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A Study On Sexual Shame And Sexual Functioning In Adult Sexual Assault Survivors

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A STUDY ON SEXUAL SHAME AND SEXUAL FUNCTIONING IN ADULT SEXUAL
ASSAULT SURVIVORS

A Dissertation

Presented to the Faculty of
Antioch University New England

In partial fulfillment for the degree of
DOCTOR OF PSYCHOLOGY

by

Aili Jones

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August 2023

A STUDY ON SEXUAL SHAME AND SEXUAL FUNCTIONING IN ADULT SEXUAL
ASSAULT SURVIVORS

This dissertation, by Aili Jones, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of
Antioch University New England
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

A STUDY ON SEXUAL SHAME AND SEXUAL FUNCTIONING IN ADULT SEXUAL ASSAULT SURVIVORS

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Keene, NH

A large portion of women will experience sexual violence in their lives. As many as one in four women report having experienced sexual assault, and there are some who believe that the true number of sexual assault survivors is much higher. Women who are sexually assaulted experience a wide range of emotional, physical, and sexual symptoms related to the trauma. The psychological impacts of sexual violence, including post-traumatic stress disorder (PTSD), depression, and anxiety have been studied and treatments developed. The sexual functioning of sexual assault survivors, however, has not been as thoroughly studied. One relatively new area of study is sexual shame. There has been a link found between sexual shame and sexual functioning in women who experienced sexual violence in childhood. There had not been any studies done to determine if the same is true for women who first experienced sexual violence in adulthood, after they became sexually active and therefore had a developed level of sexual functioning before the assault occurred. The current study sought to fill in this gap in knowledge. The study examined if the same relationship existed between sexual shame and sexual functioning in adult women sexual assault survivors, between the ages of 18 and 50, who did not experience their first sexual assault until after they became sexually active. The researcher found that there was a correlation between multiple aspects of sexual functioning and sexual shame, although not all components

were positively correlated. This dissertation is available in open access at AURA (<https://aura.antioch.edu>) and OhioLINK ETD Center (<https://etd.ohiolink.edu>).

Keywords: sexual assault, sexual shame, sexual functioning, sexual health

Acknowledgements

I would like to thank many individuals whose support has made it possible for me to complete this dissertation.

First, I would like to thank my committee. Lorraine and Shannon, thank you for your time and insights, as well as your thoughtful questions about my thinking and my study. I appreciate your willingness to work with me and help me fully develop this study. Roger, thank you for all your support. There were many times when I felt that I was going to have to give up and your belief in me helped me continue when it didn't feel possible. I am truly grateful for all the work you did with me to make this study become a reality and not a dream.

I would also like to thank my friends. It is impossible to list every individual who supported me during this endeavor, but I can truly say that without my friends behind me I would have failed. You were there to laugh with me and cry with me, to give me grace and tough love, depending on what I needed. I will never be able to thank you all enough for being a part of my village.

I also need to thank my family. Thank you to my parents, Olin and Nancy, and my sisters and their partners; Mariah, Talmage, Avery, Aimil, Jubilee, Larry, Karis, and Dace. You each believed in me and let the world know how proud you are of me. I was uplifted by you, even in the hardest days of writing this dissertation. Mom, you were especially supportive. You helped nurture me and my children in multiple ways and I don't know where I would be without you and John. My family also includes my in-laws, Nancy, Dave, Krissy, and Kevin who each offered me love and support throughout this process. Thank you to each and every member of my family. I truly could not have done this without you all.

Lastly, I want to thank my husband and my kids. Davey, thank you for supporting me while I pursue my career goals. Elbie and Finleigh, there are no words to express my gratitude for the two of you. You have given me so much joy. Everything I do, I do with you in my heart.

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CHAPTER I: INTRODUCTION

Sexual violence has been a problem in the United States for several decades. It has been the subject of numerous local and federal studies in order to examine how widespread sexual violence is, and how many individuals are victims of such attacks. The most recent studies show that the numbers of victims of sexual violence continue to remain high, and both men and women can experience sexual violence victimization. A 2010 report by the National Center for Injury Prevention (NCIP) and the Centers for Disease Control (CDC) reports that nearly one in two women (44.6%) will be the victim of sexual violence other than rape during their lifetime, while one in five men (22.2%) will experience sexual violence victimization other than rape (Black et al., 2010). Examples of non-rape sexual violence include sexual coercion, unwanted sexual contact, and non-wanted sexual experiences. Additionally, one in five women will be raped in their lifetime, while one in 71 men will be raped in their lifetime (Black et al., 2010). The NCIP and CDC repeated the study in 2016 and 2017 and found that sexual violence remains a common experience for women. Over half of women experience sexual violence that involves physical contact and one in four women experience completed or attempted rape (Basile et al., 2022). The latest statistics on the CDC website also states that one in three men have experienced sexual violence that involves physical touch, while one in 26 men will experience attempted or complete rape (Basile et al., 2022). The latest research shows that rates of women who experience sexual violence remains high, and it is therefore important that understanding the impacts of sexual violence and how to most effectively support survivors remains well-studied.

Unfortunately, children are also likely to be victims of sexual violence. According to the National Sexual Violence Resource Center (NSVRC), one in four girls and one in six boys will be sexually abused before they are 18 years old (NSVRC, 2023). Of all female rape victims,

more than half (54%) were raped before the age of 18 (Black et al., 2010). Early sexual abuse can be a risk factor for future sexual abuse. Individuals who experience sexual violence victimization before the age of 12, and then again between the age of 13 and 17 are at much higher risk for experiencing sexual violence victimization in the future (Black et al., 2010). In fact, more than one-third of women who are raped before age 18 are raped again as an adult (NSVR, 2023)

While these numbers are staggering, there is reason to believe that the actual numbers of individuals who experience sexual violence are even higher. Rape is the single most under-reported crime (NSVRC, 2023). Sexual assault crimes are not reported to the police 63% of the time, and only 12% of child sexual abuse cases are reported (NSVRC, 2023). It is difficult to determine exactly how many people are victims of sexual violence, but it is easy to understand how widespread an issue it is in the United States.

