agresseur qui permet à l'enfant de survivre en conservant l'image non-abusive du parent agresseur, l'image d'un monde sécuritaire et juste et l'image de soi comme invulnérable. Cependant, pour conserver ses représentations, il doit se sacrifier en introjectant la culpabilité et la violence des actes abusifs. Ainsi, il remplace la peur et l'impuissance vécue lors de l'ASE par un sentiment d'omnipotence et une illusion de contrôle. S'en suit un clivage interne marqué par une grande confusion puisque l'enfant se perçoit à la fois victime et coupable.

La notion de compulsion de répétition, d'abord présentée par Freud (1920) et reprise sous différentes formes par plusieurs auteurs (Bergner, 2002; Horowitz & Becker, 1971; Levy, 2000; Stoller, 1975; van der Kold, 1989), fait référence au processus par lequel le survivant s'expose répétitivement à des situations rappelant le trauma original en y vivant les émotions comme si l'expérience était actuelle au lieu d'appartenir au passé. Lors de l'ASE, la détresse intense, dont l'impuissance, déborde le système régulateur interne ce qui empêche l'enfant de l'intégrer dans ses représentations et d'y donner un sens. Face à cette incompréhension, la répétition du trauma en pensée, image, rêve ou comportement est une tentative de maitrise ou de symbolisation du trauma afin de l'intégrer adéquatement aux représentations internes de soi et des autres. Cette compulsion à la répétition a été observée au sein du jeu traumatique des enfants victimes d'ASE (Ensink & Normandin, 2011; Terr, 1990). Cette répétition obsessive d'épisodes du trauma dans le jeu constituerait une tentative vaine de l'enfant de maîtriser son vécu traumatique. Elle engendrait par contre plus de terreur à cause du parallèle étroit entre les fantaisies et la réalité (Terr, 1990). Cette répétition du trauma pourrait également, entre autres, entrainer la répétition compulsive de scénarios ou perversions sexuelles ayant leur origine directe dans cette expérience sexuelle abusive. Ainsi, le comportement sexuel compulsif constituerait la reviviscence de l'ASE afin de se venger, d'y trouver un sens ou de reprendre le contrôle des sentiments d'impuissance vécus et de transformer le traumatisme infantile en triomphe adulte (Stoller, 1975). Par exemple, le survivant peut mettre en acte des scénarios sexuels dans lesquels il punit et humilie une femme qui l'a puni ou humilié dans le passé. Ainsi, il reprend le contrôle puisque le trauma sexuel se transforme en plaisir, orgasme et donc en victoire sur cette femme (Bergner, 2002; Stoller, 1975). Cependant, cette tentative de rétablissement, même si elle peut être satisfaisante momentanément, se révèle peu efficace augmentant la détresse ainsi que les sentiments de dégradation et de perte de contrôle à cause des conséquences sur le survivant et son entourage. Ainsi, le survivant s'enlise dans un cycle compulsif s'obligeant à une répétition incessante, selon un schéma stéréotypé, ce qui perpétue ultimement des sentiments chroniques d'impuissance et de perte de contrôle.

Plus récemment, les répercussions de l'ASE ont été expliquées via des déficits de mentalisation du trauma (Berthelot, Ensink, & Normandin, 2013; Ensink, Berthelot, Bernazzani, Normandin, & Fonagy, 2014; Ensink et al., 2015; Fonagy & Target, 1997). Ce concept fait référence au processus par lequel l'ASE compromet l'acquisition développementale de la mentalisation ou de la capacité réflexive. Lors de l'ASE, l'enfant est la plupart du temps privé d'un parent pouvant l'aider à identifier ses états mentaux et est laissé seul avec des états mentaux insupportables qu'il ne peut réguler par lui-même. En effet, l'ASE est un défi à intégrer psychologiquement puisqu'en situation d'agression intrafamiliale, le parent peut être à la fois source de sécurité et de soins et source de peurs et d'agression ou source de confusion et d'incompréhension lorsque le parent non-agresseur ne réagit pas adéquatement au dévoilement de l'agression. Ainsi, l'enfant confronté à des états mentaux incohérents et incapable d'intégrer ou d'expliquer cette dualité chez son parent, se coupe de toute réflexion en termes d'états mentaux pour ne pas être envahi en inhibant sa capacité de mentalisation. À ce stade, il risque d'interpréter toute situation problématique comme relevant de ses caractéristiques personnelles uniquement puisqu'il y a confusion entre la réalité interne et externe (Berthelot et al., 2013; Fonagy & Target, 1997). Ainsi, les victimes n'ayant pas obtenu l'aide nécessaire pour bien mentaliser le trauma seraient particulièrement à risque de présenter des répercussions à long terme particulièrement en contexte d'attachement comme au sein d'une relation conjugale. Quelques recherches récentes appuient l'existence d'échecs de mentalisation en contexte d'ASE et leurs effets au sein des relations de couple (Berthelot et al., 2013; Ensink et al., 2014; Ensink et al., 2015).

Ces notions issues des théories psychanalytiques et psychodynamiques reposent principalement sur des hypothèses cliniques et plusieurs critiques ont été soulevées vis-à-vis ces propositions. Malgré leur incontestable richesse clinique, ces notions ont été très peu validées empiriquement. De plus, elles permettent difficilement d'expliquer la diversité de répercussions sexuelles et conjugales répertoriées ou leur évolution. Enfin, ces notions ont principalement été développées pour expliquer les répercussions des traumas, en général. Ainsi, elles n'expliquent pas les répercussions spécifiques à l'ASE et ne tiennent pas compte de la sévérité des agressions subies.

Intégration des modèles théoriques

Ces modèles théoriques soutiennent tous le rôle de l'ASE dans le développement de difficultés conjugales et sexuelles à l'âge adulte, que ce soit via l'activation, lors de l'ASE, d'une ou plusieurs dynamiques traumatogéniques, de relations interpersonnelles teintées de dynamiques d'attachement altérées, de représentations cognitives distorsionnées de soi et des autres, de stratégies de régulation émotionnelle dysfonctionnelles, du retour au sein de la relation conjugale des émotions traumatiques refoulées ou des déficits de mentalisation. Ainsi, ils suggèrent que les survivants sont particulièrement à risque de vivre de fortes difficultés d'intimité, de dévoilement de la vulnérabilité, de confiance vis-à-vis autrui et de tolérance à

l'intimité sexuelle au sein des relations amoureuses. Ils sous-tendent donc l'importance d'examiner de plus près le fonctionnement conjugal général des survivants d'ASE, mais également les enjeux liés à la trahison conjugale et à l'atteinte d'un statut relationnel reflétant un niveau d'engagement et d'intimité élevée. Ainsi, l'activation des dynamiques de trahison, d'identification à l'agresseur et de dysrégulation émotionnelle au sein du couple augmente le risque de reproduire le bris de confiance et de frontières ayant eu lieu lors de l'agression par l'engagement sexuel extradyadique. De plus, les relations conjugales associées à un haut niveau d'engagement sont probablement plus bouleversantes pour certains survivants. Elles remettent en cause des stratégies de régulation émotionnelle utilisées depuis longtemps, mais qui ne tiennent plus au long cours. Ainsi, ce contexte d'engagement accru favorise probablement le retour des émotions traumatiques refoulées et le développement de réponses sexuelles d'évitement (Briere, 2002; Freud, 1896). Cette hypothèse fondée essentiellement sur des données cliniques justifie l'examen du rôle du statut relationnel dans la présente thèse. En résumé, le modèle conceptuel privilégié ici examine le fonctionnement conjugal des survivants sous trois angles principaux soit l'ajustement dyadique ou conjugal, les relations sexuelles extradyadiques et le statut relationnel.

Ce modèle tente aussi d'expliquer partiellement la variabilité des répercussions sexuelles au long cours de l'ASE. Par exemple, lorsque la dynamique de sexualisation traumatique est actualisée, probablement plus fortement si l'agression impliquait la pénétration, elle peut amener le survivant à une sexualisation précoce, compulsive ou à risque. Cependant, lorsque jumelée aux trois autres dynamiques, il est également plausible que cette sexualisation traumatique entraîne un évitement phobique de la sexualité qui est associé à des sentiments de trahison, de stigmatisation, et d'impuissance. Cette variabilité de réponses sexuelles est également reprise au sein de la dimension de la régulation émotionnelle dysfonctionnelle où l'accent est mis sur les stratégies d'évitement inadaptées. Ainsi, le survivant aurait tendance à éviter les émotions associées à l'agression par l'évitement de la sexualité, la dissociation lors des activités sexuelles ou les compulsions sexuelles. De son côté, la compulsion de répétition a été principalement examinée chez de jeunes enfants, mais à l'âge adulte elle peut se traduire par des compulsions sexuelles. Ainsi, deux patrons de réponses sexuelles associés à l'ASE seront ici examinés afin de mieux comprendre le fonctionnement sexuel des survivants via les notions d'évitement sexuel et de compulsion sexuelle.

L'inclusion des caractéristiques de l'ASE au sein du modèle conceptuel de la thèse semble également primordiale puisqu'elles influenceraient l'activation des différentes dynamiques traumatogéniques et donc probablement les symptômes sexuels et conjugaux à l'âge adulte. Ainsi, l'ASE sera conceptualisée directement en tant que variable de sévérité de l'agression incluant la relation avec l'agresseur, la nature des contacts et la fréquence des agression puisque ce sont les caractéristiques de l'ASE les plus fréquemment associées à un effet de type dose-réponse lors de l'examen des répercussions de ce trauma sexuel (Berthelot,

Godbout, Hébert, Goulet, & Bergeron, 2014; Cutajar et al., 2010; Lacelle, Hébert, Lavoie, Vitaro, & Tremblay, 2012).

En dépit de la richesse de ces modèles théoriques de l'ASE, aucun ne tient compte de la cooccurrence des symptômes sexuels et conjugaux. De plus, l'émergence de répercussions distinctes selon le genre ainsi que l'évolution des difficultés sexuelles et conjugales dans le temps selon l'âge ou la durée de l'union n'y sont pas abordées. La notion de retour du refoulé suggère tout de même que certaines difficultés sexuelles ou conjugales puissent émerger après un temps de latence traumatique. Ce retour se produirait précisément au moment où les relations intimes atteindraient un sommet à l'âge adulte. C'est le parallélisme étroit des dynamiques de confiance, de trahison, d'engagement accru et d'intimité psychologique et sexuelle à l'enfance et à l'âge adulte qui expliquerait ce phénomène de résurgence. Évidemment, ici aussi, ces hypothèses cliniques méritent d'être examinées de plus près. Ainsi, le modèle conceptuel de la présente thèse entraînera l'examen des différences de genre et le contrôle de l'âge des participants tout comme de la durée de l'union.

Répercussions de l'agression sexuelle en bas âge

Les auteurs des études transversales ainsi que des rares études longitudinales portant sur les conséquences de l'ASE recensent un vaste éventail de répercussions à court et long terme sur la santé physique, psychologique, relationnelle et sexuelle des survivants (Dube et al., 2005; Fergusson, McLeod, & Horwood, 2013; Irish, Kobayashi, & Delahanty, 2010; Latzman & Latzman, 2015; Trickett et al., 2011). Le tableau clinique observé en situation de traumas sexuels est donc plutôt hétérogène, allant d'une sévérité polysymptomatique, à l'absence de symptômes. Les résultats de l'étude longitudinale menée par Trickett et al. (2011) auprès de 166 jeunes adolescentes, suivies pendant plus d'une dizaine d'années, démontrent cependant que, dans certains cas, les répercussions de l'ASE émergent au fil du temps lors de périodes critiques ou de transitions développementales normatives telles que, par exemple, la puberté, le début des activités sexuelles ou la première grossesse. La formation d'une union intime constitue l'une de ces périodes transitoires pouvant déclencher l'apparition de symptômes traumatiques. En effet, le développement d'une relation amoureuse active divers enjeux augmentant le sentiment de vulnérabilité des partenaires : un accroissement des interactions privées nécessitant une forte dose de confiance, la révélation d'informations personnelles sensibles ou secrètes, une fréquence plus régulière de contacts sexuels, etc. Chez les survivants d'ASE, ces enjeux sont parfois vécus avec beaucoup d'acuité. En effet, souvent, l'agresseur représente une personne de confiance, en situation d'autorité, qui exige le secret et s'immisce progressivement ou abruptement dans la vie sexuelle d'un individu vulnérable. Ainsi, chez certains, le processus de formation d'une union risque de réactiver, implicitement ou explicitement, certaines des peurs éprouvées lors de l'agression, les sentiments de rage réprimés et une profonde ambivalence à l'égard de l'intimité psychologique

et sexuelle. Jusqu'à présent, et nous passerons ces travaux en revue plus loin, cette proposition n'a fait l'objet que d'un très petit nombre de recherches empiriques.

À cette hypothèse générale s'ajoutent trois enjeux de fond qui traversent la thèse. En effet, il convient d'abord de déterminer si ces séquelles s'expriment dès les premières expériences amoureuses et sexuelles ou si elles apparaissent plus intensément lorsque la relation se formalise selon diverses normes sociales, légales, économiques ou religieuses typiques de statuts relationnels marqués par un fort degré d'engagement interne et externe ; par exemple lors du mariage ou lorsqu'une union consensuelle est contractée (Stanley, Rhoades, & Whitton, 2010). De même, dans ces cas, est-ce que les symptômes traumatiques s'observent peu importe l'âge et la durée de l'union ou sont-ils plutôt le lot d'individus mariés ou cohabitants depuis plus longtemps?

Il s'agit ensuite de vérifier si les répercussions conjugales et sexuelles notées varient selon le genre des individus. À cet égard, plusieurs hypothèses s'affrontent. La première hypothèse se fonde sur le constat d'une exposition différentielle au stress de l'ASE. Les femmes étant exposées à un plus grand nombre d'incidents, plus fréquemment intrafamiliaux, de gravité plus élevée, en contexte de vulnérabilité personnelle et sociale accrue, les séquelles seraient donc plus fortes chez celles-ci que chez les hommes (Cutajar et al., 2010; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Ullman & Filipas, 2005). La deuxième hypothèse stipule que chez les hommes, deux patrons de réaction pourraient expliquer une symptomatologie plus sévère que chez les femmes (Gil, 2014). Dans un premier cas, certains auteurs affirment que les jeunes garçons agressés par des femmes auraient de la difficulté à étiqueter leur expérience comme une agression l'identifiant comme une initiation précoce et consensuelle à la sexualité. Cette perception amènerait beaucoup de confusion dans leurs relations intimes et sexuelles subséquentes tout en les privant d'un support bénéfique (Easton, Coohey, Rhodes, & Moorthy, 2013; Sorsoli, Kia-Keating, & Grossman, 2008). Dans le second cas, les jeunes garçons agressés par des hommes éprouveraient une détresse plus forte à cause de questionnements liés à leur identité sexuelle et parce que ces agressions seraient généralement plus graves : nature des gestes posés, violence physique associée, etc. (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005; Martin, Bergen, Richardson, Roeger, & Allison, 2004; Roberts, Glymour, & Koenen, 2013). Cette opposition entre ces deux premières constatations a inspiré la troisième hypothèse qui stipule des différences entre le type de répercussions selon le genre. En général, les femmes présenteraient d'avantage de répercussions internalisées et des stratégies d'évitement tandis que les hommes auraient tendance à l'externalisation et l'agir comportemental (Aaron, 2012; Ullman & Filipas, 2005; Watkins & Bentovim, 1992). La quatrième hypothèse fait appel au phénomène de similitude inter-genre qui suggère que les hommes et les femmes présentent une réponse similaire au trauma (Dube et al., 2005; Fergusson et al., 2013; Maikovich-Fong & Jaffee, 2010). Cette hypothèse, appuyée par la majorité des méta-analyses (Hillberg, Hamilton-Giachritsis, & Dixon, 2011), ressortirait plus franchement lorsque le niveau de sévérité de l'agression est pris en compte (Paolucci, Genuis,

& Violato, 2001). Nous disposons de très peu d'informations scientifiques de qualité sur la validité de ces hypothèses et la présente thèse apportera donc une contribution significative à ce débat.

Il convient finalement de tenir compte de la sévérité de l'ASE puisque l'intensité variable pourrait également jouer un rôle dans la diversité des répercussions sexuelles et conjugales documentées. Selon les résultats de Heath, Bean et Feinauer (1996), la sévérité de l'ASE est le plus robuste prédicteur des variations dans la symptomatologie traumatique à long terme ; expliquant de 3 à 18% de la variation. En général, les études font ressortir un effet de type dose-réponse en se basant sur la fréquence des agression, la relation avec l'agresseur et la nature des contacts. Ainsi, en comparaison aux autres formes d'ASE, les agressions sexuelles intrafamiliales impliquant la pénétration anale ou vaginale et ayant une fréquence élevée sont associées à davantage de symptômes à l'âge adulte (Cutajar et al., 2010; Lacelle et al., 2012; Randolph & Reddy, 2006; Trickett et al., 2011). D'ailleurs, comme nous le verrons dans la prochaine section, certaines répercussions sexuelles et conjugales sont observables seulement lorsque l'aspect intrusif de l'ASE subie est pris en considération (Berthelot et al., 2014; Najman et al., 2005; Whisman, 2006). L'agression fréquente, avec pénétration ou perpétrée par un membre de la famille, risque de susciter davantage d'incompréhension ou d'impuissance, d'être associée à des douleurs physiques intenses et d'augmenter fortement le stress émotionnel vécu par l'enfant exacerbant les répercussions à long terme. Il semble donc capital de modéliser directement la sévérité de l'agression plutôt que de recourir à une variable dichotomique catégorisant l'individu selon qu'il ait été victime ou non d'ASE. L'application de cette dernière méthode de classification binaire masque peut-être d'importantes différences lors de l'examen des répercussions de l'ASE.

Répercussions conjugales

La documentation scientifique émergente met en lumière diverses répercussions délétères de l'ASE sur le fonctionnement conjugal à l'âge adulte (DiLillo, 2001; Rumstein-McKean & Hunsley, 2001). L'ensemble des travaux empiriques, menés au cours des quinze dernières années (c.-à-d., 2000 à 2015), sont présentés dans le Tableau 1. Cette recension comprend également un examen systématique des tailles d'effet observées dans les différentes recherches en privilégiant l'utilisation des corrélations (*r*). Les balises de Cohen (1988) suggère d'interpréter une corrélation de plus de 0.10 comme un effet de petite taille, une corrélation de plus de 0.30 comme un effet de taille moyenne et une corrélation de plus de 0.50 comme un effet de grande taille. L'analyse de ce tableau fait ressortir quelques grandes conclusions préliminaires. Tout d'abord, qu'il s'agisse du mariage ou de la cohabitation, l'ASE est significativement associée à la capacité ultérieure des survivants de former une relation de couple durable dans deux études sur cinq (Cherlin, Burton, Hurt, & Purvin, 2004; Larson, Newell, Holman, & Feinauer, 2007). Ensuite, ces unions semblent fondées sur une capacité plus faible d'engagement et conduisent à des taux plus élevés de séparation ou de divorce; cette différence significative se manifeste dans quatre études sur cinq (Colman & Widom, 2004; Watson & Halford, 2010; Whisman, 2006).

Enfin, chez les individus qui parviennent à établir une union, l'ASE est associée à une plus faible satisfaction conjugale dans 13 études sur 24 (p. ex., Liang, Williams, & Siegel, 2006; Miller, Schaefer, Renshaw, & Blais, 2013; Watson & Halford, 2010) et à une prévalence plus forte de conduites sexuelles extradyadiques dans les trois échantillons de femmes, mais pas dans celui composé d'hommes (Colman & Widom, 2004; Frias, Brassard, & Shaver, 2014; Whisman & Snyder, 2007). Les études fournissant les informations nécessaires au calcul de la taille d'effet ont également été regroupées en utilisant des analyses méta-analytiques à effets aléatoires afin d'obtenir une taille d'effet global pour deux répercussions conjugales examinées dans la présente thèse. Ces analyses révèlent des associations significatives de faible magnitude entre l'agression et la satisfaction conjugale (k = 16; r_{global} = -.09, 95% IC [-.12 à -.06]; Z = -5.47, p < .001) ainsi qu'entre l'agression et les conduites infidèles (k = 3; r_{global} = .20, 95% IC [.08 à .31]; Z = 3.33, p = .001). Ces résultats préliminaires, limités puisqu'ils ne reposent chacun que sur quelques études seulement, tracent tout de même un portrait sombre de la situation conjugale associée à l'ASE. Les conclusions d'une étude récente montrent aussi la présence de difficultés conjugales persistantes même en introduisant des variables contrôles telles que les traumatismes additionnels vécus à l'âge adulte et les symptômes de stress post-traumatique qui y sont associés (Miller et al., 2013). D'autres répercussions documentées plus largement, non rapportées dans le Tableau 1 étant donné le nombre plus important d'études, peuvent également avoir un impact négatif au sein des relations de couple des survivants. En effet, les représentations d'attachement empreintes d'anxiété abandonnique ou d'évitement de l'intimité (Aspelmeier et al., 2007; Cantón-Cortés, Rosario Cortés, & Cantón, 2015; Frias et al., 2014; Godbout et al., 2006) de même que la probabilité d'être victime ou de commettre des gestes de violence conjugale (Brousseau, Hébert, & Bergeron, 2012; DiLillo et al., 2009) ont été associées à l'ASE.

L'analyse du tableau révèle aussi que la nature et l'ampleur des séquelles de l'ASE sont déterminées par certaines variables intermédiaires clés telles que la gravité des expériences abusives vécues (c.-à-d., fréquence, intrusion et proximité avec l'agresseur; Berthelot et al., 2014; DiLillo et al., 2009; Liang et al., 2006; Paradis & Boucher, 2010; Sandberg, Feldhousen, & Busby, 2012; Vaillancourt-Morel, Godbout, Sabourin, Péloquin, & Wright, 2013; Whisman, 2006), le rôle protecteur de la qualité du soutien parental reçu lors du dévoilement de l'agression (Godbout et al., 2014) de même que l'effet tampon potentiel des représentations d'attachement empreintes de sécurité (Frias et al., 2014; Godbout et al., 2006). Enfin, la consultation des études montre la pauvreté des données empiriques traitant des différences de genre. En effet, seulement 11 études sur 29 ont examiné les différences entre les hommes et les femmes ; trois études se sont intéressées seulement aux hommes, neuf seulement aux femmes et six ont inclus les deux genres, mais n'ont pas examiné les différences entre les hommes et les femmes. Parmi les 11 études ayant tenu compte des différences de genre, sept ne révèlent pas de taux distincts d'insatisfaction conjugale, de problèmes plus aigus de confiance envers le partenaire, d'inégalités dans l'atteinte d'un statut relationnel particulier, de taux plus

élevés d'infidélité, de divorce ou de séparation ou une fréquence plus forte de problèmes conjugaux. À l'opposé, quatre études révèlent des différences inter-genres; plus faible satisfaction conjugale significative seulement chez les hommes dans trois études ou seulement chez les femmes dans une étude ainsi qu'un taux plus élevé d'infidélité chez les femmes dans une étude seulement.

Ces résultats sont limités par le nombre encore restreint d'études sur cette thématique. Les conclusions qui ressortent de l'analyse sont tout de même pertinentes puisqu'elles reposent sur l'amalgame de données provenant de 55 000 individus. En définitive, les associations faibles notées entre l'ASE et le fonctionnement conjugal ultérieur suggèrent qu'en toute probabilité, ces effets sont complexes, subtils ou indirects. Pourtant, peu d'études se sont intéressées aux variables intermédiaires pouvant expliquer les variations dans le fonctionnement conjugal subséquent à l'ASE (Frias et al., 2014; Godbout et al., 2006; Perry, Dilillo, & Peugh, 2007; Walker, Holman, & Busby, 2009). Ces modèles intégrateurs constituent une percée scientifique importante dans le domaine et ils conduiront éventuellement au développement d'interventions cliniques efficaces pour les victimes et leurs partenaires. Il faut toutefois continuer d'identifier d'autres variables intermédiaires pouvant expliquer le fonctionnement conjugal subséquent à l'ASE. Nous proposons de vérifier si l'évitement sexuel et la compulsion sexuelle à l'âge adulte constituent des manifestations plausibles de séquelles de l'ASE et si elles sont associées à diverses issues conjugales dont la détresse relationnelle, la présence de conduites d'infidélité et des perturbations du processus de formation des unions, plus particulièrement l'atteinte d'un statut relationnel marquant un plus fort engagement social entre les conjoints. Ainsi, la présente thèse tient mieux compte que les recherches précédentes (voir DiLillo et al., 2009, pour une exception intéressante) de l'enchevêtrement des problèmes de couple et des difficultés sexuelles (Dewitte, 2014). De plus, des comparaisons inter-genres sont effectuées systématiquement pour toutes les variables conjugales et sexuelles à l'étude.

