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Sexual self-concept among men and women child sexual abuse survivors: Emergence of differentiated profiles

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ABSTRACT

Background: Child sexual abuse (CSA) can impact survivor's sexuality, notably regarding sexual self-concept, a key component of sexual well-being. Yet, sexual self-concept has been understudied among CSA survivors and gender differences have been sparsely investigated.
Objective: The current study aimed to identify CSA survivors' distinct profiles according to their sexual self-concept, and compare these profiles based on factors such as CSA characteristics, gender, current age, sexual functioning and adult sexual assault (ASA).
Participants and setting: A total of 176 CSA survivors (60 % women, 40 % men), recruited through community organizations for CSA victims and social media publications, completed an online survey.
Methods: Hierarchical cluster analysis was performed using the Sexuality Scale (Snell & Papini, 1989). Chi-square and ANOVA tests were used to compare the groups on external variables.
Results: Cluster analysis revealed the best overall fit for a three-group model. The Confident and non-preoccupied profile (48 %) is characterized by a moderate score on sexual esteem and the lowest scores of sexual preoccupation and depression. The Demeaning and depressive (37 %) profile is characterized by the lowest scores on sexual esteem and the highest scores on sexual depression. The Hyperconfident and preoccupied profile (15 %) shows the highest scores on sexual esteem and sexual preoccupation.
Conclusion: Sexual self-concept is an important component of sexuality that needs to be addressed by practitioners working with CSA survivors. Given heterogeneity and gender differences among survivors, identification of profiles is relevant for adapting interventions and clinical care.

1. Introduction

Worldwide, about one in five women and one in ten men have reported experiencing child sexual abuse (CSA; Stoltenborgh, Van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Child sexual abuse refers to being compelled or obliged to participate in unwanted sexual touching or unwanted sexual intercourse before the age of majority (Finkelhor, Hotaling, Lewis, & Smith, 1990). CSA can affect multiple domains of a survivor's life, notably sexuality in adulthood (Bigras, Godbout, Hébert, & Sabourin, 2017). For example, studies have indicated that CSA survivors are more prone to engage in risky sexual behaviors (Fernet, Hébert, Gascon, & Lacelle, 2012; Homma, Wang, Saewyc, & Kishor, 2012), to experience flashbacks during sexual activities (Carreiro, Micelli, Sousa, Bahamondes, & Fernandes, 2016), sexual dissatisfaction (Lopez et al., 2017; Rellini & Meston, 2011), sexual aversion or compulsivity

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(Aaron, 2012; Vaillancourt-Morel et al., 2015), and sexual dysfunctions (Lopez et al., 2017). In addition, survivors may use sexuality as a strategy to cope with negative feelings (Lemieux & Byers, 2008). Past studies have also showed that CSA characteristics (e.g. offender's identity, sexual acts committed, frequency, duration of the abuse) must be taken into account as they may relate to different sexual outcomes in adulthood (Loeb, Gaines, Wyatt, Zhang, & Liu, 2011; Vaillancourt-Morel et al., 2016). However, inconsistent results were found regarding gender differences in sexual outcome among CSA survivors. For instance, past studies sampling both male and female CSA survivors have found that men show more sexual compulsivity than women (Skegg, Nada-Raja, Dickson, & Paul, 2010; Vaillancourt-Morel et al., 2015), while another study found a link between CSA and addictive sexual activities in both male and female survivors (Plant, Plant, & Miller, 2005). In the same way, sexual avoidance is also the subject of inconsistent results regarding gender differences in CSA survivors (Lemieux & Byers, 2008; McCallum, Peterson, & Mueller, 2012). Moreover, while previous studies have highlighted a link between CSA and adult sexuality, this association is frequently investigated in terms of behaviors rather than attitudes and self-concept. Yet, sexual self-concept constitutes an important predictor of sexual behaviour (Hensel, Fortenberry, O'Sullivan, & Orr, 2011) as well as an important component of sexual health (Deutsch, Hoffman, & Wilcox, 2014; Rostosky, Dekhtyar, Cupp, & Anderman, 2008), which highlights its importance when examining sexuality in CSA survivors.

