Sexual Satisfaction and Dysfunction in Female Survivors of Sexual Violence: The Moderating Effect of Sexual Motivations

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ABSTRACT

SEXUAL SATISFACTION AND DYSFUNCTION IN FEMALE SURVIVORS OF SEXUAL VIOLENCE: THE MODERATING EFFECT OF SEXUAL MOTIVATIONS

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Northern Illinois University, 2022
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One in four women is sexually assaulted at some time during her life, which often results in negative effects including lower levels of sexual satisfaction and higher rates of sexual dysfunction. While sexual violence has been consistently linked to lower levels of sexual satisfaction and higher rates of sexual dysfunction, not all women who experience sexual violence go on to experience these negative effects. This suggests that there may be another factor involved in the development of post-assault sexual problems. Research indicates that one factor may be motivation for sexual intercourse as different motivations have shown predictive value for sexual outcomes, including sexual satisfaction. Despite these connections, there is a gap in the literature examining the relationship between sexual violence, sexual motivations, sexual satisfaction, and sexual dysfunction. This study addressed this gap by surveying 127 college-aged women to investigate (a) the impact of sexual violence on sexual satisfaction and sexual dysfunction, (b) the relationship between sexual satisfaction and sexual dysfunction, (c) the relationship between sexual satisfaction/dysfunction and sexual motivations, and (d) the moderating role of sexual motivation on the relationship between sexual violence and sexual satisfaction/dysfunction. While these hypotheses were not supported, there was a significant
relationship between sexual satisfaction and sexual dysfunction. Additionally, the covariate of relationship motivation predicted sexual satisfaction and sexual dysfunction. Future research is necessary to further examine the relationships among sexual violence, sexual motivation, sexual satisfaction, sexual dysfunction, and relationship satisfaction because the current study failed to support existing literature.
SEXUAL SATISFACTION AND DYSFUNCTION IN FEMALE SURVIVORS OF SEXUAL VIOLENCE: THE MODERATING EFFECT OF SEXUAL MOTIVATIONS

BY
KYLA A. LEONARD

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A THESIS SUBMITTED TO THE GRADUATE SCHOOL IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE MASTER OF ARTS

DEPARTMENT OF PSYCHOLOGY

Thesis Director:
Michelle Lilly
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CHAPTER 1
INTRODUCTION

One in four women is sexually assaulted at some time during her life (Koss et al., 1987), which often results in negative effects such as depression, suicidality, posttraumatic stress disorder (PTSD), fear, stress, dissociation, anxiety, sexual dysfunction, and less sexual satisfaction (Campbell et al., 2009; Kilpatrick et al., 1981; Letourneau et al., 1996; Temple et al., 2007; Van Berlo & Ensink, 2000). While depression and fear levels tend to decrease somewhat with time, sexual problems tend to endure (Becker et al., 1982; Ellis et al., 1981; Nadelson et al., 1982; Riggs et al., 1992).

Sexual satisfaction and sexual dysfunction are important factors in an individual’s life, and they have been shown to be related to depression and PTSD, whereas higher levels of sexual satisfaction are related to more love and relationship stability, life satisfaction, happiness, and higher self-esteem (Laumann et al., 1999; Ménard & Offman, 2009; Sprecher, 2002; Ventegodt, 1998). Sexual satisfaction and sexual dysfunction have consistently been linked to sexual violence. Research indicates that sexual violence is related to lower levels of sexual satisfaction and higher levels of sexual dysfunction (Burgess & Holmstrom, 1979; Ellis et al., 1981; Leonard & Follette, 2002; Norris & Feldman-Summers, 1981; Van Berlo & Ensink, 2000).

Many studies provide evidence for the deleterious effects of sexual assault; however, there is little research on the impact of sexual violence on sexual satisfaction and sexual dysfunction. Though the literature suggests a strong relationship between sexual violence and
sexual satisfaction/dysfunction, not every victimized woman goes on to have lowered levels of sexual satisfaction and dysfunction. This suggests there are other factors involved in the relationship between victimization and sexual satisfaction/dysfunction. One potential factor is the motivation for sexual intercourse. Motivations for sexual intercourse have shown predictive value for sexual outcomes, including sexual satisfaction, such that women who engage in sexual intercourse for intimacy with their partner, to feel pleasure, and to increase their self-view report more sexual satisfaction (Cooper et al., 1998; Impett & Tolman, 2006; Stephenson et al., 2011).

Notably, there are few recent studies that have studied sexual satisfaction and sexual dysfunction. The following comprehensive literature review is largely made up of research conducted 30 to 40 years ago. The results of these studies are indicative of a relationship between sexual violence and satisfaction/dysfunction; thus, it is important that this important work be continued and that the findings inform and guide present research. The current study examined the relationship between sexual violence and sexual satisfaction, as well as the relationship between sexual violence and sexual dysfunction. Consistent with previous research, it was hypothesized that sexual violence would be related to lower levels of sexual satisfaction and higher levels of sexual dysfunction. Additionally, the current study explored sexual motivations as a potential moderator in the relationship between sexual violence and sexual satisfaction/dysfunction. It was hypothesized that the motivations of coping and peer approval would result in a stronger relationship between sexual violence and sexual satisfaction/dysfunction while the motivations of intimacy, enhancement, and self-affirmation would weaken the relationship.
Sexual Satisfaction and Sexual Dysfunction

In the extant literature, sexual well-being is defined in myriad ways that fall under the broad categories of sexual satisfaction and sexual dysfunction. Sexual satisfaction, defined as the degree to which an individual experiences fulfilling sexual experiences, is related to past experiences, future aspirations, and current expectations (Davidson et al., 1995). Sexual satisfaction has been operationalized in research as desire, frequency of sexual activity, frequency of orgasm, and the subjective report of satisfaction. In addition to sexual satisfaction, sexual well-being considers sexual dysfunctions. Sexual dysfunction has been operationalized as low frequency of sexual activity, sexual anxiety, physiological arousal dysfunction, psychological desire dysfunction, and orgasm dysfunction.

It is important to note that sexual dysfunction is not simply the opposite of sexual satisfaction nor the lack of sexual satisfaction. Evidence has shown that sexual satisfaction and sexual dysfunction are not significantly associated, and results indicate that different factors may account for sexual satisfaction and sexual functioning (Derogatis, 1997; Ferenidou et al., 2008; Heiman et al., 1986; Jehu et al., 1988; King et al., 2007; Leonard et al., 2008; Stephenson & Meston, 2010). In a study of 204 couples, it was found that 24% of males and 42% of females who self-selected into the study as sexually satisfied and sexual-problem free actually had at least one sexual dysfunction (Heiman et al., 1986). These individuals who labeled themselves as “sexually satisfied and sexual-problem free” also reported sexual dysfunction. This finding provides evidence that sexual satisfaction is frequently experienced as distinct from sexual dysfunction, such that levels of sexual satisfaction can be perceived as high when a sexual dysfunction is occurring. Additionally, Leonard et al. (2008) collected a sample of 22 women...
who had been sexually abused in childhood or adolescence and found that there was no significant correlation between self-reported sexual satisfaction and sexual dysfunction \((r = .30, p > .05)\). Interestingly, two of the five women who were classified as clinically dysfunctional rated their current quality of sexual satisfaction as “very good,” the second highest response option. Notably, however, the study may have been underpowered to detect effects. Finally, survivors of childhood sexual abuse have been shown to have a weaker association \((\beta = -.020871, t = -4.37, p < .001)\) between physiological and subjective sexual arousal compared to women with no history of abuse (Rellini & Meston, 2006). Together, these findings show that women with a history of CSA are more likely to have weaker associations between physiological arousal and psychological arousal, such that their subjective sexual satisfaction may be high but their bodies may have an adverse reaction. Considering the differences in reported sexual satisfaction and sexual dysfunction in victimized and nonvictimixed individuals, these constructs were considered separately in the present study.

Despite the differences in definition, it is clear that sexual satisfaction and sexual dysfunction are important components to overall well-being that should not be overlooked (Apt et al., 1996). For example, sexual dysfunctions are often related to PTSD and depression (Van Berlo & Ensink, 2000) and higher levels of sexual satisfaction are related to higher levels of love and stability in a committed relationship, life satisfaction, happiness, and higher self-esteem, which often act as protective factors in victimized populations (Laumann et al., 1999; Menard & Offman, 2009; Sprecher, 2002; Ventegodt, 1998). In a population of victimized individuals who are already at risk for negative psychological and physical outcomes, poor sexual satisfaction and higher levels of sexual dysfunction could exacerbate and prolong adverse posttrauma outcomes. The current study focused on sexual satisfaction and sexual dysfunction separately, with sexual
satisfaction defined as the sense of satisfaction or fulfillment with one’s sexual life (Davidson et al., 1995) as shown through levels of psychological desire and subjective ratings of satisfaction. The current study observed sexual dysfunction through self-report of desire, arousal, lubrication, orgasm, satisfaction, and pain.

Model of Sexual Dysfunction in Survivors

While there is not a widely accepted theory of sexual dysfunction in women who have experienced violence, many theories have attempted to explain the pathways from sexual victimization to negative sexual outcomes (i.e., sexual dysfunction), such as the negative-association hypothesis (Feldman-Summers et al., 1979), rape trauma syndrome (Burgess & Holmstrom, 1979), and various phase responses to the sexual trauma (Becker & Abel, 1981; Sutherland & Scherl, 1970). Though there is not one theory or model widely accepted by the field, Rellini (2008) developed the most comprehensive explanation of the development of sexual problems after child sexual abuse. Rellini’s model is derived from pre-existing models of sexual response and aligns with other supported explanations of postvictimization sexual disturbance (Holmes & St. Lawrence, 1983; Kilpatrick et al., 1982; Letourneau et al., 1996; Loeb et al., 2002).

Rellini’s (2008) sexual dysfunction model was developed to understand sexual dysfunction in survivors of child sexual abuse by distinguishing between psychological and physiological sexual arousal problems. The model describes sexual dysfunction as a result of both first-order processes and second-order processes. First-order processes largely occur outside awareness and are automatic responses; for example, a startle to a loud noise is a first-order process. These first-order processes impact mood, thoughts, and physiological responses through
unconscious sexual memories. The first-order processes influence the second-order processes, which occur in conscious awareness. The second-order processing of sexual stimuli is more complex because it includes contextual factors such as mood, values, cultural scripts, attitudes, social norms, and perception of sexual self. Sexual violence can impact an individual through first-order unconscious memories and/or second-order processing of the event and cognitions related to it.

The combination of the first- and second-order processes produces the final level of sexual arousal, with different types of responses (i.e., mood, thoughts, and physiological response) promoting increased or decreased feelings of pleasure (Wielgel et al., 2006). According to the model, it is possible to experience both physiological sexual arousal and decreased psychological desire, which results in a number of sexual dysfunctions (i.e., desire dysfunction, dyspareunia, nonorgasmia, etc.). Experience of both priming and inhibitory sexual arousal is exhibited when physiological and psychological arousal are in disagreement. For example, Rellini and Meston (2006) observed the physical arousal (vaginal pulsing) and self-reported psychological level of arousal on a scale from 0 (neutral) to 7 (very aroused or turned on) in 18 women who experienced child sexual abuse and 10 control women. They found that victimized women with PTSD ($\beta = .02$, $t = -5.08$, $p < .01$) and without PTSD ($\beta = -.02$, $t = -4.37$, $p < .01$) showed less agreement between their physiological arousal and psychological reports of arousal than the nonvictimized control group. The distinction between physiological and psychological arousal also provides evidence that sexual satisfaction and sexual dysfunction are separate constructs that may occur through different processes, but both are impacted by sexual violence.
Dysfunctions in CSA and Adult Sexual Assault Survivors

Sexual dysfunction has been seen in approximately one third of women who have experienced sexual assault (Norris & Feldman-Summers, 1981). In a study comparing CSA survivors and adult sexual assault survivors, Becker and colleagues (1982) found that at two months to more than a year postassault, 56% of rape and sexual abuse victims reported at least one sexual dysfunction, with 70% of sexually dysfunctional participants reporting that the assault preceded the dysfunction. Further, reported experiences of arousal and desire dysfunctions were correlated in incest victims, suggesting that these may often co-occur ($r = .84$, $p < .001$). Interestingly, these associations were not present for victims who experienced rape but not incest. Bartoi and Kinder (1998) conducted a similar study in which they compared child sexual abuse victims, adult sexual abuse victims, and nonabused women to explore differential effects of abuse on sexual functioning. They found that the victimized women were less satisfied with the quality of their most recent sexual relationship and had more unsafe sexual partners. Women abused in adulthood specifically were more sexually dissatisfied and more nonsensual (i.e., caressed their partners less) than the control group. There were no differences found between women who were abused as adults and those who were abused as children in regard to interpersonal communication, number of unsafe sexual encounters, or number of unwanted pregnancies. The groups did not differ in prevalence of physiological dysfunctions such as vaginismus (involuntary tightening of the vagina) or anorgasmia (inability to reach orgasm) as adults. When compared to nonabuse, the Cohen’s $d$ scores ranged between .372 and .622, with the largest effect size seen for nonsensuality.
Dysfunctions in CSA Survivors

Research has shown that child sexual abuse has a medium to large effect \( (d = .53-.72) \) on later sexual dysfunction (Stephenson et al., 2014). In a series of studies, researchers utilized measures of physiological arousal (i.e., vaginal photoplethysmography, a device designed to assess vaginal blood flow; Geer, 2005) and subjective arousal in women who experienced child sexual abuse (Rellini et al., 2009; Rellini & Meston, 2006; Schacht et al., 2007). Results from these studies indicate that women with a history of CSA have a weaker vaginal response to erotic videos than women with no history of abuse. Vaginal blood flow, or vaginal response, is an indication of sexual arousal. The lack of vaginal response to sexual stimuli is often indicative of a sexual dysfunction. Further, the weaker vaginal response was shown more often in women with a history of child sexual abuse who complain of having sexual problems. Similarly, among women who report having sexual problems, those with a history of CSA show a significantly weaker vaginal response than those with no history of abuse (Rellini, 2008).