Tableau 1. Résumé des études portant sur les répercussions conjugales de l'agression sexuelle à l'enfance (ASE)

Références	Échantillon	Trauma	Répercussions conjugales (tailles d'effet)
1. Berthelot et al. (2014)	218 adultes qui consultent en thérapie sexuelle (CA, QC)	ASE	- Association non-significative avec la satisfaction conjugale (r = -.08)
		ASE avec pénétration	- Satisfaction conjugale plus faible (r = -.20)
2. Browning (2002)	1511 hommes (É.U.)	ASE	- Satisfaction émotionnelle plus faible (r = -.15)
3. Cherlin et al. (2004)	2658 mères de familles à faible revenu (É.U.)	ASE	- Probabilité plus faible d'être dans une relation conjugale stable (r = -.65) ou d'être marié (r = -.25) - Probabilité plus élevée d'être dans une relation de couple incluant la cohabitation (r = .25) ou d'être célibataire (r = .16)
4. Colman et Widom (2004)	1196 jeunes adultes incluant 676 cas signalés d'abus ou de négligence et 520 cas contrôle (É.U.)	ASE	- Effet non-significatif sur le statut conjugal (marié r = .08; cohabitation r = .10; en couple r = -.05) - Taux de divorce (r = .22) et de séparation (r = .30) plus élevés - Effet non-significatif sur la prévalence de la fidélité (r = .16) - Taux plus élevés d'infidélité chez les femmes r = .30 (hommes n.s. r = .07) - Qualité de la relation plus faible chez les femmes r = -.17 (hommes n.s. r = -.03)
5. DiLillo et al. (2009)	202 couples de jeunes mariés (É.U.)	Sévérité de l'ASE	- Association non-significative avec la satisfaction conjugale et la confiance envers le partenaire
6. Dube et al. (2005)	17337 adultes dont 12 022 mariés (É.U.)	ASE	- Fréquence plus élevée de problèmes au sein du mariage actuel (r = .13)
7. Fairweather et Kinder (2013)	287 étudiantes en couple (É.U.)	ASE	- Association non-significative avec la satisfaction conjugale - Niveau de consensus au sein du couple plus faible
8. Fergusson et al. (2013)	987 adultes (New Zealand)	ASE	- Association non-significative avec la satisfaction conjugale (r = -.04)
9. Frias et al. (2014)	807 femmes (CA, QC)	ASE	- Probabilité plus élevée d'infidélité (r = .15) - Probabilité plus élevée d'infidélité perçue chez le partenaire (r = .17)
10. Godbout et al. (2014)	348 participants en relation de couple (CA, QC)	ASE sans soutien	- Satisfaction conjugale plus faible chez les survivants n'ayant pas obtenu de soutien parental suite au dévoilement que ceux sans histoire d'ASE (r = -.14)
11. Godbout et al. (2006)	632 couples (CA, QC)	ASE	- Association non-significative avec la satisfaction conjugale (r = -.05)
12. Larsen, Sandberg, Harper et Bean (2011)	634 adultes qui consultent en thérapie familiale (É.U.)	Fréquence de l'ASE	- Association non-significative avec la qualité de la relation conjugale (instabilité conjugale, nombre de sphères problématiques) (r = .04)

13. Larson et al. (2007)	142 hommes victimes d'ASE et 140 hommes sans histoire d'ASE (É.U.)	ASE extrafamiliale	- Statuts relationnels caractérisés par un engagement plus faible (célibataire *r* =.51, fiancé *r* = -.35) - Qualité de la relation plus faible (stabilité et satisfaction conjugale, attentes envers le mariage, communication empathique)
14. Leclerc, Bergeron, Binik et Khalife (2010)	151 femmes souffrant de dyspareunie (CA, QC)	ASE	- Association non-significative avec la satisfaction conjugale (*r* = -.12)
15. Liang et al. (2006)	136 femmes victimes d'ASE dont 47 mariés (É.U.)	Sévérité de l'ASE	- Satisfaction conjugale plus faible
16. Miller et al. (2013)	218 vétérans déployés entre 2001 et 2008 (É.U.)	ASE	- Satisfaction conjugale plus faible (*r* = -.19)
17. Nelson et al. (2002)	1991 jumeaux (Australie)	ASE	- Taux de divorce plus élevé *(r* = .24)
18. Nelson et Wampler (2000)	161 couples hétérosexuels qui consultent en thérapie conjugale ou familiale (É.U.)	ASE	- Satisfaction conjugale plus faible chez les hommes *r* = -.17 (femmes n.s. *r* = -.11)
19. The NIMH Multisite HIV/STD Prevention Trial for African American Couples Group (2010)	535 couples recrutés dans une clinique pour VIH (É.U)	ASE	- Association non-significative avec la satisfaction conjugale (*r* = -.03) - Association non-significative avec taux de séparation (*r* = .06) - Probabilité plus élevée d'être marié (*r* = .08)
20. Paradis et Boucher (2010)	1728 étudiants universitaires (CA, QC)	ASE intrafamiliale	- Association non-significative avec les problèmes interpersonnels au sein du couple (*r* = .07)
21. Perry et al. (2007)	65 couples de jeunes mariés (É.U.)	ASE	- Satisfaction conjugale plus faible chez l'homme *r* = -.28 (femmes n.s. *r* = -.06)
22. Randolph et Reddy (2006)	63 femmes souffrant de dyspareunie (É.U.)	ASE	- Association non-significative avec le statut conjugal (*r* =.22)
23. Sandberg et al. (2012)	388 femmes et 296 hommes qui consultent en thérapie familiale (É.U.)	Fréquence de l'ASE	- Satisfaction conjugale plus faible chez l'homme *r* = -.13 (femmes n.s. *r* = -.09)
24. Testa, VanZile-Tamsen et Livingston (2005)	732 femmes (É.U.)	Sévérité de l'ASE	- Association non-significative avec la satisfaction conjugale

25. Vaillancourt-Morel et al. (2013)	705 adultes qui consultent en thérapie de couple ou individuelle (CA, QC)	ASE	- Association non-significative avec la satisfaction conjugale (r = -.04)
		ASE avec pénétration	- Satisfaction conjugale plus faible (r = -.17)
26. Walker et al. (2009)	15831 mariés ou en relation de cohabitation (É.U.)	Fréquence de l'ASE	- Qualité plus faible de la relation de couple (r = -.11)
27. Watson et Halford (2010)	1335 femmes (Australie)	ASE	- Association non-significative aux taux de mariage (r = .05) - Taux plus élevés de séparation conjugale (r = .19) - Satisfaction conjugale plus faible (r = -.07)
28. Whisman (2006)	1868 femmes et 1560 hommes mariés, séparés ou divorcés (É.U.)	ASE	- Satisfaction conjugale plus faible - Association non-significative avec taux de divorce/séparation (r =.01)
		ASE avec pénétration	- Satisfaction conjugale plus faible - Taux de divorce/séparation plus élevé (r = .19)
29. Whisman et Snyder (2007)	4884 femmes mariées (É.U.)	ASE avec pénétration	- Probabilité plus élevée d'infidélité (r = .31)

Note. Lorsque nécessaire, les données disponibles dans les articles ont été transformées en corrélation (r) afin d'uniformiser la présentation des tailles d'effet. Interprétation des corrélations : faible r > .10; moyenne r > .30; forte r > .50.

Répercussions sexuelles

Les répercussions sexuelles à l'enfance, à l'adolescence et à l'âge adulte de l'ASE regrouperaient les symptômes qui distingueraient le mieux les survivants d'ASE, des victimes d'autres formes de mauvais traitement à l'enfance suggérant une certaine spécificité des séquelles en matière de sexualité (Blain, Muench, Morgenstern, & Parsons, 2012; Briere et al., 2001; Sansone, Muennich, Barnes, & Wiederman, 2009). En effet, quelques recherches ont démontré que les symptômes sexuels subséquents à l'ASE peuvent se développer rapidement durant l'enfance par des comportements sexuels inappropriés ou précoces en comparaison aux normes développementales établies (Friedrich et al., 2001; Gagnon & Tourigny, 2011; Hall, Mathews, & Pearce, 2002). D'autres études suggèrent que les répercussions sexuelles identifiées durant l'enfance peuvent perdurer ou émerger à l'adolescence par des comportements sexuels à risque, des activités sexuelles précoces et un nombre élevé de partenaires sexuels (Jones et al., 2013; Loeb et al., 2002; Loftus & Kelly, 2012; Noll, Trickett, & Putnam, 2003). Les résultats de Fergusson, Horwood et Lynskey (1997) qui ont évalué à intervalles réguliers une cohorte de 520 adolescentes de la naissance à 18 ans, indiquent que l'exposition précoce à la sexualité via l'ASE augmente la probabilité de participer à une activité sexuelle consensuelle plus jeune ce qui, à son tour, augmente le risque de relations sexuelles non protégées, de partenaires sexuels multiples et d'autres comportements sexuels à risque.

À l'âge adulte, l'analyse des travaux empiriques a permis d'identifier plus de 70 études ayant documenté l'association entre l'ASE et divers aspects du fonctionnement sexuel (pour une recension de la littérature voir, Aaron, 2012; Rellini, 2014; Senn, Carey, & Vanable, 2008; Zwickl & Merriman, 2011). Cependant, comme la thèse porte essentiellement sur l'amalgame des séquelles sexuelles et conjugales de l'ASE et que les séquelles sexuelles non-spécifiques aux relations de couple sont nombreuses, nous nous en tenons ici à un résumé des conclusions générales de ces travaux sans les synthétiser dans un tableau qui comprendrait plus d'une centaine d'études. Nous présentons ensuite en détail les répercussions sexuelles de l'ASE examinées spécifiquement auprès d'adultes en relation de couple.

Tout d'abord, cette importante documentation scientifique portant sur la sexualité des survivants d'ASE montre clairement une variabilité de réponses sexuelles s'organisant en deux trajectoires apparemment antagonistes. En effet, la consultation de ces études révèlent d'abord une absence de séquelles sexuelles observables chez une proportion significative de survivants (Dennerstein, Guthrie, & Alford, 2004; Hullfish et al., 2009; Rellini & Meston, 2007) et, chez d'autres, des répercussions sexuelles variant de l'inhibition sexuelle incluant le désir sexuel hypoactif, l'anxiété sexuelle, l'évitement ou l'abstinence sexuelle, les dysfonctions sexuelles, la faible estime sexuelle (Easton et al., 2011; Leclerc et al., 2010; McCallum et al., 2012; Najman et al., 2005; Seibel, Rosser, Horvath, & Evans, 2009), à la désinhibition sexuelle dont la compulsion ou l'impulsivité sexuelle, un nombre élevé de partenaires sexuels et les conduites sexuelles à risque (Blain et al., 2012; Hequembourg,

Bimbi, & Parsons, 2011; Walsh, Latzman, & Latzman, 2014; Whetten et al., 2012; Wilson & Widom, 2008). Ce mode d'organisation des séquelles sexuelles en deux trajectoires à l'âge adulte est utilisé dans la majorité des revues récentes de la documentation scientifique (Aaron, 2012; Colangelo & Keefe-Cooperman, 2012; Rellini, 2008; Schwartz & Galperin, 2002) et dans de rares études empiriques (Browning, 2002; Lemieux & Byers, 2008; Noll et al., 2003). En effet, l'analyse d'Aaron (2012) fait ressortir que peu de chercheurs se sont penchés sur ces deux patrons de réponses sexuelles dichotomiques au sein d'une même étude, examinant la plupart du temps l'un ou l'autre des comportements sexuels problématiques. De plus, de façon générale, l'association entre l'ASE et l'évitement de la sexualité à l'âge adulte est moins appuyée empiriquement que la présence de compulsions sexuelles ou de comportements sexuels à risque (Browning, 2002; Paolucci et al., 2001).

Cette organisation en deux trajectoires sera privilégiée au sein de la présente thèse. Elle permet d'inclure les diverses répercussions sexuelles recensées dans les études empiriques et d'examiner ces trajectoires au sein des relations conjugales des survivants. Certains chercheurs interprètent un nombre élevé de partenaires sexuels comme un comportement sexuel à risque ou une conduite compulsive et un faible nombre de partenaires sexuels comme une forme d'évitement de la sexualité et un signe de difficultés sexuelles (Browning, 2002). Cependant, au-delà du besoin sexuel excessif ou de l'évitement de la sexualité, plusieurs facteurs (p.ex. : valeurs religieuses, absence d'un partenaire amoureux) influencent le nombre de partenaires sexuels. Afin de pallier cette faille méthodologique, il conviendra d'examiner directement les comportements sexuels à l'aide de questionnaires auto-rapportés validés empiriquement portant directement sur les comportements sexuels compulsifs et l'évitement de la sexualité. Le terme compulsion sexuelle sera préféré aux autres concepts présentés dans les écrits scientifiques (addiction sexuelle, hypersexualité, impulsivité sexuelle). Les éléments qui permettent de définir la présence de compulsions sexuelles sont les comportements sexuels répétitifs, les pensées sexuelles intrusives, l'absence de contrôle ainsi que la persistance de ces conduites en dépit de conséquences négatives. Il s'agit donc d'un besoin irrésistible d'assouvir une pulsion sexuelle qui devient incontrôlable (Coleman, 1991). À l'opposé, l'aversion sexuelle réfère autant à l'aversion éprouvée qu'à l'évitement de la sexualité. L'aversion met l'accent sur les aspects affectifs soit la peur, l'anxiété ou le dégoût tandis que l'évitement se caractériserait plutôt par un ensemble d'attitudes et de comportements. Le terme évitement sexuel est donc plus englobant que la notion d'aversion. De plus, les causes de l'évitement sont multiples, elles incluent l'aversion, mais également, par exemple, la culpabilité ou les difficultés conjugales qui pourraient amener l'individu à éviter la sexualité. L'évitement sexuel peut donc être conceptualisé comme l'évitement intentionnel des situations sexuelles ou des interactions sexuelles (Brotto, 2010; Katz, Gipson, Kearl, & Kriskovich, 1989).

De façon générale, il semble donc que les effets sexuels traumatiques de l'ASE se traduisent par des trajectoires opposées soit des comportements sexuels compulsifs ou l'évitement des activités sexuelles.

Cependant, le fonctionnement sexuel au sein des couples des survivants d'ASE n'a été que peu étudié (Davis & Petretic-Jackson, 2000; Whiffen & Oliver, 2004). Seulement trois études examinant empiriquement le rapport dynamique entre les répercussions sexuelles et conjugales de l'ASE ont été recensées.

En premier lieu, DiLillo et al. (2009) ont suivi sur une période de deux ans, une cohorte de 200 couples nouvellement mariés. Ils n'observent pas d'association indirecte via la fréquence des activités sexuelles entre la sévérité de l'ASE et la satisfaction conjugale. À notre connaissance, cette étude est la seule ayant examiné les effets du fonctionnement sexuel au sein de la relation de couple sur la satisfaction conjugale des survivants d'ASE. Cependant, certaines limites peuvent expliquer l'absence de résultats significatifs, ce qui justifie la nécessité de s'intéresser à nouveau à l'hypothèse d'une association directe ou indirecte entre l'ASE, la sexualité et l'ajustement dyadique. Par exemple, l'exclusion des couples ayant divorcé en cours d'étude, plusieurs ayant vécu une ASE et le choix d'un échantillon de couples nouvellement mariés conduisent à l'exclusion de couples présentant probablement les taux les plus élevés d'insatisfaction conjugale.

En deuxième lieu, l'étude longitudinale de Testa et al. (2005), menée auprès d'un échantillon de 937 femmes suivies sur une période de 12 mois indique que la sévérité de l'ASE est associée aux comportements sexuels à risque (c.-à.-d., nombre élevé de partenaires, première relation sexuelle précoce, relations sexuelles complètes lors d'un premier rendez-vous). Ces comportements sexuels à risque sont associés à l'affiliation à un partenaire présentant des facteurs de risque d'une sexualité problématique (c.-à-d., infidélité dans la relation, nombre élevé de partenaires à vie) et de violence conjugale dans la relation actuelle ce qui a pour effet de diminuer la satisfaction conjugale. En résumé, cette étude n'a pas examiné les comportements sexuels des survivants d'ASE au sein de la relation de couple actuelle puisque les comportements sexuels à risque évalués chez les survivantes ont, pour la plupart, eu lieu avant le début de la relation de couple en cours. Cependant, leurs résultats sont tout de même intéressants pour la présente thèse puisqu'ils suggèrent que la satisfaction conjugale des survivantes est diminuée via une sexualisation des relations et l'affiliation à un partenaire violent et ayant des conduites sexuelles à risque. Ainsi, ils soutiennent l'hypothèse que la compulsion sexuelle aurait un rôle médiateur entre l'ASE et le fonctionnement conjugal. De plus, le modèle médiationnel testé révèle qu'il tient autant chez les femmes mariées que chez celles qui ne le sont pas. Cette invariance suggère que le statut marital ne modifie pas les relations entre l'ASE, les comportements sexuels à risque et la satisfaction conjugale. Cependant, comme cette étude n'examine pas directement les comportements sexuels actuels des conjoints, le statut conjugal joue probablement un rôle moins important ce qui expliquerait qu'il ne soit pas significatif.

En troisième lieu, Randolph et Reddy (2006) ont examiné le fonctionnement sexuel de 63 femmes souffrant de dyspareunie. Les résultats indiquent que l'ASE est associée à une plus faible fréquence de relations sexuelles,

des orgasmes moins satisfaisants et un sentiment plus faible de proximité vis-à-vis leur partenaire sexuel. Cependant, ces associations ne diffèrent pas selon le statut relationnel infirmant l'hypothèse qu'en comparaison aux survivantes célibataires, les survivantes d'ASE mariées ou en relation de cohabitation ont un fonctionnement sexuel plus symptomatique. Malgré ces résultats non-significatifs, le regroupement des femmes mariées et en cohabitation avec leur partenaire peut avoir masqué les différences d'engagement propres à ces deux statuts relationnels (Thornton, Axinn, & Xie, 2007).

Afin d'ajouter à ce nombre limité d'études, les conduites sexuelles extradyadiques peuvent être conceptualisées comme un enjeu sexuel et conjugal puisqu'elles représentent l'émergence de difficultés sexuelles au sein des relations de couples. Tel que précisé précédemment lors de l'analyse des répercussions conjugales, trois études empiriques font ressortir, chez des femmes, la présence d'une association entre l'ASE et les conduites sexuelles extradyadiques (Colman & Widom, 2004; Frias et al., 2014; Whisman & Snyder, 2007). Ces résultats peuvent s'expliquer par un évitement de la sexualité au sein de la relation. Cet évitement entraînerait un investissement sexuel à l'extérieur de la relation actuelle. Cependant, à notre connaissance, aucune étude n'a examiné le rôle des attitudes et des comportements sexuels au sein du couple pour comprendre les conduites extradyadiques. De plus, le lien entre l'ASE et l'infidélité n'a pas été confirmé chez les hommes ou examiné en tenant compte de la durée de l'union ou de l'âge des conjoints.

Devant ce nombre limité d'études empiriques, l'étude qualitative de Jacob et Veach (2005) réalisée à partir de l'analyse d'une entrevue auprès de dix femmes en couple avec un homme victime d'ASE apporte un éclairage intéressant. Le discours des conjointes révèle que certains conjoints survivants présentent un évitement de la sexualité particulièrement lorsque la conjointe initie le contact sexuel tandis que d'autres agissent sexuellement de manière impulsive et compulsive. Neuf conjointes rapportent des variations extrêmes dans la fréquence des comportements sexuels au sein de leur couple, incluant des périodes d'abstinence complète et des périodes d'hypersexualité dans lesquelles l'homme peut initier les relations sexuelles plusieurs fois par jour. De plus, la moitié des conjointes indiquent que leur partenaire a été sexuellement infidèle à de multiples occasions. Cependant, l'impact de ces comportements sexuels sur la satisfaction conjugale ou dans l'émergence des relations extraconjugales n'est pas discuté. De plus, cette étude ne permet pas d'examiner l'évolution des comportements sexuels lorsque l'engagement et l'intimité augmentent au sein de l'union.

Certaines critiques générales peuvent également être formulées et appuient la pertinence des objectifs de la présente thèse. Tout d'abord, même si la récente revue des écrits de Dewitte (2014) démontre l'importance de prendre en compte l'enchevêtrement des difficultés sexuelles et du contexte relationnel, seulement six groupes de chercheurs ont suivi cette recommandation dans l'étude empirique du fonctionnement sexuel et conjugal des survivants d'ASE. De plus, quatre études sur six portent uniquement sur un échantillon féminin

empêchant l'examen des différences inter-genres. Enfin, même si les études s'intéressant aux répercussions sexuelles de l'ASE démontrent bien la présence des deux trajectoires sexuelles, aucune étude empirique ne permet l'examen simultané de la compulsion sexuelle et de l'évitement sexuel tandis que l'étude qualitative révèle la présence de ces deux patrons au sein des relations de couple. En effet, DiLillo et al. (2009) examinent la fréquence des activités sexuelles et la satisfaction sexuelle ce qui masque la présence des deux patrons de réponse sexuelle. Testa et al. (2005) s'intéressent aux comportements sexuels à risque ce qui s'inscrit au sein de la trajectoire compulsive tout comme les études portant sur les relations extradyadiques et Randolph et Reddy (2006) étudient le fonctionnement sexuel auprès de femmes souffrant de dyspareunie ce qui reflète uniquement la trajectoire d'évitement.

Objectifs de la thèse

Dans ce contexte, l'objectif général de la thèse est d'approfondir la compréhension du fonctionnement conjugal et sexuel des survivants d'ASE en portant une attention particulière aux interrelations entre les deux types de répercussions. En s'appuyant sur la documentation clinique et empirique présentée, les deux premiers articles de la thèse évaluent la validité d'un modèle médiationnel de l'association entre l'ASE, les séquelles sexuelles à l'âge adulte et divers indicateurs de la qualité du fonctionnement conjugal. Dans le premier article, le fonctionnement sexuel sera examiné en tenant compte de variables mesurant les deux principales trajectoires de symptômes sexuels répertoriés empiriquement suite à l'ASE, soit l'évitement sexuel et la compulsion sexuelle tandis que le fonctionnement conjugal sera opérationnalisé par un indicateur général du fonctionnement conjugal, soit la satisfaction conjugale. Il est attendu que l'ASE soit associée à des niveaux plus élevés d'évitement de la sexualité et de compulsions sexuelles qui sont reliés ensuite à une plus faible satisfaction conjugale. Dans le deuxième article, le modèle médiationnel est repris en examinant les relations sexuelles extradyadiques comme indicateur du fonctionnement conjugal et sexuel. De plus, le modèle tient exclusivement compte de la compulsion sexuelle, car elle jouerait un rôle clé dans l'explication du risque des conduites infidèles. Nous émettons l'hypothèque que l'ASE est associée directement aux conduites sexuelles extradyadiques et indirectement via une augmentation de la compulsion sexuelle suite à l'ASE. Le troisième article complexifie le modèle médiationnel des deux premiers articles en examinant le rôle du contexte relationnel sous-jacent aux difficultés sexuelles des survivants d'ASE. Ainsi, cet article reprend l'analyse des deux patrons de réponses sexuelles soit la compulsion et l'évitement sexuel et utilise le statut relationnel des participants comme indicateur d'engagement conjugal. Il est attendu que la compulsion sexuelle soit plus forte lors de relations sexuelles avec de nouveaux partenaires tandis que l'évitement sexuel émergerait plus clairement dans les relations conjugales stables lorsque l'engagement et l'intimité augmentent. Ainsi, nous émettons l'hypothèse que les survivants célibataires ou en relation de fréquentation présentent principalement

des comportements sexuels compulsifs, les survivants en relation de cohabitation, de la compulsion et de l'évitement sexuel tandis que les survivants mariés présentent principalement de l'évitement sexuel.

À ces hypothèses générales s'ajoutent des objectifs secondaires qui traversent les trois articles de la thèse. Tout d'abord, l'évolution des répercussions sexuelles et conjugales de l'ASE selon l'âge du participant ou la durée de la relation demeure inconnue. Ainsi, le troisième article porte spécifiquement sur l'émergence des comportements sexuels selon le statut relationnel et les trois articles de la thèse incluent l'âge du participant et la durée de la relation au sein des modèles d'analyse. Ensuite, à cet examen se greffe, au sein des trois articles, une analyse de l'invariance des modèles médiationnels selon le genre des participants. Cette comparaison vise à mieux différencier les répercussions sexuelles et conjugales de l'ASE spécifiques aux hommes ou aux femmes tout en tentant de clarifier le débat opposant les hypothèses de différences et de similarités inter-genres. Enfin, quelques chercheurs soutiennent, données empiriques à l'appui, que la gravité de l'ASE (p. ex., agression avec pénétration, agression intrafamiliale, agression chronique) constitue un facteur de risque du développement de difficultés sexuelles et conjugales à long terme (Berthelot et al., 2014; Watson & Halford, 2010; Whisman, 2006). En conséquence, les trois articles de la présente thèse incluent la sévérité de l'ASE au sein des modèles intégrateurs.

Chapitre II : Avoidant and compulsive sexual behaviors in male and female survivors of childhood sexual abuse (Article 1)

Publié en février 2015 dans la revue *Child Abuse & Neglect*, DOI: 10.1016/j.chiabu.2014.10.024.

Avoidant and compulsive sexual behaviors in male and female survivors of childhood sexual abuse

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Marie-Pier Vaillancourt-Morel was supported by a doctoral fellowships from the Social Sciences and Humanities Research Council (SSHRC) and the Centre de Recherche Interdisciplinaire sur les Problèmes Conjuguaux et les Agressions Sexuelles.

We thank Hélène Paradis for her assistance in the statistical preparation of the manuscript.

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Résumé

Les objectifs principaux de cette étude sont de tester un modèle théorique médiationnel au sein duquel la relation entre l'agression sexuelle en enfance (ASE) et l'ajustement dyadique est expliquée via l'évitement sexuel et la compulsion sexuelle et d'examiner l'invariance selon le genre de ce modèle. Un échantillon de 686 adultes actuellement en relation de couple a complété des questionnaires auto-rapportés en ligne. Le taux de prévalence de l'ASE est de 20% chez les femmes et de 19% chez les hommes. Appuyant nos hypothèses, les analyses acheminatoires et les analyses d'équations structurelles montrent que, pour les femmes et les hommes, l'ASE est associée à plus d'évitement sexuel et de compulsions sexuelles, qui sont reliés, à leur tour, à une plus faible satisfaction conjugale. Dans l'ensemble, ces résultats suggèrent que l'évitement et la compulsion sexuelle constituent des cibles d'intervention pertinentes auprès des couples au sein desquels un ou les deux partenaires sont survivants d'ASE.

Mots clés : agression sexuelle à l'enfance; comportements sexuels, ajustement dyadique, compulsivité sexuelle, évitement sexuel

Abstract

The main objectives of this study were to test a theory-based mediation model in which the relation between childhood sexual abuse (CSA) and dyadic adjustment is mediated through adult sexual avoidance and sexual compulsivity and to examine the gender-invariance of this model. A sample of 686 adults currently involved in a close relationship completed online self-report computerized questionnaires. Prevalence of CSA was 20% in women and 19% in men. In line with our hypotheses, path analyses and structural equation analyses showed that, for both women and men, CSA was associated with more sexual avoidance and sexual compulsivity, which, in turn, predicted lower couple adjustment. Overall, these findings suggest that both avoidant and compulsive sexuality are relevant intervention targets with couples in which one or both partners are CSA survivors.

Keywords: childhood sexual abuse; sexual behaviors; dyadic adjustment; sexual compulsivity, sexual avoidance

Introduction

Child sexual abuse (CSA) survivors form a heterogeneous population and it is now well-established that the short- and long-term course of these experiences vary according to personal/familial pre-traumatic vulnerabilities, the nature and severity of the abuse and the quality of familial, social and professional support offered to the survivors (e.g., Godbout, Briere, Sabourin, & Lussier, 2014; Hébert, 2011; Liang, Williams, & Siegel, 2006; Watson & Halford, 2010). In their landmark longitudinal study, Trickett, Noll, and Putnam (2011) also pointed out that, in some cases, symptoms emerge more clearly over time, at critical periods of development. For CSA survivors, the formation of a cohabiting or married relationship may represent such a critical period where romantic attachment, intimacy, and sexual issues coincide to create certain challenges during young and middle adulthood. The current scientific literature suggests that many adult CSA survivors have difficulty forming close relationships and report more instability in these relationships as well as poorer dyadic adjustment (DiLillo & Long, 1999; Larson, Newell, Holman, & Feinauer, 2007; Liang et al., 2006; Miller, Schaefer, Renshaw, & Blais, 2013; Whisman, 2006), more severe domestic violence (Whitfield, Anda, Dube, & Felitti, 2003; Widom, Czaja, & Dutton, 2014), and elevated rates of relationship dissolution (Colman & Widom, 2004; Watson & Halford, 2010; Whisman, 2006). When present, these long-term negative repercussions of CSA have been explained through chronic and dysfunctional self- and partner-schemas characterized by confusion, fear, shame, self-denigration, feelings of emptiness, deep mistrust, aggressiveness, etc. (Briere & Runtz, 1993; Finkelhor & Browne, 1985).

Romantic relationship difficulties experienced by CSA survivors need further exploration since the clinical picture in adulthood is complex and evolving across time within relationships. Some studies have revealed that the magnitude of the association between CSA and relationship maladjustment is small and sometimes non-significant, indicating that many CSA survivors develop satisfying romantic relationships as adults (Berthelot, Godbout, Hébert, Goulet, & Bergeron, 2014; DiLillo, Lewis, & Di Loreto-Colgan, 2007; Larsen, Sandberg, Harper, & Bean, 2011; Nelson & Wampler, 2000; Watson & Halford, 2010). These studies have demonstrated that the association between CSA and relationship adjustment is probably indirect and mediated by key variables playing a role in the development of these long-term consequences.