Self-theorists describe self-concept as the thoughts and feelings one has in reference to oneself (Rosenberg, 1979). More specifically, sexual self-concept derives from the general self-concept that is formed during childhood and adolescence from the emotional bonds shared with parents and peers (Arnett, 2000); it plays a key role in understanding and representing oneself as a sexual being. It encompasses many self-related concepts such as identity, self-view, self-schema and self-esteem (Vickberg & Deaux, 2005). Although sexual self-concept has been widely studied among the general population, especially among women (Andersen & Cyranowski, 1994; Vickberg & Deaux, 2005) and adolescent girls (Buzwell & Rosenthal, 1996; Hensel et al., 2011; Rostosky et al., 2008), it remains understudied among CSA survivors. The few studies that have examined the way in which survivors view themselves as sexual beings have focused moreso on sexual esteem (i.e. individual self-evaluation of worth as a sexual being; Buzwell & Rosenthal, 1996) and sexual self-schemas (i.e. cognitive attributions and evaluations of the sexual self; Andersen, Cyranowski, & Espindle, 1999), which are more specific components of broader sexual self-concept. Notably, CSA survivors report moral-type sexual self-esteem (Kelley & Gidycz, 2015) and tend to have poorer global sexual self-esteem (Turner, Finkelhor, & Ormrod, 2010; Van Bruggen, Runtz, & Kadlec, 2006). In addition, another study found that CSA survivors whose abuse involved penetration reported mixed sexual appraisals of themselves (i.e., lower sexual self-esteem combined with positive sexual self-schemas), and a greater propensity to engage in risky sexual behaviors (Lemieux & Byers, 2008). As for the study of Niehaus, Jackson, and Davies (2010), it shows that female survivors of CSA are experiencing more detrimental sexual self-views, such as being immoral or irresponsible with their sexuality. Their results also indicate that detrimental sexual self-views moderate the relationship between CSA and sexual revictimization in adolescence (Niehaus et al., 2010). The study of Van Bruggen et al. (2006) on undergraduate women found that sexual self-esteem and sexual concerns mediate the relationship between CSA and sexual revictimization after age fourteen. Moreover, negative sexual self-schemas were also associated with lower sexual satisfaction in women survivors (Rellini & Meston, 2011).

Yet, the few studies documenting the correlates of CSA have focused on female survivors of CSA, which disregards male survivor experiences and limits overall gender comparison. On a methodological note, the repercussions of CSA on sexuality, and especially sexual self-concept, have mainly been studied using variable-centered approaches. However, the diversity of experiences regarding CSA and sexual outcomes that are reported by survivors attest to the relevance of identifying distinct profiles among this heterogeneous population (Yancey, Hansen, & Naufel, 2011). This lead us from considering objective components of the participant's experiences regarding sexual self-concept by using person-centered approach in data analysis, which identifies groups of individuals who share similar characteristics, but who are different from other groups (Lubke & Muthén, 2005).

The current study pursued two objectives. The first objective was to identify distinct profiles of CSA survivors relative to their sexual self-concept using hierarchical cluster analysis. The second objective was to compare these profiles on the characteristics of the abuse, gender, current age and sexual functioning (i.e., sexual disorders, sexual compulsivity, sexual satisfaction, number of sexual partners and adult sexual assault [ASA]) with chi-square tests and general linear models (ANOVAs).

2. Method

2.1. Participants

A sample of 175 participants (60 % female) who reported one or more experiences of CSA was recruited. CSA was assessed based on the definition of the Criminal Code of [Blind for review](1985), which refers to any sexual act between a child under 16 years old and a person older by five or more years old, or in a position of authority, which implies or not the presence of physical force or the consent of the child. Participants were aged between 18 and 70 years old (M = 41.17). Participants identified themselves mainly as Canadian (74 %) and heterosexual (73 %). Most respondents had completed a bachelor's degree (35 %), while fewer had completed a graduate degree (23 %), post-secondary degree (17 %), or a high school degree or less (20 %). The majority of respondents (55 %) had a part- or full-time job at the time of the study; while others were students (17 %) or neither (28 %). Almost half of the sample (45 %) reported being single, while others were in cohabitation (27 %), married (14 %), in a relationship with a regular partner (12 %) or other (2%).

The majority of participants reported that their offender was a family member, representing 58 % of the cases, while it was an acquaintance in 43 %, a stranger in 24 %, and a romantic partner (i.e. for participants who were abused in adolescence) in 17 % of the cases. The total is above 100 % because survivors were able to report more than one offender. Sexual abuse experiences involved attempted or completed oral, vaginal or anal penetration (71 %), sexual touching (27 %) and sexual acts without physical contact

(e.g., exhibitionism, voyeurism, exposure to child pornography or sexual proposal; 2%). The frequency of the sexual acts sustained by the survivors are as follows: a single event (15 %), 2–5 times (20 %), 6–20 times (27 %), and more than 20 times (38 %). Survivors reported that the CSA lasted 10 years or more (20 %), between 2–10 years (56 %), approximately 1 year (10 %), or less than 1 year (14 %).

2.2. Measures and variables

2.2.1. Sociodemographics

Participants responded to sociodemographic questions documenting their age, gender, ethnicity, occupation, education, relational status, and number of romantic and sexual relationships.

