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Sexual Satisfaction and Functioning in Women with Histories of Sexual Victimization

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Abstract

TITLE: Sexual Satisfaction and Functioning in Women with Histories of Sexual Victimization

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The present study evaluated the relationship between a history of sexual abuse and adult sexual satisfaction and functioning. This included examining psychological symptomology, revictimization, and the degree of sexual functioning and sexual satisfaction of women who reported childhood, adolescent, and/or adult sexual traumas. This study contributes to the limited research on the sexual functioning of women with childhood sexual trauma histories. Sexual satisfaction and sexual functioning were found to be related, yet separate areas in which women with sexual abuse histories may experience difficulties. There was evidence of an association between psychological distress and trauma history in that the presence of more severe depression, PTSD and experiential avoidance were all related to lower sexual satisfaction and functioning. Moreover, women who were revictimized reported higher rates of psychological symptoms and lower sexual satisfaction. Women with a history of CSA who were revictimized in adolescence and adulthood experienced more severe PTSD, depression, and experiential avoidance than women with only two incidents of sexual abuse, women with one incident of sexual abuse, and women with no sexual trauma history. Psychological symptomology was found to have the most significant effect on women's sexual satisfaction. Future research should utilize clinical interviews to better understand the histories of women who have been sexually victimized, as well as evaluate sexual functioning in order to address the overall well-being of women with trauma histories. Clinical implications are discussed.

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Literature Review

Introduction.

Childhood sexual abuse (CSA) is a public health issue, with prevalence rates ranging from approximately 3 to 27% of women (Molnar, Buka, and Kessler, 2001). CSA is considered a major risk factor for negative outcomes, such as posttraumatic stress disorder (Senn, Carey & Vanable, 2008), depression, anxiety, substance abuse, interpersonal isolation, sexual difficulties and dissatisfaction, and risk of revictimization (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). While many women may experience negative outcomes, some will recover from traumatic events or show resilience through a natural process. However, for many women, experiences of CSA have been shown to be related to sexual functioning and satisfaction, and possibly related to a number of factors, including post-traumatic stress symptomology, experiential avoidance, and risky sexual behaviors. Because of the severity of symptoms in some survivors, it is vital for clinicians to understand the potential sexual, psychological, and behavioral impacts of CSA on adult functioning. This is important for both identification of specific treatment needs and development of early intervention programs.

Child Sexual Abuse

Definitions.

Although a number of definitions of the term childhood sexual abuse (CSA) exist throughout the empirical literature, variations in the use of this term has lead

researchers to develop behaviorally specific definitions of CSA. However, legal, clinical, and research definitions may vary as a function of their different purposes (Haugaard, 2000). For example, legal definitions of CSA may vary from state to state, whereas clinical definitions have varied as empirical literature developed and researchers operationalized definitions. Due to the difficulties in developing a common definition of CSA, many researchers have used more broad definitions to define CSA. Some problematic implications of such broad definitions include a lack of clarity in the prevalence rates of CSA related to a lack of behaviorally specific definitions when asking about abuse. Using general terms, such as molestation, abuse, and inappropriate sexual behaviors, has caused some confusion in the literature. Thus, best practice in research requires use of behaviorally specific measures.

Despite an effort to further operationally define the terms of CSA collectively, many definitions of CSA in the literature can be seen to vary, especially in reporting the age of a victim whom is deemed "a child," as well as the type of sexual act performed (Senn, Carey, & Vanable, 2008). A meta-analysis which reviewed the commonalities of definitions of CSA in the empirical literature found that CSA typically refers to abuse that occurs during childhood or adolescence, meaning before the age of 18. However, it was also noted that some researchers have utilized cut offs ranging from 17 years old to as young as 13 years

old. Noting the differences in defining victim age is important because research has indicated differences in outcomes associated with childhood and adolescent sexual victimization (Kelley & Gidycz, 2015). Findings indicate that individuals who are victimized after age 16 may experience more negative psychological outcomes, such as depression, anxiety, and antisocial behavior (Marker, Kemmelmeier, & Peterson, 2001). Additionally, in a study comparing the psychological outcomes of childhood sexual abuse and adolescent sexual abuse, researchers found that adolescents who are sexually victimized display more significant psychopathology, such as trauma-related disorders and mood disorders, as well as poor social adjustment and risky sexual behaviors (Kaltman, Krupnick, Stockton, Hooper, & Green, 2005).

Senn, Carey, and Vanable (2008) also noted some researchers use the discrepancy in age between the perpetrator and the victim to define abuse. In definitions that utilize the age-discrepancy variable, acts are only considered sexual abuse if the perpetrator is a certain number of years older than the child. Typically, researchers utilize an age discrepancy of five years. The meta-analysis added that other researchers have chosen to utilize a graded age-discrepancy definition, meaning the age difference between the perpetrator and the child is less for younger children than for older children. Additionally, researchers have also varied in their definitions of the type of sexual act that is considered to be abuse. Some definitions

include non-contact sexual acts, such as sexual exhibitionism or showing a child pornography; others require contact, such as kissing or fondling; and the most restrictive definitions consider only acts where penetrative contact occurs, such as in oral, vaginal, or anal intercourse, as sexual abuse (Senn, Carey, & Vanable, 2008; Murray, Nguyen, & Cohen, 2014). Many researchers have incorporated the use of force into definitions of CSA, and some consider an act to be sexual abuse, regardless of age, if force was used by the perpetrator (Senn, Carey, & Vanable, 2008). Murray, Nguyen & Cohen (2014) noted that many definitions of CSA commonly reflect the unlawfulness of acting sexually upon anyone against his or her will, regardless of the use of physical force, physical contact, or injury.

Despite the range of definitions of CSA across studies, there are definitions that are most commonly seen in the literature. For example, Finkelhor (1979) defined CSA as contact and non-contact sexual acts involving a child victim age 12 or younger and someone 5 or more years older than the child, or an adolescent victim between the ages of 13 or 16 and an adult at least 10 years older than the adolescent. Briere (1995) defined CSA as forced sexual contact that occurs before age 17 or with someone at least 5 years older.

In this study, we define CSA as sexual contact ranging from fondling to completed vaginal, oral, or anal intercourse that occurred prior to age 18 by someone 5 years older than the subject or of any age if the contact was not desired

or involved force. In addition, we categorized the abuse into child and adolescent groups. Therefore, adolescent sexual abuse was defined as sexual contact ranging from fondling to completed vaginal, oral, or anal intercourse that occurred after age 14, but prior to age 18, by someone 5 years older than the subject or of any age if the contact was not desired or involved force.

Disclosure/Stigma.

Most studies of survivors of CSA rely on adults to retrospectively report their experiences. While there has been some concern that reports may be affected by an adult's difficulty in recalling the events from his or her childhood (Murray, Nguyen & Cohen, 2014), researchers continue to rely on participant recall of life events. It is common for women to experience periods in their lives where they do not recall the abuse that was reported when they were children (Williams, 1994). It is generally difficult to access objective reports from individuals whom were close to the survivor, as many incidents of CSA go unseen or are hidden from family and friends (Murray, Nguyen & Cohen, 2014). Additionally, many incidents of CSA are not confirmed by medical or forensic evaluations due to the large number of cases that are never reported to the authorities at the time of the abuse (Williams, 1994). One hypothesized barrier to disclosure is that the individual can be affected by the stigmatization of CSA and may experience a shameful and self-blaming attributional style (Feiring, Taska, & Lewis, 1996). Children's perceptions of

responsibility for the abuse, as well as feelings of guilt and shame, and loss of self-worth, may affect their willingness to disclose the abuse (Murray, Nguyen & Cohen, 2014). Interestingly, self-blame attributions, delayed disclosure, and negative social reactions from others have been associated with more negative health outcomes and adjustment (Ullman, 2007). Particularly when a survivor discloses abuse and receives negative reactions from trusted family members or friends, negative reactions may be viewed as an intimate betrayal of the survivor's relationships with others. Additionally, research has found that individuals who have been sexually assaulted by multiple perpetrators were more likely to delay disclosure of the abuse due to feelings of self-blame and shame (Kellogg and Hoffman, 1997). However, Loftus, Polonsky, and Fullilove (1994) found that 81% of their sample of adult women, who retrospectively recalled childhood sexual abuse, remembered the abuse their whole lives. This suggests that these reports are still a valid way to assess women with CSA histories.

Long-Term Correlates of Childhood Sexual Abuse

Exposure to traumatic events has been shown to be related to negative psychological outcomes, including depression, post-traumatic stress disorder, and suicide (Heim & Nemeroff, 2001; Polusny & Follette, 1995). Specifically, CSA has been found to be related to several long-term psychological correlates that

significantly impact the daily functioning of the survivor. In a review of the literature on long-term correlates of CSA, many studies suggest an association between experiences of childhood sexual abuse and psychological difficulties, such as depression, anxiety, and poorer sexual adjustment and dysfunction, as well as an increased risk of revictimization (Polusny & Follette, 1995).

Recent literature has expanded the understanding of the risk factors associated with CSA. In particular, research has shown that children whom are exposed to one type of victimization, such as CSA, often have a higher prevalence of various types of childhood maltreatment, such as physical and emotional abuse, and neglect (Rellini & Meston, 2011; Lacelle et. al., 2012). In comparison to children whom have suffered one type of abuse, children who have been exposed to multiple types of maltreatment are associated with more negative outcomes and a more complex set of symptoms (Lacelle, Hérbert, Lavoie, Vitaro, & Tremblay, 2012).

The empirical literature suggests that multiple forms of trauma may result in more psychological symptomology. In their study of cumulative trauma, Follette, Polusny, Bechtle and Naugle (1996) examined the relationship between cumulative, or multiple, traumatic experiences on the development of trauma-related symptoms. Researchers focused on experiences of CSA, adult sexual assault, and adult domestic abuse, and they found that cumulative traumatic

experiences are related to an increase in symptomology. Specifically, women who reported multiple types of victimization or trauma reported significantly more trauma-related symptomology, including anxiety, depression, and dissociation.

Depression.

Depression is considered one of the most common long-term correlates of CSA and has been extensively documented in the literature (Polusny & Follette, 1995). Early life trauma, such as CSA, has also been associated with developing major depressive disorder as an adult. However, even in those individuals who do not develop major depressive disorder, individuals with CSA histories have been found to have higher levels of depressive symptomology than those who do not have these histories (Polusny & Follette 1995; Schoedl, Cardobobbi Pupo Costa, Mari, Mello, Tyrka, Carpenter, & Price, 2010; Subica, 2013). Research has found that individuals who are exposed to sexual abuse at an early age, such as in childhood or adolescence, were more likely to have severe and prominent depressions symptoms following a victimization in adulthood (Schoedl, et. al., 2010). Additionally, Schoedl et. al. (2010) discovered that individuals who reported CSA had an increased odds ratio of 5.18 for developing depression. A review of the literature suggested 30-40% of CSA survivors report a lifetime history of depression, and 10-20% of individuals without a history of abuse reported depression (Musliner & Singer, 2014). Researchers have suggested that individuals

with CSA histories may experience an earlier onset of depressive symptoms, longer episode duration, and more severe illness characteristics, which may indicate their need for a range of therapy options.