Because CSA has consistently been related to a variety of negative sexual attitudes and behaviors emerging in middle-childhood (e.g., intrusive or inappropriate sexual behaviors; e.g., Friedrich et al., 2001; Trickett et al., 2011) and in adolescence (e.g., early age at first intercourse, a high number of sexual partners, high-risk sexual behaviors, teenage pregnancy and early motherhood; e.g., Loeb et al., 2002), it is not surprising that researchers are beginning to notice that CSA is related to adverse sexual health outcomes in adult intimate relationships. For example, CSA predicts multiple aspects of sexual functioning, including low frequency of intercourse (Dennerstein, Guthrie, & Alford, 2004), or inversely heightened sexuality (Wilson & Widom, 2008),

negative sexual attitudes (DiLillo et al., 2007), sexual dissatisfaction (Rellini & Meston, 2007), lower sexual self-esteem, higher sexual concerns, heightened risk of sexual revictimization (Van Bruggen, Runtz, & Kadlec, 2006), self-reported infidelity (Colman & Widom, 2004; Frias, Brassard, & Shaver, 2014), and a vast array of sexual dysfunctions (Najman, Dunne, Purdie, Boyle, & Coxeter, 2005). The rigorous examination of adult sexual sequelae is important because it has been suggested that they may specifically distinguish CSA survivors from victims of other types of childhood trauma (Blain, Muench, Morgensten, & Parsons, 2012).

Although various studies have reported an association between CSA and negative sexual health outcomes, most researchers have focused on sexual difficulties as an outcome of CSA or as a component of relationship difficulties rather than as a potential mediator of the association between CSA and dyadic adjustment. However, in their review, Christopher and Sprecher (2000), reported several studies focusing on intimate relationships who have demonstrated that sexuality in marriage or in dating relationships is positively related to several indicators of relationship satisfaction. Indeed, because sexuality is an integral component of intimate relationships, it is not surprising that unsatisfactory, conflictual, dysfunctional or non-existent sexuality has a powerful impact on marital quality and can threaten marital viability and stability (McCarthy, 2003; Yeh, Lorenz, Wickrama, Conger, & Elder, 2006). Building on previous research suggesting a consistent association between CSA and negative sexual health outcomes, an indirect link between CSA and couple adjustment, and finally, a positive relation between sexuality and couple satisfaction, the general goal of this study was to test a theory-based mediation model in which the relation between CSA and dyadic adjustment is mediated by adult sexual behaviors.

Aaron (2012), as well as Colangelo and Keefe-Cooperman (2012), systematically reviewed the literature on CSA and adult sexual functioning and independently concluded that the disparate outcomes can be organized into two competing pathways. The first path goes from CSA to internalized sexual symptoms characterized by avoidance, either caused by abuse flashbacks, aversion, dissociation during intercourse, negative feelings and dysfunctions. The second path indicates that CSA may lead to the development of externalized, compulsive sexual behaviors and is also referred to as hypersexuality or addictive sexuality. Aaron (2012) asserted that avoidance may be women's typical long-term sexual response to CSA whereas in men, sexual compulsivity would be the normative reaction.

The empirical basis for these theoretically hypothesized gender-differences is at best weak. Most studies of sexual compulsivity have been conducted exclusively on men (Blain et al., 2012; Forouzan & Van Gijseghem, 2005; Parsons, Grov, & Golub, 2012). For example, in a large sample of men who have sex with men, Parsons et al. (2012) observed that men showing sexual compulsivity were twice as likely as other men to have experienced CSA. In a study sampling both women and men, Skegg, Nada-Raja, Dickson, and Paul (2010)

revealed that the association between CSA and sexual compulsivity was significant for men but not for women. However, in a large representative sample of UK women and men, Plant, Plant, and Miller (2005), reported that CSA predicted addictive sexual activities in both men and women. This small pool of studies points to inconsistent gender-specific outcomes in the relation between CSA and sexual compulsivity, supporting the need to scrutinize this relationship.

The association between CSA and sexual avoidance has also received little empirical attention and the evidence for gender differences is mixed. In a study of 272 women survivors of CSA, Lemieux and Byers (2008) found that women who have experienced sexual penetration or attempted sexual penetration were more likely to have both purposely abstained from sexual activity and more frequently engaged in casual or unprotected sex. Likewise, while studying a sample consisting of 65 male CSA survivors, Forouzan and Van Gijseghem (2005) reported sexual fears as well as compulsive masturbation. Finally, McCallum, Peterson, and Muller (2012) showed that CSA was associated with sexual avoidance in men recruited in a sexually transmitted disease clinic but not in an online survey. Again, there is no conclusive evidence that women experience more sexual avoidance than men. On the contrary, it can be argued that the sexual avoidance and sexual compulsive pathways proposed by Aaron (2012) and Colangelo and Keefe-Cooperman (2012) to explain the longitudinal course of CSA may not be exclusionary but co-occur with sexual distress symptoms in both women and men survivors. Whereas such a proposition may appear counterintuitive or paradoxical, sexual ambivalence, fueled by both sexual pathways (i.e., compulsion to engage in sexual activity while believing sex is bad), has been reported in adolescent female incest victims (Noll, Trickett, & Putnam, 2003).

Although these findings are interesting, they originate from a relatively small number of empirical studies, conducted with undersized samples of adults, and lumping participants together regardless of their marital status (single or in a couple relationship). In addition, direct gender comparisons are rare because many studies examining relational and sexual outcomes of CSA in adult survivors have sampled only women (e.g., Lemieux & Byers, 2008; Liang, et al., 2006), small samples of men (e.g., Blain et al., 2012; Forouzan & Van Gijseghem, 2005) or have included both but in ways that precluded gender comparisons (e.g., Berthelot et al., 2014).

To summarize, the specific nature of the association between CSA and couple adjustment remains undetermined and very few studies have integrated sexuality and dyadic adjustment with CSA into a coherent model (Davis & Petretic-Jackson, 2000; Whiffen & Oliver, 2004). To our knowledge, only one study has examined the effect of sexual functioning in the intimate relationship on couple satisfaction in CSA survivors. In their large-scale longitudinal study of 202 randomly selected newlywed couples, DiLillo, Peugh, Walsh, Panuzio, Trask and Evans (2009) examined a range of marital domains assessed three times over a two-year

period and evaluated possible proximal intervening variables such as sexuality and trauma symptoms. This study revealed several relevant results including a much stronger link between maltreatment and marital outcome for men compared to women and the pervasive impact of CSA on physical aggression in the current relationship. This study also suggested that the relationship between CSA severity and marital satisfaction over time was not mediated by the frequency of sexual activities (DiLillo et al., 2009). However, several factors may account for this non-significant finding and underline the need to test direct or indirect associations between CSA, sexuality and dyadic adjustment. For example, the elimination of couples who divorced during the study (many of whom had sexual abuse histories), a sample with limited severity of CSA (i.e., rarely included forced sexual intercourse), and the sample choice of newlywed couples may all have weakened expected linkages. Studies allowing a full examination of couples having a wider range of couple difficulties associated with more severe CSA and longer duration of relationships are needed. Moreover, sexuality was examined with a two-item measure assessing frequency of sexual activities and sexual satisfaction. Thus, the hypothesis that the sexual outcomes of CSA are mostly observable through inhibition and compulsiveness could not be examined.

The Current Study

Based on previous research, the overall goal of this study was to test a theory-based mediation model in which the relation between CSA and dyadic adjustment is mediated through adult sexual behaviors in a sample of men and women currently involved in a close relationship. In the current study, we conducted path analyses and Structural Equation Modeling (SEM) to formally evaluated the theory-based hypothesis that CSA leads to increased adult sexual avoidance and sexual compulsivity, which in turn are negatively related to adult dyadic adjustment. We performed SEM to examine the role of CSA severity in our mediation model. In addition, to test Aaron's (2012) differential pathways hypothesis across gender, the gender-invariance of our mediation model was examined.

Method

Procedure

A convenience sample of French-Canadian men and women over the age of 18 was recruited to participate in an online study assessing the determinants of sexuality. Participants were recruited on a voluntary basis through various methods; messages on social networks such as Facebook and Twitter, a Facebook fan page, the researcher's university's electronic list that contains administrative, student, and staff listings, and posters in various locations (e.g., coffee shops, support centers for victims of sexual assault). Interested participants accessed a hyperlink, which led them to an anonymous survey hosted by a secured website: LimeSurvey,

where they electronically signed a consent form. There was no compensation for their participation in the study, which was approved by our University's Institutional Review Board.

Participants

Adult participants (i.e., above 18 years old) were eligible for this study if they were currently involved in a married, cohabiting or dating relationship. Of the 932 eligible participants who started the survey, 75% (n = 702) provided usable data: i.e., completed the question on CSA and at least one of the three outcome questionnaires. We excluded five participants whose answers appeared invalid; they responded with the same answer to all of the survey items. In 11 cases, the age between the respondent and partner made it difficult to assess the age difference and thus as it was not possible to accurately code the participant's experience as CSA or not, these cases (n = 11) were excluded. Thus, the final sample consisted of 686 participants. No significant differences were observed in the socio-demographic characteristics (i.e., age, education, occupation, annual income, sexual orientation, marital status) of participants in the final sample and participants who were removed, with the exception of gender $^2(1) = 13.69$, $p < .001$; there was a higher proportion of men in the excluded group (35%, n = 86) compared to the proportion in the final sample (23%, n = 157). The majority of those male participants were excluded because they started the survey but did not complete the key variables (i.e., they dropped out before completing the questions on CSA and at least one of the three outcome questionnaires).

All participants were French-speaking Canadians, 77% (n = 529) were women and 23% (n = 157) were men. The age of participants ranged from 18 to 77 years (M = 27.51, SD = 9.24). Most participants had a college degree (42%, n = 287), and others had an undergraduate (30%, n = 207) or a graduate degree (20%, n = 135); 61% (n = 416) were currently students, and 37% (n = 253) were employed full- or part-time. Concerning annual income, 32% (n = 216) of participants reported less than CAD$10,000/year, 32% ($n$ = 220) between CND$10,000 and CND$30,000, 18% (n = 122) between CND$30,000 and CND$50,000 and 18% (n = 123) reported an income above CND$50,000. Most participants identified themselves as heterosexual (86%, n = 587), 4% (n = 30) reported being homosexual and 8% (n = 55) reported being bisexual. The average duration of the current relationship was 5.24 years (SD = 6.91); 14% (n = 99) were married, 86% (n = 351) were cohabiting, and 34% (n = 236) were dating without living together.

Measures

All measures were administered as a self-report computerized questionnaire. Participants completed a sociodemographic questionnaire, with questions about sex, age, marital status, sexual orientation, education, occupation, and annual income.

Childhood sexual abuse. CSA was defined as any sexual act between a child under 16 years of age and a person five or more years older, or in a position of authority, with or without the presence of physical force or violence and with or without the "consent" of the child. To assess the occurrence of CSA, a 12-item measure evaluated if, when they were a child (before 16 years old), participants had a sexual experience with one (or more) individuals who were at least five years older or in a position of authority or an adult stranger. Participants who responded affirmatively to one of those items were classified as having experienced CSA and were asked to describe their experience with nine follow-up questions on the characteristics of the sexual experience. Follow-up questions referred to the participant's age at the first abuse, the frequency of abuse, the sex of the perpetrator and the act(s) perpetrated (e.g., complete penetration, oral sex, touching). Because CSA survivors, especially men, are sometimes reluctant to admit being victimized or may not label their sexual experience as a CSA, by interpreting this experience as consensual or a sexual initiation (Weiss, 2010), we used neutral terms such as sexual experiences.

In the path analyses, CSA was a dichotomous observed variable coded according to the presence or absence of a CSA history; 0 (no-CSA) and 1 (CSA). In the SEM analyses, CSA severity was operationalized by three characteristics of the sexual experience which were used as indicators of a latent factor: the chronicity of abuse, the type of act perpetrated, and the relationship with the perpetrator. These characteristics were coded so that a high score indicated a greater severity of the abuse as suggested by current literature considering these characteristics (Watson & Halford, 2010; Whisman, 2006). Chronicity of abuse represented the number of times the abuse occurred and was coded from 0 (nonvictim), 1 (one time), 2 (two to five times), to 3 (more than five times). Type of act perpetrated was coded according to the intrusiveness of the CSA and varied from 0 (nonvictim), 1 (without direct contact, i.e., voyeurism or exposure), 2 (touching), 3 (oral sex), to 4 (anal or vaginal penetration). Relationship with the abuser was coded according to the closeness to the abuser and varied from 0 (nonvictim), 1 (stranger), 2 (known person), 3 (family member), to 4 (parental figure). For participants reporting multiple abusive experiences, the most intrusive incident was coded.

Sexually avoidance behaviors. A French version of the sexual avoidance subscale (Katz, Gipson, & Turner, 1992) of the Sexual Aversion Scale (Katz, Gipson, Kearl, & Kriskovich, 1989) was used to assess avoidant behaviors relating to sexual contact. This subscale includes 10 items on a four-point Likert-type scale ranging from one (not at all like me) to four (very much like me). Items are summed to obtain a total score ranging from 10 to 40, where a high score corresponds to a greater tendency to avoid sexual activity. Sample items include "I am afraid to engage in sexual intercourse with another person" and "I try to avoid situations where I might get involved sexually". This subscale demonstrated good psychometric qualities in previous studies (e.g., Cronbach's alpha of .87 in La Rocque & Cioe, 2011). Past studies also suggested satisfactory construct validity, indicating for example that sexual avoidance, worry and low sexual desire were separate but related

constructs (Katz & Jardine, 1999). Finally, test-retest reliability over a one-month period was high (r = .90; Katz et al., 1989). In the current study, Cronbach's alpha for the sexual avoidance subscale is .82.

Sexually compulsive behaviors. A French version of the Sexual Compulsivity Scale (Kalichman, Johnson, Adair, Rompa, Multhauf, & Kelly, 1994) was used to assess difficulties to manage sexual thoughts and behaviors. This scale includes 10 items assessing the extent to which participants agree to a series of statements related to sexually compulsive behaviors, sexual preoccupations, and sexually intrusive thoughts. This scale is rated on a four-point Likert scale ranging from one (not at all like me) to four (very much like me). The global score ranges from 10 to 40 and is computed by summing the items. A high score indicates high levels of sexual compulsivity. There is no validated clinical cut-off score for this scale. However, there is some agreement in the scientific literature that individuals scoring above 24 demonstrate severe problems related to sexual compulsivity (Hook, Hook, Davis, Worthington, & Penberthy, 2010). Sample items include "My sexual thoughts and behaviors are causing problems in my life" and "I sometimes fail to meet my commitments because of my sexual behaviors". The scale has demonstrated good internal consistency (e.g., Cronbach's alpha ranging between .87 and .92, Kalichman & Rompa, 1995; 2001). Temporal stability over a 3-month interval demonstrated acceptable reliability (r_{xy} = .80). In the present sample, the alpha coefficient is .86.

Couple adjustment. A shortened four-item French-Canadian version (Sabourin, Valois, & Lussier, 2005) of the Dyadic Adjustment Scale (DAS; Spanier, 1976, translated in French by Baillargeon, Dubois, & Marineau, 1986) was used to assess relationship quality. The DAS-4 was constructed from items from the satisfaction factor of the 32-item scale (Sabourin et al., 2005). The first three items of the DAS-4, rated on a six-point Likert scale ranging from one (never) to six (always), are "How often have you considered divorce, separation, or terminating your relationship?", "In general, how often do you think that things between you and your partner are going well?", and "Do you confide in your mate?". The fourth item, a general indicator of relationship happiness, is scaled on a seven-point Likert scale, ranging from one (extremely unhappy) to seven (perfectly happy); participants are asked to indicate the answer which best describes the degree of happiness experienced in their relationship. Global scores on the DAS-4 range from four to 25, with higher scores reflecting a higher level of relationship quality. Generally, a score of 13 represents the clinical cut-off used to differentiate clinically significant couple distress individuals from those satisfied with their relationship (Sabourin et al., 2005). The shortened version of the DAS was used because it has the advantage of being less time consuming than the DAS-32, yet provides comparable information on couple satisfaction. Non-parametric item response analysis of 8,000 participants has demonstrated that the DAS-4 effectively predicts couple dissolution, and is less contaminated by socially desirable responding than the 32-item version. Internal consistency, predictive validity and temporal stability of the DAS-4 have been demonstrated and are similar to

the reliability and validity of the 32-item scale (Sabourin et al., 2005). In the present study, Cronbach's alpha is .80.

Statistical Analyses

Data were first screened for outliers and to assess linearity, normality, and multicollinearity. The data distribution of both mediating variables exhibited non-normality features (i.e., sexual compulsivity: skew = 1.58 and kurtosis = 2.89; sexual avoidance: skew = 3.26 and kurtosis = 14.94). Due to non-normality, a logarithm transformation was performed on sexual compulsivity scores (after transformation: skew = 0.83 and kurtosis = 0.36) and a reciprocal transformation was performed on sexual avoidance scores (after transformation: skew = 1.35 and kurtosis = 1.24) (Tabachnick & Fidell, 2003). Subsequently, descriptive analyses were conducted to examine rates and severity of CSA. Correlations, univariate *t*-tests, analysis of variance, and a chi-square test were performed to assess the relation between study variables. The main hypotheses were tested using path analyses, with the effects of CSA as the predictor, sexual behaviors as mediators, and dyadic adjustment as the outcome variable. Path analysis is a statistical technique that allows testing both direct and indirect relationships among different variables or latent variables that may be correlated (Kline, 2010). Between-gender differences were tested using a multiple group analysis. Descriptive statistics were computed using *SPSS* 20 and path analyses were conducted using M*plus*, version 7 (Muthén, & Muthén, 1998-2012). M*plus* accounts for missing data using the full information maximum likelihood estimation (Muthén, & Muthén, 1998-2012). As recommended by McDonald and Ho (2002), overall model fit was tested by considering together the comparative fit index (CFI), the root mean square error of approximation (RMSEA) and the chi-square statistic. A nonstatistically significant chi-square value, a CFI value of .90 or higher, and a RMSEA value below .06 are indicators of good fit. Since chi-square tests are sensitive to sample size (Kline, 2010), we also used the ratio of chi-square to degrees of freedom (χ^2/df). Values less than five indicate a satisfactory fit but a more severe cut-off value of three is ideal (Ullman, 2001).

Results

Descriptive Statistics

In the present sample, 20% (*n* = 104) of women and 19% (*n* = 29) of men reported a sexual experience that satisfied the current criteria for CSA. The average age of participants when the first abusive incident occurred was 9.01 years (*SD* = 3.41) for women and 10.14 years (*SD* = 3.42) for men. Concerning the chronicity of CSA, 21% (*n* = 22) of women and 28% (*n* = 8) of men reported being abused once, 49% (*n* = 51) of women and 35% (*n* = 10) of men reported being abuse two to five times, and 29% (*n* = 30) of women and 31% (*n* = 9) of men reported being abused more than five times. Most of the sexually abused participants were abused by a family member who was not a parental figure (women: 74%, *n* = 77; men: 69%, *n* = 20). However, among

women and men, respectively, the following CSA perpetrators were reported: 11% (*n* = 11) and 3% (*n* = 1) a parental figure, 9% (*n* = 9) and 17% (*n* = 5) a known person, and 7% (*n* = 7) and 10% (*n* = 3) a stranger. Finally, concerning the act perpetrated, women mostly reported sexual fondling or touching (67%, *n* = 70) whereas 13% (*n* = 13) reported oral sex and 12% (*n* = 12) reported sexual intercourse with penetration. Among male survivors, 21% (*n* = 6) endorsed sexual fondling or touching, 28% (*n* = 8) reported oral sex, and 35% (*n* = 10) reported sexual intercourse with penetration.

CSA, Sexual Behaviors, and Couple Adjustment: Univariate and Correlational Analyses

Means and standard deviations for sexual behaviors and couple adjustment in women and men with and without a CSA history are reported in Table 2, which also includes correlations among CSA, sexual behaviors, and couple adjustment. There were no significant differences between men and women for CSA rates (χ^2 (1) = .07, p = .79), sexual avoidance behaviors (t (650) = -.20, p = .84, η^2 < .001), and couple adjustment (t (648) = 1.46, p = .14, η^2 = .003). However, when compared to women, men reported more sexual compulsivity (t (649) = -7.34, p < .001, η^2 = .10). When compared to participants without a history of CSA, CSA survivors showed more sexual compulsivity (t (638) = -3.50, p = .001, η^2 = .03), sexual avoidance (t (639) = -2.90, p = .004, η^2 = .02), and lower couple adjustment (t (637) = 2.56, p = .01, η^2 = .01). Based on available cut-off scores for each scale, 5% (*n* = 25) of women and 19% (*n* = 29) of men reported a severe rate of sexual compulsivity while 4% (*n* = 19) of women and 4% (*n* = 6) of men reported clinically significant couple distress. For both men and women, CSA was positively associated with sexual avoidance and compulsivity. Because of the small number of sexually abused men in the sample, CSA was significantly correlated with dyadic adjustment only for women, even though the correlation was stronger in men than in women. For both women and men, sexually avoidant and compulsive behaviors were related to lower couple adjustment. In both genders, sexual avoidance was positively associated with sexual compulsivity. However, the correlations were generally small.

To examine the theoretically hypothesized gender differences in the aftermath of CSA (Aaron, 2012), univariate *t*-tests between women and men CSA survivors were conducted. There were no significant differences between men and women CSA survivors for sexual avoidance behaviors (t (122) = -.53, p = .60, η^2 = .002) and couple adjustment (t (123) = 1.21, p = .23, η^2 = .012). However, when compared to women CSA survivors (*M* = 15.78, *SD* = 5.77), men CSA survivors (*M* = 21.33, *SD* = 7.08) reported more sexual compulsivity (t (122) = -4.20 p < .001, η^2 = .13).

Exploratory and Confirmatory Factor Analyses of the Sexual Avoidance and Sexual Compulsivity Scales

The mediation model assessed in the present study is based on the hypothesis that sexual avoidance and compulsivity are two distinct constructs with minimal overlap. Thus, the structural validity of these concepts was tested using both exploratory and confirmatory factor analysis. The 20 items of the Sexual Avoidance and Sexual Compulsivity Scales were entered in a principal component analysis with promax rotation and correlated factors. This analysis confirmed the presence of two separate components (eigenvalues of 4.90 and 3.93), explaining 44% of the variance, each item being predominately related with its conceptual scale (saturation coefficients ranged from .55 to .80 for sexual compulsivity, and from .48 to .73 for sexual avoidance), and no items had cross-loadings of more than .30. There was a small but non-significant correlation between sexual avoidance and compulsivity (r = .09). The results of a confirmatory factory analysis also confirmed that this correlated two-factor model produced an acceptable fit to the data (χ^2 (169) = 403.59, p < .001; RMSEA = .05, 90% CI (.04 - .05); CFI = .96; χ^2/df = 2.39). The path between each item and its respective factor was significant; the correlation between the two latent factors was .12 (see Figure 1). The proportion of variance explained by each item was significant, ranging from 35% to 85%.

The Mediational Role of Sexual Avoidance and Compulsivity in the Relation between CSA and Couple Adjustment

The main hypothesis of the present study was that, in women and men, sexual avoidance and sexual compulsivity play a mediational role between CSA and couple adjustment. Because past empirical studies did not conclusively show that CSA mainly produces sexual avoidance in women and sexual compulsivity in men, our mediational model also examined this gender moderation assumption. Thus, a multiple-group path analysis (Dimitrov, 2006) was conducted to test the gender-invariance of this mediational model. The configural model was first assessed simultaneously for both women and men, allowing all paths to be estimated freely to ensure that it is a well-fitting model. This configural model also provided a comparison base when examining the more restrictive model of gender invariance. Results indicated good fit for the configural model: χ^2 (2) = 5.31, p = .07; RMSEA = .06, 90% CI (.00 - .14); CFI = .94; χ^2/df = 2.65. We then constrained all paths in the path analysis model to be equal across gender. This restricted model also fit the data well: χ^2 (7) = 7.99, p = .33; RMSEA = .02, 90% CI (.00 - .07); CFI = .98; χ^2/df = 1.14. We then compared these models using a corrected chi-square difference test (Satorra-Bentler scaled chi-square; Satorra & Bentler, 2001) to determine whether gender moderated the association between CSA, sexual behaviors, and couple adjustment. The difference in the chi-square values for the configural and restricted models was not significant, $\chi^2_{difference}$ (5) = 1.76, p = .88, indicating that the model held across gender.

Because the model was gender-invariant, only the final restricted model with standardized coefficients is presented in Figure 2. The final model indicates that CSA was positively and significantly associated to both sexual compulsivity and sexual avoidance. In turn, sexual compulsivity and sexual avoidance significantly predicted lower dyadic adjustment. Finally, when sexual compulsivity and avoidance were entered in the model, the path between CSA and dyadic adjustment became non-significant (β = -.14, *SE* = .10, *p* = .18), indicating full mediation. Indeed, the association between CSA and dyadic adjustment before the inclusion of mediators was significant (β = -.25, *SE* = .10, *p* = .01), explaining 1% of the variance in dyadic adjustment. We used the bootstrap confidence intervals method to examine the magnitude and significance of the indirect effects (Shrout & Bolger, 2002). This showed that the indirect effects through sexual compulsivity (*b* = -.06, 95% CI -.11 to -.02) and sexual avoidance (*b* = -.06, 95% CI -.14 to -.02) are significant. Overall, CSA and sexual behaviors accounted for 5% of the variance in dyadic adjustment for women and 6% for men. For women, CSA accounted for 3% of the variance in sexual compulsivity and 2% of the variance in sexual avoidance. For men, CSA accounted for 2% of the variance in sexual compulsivity and 2% of the variance in sexual avoidance. To confirm the generalizability of the mediational model and examine if these results hold when we control for sociodemographic variables that could affect the strength of the relations between variables, we conducted additional analyses, controlling for the age of the participant and length of the relationship. Given the strong correlation between these two control variables (*r* = .75), and to prevent multicollinearity, only participants' age was introduced as a covariable because it was the one most strongly correlated to the three outcomes variables, sexual compulsivity, sexual avoidance and couple adjustment. Adding this variable to the mediational model did not change the significance and strength of the associations between variables. This additional analysis confirmed that the mediational model held independently of age and length of the relationship.

To examine the role of CSA severity and confirm the validity of the mediational model, Structural Equation Modeling (SEM) was performed. This statistical technique estimates relationships among latent variables, minimizing the effects of measurement error (Kline, 2010). The latent factor for CSA severity was represented by three indicators (chronicity of CSA, type of act perpetrated, relation with the perpetrator) whereas for couple adjustment, it was formed through four indicators (i.e., the four items of the DAS-4). To minimize the number of SEM indicators, we measured the latent factors for sexual compulsivity and sexual avoidance by grouping items into six indicators (three for sexual compulsivity and three for sexual avoidance). The analysis of the measurement model showed that each latent variable was well represented by its indicators.