2.2.2. CSA and characteristics

A 12-item self-reported questionnaire assessed the presence of CSA victimization based on the definition of the Criminal Code of Canada (Vaillancourt-Morel et al., 2015). The questionnaire asked participants if they endured: 1) unwanted sexual behaviors prior to 18 years old ("Before the age of 18 years old, I had sexual behavior with an adult or a child when I did not want it") or 2) any sexual contact prior to 16 years old with someone 5 years older or in a position of authority ("Before the age of 16 years old, I had sexual behavior with an individual with 5 years age difference or more or who was in position of authority"). CSA was computed into a dichotomous variable and was scored as absent (0) or present (1) if participants answered "yes" to any of the options above. Because CSA survivors, especially male survivors, are sometimes reluctant to admit being victimized or may not label their sexual experience as CSA, by interpreting this experience as consensual or a sexual initiation (Weiss, 2010), we selected a measure using neutral terms, such as asking participants about these sexual experiences instead of asking them if they perceived being a "victim of sexual abuse." Previous studies found that the reliability estimates were satisfactory using the items measuring the characteristics of CSA with a total CSA severity scale alpha coefficient of .86 (Vaillancourt-Morel et al., 2016). This questionnaire then assessed CSA characteristics that were used for the external validation of profiles, including: offender's identity (i.e. *family member, extended family member, acquaintance, stranger, person in authority, romantic partner*), sexual acts committed (i.e. *attempted or completed oral, vaginal or anal penetration, sexual touching and sexual acts without physical contact*), duration (ranging from *0-1 month* to *5 years or more*) and frequency (i.e. ranging from *1 time* to *so many times I can't count*) of CSA experiences.

2.2.3. Adult sexual assault

Occurrence of ASA was assessed with a 3-item self-reported questionnaire, also using neutral terms, whereas participants were asked if they endured ASA with the following question: "Have you ever experienced unwanted sexual behaviors above 18 years old?" This questionnaire also assessed the types of sexual acts committed, offender's identity and strategies used by the offender to compel (e.g. threatening, using alcohol or drugs).

2.2.4. Sexual self-concept

The 15-item French and short version of the Sexuality Scale (Snell & Papini, 1989; Wiederman and Allgeier, 1993) was used to measure sexual self-concept. The questionnaire is composed of three 5-items sub-scales: (a) Sexual esteem (e.g., I have confidence in myself as a sexual partner); (b) Sexual preoccupation (e.g., I think about sexuality more than anything else) and (c) Sexual depression (e.g., The sexual aspects of my life depress me). This questionnaire is rated on a 5-point Likert scale ranging from 1 = *Disagree* to 5 = *Agree*. This scale has excellent psychometric qualities for its original version (alpha ranged from .90 to .93; Snell, Fisher, & Schuh, 1992). In this sample, the Cronbach's alpha for this measure was .74.

2.2.5. Sexual satisfaction

Sexual satisfaction was measured using the 5-item French version of the Global Measure of Sexual Satisfaction, one of the scales of the Interpersonal Exchange Model of Sexual Satisfaction (Lawrance & Byers, 1995), which measures the quality, pleasure, valence, connotation, satisfaction and importance that participants attribute to their sexual life. Items are answered on a 7-point Likert scale and added to compute a total score ranging from 5 to 35, where a higher score represents a greater sexual satisfaction. The original version of this scale has excellent psychometric qualities (alpha ranged from .95 to .96; Byers & Macneil, 2006). In the present study, the Cronbach's alpha for this measure is .92.

2.2.6. Sexual disorders

The 7-item French version of the Arizona Sexual Experience Scale (ASEX; McGahuey et al., 2000) was used. The questionnaire assesses sexual functioning with various items (e.g. level of sexual desire, ability to reach orgasms) and allows the identification of sexual disorders. Items are answered on a 6-point Likert scale ranging from 1 = *Extremely* to 6 = *Absence of* or *Never*. Items are then added to obtain a total score ranging from 7 to 42, where high scores indicate higher levels of sexual disorders. This scale showed excellent psychometric qualities in past studies (alpha ranged from .71 to .91; McGahuey et al., 2000; Vaillancourt-Morel et al., 2017). Cronbach's alpha was .82 in the present study.

2.2.7. Sexual compulsion

The 10-item French version of the Sexual Compulsivity Scale (Kalichman et al., 1994; Vaillancourt-Morel et al., 2015) was used to measure sexual compulsion, which refers to difficulties in managing sexual thoughts and behaviors as well as sexual addiction.

Participants rated their agreement to each item on a 4-point scale ranging from 1 = *Not like me at all* to 4 = *Totally like my* (e.g., I sometimes fail to meet my commitments and responsibilities because of my sexual behaviors). The items are added to yield a total score ranging from 10 to 40, where a higher score represents a higher level of sexual compulsivity. This scale has excellent psychometric qualities for its original (alpha ranged from .87 to .92; Kalichman & Rompa, 1995, 2001) and French (alpha ranged from .87 to .92; Vaillancourt-Morel et al., 2015) versions. In the current study, the Cronbach's alpha was .91.

2.3. Procedures

Participants were recruited through social media publications, posters in community organizations for CSA victims, and through word of mouth. Participants had to complete an online survey on a secure website (i.e. Lime Survey) and signed a consent form electronically. The study protocol was detailed to ensure adequate comprehension of the study goals, procedure, risks and benefits, confidentiality, and voluntary-based participation. This study received approval from the institutional research ethics board.

2.4. Statistical analysis

First, descriptive analyses were performed in order to document sociodemographic characteristics of the sample and to examine variables distributions. Due to an asymmetric distribution of the number of sexual partners, a winsorization procedure was performed. This method allows to impose a limit on the number of standard deviations for isolated outlying values (Wilcox, 2005). A maximum of 3 standard deviations was imposed for the number of sexual partners before performing the hierarchical classification analysis.

