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Cumulative Adverse Childhood Experiences and Sexual Satisfaction in Sex Therapy Patients: What Role for Symptom Complexity?

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ABSTRACT

Introduction: Patients consulting for sexual difficulties frequently present additional personal or relational disorders and symptoms. This is especially the case when they have experienced cumulative adverse childhood experiences (CACEs), which are associated with symptom complexity. CACEs refer to the extent to which an individual has experienced an accumulation of different types of adverse childhood experiences including sexual, physical, and psychological abuse; neglect; exposure to inter-parental violence; and bullying. However, past studies have not examined how symptom complexity might relate to CACEs and sexual satisfaction and even less so in samples of adults consulting for sex therapy.

Aim: To document the presence of CACEs in a sample of individuals consulting for sexual difficulties and its potential association with sexual satisfaction through the development of symptom complexity operationalized through well-established clinically significant indicators of individual and relationship distress.

Methods: Men and women (n = 307) aged 18 years and older consulting for sexual difficulties completed a set of questionnaires during their initial assessment.

Main Outcome Measures: (i) Global Measure of Sexual Satisfaction Scale, (ii) Dyadic Adjustment Scale—4, (iii) Experiences in Close Relationships—12, (iv) Beck Depression Inventory—13, (v) Trauma Symptom Inventory—2, and (vi) Psychiatric Symptom Inventory—14.

Results: Results showed that 58.1% of women and 51.9% of men reported at least four forms of childhood adversity. The average number of CACEs was 4.10 (SD = 2.23) in women and 3.71 (SD = 2.08) in men. Structural equation modeling showed that CACEs contribute directly and indirectly to sexual satisfaction in adults consulting for sex therapy through clinically significant individual and relational symptom complexities.

Conclusion: The findings underscore the relevance of addressing clinically significant psychological and relational symptoms that can stem from CACEs when treating sexual difficulties in adults seeking sex therapy.
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Key Words: Symptom Complexity; Mental Health; Relatedness; Sexual Satisfaction; Adverse Childhood Experiences

INTRODUCTION

Psychosexual and relational risk factors of low sexual satisfaction are increasingly well delineated and encompass a wide array of individual and relational dynamics.[1] For example, anxious and depressive moods operate in conjunction with various features of relationship distress (eg, affective communication, anxious and avoidant attachment) to predict sexual well-being or satisfaction.[2] Sex and relationship duration generally moderate these associations, underlying the need to include these variables in integrative models.[3—5] Recent reviews and empirical studies have suggested that models aiming to better understand sexual satisfaction need to consider early developmental adversities that can shape sexual knowledge, attitudes, and behaviors.[6—8] Specifically, adverse childhood life experiences (ACEs) have been shown to contribute, throughout the life course, to sexual anxieties, avoidance or compulsion, and ultimately to decreased sexual satisfaction.[6,8—10] There is an increasingly large body of literature on the association of child sexual abuse[11] and other forms of ACEs, namely child physical abuse and neglect,[8,12—15] with

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sexual functioning, yet the link with sexual satisfaction per se is less studied. Moreover, recent studies have indicated that multiple co-occurring forms of child adversity better predict overall physical and mental health problems[16] and trauma-related symptoms.[17] In fact, the trauma-focused empirical literature increasingly indicates that cumulative ACEs (CACEs) are more likely to lead to negative outcomes than exposure to a single type of ACE independently of its severity.[17–19] These results suggest that the association between ACEs and adult negative outcomes follow a dose-response model in which exposure to more adversities predicts poorer functioning.[20] In one of the few studies examining the link between CACEs and sexual satisfaction, in adults from the community, Bigras et al[6] observed a stable effect of CACEs on decreased sexual satisfaction, even when removing the specific effects of child sexual abuse. CACEs can decrease sexual satisfaction because childhood adversity often occurs at the hand of significant attachment figures, in situations where intense negative feelings such as fears, perceived betrayal, abandonment, and loss[21,22] are experienced, are carried throughout life, and potentially are triggered or re-evoked in sexual relationships, thus affecting sexual satisfaction.[23] Although current evidence-based sex therapy manuals include general recommendations for sexually traumatized individuals,[11] the prevalence of various forms of child maltreatment and the correlates of those adverse experiences in patients consulting in sex therapy clinics remain largely unknown.[24,25]