The SEM model showed satisfactory fit indices: χ^2 (59) = 92.96, *p* = .003; RMSEA = .03, 90% CI (.02 -.04); CFI = .99; χ^2/df = 1.58. The standardized SEM model produced results similar to those of the final restricted path analysis model. The results indicate that CSA severity latent variable was positively and significantly

associated to both sexual compulsivity (*b* = .08, *SE* = .02, *p* = .001, *β* = .17) and sexual avoidance (*b* = .05, *SE* = .02, *p* = .006, *β* = .15). In turn, sexual compulsivity (*b* = -.25, *SE* = .07, *p* = .001, β = -.17) and sexual avoidance (*b* = -.45, *SE* = .11, *p* < .001, *β* = -.21) significantly predicted lower dyadic adjustment, while the path between CSA severity and dyadic adjustment was non-significant (*b* = -.03, *SE* = .03, *p* = .26, *β* = -.05). The model showed that the indirect effects through sexual compulsivity latent variable (*b* = -.02, 95% CI -.01 to -.04) and sexual avoidance latent variable (*b* = -.02, 95% CI -.01 to -.05) are significant. Finally, we then tested the invariance of the model across men and women using SEM. Results revealed a non-significant chi-square difference for the measurement model ($\chi^2_{difference}$ (6) = 2.77, *p* = .84) and the mediational SEM model ($\chi^2_{difference}$ (5) = 5.07, *p* = .41), indicating that the model also held across gender in SEM. As in the path analysis model, we then controlled for age of the participants in the SEM model. Again, this addition to the SEM model did not change the significance and the strength of the associations between variables in the mediational model.

Discussion

The major finding of this study concerns the mediators of the CSA–dyadic adjustment relationship. Sexual compulsivity and sexual avoidance mediated the relation between CSA and dyadic adjustment for both women and men. More precisely, CSA was associated with more sexual avoidance and sexual compulsivity, which, in turn, predicted lower couple adjustment. To our knowledge, this is the first study suggesting that, in CSA survivors, these two forms of sexual functioning are associated with couple satisfaction. DiLillo et al. (2009) have previously reported non-significant findings for sexual intercourse frequency in relation to couple satisfaction in married couples. The present findings clearly showed that alternative sexual mediators may be useful markers of sexual difficulties in CSA survivors. In addition, our results go beyond the conclusions of past studies focusing either on sexual inhibition or on compulsiveness in samples consisted strictly of women or men (Forouzan & Van Gijseghem, 2005; Jacob & Veach, 2005; Lemieux & Byers, 2008; Parsons et al., 2012). Thus, they provide preliminary support for a dual-pathway model of sexual outcomes in CSA survivors such as those proposed by Aaron (2012) and Colangelo and Keefe-Cooperman (2012). However, these theoretical proposals need to be extended to take into account that for CSA survivors, symptoms of sexual inhibitions and compulsiveness may coexist and create sexually ambivalent attitudes and behaviors (Noll et al., 2003).

The experience of sexual and psychological intimacy in adult relationships represents a challenging developmental task that may trigger unresolved trauma-related affects (i.e., fear, guilt, panic, pain, helplessness, anger, shame, etc.). When past affect-laden memories have not been defused with the help of trustful adults, sexual interactions may be organized along patterns of dominance and submissiveness that tend to disrupt the quality of object relations (Kernberg, 2011). In some cases, heightened submissiveness might develop as an automatic response to a distorted representation of the partner as an abuser who is then perceived as sexually uncaring, self-centered, and forcefully demanding. Sexually submissive behaviors under

conditions of fear and threats typically represent passive coping strategies that have been found to lead to the inhibition of sexual pleasure and a phobic avoidance of sexual activities (Aaron, 2012). In other cases, sexual compulsiveness may emerge as a dominance-oriented coping strategy designed to overcome a view of the self as a passive, helpless victim or as a desperate attempt to explore the mind of the abuser (Gold & Heffner, 1998).

However, our findings also show that sexual avoidance and compulsiveness are not mutually exclusive and that both groups of symptoms may co-occur within CSA survivors and help to explain couple dissatisfaction. This is consistent with a pattern of disorganized attachment (Alexander, 1992) and with the rapidly oscillating mental states often documented in CSA survivors (Buttenheim & Levendosky, 1994). Sexual avoidance and compulsivity may also surface at different developmental stages of the couple's relationship, with compulsivity characterizing the early stage followed by avoidance when commitment pressures increases (Jacob & Veach, 2005; Schwartz & Galperin, 2002). However, the quality of object relations and patterns of dominance and submissiveness has rarely been assessed and even fewer studies have explored the issues of intimacy and sexual functioning within the sexual relationships of CSA survivors, thus, mechanisms by which CSA may affect adult sexuality remain misunderstood (Davis & Petretic-Jackson, 2000; Schwartz & Galperin, 2002).

Our mediational model demonstrated invariance across gender. This is an important finding even if it fails to support Aaron's (2012) differential pathways hypothesis whereby in men, CSA may be mostly associated with sexual compulsiveness whereas in women, sexual avoidance would predominate. Despite this invariance across gender, mean comparisons between men and women CSA survivors indicated that men CSA survivors reported more sexual compulsivity than women CSA survivors, partially supporting Aaron's (2012) theoretical hypothesis. Two methodological factors probably explain our ability to demonstrate gender invariance. First, the present results stem from a community sample of generally well-functioning adults in intimate couple relationships. This may reduce gender differences observed in past studies using clinical samples (Nelson & Wampler, 2000). Second, some aspects of our methodology may have facilitated greater disclosure of CSA in male survivors (almost 20% as compared to approximately 8% in a recent meta-analytic study; Stoltenborgh, Van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011). For example, the use of an anonymous Internet-based survey (Bagley & Genuis, 1991), a broader definition of CSA, and a neutral inquiry that did not specifically label reported sexual experiences as CSA or the participants as victims may have helped to identify more men as CSA survivors. If some male survivors had been excluded from the group of CSA survivors and placed in the control group, this could have contributed to artificial evidence of a gender difference. Thus, the present results corroborate the equity model of sexuality hypothesizing more similarities than differences between men and women in sexual behavior, roles and values, unlike the traditional male-

female double standard (McCarthy & Bodnar, 2005). This parallels previous findings regarding CSA-related outcomes in men and women (Godbout, Lussier, & Sabourin, 2006).

Although we presented an integrative mediational model that satisfactorily represented the associations between CSA, sexual behaviors and later couple outcomes, it is important to note certain limitations of the present study. Given the cross-sectional nature of this study, it is not possible to draw causal conclusions about our mediational findings. Couple satisfaction may also have an impact on sexual behaviors, or more likely, these constructs are probably mutually influential. Researchers should consider conducting longitudinal studies to better understand the complex interplay of couple difficulties and individual sexual behaviors following CSA. An online survey was used in order to facilitate the examination of such a sensitive subject as sexual abuse and sexual behavior. However, the representativeness of our sample and generalizability of our results may be limited by this sampling strategy. First, this sample excluded individuals who did not have access to the Internet. Although the majority of North Americans now have online access, data suggest that Internet users are more likely than non-users to be White, young, and to have children (U.S. Department of Commerce, 2002). Second, the potential for self-selection biases regarding individuals who volunteer for online sexuality research, and the over-representation of women in our final sample (compared to our excluded sample) may also reduce the generalizability of this study. Future studies are needed to replicate our mediational model with different subject populations and in different settings.

The use of simple retrospective self-reports of adults recalling child abuse histories could have also led to underreporting biases or distortions in the recall of traumatic events. However, the high prevalence rates, particularly among men, suggest that the neutral inquiry used in this study may have decreased underreporting biases by facilitating disclosure. To increase item neutrality, we developed an instrument to assess CSA that used terms such as sexual experiences instead of sexual abuse. The use of neutral terms in CSA assessment and of a non-standardized scale involved potential bias and, thus, the results of the present study should be replicated in other studies using validated scales and the instrument developed for this study should be more extensively validated.

It should be noted that the current study only evaluated two sexual outcomes and one couple outcome. As such, it is possible that CSA is predictive of other types of sexual or relationship outcomes not included in this study, such as sexual motivations, intimacy difficulties or intimate partner violence. The mediation model assessed is based on the dual-pathway model of sexual outcomes suggested by Aaron (2012) and Colangelo and Keefe-Cooperman (2012). It will be important to extend this model to take into account the coexistence of both sexual behaviors and thus the presence of sexually ambivalent behaviors. Moreover, the mediational model takes into account a gender moderation hypothesis, which was not confirmed. It is possible there are

differences in adjustment as a function of other personal or marital moderators, such as age of the participants, commitment level, legal marriage versus co-habitation, or length of the relationship. Future studies should examine if the associations are confirmed across those moderators or, at least, control for these variables.

For the outcomes that were examined, the amount of variance explained by the models was modest. This is consistent with the notion that sexual behavior and couple satisfaction have multiple determinants. Moreover, CSA is a distal factor for both outcomes, which suggests that other, perhaps more proximal intervening factors that were not considered in this study may have an important contribution in our model (e.g., communication skills or problem-solving behaviors). Future investigators may adopt a Structural Equation Modeling approach to investigate the mediators of the relation between CSA, sexual behaviors and dyadic adjustment, in which multiple measures of sexuality and couple relationship are used. This approach would allow researchers to better assess the constructs of interest and confirm our results for the presence of two sexual pathways in the aftermath of CSA. In addition, other studies have suggested that men and women report similar negative consequences of CSA but that the mechanisms behind CSA outcomes may be different (Senn, Carey, Vanable, Coury-Doniger, & Urban, 2006). Further examination of such mechanisms behind both sexual pathways for both women and men is needed.

Finally, since we only recruited participants in a couple relationship who volunteered to participate in this survey, it is impossible to extend our conclusions to single and unpartnered CSA survivors. It will be important to confirm the presence of both sexual pathways in other marital and relationship contexts (e.g., separately examining same-sex relationships) and to explore their impact on interpersonal relationships. Regardless of these limitations, the findings from the present study suggest a developmental process in which CSA may set women and men on a similar path leading to marital difficulties via multiple sexual pathways.

The current study has implications for researchers and practitioners. The findings from this study suggest potential targets for interventions. The observation that sexual compulsivity and avoidance mediate couple satisfaction for men and women underscores the importance to consider the two sexual pathways in the evaluation of CSA survivors for both genders and to assess more fully the way the CSA may have disrupted the quality of object relations and attachment representations (Buttenheim & Levendosky, 1994; Schwartz & Galperin, 2002). These findings also suggest sexuality as a relevant intervention target with couples in which one or both partners are CSA survivors. An intervention might attempt to help survivors understand how CSA can lead to maladaptive sexual behaviors due to difficulty with managing intimacy or because of maladaptive representations of self and of others. A better understanding of the role of CSA in different sexual behaviors may promote the development of efficient targeted treatments for distinct subgroups of CSA survivors. A

prevention implication of our findings is that an effective intervention focusing on both sexual pathways after CSA may offset the development of long lasting couple distress in adulthood.

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Table 2. Descriptive statistics and bivariate correlations among CSA, sexual behaviors, and couple adjustment for women and men.

	Women		Men		CSA		No-CSA		1.	2.	3.	4.
Variable	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*				
1. CSA	-	-	-	-	-	-	-	-	-	.14**	.13**	-.09*
2. Sexual compulsivity	14.39	4.68	18.41***	6.08	16.99	6.47	14.83***	4.88	.23**	-	.09*	-.15**
3. Sexual avoidance	11.98	3.23	12.04	3.94	13.00	4.52	11.76**	3.04	.19*	.21*	-	-.19**
4. Couple adjustment	20.16	3.06	19.74	3.05	19.46	3.13	20.24**	3.03	-.15	-.18*	-.22**	-

Note. Correlations for women (*N* ranged between 507 and 522) are presented above the diagonal, and correlations for men (*N* ranged between 142 and 153) are presented below the diagonal.
* $p < .05$. ** $p < .01$. *** $p < .001$.

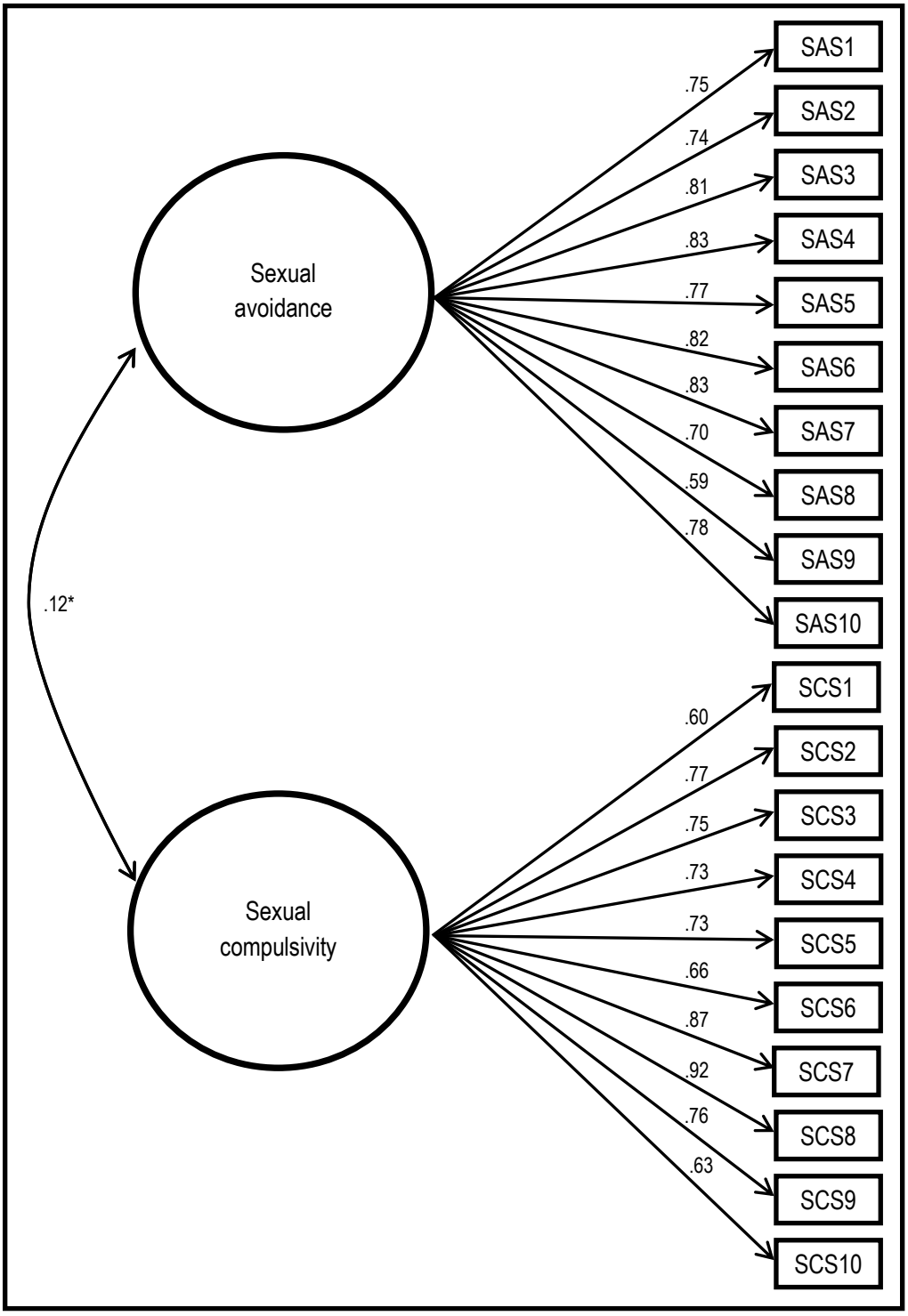

Figure 1. Confirmatory factor analysis of the sexual avoidance and sexual compulsivity scale. Note. * $p < .05$. All other paths are significant at $p < .001$.

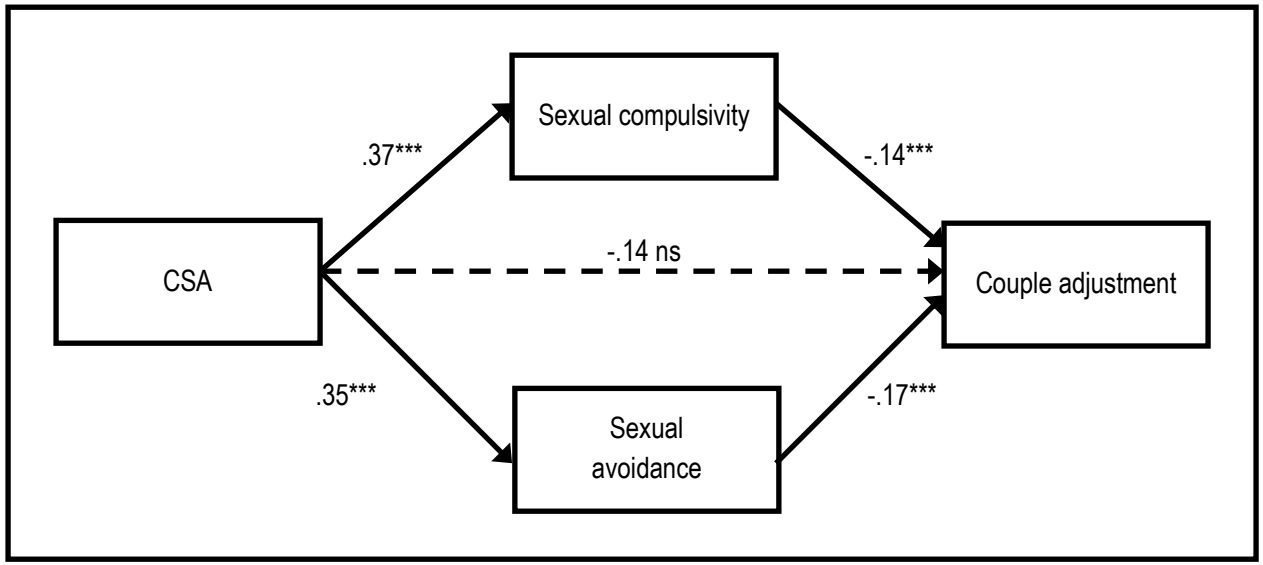

Figure 2. Restricted path analysis model of sexual behaviors as mediators of the association between CSA and subsequent couple adjustment.
Note. CSA was coded 0 = no-CSA, 1 = CSA.
ns = non-significant. * $p < .05$. ** $p < .01$. *** $p < .001$.

Chapitre III : Extradyadic sexual involvement and sexual compulsivity in male and female sexual abuse survivors (Article 2)

Publié en septembre 2015 dans le *Journal of Sex Research,* DOI: 10.1080/00224499.2015.1061633.

Extradyadic sexual involvement and sexual compulsivity in male and female sexual abuse survivors

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Marie-Pier Vaillancourt-Morel was supported by doctoral fellowships from the Social Sciences and Humanities Research Council (SSHRC) and the Research Centre on Intimate Relationship Problems and Sexual Abuse (CRIPCAS).

Natacha Godbout was supported by a research scholar grants from the Fonds de recherche du Québec – Santé (FRQ-S).

We thank Hélène Paradis and Bei Feng for their assistance with the statistical analyses.

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Résumé

Nous avons testé un modèle médiationnel au sein duquel la relation entre la sévérité de l'agression sexuelle en enfance (ASE) et les conduites sexuelles extradyadiques est expliquée via la compulsion sexuelle. Les participants sont 669 adultes actuellement en relation de couple ayant complété des questionnaires auto-rapportés. Le taux de prévalence des conduites sexuelles extradyadiques s'élève à 32% chez les femmes survivantes et à 57% chez les hommes survivants, plus du double du taux observé chez les participants sans histoire d'ASE. La compulsion sexuelle est significativement plus élevée chez les participants ayant de multiples partenaires extradyadiques que chez des participants rapportant une seule relation extradyadique, ces derniers ayant, malgré tout, une moyenne plus élevée que les participants ne rapportant aucun partenaire extradyadique. Ce modèle d'équations structurelles est invariant selon le genre et il indique que la sévérité de l'ASE est associée positivement et significativement à la compulsion sexuelle, qui, à son tour, prédit les conduites sexuelles extradyadiques. Cependant, il existe également une association directe entre l'ASE et les conduites sexuelles extradyadiques. La sévérité de l'ASE est associée, directement et indirectement, via des scores élevés de compulsion sexuelle, à une probabilité plus forte de conduites sexuelles extradyadiques.

Mots clés : aggression sexuelle à l'enfance; conduites sexuelles extradyadiques; infidélité; compulsivité sexuelle

Abstract

We tested a mediation model in which the relationship between CSA severity and extradyadic sexual involvement (ESI) is explained through sexual compulsivity. Participants were 669 adults currently involved in an intimate relationship who completed self-report questionnaires. Prevalence of ESI was 32% in women and 57% in men survivors, more than twice the rates among participants with no CSA history. Sexual compulsivity was significantly higher in participants with multiple extradyadic partners as compared to participants reporting only one extradyadic relationship, who nevertheless scored higher than participants reporting no extradyadic partner. The hypothesized structural equation model was invariant across men and women and indicated that CSA severity is positively and significantly associated with sexual compulsivity that, in turn, predicted ESI. However, there was also a direct association between CSA and ESI. High CSA severity, directly and through high sexual compulsivity, led to the highest probability of ESI.

Keywords: Childhood sexual abuse; extradyadic involvement; infidelity; sexual compulsivity

Introduction

Although the majority of women and men strongly values monogamy and disapproves extramarital sexual behavior, 20% to 40% of men and 14% to 25% of women report having been sexually involved with someone other than their partner at least once in their lives (Allen & Atkins, 2012; Mark, Janssen, & Milhausen, 2011). Extradyadic sexual involvement (ESI) is traditionally defined as the act of having sexual intercourse with someone other than one's partner while being committed to an exclusive romantic relationship (Glass & Wright, 1985). Although the unveiling of an infidelity episode occasionally has been associated with relationship improvement or enrichment (e.g., Olson, Russell, Higgins-Kessler, & Miller, 2002), it is generally conceptualized as an acute, potentially life-changing, situational stressor that predicts a variety of negative outcomes ranging from serious health issues (i.e., sexually transmitted infections, unwanted pregnancy) to chronic feelings of anger, betrayal and humiliation, leading to anxiety or depressive disorders (e.g., Atkins, Marín, Lo, Klann, & Hahlweg, 2010; Gordon, Baucom, & Snyder, 2004; Hall & Fincham, 2009).

ESI also may trigger a diminution in relationship quality (e.g., declines in couple satisfaction, high-conflict and volatile interactions) and stability (e.g., repeated breakups and reconciliations, threats of divorce, and separation or divorce) (Mattingly, Wilson, Clark, Bequette, & Weidler, 2010). In addition, infidelity, or accusations of infidelity, is one of the leading causes of intimate partner violence, and, in extreme cases, of husband-wife homicide (Buss & Duntley, 2014; Nemeth, Bonomi, Lee, & Ludwin, 2012). ESI remains one the most often stated reasons for union dissolution (Amato & Previti, 2003; Lampard, 2014), and is one of the main clinical challenges confronting specialists in couple therapy (Whisman, Dixon, & Johnson, 1997; Wilkinson, Littlebear, & Reed, 2012). The negative repercussions of such behavior are not restricted to adult partners but may spill over to family problems associated with children's exposure to interparental difficulties and high-conflict divorce (Platt, Nalbone, Casanova, & Wetchler, 2008). Given the high prevalence and adverse consequences of ESI, it is important, for both clinicians and researchers, to identify and understand relevant developmental and proximal precursors (Christian-Herman, O'Leary, & Avery-Leaf, 2001).

A review of the theoretical, clinical, and empirical literature suggests that sexual infidelity is a dynamic, personal, interactional, and social process that requires a multilayered perspective (Allen et al., 2008; Baucom, Snyder, & Gordon, 2009; Maddox Shaw, Rhoades, Allen, Stanley, & Markman, 2013; Tsapelas, Fisher, & Aron, 2011). Sources of risk range from sociodemographic, neurobiological and personality processes to interpersonal, cultural and systemic factors. However, far less attention has been paid to developmental precursors of ESI. One potential antecedent, child sexual abuse (CSA), may be especially relevant, given its known impacts on subsequent sexual behavior and relational difficulties.

CSA is a commonly occurring phenomenon and prevalence estimates range from 13 to 32% in women to between five to 14% in men (e.g., Briere & Elliott, 2003; Murray, Nguyen, & Cohen, 2014; Saunders & Adams, 2014). Negative sexual and relational outcomes are frequently related to abuse severity, which is typically assessed using three criteria: abuse frequency, intrusiveness of the act perpetrated, and relationship with the aggressor (Randolph & Reddy, 2007; Rellini & Meston, 2007). CSA that lasts for a longer duration, includes penetration, and involves a family member are associated with worse outcomes (Berthelot, Godbout, Hebert, Goulet, & Bergeron, 2014; Rellini & Meston, 2007; Watson & Halford, 2010). In children, CSA sometimes leads to increased or premature sex behavior – alone or with peers (Friedrich et al., 2001). Distorted sexual cognitions and premature sexual knowledge can, over adolescence, lead to maladaptive sexual decision-making and outcomes: early age at first intercourse, a higher number of sexual partners, high-risk sexual behaviors, sexually transmitted infections, teen pregnancy, and early motherhood (Jones et al., 2013; Loeb et al., 2012; Trickett, Noll, & Putnam, 2011; Wilson & Widom, 2008).

This premature – and typically coerced or forced – exposure to sexuality through CSA may form a distinct pathway to ESI in adolescence and adulthood. As in CSA, infidelity is frequently steeped in betrayal, fear, confusion, secrecy, guilt, shame, and transgression (Allen et al., 2005; Baucom et al., 2009). In adult CSA survivors, sexual desire and identity development may have become associated with emotional pain, harmful disloyalty, and rule breaking, which in turn can increase vulnerability to extradyadic sexual contacts. For example, contextual cues specific to typical extradyadic situations (e.g., a forbidden relationship with an unavailable and deceptive partner, sexual feelings accompanied by anxiety, guilt, and shame; Allen et al., 2005; Brand, Markey, Mills, & Hodges, 2007; Maddox Shaw et al., 2013) are thought to trigger unresolved past traumatic memories of CSA that, in turn, may lower protective boundaries against potentially harmful relationships. Unprocessed affect-laden memories of CSA, when chronically avoided or underegulated, might be dealt with by distracting sexual behaviors (Briere, 2002; Briere, Hodges, & Godbout, 2010) that play out in ESI.

Three large-scale empirical studies have examined the hypothesis that CSA is associated with a heightened risk of ESI (Colman & Widom, 2004; Frias, Brassard, & Shaver, 2014; Whisman & Snyder, 2007). In a longitudinal study of 1179 individuals, Colman and Widom (2004) followed abused and neglected children and a matched comparison group over a 25-year period to document the long-term consequences of childhood victimization across a number of relationship outcomes. They observed that female CSA survivors were 3.5 times more likely to engage in extradyadic activities compared to women who had not experienced CSA. However, CSA was not a significant risk factor for men. Likewise, in a national survey of 4884 American married women, Whisman and Snyder (2007) found that women with a history of CSA were four times more likely to report infidelity behaviors when compared to women without such a history. Finally, in a recent online

survey including 807 women, Frias and colleagues (2014) demonstrated that extradyadic involvement was twice as likely among CSA survivors (22.1% versus 10.6% in non-victims).

Information on CSA and ESI in men, however, is sparse and inconsistent. The single empirical study that included both genders revealed non-significant findings in men (Colman & Widom, 2004). Jacob and Veach (2005), however, provided qualitative evidence for a high rate of ESI in male CSA survivors. They interviewed ten female partners of male survivors and discovered that half of the CSA survivors had been sexually involved with other partners (i.e., engaged in romantic affairs or anonymous one-night stands). Given that CSA has been consistently associated with extradyadic relations in women, and taking into account the few and inconsistent findings in men, there is a need for additional research to assess whether gender moderates the association between CSA and extradyadic involvement. Moreover, although the CSA-ESI association seems robust, at least in women, most CSA survivors do not become involved in extradyadic relations, suggesting that complex mediating or moderating mechanisms may underlie the vulnerability of some CSA survivors to extradyadic relations.