2.4.1. Hierarchical cluster analysis

In order to identify distinct and homogeneous profiles among CSA survivors, a hierarchical cluster analysis was performed with SPSS 25 using the total continuous score on each individual subscale (i.e. sexual esteem, preoccupation and depression) of the Sexuality Scale (Snell & Papini, 1989). The square Euclidian distance was used as the measure of similarity, combined with the Ward's hierarchical cluster as the clustering algorithm. The Euclidian distance measure was privileged because of its ability to minimize the variance between groups and because this measure generally performs well when used with the Ward's hierarchical method (Murtagh & Legendre, 2014). Furthermore, the Ward's method is generally considered the best among hierarchical cluster methods, as the algorithm produces a dendogram that groups together all participants into a single entity (Hébert, Parent, Daignault, & Tourigny, 2006). Then as the clusters are condensed, Ward's method accounts for loss of information as the sum of squared deviations of every point from the mean of the cluster to which it belongs (Hébert et al., 2006). Since the scores were consistent and continuous, and these variables were all extracted from the same scale, data standardization was not necessary. Hierarchical cluster analysis was performed, wherein the percentage of change observed in agglomeration coefficients for the groups was analyzed. The data revealed a small percentage of change in coefficients from the fourth cluster solution (Table 1), which indicated that clusters being combined are considered too different to form a homogeneous group (Yim & Ramdeen, 2015). Considering the interpretability of factors and their theoretical relevance, as suggested by Hair, Anderson, Tatham, and Black (1998), the three-cluster solution provided the most meaningful description of CSA survivors' sexual self-concept. Then, the Least Significant Difference (LSD) post-hoc test (Williams & Abdi, 2010) was also performed to examine the differences between the mean scores on each of the three subscales (i.e. sexual esteem, depression and preoccupation) for the three groups.

2.4.2. External validity analysis

After forming groups varying on their level of sexual self-concept, chi-square and general linear models (ANOVAs) were performed on external variables (i.e. current age, gender, CSA characteristics, sexual function and ASA) that were previously identified as relevant correlates by existing literature on CSA, using LSD post-hoc test. These analyses were performed in order to further understand the profiles and to examine specific group differences on the selected variables. The resulting profiles were compared according to internal and external variables only for results that were statistically significant ($p < 0.05$).

Table 1
Agglomeration Coefficient Analysis.

Stages	Cluster combined		Coefficients	Stage cluster first appears		Next stage
	Cluster 1	Cluster 2		Cluster 1	Cluster 2	
1	166	251	.000	0	0	75
2	147	210	.000	0	0	36
3	16	203	.000	0	0	64
4	25	75	.000	0	0	147
5	181	295	.020	0	0	66
6	276	286	.040	0	0	44

Table 2
Comparison Between Profiles.

Internal variable	**Profile 1** *Confident and Non-Preoccupied* (n = 84)	**Profile 2** *Demeaning and Depressive* (n = 64)	**Profile 3** *Hyperconfident and Preoccupied* (n = 27)	F	Statistically significant differences between profiles (LSD)
		M (SD) or %			
Sexual self-concept (3 dimensions)					
Sexual esteem (1 – 5)	3.35 (0.92)	2.17 (0.91)	4.00 (0.87)	47.89***	3 > 1 > 2
Sexual preoccupation (1–5)	1.73 (0,66)	2.66 (1.17)	4.00 (0.61)	70.11***	3 > 2 > 1
Sexual depression (1 – 5)	1.89 (0,87)	4.1 (0.66)	2.09 (0.73)	158.48***	2 > (3 & 1)
External variables					
Sexual compulsion (1 – 4)	1.38 (0.47)	1.88 (0.83)	2.33 (0.77)	23.47***	3 > 2 > 1
Sexual disorders (1 – 6)	2.95 (0.73)	3.53 (0.95)	2.24 (0.52)	26.50***	2 > 1 > 3
Sexual satisfaction (0 – 7)	4.86 (1.30)	2.94 (1.20)	5.16 (1.30)	50.18***	(3 & 1) > 2
Number of sexual partners	33.89 (50.53)	48.87 (95.51)	91.22(126.86)	4.17**	3 > (2 & 1)
Age at 1st consensual sexual intercourse	16.70 (3.18)	18.78 (4.68)	15.22 (3.46)	8.94***	2 > (1 & 3)
Offender's identity					
Family member	20 % ^{ab}	32 % ^{b}	12 % ^{a}	4.08*	
Acquaintance	36 % ^{a}	50 % ^{ab}	60 % ^{b}	3.97*	
Romantic partner	17 % ^{ab}	7% ^{b}	24 % ^{a}	3.87*	
Gender					
Female	60 % ^{a}	29 % ^{b}	11 % ^{b}	14.66***	
Male	30 % ^{a}	48 % ^{b}	22 % ^{b}		

Note. Means in the same row with different superscript letters differ significantly ($p <$ 0.05) from one another other.
* $p < 0.05$.
** $p < 0.01$.
*** $p < 0.001$.