Post-Traumatic Stress Disorder.

Stressful life events may have an intense and lasting impact on an individual, and while some individuals experience a resiliency that allows them to naturally recover from such events, others will develop post-traumatic stress disorder as a direct consequence of the trauma (Bonnano, 2004). Research has suggested that childhood sexual abuse uniquely predicts the development of PTSD, and that abuse in childhood is a stronger predictor of PTSD than trauma in adulthood (Subica, 2013). Some research has found individuals who reported CSA had a .91 odds ratio for developing PTSD compared to individuals without such histories (Schoedl et. al., 2010). Additionally, in a study that examined the risk factors for posttraumatic stress disorder, researchers found that 45% of the sample of women seeking help at a center for rape victims met the criteria for a PTSD diagnosis, whereas 70% reported significant posttraumatic stress symptoms (Elklit & Christiansen, 2013). PTSD is often explained using a two-factor theory, which utilizes classical and operant conditioning constructs to explain the emotional avoidance often seen in individuals post-trauma. Traumatic events, such as CSA, often evoke anxiety and fear in an individual, which is then paired with the initial

event. The individual then learns that by avoiding similar situations, one is able to avoid the anxious and fearful reactions associated with the event. Therefore, the avoidance becomes reinforcing, as the individual escapes the aversive feelings.

Exposure to traumatic experiences as a child can increase the risk of developing PTSD later in life (Schoedl et. al., 2010). Some researchers have found the risk of developing PTSD following CSA to be linked with the severity of the abuse, which is based on several factors including the type of abuse, the duration, and the frequency (McLean, Morris, Conklin, Jayawickreme, & Foa, 2014). In this regard, some studies have suggested that women with histories of CSA that included more severe types of abuse, such as penetration, experience higher rates of PTSD than women who did not experience penetration. Additionally, age of onset of sexual abuse has been shown to have an effect on the development of PTSD symptoms in adulthood (Schoedl et. al, 2010). Some individuals with earlier exposure to sexual victimization, such as those whom experiences abuse in childhood or adolescence, have been found to have more severe depression and PTSD symptoms if they were revictimized. Another important factor in analyzing the occurrence and severity of PTSD in women with CSA histories is the relationship between the perpetrator and the victim. Some studies have shown PTSD symptoms to be significantly higher in women who were abused by a family member compared to those who were abused by a stranger (Lev-Wiesel, Amir, &

Besser, 2005). Some researchers suggest that the security of adult attachments may impact a CSA survivor's vulnerability to the development of PTSD in adulthood (Twaite & Rodriguez-Srednicki, 2004). Individuals whom experience CSA may fail to develop secure attachments to adult figures that help to protect them from the extreme stress related to traumatic experiences later in life. This leaves them more vulnerable to the effects of any stressor on their psychological functioning.

Revictimization.

Research has been devoted to understanding the link between CSA and future victimization, referred to as revictimization (Classen, Palesh, & Aggarwal, 2005). For example, Fergusson, Horwood, and Lynskey (1997) found that individuals who experienced CSA are at a greater risk for future sexual assault or abuse. Revictimization has previously been defined as the experience of repeated occurrences of sexual victimization among those with a preexisting history of sexual trauma (Follette & Vijay, 2008). Some researchers have found that women who have CSA histories are two to three times as likely to experience revictimization as an adult than women without such histories (Barnes, Noll, Putnam, & Trickett, 2009; Cloitre & Rosenberg, 2006; Classen, Palesh, & Aggarwal, 2005). Researchers suggest revictimized women compose the largest subgroup of sexually assaulted women (Cloitre & Rosenberg, 2006). In regards to college samples, it has been found that women with CSA histories are 1.4-2.1 times

more likely to experience sexual assault as an adult than college women without an abuse history. Additionally, researchers have suggested survivors of CSA with a history of two or more sexual assaults before the age of 18 were more likely to have experienced problems with sexual desire, arousal and orgasms (Kinzl, Traweger, & Biebl, 1995).

Risser, Hetzel-Riggin, Thomsen, and McCanne (2006) noted several studies that suggested severity of CSA, type of CSA (i.e. contact or noncontact abuse), duration of CSA, and the use of force are all associated with increased risk of adult sexual revictimization. Research has indicated that women who have been sexually revictimized are significantly more likely to have a lifetime diagnosis of PTSD than women whom had histories of CSA alone (Arata, 1999). Interestingly, research has also suggested than PTSD may serve as a significant mediator in the relationship between CSA and revictimization; most notably, the hyperarousal cluster of symptoms are found to be a risk factor for revictimization(Risser, Hetzel-Riggin, Thomsen, & McCanne, 2006). Hyperarousal symptoms may cause an individual to experience difficulty in discerning and responding to situation-specific cues. Additionally, some researchers discovered that individuals who suffered sexual abuse at earlier ages, such as childhood and adolescence, were more prone to severe and prominent depressive symptoms following revictimization in adulthood (Schoedl, Cardobobbi Pupo Costa, Mari, Mello, Tyrka, Carpenter, & Price, 2010).

Sexual Functioning

The etiology of sexual dysfunctions is complex and difficult to study empirically for a variety of factors (Wincze & Weisberg, 2015) and has led to a lack of controlled studies on the development of sexual dysfunctions. However, research through clinical observation has allowed researchers from many disciplines to develop general hypotheses about how sexual difficulties are developed. Wincze & Weisberg (2015) suggest sexual dysfunction is not singly determined, but develops from a multitude of causes. Sexual dysfunction may develop from three main categories which include predisposing, precipitating, and maintaining factors. Predisposing factors or characteristics, such as childhood sexual trauma or certain genetic medical conditions, may lead an individual to experience sexual difficulties. Precipitating, or triggering factors, such as stress may serve as an aggravating factor for a diathesis that places an individual at further risk for developing sexual problems. The diathesis stress model postulates that some individuals have an underlying vulnerability, such as CSA, and an added stressor can trigger sexual problems. Lastly, maintaining factors, such as performance anxiety, are ongoing and may be helpful to understand when attempting to understand why a sexual dysfunction persists. Causes of sexual dysfunction may also be categorized into biological or medical causes, psychological causes, or social causes (Wincze & Weisberg, 2015). Biological or

medical factors, such as vaginal dryness from the hormonal changes associated with menopause, may cause pain during intercourse for some women. Psychological factors, such as body disgust or intrusions due to post-traumatic stress, may also contribute to the development of sexual dysfunction. In addition, painful intercourse may be a result of both medical and psychological factors. Likewise, social factors such as religious beliefs may impact sexual functioning. While each individual category could lead to sexual problems, the literature suggests that the interaction between two or more of these variables would make an important contribution to an individual's sexual functioning.

Becker, Akinnwe, Abel, Axelrod, and Cichon (1984) added that the learning theory can explain the development of sexual problems related to assault. This explanation refers to the two-factor learning theory that states an assault evokes anxiety and fear in a survivor, which influences the survivor's view of the sexual aspect of the assault. The sexual aspect then elicits a negative reaction, even when not tied directly to the initial assault. A survivor may then avoid experiencing the negative reaction in later sexual activities by avoiding sexual activity. This allows the negative reaction to sexual activity to endure, which reinforces the fear and anxiety long-term.

Masturbation and Sexuality.

Masturbation is believed to serve many purposes, such as enabling people to learn about their bodies, as well as what pleases them sexually and how their bodies respond to sexual stimulation (Hurlbert & Whittaker, 1991). Some researchers have linked female masturbation to higher self-esteem, increased orgasm consistency and variation, and increased sexual desire. Hurlbert and Whittaker noted that marital and sexual satisfaction was increased for women who masturbated in their study of military wives. A review of the subject of female masturbation noted that while earlier research on female masturbation tended to associate the act with negative outcomes, such as guilt and depression, more recent research, although scarce, has focused on more positive aspects of masturbation (Fahs & Frank, 2014). These positive outcomes include increased sexual satisfaction, improvement of mood, and better sexual self-image.

Childhood sexual abuse may impact whether a woman chooses to self-stimulate through masturbation. Noll, Trickett, & Putnam (2003) reported histories of CSA may cause a survivor to become preoccupied with sexual activity. This may manifest in children as excessive masturbation, increased sexual play and earlier sexual intercourse. However, experiential avoidance may cause a woman to avoid any sexual experience that brings about memories, thoughts, or feelings of her earlier abuse, causing her to avoid self-stimulation as a result.

Sexual Disorders for Women.

Although sexual dysfunction occurs in both men and women, some dysfunctions are unique to women and their experiences. Women tend to experience sexual dysfunctions that affect their interest or desire, ability to orgasm, or that create pain while having sexual intercourse. Female Orgasmic Disorder is characterized by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) as a disorder in which a woman has difficulty experiencing an orgasm and/or experienced markedly reduced intensity of orgasms (American Psychological Association, 2013). Orgasmic experience is subjective (Wincze & Weisberg, 2015), as sensations are experienced in very different ways both between women's subjective experiences and across sexual occasions by the same woman (American Psychological Association, 2013). Women who are diagnosed with female orgasmic disorder experience these problems across approximately 75-100% of their sexual activity, which lasts for at least six months. Despite being a requirement for diagnosis according to the DSM-5, some researchers feel the criteria is restrictive, especially regarding the amount of subjective distress reported by women (Wincze & Weisberg, 2015). Prevalence rates of female orgasmic disorder reported by the DSM-5 range from 10% to 42% of women (American Psychological Association, 2013), however, Wincze & Weisberg report when using the DSM-5 criteria, lower prevalence rates are found compared to when women are

asked whether they were able to experience orgasm. According to the DSM-5 criteria, women who are not distressed by their lack of orgasm do not meet the criteria for Female Orgasmic Disorder (American Psychological Association, 2013).

Female Sexual Interest/Arousal Disorder incorporates the possible difficulties a woman may experience with desire or drive to engage in sexual activity, as well as the physiological responses to sexual excitement (Wincze & Weisberg, 2015). This diagnosis resulted from the merging of female hypoactive sexual desire disorder and female arousal disorder for the DSM-5 (Meston & Stanton, 2017). The DSM-5 diagnostic criteria states that a marked reduction in sexual interest and/or arousal can be manifested in a number of different ways. This reduction may be noted as absent or reduced sexual thoughts or fantasies, reduced interest in sexual activity, no or reduced initiation of sexual activity, and lack of response to partner's advances (American Psychological Association, 2013). Additionally, it may manifest as a lack of interest or arousal in response to sexual cues, either internal or external. Additionally, there may be an absence or reduction in sexual excitement or pleasure, and absence or reduction of genital or nongenital sensations, in nearly all sexual encounters, typically across 75-100% of encounters. Wincze and Weisberg (2017) noted that women with female sexual interest/arousal disorder may present in many different ways, as the diagnostic criteria requires

women to possess three out of six symptoms for a minimum duration of six months. Female sexual interest/arousal disorder as a new diagnosis has not yielded prevalence studies as of yet (Meston & Stanton, 2017). However, studies of the low sexual interest associated with the former female hypoactive sexual desire disorder and the low sexual arousal of the former female arousal disorder. Studies have shown between 22 and 43% of women in the United States reported low sexual interest, while low sexual arousal, typically associated with lack of vaginal lubrication, was reported by 8-31% of women.