Definition of Terms

There are four terms that are important to identify and distinguish within the present study. It is common for the terms sexual violence and rape to be used interchangeably, which can cause confusion when exploring the experiences and impacts of these types of crimes. It is also important to understand what sexual health is, in order to understand how victims of sexual violence can be impacted. These four terms will be defined here, and sexual health will also be further explored while reviewing the current literature.

Sexual Violence

This study will be looking at the experience of sexual violence, which encompasses all types of sexual assault. The CDC defines sexual violence as a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who

is unable to consent or refuse. It includes forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; non-physically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party. Sexual violence involves a lack of freely given consent as well as situations in which the victim is unable to consent or refuse (Basile et al., 2014).

Rape

Rape is one of the sexual attacks that fall under the broader umbrella of sexual violence. The CDC defines rape as any completed or attempted unwanted vaginal (for women), oral, or anal penetration through the use of physical force (such as being pinned or held down, or by the use of violence) or threats to physically harm and includes times when the victim was drunk, high, drugged, or passed out and unable to consent. Rape is separated into three types: completed forced penetration, attempted forced penetration, and completed alcohol or drug facilitated penetration (Black et al., 2010).

Sexual Health

The World Health Organization (WHO; 2023) defines sexual health as:
a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (Sexual Health section)

Sexual Shame

Brené Brown (2007) defines shame as an “intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (p. 5). Sexual shame creates these feelings based on our past and present sexual experiences and thoughts (Brown, 2007). Another definition is provided by Clark (2017) who defined sexual shame as a feeling of disgust or humiliation towards one’s sexual identity.

The following literature review will explore these areas in more detail and help to provide the context of why this study is important. It will highlight the breadth and depth of symptoms women experience after sexual assault, including physical, emotional, and sexual symptoms.

These symptoms can last for years, which is why it is important to understand how best to treat women who have experienced sexual assault. Many of the resources in the literature review are older, which is due to a lack of current studies that generalize findings about the impacts of sexual assault. Although more recent studies have been conducted, they are specific to different types of assault or groups of victims. Many of these studies also cite the literature cited in this study. The literature will also help identify areas where the current understanding of the impacts of sexual assault are not fully understood. Based on those gaps in knowledge, the author will describe the way the current study is designed to fill in information gaps. The method section will introduce the two measures that will be used to examine the relationship between sexual shame and sexual functioning in women who have experienced sexual assault.

CHAPTER II: LITERATURE REVIEW

Impacts of Sexual Violence

Psychological Impacts

Post-Traumatic Stress Disorder

Sexual violence is often experienced as a traumatic event for the victim, which can lead to a variety of both short-term and long-term psychological consequences. One of the most common psychological consequences for sexual violence victims is Post-Traumatic Stress Disorder (PTSD; Faravelli et al., 2004). Compared to a control group of individuals who have not been the victims of rape, women who had been raped had a much higher rate of developing PTSD (Faravelli et al., 2004). A majority of women who experience sexual violence victimization have symptoms that meet the criteria for PTSD. One week after the assault, 97% of victims exhibit symptoms that meet the criteria for PTSD, while 12 weeks later 47% continue to meet the diagnostic criteria (Rothbaum et al., 1992). PTSD symptoms related to rape can include unpleasant intrusive imagery, nightmares, enhanced startle responses, sleep disturbance, guilt, difficulty with memory or concentration, and fear or avoidance of stimuli that reminds the victim of the rape (Steketee & Foa, 1987). Although for many rape victims, PTSD symptoms can resolve themselves within a few months, other victims will have symptoms that last for long periods of time (Steketee & Foa, 1987). PTSD symptoms are some of the most common long-term symptoms victims of sexual violence experience (Hanson, 1990). Although many individuals experience PTSD as a result of sexual violence victimization, there are mediating factors that impact the severity of symptoms. Sexual violence attacks that involve physical violence result in more severe PTSD symptoms initially. Attacks that involve alcohol use result

in more moderate symptoms initially, but become more severe over time (Peter-Hagene & Ullman, 2015).

Fear and Anxiety

While many victims of sexual violence will experience PTSD symptoms, some victims will not meet the diagnostic criteria despite exhibiting symptoms. Two of the most prevalent symptoms of sexual assault, outside of a diagnosis of PTSD, are fear and anxiety. During the attack and immediately following the attack, victims experience intense fear and anxiety, and have symptoms including feeling scared, terrified, shaking, trembling, and having a racing heartbeat or racing thoughts (Steketee & Foa, 1987). These intense symptoms can last for two to three hours following the attack (Steketee & Foa, 1987). Victims of rape have higher levels of fear and anxiety than those who are not victims of sexual violence when surveyed six days after the attack, and continue to have more elevated rates of symptoms at six-month and one-year follow-up assessments (Resick, 1993; Steketee & Foa, 1987). It appears as though fear and anxiety symptoms can be long lasting, as victims who are surveyed continue to exhibit symptoms of fear and anxiety a year after the attack has occurred (Kilpatrick et al., 1981; Resick, 1993). The elevated symptoms appear to dissipate around 18 months, but are elevated again when victims are surveyed two and three years after the attack (Resick, 1993). In addition to the longevity of fear and anxiety symptoms, there is evidence that the symptoms become more widespread over time. At a six-month follow-up assessment, the fear and anxiety has become less stimuli specific and has become a general fear of being attacked (Steketee & Foa, 1987).