ESI, even if underresearched, seemingly fits within the network of adverse couple and sexual outcomes associated with CSA (Godbout, Briere, Sabourin, & Lussier, 2014; Miller, Schaefer, Renshaw, & Blais, 2013; Watson & Halford, 2010; Widom, Czaja, & Dutton, 2014). Recent reviews of the CSA literature suggest that sexual betrayal of a close partner may emerge as a result of overwhelming sexual compulsions developed in the context of past sexual trauma (Aaron, 2012; Colangelo & Keefe-Cooperman, 2012). Although this proposition remains untested within the context of CSA, sexual compulsivity has been conceptualized as a sexual coping mechanism designed to temporarily relieve intolerable inner tensions (Briere & Scott, 2014; Opitz, Tsytsarev, & Froh, 2009; Perera, Reece, Monahan, Billingham, & Finn, 2009; Plant, Plant, & Miller, 2005). Repetitive or indiscriminant sexual behavior may address some CSA survivors' feelings of sexual inadequacy, fill a need for attention, validation or love, or provide a sexual sense of power and control (Bergner, 2002; Price, 2003; Zapf, Greiner, & Carroll, 2008). In this context, ESI may serve as a way to temporarily escape, avoid, relieve or neutralize distress, via externalized sexual behaviors that provide excitement, connection, validation, and/or sexual pleasure. This sexual compulsivity mediation hypothesis is consistent with various trauma theoretical perspectives derived from cognitive-behavioral (Deblinger, Mannarino, Cohen, Runyon, & Heflin, 2015) and psychodynamic (Terr, 2003) viewpoints. For example, in the self-trauma (Briere, 2002) and in the traumatogenic dynamics (Finkelhor & Browne, 1985) models, the concept of repetition compulsion refers directly or indirectly to sexual behaviors as a form of behavioral re-enactment of CSA or a coping strategy developed to face the effects of childhood trauma.

In the absence of definitive literature, the possibility that sexual compulsivity may mediate the link between CSA and ESI should be explored. Although the present study focused on a sexual compulsivity mediation hypothesis, ESI might occur for a large number of motives (e.g., attachment insecurities, Frias et al., 2014; communication/problem-solving behaviors, Baucom et al., 2009). In addition, although sexual compulsivity has been found to be more prevalent and severe in men relative to women (Ballester-Arnal, Gómez-Martínez, Llario, & Salmerón-Sánchez, 2013; Gullette & Lyons, 2005; Kaplan & Krueger, 2010), its association with CSA has been studied primarily in the former (Blain, Muench, Morgensten, & Parsons, 2012; Parsons, Grov, & Golub, 2012). In light of research suggesting that CSA-related sexual compulsivity may be more specific to men than women, gender might moderate the strength of the associations between CSA, sexual compulsivity, and ESI.

Objectives and Hypotheses of The Current Study

The overall goal of this study was to examine CSA severity as a potential long-term risk factor for ESI in women and men. The first aim was to use structural equation modeling (SEM) to test a mediation model whereby the relationship between CSA severity and ESI is explained through sexual compulsivity. The second aim was to test a gender moderation hypothesis within the proposed mediation model. Given the gender specific findings reported in the literature, the invariance of the SEM model was examined to determine if the strength of the associations between CSA, sexual compulsivity, and ESI varied between men and women. Based on previous findings and theory, we hypothesized that (1) CSA severity will be associated to higher sexual compulsivity, which in turn would lead to an increased probability of ESI; (2) the association between CSA, sexual compulsivity, and ESI will be stronger for men than for women.

Method

Participants

Adult participants (i.e., above 18 years old) were eligible for this study if they were currently married or involved in a couple relationship, whether they cohabited or not with their partner (i.e., a non-cohabiting form of romantic involvement is referred as “dating”). Of the 1472 individuals who started the survey, 932 (63.3%) indicated being currently involved in a couple relationship. Of these, 669 (71.8%) provided usable data (i.e., completed the question on CSA and ESI). Thus, the final sample comprised 669 French-speaking Canadians aged between 18 and 77 years old (M = 27.56, SD = 9.18), and included 77.9% (n = 521) women and 22.1% (n = 148) men. Within this sample, 14.6% (n = 98) were married, 51.4% (n = 344) were unmarried and living with their partner, and 33.9% (n = 227) reported being in a dating relationship and living separately. The average duration of the current relationship was 5.30 years (SD = 6.97). Most of the respondents (85.8%, n = 574) identified themselves as heterosexual, 27 reported being homosexual (4.0%) and 55 reported being

bisexual (8.2%). A total of 41.7% (n = 279) of the participants had a college degree, whereas 30.5% (*n* = 204) had an undergraduate degree and 20.0% (*n* = 134) had a graduate degree; 60.5% (*n* = 405) were students and 37.1% (*n* = 248) were full-time or part-time workers. Annual income varied significantly among participants, with 31.7% (*n* = 212) reported less than CAD$ 10,000/year, 31.8% (*n* = 213) between CAD$10,000 and CAD$30,000, 18.1% (n = 121) between CAD$30,000 and CAD$50,000, and 17.9% (*n* = 120) above CAD$50,000. As compared to the 2011 national and regional population census (Statistics Canada, 2012; Institut de la statistique du Québec, 2014), the current sample included a larger number of women (77.9% vs. 50.3%), younger participants (M_{age} = 27.56 years vs. M_{age} = 41.5), and individuals from a lower socioeconomic background (31.7% less than CAD$10,000/year vs. 13.34%, and 17.9% above CAD$50,000 vs. 25.09%).

Measures and variables

CSA. Based on the Criminal Code of Canada, CSA was defined as any sexual act between a child under 16 years of age and a person five or more years older, or in a position of authority, with or without the presence of physical force or violence and with or without the "consent" of the child. To assess the occurrence of CSA, a 12-item questionnaire, based on measures described by Mendel (1995), Finkelhor (1979), and Fromuth and Burkhard (1989), was developed for this online survey. This questionnaire evaluated if, before the age of 16, participants had any sexual experiences with one (or more) individual at least five years older or in a position of authority. In order to characterize potential abusers, twelve response choices were presented: 1. natural or adoptive mother, 2. natural or adoptive father, 3. stepmother, 4. stepfather, 5. grandmother, 6. Grandfather, 7. sister, 8. brother, 9. other family member, 10. family friend or acquaintance at least five years older, 11. teacher, babysitter or instructor, 12. stranger at least five years older than them. In order to estimate the severity of CSA, participants who responded affirmatively to one or more of those 12 items were asked nine follow-up questions to describe their experience including age at first victimization, the frequency of abuse, and the act(s) perpetrated (e.g., complete vaginal or anal penetration, oral sex, touching).

CSA severity was operationalized in the SEM analyses through three characteristics of the victimization experience, used as indicators of a CSA latent variable: the frequency of abuse, the intrusiveness of the act perpetrated, and the relationship with the perpetrator. For the latent variable, these characteristics were coded so that a high score indicated a greater severity of CSA as suggested by the literature on these characteristics (Berthelot et al., 2014; Watson & Halford, 2010; Whisman, 2006). CSA frequency represented the number of times the abuse occurred and was coded from zero (nonvictim), one (one time), two (two to five times), to three (more than five times). The act perpetrated was coded according to the intrusiveness of the CSA and varied from zero (nonvictim), one (without direct contact, i.e., voyeurism or exposure), two (touching), three (oral penetration), to four (anal or vaginal penetration). Relationship with the abuser was coded according to

the closeness to the abuser and varied from zero (nonvictim), one (stranger), two (known person), three (family member), to four (parental figure). For participants reporting multiple CSA, the most intrusive incident was coded. In the present sample, the alpha coefficient for these three CSA characteristics was .96.

ESI. ESI was defined as the action of having sexual intercourse with someone other than one's actual partner while being committed to a romantic relationship (Glass & Wright, 1985). This concept was operationalized on the basis of the participants' response to the question: "Excluding your actual partner, since the beginning of your current romantic relationship, with how many people have you had sexual intercourse?" Those who reported having sexual intercourse with one person or more were coded as having engaged in an extradyadic sexual relation; i.e. this variable was binary (0 = no ESI; 1 = ESI). This question also allowed to assess the number of extradyadic partners and was coded as (0) no extradyadic partner, (1) single extradyadic partner, and (2) multiple extradyadic partners. Participants who reported an ESI were asked a follow-up question to determine when was their last sexual relation with this person. The use of a self-reported question using neutral terms was suggested by Whisman and Snyder (2007) to promote disclosure of extradyadic sexual activities.

Sexually Compulsivity. To assess difficulties in managing sexual thoughts and behaviors, a French version of the Sexual Compulsivity Scale (Kalichman et al., 1994) was used. This scale includes 10 items assessing the extent to which participants agree to a series of statements related to sexually compulsive behaviors, sexual preoccupations, and sexually intrusive thoughts. Recent exploratory factor analyses indicated a two-factor solution, but in both studies only the total score was used (Ballester-Arnal et al., 2013; McBride, Reece, & Sanders, 2008). This questionnaire is rated on a four-point Likert scale ranging from one (not at all like me) to four (very much like me). The global score ranges from 10 to 40 and is computed by summing the items. A high score indicates high levels of sexual compulsivity. Sample items include "My sexual thoughts and behaviors are causing problems in my life" and "I sometimes fail to meet my commitments and responsibilities because of my sexual behaviors". Past studies have suggested that a high score on this scale is associated with greater numbers of sexual partners, higher frequencies of masturbation, engaging in higher rates of sexual risk behaviors and being recently diagnosed with multiple sexually transmitted infections in both men and women (Kalichman & Rompa, 2001; Kalichman & Cain, 2004). This scale has been reported to have good internal consistency and temporal stability (Kalichman & Rompa, 1995; Kalichman & Rompa, 2001). In the present sample, the alpha coefficient for this measure was .86.

Procedure

Men and women above 18 years old were recruited on a voluntary basis in the Canadian province of Quebec to participate in an online survey assessing the determinants of sexuality in adulthood. Advertisements

informed participants that their participation would be anonymous, the survey could be completed in 45 to 60 minutes and that it included questions on early sexual experiences, current sexual behaviors, marital and extramarital relationships and personal characteristics. Various methods were used to reach these participants: messages on social networks such as Facebook and Twitter, emails sent using the electronic list of the university community members, and posters in various locations (e.g., stores, service centers, coffee shops, non-profit community organizations, and support centers for victims of sexual assault). No compensation was offered for participating in the study. Interested participants were invited to click on a hyperlink, which led them to *Lime Survey*, a secured website holding the online survey. Data was automatically collected in a secured and private database. All participants electronically signed a consent form in order to be enrolled in the study. The Institutional Review Board of Laval University approved this research.

Statistical Analyses

Data were first screened for outliers and to assess linearity, normality, and multicolinearity. Descriptive analyses were then conducted to examine the rates of CSA and ESI. Pearson's correlations, chi-square analyses and ANOVA's were performed to assess the relation between study variables. Descriptive, univariate and correlational analyses were computed using *SPSS* 20. The main hypotheses were tested using SEM, with CSA severity as the predictor, sexual compulsivity as the mediator, and ESI as the outcome variable.

SEM is a statistical technique that estimates relationships among latent variables, minimizing the effects of measurement error (Kline, 2010). Between-gender differences were tested using a multiple group analysis. SEM were conducted using M*plus*, version 7, with the weighted least squares mean- and variance-adjusted estimator (WLSMV). WLSMV does not assume normally distributed variables and is considered the optimum technique for modeling binary outcomes (Brown, 2006; Muthén & Muthén, 1998-2012). Because the relation with a nominal binary outcome (i.e., ESI) is nonlinear, the estimated probit coefficients were converted to probabilities to allow a more precise interpretation of the results (Brown, 2006; Muthén & Muthén, 2009). As a result, we computed probabilities of ESI for direct and indirect effects using formulas developed by Muthén & Muthén (2009): for the probability of direct effect, $P(ESI = 1|\eta_2) = 1 - \phi[(\tau - \lambda_2\eta_2) / \sqrt{\theta}]$ and for the probability of indirect effects, $P(ESI = 1|\eta_2,\eta_1) = 1 - \phi[(\tau - \lambda_1\eta_1 - \lambda_2\eta_2) / \sqrt{\theta}]$[1].

[1] Where τ is the threshold of the model
λ_1 is the regression coefficient between sexual compulsivity and ESI
λ_2 is the regression coefficient between CSA severity and ESI
η_1 is the value of sexual compulsivity latent factor
η_2 is the value of CSA severity latent factor
θ is the residual value of infidelity
ϕ is the normal distribution function

As recommended by McDonald and Ho (2002), overall model fit was tested by considering together the comparative fit index (CFI), the root mean square error of approximation (RMSEA), the chi-square statistic and the ratio of chi-square to degrees of freedom (χ^2/df). A combination of a nonstatistically significant chi-square value, a CFI value of .90 or higher, a RMSEA value below .06, and a ratio of chi-square to degrees of freedom less than three are thought to represent a good fit (Kline, 2010; Ullman, 2001).

Results

Descriptive Statistics

CSA. In the present sample, 20.0% of women (n = 104) and 18.9% of men (n = 28) reported a sexual experience that satisfied the current criteria for CSA; this gender difference was not significantly different, $\chi^2(1,669) = 0.08$, $p = .778$, Cramer's V = .01. The characteristics of sexual abuse, for women and men CSA survivors, are reported in Table 3.

ESI. In the present sample, 18.2% of women (n = 95) and 31.8% of men (n = 47) reported at least one extradyadic partner, and ESI was significantly more common in men than in women, $\chi^2(1,669) = 12.61$, $p < .001$, Cramer's V = .14. The average number of extramarital partners was 2.12 (SD = 1.96) in women and 4.11 (SD = 8.13) in men. The latest episode of sexual infidelity had occurred more than one year ago in 51.6% of women (n = 49) and 44.7% of men (n = 21), and in the last year for 48.4% of women (n = 46) and 51.1% of men (n = 24).

CSA, Sexual Compulsivity, and ESI: Univariate and Correlational Analyses

Pearson's correlations between all variables included in the SEM model are reported in Table 4. All of the indicators of CSA severity were significantly associated with sexual compulsivity and ESI for both men and women. Sexual compulsivity was positively associated with ESI for women, but not men.

The prevalence of ESI, as well as means and standard deviations for sexual compulsivity in women and men, for both CSA survivors and participants without history of CSA, are reported in Table 5. Chi-square analyses were used to test differences in infidelity for male versus female CSA survivors. Results revealed that both male and female CSA survivors reported significantly more ESI than men and women without history of CSA, women: $\chi^2(1,521) = 15.88$, $p < .001$, Cramer's V = .18; men: $\chi^2(1,148) = 10.27$, $p = .001$, Cramer's V = .26. Female CSA survivors reported 2.13 times more ESI than non-victims, while this rate was 2.21 times greater for male survivors. Results of an ANOVA showed that men reported significantly more sexual compulsivity than women, $F(1,630) = 51.84$, $p < .001$, $\eta^2 = .08$, and that CSA survivors reported significantly more sexual compulsivity than non-victims, $F(1,630) = 20.48$, $p < .001$, $\eta^2 = .03$. However, the effect of CSA history on sexual compulsivity does not significantly vary according to gender, $F(1,630) = 2.77$, $p = .097$, $\eta^2 = .004$.

Additional univariate analyses were conducted using as a dependent variable the number of extradyadic partners reported: those without a history of any extradyadic partner, those with a single extradyadic partner, and those with multiple extradyadic partners. A chi-square analysis compared the frequency of CSA history between these three groups. Results revealed that participants with multiple extradyadic partners reported significantly more CSA (n = 23, 34.8%) than those who did not report having an extradyadic partner (n = 83, 15.7%), $\chi^2(2, 669) = 24.86$, $p < .001$, Cramer's V = .19. This difference was also significant between participants who reported a single extradyadic partner (n = 26, 34.2%) and those with no extradyadic partner, although CSA did not distinguish participants who reported multiple versus a single extradyadic partner. However, results of an ANOVA with post hoc comparisons indicated that participants with multiple extradyadic partners reported significantly more sexual compulsivity (n = 60, M = 19.07, SD = 6.79) than those who mentioned a single extradyadic partner (n = 76, M = 16.16, SD = 5.80, p = .003) or who did not report an extradyadic partner (n = 498, M = 14.57, SD = 4.69, $p < .001$), $F(2,631) = 22.78$, $p < .001$, $\eta^2 = .07$. Sexual compulsivity was also higher in participants with a single incident than in those who reported no extradyadic partner (p = .03).

The Mediational Role of Sexual Compulsivity in the Relation between CSA and ESI

To test the hypothesis that sexual compulsivity plays a mediational role between CSA and ESI, SEM was performed using CSA as a latent variable measured by three indicators; frequency of CSA, type of act perpetrated and the relation with the perpetrator. In order to minimize measurement error, sexual compulsivity was operationalized as a latent variable rather than as a manifest continuous variable. However, to stabilize parameter estimates, reduce nonnormality, increase model efficiency to define the latent construct, and minimize the number of SEM indicators without loss of information, we opted for a "subset-item-parcel approach"; items were aggregated into several parcels and these parcels were used as indicators of the sexual compulsivity latent factor (Matsunaga, 2008). As recommended by Matsunaga, using a correlational algorithm, the 10 items of the Sexual Compulsivity Scale were aggregated into three parcels. This approach was optimal since the homogeneity and unidimensionality of the Sexual Compulsivity Scale are well-established. ESI was measured as a manifest dichotomous variable (i.e., 0 = no extradyadic relationship; 1 = at least one extradyadic relationship). The analysis of the measurement model showed that the two latent variables were well represented by their indicators or parcels with satisfactory fit indices: $\chi^2(8) = 6.22$, p = .623; RMSEA = .00, 90% CI (.00 to .04); CFI = 1.00; χ^2/df = 0.78. Standardized coefficients were all significant, ranging from .69 to .85 for compulsivity, and from .93 to .98 for CSA severity.

Results of SEM showed that the proposed model fits the data well, with satisfactory fit indices: $\chi^2(12) = 11.84$, p = .458; RMSEA = .00, 90% CI (.00 to .04); CFI = 1.00; χ^2/df = 0.99. Figure 3 displays the standardized coefficients for the structural model, which indicate that CSA severity was positively and significantly

associated with sexual compulsivity and ESI. In turn, sexual compulsivity significantly predicted ESI. Thus, CSA severity was found to affect ESI directly, as well as indirectly through sexual compulsivity. The association between CSA severity and ESI before the inclusion of the mediator, sexual compulsivity, was significant (β = .24, *SE* = .05, $p < .001$) and explained 5.8% of the variance in ESI. When sexual compulsivity was entered in the model, the path between CSA severity and ESI was still significant but diminished (β = .19, *SE* = .05, $p < .001$), indicating partial mediation. Overall, the model accounted for 13.1% of the variance for ESI and 3.2% of the variance for sexual compulsivity.

To allow a more precise interpretation of the SEM results, probabilities of ESI for direct and indirect effects were computed (Muthén & Muthén, 2009). For the direct effect of CSA severity on ESI, the probability of ESI for an average level of CSA severity (i.e., for the mean of the latent factor) was .20. This probability increased to .26 for a high level of CSA severity (i.e., at +1 standard deviation). For the indirect effect of CSA severity on ESI via sexual compulsivity, the probability of ESI for an average level of CSA severity and an average level of sexual compulsivity, using latent means, was .20. This probability increased to .29 when sexual compulsivity was high and to .36 if both CSA severity and sexual compulsivity were high (i.e., at +1 standard deviation). On the compulsivity scale, a score one standard deviation above the mean (*M* = 15.18, *SD* = 5.23) corresponded to a score of 20.41.

In order to examine the gender moderation hypothesis for the mediational model, a multiple-group gender-invariance SEM analysis (Dimitrov, 2006) was conducted. The SEM model was first assessed simultaneously for women and men, allowing all paths to be estimated freely, to ensure that the model held for both gender. Results revealed a good-fitting multigender model: $\chi^2(28) = 44.46$, $p = .025$; RMSEA = .04, 90% CI (.02 to .06); CFI = .97; $\chi^2/df = 1.59$. This SEM model was then compared to a more restrictive model of gender invariance in which all paths are constrained to be equal across men and women. Models are compared using a chi-square difference test; a univariate incremental chi-square value probability smaller than 0.05 indicates evidence of differences across men and women. Results indicated a non-significant chi-square difference for the measurement model ($\chi_{difference}^2(4) = 2.70$, $p = .609$) and the mediational SEM model ($\chi_{difference}^2$ (3) = 4.32, $p = .229$), indicating that the SEM model was equivalent across men and women.

Finally, we also conducted an additional SEM analysis controlling for sociodemographic variables, specifically participant's current age and length of present relationship, that could affect the generalizability and strength of the relationships between variables. Given the multicolinearity between these two variables (r = .77), participants' age and length of the relationship were introduced individually as covariates in two different SEM models. Adding participants' age as a covariate to the model did not change the significance or strength of the association between variables and resulted in satisfactory fit indices: $\chi^2(16) = 18.03$, $p = .322$; RMSEA = .01,

90% CI (.00 to .04); CFI = 1.00; χ^2/df = 1.13. Replacing participants' age with length of the relationship as a covariate also resulted in satisfactory fit indices: $\chi^2(16) = 17.60$, $p = .348$; RMSEA = .01, 90% CI (.01 to .04); CFI = 1.00; χ^2/df = 1.10. These additional analyzes confirmed that the mediational model held independent of age and length of the relationship.

Discussion

ESI within dating, cohabiting, and married couples is often an acute stressor, frequently grounded in a broad range of proximal precursors, including low commitment, poor intimacy, sexual dissatisfaction, communication and problem-solving deficits (Allen et al., 2005; Allen et al., 2008; Maddox Shaw et al., 2013; Tsapelas et al., 2011). The results of the present study clearly show that although ESI might be an existential decision rooted in moment-to-moment personal choices and experiences, it is also linked to early sexual trauma. In addition, as the frequency and the intrusiveness of sexually abuse is higher, and as the closeness of family ties to the aggressor is stronger, the risk of ESI increases. Thus, the severity of these sexual contacts predicts negative adult sexual outcomes, a finding that adds to the recent research literature on the detrimental effects of CSA in many aspects of adult intimate relationships (Senn & Carey, 2010; Stephenson, Pulverman, & Meston, 2014; Walsh, Latzman, & Latzman, 2014).

The prevalence of ESI within a current relationship was 32% and 57% for female and male survivors, respectively; rates that are more than twice as high than what was observed in non-survivors. This is a significant finding because it provides further evidence that CSA survivors are at significant risk for behaviors that threaten their ongoing dyadic involvement. For women, these results are consistent with the existing, albeit limited, literature (Colman & Widom, 2004; Frias et al., 2014; Whisman & Snyder, 2007). To our knowledge, however, this is the first study establishing that this also applies to male CSA survivors. The only other study examining ESI in men having experienced CSA, Colman and Widom (2004) reported non-significant findings. It should be noted, however, that Colman and Widom (2004) focused solely on court-substantiated cases of CSA whereas, in fact, a substantial proportion of CSA is not reported to authorities (MacMillan, Jamieson, & Walsh, 2003). In addition, their analyses were restricted to married participants, and extradyadic involvement was stringently defined as sexual intercourse with a minimum of three different individuals other than their partner. Although further studies are needed to replicate the current results, our findings indicate that the CSA-ESI association is generalizable to both women and men. However, the base rate of CSA is generally higher in women than in men, whereas, for ESI, this ratio is reversed, with men being almost twice as likely to engage in ESI than women. The current results indicate that a history of CSA increases the risk of ESI is a similar manner in men and women, directly and through higher sexual compulsivity. Future research is indicated to further explore the predictors of this reversal in the proportion of women and men reporting CSA and ESI, including a greater tendency for men, as compared to women, to

under-identify as a CSA survivor (Holmes, 2008) and, yet, to be more likely use ESI as a coping mechanism to relieve distress (Tsapelas et al., 2011).

The association between CSA and ESI is consistent not only with several studies but also with theoretical models developed to account for the short- and long-term effects of CSA. These different explanations, couched in the language of traumatogenic dynamics (Finkelhor & Browne, 1985), self-trauma disturbance (Briere, 2002), or repetition compulsion (Terr, 2003), all point to abuse-related difficulties in affect regulation, trust, and relational power dynamics that might undermine adult sexuality. Whether ESI is conceptualized as a coping strategy designed to reduce painful affects, or as a form of behavioral re-enactment of CSA, these models directly or indirectly highlight sexual preoccupations or behaviors that are, to some extent, fuelled by feelings of vulnerability, powerlessness, betrayal, or rejection.

CSA was found in the present study to be associated with adult sexual compulsions and behaviors that, in turn, predicted ESI. In this regard, CSA appears to affect extradyadic involvement directly, as well as indirectly through sexual compulsivity. These data also indicate that individuals reporting more severe CSA report higher sexual compulsivity, both of which increased the likelihood of infidelity.

Bergner (2002) has hypothesized that sexually compulsive individuals are obsessed with the enactment of specific sexual scenarios that have their origins in early experiences of degradation, such as CSA. These scenarios are thought to occur within the couple relationship but also in extradyadic involvements. In this way, sexually compulsive behaviors may represent an attempt to recover from past traumatic sexual experiences, such as CSA, by repeatedly engaging in sexual behaviors in a variety of contexts (Briere, 2002). When they are pursued through extradyadic contacts, these recovery attempts are typically maladaptive and distress-producing, because they are conducted in a highly charged affective context, suffused with ambivalence, insecurity, betrayal, and mistrust. In this regard, CSA may set up a dysregulating cycle producing increasingly more negative outcomes (Bergner, 2002; Briere & Scott, 2014; Terr, 2003).

Although past studies indicate that sexual compulsivity is a common coping mechanism primarily for male survivors of CSA (Opitz et al., 2009; Perera et al., 2009; Plant et al., 2005), the mediation model presented here was invariant across women and men. This finding supports a gender similarity hypothesis, whereby most of the long-term repercussions of CSA converge for both men and women (Dube et al., 2005; Maikovich-Fong & Jaffee, 2010). In the present study, however, although the structural relations between CSA, sexual compulsivity, and ESI did not differ across gender, mean differences revealed that, as compared to women, men reported more sexually compulsive thoughts and behaviors. These differences may partly explain why the risk of ESI is generally twice as high in men than in women.

In addition to its mediation by sexual compulsivity, there was a direct pathway from CSA to ESI in the present study. This finding suggests that sexual compulsion, per se, does not capture the totality of the relationship between CSA and ESI, and that other mechanisms (e.g., attachment insecurities; Frias et al., 2014) potentially contribute to variations in sexual behaviors outside the couple relationship. This is not surprising, given that sexual behaviors have multiple determinants (Dewitte, 2014) and that CSA is a distal risk factor of ESI, whereas other theoretical frameworks have proposed a wide range of more proximal sources of risk, such as low sexual or couple satisfaction, negative or high conflict communication, and insecurities about sexual self (Allen et al., 2005; Allen et al., 2008; Maddox Shaw et al., 2013; Tsapelas et al., 2011) that are not included in the model tested here.