According to the DSM-5, Genito-Pelvic Pain/Penetration Disorder refers to a woman's difficulties with having sexual intercourse, vulvo-vaginal or pelvic pain during penetration attempts, fear of pain or vaginal penetration, and tension of the pelvic floor muscles (American Psychological Association, 2013). Research has suggested that approximately 21% of women in the United States experience painful intercourse at some point in their lives (Graziottin & Gambini, 2017).

Trauma and Sexual Functioning.

PTSD symptoms, such as nightmares or intrusive memories, can be so distressing that they lead to significant restrictions in an individual's overall quality of life (Yehuda, Lehrner, & Rosenbaum, 2015), such as limiting an individual's ability to attend family events, have close relationships with others, or have a stable sleep cycle. In addition to these limitations, some of the areas of functioning that

can be affected by PTSD are an individual's sexual satisfaction and function, including the ability to engage in sexual activity, sexual interest, desire and arousal. Researchers have noted that although some literature has focused on the development of sexual dysfunction as a result of sexual trauma, more recent studies have suggested that the association may also be related to PTSD symptoms, rather than exclusively the sexual trauma itself. A review of the literature on PTSD and sexual dysfunctions noted that many studies have found sexual dysfunction is greater in individuals with PTSD compared to individuals with similar traumatic exposures whom did not develop PTSD (Yehuda, Lehrner, & Rosenbaum, 2015). The symptoms associated with PTSD, such as depressive, hyperarousal, and avoidance symptoms, may create several problems in sexual functioning. PTSD and sexual activity both involve a certain level of physiological arousal, however, healthy sexual activity requires the inhibition of fear and threat networks, which may be impaired in individuals with PTSD. Similarly, the depressive symptoms of PTSD, such as emotional numbing and anhedonia, may impact an individual's ability to maintain sexual interest and desire. Furthermore, sexual activity requires feelings of pleasure, intimacy, trust and safety, which are distinct experiences that individuals with PTSD are known to experience difficulty with. Individuals with PTSD may avoid emotional and vulnerability, both of which are often necessary for healthy sexual interaction. Constant hypervigilance, avoidance, and depressive

symptoms such as feelings of helplessness, anger, or fear, may prevent an individual with PTSD from experiencing proper sexual functioning and satisfaction. This helps to further explain the apparent incompatibility between PTSD and healthy sexual activity.

Childhood Sexual Abuse and the Development of Sexuality

CSA is thought to have significant effects throughout development, especially regarding the development of sexuality (Noll, Trickett, & Putnam, 2003). One conceptualization of the effect of CSA on the development of sexuality includes the model of Traumagenic Dynamics, which postulates that traumatic sexualization, betrayal, powerlessness, and stigmatization are four factors that, in conjunction with each other, contribute to the distorted view of a child's sense of self and the world (Finkelhor & Browne, 1985). Specifically, traumatic sexualization is defined by researchers as the "process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse." When children are rewarded with affection, attention, or gifts for sexual behavior, they may learn that sexual behavior can be used as a tactic to get others to provide developmentally appropriate needs. Traumatic sexualization may also give distorted meaning to a child's sexual and nonsexual anatomy, as well as aid in the

development of frightening memories of the abuse being associated with sexual activity in the child's mind. Finkelhor and Brown (1985) also note that children whom have been traumatically sexualized can develop inappropriate sexual behaviors that are further impacted by misconceptions about their own sexual self-concept and unusual emotional associations to sexual activities.

Rellini and Meston (2011) suggested that early sexual trauma affects survivors' perceptions of sex, as well as their perception of their sexual self. The sexual self is impacted by inaccurate and harmful ideas about the survivor's sexuality, which is thought to be developed through modeling, reinforcement, and punishment by the abuser (Lemieux & Byers, 2008). This may cause survivors to experience negative feelings about sexual situations, which distracts them from processing sexually-relevant information that is needed for sexual arousal (Rellini & Meston, 2011). The distraction is thought to cause problems in sexual functioning and satisfaction.

Childhood Sexual Abuse and Sexual Functioning

While childhood sexual abuse has been found to have a range of short-term and long-term consequences, some increased interest has appeared within recent research on the effects of CSA on adult sexual functioning (Leonard and Follette, 2002). However, there has been limited understanding of the effect of specific

factors, including abuse, that impact sexual functioning later in life. CSA is thought to be associated with adult sexual disturbance in a number of ways (Leonard and Follette, 2002). A child who experiences CSA is often subjected to confusing messages from the perpetrator that may cause them to feel pain, fear, anger or guilt. The survivor's first experience with sexual material, content, and situations is often complicated by these messages and may then affect their adult thoughts and feelings on sexual situations. Women who have experienced CSA have been found to experience impaired sexual functioning and satisfaction, in that they experienced less frequent orgasms, lower levels of subjective sexual satisfaction, and higher rates of sexual dysfunction than women who did not experience CSA (Schloredt and Heiman, 2003). As reported in a review article by Leonard and Follette (2002), many researchers have found empirical support for the idea that individuals who have survived CSA have experienced problems with sexual desire and arousal. In fact, past research has found experiencing adult-child sexual contact was highly associated with arousal disorder, whereas experience of forced sexual contact by a man was highly associated with both arousal and desire disorders (Heiman, 2002).

A study completed by Jehu (1988) researched sexual dysfunction and women with CSA histories. Interview questions focused on sexual functioning domains including desire, aversion or phobia, arousal, orgasm, satisfaction, sexual pain and vaginismus. Ninety-four percent of the women in this sample were found

to have complained of at least one of these sexual dysfunctions. These problems may explain why some CSA survivors avoid subsequent, consensual sexual experiences later in life, and/or are unhappy with their later sexual experiences. Some researchers have discovered that individuals who suffered more severe sexual abuse as children experiences greater experiential avoidance and less orgasms (Staples, Rellini, & Roberts, 2012). Additionally, Wincze and Weisberg (2015) noted many psychosocial factors that contribute to problems of female sexual interest and/or arousal. Of those factors, many refer directly to the early messages girls are subjected to about sexual activity, as well as a history of sexual trauma. Children who learn that sexual activity is sinful or "bad" may feel guilt associated with sexual activity and interest, which may affect their ability to be sexually interested in the long-term. These researchers have also noted sexual abuse as a risk factor for the development of genito-pelvic pain/penetration disorder. In fact, a study which compared women with genito-pelvic pain to those without pain found that women whom experienced genito-pelvic pain were 6.5 times more likely to have severe CSA histories (Harlow & Stewart, 2005).

Childhood Sexual Abuse and Experiential Avoidance

Experiential avoidance is defined as "the phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g.

bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that accompany them" (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Sexual functioning may be effected by experiences of CSA in many ways that can be observed on a spectrum based on experiential avoidance (Noll, Trickett, & Putnam, 2003). Some women avoid the experience of intercourse or sexual activity by isolating themselves sexually, while others avoid the emotions and cognitions associated with sexual activity by engaging in risky sexual behaviors, including unsafe sex. Avoidance of sexual behavior is commonly referred to as hyposexuality. A woman may experience experiential avoidance in an attempt to avoid experiencing unpleasant sensations or memories associated with sexual experiences (Staples, Rellini, & Roberts, 2012). Hypersexuality, or the increase in sexual behaviors, may be defined as "the tendency to engage in sexual activities impulsively with strangers or in risky situations and without using protection," (Rellini, 2008, p. 32). On the other end of the spectrum, survivors may become sexually avoidant of sexual feelings and thoughts, and may display sexual dysfunction, feelings of guilt and anxiety (Noll, Trickett, & Putnam, 2003). This polarity in responding to sexual situations is an example of the dialectic of trauma, as described by Herman (1997). Research has also found that CSA survivors may avoid painful thoughts, feelings and memories associated with the abuse by not

engaging in future sexual activity, and that these women may endorse more sexual dysfunction than women without these traumatic histories (Leonard, Iverson, & Follette, 2008; Polusny & Follette, 1995). Avoiding sexual experiences may maintain and reinforce memories of negative sexual experiences associated with early abuse (Staples, Rellini, & Roberts, 2012).

Some researchers have noted that women may engage in both abstinence of sexual activity, which reflects a withdrawal from sexual relationships with others, and more frequent sexual activity, which reflects a sexualization of relationships with others, at different times (Lemieux & Byers, 2008). This suggests that women engage in different patterns of sexual behavior at different points in time depending on the context. In addition to sexual difficulties, experiential avoidance has been shown to be related to depression and posttraumatic stress disorder (Palm & Follette, 2011).

Overview of Current Study & Critique of the Literature

The present project is intended to further the understanding of the sexual difficulties of women with CSA histories. The sexual functioning of women with childhood trauma histories is an important area that warrants further study, and has not been adequately researched. Factors such as the complexity of psychological symptomology, revictimization, and experiential avoidance may be crucial to the

understanding of the types of sexual dysfunctions women with childhood trauma histories face. Previous research has not adequately explored the relationships between these factors and women's sexual satisfaction and functioning, leaving questions regarding both the nature and the influence these problems have on women's sexual functioning.

In this study, we surveyed a community sample of women in order to understand the influences of victimization and revictimization, psychological symptomology, and experiential avoidance on subjective sexual satisfaction and sexual functioning. This study is unique in that we examined women with histories of CSA, revictimized women, and women without a history of abuse to compare their levels of sexual satisfaction and function. Because of its relation to sexuality, the role of masturbation was also examined, as there is no literature on the masturbation behaviors of women with CSA histories and their subjective sexual satisfaction. There were a number of research questions related to the range of sexual difficulties in women with a history of sexual trauma and a range of sexual behaviors.

Hypothesis 1: There will be a relationship between women's scores on measures of sexual functioning and sexual satisfaction.

Hypothesis 2: Women with a history of childhood sexual trauma will have lower ratings of sexual satisfaction and sexual functioning than women without a history of childhood sexual trauma.

Hypothesis 3: Women with a history of multiple types of sexual abuse will have the lowest rates of sexual satisfaction and sexual functioning.

Hypothesis 4: Women with a history of childhood sexual trauma who have more severe PTSD symptomology, depression, and higher levels of experiential avoidance will endorse lower ratings of sexual satisfaction and sexual functioning.