3. Results

The three extracted profiles are presented in Table 2, in which the means, standard deviations and post-hoc indicators for sexual self-concept and other continuous external variables are displayed. Proportions (%) are also provided according to each profile for external variables, namely for the offender's identity (i.e. family member, acquaintance, romantic partner), gender and sexual function variables. Given the non-significant results regarding the comparison of profiles by current age of participants, certain types of CSA characteristics such as sexual acts committed, frequency and duration of CSA experiences and occurrence of ASA (i.e. re-victimization), were excluded from the results. Description of the profiles is based on results that are statistically significant (*p < 0.05, **p < 0.01, ***p < 0.001)

3.1. Profile 1: ***Confident and non-preoccupied*** *(48 %)*

Although this profile does not show the highest average score of sexual esteem, survivors in this profile reported a relatively high average score of sexual esteem in comparison to average scores found in previous studies on undergraduate students (i.e. M = 1.04 for men and M = .67 for women; Wiederman & Allgeier, 1993), which indicates that individuals in this profile are relatively confident as sexual partners. This profile also displayed the lowest average score on the sexual preoccupation and sexual depression variables, in comparison to the other two profiles. In terms of external characteristics, survivors from this profile reported the lowest average score of sexual compulsion, as well as the fewest sexual partners in their lifetime, compared to survivors in the other profiles. This profile presented a significantly higher proportion of female survivors than the other two profiles.

3.2. Profile 2: ***Demeaning and depressive*** *(37 %)*

Survivors in this profile reported the lowest average score of sexual esteem, and the highest score of sexual depression compared to the other two profiles. Survivors in this profile reported much higher average scores in comparison to average scores of sexual depression found in previous studies on undergraduate students (i.e. M = −1.03 for men and M = −0.88 for women; Wiederman & Allgeier, 1993), which indicates that survivors in this profile are much more depressed over their sexuality. This profile also displayed an average score of sexual preoccupation that was higher than survivors in the Confident and non-reoccupied profile, but lower than survivors in the Hyperconfident and preoccupied profile. Regarding external variables, survivors in this profile had their first consensual sexual intercourse at a later age than survivors in the other profiles. They also distinguished themselves by the highest rate of

sexual disorders and the lowest score of sexual satisfaction, compared to other profiles. In addition, survivors in this profile were more likely to have been victimized by a family member, than survivors belonging in the Hyperconfident and preoccupied profile. This profile presents the largest proportion of male survivors, which differs significantly from the Confident and non-preoccupied profile only.

3.3. Profile 3: ***Hyperconfident and preoccupied*** *(15 %)*

Survivors in this profile showed the highest average score of sexual esteem and sexual preoccupation, compared to those in the other two profiles. Compared to average scores found in a sample of undergraduate students, survivors in this profile reported much higher average scores on sexual esteem (i.e. $M = 1.04$ for men and $M = .67$ for women; Wiederman & Allgeier, 1993) as well as much higher average scores on sexual preoccupation (i.e. $M = -0.49$ for men and $M = -1.2$ for women; Wiederman & Allgeier, 1993). This comparison between average scores indicates that survivors in this profile are very confident as sexual partners but are also especially preoccupied with sexuality. They also reported a lower average score of sexual depression when compared to survivors in the Demeaning and depressive profile but not when compared to the Confident and non-preoccupied profile. In regard to external characteristics, this profile had the highest average scores of sexual compulsion and sexual satisfaction. They also had more sexual partners in their lifetime and the lowest average score of sexual disorders, when compared to survivors in other profiles. Survivors in this profile were more likely to report having been victimized by an acquaintance when compared to survivors in the Confident and non-preoccupied profile, and by a romantic partner when compared to survivors in the Demeaning and depressive profile. This profile was the least prevalent among both male and female survivors, which differs significantly from the Confident and non-preoccupied profile only.

4. Discussion

Consistent with previous findings, the results of the current study suggest that CSA survivors do not form a homogenous group (Bennett, Hughes, & Luke, 2000; Yancey et al., 2011). According to the profiles that have emerged, sexuality and sexual self-concept appear to unfold differently in survivors and tend to be different for men and women.