Additional studies have also provided evidence of the deleterious effects of child sexual abuse on later sexual dysfunction (for a review, see Leonard & Follette, 2002). Leonard et al. (2008) surveyed 22 community and university women who reported a history of childhood and/or adolescent sexual abuse. Out of these women, 22.7% reported clinical levels of sexual dysfunction, with orgasm dysfunction being the most prevalent problem. In a representative national probability sample of 1,749 adult women, 20-59.2% reported at least one sexual dysfunction, including desire dysfunction, arousal dysfunction, orgasm dysfunction, dyspareunia, anxiety about performance, and lack of pleasure during sex (Laumann et al., 1994). Women who reported CSA or adult sexual assault were one to three times more likely to report an arousal
disorder than women who did not report previous assault exposure (95% CI, 1.11-2.71; 95% CI, 1.31-3.07). Out of 51 women with a history of CSA in a clinical, treatment-seeking sample, 94% reported sexual problems including desire dysfunction, aversion/phobia, arousal dysfunction, orgasm dysfunction, lower levels of satisfaction, dyspareunia, and vaginismus (Jehu et al., 1988). A college sample reported that about 65% of women who experienced CSA met DSM-III criteria for one or more sexual dysfunctions (Jackson et al., 1990).

Dysfunctions in Adult Sexual Assault Survivors

Becker et al. (1986) conducted a study in which they aimed to understand the prevalence of the following sexual dysfunctions: fear of sex, arousal dysfunction, desire dysfunction, dyspareunia, vaginismus, primary nonorgasmia, secondary nonorgasmia, situational secondary nonorgasmia, or other sexual problems using the Sexual Arousability Inventory (Hoon et al., 1976). To investigate this question, 372 adult female sexual assault survivors and 99 non-assaulted women were interviewed upon arrival to a victim treatment center or hospital, respectively. To ensure unbiased incidence reports, those who presented for sexual dysfunction were excluded. They found that 58.6% of the women reported having at least one sexual problem compared to 17.2% of people who were not assaulted. Furthermore, 66.4% of the survivors who reported dysfunction reported multiple sexual problems. Survivors were significantly more likely to experience fear of sex ($d = .59$) and arousal dysfunction ($d = .33$) than the nonassaulted controls. In the “other sexual problems” category, survivors reported flashbacks of the assault/rape while engaging in sexual behavior, while the control group reported less intense orgasms or increased boredom.
Compared to nonvictims, women who experienced sexual assault were two times more likely to experience sexual dysfunction (Kilpatrick et al., 1988). In survivors of adult sexual assault, 80% of women aged 17 to 73 in a clinical, hospital sample reported disruption in sexual functioning (i.e., change in frequency of sexual behavior, sexual aversion, flashbacks, vaginismus, and orgasm dysfunction) postassault (Burgess & Holmstrom, 1979). Notably, the sexual assault is often considered the antecedent to the dysfunction by the survivor (Becker et al., 1982).

These dysfunctions have been shown to be an enduring phenomenon, with 50% of completed-rape survivors and 25% of attempted-rape survivors reporting sexual problems after a year (Becker et al., 1982) and reports of rape-related difficulties as many as 13 years following an assault (Riggs et al., 1992). Ellis et al. (1981) observed 116 female rape victims over 48 weeks to determine levels of sexual dysfunction. While many victims’ sexual activity returned to normal within four to six months, 10-20% of the victims reported sexual problems lasting years. Of the women who were sexually active before the assault, 61% stopped having sex with their partner completely or decreased their sexual frequency four weeks after the assault. Nadelson et al. (1982) reported similar findings with more than half of rape survivors reporting sexual difficulties one to two years postassault. Further, 25% avoided any sexual relationship after rape (Nadelson et al., 1982).

Sexual anxiety has been shown to have a prominent role in the sexual experiences of those who have had complex childhood trauma (Lacelle et al., 2012; Rellini & Meston, 2011; Staples et al., 2012). Sexual anxiety has been shown to lead to lower levels of sexual satisfaction (Bigras et al., 2017; Bigras et al., 2015) and may predict or correlate with further dysfunction. In one within-subjects study, a sexually positive and a sexually anxious narrative were presented to
19 undergraduate women (Beggs et al., 1987). Upon being exposed to the sexual narratives, vaginal blood flow was monitored via vaginal photoplethysmography, a device inserted into the vagina that directly measures the amount of blood in the walls of the vagina, which is interpreted to be the level of arousal. In the induced sexual anxiety condition, the women had significantly less increase of vaginal blood flow than the control group. In an analysis of blood flow, the women did not continue to show increases in blood flow, whereas the positive condition showed a linear increase in vaginal blood flow, or arousal, throughout the presentation of sexual stimuli. The results of this study indicate that women who experience sexual anxiety exhibit significantly less initial physical arousal and less of an increase of arousal over time than in a positive sexual experience. Thus, if an individual experiences recurrent sexual anxiety, she is more likely to experience the sexual dysfunction of sexual arousal.

Impact of Sexual Violence on Sexual Satisfaction

Few studies investigate the relationship between different forms of sexual violence (i.e., child sexual abuse, adolescent sexual assault, and adult sexual assault) and sexual satisfaction. However, the studies that do take note of this relationship provide evidence that sexual violence and sexual satisfaction are inversely related (Van Berlo & Ensink, 2000).

Sexual Satisfaction in Sexual Trauma Survivors

A sample of 50 female sexual assault survivors aged 19 to 55 who presented to a rape counseling clinic responded to questionnaires regarding their sexual experiences (Feldman-Summers et al., 1979). They found that behaviors most similar to one’s sexual assault experiences (e.g., genital touching and intercourse) were rated as significantly less satisfying
after the rape compared to before the rape (Feldman-Summers et al., 1979). Sexual satisfaction was measured by asking participants to rate their satisfaction on a scale of 1 (very satisfied) to 5 (not satisfied) for 23 sexual activities (e.g., sexual intercourse, kissing your partner). Notably, ratings of satisfaction for affectionate (e.g., holding hands) and autoerotic (e.g., masturbation) behaviors were not different before and after the rape, indicating that only satisfaction of behaviors related to the assault seem affected.

In another retrospective study, 116 female college students rated their satisfaction with sex-related activities for four different time points: one month prior to sexual victimization, one month after, three months after, and at time of survey (Orlando & Koss, 1983). Women who experienced sexual assault rated their levels of sexual satisfaction as lower than the pre-assault ratings at one month postassault \( (d = .142) \). Methodology was kept consistent with Feldman-Summers, such that participants rated their sexual satisfaction on a 5-point Likert scale for the same set of 23 activities.

Jackson et al. (1990) compared 22 college women who had reported child sexual abuse perpetrated by a family member at least 5 years older than them to a matched control group. They used the Derogatis Sexual Functioning Inventory (DSFI; Derogatis & Melisaratos, 1979). This measure assesses sexual satisfaction as good communication, satisfaction with partner, fulfillment, desire, satisfying orgasms, and confidence in performance (e.g., “I have satisfying orgasms”; “After sex I feel relaxed”) on a 9-point frequency scale. Women reporting CSA expressed significantly less sexual satisfaction than those who had not been sexually abused as children \( (F(1,32) = 10.49, p < .01) \). However, both groups had similar reports of sexual attitudes, experience, drive, and fantasies.
In recent research, Leonard et al. (2008) surveyed 22 women who had experienced childhood and/or adolescent sexual abuse to investigate the relationship between sexual satisfaction and predictor variables including experiential avoidance, relationship satisfaction, relationship violence, anger, and psychological distress. Out of the 22 women, only 59% reported feeling sexually satisfied in their current sexual relationship. Sexual satisfaction was significantly correlated with relationship satisfaction ($r = -.75, p < .01$), psychological distress ($r = .69, p < .01$), anger ($r = .53, p < .01$), experiential avoidance ($r = .66, p < .01$), and relationship violence ($r = .64, p < .01$).

Interestingly, relationship to perpetrator was not related to differences in levels of sexual satisfaction in another study (Koss et al., 1988). A national sample of 3,187 female college students responded to a measure rating physical satisfaction on a scale of 1 (don’t do it) to 5 (very satisfying) for the following three activities: petting and stroking, hugging and kissing, and sexual intercourse. There was no significant difference in reported satisfaction among groups of women who were raped by a nonromantic acquaintance, casual date, steady date, or spouse/family ($F(3, 411) = 2.29, p = .077$).

These studies provide preliminary evidence that sexual violence, whether adult sexual assault or childhood sexual abuse, has a negative effect on sexual satisfaction. Despite the differences in operationalization and measurement, evidence has supported the relationship between sexual violence and sexual satisfaction.

Conflicting Evidence

While it is clear that at least some women experience lower levels of sexual satisfaction and higher levels of sexual dysfunction postvictimization, the number of women experiencing
such difficulties varies widely across studies. As discussed above, as many as 61-66% of women experience lower levels of sexual satisfaction and higher levels of sexual dysfunction after a sexual trauma (Ellis et al., 1981; Norris & Feldman-Summers, 1981); however, some studies indicate that there is no difference among women’s posttrauma sexual experience (Bigras et al., 2015; Burgess & Holmstrom, 1979; Culbertson & Dehle, 2001; Feldman-Summers et al., 1979). For example, one study shows that women were less sexually active than they were before the sexual trauma. The majority of victims were abstinent for six months between the rape and the study (38%), 33% decreased sexual activity, and 10% increased activity (Burgess & Holmstrom, 1979). However, other studies do not indicate a difference in frequency of sexual activity between women who were sexually victimized and those who were not. Feldman-Summers and colleagues (1979) reported that the frequency of oral sex, sexual intercourse, anal intercourse, masturbation, and orgasms were not significantly different between survivors of sexual violence and women who had not experienced sexual violence. Norris and Feldman-Summers (1979) extended that line of research and indicated that the sexual assault was not able to predict psychosexual effects, despite the fact that one-third of the participants reported a decrease in sexual satisfaction pos-assault. Culbertson and Dehle (2001) reported that assaulted and non-assaulted groups showed no difference on current sexual satisfaction. This result has also been seen in a population of women who had experienced child sexual abuse, in which sexual satisfaction was shown to have no difference between CSA and no CSA groups (Bigras et al., 2015). Wide discrepancies of these sexual difficulties across studies suggest the possibility of factors that moderate the association between sexual violence and sexual satisfaction. However, few studies have identified potential moderating variables.
Moderating Effect of Sexual Motivations

While research has shown that sexual violence impacts sexual satisfaction and dysfunction, not all women who experience sexual victimization go on to develop a sexual dysfunction or low levels of satisfaction. Thus, it can be posited that other factors influence this relationship. Research suggests that one important factor is sexual motivations, or the reasons people engage in sexual intercourse (Cooper et al., 1998; Impett et al., 2005; Impett & Tolman, 2006; Meston & Buss, 2007). Though a relationship among all the factors of interest has not been examined in this way, sexual motivations have been associated with sexual satisfaction and violence separately (Impett & Tolman, 2006; Miron & Orcutt, 2014; Orcutt et al., 2005; Stephenson et al., 2011). Thus, sexual motivations were hypothesized to influence the relationship between sexual violence and sexual satisfaction/sexual dysfunction.

The literature indicates that women are motivated to engage in sexual behavior to fulfill both psychological and physical needs (Browning et al., 2000; Cooper et al., 1998; Hill & Preston, 1996; Randolph & Winstead, 1988; Sprague & Quadagno, 1989; Stephenson et al., 2011), but the literature does not agree on what the exact motivations driving these behaviors are. Current theories of conscious motivations drastically vary from as many as 237 distinct reasons people have sex (Meston & Buss, 2007) to as few as four (Impett et al., 2005). However, the most prevalent conceptualization of sexual motivation is from Cooper et al. (1998), which served as the basis of the present study.

The longitudinal research conducted by Cooper et al. (1998) is a significant contribution to understanding the impact of sexual motivation, specifically its predictive value and relationship to sexual behaviors across time. Cooper et al. (1998) conducted a comprehensive
series of investigations to assess sexual motivations and the functions of sexual intercourse in relationships. In the first study of the series, Cooper et al. (1998) collected qualitative responses to an open-ended question (i.e., What are some of the reasons you decided to have sex?) from college students aged 17 to 21. The 335 individual responses were analyzed to determine four sexual motivation categories: enhancement, intimacy, coping, and approval. These factors are also classified along two domains (self vs. other and approach vs. avoidance). Sexual behaviors are posited to be either focused on self or others. Behaviors along the approach-avoidance domain are described as either the pursuit of positive/pleasurable experiences or the avoidance/escape from negative or painful experiences. Other researchers have utilized these domains to describe sexual functioning as well (Impett et al., 2005; Impett et al., 2008).

The second study, developed from the previous study, involved the administration of the Motivations for Sexual Intercourse (MSI; Cooper et al., 1998) to 476 sexually experienced undergraduate students in order to assess each of the four categories. A factor analysis resulted in six, instead of four, categories. These categories have been separated into “positive” and “negative” motivations, driven by approach or avoidance. The positive motivations are: enhancement (i.e., pleasure, feeling good), intimacy (i.e., feeling close to partner), and self-affirmation (i.e., affirming or bolstering one’s sense of self). The negative motivations are: coping (i.e., using sex to cope with negative emotions), partner approval (i.e., pleasing or appeasing one’s partner), and peer approval (i.e., using sex to impress or fit in with one’s peer group).

In the third study, a community sample of 1,666 sexually experienced adolescents and young adults were surveyed at two time points a year and a half apart. In this community study, the six-factor structure of the measure was observed again using confirmatory factor analysis. It
was also found that different sexual motivations were predictive of sexual behaviors. They found that individuals who engaged in enhancement motivations were more likely to engage in risky sexual contact and have negative outcomes. Individuals who engaged in sexual activity to cope were more likely to engage in promiscuous sex (defined as having multiple sex partners, intercourse with strangers, one-night stands, and intercourse with someone who has many partners) than individuals who do not engage in sexual activity to cope. Notably, coping mechanisms did not predict use of protection, unplanned pregnancies, or STD diagnoses. These results are indicative of the predictive value of sexual motivations. Unfortunately, the authors did not include information necessary to calculate effect sizes. Further, correlations between responses were stable across this time with correlation coefficients ranging between .47 and .67, indicating that sexual motivation is typically stable over time.