Methods

Recruitment. The study advertisement on MTurk was listed as "Survey asking questions about various sexual histories and behaviors of women. 30 minutes or less to complete. 18 years or older." MTurk workers who previewed the advertisement were provided with information regarding eligibility, compensation, and time commitment for completion. Participants were also initially advised that the study will require them to answer questions about their sexual histories and behaviors, including victimization history.

Procedure. Participants were routed from the MTurk website to an online survey created in Qualtrics, a web-based survey tool utilized for data collection. Participants read the informed consent, which included information about the study

content, confidentiality, and contact information. Attention check items required participants to identify the color amongst four responses on one question, and choose the answer respond of "no" to the another question. Participants were excluded from the study if they failed the attention check items. At the end of the survey, participants were provided with the number for the United States' National Sexual Assault Hotline.

Participants. 382 adult Amazon Mechanical Turk (MTurk) workers were recruited to participate in this study. Amazon MTurk is an online marketplace that allows businesses to recruit workers to complete Human Intelligence Tasks (HITs) and earn money for their work. Casler, Bickel, and Hackett (2013) found that behavioral science research results conducted through MTurk were almost indistinguishable from in-person participation results, even when the studies utilized behavioral tasks. These researchers also suggested unique benefits of using MTurk to conduct research studies in this field, such as an increasingly diverse sample, and quick and reliable participant recruitment. Additionally, further research has suggested than crowdsourcing software such as MTurk may be a useful tool in studying clinical populations (Shapiro, Chandler, & Mueller, 2013). Researchers have noted that the prevalence of depression, anxiety, and trauma-related disorders matches or exceeds what is expected in the general population,

and that participants may be more willing to disclose mental health information through online studies.

Participants were included in the study if they were women, currently living within the United States, age 18 or older, and have at one point been sexually active. Additionally, participants were required to pass attention check items to ensure accuracy in responding. Workers earned $2.00 their participation in the study.

Eleven individuals who reviewed the informed consent declined to participate in the study. Some participants were excluded from the study based on failing the attention check items (*n*= 9), selecting the "male" gender (*n*= 54), being under 18 years old (*n*= 2), or reporting they had never been sexually active (*n*= 6). An additional 20 participants were excluded from the study for dropping out early in the study. This left for a final sample of 280 participants who met the criteria for participation.

The majority of the sample were between the ages of 20 and 29 years old (45%), married (43.6%), and identified as White/Caucasian (59.3%). Nearly 78% of the sample reported a history of being diagnosed with a mental health disorder, whereas nearly 23% reported no past or current diagnoses. The majority of the sample identified past or current mental health treatment (61.5%). Additionally,

only 18.2% of the sample denied any past history of sexual abuse, leaving 81.8% reporting a history of childhood, adolescent, or adult sexual abuse. *See Table 1.*

Materials

Demographics.

Participants were asked to provide basic demographic information, including the following: age, marital status, race/ethnicity, whether they are currently or have sought psychological treatment in the past, and psychological conditions they have been treated for in the past.

Victimization History. The Wyatt Sexual History Questionnaire (WSHQ; Wyatt, Lawrence, Vodounon MPh, & Mickey, 1993) measures retrospective coercive sexual histories using behaviorally specific definitions. We utilized a subset of items from the WSHQ to obtain information regarding women's childhood sexual abuse experiences. The age of onset and circumstances of both nonconsensual sexual behaviors were assessed.

The Sexual Experiences Survey (SES; Koss & Gidycz, 1985) is designed to assess various degrees of sexual victimization. Items from this survey were utilized to address unwanted sexual experiences between the ages of 14 and 17, and through adulthood. The survey used was condensed and was based on

modifications by Polusny (1998). A sum composite score was created to assess the levels of revictimization.

Sexual Function and Satisfaction. The Female Sexual Function Index (FSFI; Rosen, Brown, Heiman, Leiblum, Meston, Shabsigh, Ferguson, & D'Agostino, 2000) is a 19-item self-report questionnaire designed to assess sexual function in women across six key domains. These domains include desire, arousal, lubrication, orgasm, satisfaction, and pain. A full scale score is calculated by adding the six domain scores. Developers found test-retest reliability to be high for each individual domain (r = 0.79 to 0.86) and a high degree of internal consistency were observed (*Chronbach's alpha* of 0.82 and higher).

For this study, questions were developed to assess satisfaction with masturbation behaviors. There is no adequate published measure of this behavior in the sexual functioning literature. Participants were asked four questions: Have you ever masturbated? How comfortable are you with masturbating? How often do you achieve orgasm when you masturbate? How satisfied are you with your engagement in masturbation? Higher scores indicated higher levels of satisfaction with masturbation behaviors.

The Sexual Satisfaction Scale for Women (SSS-W; Meston & Trapnell, 2005) is a 30-item comprehensive measure of sexual satisfaction and distress. It focuses on five domains, including contentment, communication, compatibility,

relational concern, and personal concern, with six items per domain. A full scale score is calculated by adding the five domain scores. Developers found test-retest reliability to be moderately high for all domains among women with sexual dysfunction (r = 0.62-0.79) and control women (r = 0.58-0.79). In a combined sample of women with sexual dysfunction and control women, Chronbach's alpha exceeded 0.80 for all domains except Communication (0.74).

Experiential Avoidance. The Acceptance and Action Questionnaire-II (AAQ-II; Bond, Hayes, Baer, Carpenter, Guenole, Orcutt, Waltz, & Zettle, 2011) is a 7-item self-report questionnaire that measures psychological inflexibility or experiential avoidance, with higher scores reflecting greater levels of experiential avoidance. Scores range from 7 to 49. Psychometric properties are shown to be reliable, as evidenced by a mean alpha coefficient of 0.84, and a 12-month test-retest reliability of 0.79.

Post-Traumatic Stress Disorder. The PTSD Checklist for DSM-5 (PCL-5; Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013) is a 20-item self-report measure that assesses the four clusters and twenty symptoms of PTSD in the DSM-5. Higher scores reflect more severe symptoms of PTSD. Developers indicated high test-retest reliability (r = 0.84) and good internal consistency (*Chronbach's alpha* of 0.96).

Depression. The Center for Epidemiological Studies – Depression (CES-D; Radloff, 1977) is a 20-item measure that examines symptoms commonly used in the literature. Symptoms related to depression, such as sleep difficulties, poor appetite, and feelings of loneliness are assessed. High scores indicate greater depressive symptoms.

Results

All participants were assessed for a history of sexual trauma. As noted in Table 1, 35% of the sample reported a history of CSA, 61.4% reported a history of adolescent sexual abuse, and 63.6% reported a history of adult sexual abuse. Notably, 58% of the sample reported revictimization after CSA. Only 18.2% denied a sexual abuse history.

Table 2 presents correlations between psychological variables and measures of sexual functioning and satisfaction. A bivariate correlation was conducted to identify a relationships between sexual victimization frequencies (M = 1.83, SD = 1.16), sexual functioning (M = 23.46, SD = 8.37), sexual satisfaction (M = 94.14, SD = 24.32), PTSD symptoms (M = 46.56, SD = 22.63), depression symptoms (M = 18.50, SD = 13.38), and experiential avoidance (M = 24.44, SD = 22.63).

Results showed that sexual victimization frequencies are negatively correlated with sexual satisfaction, r (225) = -.376, $p < .001$. As predicted based on

previous research, sexual victimization frequencies are positively correlated with the following: PTSD symptoms, r (236) = .555, p< .001; Depression symptoms, r (229) = .378, p< .001; and experiential avoidance, r (243) = .503, p< .001.

As expected, sexual functioning is positively correlated with sexual satisfaction, r (239) = .559, p< .001. However it is important to note that the relationship of these two variables leaves some of sexual satisfaction unexplained and other factors are impacting this relationship. Functioning is negatively correlated with the following: PTSD symptoms, r (247) = -.177, p< .001; Depression symptoms, r (244) = -.243, p< .001; and experiential avoidance, r (258) = -.240, p< .001. Sexual satisfaction is negatively correlated with PTSD symptoms, r (227) = -.608, p< .001; Depression symptoms, r (229) = -.604, p< .001; and experiential avoidance, r (239) = -.632, p< .001. Results show stronger relationships between sexual satisfaction and psychological symptoms than those between sexual functioning and psychological symptoms. This suggests that other variables, such as psychological symptomology, may impact sexual satisfaction more so than sexual functioning. Experiential avoidance was highly correlated with PTSD and depression scores, as well as measures of sexual variables.

Sexual Functioning.

An independent samples t-test was conducted to compare ratings of sexual functioning in all women who endorsed CSA histories, including those who were

revictimized, and women without any history of sexual trauma. Levene's test was significant for sexual functioning ratings, and therefore, the assumption of homogeneity of variances was violated. A Mann-Whitney test did not reveal differences in the mean rank of sexual functioning scores between the all women who endorsed CSA histories (*Md*= 23.20) and those without a history of trauma (*Md*= 26.75), *U* = 3456.50, p= .085, however, a trend in scores was noted.

A one-way ANOVA was conducted to determine if there was a significant difference in sexual functioning scores between women with various frequencies of sexual victimization. The participants were divided into four groups based on sexual victimization frequencies (group 1: no history of sexual victimization; group 2: one type of trauma; group 3: two types of trauma; group 4: three types of trauma). The assumption of homogeneity of variances was violated for sexual functioning (Levene statistic = 5.74, $p = .001$). Therefore, the more conservative Welch ANOVA test was used, and a statistically significant difference was found, $F(3, 103.39) = 2.78$, $p = .05$. Post-hoc tests using Tukey HSD planned comparison revealed that sexual functioning scores in the group with three sexual traumas ($M = 21.81$, $SD = 7.12$) was significantly lower than the group with two sexual traumas ($M = 25.53$, $SD = 8.24$.

A hierarchical multiple regression was conducted to examine if CSA history and PTSD scores predicted adult subject's sexual functioning. In step 1, CSA history (No CSA, History of CSA) was included as a predictor, and it did not explain a significant amount of variance in sexual functioning (R^2 = .001, F(1, 203) = 1.54, *n.s.*). In step 2, PTSD scores were added in the model, and they explained an additional 3% of the variance in sexual functioning (ΔR^2 = .03, ΔF (2, 202) = 6.04, p = .05), indicating that only PTSD predicted sexual functioning (β= -.19, p < .05).

A hierarchical multiple regression was conducted to examine if CSA history and depression scores predicted adult subject's sexual functioning. In step 1, CSA history (No CSA, History of CSA) was included as a predictor, and it did not explain a significant amount of variance in sexual functioning (R^2 = .003, F(1, 198) = .69, *n.s.*). In step 2, depression scores were added in the model, and they explained an additional 6% of the variance in sexual functioning (ΔR^2 = .06, ΔF (2, 197) = 12.18, p < .01), indicating that only depression scores was a significant predictor of sexual functioning (β= -.26, p = .001).