Depression

Depression is another common sequela of sexual violence. Depression is experienced by a majority of sexual violence victims. Faravelli et al. (2004) found that 87% of women who were

raped experienced a depressed mood. This was higher than the depressed mood found in women who had experienced other traumatic, life-threatening events (Faravelli et al., 2004) which indicates that rape can have a more severe impact on depression than other types of traumatic events for women. Steketee and Foa (1987) also found an increase in depression among victims of rape. Steketee and Foa found, however, that the rates of depression among rape survivors were not as consistent long-term as fear and anxiety. They noted that there has been inconsistency among studies in terms of how long depression lasts. Some studies (Atkeson et al., 1982; Frank & Stewart, 1984) indicate that depressive symptoms diminish at three to four months, and then are not elevated above the general population when reassessed at a year. However, other studies (Ellis et al., 1981; Nadelson et al., 1982) found that depression related to the rape could last for years after the assault. More recently, Brunton and Dryer (2022) found that in Australian women who had experienced sexual violence, depression rates were significantly higher than women who had not experienced sexual violence, and that the rates of depression were consistently higher when retested 12 years later. Rothman et al. (2021) similarly found long-term increased rates of depression in women who had experienced sexual violence in college. Rothman et al. (2021) found that women who experienced sexual violence in college were still experiencing increased depression nine years later. Suicidal ideation as well as suicidal attempts has also been linked to being raped. Kilpatrick et al. (1992) found that 13% of rape victims, versus 8 % of nonvictims, had contemplated suicide. They also found the 13% of rape victims, compared to 1% of nonvictims, had made a suicide attempt. It is clear that rape can have severe impacts on depression and suicidal ideation.

Somatic Impacts

Pain

In addition to the psychological impacts caused by rape, there are physical consequences as well. Pain, even in areas that did not experience trauma during the assault, has been found to be one of the physical impacts caused by rape. Ulirsch et al. (2014) found that clinically significant new and worsening pain (CSNWP) was a frequent experience for individuals who had experienced a sexual assault. This pain was common at 6 weeks post assault, as well as three months later (Ulirsch et al., 2014). They also found that at six weeks, only 23% of CSNWP was in areas where physical trauma was documented during the evaluation after the assault. This study also found that the correlation between the CSNWP and PTSD was low to moderate, which indicates that the pain is a distinct impact of rape (Ulirsch et al., 2014). Headaches, caused by migraines and tension, as well as stomachaches appear to be common areas where sexual assault survivors experience pain (Kimerling & Calhoun, 1994; Stein et al., 2004). Stein et al. (2004) also found that pain in the face and jaw, as well as muscle and joint pain, was significantly elevated in women who had experienced sexual assault, compared to women who had not. Kimerling and Calhoun (1994) found that back pain was also a frequent and significant symptom experienced by individuals who had been sexually assaulted.

Other Somatic Impacts

Pain is one of the most significant somatic impacts of being sexually assaulted, both in terms of frequency and severity. However, there are also other somatic impacts that are reported by individuals who have been sexually assaulted. Individuals who have been sexually assaulted reported being bothered by chest pain and cardiac arrhythmias, as well as shortness of breath and asthma attacks (Kimerling & Calhoun, 1994; Stein et al., 2004). Stein et al. (2004) also found that

there was an increase in reports of insomnia. Kimerling and Calhoun (1994) found that there was an increase reported in experiencing allergies, menstrual symptoms, weight changes and even high blood pressure. They also found, however, that these symptoms were less frequent and less severe after one year, while psychological impacts remained raised to clinical levels (Kimerling & Calhoun, 1994). This study also found that survivors were not more likely to seek out psychological services although they were more likely to seek out medical services for their physical complaints. This could mean that how we interpret and treat symptoms of sexual assault impacts recovery for assault survivors and there should be a closer examination of the components of psychological and physical symptoms.

Sexual Health and Sexual Dysfunction

Sexual Health

Sexual Rights

As defined by WHO (2023), sexual health is the “state of physical, emotional, mental, and well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity” (Sexual Health section). This means that sexual health is not simply being free from any illness relating to the physical and emotional components of sexual activity. Rather, sexual health must be a positive state of being, emotionally and physically. The WHO also states that in order for sexual health to be attained and maintained, the sexual rights of an individual must be protected. The WHO (2023) lays out nine sexual rights that must be protected in order for individuals to maintain sexual health. Those nine rights are:

- the rights to equality and non-discrimination
- the right to be free from torture or to cruel, inhumane or degrading treatment or punishment

- the right to privacy
- the rights to the highest attainable standard of health (including sexual health) and social security
- the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- the right to decide the number and spacing of one's children
- the rights to information, as well as education
- the rights to freedom of opinion and expression, and
- the right to an effective remedy for violations of fundamental rights. (Sexual Rights section)

All nine of these rights must be attained for someone to have good sexual health.