Interpretation of the present findings should be tempered by the consideration of certain potential limitations. Our SEM results are cross-sectional, and therefore cannot be considered proof of causality. ESI may also fuel sexual compulsivity, and thus the association between these two phenomena may be bidirectional. Further, the ordering of variables in the present study was based on clinical and theoretical arguments and should be confirmed in longitudinal studies. Moreover, the representativeness of our sample is limited by a number of factors, including the use of a convenience sample recruited through an online survey with more women than men. Thus, the reported prevalence rates reported here may not completely mirror those found in the general population. Moreover, additional variables, such as sexual orientation, socioeconomic status, and the degree to which dyadic relationships contained a sexual exclusiveness agreement were not taken into account in the mediational model. Future studies are needed to replicate the present results with different populations and in different settings. Regarding sexual exclusivity, for example, future research might examine the association between CSA and extradyadic behaviors in openly non-exclusive relationships compared to monogamous relationship, although such research would require large samples given the low prevalence of consensual non-monogamous relationships in the general population (Rubin, Moors, Matsick, Ziegler, & Conley, 2014).

In addition, this investigation was based on retrospective self-reports that may introduce biases or distortions in the recall of CSA and underreporting of infidelity. However, the prevalence rates of CSA and ESI in men and women in the present study are similar to those observed in the general population (Allen & Atkins, 2012; Briere & Elliott, 2003; Mark et al., 2011), potentially supporting the validity and generalization of the current results.

Finally, although the present study examined the mediating role of sexual compulsivity and the moderator role of gender, and controlled for the age of the participant and length of the relationship, it is likely that the relationship between CSA and ESI is even more complex. Future investigators should consider other proximal (e.g., relationship quality, communication skills, current life stressors) and distal (e.g., other childhood trauma,

parental extradyadic involvement) risk factors for ESI. Gender differences may emerge only over time and their relative contribution would be best identified in longitudinal studies. Moreover, although this study represents an advance in the examination of the mechanism linking CSA and ESI, it did not use a dyadic statistical approach in which risk factors for both partners are considered simultaneously, testing for within-couple actor and partner effects (Kenny, Kashy, & Cook, 2006). The use of this or other complex statistical approaches in future research may more fully capture the interpersonal dynamics of sexuality (Dewitte, 2014).

The current results have implications for practitioners. The pathway through which CSA is associated with ESI suggests the value of therapeutic activities that address the mechanisms whereby childhood sexual victimization contributes to sexual compulsivity and ESI. Among these are interventions that focus on abuse-related relational schema, affect dysregulation that drives involvement in maladaptive behaviors, insecure attachment, and conditioned emotional responses to early sexual memories and cues (e.g., Briere, 1996; Cloitre, Courtois, Charuvastra, Carapezza, Stolbach, & Green, 2011; Courtois, 2010), as well as, when possible, couples-focused therapy wherein both partners are helped to understand and address ESI and sexual compulsivity as, at least in part, potential effects of sexual abuse.

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Table 3. Characteristics of sexual abuse for CSA survivors.

Variables		Women CSA % of 104 (*n*)	Men CSA % of 28 (*n*)
Age at first CSA		9.02 (3.42)	10.07 (3.46)
Frequency of CSA	One time	21.2% (22)	25.0% (7)
	Two to five times	49.0% (51)	35.7% (10)
	More than five times	28.8% (30)	32.1% (9)
Relationship with the perpetrator	Stranger	8.7% (9)	14.3% (4)
	Known person	16.3% (17)	46.4% (13)
	Family member	76.0% (79)	71.4% (20)
	Parental figure	10.6% (11)	3.6% (1)
Act perpetrated	Without direct contact	49.0% (51)	67.9% (19)
	Touching	85.6% (89)	71.4% (20)
	Oral penetration	19.2% (20)	46.4% (13)
	Vaginal/anal penetration	11.5% (12)	35.7% (10)

Note. CSA = childhood sexual abuse.
Means and standard deviations in parenthesis for age at first CSA.
Participants could report more than one perpetrator and more than one act perpetrated.

Table 4. Correlations among CSA severity, sexual compulsivity, and extradyadic involvement for men and women.

Variables	1.	2.	3.	4.	5.
1. CSA: Frequency	-	.93***	.87***	.21*	.23**
2. CSA: Act perpetrated	.92***	-	.88**	.22*	.24**
3. CSA: Relation with the perpetrator	.92***	.89***	-	.25**	.25**
4. Sexual compulsivity	.14**	.15**	.12**	-	.14
5. Extradyadic involvement	.17***	.16***	.20***	.21***	-

Note. Correlations for women (N ranged between 498 and 521) are presented below the diagonal, and correlations for men (N ranged between 134 and 148) are presented above the diagonal.
CSA = childhood sexual abuse.
* p < .05. ** p < .01. *** p < .001

Table 5. Descriptive statistics of sexual compulsivity and extradyadic involvement among CSA and non-CSA survivors for women and men.

	Women		Men	
	No-CSA	CSA	No-CSA	CSA
Variables	*n* = 402-417	*n* = 97-104	*n* = 109-120	*n* = 26-28
Sexual compulsivity	14.05 (4.36)	15.78 (5.77)	17.40 (5.46)	21.15 (7.15)
Extradyadic involvement	14.9%	31.7%	25.8%	57.1%

Note. Means and standard deviations in parenthesis for sexual compulsivity.
CSA = childhood sexual abuse.

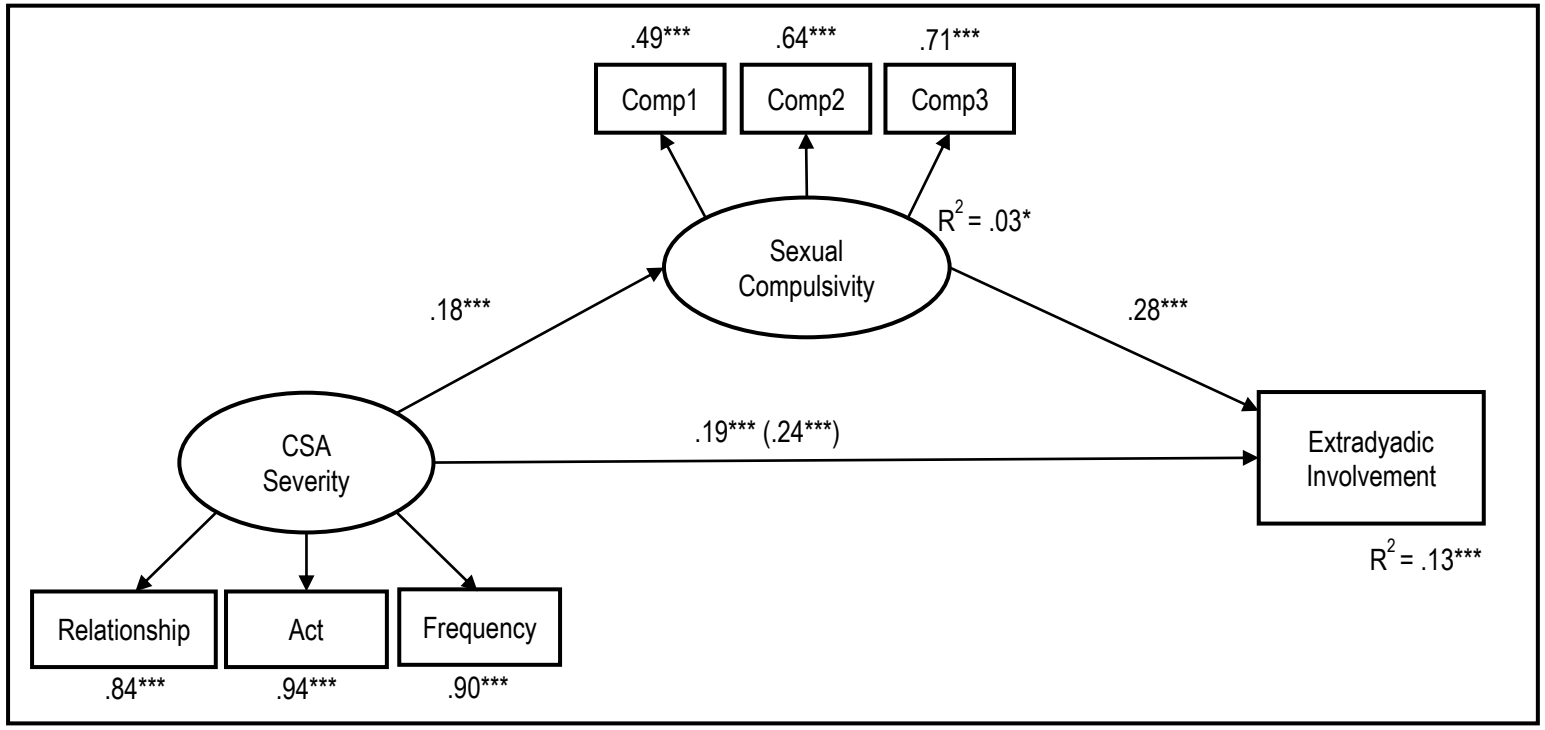

Figure 3. Structural equation modeling of sexual compulsivity as a mediator of the association between CSA severity and extradyadic involvement in the overall sample.

Note. The coefficient in parentheses indicates the association between CSA severity and extradyadic involvement before the inclusion of the mediator, sexual compulsivity.

* $p < .05$. *** $p < .001$.

Chapitre IV : Adult sexual outcomes of child sexual abuse vary according to relationship status (Article 3)

Publié en janvier 2016 dans le Journal of Marital and Family Therapy, DOI: 10.1111/jmft.12154

Adult sexual outcomes of child sexual abuse vary according to relationship status

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Marie-Pier Vaillancourt-Morel was supported by doctoral fellowships from the Social Sciences and Humanities Research Council (SSHRC). Natacha Godbout was supported by a research scholar grants from the Fonds de recherche du Québec – Santé (FRQ-S).

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Résumé

L'objectif de cette étude est d'examiner la valeur d'un modèle de modération spécifiant que les associations entre la sévérité de l'agression sexuelle à l'enfance (ASE) et les répercussions sexuelles (c.-à-d., évitement et compulsion sexuelle) diffèrent en fonction du statut relationnel. Un échantillon de 1033 adultes a répondu à des questionnaires auto-administrés en ligne. Les résultats d'analyses acheminatoires indiquent que les survivants célibataires sont plus susceptibles de rapporter de la compulsion sexuelle, les survivants cohabitant, une combinaison d'évitement et de compulsion sexuelle, et les survivants mariés, de l'évitement sexuel. Ce modèle est invariant selon le genre et tient même lorsque l'âge et la durée de la relation sont contrôlés. Ces résultats suggèrent que l'évitement sexuel et la compulsion sexuelle associés à la sévérité de l'ASE varient selon le statut relationnel.

Mots clés : agression sexuelle à l'enfance; comportements sexuels; statut relationnel; compulsivité sexuelle; évitement sexuel

Abstract

This study tested a moderation model in which the association between child sexual abuse severity and negative sexual outcomes (i.e., sexual avoidance and compulsivity) differed as a function of relationships status (i.e., single, cohabiting, and married individuals). A sample of 1,033 adults completed self-report questionnaires online, and 21.5% reported childhood sexual abuse. Path analyses indicated that child sexual abuse severity was associated with higher sexual compulsivity in single individuals, both higher sexual avoidance and compulsivity in cohabiting individuals, and higher sexual avoidance in married individuals. The moderation model was invariant across men and women. These results suggest that the time course of negative sexual outcomes associated with child sexual abuse may follow distinct patterns of expression according to relationship status.

Keywords: Childhood sexual abuse; sexual behaviors; relationship status; sexual compulsivity, sexual avoidance

Introduction

Couple and family therapy guidelines and manuals generally pay relatively little attention to past child sexual abuse in their adult patients and, on those occasions when it is discussed, tend to consider it a specialty practice issue (Gurman, Lebow, & Snyder, 2015). Yet, recent studies show significant rates of childhood sexual abuse in clinically treated couples, especially when sexual difficulties are present (Berthelot, Godbout, Hébert, Goulet, & Bergeron, 2014). These findings suggest a need to better understand the repercussions of child sexual abuse on couple outcomes, including sexual problems, and support the routine implementation of empirically based assessment of past child sexual abuse in couple and family therapy. This is important not only because of the prevalence of the phenomenon, but also given recent research indicating that sexual abuse may partially explain the interplay of couple issues and may contribute to some of the difficult-to-treat sexual avoidance or compulsive problems found in some partners presenting for treatment (Vaillancourt-Morel et al., 2015). The objective of this study was to determine whether the specific nature of childhood sexual abuse-related sexual symptoms, as they are experienced in adulthood, can partly be explained by relationship commitment processes.

Child Sexual Abuse and Adult Sexual Outcomes

A growing empirical literature suggests that childhood sexual abuse can result in a range of long-term adverse sexual outcomes (Rellini, 2014). These sexual reactions have been reported in prospective studies of a variety of different populations, including survivors of child maltreatment with substantiated official records (Wilson & Widom, 2008), community samples of adolescents (Jones et al., 2013), and gay, bisexual, or heterosexual adults (Icard, Jemmott, Teitelman, O'Leary, & Heeren, 2014). They also have been assessed through retrospective self-reports in representative international samples (Plant, Plant, & Miller, 2005) and in diverse clinical groups of persons suffering from sexual dysfunctions (Randolph & Reddy, 2006) or attending health centers for sexually transmitted diseases (Senn & Carey, 2010).

An examination of these studies reveals that sexual reactions to childhood sexual abuse are highly variable: notably absent in a significant portion of survivors (Hullfish et al., 2009), and, in others, ranging from sexual inhibition, sexual avoidance or aversion, low desire, and vaginal or pelvic pain (McCallum, Peterson, & Mueller, 2012), to sexual disinhibition, compulsive or impulsive sex, risk-taking sexual behaviors, and numerous sequential or simultaneous sexual partners (Wilson & Widom, 2008). As shown in a recent literature review (Aaron, 2012), this variability in negative sexual outcomes is well represented by a compulsive-avoidance continuum. Studies show that compulsive and avoidant sexual behaviors may coexist in survivors of child sexual abuse (Noll, Trickett, & Putnam, 2003; Vaillancourt-Morel et al., 2015), and that more severe

abuse experiences tend to lead to more negative sexual outcomes (Randolph & Reddy, 2006; Trickett, Noll, & Putnam, 2011).

Survivors' negative sexual outcomes might be explained through the convergence of traumagenic dynamics (i.e., early sexualization, betrayal, stigmatization, and powerlessness; Finkelhor & Browne, 1985), self-capacity disturbances (i.e., alterations in interpersonal relatedness, identity, and affect regulation; Briere & Scott, 2014), and unresolved intrapersonal issues (i.e., mentalization deficits, disorganized attachment; Kwako, Noll, Putnam, & Trickett, 2010). However, as Rellini (2014) observed, this juxtaposition of factors do not fully explain why sexual reactions to sexual abuse are highly variable. Indeed, we know little about why some survivors respond with compulsive sexual problems while others develop avoidance symptoms (Aaron, 2012). Most studies have focused either on inhibited or disinhibited sexual responses to child sexual abuse, but not both. When examined concurrently, sexual avoidance and compulsivity are associated with child sexual abuse, but with small effects or high variability among survivors (Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Noll et al., 2003; Vaillancourt-Morel et al., 2015). Interestingly, clinical case observations suggest that, over time, sexual outcomes may evolve from no noticeable effects, to compulsivity, and then progress to systematic avoidance (Jacob & Veach, 2005). This hypothesis, although congruent with clinical experience, has not been evaluated empirically.

Variability in Adult Sexual Outcomes of Child Sexual Abuse as Explained by Relationship Status

We propose that adult sexual outcomes of child sexual abuse may be partly explained by relational commitment, which is represented by relationship status. We hypothesized that a higher commitment to a steady partner (i.e., in married individuals) may interact with traumagenic processes, self-capacity disturbances, and unresolved intrapersonal issues to engender sexual avoidance responses that are not as readily apparent in noncommitted survivors (Briere & Scott, 2014; Finkelhor & Browne, 1985; Kwako et al., 2010). In contrast, when commitment is lower (i.e., in single individuals), child sexual abuse might be more likely to lead to sexual compulsivity, based on its sexualization effects. In the intermediate situation (i.e., in cohabiting individuals), sexual abuse would be associated with both compulsivity and avoidance.

Clinical case observations support this proposition and suggest that sexual compulsivity may predominate in single individuals, or in the very early stages of relationships (Jacob & Veach, 2005; Rellini, 2014). In such cases, childhood sexual abuse survivors may use sexual behaviors as a way to pursue relationships, achieve proximity, maintain self-worth, reduce emotional distress, and assuage abandonment anxieties. In low-commitment situations, early and intense sexual responses, need for approval and closeness, and/or the

desire to distract from triggered emotional distress may override sexual safety barriers, intimacy fears, or sexual ambivalence and result in higher sexual compulsivity.

In contrast, as commitment intensifies, the development of intimacy may increase feelings of vulnerability, which can trigger unresolved past traumatic issues and feelings associated with having been violated by sexual abuse. As a result, the survivor may increasingly avoid sexual stimuli in the relationship in order to reduce the chances of being triggered and may, in fact, become increasingly dissociated in response to reactivated abuse-related trauma, leading to decreased desire or relational disconnection. As well, there may be a more cognitive component, in which the survivor has learned to use sex as a way to form relationships and gain approval -- strategic behavior that, especially for the increasingly triggered survivor, may no longer appear relevant once a committed relationship has occurred.

Sexual preoccupation and avoidance have sometimes been assumed to fall along gender lines. Specifically, it is assumed that male sexual abuse survivors tend to experience more sexual compulsivity than female survivors, whereas female survivors report more sexual avoidance than male survivors (Aaron, 2012). Yet empirical support for these conclusions is, at best, incomplete (Vaillancourt-Morel et al., 2015). As a result, it is important that studies of the effects of relational status on sexual avoidance versus compulsivity be examined for both men and women.

To our knowledge, the moderating role of relationship status in the association between child sexual abuse and adult sexual outcomes has been assessed on only one occasion (Randolph & Reddy, 2006). Other studies have focused primarily on a specific relationship type (e.g., newlywed couples; DiLillo et al., 2009) or have combined participants regardless of their relationship status (Najman et al., 2005). In other cases, although the sexual outcomes of child sexual abuse have been examined while controlling for marital or cohabitation status (Noll et al., 2003) or relationship duration (Vaillancourt-Morel et al., 2015), these studies did not examine the possible interaction between abuse and relationship status. In the only relevant study, Randolph and Reddy (2006) examined sexual functioning according to child sexual abuse history in 63 women suffering from chronic pelvic pain. Controlling for age and relationship status, child sexual abuse was associated with lower rates of sexual activity, less satisfaction with orgasms and lower feelings of closeness with their sexual partner. However, the interaction effect between child sexual abuse and relationship status did not predict sexual functioning. Despite its attention to relationship status, this study overlooked sexual compulsivity. Moreover, the combination of cohabiting and married women into a single group may have obscured potential differences in commitment levels between these two categories of participants. As well, Randolph and Reddy limited their study to women, thereby constraining the generalizability of their findings.

The Current Study

This study was based on the clinical hypothesis that, in adult survivors of child sexual abuse, symptoms of sexual disturbances would differ as a function of survivors' level of relationship commitment. This hypothesis was examined using path analysis to test a moderation model in which the association between child sexual abuse severity and negative sexual outcomes (i.e., sexual avoidance and compulsivity) differs across relationships status. More specifically, we hypothesized that child sexual abuse severity would be associated with higher sexual compulsivity in single individuals, as opposed to both higher sexual avoidance and compulsivity in cohabiting individuals, and higher sexual avoidance in married individuals. The second goal of the study was to examine whether this model fit well for both women and men (i.e., gender-invariance). Finally, to avoid confounds between current age, length of present relationship, and relationship status, our third aim was to verify if the final moderation model held after controlling for participants' age and length of relationship.

Method

Procedure

Adults participants were recruited from French-speaking Canadians from the general population and university students through various methods: messages on social networks such as Facebook and Twitter (using a page specifically created for this "Study on the determinants of sexuality in adulthood"), emails sent using university electronic lists, and posters at various locations (e.g., stores, service centers, coffee shops, nonprofit community organizations, and support centers for victims of sexual assault). Individuals were invited on a voluntary basis to participate in a 45-min online survey assessing the determinants of sexuality in adulthood. Interested participants accessed a hyperlink which led them to Lime Survey, a secured website holding the online anonymous survey. All participants electronically signed a consent form, and then completed the survey, after which the data were automatically stored in a secure and private database. No compensation was offered for participating in the study. The Laval University Institutional Review Board evaluated this study concluded that it carried a "greater than minimal risk" and approved it after a full board review.

Participants

Of the 1,475 voluntary French-speaking Canadians who began the survey, 1,033 (70.0%) completed the question on child sexual abuse history and were included in this study. Of these, 73.6% (n = 760) were women and 26.4% (n = 273) were men. Participants' mean age was 27.05 years (SD = 8.85, ranging from 18 to 77 years). A total of 9.5% (n = 98) were married, 33.7% (n = 348) were in a nonmarital cohabiting relationship, and 56.8% (n = 587) were single (323 single, 2 widowed, 23 divorced/separated, 239 dating). For participants who were either dating, married, or cohabiting, the length of time in the current relationship averaged 5.29 years (SD = 6.93). Most participants identified themselves as heterosexual (84.4%, n = 872), 4.6% (n = 48)

reported being homosexual, and 8.4% (*n* = 87) reported being bisexual. The majority of participants were students (63.2%, *n* = 652) and a third were employed full- or part-time (34.0%, *n* = 351). Among participants, 33.9% (*n* = 350) earned less than Can$10,000; 32.5% (*n* = 336) earned between Can$10,000 and Can$29,999; 16.6% (*n* = 171) earned between Can$30,000 and Can$49,999; and 16.1% (*n* = 166) earned Can$50,000 or more. For international comparison, in Canada, the low income threshold for one person is Can$22,720 and the 2014 average exchange rate from U.S. dollars to Canadian currency was 1.10 (Statistics Canada, 2014). The majority of participants had some college or university level education (91.9%, *n* = 949).

Measures

Four variables were analyzed in this study: (a) relationship status, (b) child sexual abuse severity, (c) sexual compulsivity, and (d) sexual avoidance.

Relationship status. Relationship status is frequently used as a proxy variable to measure a hierarchy of commitment levels. Traditional classification systems generally refer to legal status, such as being single, in a common-law or cohabitating union, or in a marital relationship (Stanley, Rhoades, & Whitton, 2010). Using relationship status to assess commitment, marriage is placed at the top of the commitment hierarchy to indicate that the economic, legal, religious, sexual, and social norms governing married people's behavior are stronger than those regulating the relationship of cohabiting or single individuals. Marriage also represents a public long-term commitment, whereas cohabitation is by nature more informal, private, easier to break, or based on decision-making processes that require less commitment (Stanley et al., 2010; Van der Lippe, Voorpostel, & Hewitt, 2014). In this commitment hierarchy, common-law unions may represent an intermediate position between marriage and singlehood. Finally, singlehood is placed at the bottom of the commitment hierarchy to reflect low or no commitment to a steady partner. Despite variations in definitions, singlehood is usually thought to include all individuals not presently in a formal couple relationship, (i.e., single, separated, divorced, or widowed, and dating). Indeed, dating is a noncohabiting form of romantic involvement that is not bound by the legal rights and obligations attached to cohabitation or marriage, and where values regarding sexual exclusivity may be ambiguous and mirror a low level of commitment (Stanley et al., 2010).

In the present study, relationship status was assessed using a sociodemographic questionnaire that included personal and relationship information (e.g., gender, age, relationship status, length of relationship, occupation, sexual orientation, income, and education). Participants who reported themselves to be "married" were coded *married* (1), participants who endorsed "cohabiting with their partner" but not being married were coded *cohabiting* (2), and participants who reported "dating", "single", "widowed", "separated", "divorced" were coded *single* (3).

Child sexual abuse severity. To assess severity of child sexual abuse, a 10-item measure, based on past questionnaires proposed by Finkelhor (1979) and Fromuth and Burkhart (1989), was developed. A child sexual abuse history was defined as any sexual act (i.e., noncontact, touching, oral, anal or vaginal penetration) between a child under 16 years of age and a person 5 or more years older, or in a position of authority, with or without the presence of physical force or violence, and with or without the "consent" of the child. The first item evaluated if, before 16 years old, participants had any sexual experience with one (or more) individuals at least 5 years older or in a position of authority. To categorize potential abusers, 12 choices were presented: natural or adoptive mother, natural or adoptive father, stepmother, stepfather, grandmother, grandfather, sister, brother, other family member, family friend or an acquaintance at least five years older, teacher/babysitter/instructor, or stranger at least 5 years older than the respondent. Participants who responded negatively to all of those choices were coded as nonvictims. Those who responded affirmatively to one of those 12 items were classified as having experienced child sexual abuse. Those two categories were used to compare nonvictims vs. survivors of child sexual abuse in the descriptive analyses.

Based on previous empirical findings (e.g., Berthelot et al., 2014; Godbout, Sabourin, & Lussier, 2009; Vaillancourt-Morel et al., 2015; Watson & Halford, 2010), a severity composite index was then constructed by summing the coding of three separate indices: the frequency of abuse, the intrusiveness of the act perpetrated, and the relationship with the perpetrator, resulting in a scale ranging from zero to 11 where a high score indicated greater CSA severity. Child sexual abuse frequency represented the number of times the abuse occurred and was coded from zero (nonvictim), one (one time), two (two to five times), to three (more than five times). The act perpetrated was coded according to the intrusiveness of sexual abuse and varied from zero (nonvictim), one (without direct contact, i.e., voyeurism or exposure), two (sexual touching), three (oral contact), to four (anal or vaginal penetration). Relationship with the abuser was coded according to the closeness to the abuser and varied from zero (nonvictim), one (stranger), two (known person), three (family member), to four (parental figure). For participants reporting multiple sexually abusive episodes, the most intrusive incident was coded. In the present sample, the correlations between these three severity components ranged between .87 to .91, with a total child sexual abuse severity scale alpha coefficient of .86.

Sexual compulsivity. Sexual compulsivity was measured using a French version of the Sexual Compulsivity Scale (Kalichman et al., 1994). This 10-item measure assesses participants' obsessive preoccupation with sexuality, their inability to manage their sexual thoughts and/or behaviors, and the consequent effects on daily functioning. Sample items include "My sexual thoughts and behaviors are causing problems in my life" and "I have to struggle to control my sexual thoughts". This scale is rated on a four-point Likert scale ranging from one (*not at all like me*) to four (*very much like me*). The global score ranges from 10 to 40 and is computed by summing the items. A high score indicates high levels of sexual compulsivity. The structural validity of this total

score was confirmed in recent exploratory and confirmatory factor analyses, indicating a good fit for a one-factor solution, with significant paths from the latent factor to each item ranging from .60 to .77 (Vaillancourt-Morel et al., 2015). The scale has demonstrated satisfactory internal consistency (e.g., Cronbach's alpha ranging between .87 and .92; Kalichman & Rompa, 2001) and temporal stability over a 3-month interval (r = .80; Kalichman & Rompa, 1995). In the present study, the alpha coefficient of this scale was .86.