The final study in the series by Cooper et al. (1998) was a longitudinal assessment of 299 individuals from the original community sample. The participants were interviewed at two time points at least one year apart. Results revealed that each of the six sexual motivations were moderately to highly stable, which indicated that sexual motivation is more trait-like than state-like. Sexual motivations at the first time point were significantly predictive of sexual behavior, such that coping and enhancement motives increased level of risk taking across time. Additionally, peer approval and self-affirmation motives were related to increased sexual risk-taking and less use of contraception over time. Those who reported self-affirmation motivations for sexual intercourse were more likely to experience an unplanned pregnancy. Partner approval motivations were unrelated to changes in behavior. These studies suggest that individuals who are motivated by the negative or avoidance motivations (coping and peer approval) may be at
higher risk for negative sexual outcomes. The current study extended this line of research to investigate negative sexual outcomes of low levels of sexual satisfaction and sexual dysfunction. Sexual motivation has been shown to predict greater risk taking, number of sexual partners, contraceptive use, relationship satisfaction, closeness, and conflict within relationships (Browning et al., 2000; Cooper et al., 1998; Grossbard et al., 2007; Hill & Preston, 1996; Impett et al., 2008). However, studies regarding sexual motivation and sexual satisfaction are limited to date. Impett and Tolman (2006) conducted the first study to explore the link between sexual motivations and sexual satisfaction. By administering a survey to 116 girls aged 16 to 19, they sought to assess the approach sexual motivations (i.e., seeking out pleasurable experience) by using a four-item survey asking whether the girls were “in love,” “ready,” and “attracted to my partner” and if “it was romantic.” To assess sexual satisfaction, Impett and Tolman (2006) also used a four-item sexual satisfaction questionnaire with the following responses: “It was a good experience,” “It made me happy,” “I liked how my body felt,” and “It made me feel closer to the other person.” Respondents answered either yes or no to all questions. They found that approach motivations (i.e., pursuit of pleasurable and/or pleasant experiences) were positively associated with satisfaction ($r = .48, p < .001$). This finding indicates there is a connection between sexual motivation and satisfaction, which was a focus of the current research study.

Stephenson and colleagues (2011) extended this research by investigating predictive power of sexual motivations on sexual satisfaction in 544 undergraduate students. Sexual motivations were assessed using the YSEX? Scale, which classifies motivations into the following four categories: physical (stress reduction, physical pleasure, physical desirability, and experience seeking), goal attainment (resources, social status, revenge, and utilitarian reasons), emotional (love, commitment, and emotional expression), and insecurity (boost self-esteem,
mate guarding, and duty/pressure; Meston & Buss, 2007). Sexual satisfaction was measured using the Sexual Satisfaction Scale – Women (SSS-W; Meston & Trapnell, 2005), which asks about contentment, communication, compatibility, personal concern, and relational concern on a scale from 1 to 5, with higher scores indicating more satisfaction. The strongest model for the women in this sample included love/commitment, self-esteem, resource motives, experience seeking, pleasure, and expression motives, indicating that factors of intimacy, self-affirmation, and enhancement are linked to higher levels of sexual satisfaction. While these associations were found in nonclinical, nonvictimized women, studies have shown a relationship between motivations for sexual motivations and sexual victimization.

One study examined the effect of sexual motivations on the relationship between child sexual abuse and risky sexual behavior in 297 male and female adolescents aged 14 to 17 from child welfare agencies (Wekerle et al., 2017). An effect of sexual abuse on sexual motives was found \( F(6,244) = 3.92, p = .001, \text{ partial } \eta^2 = 0.09 \), such that individuals who were sexually abused endorsed more negative sexual motivations (coping, partner approval, peer approval) than those who were not sexually abused. Orcutt et al. (2005) found that in 600 community women, coping motivations were significantly associated with childhood psychological abuse \((.26, p < .05)\), physical abuse \((.20, p < .05)\), and sexual abuse \((.12, p < .05)\). Coping motivation partially mediated the relationship between sexual violence and risky sexual behavior. Similarly, in 541 sexually active female college students from the Orcutt et al., (2005) study, coping motivations were endorsed for, but not directly related to, experiences of child sexual abuse or adolescent sexual assault (Miron & Orcutt, 2014). Interestingly, coping motivations in victims of child and adolescent violence were predictive of risky sexual behavior.
Further, Shapiro (1997) tested coping motivations as a mechanism through which child sexual abuse influences risky sexual behaviors. It was found that using sex to cope with distress was not a mediator between child sexual abuse and risky sexual behaviors despite the overlap between the constructs. Of note, coping motivation was more strongly related to risky sexual behavior among non-Black women than Black women. While Shapiro (1997) did not find evidence of coping motivations to be a mediator, the literature suggests that using sex to cope with distress is significantly related to sexual violence. Therefore, the current study assessed for an interaction between negative sexual motivations (including coping motivations) and sexual violence.

The reviewed studies provide support for the theory that there are various motives for engaging in sexual activity, including pleasure, social needs, and emotional needs. These motivations have been shown to be associated with sexual outcomes such as risky sex, sexual desire, and sexual satisfaction. However, few studies have examined sexual motivation in regard to sexual satisfaction, dysfunction, or violence. The literature on these individual constructs is limited and the role of moderating factors in the relationship between sexual violence and satisfaction/dysfunction has yet to be examined.

The Current Study

The current study sought to address this gap by assessing the impact of sexual motivation on sexual dysfunction and sexual satisfaction in a population of women who have experienced sexual violence versus women who have not.

Hypothesis 1: Impact of Sexual Violence on Sexual Satisfaction and Sexual Dysfunction
H1a: Survivors of sexual violence will report significantly lower levels of sexual satisfaction than women who have not experienced sexual violence.

H1b: Survivors of sexual violence will report significantly higher levels of sexual dysfunction than women who have not experienced sexual violence.

H1c: Survivors of sexual violence will report clinical levels of dysfunction significantly more than woman who have not experienced sexual violence.

Hypothesis 2: Relationship Between Sexual Satisfaction and Sexual Dysfunction

H2: Self-reported sexual satisfaction and sexual dysfunction will not be significantly associated in the sample regardless of sexual violence history.

Hypothesis 3: Sexual Satisfaction/ Sexual Dysfunction by Sexual Motivation Type

H3a: Intimacy, self-affirmation, and enhancement sexual motivations will be associated with higher sexual satisfaction in all women.

H3b: Coping and peer approval sexual motivations will be associated with lower sexual satisfaction in all women.

Hypothesis 4: Moderating Role of Sexual Motivation on Sexual Satisfaction/Dysfunction

H4a: Greater coping and peer approval sexual motivations will strengthen the relationship between sexual violence and sexual satisfaction. Lower scores on sexual motivations of coping and peer approval will attenuate the relationship between sexual violence and satisfaction.

H4b: Greater intimacy, self-affirmation, and enhancement sexual motivations will weaken the relationship between sexual violence and sexual satisfaction. Lower scores on intimacy, self-affirmation, and enhancement motivations will strengthen the relationship between sexual violence and satisfaction.
H4c: Greater coping and peer approval sexual motivations will strengthen the relationship between sexual violence and sexual dysfunction. Lower scores on sexual motivations of coping and peer approval will attenuate the relationship between sexual violence and dysfunction.

H4d: Greater intimacy, self-affirmation, and enhancement sexual motivations will weaken the relationship between sexual violence and sexual dysfunction. Lower scores on intimacy, self-affirmation, and enhancement motivations will strengthen the relationship between sexual violence and dysfunction.
CHAPTER 2

METHOD AND PROCEDURES

Participants

Data were collected from 215 female undergraduate students enrolled in psychology courses at a large midwestern university. Participants received research credit for their class. Participants were required to be at least 18 years of age and in a committed, romantic relationship with a partner with whom they were sexually active. Fifty-six participants were removed because they were not in a committed, romantic relationship with a partner with whom they were sexually active. Thirty-one participants were removed because they failed the instructional check. One other participant was a multivariate outlier and so removed. Thus, the final sample consisted of 127 cisgender women ($M_{\text{age}} = 19.10$, $SD = 1.67$, range 18 – 31). The majority reported their race as White ($n = 55$; 43.3%), followed by Black or African American ($n = 36$; 28.3%), Latino/Hispanic ($n = 20$; 15.7%), biracial ($n = 14$; 11.0%), and Asian or South-Asian ($n = 1$; 0.8%). One participant preferred not to report their race. Participants were largely heterosexual ($n = 103$) with 15 reporting that they identified as bisexual, three identified as homosexual, one identified as pansexual, and three reported as other. Two participants preferred not to respond with their sexuality. The majority of participants reported their relationship status as “dating seriously” ($n = 81$; 63.8%), followed by “dating casually” ($n = 33$; 25.9%), “living with someone” ($n = 11$; 8.6%), and “married” ($n = 2$; 1.6%). The majority reported that they
were in their freshman year of college \((n = 81; 63.8\%)\), followed by sophomore \((n = 31; 24.4\%)\), junior \((n = 10; 7.9\%)\), senior \((n = 2; 1.6\%)\), and more than four years \((n = 3; 2.4\%)\). The majority of participants did not identify as religious \((n = 58; 45.7\%)\) with the most common religions being Christian and Catholic. The following religions were reported by one person each: Baptist, Lutheran, Muslim, Paganism, and Protestant.

G*Power 3.1 (Faul et al., 2009) analyses were conducted to determine the required sample size for the current study: for the ANOVA, fixed effects, special effects, main effects, and interactions within the F tests family, power for an a priori analysis was conducted using a medium effect size, two groups, and power of .80. The recommended sample size was 64 for the analysis of the victimized group in Hypothesis 4. There were 62 participants in the “victimized” group and 65 in the “nonvictimized” group in the current study (see Chapter 3). As such, the current study was adequately powered to detect effects.

Measures

**Relationship Satisfaction**

The Relationship Assessment Scale (RAS; Hendrick, 1988; Appendix A) is a psychometrically sound seven-item measure developed to provide a general, short assessment of relationship satisfaction (Hendrick, 1988). Examples of items include, “How well does your partner meet your needs?” and “How good is your relationship compared to most?” Scores range from 1 (low satisfaction) to 5 (high satisfaction). The RAS was utilized to assess for the potential covariate of relationship satisfaction. For the current study, the measure was scored as continuous, with higher scores indicating higher levels of satisfaction. It has been shown to have
strong convergent validity ($r = .74$) when compared to another frequently used measure of marital satisfaction, the Kansas Marital Satisfaction Scale (KMSS; Schumm et al., 1986). Test-retest reliability was .85 when tested in both male and female college students over the course of six to seven weeks (Hendrick, 1988; Hendrick et al., 1998). There were no differences found in response patterns in ethnically or age diverse respondents (Hendrick, 1988; Hendrick et al., 1998; Vaugh & Matyastik Baier, 1999). The RAS demonstrated good internal consistency in the current study ($a = .82$).

**Sexual Motivation**

The Motivations for Sexual Intercourse Survey (MSI; Cooper et al., 1998; Appendix B) is a 29-item measure of participants’ specific motives for sexual intercourse. The items are organized into the following four categories: (a) self/negative reinforcement in which the participant reports using sex to avoid, minimize, or escape negative emotions; (b) social/negative reinforcement in which sex is used to avoid, minimize, or escape negative social experiences; (c) self/positive reinforcement in which the participant uses sex to enhance positive emotions; and (d) social/positive reinforcement in which sex is used to enhance social connections.

Additionally, the MSI is comprised of six subscales: enhancement, intimacy, coping, self-affirmation, partner approval, and peer approval. The MSI assesses global motives for sexual intercourse (e.g., “How often do you have sex to feel better when lonely?”). Responses are rated on a 5-point Likert-type scale from 1 (almost never/never) to 5 (almost always/always). The MSI was used to assess participants’ motivations for sexual intercourse in order to observe the relationship between sexual motivations and sexual satisfaction/dysfunction as well as the role of sexual motivations as a potential moderator. Cooper and colleagues (1998) have reported
adequate incremental validity, as it has been shown to account for more variance than measures of emotional responses to sex or desire for sex scales. When compared to the Sociosexual Inventory (SOI; Simpson & Gangestad, 1991), the MSI was shown to be divergent from the scales of sensation seeking and social approval and convergent with the expected scales of positive and negative responses to sex in a population of adolescents and young adults. In the current study, alpha coefficients for each of the six subscales were .87, .90, .82, .87, .84, and .87, respectively (Cooper et al., 1998). The MSI demonstrated adequate to excellent internal consistency in the current study; the alpha coefficients for each of the subscales in the current study were .71, .92, .89, .89, and .88, respectively.

**Sexual Satisfaction**

The Index of Sexual Satisfaction (ISS; Hudson et al., 1981; Appendix C) is a 25-item measure of degree of sexual satisfaction. Items are measured on a scale of 1 (*rarely or none of the time*) to 5 (*most or all of the time*) and is scored by computing the sum of all the items. This measure was used to observe sexual satisfaction as one of the dependent variables. The ISS demonstrated excellent internal consistency in the current study (*a* = .90).

**Sexual Dysfunction**

The Female Sexual Function Index (FSFI; Rosen et al., 2000; Appendix D) was developed to assess female sexual dysfunction present in the past four weeks. This 19-item measure is comprised of six subscales: desire, arousal, lubrication, orgasm, satisfaction, and pain. The FSFI has high internal consistency (Cronbach’s alpha = .82) and adequate test-retest reliability (*r* = .79 to .86). In a population of women who had experienced child sexual abuse,
internal reliability was excellent (alpha = .94); thus, it is an appropriate measure to use on a
victimized and nonvictimized population. Items are scored on a Likert-type scale from 1 to 5,
with some scales including a zero or an “I have not engaged in sexual activity” option. The FSFI
measured the dependent variable of sexual dysfunction as comprised of a composite score from
the six subscales. A cut score of 27 or greater from this measure was utilized to distinguish
between normal sexual functioning and clinically significant sexual dysfunction (Wiegel et al.,
2005). The FSFI demonstrated good internal consistency in the current study (a = .89).

Sexual Victimization

The Sexual Experiences Survey – Short Form Victim (SES-SFV; Koss et al., 2007;
Appendix E) is a widely used, 10-item measure of participants’ experience of sexual
engagement. It utilizes nonjudgmental, specific language and avoids legal jargon to encourage
recall in participants (Koss et al, 2007). The first seven items of the survey assess the frequency
(i.e., 0, 1, 2, or 3+ times) of different types of sexual victimization, as well as tactics used by the
perpetrator (e.g., using force, telling lies, threatening physical harm). In addition, the gender and
age of the participant, whether or not the experiences happened one or more times, and the sex of
the perpetrator are asked. Finally, the survey includes a forced-choice question asking
participants if they have ever been raped. The survey asks participants to respond with the
frequency of unwanted sexual victimization and perpetrator tactics on a scale of 0 to 3+ within
the past 12 months and since age 14. This measure was used for inclusion of the victimized
group. Endorsement of any item (unwanted sexual contact, sexual coercion, attempted rape, and
rape) on the SES-SFV acted as inclusion criterion for the victimized group. Internal consistency
for this measure has been reported as ranging between .70 and .92 (Johnson et al., 2017; Koss et
al., 2007). Out of 433 female participants, 70% filled out the SES-SFV identically for unwanted experiences reported “since age 14,” and 73% had exact matches for the “past year,” providing evidence that the SES-SFV has adequate test-retest reliability. There was no difference in responses between the women who filled out the survey in person and those who completed it online, indicating that this measure is appropriate for this online study.