Sexual Satisfaction.

An independent samples t-test were conducted to compare ratings of satisfaction in all women who endorsed CSA histories, including those who were revictimized, and women without any history of sexual trauma. When assessing

differences in sexual satisfaction scores across the two groups, the assumption of homogeneity of variances was met (Levene statistic = .03, p = .88). There was a significant difference in the satisfaction of all women in the sample with a history of CSA (M = 88.71, SD = 23.04) and women without a history of trauma (M = 104.90, SD = 22.20), $t(198) = 4.31$, p= .000).

A one-way ANOVA was conducted to determine if there was a significant difference in sexual satisfaction scores between women with various frequencies of sexual victimization. The participants were divided into four groups based on sexual victimization frequencies (group 1: no history of sexual victimization; group 2: one type of trauma; group 3: two types of trauma; group 4: three types of trauma). The assumption of homogeneity of variances was violated for sexual satisfaction (Levene statistic = 11.13, p = .000). Therefore, the more conservative Welch ANOVA test was used, and a statistically significant difference was found for sexual satisfaction, $F(3,99.04) = 23.89$, p = .045. Post-hoc tests using Tukey HSD planned comparison showed sexual satisfaction scores in the group with three types of sexual traumas (M = 79.88, SD = 16.95) was significantly lower than the mean score of the group with two types of sexual traumas (M = 103.54, SD = 23.10), the group with one type of sexual trauma (M = 97.28, SD = 27.27) and the group with no sexual trauma history (M = 104.90, SD = 22.20).

A hierarchical multiple regression was conducted to examine if CSA history and PTSD scores predicted adult subject's sexual satisfaction. In step 1, CSA history (No CSA, History of CSA) was included as a predictor, and it explained a significant amount of variance in sexual satisfaction (R^2 = .09, F(1, 184) = 17.69, p < .001). CSA history explained 9% of the variance in sexual satisfaction scores. In step 2, PTSD scores were added in the model, and they explained an additional 29% of the variance in sexual satisfaction (ΔR^2 = .29, ΔF (2, 183) = 85.20, p < .001), suggesting that PTSD scores predicted participant's sexual satisfaction above and beyond CSA history. In the final model, only PTSD scores was a significant predictor of sexual satisfaction (β= -.60, p < .001).

A hierarchical multiple regression was conducted to examine if CSA history and depression scores predicted adult subject's sexual satisfaction. In step 1, CSA history (No CSA, History of CSA) was included as a predictor, and it explained a significant amount of variance in sexual satisfaction (R^2 = .09, F(1, 184) = 17.90, p < .001). CSA history explained 9% of the variance in sexual satisfaction scores. In step 2, depression scores were added in the model, and they explained an additional 29% of the variance in sexual satisfaction (ΔR^2 = .29, ΔF (2, 183) = 84.13, p < .001), suggesting that depression scores predicted participant's sexual satisfaction above and beyond CSA history. In the final model, only PTSD scores was a significant predictor of sexual satisfaction (β= -.57, p < .001).

A hierarchical multiple regression was conducted to identify significant predictors of sexual satisfaction. In step 1, frequency of sexual victimization (No Sexual Trauma, One Sexual Trauma, Two Sexual Traumas, Three Sexual Traumas) was included as a predictor, and it explained a significant amount of variance in sexual satisfaction (R^2 = .19, F(4, 234) = 13.83, p < .001). Nineteen percent of the variance in sexual satisfaction was accounted for by sexual victimization frequencies. In step 2, AAQ scores were added in the model, and it explained an additional 24% of the variance in sexual satisfaction (ΔR^2 = .24, ΔF (5, 233) = 99.98, p < .001), suggesting that AAQ scores predicted participant's sexual satisfaction above and beyond sexual victimization frequencies. In the final model, AAQ scores (β= -.58, p < .001) and Three Sexual Traumas (β= -.25, p < .01) were significant predictors of sexual satisfaction, while No Sexual Trauma (β= -.12, p = .13), One Sexual Trauma (β= -.09, p =.25) and Two Sexual Traumas (β= -.03, p =.67) were not significant predictors of sexual satisfaction.

Revictimization and Symptomology.

A one-way ANOVA was conducted to determine if there is a significant difference in symptomology based on the number of victimizations experienced. The participants were divided into four groups based on sexual victimization frequency (group 1: no sexual trauma history; group 2: one sexual trauma; group 3: two sexual traumas; group 4: three sexual traumas). The assumption of

homogeneity of variances was met for PTSD (Levene statistic = 2.15, p = .10), Depression (Levene statistic = .11, p = .96), and Experiential Avoidance (Levene statistic = .47, p = .70).

Post-hoc tests using the Bonferroni correction showed that the PTSD mean score in group 4 (M = 61.11, SD = 19.86) was significantly higher than the mean score of group 1 (M = 29.34, SD = 14.85), group 2 (M = 36.27, SD = 16.62), and group 3 (M = 39.02, SD = 18.38); and group 3's mean score was significantly higher than group 1. The Depression mean score in group 4 (M = 24.78, SD = 11.34) was significantly higher than the mean score of group 1 (M = 10.57, SD = 13.14), group 2 (M = 17.50, SD = 13.07), and group 3 (M = 13.81, SD = 11.92). The Experiential Avoidance mean score in group 4 (M = 31.27, SD = 10.02) was significantly higher than the mean score of group 1 (M = 14.59, SD = 10.11), group 2 (M = 22.95, SD = 10.61), and group 3 (M = 20.80, SD = 9.84); and group 2's mean score was significantly higher than group 1.

A one-way ANOVA was conducted to determine if there is a significant difference in satisfaction with masturbation based on the number of victimizations experienced. The participants were divided into four groups based on sexual victimization frequency (group 1: no sexual trauma history; group 2: one sexual trauma; group 3: two sexual traumas; group 4: three sexual traumas). The assumption of homogeneity of variances was met (Levene statistic = 83, p = .48).

Post-hoc tests using the Bonferroni correction showed that the mean satisfaction score in group 4 (M = 8.38, SD = 2.45) was significantly lower than group 1 (M = 9.71, SD = 2.07) and group 3 (M = 9.50, SD = 2.43).

A bivariate correlation was conducted to identify relationships between satisfaction with masturbation (M = 9.01, SD = 2.43) and experiential avoidance (M = 24.44, SD = 11.94). Results showed that satisfaction with masturbation is negatively correlated with experiential avoidance, r (268) = -.239, p< .01. As women's experiential avoidance increases, their satisfaction with masturbation decreases. A bivariate correlation was conducted to identify relationships between satisfaction with masturbation (M = 9.01, SD = 2.43) and frequency of sexual victimization (M = 1.83, SD = 1.17). Results showed that satisfaction with masturbation is negatively correlated with sexual victimization frequency, r (251) = -.182, p< .01.

A one-way ANOVA was conducted to determine if there is a significant difference in sexual functioning and satisfaction scores based on the number of types of victimization experienced. The participants were divided into five groups based on victimization category (group 1: no history of victimization; group 2: history of CSA only; group 3: adolescent sexual abuse only; group 4: history of adult sexual abuse only; group 5: history of revictimization). The assumption of homogeneity of variances was violated for sexual functioning (Levene statistic =

5.74, $p = .001$), and the Welch ANOVA test was not statistically significant for sexual functioning (Welch's $F = .27$, $p = .89$). In analyzing the sexual satisfaction scores, results indicated an overall significant mean difference among the five groups for sexual satisfaction, F (4, 232) = 4.63, $p = .001$. Post-hoc tests using the Bonferroni correction showed the sexual satisfaction mean score in the revictimization group ($M = 89.51$, $SD = 22.83$) was significantly lower than the mean score of the group with no history of victimization ($M = 104.90$, $SD = 22.20$).

Discussion

While the literature on the relationship of sexual victimization in relation to psychological symptomology is clear, the association between a history of victimization and interpersonal functioning is limited. The *clinical* literature has frequently discussed the difficulties in sexual functioning and satisfaction experienced by women with a history of sexual victimization (Leonard & Follette, 2002). However, the empirical literature examining these issues remains very limited. Many studies focus on psychological symptomology, including PTSD, depression, and anxiety. However, when considering overall well-being, it is important to examine aspects of general functioning, including sexual functioning. The current study represents an addition to the literature that will inform future research in this area, as well as the clinical needs of women with trauma histories.

Demographics and Victimization History.

Results of the descriptive frequencies throughout the sample indicated some surprising demographics. Most notably, over 80% of the sample endorsed a history of childhood, adolescent, and/or adult sexual abuse, which is higher than expected based on the present literature on the prevalence rates of victimized women. Behaviorally specific definitions of abuse were utilized throughout the measures. However, total scores were represented by calculating the number of specific incidents which one may consider to be an unwanted sexual experience, in which severity of the incident was not considered. In this regard, participants were considered to be survivors of sexual trauma if they identified a low-level incident, such as being exposed to an individual's sex organs or fondling, within the given age range. Thus, this is a somewhat broad and inclusive description of victimization. Nevertheless, it provides important data on the number of women who report unwanted sexual experiences, beyond what we would call assault. Most women in the sample were between the ages of 20 and 29 years old, married, and identified as white/Caucasian. The majority of women who participated in the study reported past or current mental health treatment, and many women reported being diagnosed with a mental health disorder.

Victimization and Psychological Symptomology.

Consistent with previous literature, results showed a relationship between experiential avoidance, depression, and PTSD (Palm & Follette, 2011). Women with more severe scores on one measure of psychological symptomology also displayed higher scores on the other measures of symptomology. Depression, PTSD, and experiential avoidance have been found to be prominent long-term correlates in women with sexual trauma histories, most notably of those experiences that happened early in life, such as child or adolescent sexual trauma. These results support previous findings in identifying a relationship between these variables. Experiential avoidance has been conceptualized as the underlying process that is associated with a number of negative outcomes (Hayes et. al., 1996). Identifying a theoretical process that explains the relationship between trauma and negative outcomes is critical in developing treatments that can address the diverse range of problems observed in trauma survivors. A number of theories have considered avoidance as a negative coping process (Hayes, et al, 1996).

Victimization and Sexual Functioning.

In the current study, a significant relationship was discovered between women's scores on the Female Sexual Function Index (FSFI) and the Sexual Satisfaction Scale for Women (SSS-W). The relationship of these two variables has varied throughout the clinical literature. While often discussed together, sexual

functioning and sexual satisfaction are considered to be two separate issues that co-vary in their associations with each other. However they are measuring different aspects of sexual health (Leonard, Iverson, & Follette, 2008). For example, a woman may be physiologically functioning well sexually, however, she may still not be satisfied with her current sexual interactions. Likewise, a woman may experience sexual dysfunction but still report a satisfying sexual life. Researchers have recommended that sexual functioning and sexual satisfaction be assessed separately to best account for this possibility. There may be additional variables that impact a woman's sexual satisfaction and sexual functioning, including, but not limited to, the experience of a significant emotional connection between partners, relationship satisfaction, and general well-being. In fact, the sexual satisfaction scale has factors that assess relational and personal concerns. Thus, it is important to note the differences in these constructs when evaluating research findings. Results from the present study supported previous findings suggesting psychological symptomology negatively impacts women's sexual satisfaction and sexual functioning. Results also showed stronger negative relationships between sexual satisfaction scores and psychological symptoms than those between sexual functioning and psychological symptoms. This suggests that psychological symptomology may impact sexual satisfaction more so than sexual functioning.