Sexual Satisfaction

There are several rights of sexual health outlined by the WHO (2023) that are easy to define and identify, such as the right to privacy and deciding number of children. However, not all parts of the definition are equally clear cut. Part of the definition of sexual health states that sexual health requires the “possibility of having pleasurable and safe sexual experiences” (WHO, 2023, Sexual Health section), which indicates that there are components of sexual health that are open to interpretation. Frederick et al. (2016) did a nationwide study to further understand sexual satisfaction. They found that most participants, 83% of men and 83% of women, reported high levels of sexual satisfaction within the first six months of a relationship. However, as relationships developed, sexual satisfaction dropped, with only 43% of men and 55% of women feeling currently sexually satisfied in the relationship (Frederick et al., 2016). Frederick et al. attempted to understand what might account for relationships where sexual satisfaction remained

high. They were able to identify several factors that were associated with maintained sexual satisfaction, including frequent sex, more oral sex, consistent orgasms, varied sexual acts, mood setting, and sexual communication (Frederick et al., 2016). This study is important because it helps us understand the ways in which sexual satisfaction, which is closely linked to the rights needed for sexual health, can be addressed.

Sexual Dysfunction After Sexual Assault

Sexual Dysfunction Prevalence After Sexual Assault

In addition to the psychological and somatic impacts of sexual assault, there is a multitude of evidence that shows that sexual dysfunction is an impact of sexual assault. More than half of sexual assault survivors experience sexual dysfunction. Becker et al. (1986) found that a majority of sexual assault survivors experienced sexual dysfunction. The study found that 71% of sexual assault survivors that were experiencing sexual dysfunction attributed their dysfunction to the sexual assault that they experienced (Becker et al., 1984). There is also evidence that sexual dysfunction can last for extended periods of time. Burgess and Holstrom (1979) found that there was a range for when rape survivors felt “recovered” from the sexual dysfunctions caused by the sexual assault. In their study, Burgess and Holstrom found that 74% of survivors felt recovered. Half of these participants were “recovered” by a few months after the sexual assault, and half felt “recovered” in a few years. However, at a long-term follow-up four to six years later, there were still 26% of participants who did not feel as though their sexual health had recovered post sexual assault (Burgess & Holstrom, 1979). This is more evidence that the impacts of sexual assault can be long-lasting and impact large numbers of survivors.

Types of Sexual Dysfunction After Sexual Assault

One of the most common changes in sexual behavior was a decline in sexual activity. Burgess and Holstrom (1979) found that 71% of sexual assault survivors reported a decrease in sexual activity, including 38% of participants who had been sexually active at the time of the assault and abstained from sexual activity for at least six months after their assault. This decrease in sexual activity could be due to the sexual problems found by Becker et al. (1986). Becker et al. (1986) found that response inhibiting problems were the most common problems experienced by rape survivors. These include fear of sex, desire dysfunction, and arousal dysfunction (Becker et al., 1986). Becker et al. also found that these dysfunctions could last for long periods of time. They found that more than three years after the assault, survivors of rape who had been experiencing response inhibiting problems that they attributed to the sexual assault were still experiencing those symptoms. We know that psychological, somatic, and sexual problems can be very prevalent for sexual assault survivors and can last for long periods of time, which makes it important to understand the factors that cause some people's suffering to last for longer periods of time so that we can effectively address those needs for survivors of sexual assault.

Sexual Shame

Shame vs. Guilt

Tangney et al. (1996) found that while guilt and shame had some similarities, there were also differences between the two emotions. Some of the similarities are that shame and guilt can both be private or public emotions, and the emotions were felt to be a result of the actions of individual (Tangney et al., 1996). One notable difference between guilt and shame is that shame tended to be a more intense emotion than guilt (Tangney et al., 1996). Shame also had different impacts on the individual experiencing the emotions. People experiencing shame had more

physical responses, such as blushing or an increased heartrate (Tangney et al., 1996). Shame was also demonstrated to have different psychological impacts on the individual. They felt smaller, physically, and felt inferior to others (Tangney et al., 1996). This study indicates that shame could be a more powerful emotion than guilt.

Psychological Impacts of Shame

Tangney et al. (1996) indicated that there were impacts of shame, as indicated previously. There are other studies that indicate there are psychological impacts of shame. Kim et al. (2011) conducted a meta-analysis of available studies that looked at shame and depressive symptoms and found that shame had a significant correlation with depressive symptoms. Hedman et al. (2013) looked at the relationship between shame and social anxiety disorder. They found high levels of shame in individuals who had social anxiety disorder (Hedman et al., 2013). While neither of these studies could conclude a causal link between shame and depression or anxiety, it is important to note the relationships that were found. Depression and anxiety are also among the most common and most long-lasting impacts of sexual violence, and so it is possible that shame surrounding the event may have an impact on the symptoms experienced by the victim.

Defining Sexual Shame

Sexual shame is an area of research that has been developed more recently, which means that the definition is not as concrete as other definitions. One definition is provided by Brown (2007). Brown (2007) defines shame as the “intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging” (p. 5). When it comes to sexual shame, this feeling is caused by our sexual thoughts and experiences. Another definition was provided by Clark, who explored the etiology and phenomenology of sexual shame. The definition provided by Clark (2017) was that sexual shame refers to humiliation or disgust

towards one's own sexual identity. This is comprised of three components: (a) relationship sexual shame, (b) internalized sexual shame, and (c) sexual inferiority (Clark, 2017). These definitions both highlight that sexual shame is a powerful negative feeling about ourselves, based on previous sexual experiences, as well as how previous sexual experiences and behaviors are thought about.

Sexual Shame, Self-Esteem and Sexual Satisfaction

Sexual shame is a relatively newly studied construct; however, it appears that it is something that is experienced by large portions of people. Day (2019) found that nearly 40% of the participants representing the general population indicated that they had experienced sexual shame. Day also found that sexual shame had a negative correlation with both self-esteem and sexual satisfaction. Marcinechová and Záhorcová (2020) also found that sexual shame was inversely correlated to sexual satisfaction. They found that sexual shame, religiosity, and shame proneness were all negatively related to sexual satisfaction, with sexual shame being the strongest negative predictor (Marcinechová & Záhorcová, 2020). While the research does not point to the causation in the relationship, it is important to note that sexual shame is related to sexual satisfaction and therefore linked to sexual health.