**Child Abuse**

The Childhood Trauma Questionnaire – Short Form (CTQ-SF; Bernstein et al., 2003; Appendix F) retrospectively measures respondents’ experiences of child abuse and/or neglect through 28 items (Bernstein et al., 1994; Bernstein et al., 2003). This commonly used survey includes 28 items on a 5-point Likert-type scale from 1 (*never true*) to 5 (*very often true*). Item scores are summed to determine an overall measure of child abuse. Subscales within the overall measure can also be totaled to assess for physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect, in addition to a validity check of minimization/denial. Some items are stated in a way that requires participant interpretation (e.g., I believe that I was sexually abused) and some are more objective (e.g., Someone tried to make me do sexual things or watch sexual things). This measure was used to assess for child sexual abuse; thus, only the sexual abuse subscale was utilized to determine whether individuals were included in the victimized group based on child abuse. Convergent validity was supported by good sensitivity and specificity when compared to therapists’ trauma ratings and a clinician-rated interview (Bernstein et al., 1997; Bernstein & Fink, 1998; Fink et al., 1995). The CTQ subscale of sexual abuse demonstrated excellent internal consistency in the current study (*α* = .90).
Demographics

Demographic information (Appendix G) including gender, sex, sexual orientation, age, race/ethnicity, marital status, relationship status, sexual experience (i.e., Have you engaged in sexual relations?), year in college, parent SES, and religiosity was collected in a 12-item questionnaire.

Procedures

Participants in an introductory psychology course self-selected into this study by signing up through an online platform, SONA (Appendix H). Participants completed the survey from a remote location and not in the lab to reduce response bias (i.e., socially desirable responding). Before beginning the survey, students electronically signed a consent form (Appendix I) indicating the sensitive nature of the questions. Next, they responded to the measures described above. As participants moved from page to page, a message alerted them if they missed any questions. There was the option for participants to choose “prefer not to respond” in each question. After all the questions were administered, a short debriefing statement regarding the reason for the study, contact information for psychological services, and contact information of the researcher was presented (Appendix J).

One instructional check was used to ensure quality of responses. There was one instruction check before the Index of Sexual Satisfaction (ISS) requesting the participant to respond with a particular answer to one of the questions. Participants who did not respond correctly to the instruction check were presented the prompt again as a second chance to answer the question correctly; however, there was an error in presentation of the instructional check (see Chapter 3). Individuals who failed the instructional check were removed from the dataset.
Data Analysis Plan

Primary Analyses

Hypothesis 1: Impact of Sexual Violence on Sexual Satisfaction and Sexual Dysfunction.

H1a. Survivors of sexual violence will report significantly lower levels of sexual satisfaction than women who have not experienced sexual violence. H1b. Survivors of sexual violence will report significantly higher levels of sexual dysfunction than women who have not experienced sexual violence. H1c. Survivors of sexual violence will report clinical levels of dysfunction significantly more than woman who have not experienced sexual violence.

To compare the reported levels of sexual satisfaction in each of these sets of two groups, independent samples t tests were conducted in SPSS. Linear regression was also used including the covariate of relationship satisfaction in step one and victimization history in step two (Cohen et al., 2003). For Hypothesis H1c, a chi-square test was performed to assess the levels of clinical levels of dysfunction in association with victimization history.

Hypothesis 2: Relationship Between Sexual Satisfaction and Sexual Dysfunction. H2.

Self-reported sexual satisfaction and sexual dysfunction will not be significantly associated in the sample regardless of sexual violence history.

A correlation was used to test Hypothesis 2. Linear regression was also used with sexual satisfaction as the independent variable, sexual dysfunction as the dependent variable, and the covariate of relationship satisfaction.

Hypothesis 3: Sexual Satisfaction by Sexual Motivation Type. H3a. Intimacy, self-affirmation, and enhancement sexual motivations will be associated with higher sexual
satisfaction in all women. H3b. Coping and peer approval sexual motivations will be associated with lower sexual satisfaction in all women.

Bivariate correlations were used to test Hypothesis 3. For Hypothesis 3a, if the covariates were significant, linear regression was used with intimacy, self-affirmation, and enhancement sexual motivations as the factors and sexual satisfaction and sexual dysfunction as the dependent variables, respectively, and the significant covariates. For Hypothesis 3b, if the covariates were significant, linear regression was used with coping and peer approval sexual motivations as the factors and sexual satisfaction and sexual dysfunction as the dependent variables, respectively, and the significant covariates.

Hypothesis 4: Moderating Role of Sexual Motivation on Sexual Satisfaction. H4a. Greater coping and peer approval sexual motivations will strengthen the relationship between sexual violence and sexual satisfaction. Individuals with lower scores on sexual motivations of coping and peer approval will show an attenuated relationship between sexual violence and satisfaction. H4b. Greater intimacy, self-affirmation, and enhancement sexual motivations will weaken the relationship between sexual violence and sexual satisfaction. Individuals with lower scores on intimacy, self-affirmation, and enhancement motivations will show an attenuated relationship between sexual violence and satisfaction. H4c. Greater coping and peer approval sexual motivations will strengthen the relationship between sexual violence and sexual dysfunction. Individuals with lower scores on sexual motivations of coping and peer approval will show an attenuated relationship between sexual violence and dysfunction. H4d. Greater intimacy, self-affirmation, and enhancement sexual motivations will weaken the relationship between sexual violence and sexual dysfunction. Individuals with lower scores in intimacy, self-
affirmation, and enhancement motivations will show an attenuated relationship between sexual violence and dysfunction.

The moderating effect of each of the sexual motivations was assessed using PROCESS Model Number 1 (Hayes, 2017), for a total of four regression analyses. For Hypothesis 4a, significant covariates were entered. Sexual satisfaction was the outcome variable, sexual violence was the independent variable, and coping and peer approval sexual motivations were entered as the proposed moderators. Simple slopes analyses were performed to identify the direction of the interaction when significant. The null hypothesis was rejected if the strength of the relationship between violence and satisfaction was significantly strengthened at high levels of negative motivations. For Hypothesis 4b, significant covariates were entered. Sexual satisfaction was the outcome variable, sexual violence was the independent variable, and intimacy, self-affirmation, and enhancement sexual motivations were entered as proposed moderators. Simple slopes analyses were performed to identify the direction of the interaction when significant. The null hypothesis was rejected if the strength of the relationship between violence and satisfaction was significantly weakened at high levels of positive motivations. For Hypothesis 4c, significant covariates were entered. Sexual dysfunction was the outcome variable, sexual violence was the independent variable, and coping and peer approval sexual motivations were entered as the proposed moderators. Simple slopes analyses were performed to identify the direction of the interaction when significant. The null hypothesis was rejected if the strength of the relationship between violence and dysfunction was significantly strengthened at high levels of negative motivations. For Hypothesis 4d, significant covariates were entered. Sexual dysfunction was the outcome variable, sexual violence was the independent variable, and intimacy, self-affirmation, and enhancement sexual motivations were entered as proposed moderators. Simple slopes
analyses were performed to identify the direction of the interaction when significant. The null hypothesis was rejected if the strength of the relationship between violence and dysfunction was significantly weakened at high levels of positive motivations.
CHAPTER 3

RESULTS

Preliminary Analyses

Before conducting preliminary analyses, participants who did not meet inclusion criteria (i.e., those who did not identify as female; those who were not in a committed, romantic relationship; those who were not sexually active with their partner) were removed from the dataset. Those who failed the instructional check were also removed from the dataset. All data were screened for quality of responses using descriptive statistics (Table 1), including histograms and boxplots. There were two outliers on the negative sexual motivations variable, which were changed to three standard deviations from the mean. Mahalanobis distance was utilized to determine multivariate outliers. One participant was above the recommended cutoff of 15 and was removed. Data were visually examined for normality, skew, and kurtosis. Significant skew and kurtosis were seen in the dependent variables of sexual satisfaction and sexual dysfunction, the negative sexual motivations moderator, and the covariate of relationship satisfaction. In order to address the skewed and leptokurtic variables, log transformations were used on the sexual dysfunction, negative sexual motivations, and relationship satisfaction variables. Square root transformation was used for the sexual satisfaction variable. Linearity and homoscedasticity assumptions were assessed through residual scatterplots, where it was determined that assumptions were met. No variables showed evidence of multicollinearity or singularity as assessed by correlations (Table 2). Correlations in the victimized group (Table 3) and the nonvictimized group (Table 4) were also conducted.
Table 1

Descriptive Statistics

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<th>Variables</th>
<th>N</th>
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<th>Range</th>
<th>Skew</th>
<th>Kurtosis</th>
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<td>1. Sexual Violence</td>
<td>127</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>2. Positive Motivations</td>
<td>127</td>
<td>3.187 (.686)</td>
<td>1.47 - 5</td>
<td>-.009</td>
<td>.190</td>
</tr>
<tr>
<td>3. Negative Motivations</td>
<td>127</td>
<td>.1732 (.159)</td>
<td>0 - .59</td>
<td>.811</td>
<td>-.253</td>
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<td>4. Sexual Satisfaction</td>
<td>116</td>
<td>4.875 (1.719)</td>
<td>1 – 8.72</td>
<td>-.366</td>
<td>-.379</td>
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<tr>
<td>5. Sexual Dysfunction</td>
<td>119</td>
<td>1.078 (.116)</td>
<td>.86 – 1.37</td>
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<td>-.531</td>
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<td>1.339 (.142)</td>
<td>1 – 1.59</td>
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Table 2

Bivariate Correlations Among Study Variables

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<td>1. Sexual Violence</td>
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<td>--</td>
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<td>--</td>
<td>--</td>
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<td>2. Positive Motivations</td>
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<td>--</td>
<td>.536**</td>
<td>--</td>
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</tr>
<tr>
<td>3. Negative Motivations</td>
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<td>.536**</td>
<td>--</td>
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</tr>
<tr>
<td>4. Sexual Satisfaction</td>
<td>-.057</td>
<td>-.102</td>
<td>-.405**</td>
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<tr>
<td>5. Sexual Dysfunction</td>
<td>.111</td>
<td>-.114</td>
<td>.180</td>
<td>-.569**</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>6. Relationship Satisfaction</td>
<td>.021</td>
<td>-.114</td>
<td>-.376**</td>
<td>.525**</td>
<td>-.394**</td>
<td>--</td>
</tr>
</tbody>
</table>

Sexual Violence = dichotomous victimized and nonvictimized groups; Positive Motivations = average of enhancement, intimacy, and self-affirmation subscales on the Motivations for Sexual Intercourse Survey (MSI); Negative Motivations = average of partner approval and coping subscales on the Motivations for Sexual Intercourse Survey (MSI); Sexual Satisfaction = Index for Sexual Satisfaction (ISS) sum; Sexual Dysfunction = Female Sexual Function Index (FSFI) weighted average; Relationship Satisfaction = Relationship Assessment Scale (RAS) average.
* = p < .05, ** = p < .01.
Table 3

Bivariate Correlations Among Study Variables in Nonvictimized Group

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>1. Positive Motivations</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Negative Motivations</td>
<td>.535**</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Sexual Satisfaction</td>
<td>.112</td>
<td>-.115</td>
<td>--</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sexual Dysfunction</td>
<td>-.171</td>
<td>.025</td>
<td>-.452**</td>
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</tr>
<tr>
<td>5. Relationship Satisfaction</td>
<td>.078</td>
<td>-.149</td>
<td>.453**</td>
<td>-.354**</td>
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</tr>
</tbody>
</table>

Positive Motivations = average of enhancement, intimacy, and self-affirmation subscales on the Motivations for Sexual Intercourse Survey (MSI); Negative Motivations = average of partner approval and coping subscales on the Motivations for Sexual Intercourse Survey (MSI); Sexual Satisfaction = Index for Sexual Satisfaction (ISS) sum; Sexual Dysfunction = Female Sexual Function Index (FSFI) weighted average; Relationship Satisfaction = Relationship Assessment Scale (RAS) average.

* = p < .05, ** = p < .01.
Table 4

Bivariate Correlations Among Study Variables in Victimized Group

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Positive Motivations</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2. Negative Motivations</td>
<td>.449**</td>
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<tr>
<td>3. Sexual Satisfaction</td>
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<td>-.401**</td>
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<tr>
<td>4. Sexual Dysfunction</td>
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<td>.161</td>
<td>-.660**</td>
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</tr>
<tr>
<td>5. Relationship Satisfaction</td>
<td>-.157</td>
<td>-.517**</td>
<td>.601**</td>
<td>-.417**</td>
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</tr>
</tbody>
</table>

Positive Motivations = average of enhancement, intimacy, and self-affirmation subscales on the Motivations for Sexual Intercourse Survey (MSI); Negative Motivations = average of partner approval and coping subscales on the Motivations for Sexual Intercourse Survey (MSI); Sexual Satisfaction = Index for Sexual Satisfaction (ISS) sum; Sexual Dysfunction = Female Sexual Function Index (FSFI) weighted average; Relationship Satisfaction = Relationship Assessment Scale (RAS) average.

* = p < .05, ** = p < .01.
Utilizing Little’s MCAR test (Little, 1988), missing data for the full sample of independent variables, dependent variables, and potential covariates were found to be missing completely at random (MCAR; \( p = .053 \)). As the data are MCAR and the overall extent of missing data was minimal (6.6%), listwise deletion was utilized in all inferential analyses.

Development of the independent variable and data analysis plan was informed by the missing data on the SES-SFV. The independent variable of sexual violence was created by reports of child sexual abuse on the CTQ and adult sexual assault on the SES-SFV. Any participant who reported child sexual abuse was automatically placed in the “victimized” group. If the participant did not report child sexual abuse, their score from the SES-SFV was used to determine if they should be placed in the victimized group. Participants who reported adult sexual assault on the SES-SFV were also included in the “victimized” group. All participants who reported no child sexual abuse and no adult sexual assault were included in the “nonvictimized” group. Participants who did not complete the entire SES-SFV survey or did not indicate any adult sexual assault experiences were included in the “nonvictimized” group. There were 62 participants in the “victimized” group and 65 in the “nonvictimized” group. The decision to include participants with missing data on the SES-SFV was made to preserve the power needed to run proposed analyses.