Sexual avoidance. Sexual avoidance was measured with a French version of the sexual avoidance subscale (Katz, Gipson, & Turner, 1992) of the Sexual Aversion Scale (Katz, Gipson, Kearl, & Kriskovich, 1989). This 10-item subscale assesses a general tendency to avoid sexual situations and sexual interactions with a sexual partner. Sample items include "I am afraid to engage in sexual intercourse with another person" and "I try to avoid situations where I might get involved sexually". This subscale is rated on a four-point Likert-type scale ranging from one (*not at all like me*) to four (*very much like me*). Items are summed to obtain a total score ranging from 10 to 40, where a high score corresponds to a greater tendency to avoid sexual contact. The structural validity of this total score was confirmed in recent exploratory and confirmatory factor analyses, indicating a good fit for a one-factor solution, with significant coefficients from the latent factor to each item ranging from .59 to .83 (Vaillancourt-Morel et al., 2015). This subscale also demonstrated good internal consistency (e.g., Cronbach's alpha of .87; La Rocque & Cioe, 2011) and good temporal stability over a 1-month period (r = .90; Katz et al., 1989). In the current study, Cronbach's alpha for the sexual avoidance subscale was .85.

Statistical Analyses

Descriptive statistics were computed using SPSS 20, and path analyses were conducted using M*plus*, version 7.3 (Muthén & Muthén, 1998-2012). Frequencies, *t*-tests, ANOVA's, chi-square tests and correlations between study variables were computed to examine rates and severity of child sexual abuse and to describe associations between study variables. The hypotheses were tested using path analyses, with child sexual abuse severity as the predictor, gender and relationship status as moderators, participants' age and length of relationship as control variables, and sexual avoidance and compulsivity as outcome variables. The covariance between sexual avoidance and compulsivity was estimated given their association observed in previous studies (Noll et al., 2003; Vaillancourt-Morel et al., 2015). Because studied variables are naturally nonnormally distributed, the M*plus* option (i.e., MLR), allowing for maximum likelihood parameter estimation with standard errors and chi-square test statistic that are robust to nonnormality, was used in all analyses (Muthén & Muthén, 1998-2012). Missing data were treated using the pairwise method and 65 participants were not included in path analyses because of missing values on both sexual outcome variables.

Path analysis. Path analysis is an efficient way to test complex moderated relationships among different variables that may be correlated. Path analysis simultaneously estimates the strength and significance of associations between the variables, and assesses the overall model fit. The empirical covariance matrix is compared to the one expected from the theoretical model. If they match closely, then the data are said to fit the proposed model (Kline, 2010). Based on Kline's guidelines, we employed several fit indices: the comparative fit index (CFI), the root mean square error of approximation (RMSEA), the standardized root mean square residual (SRMR), and the ratio of chi-square to degrees of freedom (X^2/df). Indicators of good fit are a CFI value of .90 or higher, a RMSEA and a SRMR values below .05 and a ratio of chi-square to degrees of freedom less than three (Kline, 2010).

Moderation analysis. In path analysis, moderation effects are tested using intergroups invariance tests. A significant chi-square difference indicates that the structural paths differ across levels of a moderator (Edwards & Lambert, 2007). This inter-group path analysis approach is consistent with MacKinnon, Fairchild, and Fritz (2007) description of moderation and is recommended for categorical moderator variables (Rigdon, Schumacker, & Wothke, 1998).

Moderator effect of relationship status. To determine if the associations between child sexual abuse severity, sexual compulsivity, and sexual avoidance differed according to relationship status, we used inter-group moderated path analyses. Specifically, we compared a model in which all paths were freely estimated in the three groups (i.e., married, cohabiting, or single individuals) to a model in which the structural paths leading from the predictor variable (i.e., child sexual abuse severity) to the two sexual outcomes were constrained to be equal. Three pairwise comparisons, using chi-square tests, were conducted to examine if the model was invariant among the groups: married vs. cohabiting, married vs. single, and cohabiting vs. single individuals. A significant chi-square value indicates significant differences between the groups.

Adding the moderator effect of gender. We used inter-group moderated path analyses to assess gender invariance in the most parsimonious relationship status moderation model. In this approach, a saturated model, allowing all paths to be estimated freely between men and women, was compared to a model in which paths leading from child sexual abuse severity to sexual outcomes were constrained to be equal across gender. A significant chi-square value indicates significant differences between men and women.

Controlling for participants' age and length of relationship. Because age of the participants and length of present relationship could affect the generalizability and strength of the associations between child sexual abuse and sexual behaviors, participant's age and length of relationship were added as control variables in the final model. Satisfactory fit indices would indicate that the model holds when controlling for age and length of relationship.

Results

Descriptive Analyses

Child sexual abuse prevalence across gender and relationship status. In the present sample, 21.5% (n = 222) of participants reported a history of child sexual abuse. As reported in Table 1, the prevalence rates did not vary as a function of gender or relationship status.

Characteristics of child sexual abuse and severity reported in the survivor subsample. In the survivor subsample, the mean child sexual abuse severity score was 7.16 (SD = 1.60). Child sexual abuse frequency ranged from a single episode (23.9%, n = 53), two to five experiences (43.2%, n = 96), to more than five incidents (29.7%, n = 66). A majority of survivors (68. 9%, n = 153) reported being abused by a family member who was not a parental figure, while 9.9% (n = 22) reported abuse by a parental figure, 12.2% (n = 27) by a nonfamily member who was known by the survivor, and 9.0% (n = 20) by a stranger. Finally, 55.9% of survivors indicated that the most severe abuse was limited to sexual touching or sexual fondling (n = 124), whereas 9.9% (n = 22) reported no physical contact, 14.4% (n = 32) reported oral sex, and 18.0% (n = 40) reported vaginal or anal penetration. As reported in Table 1, mean child sexual abuse severity scores did not differ according to gender or relationship status.

Sexual compulsivity and sexual avoidance among sexual abuse survivors and nonabused participants, according to gender. Means and standard deviations for sexual compulsivity and sexual avoidance as a function of child sexual abuse history and gender are reported in Table 2. Compared to nonvictims, child sexual abuse survivors reported more sexual compulsivity, $t(965) = 4.66$, $p < .001$, $\eta^2 = .028$), and more sexual avoidance, $t(966) = 2.48$, $p = .014$, $\eta^2 = .008$. Women survivors reported more sexual compulsivity and sexual avoidance than nonabused women (compulsivity: $t[722] = 3.62$, $p < .001$, $\eta^2 = .023$; avoidance: $t[723] = 2.16$, $p = .032$, $\eta^2 = .009$). Men survivors reported more sexual compulsivity than men that were not abused (compulsivity: $t[241] = 3.41$, $p = .001$, $\eta^2 = .046$; avoidance: $t[241] = 1.25$, $p = .212$, $\eta^2 = .006$).

Sexual compulsivity and sexual avoidance among sexual abuse survivors and nonabused participants, according to relationship status. We examined sexual outcomes according to child sexual abuse history in the three relationship status groups (see Table 2). Consistent with expectations, results indicated that single and cohabiting survivors reported more sexual compulsivity than their nonabused counterparts (single: $t[539] = 3.89$, $p < .001$, $\eta^2 = .027$; cohabiting: $t[330] = 3.32$, $p = .001$, $\eta^2 = .054$; married: $t[92] = -0.31$, $p = .758$, $\eta^2 = .001$). Inversely, married and cohabiting survivors indicated more sexual avoidance than nonabused individuals (single: $t[539] = 0.92$, $p = .360$, $\eta^2 = .024$; cohabiting: $t[331] = 2.01$, $p = .048$, $\eta^2 = .024$; married: $t[92] = 2.00$, $p = .048$, $\eta^2 = .042$).

Correlations between child sexual abuse severity, sexual compulsivity, and sexual avoidance. Pearson's correlations between variables in the path analysis model, according to gender and relationship status, were computed. Child sexual abuse severity was significantly associated with sexual compulsivity in both women ($r = .15$, $p < .001$) and men ($r = .21$, $p = .001$) as well as in single ($r = .17$, $p < .001$) and cohabiting individuals ($r = .21$, $p < .001$). Child sexual abuse severity was also correlated with sexual avoidance in women ($r = .07$, $p = .046$), as well as in married ($r = .24$, $p = .24$), and cohabiting ($r = .14$, $p = .013$), individuals. The correlation between sexual compulsivity and sexual avoidance was significant for both women ($r = .11$, $p = .003$) and men ($r = .19$, $p = .003$) as well as for single participants ($r = .12$, $p = .004$).

Path Analysis of Child Sexual Abuse Severity, Sexual Compulsivity and Sexual Avoidance

Using the full sample, without gender or relationship subgroups, results of path analysis indicated that child sexual abuse severity was positively associated with sexual compulsivity ($\beta = .16$, $p < .001$) and sexual avoidance ($\beta = .08$, $p = .019$). The covariance between these sexual behaviors was significant, ($\beta = .12$, $p = .001$), indicating that sexual avoidance and sexual compulsion are positively associated.

Moderator effect of relationship status. The comparison of the model in which all paths were freely estimated for married, cohabiting, or single individuals to the model in which equality constraints were placed on all structural paths for these three groups yielded a significant chi-square difference, $\chi^2_{diff}(4) = 9.94$, $p = .041$, indicating that child sexual abuse severity differentially predicts sexual compulsivity and avoidance within the three groups (i.e., married, cohabiting, and single individuals; see Figure 1). Results show that, in single individuals, sexual abuse severity was related solely to higher sexual compulsivity. In cohabiting individuals, sexual abuse severity was related to both higher sexual avoidance and compulsivity. In married individuals, sexual abuse severity was associated with sexual avoidance only. Finally, the covariance between sexual compulsivity and avoidance was significant only in single individuals.

Results of the pairwise model comparisons revealed that married individuals significantly differed from cohabiting (χ^2_{diff} [2] = 6.13, $p = .047$) and single individuals, χ^2_{diff} (2) = 8.69 $p = .013$, in relation to sexual compulsivity and avoidance. However, the difference between cohabiting and single participants was nonsignificant, χ^2_{diff} (2) = 2.15, $p = .342$. Therefore, cohabiting and single individuals were combined into a single group, and compared to married participants. The difference between these two groups was significant, χ^2_{diff} (2) = 8.37, $p = .015$. Specifically, sexual abuse severity predicted sexual avoidance only in married participants while sexual abuse severity significantly predicted sexual compulsivity only in unmarried participants (see Figure 2). The moderation models were re-estimated excluding widowed, separated, and

divorced participants (n = 25). Results yielded no meaningful difference in the significance or strength of the coefficients, nor in the fit characteristics of the model.

Adding the moderator effect of gender. The comparison of the model in which all paths were freely estimated between four groups (i.e., married women, married men, unmarried women, unmarried men), to the model in which paths from sexual abuse severity to sexual outcomes were constrained to be equal across men and women, produced a nonsignificant chi-square difference, χ_{diff}^2 (4) = 3.66, p = .455. Thus, the moderation model indicating differences in the sexual outcomes of sexual abuse severity among married versus unmarried participants, held for both women and men. This final model, testing both relationship status and gender invariance, proved satisfactory, $\chi^2(4) = 3.66$, p = .455; RMSEA = .00, 90% CI (.00 to .09); CFI = 1.00; SRMR = .03; $\chi^2/df = 0.92$.

Respecifying child sexual abuse severity. As indicated in the Method section, the act perpetrated was coded on five point scale, where 0 = no child sexual abuse, 1 = voyeurism or exposure, 2 = touching, 3 = oral contact, and 4 = anal or vaginal penetration. Although this hierarchy was created based on the existing literature, the relative severity of various sexually abusive acts remains unresolved (Negriff, Schneiderman, Smith, Schreyer, & Trickett, 2014). Specifically, it was possible that oral contact or penetration might be of equal severity to vaginal or anal penetration in some cases. In order to evaluate this possibility, the model was re-estimated using a revised four-point act perpetrated scale where oral contact or penetration was coded at the highest level of severity, along with vaginal and anal penetration. This change in the severity scale made no meaningful difference in the significance, strength, or pattern of the model coefficients, nor in the fit characteristics of the resultant model, $\chi^2(4) = 3.72$, p = .446; RMSEA = .00, 90% CI (.00 to .09); CFI = 1.00; SRMR = .03; $\chi^2/df = 0.93$. As a result, the original model, in which oral contact was coded as less severe than vaginal or anal penetration, was retained.

Controlling for participant age and length of relationship. Because participants' current age and length of relationship were multicolinear in the present analysis (r = .75), these two variables were introduced separately as covariates in the final model. Adding participants' current age or length of relationship as a covariate in the final model did not change the significance or strength of the association between variables and resulted in satisfactory fit indices for both models; age: $\chi^2(4) = 3.95$, p = .412; RMSEA < .01, 90% CI (.00 to .10); CFI = 1.00; SRMR = .02; $\chi^2/df = 0.99$; length of relationship: $\chi^2(4) = 3.45$, p = .485; RMSEA < .01, 90% CI (.00 to .11); CFI = 1.00; SRMR = .03; $\chi^2/df = 0.86$. These additional analyses confirmed that the model held independently of participants' age and length of the relationship.

Discussion

The results of the present study are consistent with a life-course perspective, whereby some child sexual abuse repercussions become more clearly observable in reaction to circumstances, events, and norms associated with the romantic partner role (Rellini, 2014). More specifically, results indicated that child sexual abuse survivors who have attained a relationship status consistent with high formal commitments (i.e., marriage) are more likely to report sexual avoidance. In comparison, single survivors are more likely to evidence sexual compulsivity, whereas cohabiting survivors report a mixture of sexual avoidance and compulsivity. Thus, the present findings suggest that sexual abuse-related sexual avoidance and sexual compulsivity may follow distinct patterns of expression according to relationship status. To our knowledge, this is the only study simultaneously comparing both inhibited and disinhibited sexual symptoms in adult child sexual abuse survivors, using the whole spectrum of the relationship status construct.

Theoretical and Clinical Implications

This complex moderator effect may have different interpretations. Although sexual compulsivity can be observed in adult survivors of child sexual abuse who are not seriously committed in an intimate relationship, the present study suggests that sexual avoidance may replace compulsivity for those who are married or cohabiting long-term, potentially due to internal and external dynamics that inhibit psychosexual intimacy. Before being involved in a couple relationship, or during its early phases, the child sexual abuse survivor may repeatedly engage in sexual behaviors to bypass intimacy difficulties, downregulate distress, or to reduce abandonment anxieties. After a “honeymoon” period, idealization often fades (Murray, Holmes, & Griffin, 1996), after which the survivor may be repeatedly confronted with his or her own and his or her partner’s challenges and shortcomings in the context of the daily hassles and stressful events common to cohabiting and marital relationships (Kim, Noh, & Park, 2015). Over time, these challenges may trigger or interact with traumagenic processes, self-capacity disturbance, and unresolved intrapersonal issues associated with child sexual abuse. This convergence of sexual and relationship challenges may, in turn, trigger dysregulated, abuse-related feelings of pain, rage, betrayal, shame or powerlessness (Briere, 1996). This may also be associated with the collapse of dissociative coping strategies designed to split intimacy and sexual issues. Moreover, in some less healthy relationships, survivors have to deal with pathogenic couple processes (i.e., domestic violence or emotional abuse) that may trigger stronger negative reactions associated with past child sexual abuse. Thus, sexual relations may become intermingled with past violations of trust and increasingly prevalent intimacy issues, lessening the compulsive use of sexuality as a coping mechanism, potentially changing the meaning of sexual activities, and ultimately inhibiting sexual responses toward the partner. When faced with such circumstances, dating or cohabiting survivors are able to opt out of the relationship more easily, whereas the constraining social contract embedded in marriage as a public, long-term, and exclusive

commitment may exert a stronger pressure on the survivor to remain in the relationship, but engage in sexual avoidance.

Alternatively, or in addition, the causal pathway may be from sexual avoidance or sexual compulsivity to relationship status. Survivors who are sexually avoidant may engage in stable relationships characterized by commitment and intimacy in which the partner tolerates a low level of sexuality. Individuals who were sexually abused and who suffer from sexual compulsivity may self-select out of marriage and prefer the more informal, unstable, and less emotionally intimate option of serial dating or cohabitation. Nonmarried cohabiting relationships are a contemporary trend in union formation processes (Reimondos, Evans, & Gray, 2011) that may be more appealing to some sexual abuse survivors who, over the short run, feel more secure or protected in relationships that can be ended readily. They may also elect to remain single in order to avoid abuse-related anxieties about intimacy or potential abandonment that can arise in committed relationships. This hypothesis is supported by a study of shorter-term relationships in child sexual abuse survivors relative to nonsurvivors (Cherlin, Burton, Hurt, & Purvin, 2004). They found that cohabiting survivors appear to occupy an intermediary position along the inhibited/disinhibited sexual symptoms continuum, such that sexual abuse severity was associated with both sexual avoidance and sexual compulsivity. However, pairwise comparisons indicated that the relations between child sexual abuse severity and sexual outcomes for cohabiting individuals were more similar to single participants than married individuals. If replicated, these findings would be compatible with a hierarchy of commitment hypothesis, suggesting that the specific nature of sexual outcomes in child sexual abuse survivors may be a partial by-product of marital status, or that remaining single may be, in part, an abuse outcome for child sexual abuse survivors.

The finding that sexual outcomes of child sexual abuse vary according to relationship status, potentially as a function of intimacy issues, has relevance for clinicians working with sexually distressed individuals within couple relationships. The results highlight the need for systematic assessment of both partners' sexual abuse history – and its severity – in face-to-face interviews, detailed questionnaires, or, preferably, using both. Unfortunately, some couple therapists are reluctant to directly assess past abuse when it is not spontaneously disclosed by the couple. Although it is possible that some patients will feel re-traumatized when narrating these aspects of their life-story, the available research suggests that, at least in research contexts, reporting past abuses is not associated with negative outcomes (Jaffe, DiLillo, Hoffman, Haikalis, & Dykstra, 2015). In contrast, failing to ask about a history of sexual victimization may inadvertently reinforce negative abuse-related internalizations, for example the injunction not to break secrecy, the conviction that adults and professionals are not to be trusted, etc. In this regard, there may be potential reparative experiences associated with discussion of past abuse.

Some therapists also may not ask about sexual abuse history based on unease regarding mandatory reporting, especially when the presumed perpetrator still has access to minors. In such circumstances, however, it is ethically incumbent upon the clinician to protect other potential victims, even above and beyond his or her duty to the client. Although this is a complex issue, it is often suggested that clients be informed of the therapist's duty to inform authorities if there is even a possibility of current risk to a child, so that the clinician's duties in this regard do not constitute an unexpected, seeming betrayal (Briere, 1996).

The assessment of child sexual abuse should preferably be initially conducted in individual interviews followed by a couple interview where potential disclosure to the partner can be addressed. It is also important to determine whether past sexual abuse has been disclosed to the partner, and, if the survivor wishes to disclose, what the partner's reactions to this disclosure may involve. Exploration and processing of the emotional issues surrounding the survivor's history, from both the survivor's and partner's perspective, may help to deepen the patients' and therapist's understanding of the potential contributions of abuse to the present sexual difficulties. Systematic assessment of childhood sexual abuse may cause some discomfort, but will typically help explicate ongoing sexual dynamics and potentially reduce the likelihood of therapeutic impasses or failures.

Couple interventions that identify sexual compulsion and avoidance as at least partially sexual abuse-related, and address the traumatic mechanism underlying compulsive and avoidance sexual symptoms, are likely to significantly benefit abuse survivors in couple, as well as individual, treatment. For example, couple interventions that focus on issues involving sexual abuse-related fears of vulnerability and closeness, and the role of sexual activity for both the clients and the relationship, may remediate attachment injuries within the relationship, enhance intimacy and communication, and foster healthier sexuality. Attachment-oriented couple therapy, to the extent it is relevant, may also help the survivor and his or her partner to understand how past sexual abuse has led to easily triggered, inappropriately negative internal models of the partner, and specific maladaptive sexual behaviors based on proximity and intimacy (Gurman et al., 2015). As well, recognition of the antecedents to sexual difficulties that predated the current relationship, such as compulsive sexual behaviors that were initially developed to reduce abuse-related distress, and the habitual use of avoidance to increase relational safety, also may be addressed in concurrent, trauma-focused individual psychotherapy (Briere & Scott, 2014).

Although different interpretations of the relationship status findings are possible, the current findings are statistically robust and generalizable across gender, age, and relationship duration. They support a gender similarity hypothesis, and point to parallel sexual coping mechanisms for men and women child sexual abuse survivors, thereby challenging the clinical assumption that child sexual abuse necessarily results in higher

sexual compulsivity for men and increased sexual avoidance for women (Aaron, 2012). Yet, the debate regarding gender similarity versus gender differences in relational/sexual outcomes of child sexual abuse is still unresolved, and in need of additional research. It is possible that gender similarity applies for the specific sexual outcomes measured in the present study, whereas gender difference may be relevant for other sexual symptoms. Further studies should examine motivations for marriage in sexually abused participants versus nonvictims, including across gender. At minimum, our findings indicate that, for a significant number of survivors, sexual avoidance and compulsivity difficulties following child sexual abuse are more associated with relationship status than gender.

This research also suggests that a hierarchy of commitment hypothesis cannot be explained away by the documented association between age or relationship duration and marital status (Manning, Brown, & Payne, 2014). Because sexual desire and the frequency of sexual behaviors typically decrease with age and relationship duration (Murray & Milhausen, 2012), a competing hypothesis would be that married and cohabiting child sexual abuse survivors report more sexual avoidance because relationship duration is accompanied by a diminution of sexual activities in all couples. This is unlikely to be a major factor, however, since the findings reported here remained robust after controlling for age and relationship duration.

Limitations

Although our results are consistent with contemporary clinical hypotheses, and provide a more complex picture of inhibited and disinhibited sexual responses to child sexual abuse in both men and women, they are limited by several methodological issues. First, although we used path analyses, the cross-sectional nature of this study precludes causal conclusions that can be confirmed only in longitudinal studies. Second, the generalizability of our results may be reduced by the use of a convenience sample, recruited through an online survey, with a high proportion of women and university students. Moreover, differences potentially due to sexual orientation or socioeconomic status, or participants' level of sexual experience before marriage, were not evaluated, and thus we could not further qualify the association between child sexual abuse, relationships, and sexual outcomes. Third, this investigation relied on retrospective self-report measures exclusively, which may introduce typical biases, including underreporting, over-reporting, and recall issues. Computerized questionnaires, neutral inquiry in child sexual abuse assessment, and the use of standardized scales to assess sexual attitudes and behaviors hopefully facilitated the truthful/valid report of sensitive material. Fourth, no validated clinical cut-offs are available for the sexual avoidance and compulsivity scales used in this study, thus associations between CSA and these sexual outcomes should be interpreted with caution so as to not overly "pathologize" the findings reported here. As well, relationship status was used as a proxy variable to assess the commitment level of the relationship in this study, but confounding factors such as sociocultural scripts regarding marital status, religion, or the presence of children also may impact the validity of our results,

as could individual participant differences in the amount of relational commitment actually invested in dating, cohabiting, and marital relationships. Similarly although the present study examined the moderating role of relationship status and gender, as well as controlling for the age of participants and length of relationship, other factors also may contribute to the within- and between-person variability of sexual reactions to child sexual abuse, such as the presence of other types of child abuse or neglect, and quality of childhood attachment. Finally, the amount of variance accounted for in the two sexual outcomes examined here was relatively modest, although not atypical for behavioral sciences research.

Further Study

This research illustrates the need, as emphasized by Dewitte (2014), to include individual and relational variables, in more complex models, to accurately account for the development of sexual distress or disturbance. Future investigations in this area ideally will include longitudinal studies employing large samples of adolescents and emerging adults, following them into older adulthood with multiple measures of sexual symptomatology (including more detailed assessments of sexual compulsivity and avoidance), and self-reports of relational status, commitment, and intimacy. Beyond a few prospective studies (Colman & Widom, 2004; Trickett et al., 2011), conclusions about the adverse sexual outcomes of sexual abuse are drawn from cross-sectional designs, precluding fine-grained analyses that give due consideration to the interplay of evolving child sexual abuse sequelae and sexual dynamics in dating, cohabiting, and marital relationships. Finally, although the current study indicates that relationship status is significantly associated with sexual compulsion and sexual avoidance, it is almost inevitable that alternative explanations and many other factors, mediators, and moderators of negative sexual outcomes in survivors of child sexual abuse are relevant to study in this area.

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Table 6. Child sexual abuse prevalence and severity across gender and relationship status.

	Gender			Relationship status			
Variable	Women	Men	χ^2 or t	Married	Cohabiting	Single	χ^2 or *F*
CSA history % (*n*)	21.4% (163)	21.6% (59)	$\chi^2(1, 1033) < .01$; p = .995; Cramer's V = .002	28.6% (28)	19.5% (68)	21.5% (126)	$\chi^2(2, 1033) = 3.70$, $p = .157$, Cramer's V = .060
CSA severity *M* (*SD*)	7.18 (1.48)	7.10 (1.91)	$t(220) = 0.30$, $p = .765$, $\eta^2 = .001$	7.32 (1.76)	7.21 (1.48)	7.10 (1.69)	$F(2, 219) = 0.25$, $p = .781$, $\eta^2 = .002$

Note. CSA = childhood sexual abuse.

Table 7. Means and standard deviations for sexual compulsivity and sexual avoidance among child sexual abuse survivors and nonabused according to gender and relationship status.

	History of CSA *M (SD)*		Gender				Relationship status					
			Women *M (SD)*		Men *M (SD)*		Married *M (SD)*		Cohabiting *M (SD)*		Single *M (SD)*	
Variable	No-CSA	CSA	No-CSA	CSA	No-CSA	CSA	No-CSA	CSA	No-CSA	CSA	No-CSA	CSA
Sexual compulsivity	15.45 (5.30)	17.76*** (6.51)	14.60 (4.73)	16.50*** (5.94)	18.02 (6.07)	21.32*** (6.75)	15.69 (5.27)	15.31 (5.69)	14.49 (4.57)	17.63*** (7.18)	16.02 (5.64)	18.38*** (6.20)
Sexual avoidance	12.44 (3.97)	13.36* (4.88)	12.40 (3.80)	13.43* (4.90)	12.55 (4.46)	13.43 (4.84)	12.35 (3.74)	14.19* (4.58)	11.49 (2.62)	12.76* (4.85)	13.05 (4.56)	13.50 (4.96)

Note. CSA = childhood sexual abuse.
* $p < .05$. ** $p < .01$. *** $p < .001$.

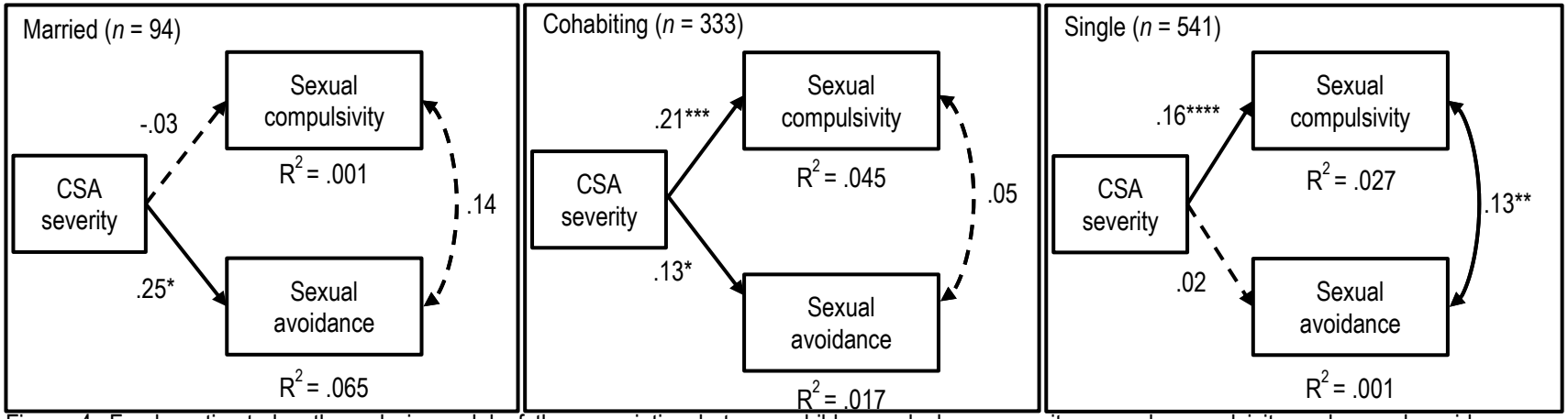

Figure 4. Freely estimated path analysis model of the association between child sexual abuse severity, sexual compulsivity and sexual avoidance across relationship status.