Sexual Shame and Childhood Sexual Abuse

Sexual shame is a recent area of study, which means that we do not understand fully how sexual shame is developed or how it impacts sexual functioning. Pulverman and Meston (2020) found that there was a strong mediating factor between sexual functioning and sexual shame in women who had experienced childhood sexual abuse. In fact, they found that it was a better indicator of sexual functioning than any other mechanism and completely mediated the

relationship between childhood sexual abuse and sexual functioning (Pulverman & Meston, 2020).

It has been well-documented that a large percentage of women will experience sexual assault in their lifetime, and that the true number of sexual assault survivors may be higher than the reported one in four women. It has also been well-studied that women will experience a wide range of symptoms, including emotional symptoms, physical symptoms, and sexual functioning symptoms. These symptoms can last for months or even years, which highlights the importance of understanding how best to help treat these symptoms. However, the sexual health of women who have experienced sexual assault has not been as thoroughly studied as the emotional and physical symptoms which could mean there are gaps in the treatment for sexual health and sexual functioning in women who have experienced sexual assault. This study aims to help fill in some of the gaps in knowledge.

Research Questions

Based on the current available understanding of sexual shame, it appears there could be a link between sexual shame and sexual health among sexual assault survivors. However, due to the dearth of current information, it is important to continue to study this relationship to help understand if sexual shame can have wider implications beyond childhood sexual assault. This study will hopefully expand our understanding of the connection between sexual shame and sexual health, which can help further treatment for survivors of sexual assault who wish to recover their sexual health. There is not enough information available to make a hypothesis about directionality of correlations between sexual shame and sexual functioning. However, this study aims to discover if there will be a relationship between these two constructs. The following questions helped guide the study.

1. Is there a relationship between sexual shame and sexual functioning in rape survivors who were sexually assaulted after becoming sexually active adults?
2. If there is a relationship between sexual shame and sexual functioning, is the relationship stronger for any of the factors of sexual functioning?
3. Which subscale, if any, of sexual functioning has the strongest correlation to sexual shame?

CHAPTER III: METHOD

Methodology

Participants

Participants for this study were women between the ages of 18 and 50, who experienced their first sexual assault after becoming sexually active. There is already an established relationship between women who experienced sexual abuse during childhood, before their first consensual sexual experience. Pulverman and Meston (2020) found that there was a strong relationship between sexual shame and sexual functioning. Their study found that people with higher levels of sexual shame experienced lower levels of sexual functioning. The current study used participants who were already sexually active at time of the assault in order to further our understanding about whether that link extends to women who did not experience sexual abuse during childhood. The upper age limit helped filter out participants whose sexual function and sexual satisfaction has decreased due to age-related factors. The American Association of Retired Persons (AARP) found that 65% of women reported a satisfying sexual life after the age of 60, compared to 73% of women 45–49 who reported a satisfying sexual relationship (Fisher, 2010). The number of women reporting a satisfying sexual relationship continues to drop as age increases (Fisher, 2010). Including women who are above the age of 50 may skew the results due to the decrease in sexual satisfaction as one ages. Participants were recruited multiple ways. There were postings on Reddit forums, with permission from moderators, that are related to sexual health and sexual well-being. Emails were also sent to graduate schools around the country to advertise for participants.

There were 388 responses; however, only 105 responses were used for the study. Of the 388 responses, 91 responses were discounted because the respondent reported that their initial

sexual assault happened before the age of 18, which was one of the screening criteria listed above. One hundred twenty-two responses were discounted because they were repeated responses. These responses were discounted for one of two reasons. The first was that the responses came in at the same time and used the same IP address. The second was identical answers that came in at the same time. For example, 15 responses came in on the same evening at exactly 5:01:14 PM and the answers were identical. Forty-seven responses were discounted due to questions being skipped in answering the surveys. Finally, 23 responses were discounted from the study because the answers on the surveys indicated that the answers were not accurate. An example of this was when on the Female Sexual Function Index (FSFI), a respondent answered questions about the quantity and quality of their sexual experience during the last four weeks in one section and then reported no sexual activity during the past four weeks in another section. In total, 283 responses had to be left out when completing the correlations.

Of the remaining 105, there was a range in age. Twenty-one participants were aged 18–24; 69 were aged 25–34; 11 were aged 35–44; and four participants were aged 45–54. There were also different ages reported for when participants became sexually active. Thirty-two participants reported becoming sexually active under the age of 18; 67 participants reported becoming sexually active between 18 and 24, and six participants reported becoming sexually active between ages 25 and 34. There was a range in the age when the participant experienced sexual violence for the first time, although there was a vast majority of participants who experienced their first sexual assault in the same age bracket. Ninety-seven participants reported that their first sexual assault occurred between the ages of 18 and 24; seven participants reported that their first sexual assault happened between the ages of 25 and 34; and only one participant reported that their first sexual assault occurred between the ages of 35 and 44.