Revictimized women have been found to be more likely to be diagnosed with PTSD at some point in their lives (Arata, 1999), and experience more severe and prominent symptoms of depression, traumatic stress symptoms, and experiential avoidance (Schoedl, Cardobobbi Pupo Costa, Mari, Mello, Tyrka, Carpenter, & Price, 2010; Follette et. al., 1996). Women with a higher number of traumatic incidences, such as endorsing a sexually traumatic incident in childhood, adolescence, and adulthood, had significantly lower sexual satisfaction scores. Importantly, women with this increased frequency of sexual trauma also displayed significantly more severe symptoms of PTSD, depression, and experiential avoidance. This suggests that women who have been revictimized experience more severe psychological symptomology and lower levels of sexual satisfaction than women whom have only endured one traumatic experience. Victimization frequencies, defined as having no sexual trauma history or having a history of only CSA, adolescent, or adult sexual abuse, or all three types of sexual victimization, were utilized throughout several analyses to examine the impact of sexual revictimization on a number of outcomes. Women who reported more sexual victimization categories differed overall in their sexual functioning scores, however, individual group differences between groups was not significant. Women with a history of three sexual traumas had lower sexual satisfaction scores than women with a history of two traumas, a history of one trauma, and no history of

trauma. These results confirm the hypothesis that women who have been revictimized experience the lowest ratings of sexual satisfaction and the highest ratings of psychological symptomology.

Whereas women without a history of sexual trauma were found to have significantly higher sexual satisfaction scores than those with a history of CSA, this was not the same for sexual functioning scores. However, despite lacking statistical significance ($p = .085$), a trend was identified showing differences in sexual functioning scores between women who endorsed a history of CSA and those without any sexual trauma history. This indicates that CSA alone can negatively impact sexual functioning in adult women.

As hypothesized, analyses utilizing the measures of psychological symptomology displayed notable results in predicting sexual functioning. Psychological symptomology, including PTSD scores and depression, predicted women's sexual functioning and satisfaction above and beyond a CSA history alone. Furthermore, experiential avoidance and having a history of three sexual traumas were both significant predictors of sexual satisfaction scores, while only experiential avoidance was a significant predictor of sexual functioning scores. Survivors of sexual trauma frequently develop avoidant processes associated with close interpersonal relationships including sexual relationships. This avoidance, or attempts at suppression, is thought to paradoxically increase symptoms and this

study demonstrates that sexual health is also impacted by that process. Results from the present study identified that experiential avoidance plays an important role in whether a woman chooses to engage in masturbation. In this study, women report being less comfortable with masturbation and are generally less satisfied with masturbation if they have a sexual trauma history. Future research in this area may choose to identify whether women's avoidance of masturbation is due to the physically sexual nature of masturbation (i.e., avoidance of sexual acts purely because it is sexual) or because of factors such as PTSD or depression symptoms.

Additional analyses were conducted to better understand the previous findings, as well as explore the factors which influence women's engagement in and satisfaction with masturbation. Revictimized women in this sample produced the most severe psychological symptomology than all other sexual trauma groups and also experienced lower sexual satisfaction than women without a sexual trauma history. This is consistent with previous literature that outlined the prominent and unique difficulties of revictimized women. Additionally, it was found that as the frequency of sexual victimization increases, satisfaction with masturbation decreases, as women with three sexual traumas were significantly less satisfied with masturbation than women with no sexual trauma history and women with a history of two sexual traumas. Lastly, women who were more experientially avoidant were less satisfied with masturbation. These results lend to the idea that

women who have been victimized may experience hyposexuality, and therefore, are both less satisfied with and are participating less in sexual activity due to experiential avoidance.

Limitations.

There were some limitations to this research. While using a platform such as Amazon mTurk to distribute a self-report measure was simple and allowed for an efficient collection of a large number of participants, it is possible that inaccurate self-reporting occurred. Participants were also given the option to not answer questions they were uncomfortable with, which resulted in incomplete data for some of the measures. This may have impacted the results due to not being able to have a total score for each participant who was included in the study. Additionally, the content of the questions asked of participants may be considered sensitive and personal, and due to prevalence of experiential avoidance within this sample, this presents the possibility of denial or avoidance of emotional content by refusal to respond to certain items. Women who chose to participate in this study were asked about their experience with sexual trauma, however, other types of trauma were not assessed. Therefore, the possibility of cumulative trauma from other sources having an impact on sexual satisfaction and functioning, and psychological symptomology, cannot be ruled out. Future research on the factors

which impact women's sexual satisfaction and functioning would benefit from a comprehensive assessment of many types of traumatic experiences.

One of the more important concerns related to this study is the large percentage of victimized women whom participated. It seems possible that the specificity of the ad for study, as well as the warning related to sensitive adult content, may have resulted in a sample with higher levels of victimized women. Because there is limited data on using mTurk to recruit for this type of research, it is not possible to assess whether this was a contributing factor. While the findings provided substantial information regarding the prevalence of unwanted sexual experiences within the female population, it may be an over-representation of the number of abused women in the population. Future research should compare findings using differing methodologies to assess sexual abuse. In addition, future research would benefit from utilizing detailed interviews rather than surveys to better understand the psychological and sexual issues that women with sexual trauma histories face.

Conclusion.

The review of the literature for this study made it clear that there are a number of gaps in the empirical literature on healthy sexual behavior of women, including women's engagement in masturbation. Despite cultural changes that have increased discussions of sexuality, specific behavioral discussions of sex, including

masturbation, remain limited in the research literature. In the current era, women are becoming more comfortable discussing sexual issues and expressing sexual freedom. Similarly, the "Me Too" movement has encouraged women from all generations to speak out about sexual assault and abuse. As women become more comfortable discussing sexuality in society, research may benefit from this willingness to disclose details of sexual trauma and the impact sexual trauma has on general well-being.

There are both clinical and research implications from this study. In a clinical setting, sexual issues prove to be an important part of overall functioning and therefore should be addressed in a therapeutic environment. When women with sexual trauma histories present to treatment, they are most often assessed for the presence of psychological difficulties, such as symptoms of PTSD, depression, and anxiety. Sexual functioning and sexual satisfaction are rarely discussed. However, results from the present study suggest that sexual functioning should be included in the assessment of factors which prevent women from experiencing a fulfilling life post-trauma. Difficulties with sexual functioning and satisfaction may be considered trauma-related sequelae, beyond that of PTSD, and should be addressed in order to enhance well-being. Moreover this study made clear the importance of experiential avoidance in relationship to all of the clinical outcomes. This finding adds to the literature suggesting that in treating survivors with diverse outcomes, it

is important to address underlying processes such as EA rather than focusing on symptoms alone. Acceptance and Commitment Therapy targets experiential avoidance and is designed to address a wide range of life difficulties. The client and therapist collaboratively develop treatment goals that are consistent with the client's valued life. Preliminary evidence suggests that ACT can be beneficial for trauma survivors and this treatment could be useful in addressing diverse concerns, such as sexual health. Providing comprehensive assessment and treatments for survivors of abuse can go beyond symptom reduction and lead to greater well-being across life domains.

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Table 1
Demographics for the Sample(n= 280)

	Frequency	Percentage
Age Ranges		
20-29	126	45%
30-39	94	33.6%
40-49	35	13.9%
50-59	19	5.4%
60-69	6	2.1%
Marital Status		
Single	78	27.9%
In a dating relationship	53	18.9%
Married	122	43.6%
Separated/Divorced	7	2.5%
Living with a partner	20	7.1%
Race/Ethnicity		
Asian/Pacific Islander	67	23.9%
Black/African American	24	8.6%
Hispanic/Latino	13	4.6%
Native American	3	1.1%
White/Caucasian	166	59.3%
Biracial/Multiracial	7	2.5%
Psychological Treatment History		
Currently in therapy	50	17.9%
Sought therapy in past, but not currently	122	43.6%
Never attended therapy	105	37.5%
Diagnosis History		
Depression	135	48.2%
Anxiety	111	39.6%
Bipolar Disorder	22	7.9%
PTSD	39	13.9%
Adjustment Problems	29	10.4%
Substance Abuse	14	5.0%
Other	14	4.0%
None	63	22.5%
Abuse History		
Childhood Sexual Abuse	98	35%
Childhood Sexual Abuse Only	17	6.1%
Adolescent Sexual Abuse	172	61.4%
Adult Sexual Abuse	178	63.6%
Revictimization	164	58.6%
No Abuse History	51	18.2%

Table 2

Means, Standard Deviations and Correlations for All Variables

Variable	*M*	*SD*	1	2	3	4	5	6
1. Vict. Frequency	1.83	1.16	-					
2. Sexual Function	23.46	8.37	-.084	-				
3. Sex. Satisfaction	94.14	24.32	.376*	.559*	-			
4. PTSD	46.56	22.63	.555*	.177*	.608*	-		
5. Dep. Symptoms	18.50	13.38	.378*	.243*	.604*	.788*	-	
6. Exp. Avoidance	24.44	22.63	.503*	.240*	.632*	.839*	.794*	-

Note: $*p < .001$

Table 3

Summary of Hierarchical Multiple Regression Analysis for Sexual Functioning

Variable	*R*	R^2	*SE* of the Estimate	R^2 change	*b*	*SE*	*t*
Model 1	.03	.001	8.28	.001			
CSA History					-.03	1.41	-.39
Model 2	.17	.03	8.17	.03			
CSA History					.06	1.54	.71
PTSD Scores					-.19	.03	-2.46*

Note: * $p < .05$, ** $p < .001$

Table 4

Summary of Hierarchical Multiple Regression Analysis for Sexual Functioning

Variable	*R*	R^2	*SE* of the Estimate	R^2 change	*b*	*SE*	*t*
Model 1	.06	.003	8.34	.003			
CSA History					-.06	1.42	-.83
Model 2	.25	.06	8.11	.06			
CSA History					.03	1.45	.42
Depression Scores					-.26	.05	-3.49**

Note: * $p < .01$, ** $p < .001$

Table 5

Summary of Hierarchical Multiple Regression Analysis for Sexual Satisfaction

Variable	*R*	R^2	*SE* of the Estimate	R^2 change	*b*	*SE*	*t*
Model 1	.30	.09	23.08	.09			
CSA History					-.30	3.95	-4.21**
Model 2	.61	.38	19.12	.29			
CSA History					-.03	3.65	-.47
PTSD Scores					-.60	.07	-9.23**