**Potential Covariates**

Potential covariates of age, relationship satisfaction, and religiosity were considered. Correlations were used for continuous variables (age and relationship satisfaction) with the DVs.
Age was not significantly correlated with sexual satisfaction ($r = -.120, p = .288$) nor was sexual dysfunction ($r = -.022, p = .848$). Relationship satisfaction was significantly correlated with both sexual satisfaction ($r = .546, p < .001$) and sexual dysfunction ($r = -.390, p < .001$); thus, relationship satisfaction was included in all inferential analyses as a covariate.

$T$ tests were used to assess the relationship between potential covariates and the IV and DVs. There was no significant difference between participants who identified as religious ($M = 5.049, SD = 1.654$) and those who did not identify as religious ($M = 5.162, SD = 1.610$) in sexual satisfaction ($t(91) = -.332, p = .740$). There was no significant difference in participants who identified as religious ($M = 1.083, SD = .116$) and those who did not identify as religious ($M = .106, SD = .103$) in sexual dysfunction ($t(93) = .996, p = .322$). There was no significant difference between victimized ($M = .254, SD = .139$) and nonvictimized ($M = .251, SD = .148$) groups in levels of sexual satisfaction ($t(92) = .098, p = .922$). There was no significant difference between victimized ($M = 19.17, SD = 2.080$) and nonvictimized ($M = 19.03, SD = 1.071$) groups in age ($t(126) = .071, p = .650$).

A chi-square test was used to assess the relationship between the dichotomous variable of religiosity and the IV of sexual violence. The chi-square test was not significant ($\chi^2(1) = .063, p = .801$), indicating that the association between religiosity and sexual violence was not significant.

Primary Analyses

**Hypothesis 1: Sexual Violence and Sexual Satisfaction/Dysfunction**

Hypothesis 1a: Lower Satisfaction in Victimized Group. Hypothesis 1a was that individuals who have experienced sexual violence would report a lower level of sexual
satisfaction. Analyses were conducted using the dichotomous variable of sexual violence coded as “nonvictimized” = 0 and “victimized” = 1 and the sum of items on the Index of Sexual Satisfaction (ISS). A linear regression was conducted to determine the association between sexual violence and sexual satisfaction (Table 5). Results indicated that there was not a significant relationship between sexual violence and sexual satisfaction when controlling for relationship satisfaction ($b = -.084, p = .368$). There was a significant relationship between relationship satisfaction and sexual satisfaction ($b = .524, p < .001$).

Hypothesis 1b: Higher Dysfunction in Victimized Group. Hypothesis 1b was that individuals who have experienced sexual violence would report a higher level of sexual dysfunction. Analyses were conducted using the dichotomous variable of sexual violence coded as “nonvictimized” = 0 and “nonvictimized” = 1 and the weighted average of items on the Female Sexual Function Index (FSFI). A linear regression was conducted to determine the association between sexual violence and sexual dysfunction (Table 6). Results indicated that there was not a significant relationship between sexual violence and sexual dysfunction when controlling for relationship satisfaction ($b = .122, p = .228$). There was a significant inverse relationship between relationship satisfaction and sexual dysfunction ($b = -.397, p < .001$).

Hypothesis 1c: Higher Clinical Dysfunction in Violence Group. Hypothesis 1c was intended to analyze clinical levels of sexual dysfunction in association with sexual victimization through a chi-square test. No participants scored above the cut score of 27 that would indicate the presence of clinical dysfunction; thus, this analysis was not conducted.
Table 5
Results of Multiple Regression for Sexual Satisfaction

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Standardized β</th>
<th>t</th>
<th>p</th>
<th>F</th>
<th>df</th>
<th>p</th>
<th>R</th>
<th>R²</th>
<th>Adj. R²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Violence</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Overall Model</td>
<td>16.547</td>
<td>2, 86</td>
<td>&lt;.001***</td>
<td>.532</td>
<td>.532</td>
<td>.266</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Relationship Satisfaction</td>
<td>5.669</td>
<td>&lt;.001***</td>
<td>.524</td>
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<tr>
<td>Sexual Violence</td>
<td>-.906</td>
<td>.368</td>
<td>-.804</td>
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<tr>
<td><strong>Positive Motivations</strong></td>
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<td>.278</td>
<td>.261</td>
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<td>Relationship Satisfaction</td>
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<tr>
<td>Positive Motivations</td>
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<td>.608</td>
<td>.530</td>
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<tr>
<td><strong>Negative Motivations</strong></td>
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<td></td>
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<tr>
<td>Overall Model</td>
<td>17.841</td>
<td>2, 86</td>
<td>&lt;.001***</td>
<td>.546</td>
<td>.298</td>
<td>.281</td>
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<td>Relationship Satisfaction</td>
<td>4.755</td>
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<td>Negative Motivations</td>
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<td>-.161</td>
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</tbody>
</table>

Note. The dependent variable for all regressions was sexual satisfaction. Sexual Violence = dichotomous victimized and nonvictimized groups; Positive Motivations = average of enhancement, intimacy, and self-affirmation subscales on the Motivations for Sexual Intercourse Survey (MSI); Negative Motivations = average of partner approval and coping subscales on the Motivations for Sexual Intercourse Survey (MSI); Sexual Satisfaction = Index for Sexual Satisfaction (ISS) sum; Relationship Satisfaction = Relationship Assessment Scale (RAS) average. * = p < .05, ** = p < .01, *** = p < .001
### Table 6

Results of Multiple Regression for Sexual Dysfunction

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$t$</th>
<th>$p$</th>
<th>Standardized $\beta$</th>
<th>F</th>
<th>df</th>
<th>$p$</th>
<th>$R$</th>
<th>$R^2$</th>
<th>Adj. $R^2$</th>
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</thead>
<tbody>
<tr>
<td><strong>Sexual Violence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Model</td>
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<td></td>
<td></td>
<td>8.506</td>
<td>2, 85</td>
<td>&lt;.001***</td>
<td>.412</td>
<td>.170</td>
<td>.150</td>
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<td>Relationship Satisfaction</td>
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<tr>
<td>Sexual Violence</td>
<td>1.216</td>
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<td>.122</td>
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<tr>
<td><strong>Sexual Satisfaction</strong></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Overall Model</td>
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<td></td>
<td></td>
<td>21.559</td>
<td>2, 79</td>
<td>&lt;.001***</td>
<td>.599</td>
<td>.359</td>
<td>.342</td>
</tr>
<tr>
<td>Relationship Satisfaction</td>
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<td>.387</td>
<td>-.095</td>
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<tr>
<td>Sexual Satisfaction</td>
<td>-4.981</td>
<td>&lt;.001***</td>
<td>-.542</td>
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</tbody>
</table>

*Note.* The dependent variable for all regressions was sexual dysfunction.

Sexual Violence = dichotomous victimized and nonvictimized groups; Positive Motivations = average of enhancement, intimacy, and self-affirmation subscales on the Motivations for Sexual Intercourse Survey (MSI); Negative Motivations = average of partner approval and coping subscales on the Motivations for Sexual Intercourse Survey (MSI); Sexual Satisfaction = Index for Sexual Satisfaction (ISS) sum; Relationship Satisfaction = Relationship Assessment Scale (RAS) average.

* = $p < .05$, ** = $p < .01$, *** = $p < .001$
Hypothesis 2: Relationship Between Sexual Satisfaction and Dysfunction

Hypothesis 2 was that reported levels of sexual satisfaction and dysfunction would not be significantly associated, regardless of sexual violence history. A linear regression revealed that there was a significant, negative relationship between sexual satisfaction and sexual dysfunction ($b = -.542, p < .001$; see Table 6). Said differently, as sexual satisfaction increased, reports of sexual dysfunction significantly decreased.

Hypothesis 3: Sexual Satisfaction and Sexual Motivations

Hypothesis 3a: Positive Motivations Predicting Higher Satisfaction. Hypothesis 3a was that higher reports of positive sexual motivations would be significantly associated with higher sexual satisfaction regardless of victimization status. The analysis was conducted using the average of positive sexual motivations (comprised of the intimacy, self-affirmation, and enhancement MSI subscales) and the sum of sexual satisfaction reported on the ISS. A linear regression was conducted to determine the relationship between positive sexual motivations and sexual satisfaction, controlling for relationship satisfaction (see Table 5). Results indicated that there was no relationship between positive sexual motivations and sexual satisfaction ($b = .048, p = .608$); however, relationship satisfaction remained a significant predictor ($b = .530, p < .001$).

Hypothesis 3b: Negative Motivations Predicting Lower Satisfaction. Hypothesis 3b was that higher reports of negative sexual motivations would be significantly associated with lower levels of sexual satisfaction regardless of victimization status. The analysis was conducted using the average of negative sexual motivations (comprised of the partner approval and coping MSI subscales) and the sum of sexual satisfaction reported on the ISS. A linear regression was
conducted to determine the relationship between negative sexual motivations and sexual satisfaction, controlling for relationship satisfaction (see Table 5). Results indicated that there was no relationship between negative sexual motivations and sexual satisfaction ($b = -.161, p = .104$); however, relationship satisfaction remained a significant predictor ($b = .467, p < .001$).

**Hypothesis 4: Moderation Role of Motivations on Satisfaction**

**Hypothesis 4a: Negative Motivations Moderate Violence and Satisfaction.** Hypothesis 4a was that negative sexual motivations would moderate the relationship between sexual violence and sexual satisfaction. Individuals with lower reported negative sexual motivations were hypothesized to show an attenuated relationship between sexual violence and sexual satisfaction. This analysis was conducted with the dichotomous variable of sexual victimization status, the average of negative sexual motivations (comprised of the partner approval and coping MSI subscales), the covariate of relationship satisfaction (average of the RAS), and the sum of sexual satisfaction reported on the ISS. Results show no significant interaction between negative sexual motivations and sexual violence in predicting sexual satisfaction ($b = -.840, 95\% CI [-4.614, 2.935], t = -.443, p = .659$). Of note, relationship satisfaction significantly predicted higher levels of sexual satisfaction ($b = 5.03, 95\% CI [2.850, -7.206], t = 4.593, p < .001$).

**Hypothesis 4b: Positive Motivations Moderate Violence and Satisfaction.** Hypothesis 4b was that positive sexual motivations would moderate the relationship between sexual violence and sexual satisfaction. Individuals with higher reported positive sexual motivations were hypothesized to show a weakened relationship between sexual violence and sexual satisfaction. This analysis was conducted with the dichotomous variable of sexual violence, the average of positive sexual motivations (comprised of the self-affirmation, enhancement, and intimacy MSI subscales), the covariate of relationship satisfaction (average of the RAS), and the sum of sexual satisfaction reported on the ISS. Results show no significant interaction between positive sexual motivations and sexual violence in predicting sexual satisfaction ($b = .840, 95\% CI [-4.614, 2.935], t = .443, p = .659$). Of note, relationship satisfaction significantly predicted higher levels of sexual satisfaction ($b = 5.03, 95\% CI [2.850, -7.206], t = 4.593, p < .001$).
subscales), the covariate of relationship satisfaction (average of the RAS), and the sum of sexual satisfaction reported on the ISS. Results showed a non-significant interaction between positive sexual motivations and sexual violence in predicting sexual satisfaction ($b = -.246$, 95% CI [-1.208, .716], $t = -.509$, $p = .612$). Of note, relationship satisfaction significantly predicted higher levels of sexual satisfaction ($b = 5.74$, 95% CI [3.71, 7.78], $t = 5.622$, $p < .001$).

Hypothesis 4c: Negative Motivations Moderate Violence and Dysfunction. Hypothesis 4c was that negative sexual motivations would moderate the relationship between sexual violence and sexual dysfunction. Individuals with lower reported negative sexual motivations were hypothesized to show an attenuated relationship between sexual violence and sexual satisfaction. This analysis was conducted with the dichotomous variable of sexual violence, the average of negative sexual motivations (comprised of the partner approval and coping MSI subscales), the covariate of relationship satisfaction (average of the RAS), and the weighted average of sexual dysfunction reported on the FSFI. Results showed a nonsignificant interaction between negative sexual motivations and sexual violence in predicting sexual dysfunction ($b = -.023$, 95% CI [-.356, .309], $t = -.139$, $p = .309$). Of note, relationship satisfaction significantly predicted higher levels of sexual satisfaction ($b = -.349$, 95% CI [-.534, -.163], $t = -3.745$, $p < .001$).

Hypothesis 4d: Positive Motivations Moderate Violence and Dysfunction. Hypothesis 4d was that positive sexual motivations would moderate the relationship between sexual violence and sexual dysfunction. Individuals with higher reported positive sexual motivations were hypothesized to show a weakened relationship between sexual violence and sexual dysfunction. This analysis was conducted with the dichotomous variable of sexual violence, the average of positive sexual motivations (comprised of the self-affirmation, enhancement, and intimacy MSI subscales), the covariate of relationship satisfaction (average of the RAS), and the weighted
average of sexual dysfunction reported on the FSFI. Results showed a nonsignificant interaction between positive sexual motivations and sexual violence in predicting sexual dysfunction ($b = -.032$, 95% CI [-.119, .055], $t = -.729$, $p = .468$). Of note, relationship satisfaction significantly predicted higher levels of sexual satisfaction ($b = -.349$, 95% CI [-.515, -.184], $t = -4.199$, $p = .0001$).

**Analyses Without Covariates**

Analyses were run without the covariate of relationship satisfaction, as inclusion of a strong, significant predictor such as relationship satisfaction could trump the effects of IVs that may otherwise be observed. Analytic results were largely similar, with the exception of Hypothesis 3b. A correlation was conducted to assess the association between negative sexual motivations and sexual satisfaction without the inclusion of the relationship satisfaction covariate. The result of this correlation showed a significant relationship between negative sexual motivations and sexual satisfaction ($r = -.405$, $p < .001$).
CHAPTER 4
DISCUSSION

One in four women is sexually assaulted in her lifetime (Koss et al., 1987), which can result in lower levels of sexual satisfaction and higher rates of sexual dysfunction (Van Berlo & Ensink, 2000). While many survivors go on to experience these negative impacts, not all survivors have these experiences. One factor that may explain this discrepancy is motivations for sexual intercourse (Cooper et al., 1998; Impett & Tolman, 2006). This study sought to understand the relationship among these factors in college-aged women who are sexually active with their romantic partner. It was hypothesized that (a) there would be differences in sexual satisfaction and dysfunction between women who have experienced sexual violence (child abuse or adult assault) and those who have not, (b) there would be no relationship between sexual satisfaction and dysfunction, (c) positive and negative sexual motivations would be associated with sexual satisfaction and dysfunction, and (d) sexual motivations would moderate the relationship between sexual violence and each of sexual satisfaction and sexual dysfunction.