Participants were also asked some demographic information. These questions were optional. The first question asked participants how they identified their sexual orientation. Ninety-two respondents identified as heterosexual; four respondents identified as homosexual; eight respondents identified as bisexual; and one participant skipped this question. Participants were also asked about their racial identity and if they identified as Hispanic. Eighty-nine participants identified as White; eight participants identified as Black; six participants identified as American Indian or Alaska Native; one participant identified as Asian or Asian American; and one participant entered their own racial identity of Multi. Fifty-nine respondents identified as Hispanic, 46 did not. Finally, respondents were asked about their religious affiliation. Forty-nine respondents reported that they had no religious affiliation; 47 respondents identified as Christian; four respondents identified as Asian Folk religion; two respondents identified as Jewish; and three participants identified as Hindu.

Measures

FSFI

The FSFI was created as a brief self-report measure of female sexual arousal and other components of sexual functioning (Rosen et al., 2000). The measure is a 19-item index, scored using a 6-point Likert scale. The first two items are scored on a 5-point Likert scale. Items 8, 10, 12, 16, 17, and 18 are reverse scored. The index measures 6 domains of female sexual function; desire, arousal, lubrication, orgasm, satisfaction, and pain. There is a minimum and maximum score for each domain, as well as a full-scale minimum and maximum score. Inter-item reliability for the six domains was tested, and found high reliability within each domain. Cronbach's alpha values were .82 and higher (Rosen et al., 2000). Test-retest reliability was also

examined, and reliability coefficients were statistically significant for all domains and for the full-scale score (Rosen et al., 2000).

Kyle Inventory of Sexual Shame

The Kyle Inventory of Sexual Shame (KISS) was created to measure levels of sexual shame. The inventory is a 25-item measure, where the last five items are used to gather demographic information from the participants. In this study, only the first 20 items that are designed to measure sexual shame will be used. The remaining 20 items are scored on a 6-point Likert scale, ranging from Strongly Disagree to Strongly Agree. There are three items that measure positive attitudes and attributes that are reverse scored to align with the rest of the measure. Those items are 3, 12, and 16. The measure has good internal consistency reliability, with a Cronbach's alpha of .929 (Kyle, 2013).

Demographic Information

Participants were also asked to fill out demographic information that included the age range of the sexual assault, and the age when the participant became sexually active. These questions were used to ensure that the responses come from women who were already sexually active when they were sexually assaulted, which means that the demographic information was also used as a screening tool for participant eligibility.

Procedure

A quantitative method was used for this study. Given the sensitive nature of sexual functioning, sexual shame, and sexual assault, it is likely that participants would feel more comfortable participating in the study if they are able to use anonymous surveys rather than personal interviews which is why the surveys were given online. Participants were recruited online, through Reddit, and through graduate schools in the United States. After the responses

were collected, the scales were scored and a Pearson's correlation was run in order to determine if there was a correlation between sexual shame and sexual functioning. A Pearson's coefficient could be used because the two scales will be scored on an interval scale, and because the seven assumptions about the data have been met. The seven assumptions are: the variables were measured on a continuous scale; the two continuous variables were be paired; the cases were independent; there was a linear relationship between the variables; both variables had bivariate normal distribution; there was homoscedasticity among the variable; and there was not any univariate or multivariate outliers (Laerd Statistics, 2020). A Pearson's correlation was run between the KISS with each domain of the FSFI, as well as the overall scale.

CHAPTER IV: RESULTS

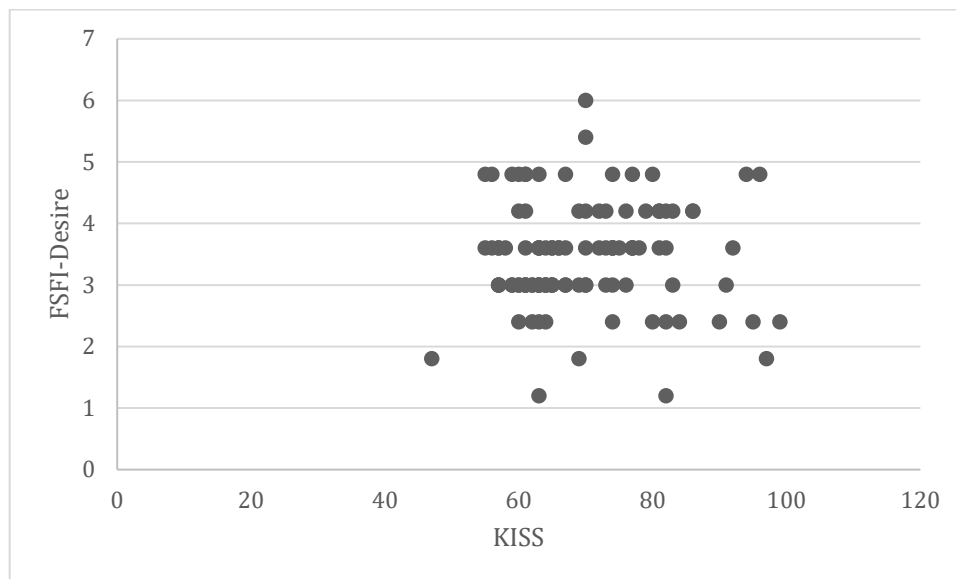
There were seven Pearson correlations run, one for each domain in the FSFI and one for the overall FSFI score compared to the KISS. There were two correlations that did not show a significant relationship between the variables and five that did show a significant relationship between the variables.

KISS and Desire Domain

The relationship between the KISS scale and the Desire domain of the FSFI did not show any significant relationship, $r(103) = .004$. Participants' score on the KISS was not related to their score on the FSFI Desire scale.