Note. CSA = childhood sexual abuse.

* $p < .05$. ** $p < .01$. *** $p < .001$.

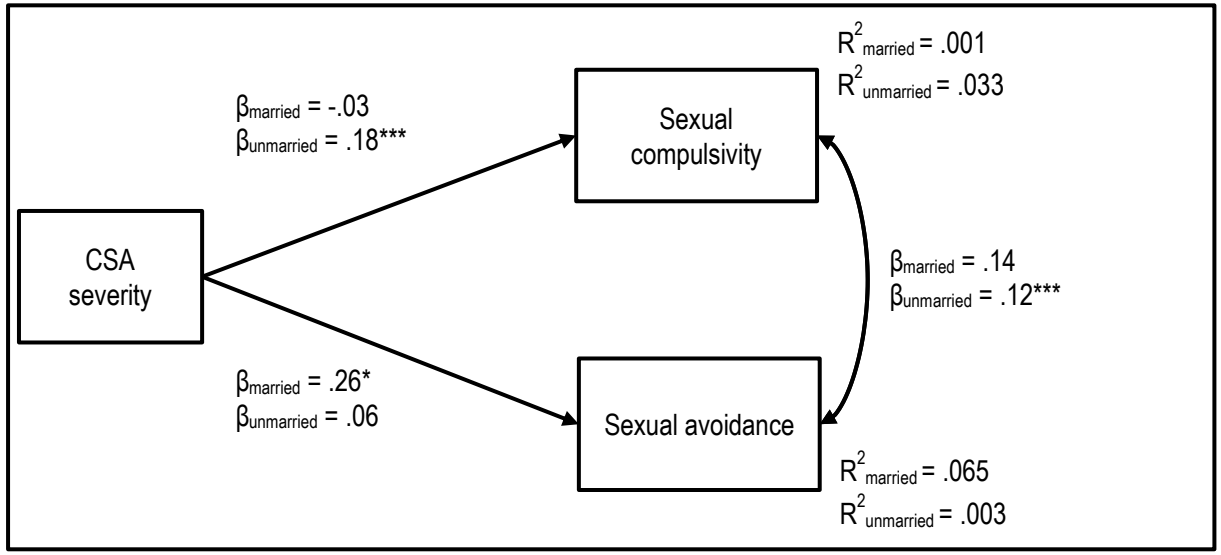

Figure 5. Freely estimated path analysis model of the association between CSA severity, sexual compulsivity and sexual avoidance across married and unmarried participants.
Note. CSA = childhood sexual abuse.
$p < .05$. ** $p < .01$. *** $p < .001$.

Chapitre V : Conclusion générale

La présente thèse avait pour objectif général d'approfondir le fonctionnement conjugal et sexuel des survivants d'ASE en portant une attention particulière à l'interaction de ces deux types de répercussions à l'âge adulte. Cet examen concomitant des difficultés sexuelles et relationnelles des survivants d'ASE permet d'étudier l'émergence de différentes réponses sexuelles au sein des relations de couple et leurs liens avec le fonctionnement conjugal. En s'appuyant sur la documentation théorique et empirique disponible, les trois études de la thèse ont évalué la validité d'un modèle conceptuel des associations entre l'ASE, les deux patrons de séquelles sexuelles à l'âge adulte (c.-à-d., compulsion sexuelle et évitement sexuel) et trois indicateurs du fonctionnement conjugal soit l'ajustement conjugal, les relations sexuelles extradyadiques et le statut relationnel en tant que variable d'approximation de l'engagement conjugal. De façon globale, les résultats confirment la validité de l'hypothèse d'une association entre l'ASE et le fonctionnement sexuel et conjugal à l'âge adulte tout en mettant en relief le caractère dynamique des rapports entre ces variables. Ces travaux ont donc mené à une série de percées scientifiques qui sont reprises dans le présent chapitre. Cette discussion générale porte sur cinq thèmes: (1) la prévalence différentielle de l'ASE selon le genre, (2) les associations entre l'ASE et les deux patrons de réponses sexuelles distinctes, (3) les associations entre l'ASE et plusieurs indicateurs du fonctionnement conjugal, (4) la modélisation des interrelations entre les répercussions sexuelles et conjugales de l'ASE et (5) l'invariance de ces modèles entre les hommes et les femmes et selon l'âge ou la durée de l'union conjugale. Ces résultats soulignent la nécessité de poursuivre le travail afin de développer des protocoles d'évaluation et de traitement concrétisant cette interdépendance. Enfin, en plus de souligner les limites de cette série d'études, nous formulons des recommandations pour les recherches futures et terminons en proposant quelques implications cliniques des résultats.

Discussion des résultats

La première percée scientifique de la thèse dont il convient de discuter est d'ordre méthodologique et elle traite de la prévalence différentielle de l'ASE selon le genre. Jusqu'à maintenant, les spécialistes s'accordent pour établir un ratio approximatif de deux femmes victimes pour chaque homme ayant été abusé. Plus précisément, la consultation des méta-analyses récentes fait ressortir, chez les femmes, des taux de victimisation oscillant de 15 à 20% tandis que, chez les hommes, ces taux s'établissent à 8% (Barth et al., 2013; Stoltenborgh et al., 2011; Tourigny et al., 2008). Or, bien que la présente étude s'appuie sur un échantillon de convenance, nos taux s'élèvent à un peu plus de 20% chez les femmes, ce qui est conforme aux résultats des méta-analyses citées plus haut, mais ils s'établissent, chez les hommes, à près de 20%, ce qui est nettement supérieur à ce qui est rapporté au sein de ces mêmes études. Nous formulons l'hypothèse provisoire, à vérifier lors d'études ultérieures faisant appel à des techniques d'échantillonnage scientifiques,

que plusieurs aspects innovants de la présente démarche méthodologique expliquent le taux de victimisation plus élevé observé chez les hommes du présent échantillon. Plusieurs facteurs sont possiblement en cause: l'utilisation de questionnaires en ligne complètement anonymes, le recours à une définition plus large de l'ASE incluant les activités sexuelles sans contact (exhibitionnisme, voyeurisme, exposition à des scènes sexuelles), et une évaluation objective de l'ASE, fondée sur des critères légaux, qui n'identifie pas l'expérience sexuelle comme une agression ou le participant comme une victime ou un survivant d'ASE. Les résultats d'une étude en cours effectué auprès du même échantillon démontrent d'ailleurs que seulement 34% des femmes et 19% des hommes décrivent l'expérience sexuelle vécue en enfance comme un abus. Ainsi, l'utilisation d'une définition subjective de l'ASE introduirait divers biais dans l'évaluation que fait l'homme de cette expérience sexuelle abusive et entraînerait un taux de prévalence cinq fois plus bas que celui s'appuyant sur la définition légale du phénomène (Vaillancourt-Morel et al., en préparation). Cette sous-estimation importante des taux de prévalence lors de l'utilisation d'une question subjective est appuyée par les résultats d'autres études empiriques suggérant des ratios allant de 1:2 à 1:6 (Holmes, 2008; Silvern, Waelde, Baughan, Karyl, & Kaersvang, 2000; Stander, Olson, & Merrill, 2002). Cette méthode d'évaluation subjective basée sur les perceptions de l'individu ne parvient pas à identifier plusieurs hommes victimes d'ASE. Le taux de prévalence de 20% chez les hommes est donc possiblement plus valide et représentatif de l'occurrence réelle de l'ASE selon la loi canadienne. Malgré tout, ce taux demeure un résultat qui doit être examiné à nouveau au sein d'échantillons représentatifs afin de confirmer la possible sous-estimation du taux de prévalence de l'ASE chez les hommes.

La thèse apporte une deuxième contribution scientifique originale en démontrant clairement que l'ASE est associée à deux patrons de réponses sexuelles distinctes, soit l'évitement de la sexualité et la compulsion sexuelle. Bien que l'analyse des séquelles sexuelles de l'ASE ait été entreprise à plusieurs reprises (Aaron, 2012; Loeb et al., 2002; Rellini, 2014; Senn et al., 2008; Zwickl & Merriman, 2011), les chercheurs se sont traditionnellement penchés exclusivement sur un seul patron de réponse, la majorité des études portant généralement soit sur la compulsion sexuelle ou, dans de plus rares occasions, sur l'évitement sexuel. À notre connaissance, l'examen simultané de ces deux formes de symptômes sexuels n'avait jamais été effectué. Le présent travail confirme non seulement l'existence de ces deux patrons de réponse mais il révèle aussi que chez certains individus, ces deux réponses sexuelles sont cooccurrentes. C'est à dire qu'un même individu peut présenter aussi bien des réponses sexuelles compulsives que d'évitement. Il restera à démontrer quels sont les facteurs qui favorisent l'émergence simultanée ou séquentielle de ces séquelles sexuelles, en apparence opposées, en situation d'ASE. Cette démonstration devra reposer sur des études longitudinales pointues qui permettront véritablement d'illustrer les trajectoires du développement de la sexualité chez les personnes qui ont vécu une ASE.

Qu'ils soient compris comme résultant d'une sexualisation traumatique (Finkelhor & Browne, 1985), comme des stratégies dysfonctionnelles de régulation émotionnelle (Briere, 2002), ou comme une compulsion de répétition (Bergner, 2002), l'évitement de la sexualité et la compulsion sexuelle constituent tous deux des mécanismes de gestion des émotions traumatiques qui visent probablement à distraire l'individu des souvenirs d'ASE non-intégrés. Cet objectif commun explique, sans doute partiellement, la coexistence de ces séquelles chez certains individus. La compulsion sexuelle se caractérise par le besoin de fuir, d'ignorer ou de neutraliser, via la recherche de l'excitation et du plaisir sexuel, des états internes intolérables suscités par l'ASE (Bergner, 2002). Dans cette perspective, les compulsions sexuelles émergeraient pour permettre à l'individu de ne pas être en contact avec les émotions traumatiques associées à la sexualité et afin de ré-établir un certain sentiment de pouvoir et de contrôle que l'ASE a affaibli. L'évitement sexuel s'apparenterait à une réaction post-traumatique typique, soit l'effort de la personne concernée d'esquiver toute situation, idée ou discussion pouvant réveiller les souvenirs du traumatisme qui généreraient une détresse immense et même, pour certains, la réminiscence du trauma. Ainsi, l'évitement de la sexualité représenterait une stratégie cognitive visant à minimiser l'impact émotionnel de l'ASE et à protéger le survivant contre un possible envahissement émotionnel. À court terme, il permet d'éviter la source d'émotions intenses, mais à long terme il renforce la peur et empêche la mentalisation adéquate du trauma (Berthelot et al., 2013; Ensink et al., 2015).

La portée scientifique de la thèse tient aussi à une troisième caractéristique des résultats qui démontrent la diversité des symptômes conjugaux associés à l'ASE. L'ASE est en effet reliée à deux issues conjugales significatives et complémentaires qui sont des marqueurs éprouvés de la détresse conjugale : l'ajustement conjugal et l'infidélité chez des individus dont l'âge et la durée de l'union sont contrôlés. Ici, c'est le caractère systématique de la démonstration qui doit être retenu. Il existait bien sûr déjà des études montrant la présence d'une détresse conjugale significative chez certains couples et quelques rares recherches sur la tendance accrue aux relations extradyadiques chez les victimes d'abus. Nous confirmons ces résultats et, dans le cas des relations sexuelles extradyadiques, nous sommes les premiers à soutenir, preuve à l'appui, que chez les hommes ayant vécu l'ASE, les taux d'infidélité doublent, tout comme chez les femmes.

Enfin, à notre connaissance, aucun groupe de chercheurs ne s'est intéressé à plus d'une ou deux issues sexuelles ou conjugales à la fois. En plus de confirmer les liens négatifs entre l'ASE et l'ajustement conjugal et sexuel, la quatrième contribution scientifique de la thèse apporte un éclairage novateur en établissant que, chez les survivants d'ASE, la compulsion sexuelle et l'évitement sexuel sont tous deux reliés à un plus faible ajustement conjugal tandis que la compulsion sexuelle augmente la probabilité de s'engager dans des relations sexuelles extradyadiques. En outre, l'examen du statut relationnel permet de constater que l'ASE est associée à la compulsion sexuelle chez les célibataires, en relation de fréquentation ou non, à l'évitement sexuel chez les individus mariés et à la fois à la compulsion sexuelle et l'évitement sexuel chez les individus

cohabitant. Cet ensemble de résultats révèle aussi que le caractère médiationnel de notre modèle général s'est avéré plausible; la compulsion sexuelle et l'évitement sexuel se sont avérés des relais stables de l'association entre l'ASE et les issues conjugales étudiées. Ainsi, la thèse souligne l'importance de tenir compte de cette dynamique des facteurs relationnels et sexuels, jusqu'à maintenant négligée par les experts dans le domaine. C'est à cette condition que la compréhension des liens complexes qui relient l'ASE et les difficultés sexuelles ou conjugales s'approfondira. Bien entendu, la magnitude des effets observés n'est pas élevée. Soulignons tout de même que le laps de temps qui s'est écoulé entre l'ASE et les symptômes sexuels ou conjugaux à l'âge adulte est grand et qu'il explique en partie la taille des effets. Les études conduites au laboratoire précédemment (Bigras et al., sous presse; Godbout et al., 2014; Godbout, Dutton, Lussier, & Sabourin, 2009; Godbout et al., 2006) montrent bien que les pourcentages de variance expliquée augmentent sensiblement lorsque d'autres médiateurs proximaux tels la sécurité d'attachement, la dysrégulation affective ou le soutien familial reçu sont introduits dans ce type de modélisation. Le tableau clinique à l'âge adulte est donc complexe, mais surtout hétérogène. Les répercussions au long cours de l'ASE sur le fonctionnement conjugal s'expriment par le biais de variables intermédiaires ou d'interactions. Si l'objectif est d'expliquer un maximum de variance, il est crucial d'adopter un modèle d'ensemble qui tient compte simultanément de plusieurs variables permettant d'expliquer la diversité ainsi que l'intensité des symptômes vécus par les victimes à différentes étapes de l'évolution du couple. Ici, l'objectif était plus circonscrit et il visait surtout à élucider la nature des associations entre l'ASE et quelques variables conjugales et sexuelles clés.

La robustesse et la généralisation de nos modélisations des rapports entre l'ASE, le fonctionnement conjugal et sexuel constituent le cinquième apport scientifique de la thèse. En effet, ces modèles sont invariants entre les hommes et les femmes en plus d'être invariant selon l'âge ou la durée de la relation. Cette absence de différences inter-genres quant aux réponses sexuelles et conjugales de l'ASE suggère une réactivité comparable au trauma et soutient l'hypothèse de similarité entre les hommes et les femmes. La prise en compte systématique de la sévérité de l'agression au sein des modèles a peut-être permis de faire ressortir cette réponse identique selon le genre. En effet, les agressions vécues par les filles diffèrent de celles subies par les garçons (Banyard, Williams, & Siegel, 2004; Maikovich-Fong & Jaffee, 2010; Ullman & Filipas, 2005). Ces différences de sévérité pourraient expliquer les répercussions inter-genres recensées précédemment mais qui disparaissent lorsque la sévérité de l'ASE est prise en compte (Paolucci et al., 2001). Même si ces résultats appuient l'hypothèse de similarité, il demeure important de continuer à scruter les différences inter-genres en utilisant des répercussions autres que sexuelles auprès d'échantillons représentatifs de la population afin de s'assurer de la généralisation de ce résultat.

Les associations entre l'ASE, le fonctionnement sexuel et conjugal ne semblent pas non plus résulter de la durée de la relation ou de l'âge du participant. Cette conclusion repose sur des analyses visant à contrôler

l'effet de ces variables. Elles permettent de clarifier que ce n'est pas selon la durée de la relation, mais bel et bien selon le niveau d'engagement au sein du couple que l'ASE est associée à un patron de réponse sexuelle spécifique soit l'évitement sexuel au sein des relations conjugales. Enfin, l'inclusion de la sévérité de l'ASE au sein du modèle conceptuel a une portée clinique intéressante. En effet, nos résultats convergent avec ceux d'études précédentes suggérant que les agressions chroniques, perpétrées par une figure parentale et impliquant la pénétration sont associées à des répercussions sexuelles et conjugales plus sévères (Berthelot et al., 2014; Lacelle et al., 2012; Vaillancourt-Morel et al., 2013; Watson & Halford, 2010). Cette distinction ne doit pas être négligée dans les recherches futures puisqu'elle permet de décrire l'hétérogénéité présente au sein d'un même groupe de survivants d'ASE.

Limites de la thèse

Bien que la présente démarche apporte son lot de découvertes, nos résultats doivent être interprétés en considérant certaines limites inhérentes au protocole de recherche adopté. Ces particularités méthodologiques contraignantes, communes aux trois études sont énumérées brièvement. Elles sont toutefois présentées en contexte dans chacune des études de la thèse, en plus des limites propres à chaque étude. En premier lieu, le protocole de recherche est de type rétrospectif. Ainsi, il n'est pas possible de statuer sur les liens causaux entre l'ASE, le fonctionnement sexuel et conjugal. L'analyse intégrée des trois études montre bien qu'en dépit d'effets indirects ou interactifs, les rapports entre le fonctionnement conjugal et sexuel sont probablement bidirectionnels. Par exemple, l'ajustement dyadique du survivant influence possiblement ses comportements et attitudes sexuels et vice-versa. En deuxième lieu, les participants ont été recrutés à l'aide d'une méthode d'échantillonnage non probabiliste résultant en un échantillon de convenance. Ainsi, la prévalence un peu plus forte, au sein de l'échantillon, de femmes et d'étudiants que ce qui est observé dans la population générale limite la généralisation des résultats. En troisième et dernier lieu, l'utilisation exclusive de questionnaires autorapportés en ligne impose des biais inhérents à cette méthode d'évaluation. En effet, ce type d'outil peut simplifier les difficultés évaluées et limite l'évaluation en profondeur de certains aspects des phénomènes examinés. De plus, la mesure rétrospective de l'ASE peut entraîner des distorsions dans le rappel de l'agression vécue. Le recours aux questionnaires en ligne comporte tout de même des avantages puisqu'il permet d'assurer l'anonymat aux participants, ce qui est recommandé pour des thématiques plus sensibles telles que l'ASE ou la sexualité.

Pistes de recherches futures

En guise de perspective future, nos résultats doivent d'abord être répliqués dans des études palliant aux limites énumérées plus haut. Ainsi, l'emploi de protocoles de recherche longitudinaux utilisant plusieurs méthodes d'évaluation au sein d'échantillons représentatifs est nécessaire pour examiner le développement et

l'évolution des réponses sexuelles à l'ASE et confirmer les relations transactionnelles entre les répercussions sexuelles et conjugales mesurées dans la présente étude. Bien sûr, de telles études d'envergure sont rarissimes dans la documentation actuelle et comportent de multiples défis à relever : éthiques, méthodologiques et économiques. Le recours à un échantillon représentatif regroupant un nombre de participants plus élevé permettrait cependant d'augmenter la taille des différents sous-groupes (hommes et femmes; abusés et non-abusés; mariés, en relation de cohabitation et célibataires) et de confirmer la valeur de nos résultats.

Ensuite, l'examen des relations entre l'ASE, le fonctionnement sexuel, le fonctionnement conjugal doit s'accompagner de plusieurs améliorations. Par exemple, des facteurs autres que l'ASE n'ont pas été mesurés dans la présente étude, mais ils peuvent avoir d'importantes répercussions sexorelationnelles. Il faudra ainsi vérifier la présence de différents types de maltraitance infantile afin d'étudier l'effet des traumas cumulatifs sur le fonctionnement conjugal et sexuel ou d'identifier les spécificités des répercussions de l'ASE. De plus, il conviendra d'examiner différents indicateurs alternatifs des deux patrons de réponses sexuelles (p. ex., les dysfonctions sexuelles pour l'évitement de la sexualité et les comportements sexuels à risque pour la compulsion sexuelle) et différentes facettes du fonctionnement conjugal (p. ex., intimité, violence conjugale, style de communication ou de résolution de conflits). De même, bien que la troisième étude de la thèse permet d'identifier l'engagement conjugal comme facteur lié au développement des différentes réponses sexuelles à l'ASE, d'autres variables pouvant expliquer l'émergence des deux patrons sexuels et des difficultés conjugales chez les survivants d'ASE doivent être étudiées (p. ex., attachement, motivations sexuelles). Dans une étude en cours, nous démontrons que la perception qu'a l'individu de l'agression vécue influence les comportements sexuels à l'âge adulte, la compulsion sexuelle étant plus élevée chez les survivants ne définissant pas cette expérience comme une agression tandis que l'évitement sexuel augmenterait chez les participants décrivant cette expérience comme une ASE (Vaillancourt-Morel et al., en préparation). Il sera également important de confronter le modèle conceptuel actuel à un modèle théorique spécifique. Par exemple, il serait intéressant d'entreprendre l'analyse du rôle des quatre dynamiques traumatogéniques (Finkelhor & Browne, 1985) ou celui des trois mécanismes suggérés par Briere (2002), la régulation émotionnelle, les dynamiques d'attachement et le développement identitaire, dans le développement des répercussions sexuelles et conjugales de l'ASE. Des recherches futures continuant à identifier plus directement les différents mécanismes explicatifs de la variabilité des réponses sexuelles et conjugales apparaissent donc essentielles. Le recours à de tels modèles complexes intégrant plusieurs variables aiderait à mieux comprendre les répercussions sexorelationnelles de l'ASE et l'interdépendance entre les diverses répercussions documentées tout en expliquant un maximum de variance. En surplus, les modèles ultérieurs doivent systématiquement examiner les différences inter-genres et tenir compte de la sévérité de l'ASE afin de continuer à appuyer ou d'infirmer l'hypothèse de similarité.

Enfin, ces propostions doivent également être approfondies en utilisant des plans d'analyse dyadiques. Tout d'abord, l'examen du fonctionnement sexuel et conjugal doit maintenant s'effectuer en prenant appui sur le point de vue des deux partenaires. Des modèles d'analyse acteur-partenaire permettraient de comprendre comment le fonctionnement sexuel et conjugal du survivant influence le fonctionnement sexuel et conjugal de son partenaire. Par exemple, il est possible que l'émergence de l'évitement sexuel au sein des relations maritales soit associée à une probabilité accrue de relations extraconjugales chez le partenaire afin de satisfaire ~~à~~ ses besoins sexuels. De plus, les analyses et la méthodologie des futures études doivent permettent l'examen de la coexistence de l'évitement et de la compulsion sexuelle chez un même survivant dans des contextes particuliers ou à des périodes spécifiques du développement des relations intimes. La troisième étude de la thèse est une percée à ce sujet, mais elle doit être poursuivie avec vigueur. Par exemple, l'évitement sexuel en enfance ou à l'adolescence n'a été que très peu documenté comparativement aux patrons de réponses compulsives. En conséquence, il est impossible de savoir si l'évitement sexuel est également présent à cette période du développement chez les survivants d'ASE. Cette variable sexuelle est bien sûr difficilement différenciable du développement sexuel normatif, ce qui complique cet examen. Pour le contexte, par exemple, il serait intéressant d'examiner le rôle de l'évitement sexuel au sein de la relation de couple dans le développement des relations extradyadiques. Notre mesure d'évitement sexuel n'étant pas spécifique à la relation de couple, son adaptation pourra donner lieu à de nouvelles recherches psychométriques. L'application de cette suggestion permettrait de confirmer les observations cliniques suggérant que certains survivants évitent la sexualité avec le partenaire conjugal tout en s'engageant de manière compulsive avec des partenaires extraconjugaux. Au surplus, cette proposition sous-tend l'importance d'une interaction continue chercheur-clinicien dans le développement des futures études.

Implications cliniques

Bien que limitées par le caractère non-clinique du présent échantillon, les conclusions des trois études ont également des implications potentielles au plan de la pratique clinique. De manière générale, les résultats soutiennent l'importance pour les survivants d'ASE d'avoir accès à des services psychologiques spécialisés en difficultés sexorelationnelles puisque les séquelles sont complexes et durables. Les protocoles d'évaluation des milieux cliniques offrant des services à une clientèle adulte doivent considérer systématiquement la présence d'ASE et la sévérité de l'agression en se basant sur une définition de l'agression similaire à celle de la thèse et ce, autant en psychothérapie individuelle que conjugale. Ainsi, il sera possible pour les cliniciens d'adapter leur évaluation afin de bien cerner les répercussions sexorelationnelles de ce trauma, par exemple, par une évaluation plus détaillée de l'évolution du fonctionnement sexuel, et d'en tenir compte lors de plan de traitement. L'intervenant gagne à être particulièrement attentif lors de l'évaluation à la dynamique entre les facteurs relationnels et sexuels associés à l'ASE afin de planifier le traitement en fonction des difficultés

présentées. Les résultats suggèrent également de manière préliminaire des pistes d'interventions potentielles pour les professionnels qui oeuvrent auprès de survivants d'ASE. Tout d'abord, en rencontre individuelle ou de couple lorsque possible, aider le survivant et son partenaire à identifier les difficultés conjugales et sexuelles comme des effets potentiels de l'ASE permettrait de diminuer le blâme, d'augmenter l'empathie envers le vécu du survivant et de tempérer l'escalade des problèmes au sein du couple. Ensuite, l'amélioration de la compréhension des mécanismes expliquant comment l'ASE a amené ces comportements sexuels et relationnels mal adaptés constitue une cible thérapeutique importante, tant pour le survivant d'ASE que pour son conjoint. Ceux-ci peuvent être dus à des difficultés à tolérer l'intimité, des représentations de soi et des autres distorsionnées par l'abus, la reviviscence des émotions vécues lors du trauma au sein de la relation, etc. (Briere & Scott, 2014; Schwartz & Galperin, 2002; Wells & Kuhn, 2015). Enfin, l'intervenant peut adopter des stratégies flexibles portant sur la diversité des mécanismes via lesquels l'ASE contribue au développement de dysfonctionnements sexuels et conjugaux. Une meilleure compréhension de ces mécanismes dysfonctionnels chez les survivants, (p.ex., le rôle des capacités du soi dans le développement des difficultés sexorelationnelles) permettrait l'apport de traitements plus adaptés aux besoins des survivants. Une intervention préventive pourrait offrir aux survivants d'ASE une évaluation multidimensionnelle répétée lors de diverses transitions développementales telles que la puberté ou la formation d'une union amoureuse afin de dépister les effets dormants de l'ASE et anticiper la cristallisation de séquelles conjugales sévères. Ces implications cliniques soulignent l'importance de partenariats de recherche avec les représentants de milieux cliniques et divers professionnels de la santé afin de continuer l'exploration clinique de ces problématiques chez les survivants et de leurs effets sur les modèles de traitement.

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