There were no significant associations between victimization status levels and sexual satisfaction or sexual dysfunction. There were also no significant associations between sexual motivations and sexual satisfaction or dysfunction. Finally, there were no interaction effects between victimization status and sexual motivations in predicting sexual satisfaction or dysfunction. While none of these hypotheses were supported, a significant relationship between sexual satisfaction and dysfunction was found. The following sections will discuss the significant
relationship between sexual satisfaction and sexual dysfunction, followed by a discussion of the null findings. Finally, limitations and future directions will be discussed.

Sexual Satisfaction and Dysfunction

Results indicated that there was a significant inverse relationship between sexual satisfaction and sexual dysfunction. This is consistent with several studies that showed a significant negative association between sexual satisfaction and sexual dysfunction. For example, Mota and colleagues (2019) report that sexual functioning was an important factor in sexual satisfaction in men who recently experienced a kidney transplant. Another study indicated that sexual satisfaction and dysfunction were strongly, inversely related in both a sample of 99 women who were undergoing treatment for sexual arousal disorder and the control sample of 220 sexually healthy women (Stephenson & Meston, 2010). Lief (2001) also discussed the inverse relationship of sexual satisfaction and separate components of dysfunction (e.g., physical arousal, desire, and orgasm).

However, findings from the current study contradict much of the existing literature that demonstrates a weak or nonsignificant relationship between sexual satisfaction and sexual dysfunction (Derogatis, 1997; Ferenidou et al., 2008; Heiman et al., 1986; King et al., 2007; Leonard et al., 2008). It is possible that the existing literature is not generalizable given that these studies were largely conducted in a population of men and women who were sexually abused and experienced clinical levels of sexual dysfunction, whereas the current study was comprised of only women who did not report clinical levels of sexual dysfunction. Further, these studies were largely underpowered with small sample sizes (Leonard et al., 2008; Rellini & Meston, 2006). Another explanation for the conflicting findings may be that little research has been
conducted on sexual satisfaction in women and has been noted to be an important area for future research (LoPiccolo & Stock, 1986). It is possible that the conflicting findings are due to varied populations and measurement. Research to replicate the current research, as well as past research, is needed.

The existing literature emphasizes the importance of not conflating sexual satisfaction and dysfunction, as changes in one do not always lead to changes in the other (Jayne, 1981; Lief, 2001; LoPiccolo & Stock, 1986; Stephenson & Meston, 2010). For example, it is possible for an individual to have no sexual dysfunction but report low sexual satisfaction (Lief, 2001). It is also possible for an individual to have high subjective sexual satisfaction while experiencing one or more types of sexual dysfunction; specifically, meaningful and satisfactory sexual experiences can occur with an arousal dysfunction, orgasm dysfunction, etc. (Jayne, 1981). It is recommended that future research endeavors continue to conceptualize, measure, and analyze sexual satisfaction and sexual dysfunction as independent constructs rather than opposites on the same continuum (Lief, 2001; Stephenson & Meston, 2010).

Relationship Satisfaction, Sexual Satisfaction, and Sexual Dysfunction

The current study found that the covariate of relationship satisfaction predicted both sexual satisfaction and sexual dysfunction. This finding replicates existing research indicating that relationship satisfaction is impactful for women’s sexual well-being (Apt et al., 1996; Blais, 2019; Byers, 2002; Lawrance & Byers, 1995; Mark & Murray, 2012; Renaud et al., 1997). This finding suggests that relationship satisfaction is an important component in the sexual experience of couples. The association between relationship satisfaction and sexual satisfaction has been conceptualized through the interpersonal exchange model of sexual satisfaction (IEMSS; Byers
& MacNeil, 2006; Lawrance & Byers, 1995). The IEMSS posits that sexual satisfaction is impacted by four factors: (a) balance of rewards and costs in the sexual relationship, (b) how sexual rewards and costs compare to the expectation of them (i.e., relative sexual rewards and costs), (c) perceived equality of sexual rewards and costs among partners, and (d) the perceived quality of aspects of the relationship that are nonsexual (Lawrance & Byers, 1995). The current study utilized the Relationship Assessment Scale (RAS; Hendrick et al., 1998), which assesses satisfaction in a relationship that is not specific to sex, with items that tap into concepts such as love, how the relationship meets one’s expectations, number of problems in the relationship, and the ability of one’s partner to meet the respondent’s needs. The RAS provides an understanding of a participant’s perceived quality of nonsexual aspects in the relationship, which is stated as one of the factors that make up the IEMSS. Thus, the findings of this study provide evidence that sexual satisfaction is associated with nonsexual relationship satisfaction as posited by the IEMSS. Results of the current study suggest strongly that future research should consider the impact of nonsexual relationship satisfaction when examining women’s sexual satisfaction and dysfunction. In fact, relationship satisfaction was the only consistently significant predictor of sexual outcomes. Khaddouma and colleagues (2014) suggest that the strong association between relationship satisfaction and sexual outcomes may be due to the fact that partners in a committed, romantic relationship are more likely to be (a) aware and responsive to the partner’s sexual desires and needs, (b) present with their somatic experiences, and (c) able to express one’s sexuality without fear of judgment.
Null Findings

No other significant relationships were found between sexual violence, sexual motivations, sexual satisfaction, or sexual dysfunction. Cronbach and Meehl (1955) state that null findings may be attributable to (a) an incorrect or incomplete theoretical foundation, (b) poor construct measurement, or (c) the study design failing to test the hypothesis properly.

The null findings may reflect incorrect theoretical reasoning for the hypotheses (Cronbach & Meehl, 1955). While there are several studies that indicate the impact of sexual violence and sexual motivations on sexual outcomes (Burgess & Holmstrom, 1979; Ellis et al., 1981; Leonard & Follette, 2002; Norris & Feldman-Summers, 1981; Van Berlo & Ensink, 2000), there are also studies that show conflicting results. Specifically, sexual violence has been related to lower levels of vaginal blood flow (Rellini, 2008) as well as difficulty feeling desire, difficulty experiencing arousal and orgasm, and dyspareunia (Laumann et al., 1994). Studies have also noted that individuals who have experienced sexual violence were two to three times more likely to experience sexual dysfunction than those who have not experienced sexual violence (Kilpatrick et al., 1988; Laumann et al., 1994). The absence of sexual satisfaction has also been documented in individuals who have experienced sexual violence compared to those who have not (Jackson et al., 1990; Orlando & Koss, 1983). However, some studies have indicated that there are no differences in posttrauma sexual experiences (Bigras et al., 2015; Burgess & Holmstrom, 1979; Feldman-Summers et al., 1979), specifically sexual satisfaction after sexual assault (Culbertson & Dehle, 2001).

Findings from the current study support the smaller body of literature citing no differences between nonvictimized and victimized groups. Taken together with the current
study’s findings, it may be that sexual violence and sexual motivations do not influence sexual outcomes as largely as relationship satisfaction. It has been shown that one instance of sexual trauma may not lead to differences in negative sexual outcomes unless cumulative trauma is also present (Lacelle et al., 2012). Another explanation may be due to sexual violence predicting sexual outcomes that were not measured in this study, such as sexual self-concept, sexual schemas, and sexual anxiety (Bigras et al., 2015).

As previously noted, the body of literature regarding sexual satisfaction and sexual dysfunction dates back to the 1970s. Given that this literature informed the present study’s hypotheses, it is possible that the null findings are due to an incomplete theoretical foundation (Chronbach & Meehl, 1955). The conceptualization of sexual behavior in the existing body of literature may not account for cultural changes that have taken place within the last 50 years. It has been shown that adults in the US from the years 2000 to 2012 had more sexually permissive views, including having more sexual partners, being more accepting of nonmarital sex, and being more likely to have casual sex compared to adults in the US from 1970 to 1980 (Twenge et al., 2015). This change in views may have come about as a result of societal changes including increased access to pornography and access to reproductive healthcare (e.g., birth control, abortion, etc.). Additionally, it is important to consider that previous research on sexual behavior was conducted by predominantly White, heterosexual, cis-gender men with Western viewpoints. This lack of diversity within the conceptualization and development of hypotheses, study designs, and statistical interpretations may have not been representative of the sexual behaviors and desires of all female participants. Further, social desirability may have played an essential role in data collection in older studies due to the more conservative views of sexual behavior. These factors are important to consider because hypotheses in the current study were developed
with the theoretical frameworks of existing literature, which may not be representative of women’s sexual experience in today’s culture. It is also possible that there are moderators and mediators missing from the theoretical model linking sexual violence and sexual outcomes that need to be identified, which can account for why some individuals demonstrate this association while others do not.

Another reason why sexual violence and sexual motivations did not predict outcomes may be due to poor construct measurement (Cronbach & Meehl, 1955). For example, the sample showed low levels, as determined by Rosen and colleagues (2000), of sexual dysfunction such that the mean of the current sample was lower than both the mean of clinical and control samples in validation studies. This suggests that participants’ sexual dysfunction was not assessed accurately or that the sample does not represent the general population of women for which the measure was validated. This is likely due to the sample of the current study being largely comprised of college-aged students, whereas validating studies utilized women of all ages. This is important as studies have shown that sexual dysfunction becomes more prevalent with age (Hayes & Dennerstein, 2005). The low levels of dysfunction may have limited the ability to detect differential associations. Without the expected range of sexual dysfunction levels, there may not have been enough room for sexual violence or sexual motivations to play a predictive role on sexual dysfunction. Further, the operationalization of sexual dysfunction was broadly defined. The FSFI assessed dysfunction across multiple domains including arousal, desire, pain, lubrication, and orgasm, with a total score being utilized for analyses (Rosen et al., 2000). The broad definition and combination of different types of dysfunctions may have introduced error in the analyses that obscures true relationships (Leonard & Follette, 2002).
The null results may also be due to poor construct development, as seen by an overgeneralized construct of sexual motivation. Positive sexual motivations include an approach towards intimacy (i.e., closeness to partner), enhancement (i.e., pleasure), and self-affirmation (i.e., affirm sense of self). The self-affirmation subscale in the MSI (Cooper et al., 1998) has been shown to have conflicting associations with the other subscales and sexual outcomes. Originally, the self-affirmation subscale was conceptualized in the two-factor schematic model (Cooper et al., 1998) to be a negative motivation for oneself, as it was used to minimize threats to self-esteem. However, additional studies by Cooper et al. (1998) showed that it correlated with both approach behaviors such as enhancement ($r = .31, p < .05$) and avoidance behaviors such as coping ($r = .64, p < .05$). This conflict has also been shown in the predictive value of low self-esteem (i.e., self-affirmation) on sexual outcomes. Some studies have indicated that low self-esteem is associated with higher frequency of sexual behavior (Ethier et al., 2006; Sterk et al., 2006), but others have shown that those with low self-esteem have a lower frequency of sexual behavior (Walsh, 1991) and negative sexual outcomes (e.g., unplanned pregnancy; Cooper et al., 1998). The classification of self-affirmative sexual motivations as positive taken with the evidence of predicting negative sexual outcomes suggests that this subscale may be introducing error. Specifically, the current study’s classification of self-affirmation as a “positive” motivation may have resulted in variables that were not structurally sound. The items “to feel more interesting,” “to prove attractiveness,” and “to feel more self-confident” all represent approach behaviors; however, they may also tap into negative sexual esteem that may be better categorized as a “negative” motivation for sexual intercourse. The poor validity of this subscale and its classification as a “positive” motivation may have influenced the integrity of the positive sexual motivations construct and therefore the analysis.
The null findings may also be due to study design (Cronbach & Meehl, 1955). Data for this study were collected largely during a shelter-in-place mandate due to COVID-19 in which many of the participants were living with their families. This mandate may have reduced the frequency of romantic or sexual interactions with their partners. It is possible that reports of their sexual satisfaction and dysfunction were not representative of participants’ typical levels of sexual well-being as they were likely not having sexual interactions as frequently, consistently, or under normal circumstances. Further, the prevalence of COVID-19 may have also introduced confounding factors such as health anxiety. Future research should consider replicating this study after all COVID-19 restrictions are no longer in place.

Additionally, this study design may have failed to accurately test hypotheses as the data contained significant missing data within the measurement of adult sexual violence (SES-SFV). This measure was administered without the “attempted vaginal assault” section due to researcher error. Further, the measure was presented in a confusing layout, resulting in many participants failing to provide responses for the category of “since 14 years old.” This category assessed the frequency of different types of sexual assault from the age of 14 up to 12 months before the date of data collection. Due to missing data, the categories in the independent variable (i.e., “victimized” and “nonvictimized”) may not have been the most accurate reflection of participants’ history of exposure to sexual violence. Specifically, the “nonvictimized” group contained 34 participants with full data indicating no history of sexual violence. There were 28 participants in the group who did not have full sexual violence data and may have been placed in the “nonvictimized” group inaccurately. While this decision was made to preserve power, variance between the victimized and nonvictimized groups was combined such that the outcomes in nonvictimized individuals may have not been accurately portrayed. It is possible that
experiences of sexual violence had no impact on sexual satisfaction and dysfunction due to the inaccurate grouping of participants.

Limitations and Future Directions

Sexual behavior is a multifaceted and complex construct that involves the interaction of many situational and personal factors. Due to this complexity, the current study has several limitations that should be considered. First, there were several limitations of the study design, including retrospective data collection and global measures of sexual motivations, sexual satisfaction, and sexual dysfunction. While a retrospective data collection approach has been utilized in several studies (Feldman-Summers et al., 1979; Orlando & Koss, 1983), it introduces potential error. For example, it may have been difficult for participants to remember specific motivations for sexual intercourse, their feelings of sexual satisfaction, and experiences of dysfunction depending on the length of time between their last sexual interaction and data collection. Further, the time between experiences of sexual violence and reports of sexual satisfaction/dysfunction were not measured or controlled. It is possible that the time between experience of sexual violence and current report of sexual satisfaction and sexual dysfunction would impact results. This is especially important in the given sample as it is known that trauma impacts memory (Barry et al., 2018) and it is therefore reasonable to expect that at least some of the memories of the traumatic events themselves, or the following consensual sexual encounters, are not recalled as accurately. Future research should consider a longitudinal diary or ecological momentary assessment approach to data collection in order to capture these effects as they occur.