Figure 4.1

Correlation Between KISS and FSFI-Desire



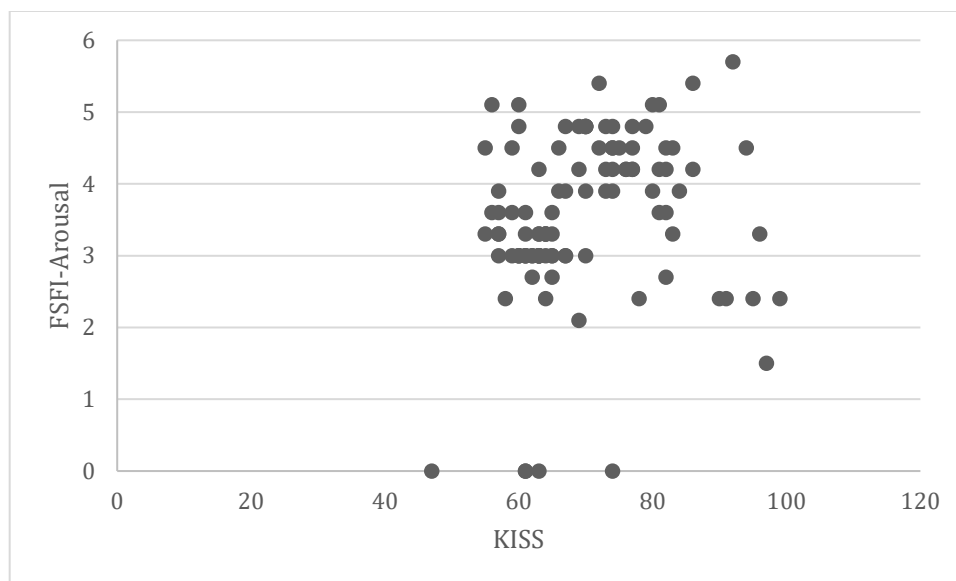
KISS and Arousal Domain

There was a positive relationship between the KISS scale and the Arousal domain of the FSFI that proved to be significant, $r(105) = .206$, $p = .035$. This indicates that as the KISS scale rises, which relates to a higher level of sexual shame, the Arousal domain also rises, which

relates to a high level of sexual functioning. Participants who had higher levels of sexual shame reported higher levels of satisfaction with their ability to achieve and maintain arousal during intercourse.

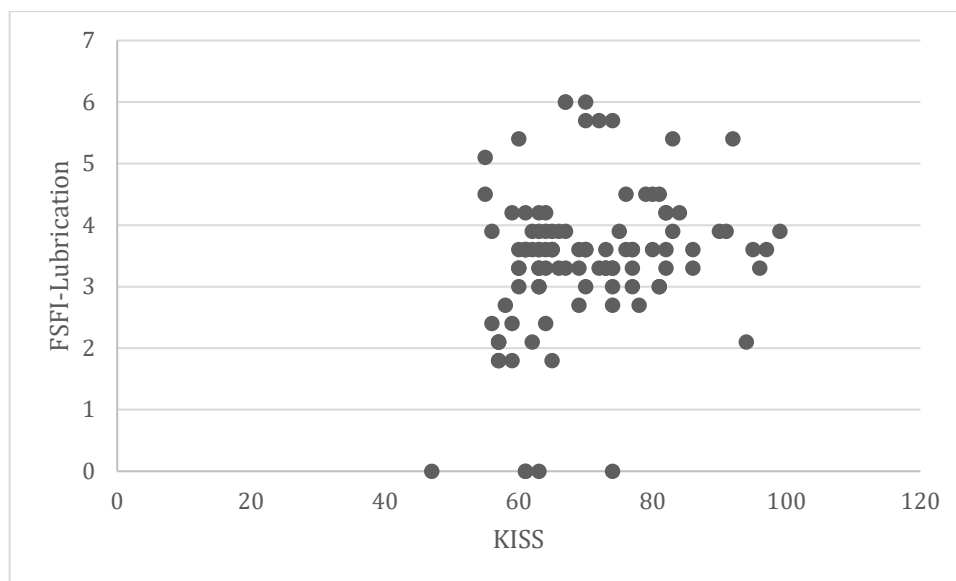
Figure 4.2

Correlation Between KISS and FSFI-Arousal



KISS and Lubrication Domain

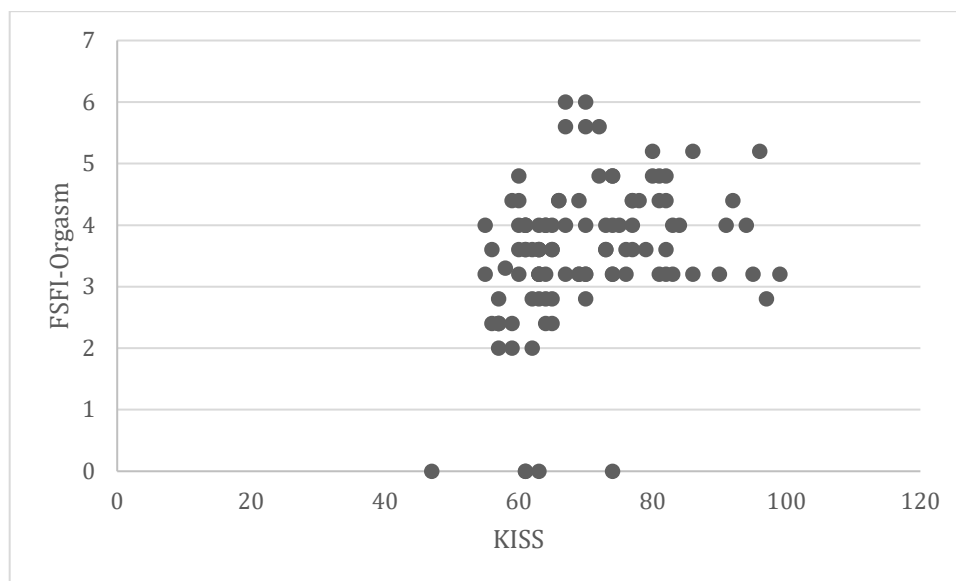
There was a positive relationship between the KISS scale and the Lubrication domain of the FSFI that was significant, $r(105) = .257, p = .008$. This positive relationship indicates that as the KISS scale rises, so does the Lubrication score on the FSFI. Participants who reported higher levels of sexual shame were more likely to achieve and maintain lubrication during sexual intercourse.