4.1. Comparison of profiles on sexual self-concept and sexual functioning

Although the scientific corpus has shown that CSA survivors can experience a wide range of sexual difficulties, some studies show that a significant proportion of victims (20 %–40 %) report no symptoms in adulthood (Finkelhor et al., 1990). This could be reflected in the Confident and non-preoccupied profile, in which individuals seem to have a more normative sexual self-concept and fewer negative sexual outcomes (i.e. lower average scores on sexual disorders and compulsion in addition to higher average scores on sexual satisfaction). This profile also includes the largest number of participants, which is consistent with previous studies showing that resilience is the most common response to trauma exposure in adulthood (Bonanno, 2005). Thus, it is plausible that CSA survivors in this profile demonstrate more positive adaptation and resilience than others at the time of the study. The Demeaning and depressive profile, and the Hyperconfident and preoccupied profile seem more characterized by divergent, perhaps even opposite, sexual self-concept and sexual functioning outcomes. These findings echo the review conducted by Aaron (2012), in which the author states that the sexuality of CSA survivors can range between two opposite ends of a continuum: withdrawal and compulsion. Withdrawal is marked by sexual aversion, flashbacks and dissociation during sexual intercourse, negative feelings regarding sexuality or intimacy, and more sexual dysfunctions. The withdrawal trajectory shares mutual components with the Demeaning and depressive profile, which is characterized by low sexual confidence, more sexual disorders, and little to no preoccupation with sexuality. Compulsion however is characterized by hypersexuality and sexual acting out, which can lead to risky sexual behaviors (Aaron, 2012). This sexual trajectory is similar to the Hyperconfident and preoccupied profile which is characterized by high sexual esteem and preoccupation as well as greater sexual functioning. Interestingly, results revealed that participants from the Demeaning and depressive profile are not the ones that have the least average score of sexual preoccupation, even if they seem to have a more negative relationship with sexuality. Snell and Papini (1989) explained that individuals who are more depressed over their sexuality may think about it more often, but through the maintaince of negative thoughts. These negative thoughts may in turn result in disturbed negative feelings and difficulties related to sexual functioning (Bigras, Godbout, & Briere, 2015).

4.2. Comparison of profiles on sexual self-concept, CSA characteristics and ASA

Findings of the participant distribution across profiles according to CSA characteristics showed that the Demeaning and depressive profile comprised of a greater number of participants who were sexually abused by a family member, whereas the Hyperconfident and preoccupied profile comprised of a greater number of participants who were sexually abused by an acquaintance or a romantic partner. These findings may be partially explained by the fact that CSA survivors who had been abused by an individual with whom they had a significant and lasting bond, like a family member, would be more likely to experienced sexual distress, poorer sexual functioning and sexual esteem (Finkelhor & Browne, 1985; Ketring & Feinauer, 1999; Stephenson, Hughan, & Meston, 2012). Nevertheless, offenders' identity was the only variable in CSA characteristics that was statistically significant ($p < 0.05$) and only for three types (i.e. family member, acquaintance, romantic partner). It is difficult to interpret or compare these results with previous studies among CSA survivors since most of them have merged frequency, duration, sexual acts committed and offender's identity into

a single variable (i.e. CSA severity). In addition, findings linking CSA severity and symptomatology in CSA survivors vary significantly from study to study and are inconsistent (Ullman & Filipas, 2005; Trickett, Noll, Reiffman, & Putnam, 2001) and even absent regarding effects on sexual self-concept in adulthood. ASA (i.e. revictimization) was not a significant factor between sexual self-concept profiles. Possible explanation could be that sexual self-concept is linked to revictimization, but indirectly. For instance, maladaptive coping strategies (e.g. alcohol or drug consumption), self-blame and PTSD symptoms are reported as strong predictors of revictimization in CSA survivors (Filipas & Ullman, 2006; Fortier et al., 2009), but they were not investigated in this study. Furthermore, the non-significant results regarding CSA characteristics and ASA can be attributed to the lack of statistical power. Thus, it is possible that the effect would be found in a larger sample.