If fact, the available literature suggests high rates of child sexual abuse in sex therapy patients (more than three times higher than those reported in the general population[24]), but other types of ACE remain less well documented. Clinical case studies have suggested that when CACEs issues and related symptoms are not successfully addressed during treatment, dropout rates can increase[26] and therapy effectiveness decreases.[27] These findings emphasize the need to concentrate research efforts on the effects of CACEs on sexual outcomes in clinical samples of sex therapy patients.

Although there is an extensive body of research examining specific forms of childhood adversity separately, they tend to co-occur.[28] This co-occurrence of childhood adversity has generated great interest in the scientific literature from which has emerged a wide array of closely related concepts, including the notion of CACEs that refers to the number of different types of adversity experienced by the same person.[6,29–31] Although past studies have shown that the accumulation of multiple forms of child maltreatment is associated with individual (eg, dissociation, depression, anxiety) and relational (eg, attachment insecurities) difficulties[32,33] that can jeopardize sexual satisfaction, the clinical significance of these negative effects has been questioned.[34] The notion of symptom complexity refers to "the number of different symptom clusters simultaneously reported in the clinical range by each participant"[19] [p. 224]. Symptom complexity has been discussed in reference to complex trauma[35] and disorders of extreme stress not otherwise specified.[36,37] The construct reflects the clinical and empirical observations that, as the number of different types of ACEs experienced by individuals increases, clinical symptoms of psychosocial distress will not only increase in a statistically significant way but also reach normative thresholds separating dysfunctional from normal populations. In consequence, the clinical burden associated with these severe co-occurring symptoms of attachment insecurity, couple distress, depression, and dissociation will meaningfully disrupt adult functioning.[28] This hypothesis was tested in a series of studies showing a linear association between the number of ACEs experienced before 18 years of age and individual symptom complexity.[28,30,38–40]

The mechanisms of these CACE effects on sexual satisfaction are unknown. However, previous ACEs could produce symptoms that accumulate over the long haul. When these symptoms become persistent, they eventually lead to lower sexual satisfaction. The self-trauma model[41] theoretically supports this assumption suggesting that CACEs might lead to cumulated symptoms in different domains, including psychological suffering, overwhelming low regulation capacities, and relational difficulties, which decrease survivors' satisfaction and adaptation in adulthood. Therefore, the present study posits that the construct of symptom complexity offers a comprehensive understanding of the relation between CACEs and the wide range of symptoms presented by adult survivors consulting for sex therapy. Thus, we examined whether CACEs would lead to an accumulation of relational and psychological symptoms and in turn be associated with lower sexual satisfaction in sex therapy patients.

Whether these findings about trauma-based symptom complexity can be extended to sexual difficulties observed in clinical settings remain to be determined. In addition, because adult sexuality is rooted in individual and relational dynamics,[1,42] conceptualizations of symptom complexity should more clearly reflect these intrapersonal and interpersonal dimensions as distinct domains of symptom complexity.

Although there is evidence associating CACEs with clinically significant symptom clusters at the individual level (ie, a combination of anxiety, depression, dissociation, and other personal symptoms in the clinical range),[39,43] it is unknown whether relational symptom complexity is related to sexual satisfaction. However, comorbidity is the norm rather than the exception in patients consulting sexual health clinics.[44] Thus, in theory, because of the complex interplay between mental and sexual health,[45] symptom complexity should predict sexual satisfaction.

Relational symptom complexity can be defined as the extent to which an individual endorses, at clinical levels, different types of relatedness impairments. To our knowledge, there are no studies on relational symptom complexity in association with CACEs and sexual satisfaction. However, there is evidence that CACEs are associated with attachment insecurity, dysfunctional intimate relationships, and negative sexual outcomes.[6,33,46,47] Thus, the