Note: * $p < .01$, ** $p < .001$

Table 6

Summary of Hierarchical Multiple Regression Analysis for Sexual Satisfaction

Variable	*R*	R^2	*SE* of the Estimate	R^2 change	*b*	*SE*	*t*
Model 1	.30	.09	23.06	.09			
CSA History					-.30	3.92	-4.23**
Model 2	.61	.38	19.14	.29			
CSA History					-.11	3.45	-1.72
Depression Scores					-.60	.11	-9.17**

Note: * $p < .01$, ** $p < .001$

Table 7

Summary of Hierarchical Multiple Regression Analysis for Sexual Satisfaction

Variable	*R*	R^2	*SE* of the Estimate	R^2 change	*b*	*SE*	*t*
Model 1	.44	.19	22.06	.14			
No Trauma					.11	5.69	1.21
One Trauma					-.02	5.89	-.21
Two Traumas					.09	5.59	.92
Three Traumas					-.36	5.16	-3.48*
Model 2	.66	.43	18.49	.24			
No Trauma					-.12	4.98	-1.51
One Trauma					-.09	4.96	-1.16
Two Traumas					-.03	4.73	-.43
Three Traumas					-.25	4.36	-2.92*
AAQ Total					-.58	.12	-10.0**

Note: * p <.01, ** p <.001

Table 8

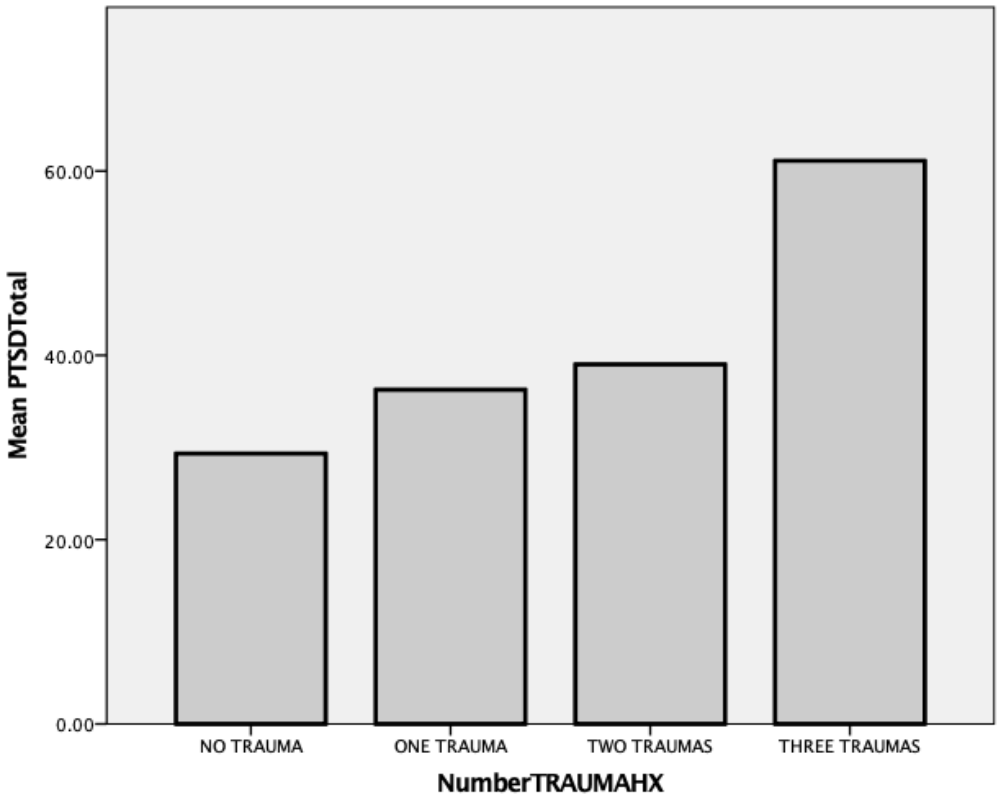
Summary of Hierarchical Multiple Regression Analysis for Sexual Functioning

Variable	*R*	R^2	*SE* of the Estimate	R^2 change	*b*	*SE*	*t*
Model 1	.18	.03	8.30	.03			
No Trauma					-.05	2.06	-.47
One Trauma					-.10	2.13	-1.09
Two Traumas					.23	2.02	-.23
Three Traumas					-.19	1.87	-1.73
Model 2	.27	.08	8.13	.04			
No Trauma					-.14	2.11	-1.45
One Trauma					-.13	2.10	-1.42
Two Traumas					-.03	2.00	-.28
Three Traumas					-.14	1.85	-1.34
AAQ Total					-.24	.05	-3.42**

Note: **p <.001

Figure 1

Mean PTSD Scores for Women with Various Sexual Victimization Frequencies



Appendix A

Demographics

What is your age? _____ years.

What is your marital status:

a. Single

b. In a dating relationship

c. Married

d. Separated/divorced

e. Living with a partner

What best describes your sexual orientation:

a. Heterosexual

b. Bisexual

c. Homosexual

d. Other

What best describes your race/ethnicity:

a. Asian/Pacific Islander

b. African American

c. Hispanic/Latino

d. Native American

e. White

f. Other

Are you currently or have you ever sought psychological treatment from a therapist or psychologist for any mental health problems? Select all that apply.

a. I am currently in therapy.
b. I have sought therapy in the past.
c. I have never attended therapy.

Select all psychological conditions you have been treated for or are currently being treated for:

a. Anxiety
b. Depression
c. Bipolar disorder
d. Post-traumatic stress disorder
e. Adjustment problems
f. Substance abuse
g. Other

Appendix B

Sexual History Questionnaire

Instructions: It is now generally recognized that many women, while they were children or adolescents, have had sexual experiences with an adult (or someone at least 5 years older than them). By sexual, we mean behavioral ranging from someone exposing themselves (their genitals) to you or someone having intercourse with you. These experiences may have involves a relative, a friend of the family, or a stranger. Some experiences are very upsetting and painful, while others are not, and some may have occurred without your consent.

PLEASE ANSWER EACH QUESTION BELOW FOR INCIDENTS THAT OCCURRED BEFORE YOU WERE 14 YEARS OLD.

1. Did anyone ever expose themselves (their sexual organs) to you?
    a. Yes
    b. No
2. Did anyone masturbate in front of you?
    a. Yes
    b. No
3. Did anyone try to seduce you with their naked body?
    a. Yes
    b. No

4. Did a relative, family friend, or stranger ever touch or fondle your body, including your breasts or genitals, or attempt to arouse you sexually?
    a. Yes
    b. No
5. Did anyone try to have you arouse them, or touch their body in a sexual way?
    a. Yes
    b. No
6. Did anyone rub their genitals against your body in a sexual way?
    a. Yes
    b. No
7. Did anyone attempt to have sexual intercourse with you (by sexual intercourse, we mean that a man or boy put his penis in your vagina)?
    a. Yes
    b. No
8. Did anyone have sexual intercourse with you?
    a. Yes
    b. No

9. Did anyone force you to have oral sex with them (by oral sex, we mean that a man or boy put his penis in your mouth or someone penetrated your vagina with their mouth or tongue)?
    a. Yes
    b. No
10. Did anyone force you to have anal sex with them (by anal sex, we mean that a man or boy penetrated your anus with their penis)?
    a. Yes
    b. No
11. Did anyone ever put their finger or another object in your vagina?
    a. Yes
    b. No
12. Did anyone ever put their finger or another object in your anus?
    a. Yes
    b. No

How old were you when any of these events <u>first</u> happened? _____ years

What was the person(s) relationship to you? Check all that apply:

a. Father/stepfather
b. Mother/stepmother

c. Sibling: How old was your sibling at the time? _____ years

d. Other relative: Please specify _____

e. Babysitter or other non-relative caretaker

f. Neighbor/Friend of the family

g. Teacher, Club Leader, Camp Counselor, etc.

h. Stranger

i. Other non-relative: Please specify _____

Appendix C

Sexual Experiences Survey Adapted from Polusny (1998)

Adolescent Sexual Experiences

Instructions: Another type of traumatic or stressful event many women have experienced is unwanted sexual advances. The person making the advances isn't always a stranger, but can be a friend, boyfriend, or even a family member. Answer each question below for incidents that occurred between the ages of 14 and 18.

1. Have you ever given in to sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments or pressure?
    a. Yes
    b. No
2. Have you had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man used his position of authority (boss, teacher, camp counselor, supervisor) to make you?
    a. Yes
    b. No
3. Have you ever had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man threatened or used

some degree of physical force (twisting your arm, holding you down, etc.) to make you?

   a. Yes
   b. No

4. Has a man attempted sexual intercourse (get on top of you, attempt to insert his penis in your vagina) when you didn't want to by threatening or using some degree of force (twisting your arm, holding you down, etc.), but intercourse ***did not occur***?

   a. Yes
   b. No

5. Has a man attempted sexual intercourse (get on top of you, attempt to insert his penis in your vagina) when you didn't want to by giving you alcohol or drugs, but intercourse ***did not occur***?

   a. Yes
   b. No

6. Have you had sexual intercourse when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

   a. Yes
   b. No

7. Have you had sexual intercourse when you didn't want to because a man used his position of authority (boss, teacher, camp counselor, supervisor) to make you?
    a. Yes
    b. No
8. Have you had sexual intercourse when you didn't want to because a man gave you alcohol or drugs?
    a. Yes
    b. No
9. Have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?
    a. Yes
    b. No
10. Has anyone ever made you have oral sex when you didn't want to by force or threat of harm?
    a. Yes
    b. No
11. Has anyone ever made you have anal sex when you didn't want to by force or threat of harm?

a. Yes

b. No

12. Has anyone ever put fingers or objects in your vagina or anus against your will by using force or threats of harm?

a. Yes

b. No

How old were you when any of these events first happened? _____ years

What was the person(s) relationship to you? Check all that apply:

j. Father/stepfather

k. Mother/stepmother

l. Sibling: How old was your sibling at the time? _____ years

m. Other relative: Please specify _____

n. Babysitter or other non-relative caretaker

o. Neighbor/Friend of the family

p. Teacher, Club Leader, Camp Counselor, etc.

q. Stranger

r. Other non-relative: Please specify _____

Appendix D

Sexual Experiences Survey

Adult Sexual Experiences

Instructions: Answer each question below for incidents that occurred after the age of 18.