An additional limitation is the use of subjective constructs. Sexual satisfaction has multiple components (e.g., physical, mental, relational) and is highly subjective and, as such, is
difficult to measure adequately. For example, the ISS includes the items, “I feel that our sex is dirty and disgusting” and “My partner is too rough or brutal when we have sex,” which were originally written to be indicators of sexual dissatisfaction. However, one study identified the item of “I feel that our sex is dirty and disgusting” as a positive representation of sexual satisfaction in a sample of 646 men and women in romantic relationships (Iglesias et al., 2009). The conflicting findings may be due to participants’ subjective sexual preferences as well as personal sexual values and expectations. This discrepancy may also be due to the development of the measures during a time period when sexually conservative attitudes were more prevalent.

A significant limitation of the current study was the proportion of missing data on the adult sexual assault variable. While the statistical approach was updated to consider the impact of the missing data, results of this study must be interpreted with caution due to the missing data approach in the sample. Additionally, the data collected for adult SES-SFV was missing the prompt for attempted rape. Results of this study were impacted because the independent variable of sexual violence was not accurately dichotomous, as some of the individuals placed into the “nonvictimized” group may have had sexual experiences that were not captured due to missing data. This type of error is significant in both research and clinical environments, as it could result in the need to collect new data, loss of funding, or a delay in providing treatment. Data collection on the SES-SFV was also impacted by the layout of the measure. Originally, it was proposed that data from the SES-SFV would be used to give another view of childhood sexual abuse because the measure collects detailed information in a category of “less than 12 years old.” However, the measure was presented in the survey in such a way that required the participants to select two answers per row: the first answer for sexual assault in the past year and the second for sexual abuse before age 12. This error influences the independent variable of sexual violence as it is not
fully descriptive without the secondary measure of childhood sexual abuse/assault. This would suggest that there may be some participants placed in the “nonvictimized” group who may have victimization experiences. Difficulty filling out this measure may have also influenced participants’ commitment to providing quality data.

The missing data on the covariate of relationship satisfaction is an additional limitation for the current study. Only 93 of the original 127 participants had data on the covariate of relationship satisfaction. As a result of this missing data, the sample size was reduced to 87 when running inferential statistics with the covariate compared to 119 when running inferential statistics without the covariate. The missing data on this variable led to a smaller sample size, which may have resulted in Type II errors. It is likely that this did not largely impact findings because the results did not differ between analyses conducted with and without the covariate. Future researchers should consider examining the impact of relationship satisfaction, which has been shown to play a role in sexual outcomes including sexual satisfaction and sexual dysfunction, as was observed in the current study.

The sample was another limitation of this study. A convenience sample of female college students was utilized. To be included in the study, the women were also required to be in a committed, romantic relationship and be sexually active with that person. This sample should be generalized with caution as it may not be representative of the population. Future research should expand on this sample by examining relationships between sexual violence, sexual motivations, and sexual outcomes in all genders and relationship types (e.g., polyamorous, sexually active with multiple partners, etc.) and further examined in all sexual orientations. It is also important to consider the relationships in those who consider themselves single or are not sexually active, for this may represent individuals who developed concerns of romantic relationships, hyposensitivity,
or hypersexuality after sexual violence. Including these populations would provide a substantial contribution to the literature. Finally, data were collected during the COVID-19 shelter-in-place mandate. Given that this experience was unique for the time period, results may not generalize to other time periods. Future research should consider replicating the current study when COVID-19 restrictions are not in place.

Finally, the lack of hypotheses regarding relationship satisfaction is a limitation for this study because the most informative relationships may not have been assessed. Future research should consider the strong associations between relationship satisfaction, sexual satisfaction, and sexual dysfunction. Future research may wish to further examine the role of relationship satisfaction while maintaining sexual satisfaction and dysfunction as separate constructs.

Conclusions

The purpose of the current study was to investigate four main research questions: (a) are there differences in sexual satisfaction and dysfunction between women who have experienced sexual violence (child abuse or adult assault) and those who have not, (b) is there no relationship between sexual satisfaction and dysfunction, (c) are positive and negative sexual motivations associated with sexual satisfaction and dysfunction, and (d) do sexual motivations moderate the relationship between sexual violence and sexual satisfaction/sexual dysfunction. While hypotheses were not supported, there was a significant relationship between sexual satisfaction and sexual dysfunction. Additionally, the covariate of relationship motivation predicted sexual satisfaction and sexual dysfunction. Future research is necessary to further examine the relationships among sexual violence, sexual motivation, sexual satisfaction, sexual dysfunction, and relationship satisfaction; as results of the current study conflict with existing literature.
REFERENCES


APPENDIX A

RELATIONSHIP ASSESSMENT SCALE
Please rate your agreement with the following statements based on the scale below:

Low Satisfaction………………High Satisfaction

1  2  3  4  5

1. How well does your partner meet your needs?  1 2 3 4 5
2. In general, how satisfied are you with your relationship?  1 2 3 4 5
3. How good is your relationship compared to most?  1 2 3 4 5
4. How often do you wish you hadn’t gotten into this relationship?  1 2 3 4 5
5. To what extent has your relationship met with your original expectations?  1 2 3 4 5
6. How much do you love your partner?  1 2 3 4 5
7. How many problems are there in your relationship?  1 2 3 4 5
The next questions ask about different reasons why a person might have sex. For each statement, choose the statement that best describes how often you personally engage in sexual activity for each of the following reasons. Remember -- there are no “right” or “wrong” answers. We just want to know what you think. For these questions, sexual activity includes behavior like passionate kissing, making out, fondling, petting, oral-to-anal stimulation, hand-to-genital stimulation, or vaginal/anal/oral intercourse.

How often do you engage in sexual activity…

Never/ almost never
Some of the time
Half of the time
Most of the time
Almost always/ always
Prefer not to respond

How often do you engage in sexual activity…

to cope with upset feelings?
to prove to yourself that your partner things you’re attractive?
To help you deal with disappointment in life?
To become more intimate with your partner?
Because it helps you feel better when you’re lonely?
To express love for your partner?
Out of fear that your partner won’t love you any more if you don’t?
Because it helps you feel better when you’re feeling low?

How often do you engage in sexual activity…

Because it feels good?
Because you don’t want your partner to be angry with you?
Just for the excitement of it?
To make an emotional connection with your partner?
Just for the thrill of it?
To become closer with your partner?
To help you feel better about yourself?
Because it makes you feel like a more interesting person?
To feel emotionally close to your partner?
**How often do you engage in sexual activity…**

<table>
<thead>
<tr>
<th>Never/ almost never</th>
<th>Some of the time</th>
<th>Half of the time</th>
<th>Most of the time</th>
<th>Almost always/ always</th>
<th>Prefer not to respond</th>
</tr>
</thead>
</table>

Because it makes you feel more self-confident?
To satisfy your sexual needs?
To reassure yourself that you are sexually desirable?
Because you worry that your partner won’t want to be with you if you don’t?
Because your partner will leave if you don’t?
To cheer yourself up?
APPENDIX C

INDEX OF SEXUAL SATISFACTION
The questionnaire is designed to measure the degree of satisfaction you have in the sexual relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows.

<table>
<thead>
<tr>
<th>None of the time</th>
<th>Very rarely</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A good part of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
</table>

1. I feel that my partner enjoys our sex life
2. Our sex life is very exciting
3. Sex is fun for my partner and me
4. Sex with my partner has become a chore for me
5. I feel that our sex is dirty and disgusting
6. Our sex life is monotonous
7. When we have sex it is too rushed and hurriedly completed
8. I feel that my sex life is lacking in quality
9. My partner is sexually very exciting
10. I enjoy the sex technique that my partner likes or uses
11. I feel that my partner wants too much sex from me
12. I think that our sex is wonderful
13. My partner dwells on sex too much
14. I try to avoid sexual contact with my partner
15. My partner is too rough or brutal when we have sex
16. My partner is a wonderful sex mate
17. I feel that sex is a normal function of our relationship
18. My partner does not want sex when I do
19. I feel like our sex life really adds a lot to our relationship
20. My partner seems to avoid sexual contact with me
21. It is easy for me to get sexually excited by my partner
22. I feel that my partner is sexually pleased with me
23. My partner is very sensitive to my sexual needs and desires
24. My partner does not satisfy me sexually
25. I feel that my sex life is boring
Instructions: These questions ask about your sexual feelings and responses in general over the course of your relationship with your partner. 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-stimulations (masturbation), or sexual fantasy.

1. How **often** did you feel sexual desire or interest?
   a. Almost always or always
   b. Most times (more than half the time)
   c. Sometimes (about half the time)
   d. A few times (less than half the time)
   e. Almost never or never

2. How would you rate your **level** (degree) of sexual desire or interest?
   a. Very high
   b. High
   c. Moderate
   d. Low
   e. Very low or none at all

3. How **often** did you feel sexually aroused (“turned on”) during sexual activity or intercourse?
   a. Almost always or always
   b. Most times (more than half the time)
   c. Sometimes (about half the time)
   d. A few times (less than half the time)
   e. Almost never or never

4. How would you rate your **level** of sexual arousal (“turn on”) during sexual activity or intercourse?
   a. Very high
   b. High
   c. Moderate
   d. Low
   e. Very low or none at all

5. How **confident** were you about becoming sexually aroused during sexual activity or intercourse?
   a. Very high confidence
   b. High confidence
   c. Moderate confidence
   d. Low confidence
   e. Very low or no confidence
6. How often have you been satisfied with your arousal (excitement) during sexual activity or intercourse?
   a. Almost always or always
   b. Most times (more than half the time)
   c. Sometimes (about half the time)
   d. A few times (less than half the time)
   e. Almost never or never

7. How often did you become lubricated ("wet") during sexual activity or intercourse?
   a. Almost always or always
   b. Most times (more than half the time)
   c. Sometimes (about half the time)
   d. A few times (less than half the time)
   e. Almost never or never

8. How difficult was it to become lubricated ("wet") during sexual activity or intercourse?
   a. Extremely difficult or impossible
   b. Very difficult
   c. Difficult
   d. Slightly difficult
   e. Not difficult

9. How often did you maintain your lubrication ("wetness") until completion of sexual activity or intercourse?
   a. Almost always or always
   b. Most times (more than half the time)
   c. Sometimes (about half the time)
   d. A few times (less than half the time)
   e. Almost never or never

10. How difficult was it to maintain your lubrication ("wetness") until completion of sexual activity or intercourse?
    a. Extremely difficult or impossible
    b. Very difficult
    c. Difficult
    d. Slightly difficult
    e. Not difficult

11. When you had sexual stimulation or intercourse, how often did you reach orgasm (climax)?
    a. Almost always or always
    b. Most times (more than half the time)
    c. Sometimes (about half the time)
    d. A few times (less than half the time)
    e. Almost never or never
12. When you had sexual stimulation or intercourse, how difficult was it for you to reach orgasm (climax)?
   a. Extremely difficult or impossible
   b. Very difficult
   c. Difficult
   d. Slightly difficult
   e. Not difficult

13. How satisfied were you with your ability to reach orgasm (climax) during sexual activity or intercourse?
   a. Very satisfied
   b. Moderately satisfied
   c. About equally satisfied and dissatisfied
   d. Moderately dissatisfied
   e. Very dissatisfied

14. How satisfied have you been with your overall sexual life?
   a. Very satisfied
   b. Moderately satisfied
   c. About equally satisfied and dissatisfied
   d. Moderately dissatisfied
   e. Very dissatisfied

15. How often did you experience discomfort or pain during vaginal penetration?
   a. Almost always or always
   b. Most times (more than half the time)
   c. Sometimes (about half the time)
   d. A few times (less than half the time)
   e. Almost never or never
   f. Did not attempt intercourse

16. How often did you experience discomfort or pain following vaginal penetration?
   a. Almost always or always
   b. Most times (more than half the time)
   c. Sometimes (about half the time)
   d. A few times (less than half the time)
   e. Almost never or never
   f. Did not attempt intercourse

17. How would you rate your level (degree) of discomfort or pain during or following vaginal penetration?
   a. Very high
   b. High
   c. Moderate
   d. Low
   e. Very low or none at all
   f. Did not attempt intercourse
APPENDIX E

SEXUAL EXPERIENCES SURVEY – SHORT FORM VICTIM
The following questions concern sexual experiences that you may have had that were unwanted. We know that these are personal questions, so we do not ask your name or other identifying information. Your information is completely confidential. We hope that this helps you to feel comfortable answering each question honestly. Place a check mark in the box () showing the number of times each experience has happened to you. If several experiences occurred on the same occasion—for example, if one night someone told you some lies and had sex with you when you were drunk, you would check both boxes a and c. “The past 12 months” refers to the past year going back from today. “Since age 14” refers to your life starting on your 14th birthday and stopping one year ago from today.