4.3. Comparison of profiles on sexual self-concept, age and gender

The distribution of men and women between the different profiles in this study indicates that male and female survivors differ in regards to their sexual self-concepts and sexual functioning. Men are more likely to find themselves in the sexually Demeaning and depressive as well as the Hyperconfident and preoccupied profiles, which appear to be opposite sexual trajectories. These results suggest that a significant number of male CSA survivors may have polarized and troublesome sexual self-concept and sexual functioning, while female survivors seem to display more “normative” sexual self-concept and sexual functioning. Furthermore, the finding that a higher proportion of men can be found in the sexually Hyperconfident and preoccupied profile is consistent with previous studies on CSA indicating that men are more likely to follow a hypersexual and compulsive trajectory than women (Labadie, Godbout, Vaillancourt-Morel, & Sabourin, 2018; Perera, Reece, Monahan, Billingham, & Finn, 2009; Vaillancourt-Morel et al., 2015); iand to report ongoing preoccupations about sexuality (Aaron, 2012; Wiederman & Allgeier, 1993). Hence, men may be more likely to cope with experience of CSA by acting out sexually and externalizing their distress (Meyer, Cohn, Robinson, Muse, & Hughes, 2017). Conversely, past studies suggest that female survivors may be more likely to follow the opposite trajectory, characterized by hyposexuality, avoidance and sexual disorders (Easton, Coohey, O’leary, Zhang, & Hua, 2011), as well as sexual dissatisfaction (Lopez et al., 2017). However, results from this study differ from previous ones as men tend to be represented in a greater proportion in the Demeaning and depressive profile, characterized by higher sexual depression, higher sexual disorders and lower sexual satisfaction scores, while women were found in a higher proportion in the profile characterized by less sexual difficulties. Possible explanations of these findings may be that responses to CSA are likely to be influenced by the different gender social norms that can lead men and women to externalize the long-term effects of this trauma differently. Notably, American norms of masculinity can lead men to validate their masculinity through sexuality, in which they are expected to be dominant,initiator and always available and willing to engage in sexual activities (Wiederman, 2005). Nevertheless, an experience in which a boy was compelled to have sexual activities and felt powerless weakens these masculine conceptions and can cause psychological distress and induce shame in the survivor’s sense of self (Alaggia & Millington, 2008; Easton, 2014). Thereby, sexual functioning as well as sexual esteem in male survivors who strongly adhere to these norms can be impacted in a negative way (Dhaliwal, Gauzas, Antonowicz, & Ross, 1996; Kia-Keating, Grossman, Sorsoli, & Epstein, 2005). Conversely, male survivors can display exaggerated masculine attitudes and norms regarding sexuality involving compulsivity and multiple partners in order to assert their masculinity, which has been undermined (Kia-Keating et al., 2005). This is reflected by a higher proportion of men in the Hyperconfident and preoccupied profile. In contrast with past studies, which have indicated that female survivors report several sexual difficulties and dissatisfaction as well as a negative sexual self-concept (Rellini & Meston, 2011), the highest proportion of women in the present study was found in the Confident and non-preoccupied profile, characterized by less sexual outcomes and a more normative sexuality. This could potentially indicate that women may have more positive strategies or resources (e.g. social support) that allow them to buffer the lingering effects of CSA than men (McDonald & Tijerino, 2013). In addition, the mean age of participants was relatively high (41.17 years old) in the current sample, and particularly among men. Yet, age and gender appear to be significant variables when studying the effects of CSA. Notably, negative impacts appear to lessen with age for women, whereas men's impacts are more likely to increase and intensify over time (Van Roode, Dickson, Herbison, & Paul, 2009). As such, this may explain, in part, why men tend to report more difficulties related to sexual self-concept and sexual outcomes than women.

4.4. Strengths and limitations

The interpretation of our results is limited in several ways. Firstly, this cross-sectional study captures participants’ experiences at a specific point of time, which does not take into account possible progression in participants’ sexual self-concept and outcomes. Secondly, the sample size in this study was relatively small, which limits the generalization of the results to other populations. Probably related to insufficient statistical power, some analyses did not show conclusive results, such as current age, occurrence of ASA and a majority of the CSA characteristics, even if several previous studies have found a link between these variables and sexual outcomes in survivors (Finkelhor et al., 1990; Loeb et al., 2011; Van Bruggen et al., 2006). Thirdly, the sample in the current study is mainly composed of Caucasian, middle class individuals who are educated, which does not represent the Canadian population in which we find greater ethnic and socioeconomic diversity. Women were also overrepresented in the sample, which may have affected the distribution of the clusters and limited gender comparison. Furthermore, most participants were recruited through community organizations for CSA victims, which limits generalization of the results to the wider population of CSA survivors, notably among those who do not seek help from services. Fourthly, while some studies on sexual victimization have found a limited social desirability effect (Anderson, Cahill, & Delahanty, 2018), there are some studies that reported that social desirability can potentially induce bias in self-report research (Van de Mortel, 2008) and influence responses to questions about sexuality. Participants who are

questioned about their sexual life may be embarrassed and fear reprisals, which may affect their answers (Catania, Gibson, Chitwood, & Coates, 1990). As such. it is still important to consider this effect on the current study since it includes variables that touch upon sexuality. Social desirability may be more present among men who strongly adhere to traditional masculine norms (King, Duncan, Clinkenbeard, Rutland, & Ryan, 2019), such as the enhancement of sexual performances as well as a larger number of sexual partners. However, participants completed the questionnaire on a computer as opposed to face-to-face, which may have possibly produced a sense of disinhibition and led to answers that are closer to the realities of the participants (Booth-Kewley, Larson, & Miyoshi, 2007).

Despite these limitations, the present findings offer some important contributions. This study's results highlighting the different trajectories of sexual self-concept and sexual functioning in CSA survivors are innovative since past studies focused almost exclusively on describing a single trajectory (e.g. hyposexual or hypersexual), rather than on comparing multiple ones. Moreover, samples in these past studies were composed solely of men or women (Jacob & Veach, 2005; Lemieux & Byers, 2008; Parsons, Rendina, Moody, Ventuneac, & Grov, 2015). Given this, gender comparison in this study is more accurate since men and women were compared on the same variables (i.e. using the same questionnaire) at the same point in time. Furthermore, sexual self-concept is an understudied issue in CSA survivors, particularly among men. In that respect, this study allows an overdue reflection on the sexuality of male CSA survivors in the same way as female survivors, which has been kept in the dark from several men for too long, due notably to their specific barriers to disclosure (e.g. issues related to masculinity; Easton, Saltzman, & Willis, 2014).