1. Have you ever given in to sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments or pressure?
    a. Yes
    b. No
2. Have you had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man used his position of authority (boss, teacher, camp counselor, supervisor) to make you?
    a. Yes
    b. No
3. Have you ever had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?
    a. Yes

b. No

4. Has a man attempted sexual intercourse (get on top of you, attempt to insert his penis in your vagina) when you didn't want to by threatening or using some degree of force (twisting your arm, holding you down, etc.), but intercourse ***did not occur***?

    c. Yes

    d. No

5. Has a man attempted sexual intercourse (get on top of you, attempt to insert his penis in your vagina) when you didn't want to by giving you alcohol or drugs, but intercourse ***did not occur***?

    a. Yes

    b. No

6. Have you had sexual intercourse when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

    a. Yes

    b. No

7. Have you had sexual intercourse when you didn't want to because a man used his position of authority (boss, teacher, camp counselor, supervisor) to make you?

    a. Yes

b. No

8. Have you had sexual intercourse when you didn't want to because a man gave you alcohol or drugs?
    a. Yes
    b. No
9. Have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?
    a. Yes
    b. No
10. Has anyone ever made you have oral sex when you didn't want to by force or threat of harm?
    a. Yes
    b. No
11. Has anyone ever made you have anal sex when you didn't want to by force or threat of harm?
    a. Yes
    b. No
12. Has anyone ever put fingers or objects in your vagina or anus against your will by using force or threats of harm?

a. Yes

b. No

How old were you when any of these events first happened? _____ years

What was the person(s) relationship to you? Check all that apply:

a. Father/stepfather

b. Mother/stepmother

c. Sibling: How old was your sibling at the time? _____ years

d. Other relative: Please specify _____

e. Babysitter or other non-relative caretaker

f. Neighbor/Friend of the family

g. Teacher, Club Leader, Camp Counselor, etc.

h. Stranger

i. Other non-relative: Please specify _____

Appendix E

The Female Sexual Function Index

INSTRUCTIONS: These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply:

Sexual activity can include caressing, foreplay, masturbation and vaginal intercourse.

Sexual intercourse is defined as penile penetration (entry) of the vagina.

Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy.

CHECK ONLY ONE BOX PER QUESTION.

Sexual desire or interest is a feeling that includes wanting to have a sexual experience, feeling receptive to a partner's sexual initiation, and thinking or fantasizing about having sex.

1. Over the past 4 weeks, how **often** did you feel sexual desire or interest?

- □ Almost always or always
- □ Most times (more than half the time)
- □ Sometimes (about half the time)
- □ A few times (less than half the time)
- □ Almost never or never

2. Over the past 4 weeks, how would you rate your **level** (degree) of sexual desire or interest?

- □ Very high
- □ High
- □ Moderate
- □ Low
- □ Very low or none at all

Sexual arousal is a feeling that includes both physical and mental aspects of sexual excitement. It may include feelings of warmth or tingling in the genitals, lubrication (wetness), or muscle contractions.

3. Over the past 4 weeks, how **often** did you feel sexually aroused ("turned on") during sexual activity or intercourse?

- □ No sexual activity
- □ Almost always or always
- □ Most times (more than half the time)
- □ Sometimes (about half the time)
- □ A few times (less than half the time)
- □ Almost never or never

4. Over the past 4 weeks, how would you rate your **level** of sexual arousal ("turn on") during sexual activity or intercourse?

- □ No sexual activity
- □ Very high
- □ High
- □ Moderate
- □ Low
- □ Very low or none at all

5. Over the past 4 weeks, how **confident** were you about becoming sexually aroused during sexual activity or intercourse?

- □ No sexual activity
- □ Very high confidence
- □ High confidence
- □ Moderate confidence
- □ Low confidence
- □ Very low or no confidence

6. Over the past 4 weeks, how **often** have you been satisfied with your arousal (excitement) during sexual activity or intercourse?

- □ No sexual activity
- □ Almost always or always
- □ Most times (more than half the time)
- □ Sometimes (about half the time)
- □ A few times (less than half the time)
- □ Almost never or never

7. Over the past 4 weeks, how **often** did you become lubricated ("wet") during sexual activity or intercourse?

- □ No sexual activity
- □ Almost always or always
- □ Most times (more than half the time)
- □ Sometimes (about half the time)
- □ A few times (less than half the time)
- □ Almost never or never

8. Over the past 4 weeks, how **difficult** was it to become lubricated ("wet") during sexual activity or intercourse?

- □ No sexual activity
- □ Extremely difficult or impossible
- □ Very difficult
- □ Difficult
- □ Slightly difficult
- □ Not difficult

9. Over the past 4 weeks, how often did you **maintain** your lubrication ("wetness") until completion of sexual activity or intercourse?

- □ No sexual activity

□ Almost always or always

□ Most times (more than half the time)

□ Sometimes (about half the time)

□ A few times (less than half the time)

□ Almost never or never

10. Over the past 4 weeks, how **difficult** was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?

□ No sexual activity

□ Extremely difficult or impossible

□ Very difficult

□ Difficult

□ Slightly difficult

□ Not difficult

11. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **often** did you reach orgasm (climax)?

□ No sexual activity

□ Almost always or always

□ Most times (more than half the time)

□ Sometimes (about half the time)

□ A few times (less than half the time)

□ Almost never or never

12. Over the past 4 weeks, when you had sexual stimulation or intercourse, how **difficult** was it for you to reach orgasm (climax)?

□ No sexual activity

□ Extremely difficult or impossible

□ Very difficult

□ Difficult

□ Slightly difficult

□ Not difficult

13. Over the past 4 weeks, how **satisfied** were you with your ability to reach orgasm

(climax) during sexual activity or intercourse?

□ No sexual activity

□ Very satisfied

□ Moderately satisfied

□ About equally satisfied and dissatisfied

□ Moderately dissatisfied

□ Very dissatisfied

14. Over the past 4 weeks, how **satisfied** have you been with the amount of

emotional closeness during sexual activity between you and your partner?

□ No sexual activity

□ Very satisfied

□ Moderately satisfied

□ About equally satisfied and dissatisfied

□ Moderately dissatisfied

□ Very dissatisfied

15. Over the past 4 weeks, how **satisfied** have you been with your sexual

relationship with your partner?

□ Very satisfied

□ Moderately satisfied

□ About equally satisfied and dissatisfied

□ Moderately dissatisfied

□ Very dissatisfied

16. Over the past 4 weeks, how **satisfied** have you been with your overall sexual life?

□ Very satisfied

□ Moderately satisfied

□ About equally satisfied and dissatisfied

□ Moderately dissatisfied

□ Very dissatisfied

17. Over the past 4 weeks, how **often** did you experience discomfort or pain during vaginal penetration?

□ Did not attempt intercourse

□ Almost always or always

□ Most times (more than half the time)

□ Sometimes (about half the time)

□ A few times (less than half the time)

□ Almost never or never

18. Over the past 4 weeks, how **often** did you experience discomfort or pain following

vaginal penetration?

□ Did not attempt intercourse

□ Almost always or always

□ Most times (more than half the time)

□ Sometimes (about half the time)

□ A few times (less than half the time)

□ Almost never or never

19. Over the past 4 weeks, how would you rate your **level** (degree) of discomfort or pain during or following vaginal penetration?

□ Did not attempt intercourse

□ Very high

□ High

- Moderate
- Low
- Very low or none at all

20. Have you ever masturbated?
    a. Yes
    b. No
21. How comfortable are you with masturbating?
    a. Not at all comfortable
    b. Not very comfortable
    c. Very comfortable
    d. Completely comfortable
22. How often do you achieve orgasm when you masturbate?
    a. Never
    b. Rarely
    c. Often
    d. Always
23. How satisfied are you with your engagement in masturbation?
    a. Not at all satisfied
    b. Not very satisfied
    c. Very satisfied
    d. Completely satisfied

Appendix F

The Sexual Satisfaction Scale for Women

1. I feel content with the way my present sex life is.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
2. I often feel something is missing from my present sex life.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
3. I often feel I don't have enough emotional closeness in my sex life.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
4. I feel content with how often I presently have sexual intimacy (kissing, intercourse, etc.) in my life.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
5. I don't have *any* important problems or concerns about sex (arousal, orgasm, frequency, compatibility, communication, etc.)	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
6. Overall, how satisfactory is your sex life?	Completely satisfactory	Very satisfactory	Reasonable satisfaction	Not very satisfactory	Not at all satisfactory
7. My partner often gets defensive when I try discussing sex.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
8. My partner and I do not discuss sex openly enough with each other, or do not discuss sex often enough.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree

9. I usually feel completely comfortable discussing sex whenever my partner wants to.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
10. My partner usually feels completely comfortable discussing sex whenever I want to.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
11. I have no difficulty talking about my deepest feelings and emotions when my partner wants me to.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
12. My partner has no difficulty talking about their deepest feelings and emotions when I want him to.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
13. I often feel my partner isn't sensitive or aware enough about my sexual likes and desires.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
14. I often feel that my partner and I are not sexually compatible enough	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
15. I often feel that my partner's beliefs and attitudes about sex are too different from mine.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
16. I sometimes think my partner and I are mismatched in needs and desires concerning sexual intimacy.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
17. I sometimes feel that my partner and I might not be physically attracted to each other enough.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree

18. I sometimes think my partner and I are mismatched in our sexual styles and preferences.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
19. I'm worried that my partner will become frustrated with my sexual difficulties.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
20. I'm worried that my sexual difficulties will adversely affect my relationship.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
21. I'm worried that my partner may have an affair because of my sexual difficulties.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
22. I'm worried that my partner is sexually unfulfilled.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
23. I'm worried that my partner views me as less of a woman because of my sexual difficulties.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
24. I feel like I've disappointed my partner by having sexual difficulties.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
25. My sexual difficulties are frustrating to me.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
26. My sexual difficulties make me feel sexually unfulfilled.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
27. I'm worried that my sexual difficulties might cause me to seek sexual fulfillment outside my relationship.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree

28. I'm so distressed about my sexual difficulties that it affects how I feel about myself.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
29. I'm so distressed about my sexual difficulties that it affects my own well-being.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree
30. My sexual difficulties annoy and anger me.	Strongly disagree	Disagree a little	Neither agree or disagree	Agree a little	Strongly agree

Appendix G

The Acceptance and Action Questionnaire – II

Below you will find a list of statements. Please rate how true each statement is for you by using the scale below to fill in your choice.

1	2	3	4	5	6	7
Never true	Very seldom true	Seldom true	Sometimes true	Frequently true	Almost always true	Always true

_____1. My painful experiences and memories make it difficult for me to live a life that I would value.

_____2. I'm afraid of my feelings.

_____3. I worry about not being able to control my worries and feelings.

_____4. My painful memories prevent me from having a fulfilling life.

_____5. Emotions cause problems in my life.

_____6. It seems like most people are handling their lives better than I am.

_____7. Worries get in the way of my success.

TOTAL _____

Appendix H

The PTSD Checklist for DSM-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4

8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling asleep or staying asleep?	0	1	2	3	4

Appendix I

The Center for Epidemiological Studies – Depression

Instructions: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way **during the past week**.

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				

12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not get “going.”				