<table>
<thead>
<tr>
<th>How many times in the past 12 months?</th>
<th>How many times since age 14?</th>
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<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
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<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3+</td>
<td>3+</td>
</tr>
</tbody>
</table>

1. Someone fondled, kissed, or rubbed up against the private areas of my body (lips, breast/chest, crotch or butt) or removed some of my clothes without my consent (*but did not attempt sexual penetration*) by:
   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.
   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.
   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.
   d. Threatening to physically harm me or someone close to me.
   e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

2. Someone had oral sex with me or made me have oral sex with them without my consent by:
   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.
   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.
   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.
   d. Threatening to physically harm me or someone close to me.
e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

3. A man put his penis into my vagina, or someone inserted fingers or objects without my consent by:
   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.
   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.
   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.
   d. Threatening to physically harm me or someone close to me.
   e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

4. A man put his penis into my butt, or someone inserted fingers or objects without my consent by:
   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.
   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.
   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.
   d. Threatening to physically harm me or someone close to me.
   e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

5. Even though it did not happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by:
   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.
   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.
   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.
d. Threatening to physically harm me or someone close to me.
e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

6. Even though it did not happen, a man TRIED to put his penis into my vagina, or someone tried to stick in fingers or objects without my consent by:
   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.
   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.
   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.
   d. Threatening to physically harm me or someone close to me.
   e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

7. Even though it did not happen, a man TRIED to put his penis into my butt, or someone tried to stick in objects or fingers without my consent by:
   a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to.
   b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn’t want to.
   c. Taking advantage of me when I was too drunk or out of it to stop what was happening.
   d. Threatening to physically harm me or someone close to me.
   e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

8. Did any of the experiences described in this survey happen to you one or more times?
   a. Yes
   b. No

9. When was the most recent experience described in this survey?
   a. Month Year fill in
10. Did any of the experiences described in this survey make you feel any of the following: fear, horror, anger, guilt, shame, or the inability to experience happiness, satisfaction, or loving feelings?
   a. Yes
   b. No
   c. I reported no experiences

11. What was the sex of the person who did them to you?
   a. Female only
   b. Male only
   c. Both females and males
   d. I reported no experiences

12. Have you ever been raped?
   a. Yes
   b. No
These questions ask about some of your experiences growing up as a child and a teenager. Although these questions are of a personal nature, please try to answer as honestly as you can. For each question, choose the response that best describes how you feel. Please use the following scale:

<table>
<thead>
<tr>
<th>When I was growing up…</th>
<th>Never True</th>
<th>Rarely True</th>
<th>Sometimes True</th>
<th>Often True</th>
<th>Very Often True</th>
<th>Prefer not to Respond</th>
</tr>
</thead>
</table>

I didn’t have enough to eat
I knew that there was someone to take care of me and protect me
People in my family called me things like “stupid”, “lazy”, or “ugly”
My parents were too drunk or high to take care of the family
There was someone in the family who helped me feel that I was important in a special way

I had to wear dirty clothes
I felt loved
I thought my parents wished I had never been born
I got hit so hard by someone in the family that I had to see a doctor or go to the hospital
There was nothing I wanted to change about my family

People in my family hit me so hard that it left me with bruises or marks
I was punished with a belt, a board, a cord, or some other hard object
People in my family looked out for each other
People in my family said hurtful or insulting things to me
I believe that I was physically abused
<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Very Often</th>
<th>Prefer not to Respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I was growing up...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had the perfect childhood</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or doctor</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I felt that someone in my family hated me</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People in my family felt close to each other</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone tried to touch me in a sexual way or tried to make me touch them</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I was growing up...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone threatened to hurt me or tell lies about me unless I did something sexual with them</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I had the best family in the world</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone tried to make me do sexual things or watch sexual things</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone molested me</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe that I was emotionally abused</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I was growing up...</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There was someone to take me to the doctor if I needed it</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe that I was sexually abused</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My family was a source of strength and support</td>
<td>True</td>
<td></td>
<td></td>
<td>True</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX G

DEMOGRAPHIC INFORMATION
Demographics Questionnaire

1. What gender do you identify with?
   a. Male
   b. Female
   c. Other (please specify) __________
   d. Prefer not to respond

2. What is your sex?
   a. Male
   b. Female
   c. Other (please specify) __________
   d. Prefer not to respond

3. Do you consider yourself to be:
   a. Homosexual, gay, or lesbian
   b. Heterosexual or straight
   c. Bisexual
   d. Other (please specify) ________
   e. Prefer not to respond

4. Do you consider yourself to be transgender?
   a. Yes
   b. No
   c. Prefer not to respond

5. What is your age? __________

6. What is your race/ethnicity (select all that apply)?
   a. American Indian or Alaskan Native
   b. Asian or South-Asian
   c. Black or African American
   d. Latino, Hispanic, or of Spanish Origin
   e. White
   f. Other (please specify) __________
   g. Prefer not to respond

7. Do you consider yourself to be in a committed, romantic relationship?
   a. Yes
   b. No
   c. Prefer not to respond

8. What is your legal marital status?
   a. Single
   b. Married or equivalent (e.g., civil union)
   c. Divorced
   d. Widowed
   e. Prefer not to respond
9. What is your relationship status now?
   a. Married
   b. Engaged
   c. Living with someone
   d. Dating seriously
   e. Dating casually
   f. Not involved
   g. Prefer not to respond

10. Are you sexually active with this person?
    a. Yes
    b. No
    c. Prefer not to respond

11. Do you consider yourself to be sexually active?
    a. Yes
    b. No
    c. Prefer not to respond

12. What is the highest year of college you have completed?
    a. None, I am a freshman
    b. 1 year (I am a Sophomore)
    c. 2 years (I am a Junior)
    d. 4 years (I am a Senior)
    e. 4+ years

13. Do you identify as religious?
    a. Yes (please specify) __________
    b. No
    c. Unsure
    d. Prefer not to respond
APPENDIX H

SONA ADVERTISEMENT
SONA Advertisement

Name of survey: Perception of Sexual Experiences

Survey description: This is a 30-minute online study measuring sexual experiences, motivations, and perceptions. You must be 18 years or older to participate.
APPENDIX I

INFORMED CONSENT
Informed Consent

You are being asked to take part in the study entitled, “Perception of Sexual Experiences.” The purpose of the study is to examine sexual experiences and sexual motivations. Findings from the study may allow for better understanding as to what influences positive and negative sexual experiences.

You will be asked to complete as set of questionnaires that will take approximately 30 minutes to complete today.

You should also be aware that you will be asked questions in the questionnaires that may be sensitive. These questions may ask detailed questions about your sexual experiences and your perception of them. You are free to skip questions as needed and may withdraw from the study at any time. There will be no identifying information that is recorded, you will only be known as a participant number.

Potential Risks:

You will be asked about some experiences and feelings that may be difficult or uncomfortable to discuss. Some of the questionnaires will ask you to recall potentially distressing events that you have experienced. Answering questions about some of these events and experiences may be uncomfortable. If you feel distressed, you can stop at any point. You are also free to skip any questions that you do not wish to answer. Withdrawal from the present study will not affect your relationship with the researchers, PSYC 102 instructors, or NIU in any way. A list of nationwide hotlines, as well as a list of resources local to DeKalb, have been included at the bottom of this page. If you experience distress associated with your participation in this study, it is recommended by the researchers to follow up with one of these resources. All of the information that you provide as a part of this study will be confidential to the full extent of the law and accessible only to research project staff for research purposes. All data will be password protected and stored in a private office. Once analyzed, your data will be encrypted. Though results from this study may be published, you will not be personally identified in any reports or publications that may result from this study.

If you feel upset during or after the study, please ask to speak with the experimenter. At the end of the study, you will be provided with phone numbers of other agencies in the DeKalb area that provide counseling. You will be provided with Dr. Michelle Lilly’s, the experimenter, phone number, and she can be reached during standard business hours.

Any further information about the experiment may be obtained by contacting Dr. Michelle Lilly or Kyla Leonard, Department of Psychology, Northern Illinois University, at (815) 753-0372. If you have questions about your rights as a research participant, please contact the NIU Office of Research Compliance, (815) 753-8588.

You realize that Northern Illinois University policy does not provide for compensation for, nor does the University carry insurance to cover injury or illness incurred as a result of participation in University-sponsored research projects.

You understand that your consent to participate in this project does not constitute a waiver of any legal rights or redress you might have as a result of your participation, and you acknowledge that you have received a copy of this consent form.
I have read the above statements. I understand the purpose of the study and have been given the chance to ask questions and express concerns about the research project. I understand that I can withdraw from the study at any time for any reason. I understand that Northern Illinois University does not provide compensation for treatment of injuries that may occur as a result of participation in this research. I give my informed consent to be a participant in this study. I have been given a copy of the consent form.

Participant (signature) and Date
APPENDIX J

DEBRIEFING AFTER STUDY COMPLETION
Debriefing After Study Completion

Thank you for your participation. We appreciate your time and willingness to take part in this research. This project is examining the role of sexual violence and sexual motivations on sexual satisfaction/dysfunction. This is first study to examine this relationship.

It is possible that the material you provided throughout this study may have elicited some distressing thoughts, feelings, or memories for you. If you need immediate assistance, please call the 24-hour Crisis Line (815) 758-6655. If you feel like you are distressed and need help, please either visit a psychological or counseling center (see attached Mental Health resources in the surrounding area). Additionally, the National Suicide Prevention Lifeline phone number is: 1-800-273-8255. The National Domestic Violence Hotline is: 1-800-799-SAFE (7233). We encourage you to print the current and next pages in the event that you would like to access these resources at a later time.

If you would like to meet with a member of the research staff to discuss the study and receive this debriefing in person, please respond to this email and we will set a meeting with you this week.

If you have any questions about the study or what you were asked, please feel free to contact Michelle Lilly at (815) 753-0372 or lillylabniu@gmail.com.

Thank you for your participation!
Mental Health Resources (provided with the informed consent and the debriefing)

Campus Services

Counseling & Consultation Services, NIU (STUDENTS ONLY) (The Counseling and Student Development Center - CSDC)

- Phone: 815/753-1206
- Address: Campus Life Building-200
- Fees: None for counseling. Modest testing fees.
- Hours: 8:00 a.m. – 4:30 p.m. Monday-Friday
- Open whenever NIU is open, including breaks.
- After Hours: Assistance after hours available by calling—815/753-1212
- Description of Services: This service provides students with short-term, individual and group counseling for a broad range of personal concerns. Career counseling services include interest assessment, workshops, and use of computerized career counseling programs. Educational counseling services include assistance with test anxiety and study skills. Assessments of drug and alcohol abuse are also provided. First appointment scheduled with 3-7 days. (Handicapped Accessible).

Community Counseling Training Center, NIU (formerly The Counseling Laboratory)

- Phone: 815/753-9312
- Address: 416 Graham Hall
- Fees: None for students, faculty, or staff.
- Hours: Call for available counseling hours.
- Description of Services: A wide range of services are offered by the counselors including both personal and vocational counseling. In general, the approach used is one that promotes growth and focuses on increasing emotional well-being and self-awareness. All counselors are doctoral or masters level students who are being supervised by members of the counseling faculty. First appointments scheduled within 3-5 days.

The Couple and Family Therapy Clinic of NIU, NIU (formerly The Family Therapy Clinic)

- Phone: 815-753-1684
- Address: Wirtz Hall 146
- Fees: The cost of services is determined by a sliding fee scale. No client is turned away due to the inability to pay. This gives clients of all income levels access to our high-quality care.
- Hours: Monday, Tuesday – 12 noon – 9:00 pm; Wednesday, Thursday - 9:00 am - 9:00pm; Friday - 9:00 am - 5:00 pm
- Website: http://www.chhs.niu.edu/familytherapyclinic/contact/index.shtml
- Description of Services: The Couple and Family Therapy Clinic at NIU is a training and research facility that is an integral component of the specialization in Marriage and Family Therapy Program (SMFT). They provide clinical services to individuals, couples, and families with a unique perspective of addressing the issues in a larger systemic context. They follow
rigorous training standards as set forth by our accrediting organization, being accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

Psychological Services Center, NIU

- Phone: 815/753-0591
- Address: Normal Rd and Lincoln Hwy.
- Fees: No fee for therapy for students; fee for assessments for students. Faculty, staff, and community members charged on a sliding scale.
- Hours: Monday – 11:00 a.m. – 7:00 p.m. Tuesday – 12:00 noon – 8:00 p.m. Wednesday-Friday-9:00 a.m. to 5:00 p.m.
- Open whenever NIU is open, including breaks.
- Description of Services: Individual, couples, family, and group psychotherapy, intellectual, personality, and academic assessments. Clients are generally seen by advanced level graduate student staff under faculty supervision. Services are tailored to meet a client's specific needs. First appointment scheduled within 7 days. (Handicapped accessible.)

Community Resources

KishHealth System Behavioral Health Services (formerly Ben Gordon Center)

- Phone: 815/756-4875
- Address: 12 Health Services Dr., DeKalb, IL 60115
- Fees: Sliding fee scales based on income. Insurance accepted.
- Hours: Monday-Thursday- 8:00 a.m. – 8:30 p.m. Friday-8:00 a.m.-5:00 p.m.
- After Hours: 815/758-6655 Crisis Line
- Description of Services: Comprehensive counseling services to all residents of DeKalb County. Services to all persons affected by mental health problems, substance abuse, and family/child welfare concerns. 24-hour sexual assault/abuse services can be accessed through the Crisis Line. First appointment scheduled within 30 days. (Handicapped accessible and on Campus Bus Route).

Braden Counseling Center

- Phone: 815/787-9000
- Address: 2580 DeKalb Ave., Suite C., Sycamore, IL 60178
- 951 S. 7th St., Suite G., Rochelle, IL 60168
- Fees: Sliding fee scales based on income. Insurance accepted.
- Description of Services: Free initial consultation. Specializes in counseling individuals, couples and families in various stages of life. Has flexible scheduling with Sycamore and Rochelle locations. Also offers a variety of evaluations, including same-day DUI evaluations, and legal and forensic work for attorneys.
Village Counseling

- Phone: 815/756-9907
- Address: 1211 Sycamore Rd., DeKalb, IL 60115
- Fees: Sliding fee scales based on income. Insurance accepted.
- Hours: Monday-9:00 a.m.-10:00 p.m., Wednesday/Thursday-9:00 a.m.-9:00 p.m., Friday-10:00 a.m.-10:00 p.m.
- Description of Services: Provides relationship-centered counseling, including life counseling for individuals, couples, families, adolescents, and children, as well as marriage and family counseling.

Family Service Agency, Center for Counseling

- Phone: 815/758-8616
- Address: 14 Health Services Dr.-DeKalb
- Fees: $75.00 per visit. Insurance accepted, including NIU Student Insurance. Payment plans and scholarship funds available.
- Hours: Monday-Wednesday-9:00 a.m. – 8:00 p.m., Thursday – Friday – 8:00 a.m. – 4:00 p.m. Additional hours available by appointment.
- Description of Services: Individual, couple, group counseling for children, adults, senior citizens, and families. First appointment scheduled within 1-7 days. (Handicapped accessible and on Campus Bus Route).

Living Rite, The Center for Behavioral Medicine.

- Phone: 815-758-8400
- Address: 1958 Aberdeen Court, Suite 2, Sycamore, IL 60178
- Fees: Based on insurance. Self-pay options are available.
- Description of Services: Individual and Group Therapy. Therapy to deal with chronic pain.

Safe Passage, Inc.

- Phone: 815-756-7930
- Hotline/Crisis: 815-756-5228
- Address: P.O. Box 621, DeKalb, IL 60115
- Description of Services: A wide variety of services are offered to victims and perpetrators of domestic and sexual violence including crisis intervention and medical advocacy for victims of domestic and sexual violence, short- and long-term housing for victims and their children, counseling, legal advocacy, children's services, community education, a batterer's intervention program, and a Latina outreach program.
Nationwide Resources

People Against Rape (PAR; 1-800-877-7252)

Rape, Abuse, Incest National Network (RAINN; 1-800-656-4673; http://www.rainn.org/)

Suicide Prevention Hotline (1-800-273-8255, http://www.suicidepreventionlifeline.org/)

National Alliance on Mental Illness (NAMI; 1-800-950-6264; http://www.nami.org/)