4.5. Implications for research and practice

Several suggestions for future research can be addressed. Notably, as the size of the sample was relatively small, the study should be replicated on a larger scale. Conducting longitudinal studies would also be relevant in order to see if participants would change from one profile to another over time, given that age, personal reflection and processing of the abuse (Feiring, Taska, & Lewis, 1996), as well as sexual experiences (Garcia, 1999), may evolve and modulate sexual self-concept in CSA survivors. Cross-validation findings with other samples would also be relevant in order to determine whether these findings represent a stable phenomenon and whether they can be replicated. Furthermore, considering that sexual self-perceptions and sexual behaviors appear to be inter-related (Garcia, 1999; Rellini & Meston, 2011), further analyses should be conducted to establish the nature of these links. Notably, confirmatory analyses such as factor analysis, mediation or moderation models should be performed. Gender comparison should also be carried out in order to offer a more comprehensive view regarding the interaction between sexual self-concept and sexual outcomes in CSA survivors. Moreover, further studies should be conducted to investigate the link between CSA characteristics and sexual self-concept in survivors. Consequently, this would allow us to see if certain characteristics, such as offender's identity, are strong predictors of sexual outcomes in male and female survivors. Qualitative studies should also be conducted to better understand the meaning that participants accord to their CSA experiences,and their impact on their sexual self-perception. This point is particularly important for clinicians and stakeholders working with CSA survivors who will not only have to understand the objective reality of CSA situations and its characteristics (e.g. offender's identity), but also the perceived experiences of survivors (e.g. their qualification of the bond with their offender; Tardif, Fernet, Proulx-Boucher, & Parent, 2005). Further studies investigating revictimization pathways and its predictors in CSA survivors are needed as well, as revictimization may exacerbate the effects of previous CSA experiences (Fortier et al., 2009). More studies should attempt to better understand the link between sexual self-concept and sexual revictimization in adulthood, especially variables that may moderate or mediate this relationship. In addition, qualitative studies should be conducted among CSA survivors to gain insight on sexual assault experiences in adulthood and the context in which they can occur. Considering the higher proportion of women found in the Confident and non-preoccupied profile, further research should also attempt to understand why female survivors seem to do better than male survivors of CSA regarding their sexual self-concepts. Potential buffering factors, such as social support, use and access to services and positive coping strategies, especially regarding sexual difficulties, should be examined.

Propositions for practice with survivors may also be formulated. In particular, interventions and clinical care should be adapted according to each profile that emerges from analyses and the specific issues that can be encountered by male and female survivors regarding their sexual self-concept. Intervention targets for the Demeaning and depressive profile should focus on improving sexual esteem, which could likely have an effect on other sexual components in their lives such as sexual disorders and satisfaction. In the Hyperconfident and preoccupied profiles, interventions target should address primarily their sexual preoccupations and how invasive they can be. The possible link between sexual self-perceptions and the risky sexual behaviour survivors adopt (i.e. large number of sexual partners combined with sexual compulsivity) could also be considered and discussed. Clinicians and other professionals working with CSA survivors, especially with male ones, should also take into consideration the strong negative feelings survivors may feel in connection to the abuse. Notably, because male survivors may experience a deep sense of shame that can last long after the abuse (Alaggia & Millington, 2008) and may hold deeply stereotypical conception of masculinity (Easton, 2014), therapy should address and attempt to deconstruct these potentially toxic beliefs. Discussing incongruence between themselves and other men regarding masculinity could be valuable in order to promote authenticity in their sexuality (Turmel & Liles, 2015). Finally, many studies pointed out that lower sexual esteem and poorer sexual functioning are considered as important factors that can lead to sexual revictimization in CSA survivors (Lemieux & Byers, 2008; Van Bruggen et al., 2006). Interventions and clinical care should further explore sexual esteem among survivors and consider its influence on their sexual behaviors. Thus, in order to lessen risk of revictimization, practitioners should provide information on the possible effects of CSA (e.g. feelings of guilt and self-blame) in survivors and how they may influence their sexual self-concept. In addition, risky sexual behaviors and compulsion should also constitute privileged intervention targets to prevent further victimization. Afterwards, professionals should take into consideration the gender of survivors they work with, as their sexual self-concept may be influenced by sexual norms and socio-cultural context in

which they live.

5. Conclusion

The current study yields that CSA survivors constitute a heterogeneous population and have differentiated sexual self-concepts. Results revealed three profiles among survivors according to their sexual self-concept. The Confident and non-preoccupied profile seem to demonstrate a more normative sexual self-concept, whereas the Demeaning and depressive as well as the Hyperconfident and preoccupied profiles displayed seemingly opposite sexual self-concepts. Notably, survivors from the Demeaning and depressive profile show a higher level of sexual depression while survivors from the Hyperconfident and preoccupied profile stand out by the highest level of sexual esteem and preoccupation. Moreover, gender comparisons between profiles revealed that women are found in greater number within the Confident and non-preoccupied profile while men are found in greater number in the Demeaning and depressive profile, which highlights that men tend to have a more detrimental sexual self-concept than women. Thus, the diversity of sexual concepts found in this study as well as gender differences raise the need to provide tailored interventions and clinical care among CSA survivors.

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