Figure 4.3*Correlation Between KISS and Lubrication***KISS and Orgasm Domain**

There was also a positive relationship between the KISS scale and the Orgasm domain of the FSFI that proved to be significant, $r(105) = .324, p = .001$. This positive relationship indicates that as the KISS scale rises, so does the Orgasm score on the FSFI. This was the largest correlation between the KISS score and a domain of the FSFI. Participants with higher levels of sexual shame generally experienced more frequent, more satisfying orgasms and were able to achieve orgasms more easily.

Figure 4.4

Correlation Between KISS and FSFI-Orgasm

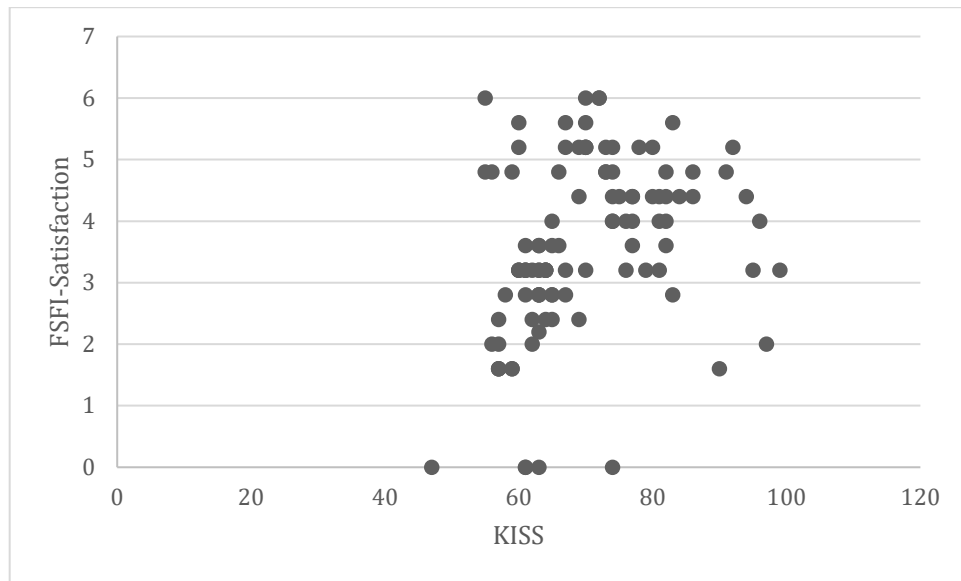


KISS and Satisfaction Domain

There was a positive relationship between the KISS scale and the Satisfaction domain of the FSFI that was significant, $r(105) = .316, p = .001$. This positive correlation indicates that as the KISS scale rises, so does the Satisfaction score on the FSFI. Participants who reported higher levels of sexual shame experienced higher levels of satisfaction in their sexual relationships and with their sexual experiences.

Figure 4.5

Correlation Between KISS and FSFI-Satisfaction

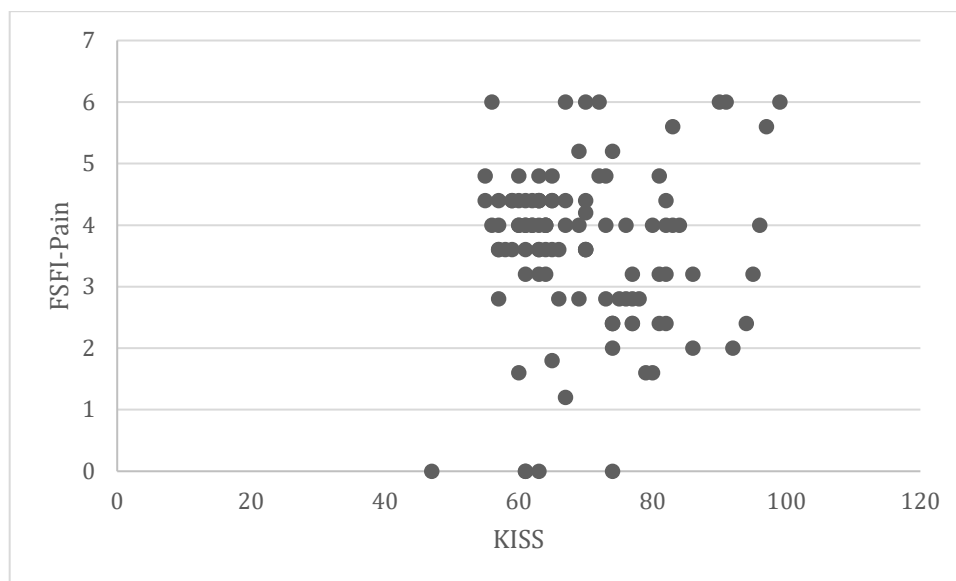


KISS and Pain Domain

There was not a significant relationship between the KISS scale and the FSFI Pain domain, $r(105) = .045$. The level of sexual shame reported did not relate to the level and frequency of pain experienced by participants.

Figure 4.6

Correlation Between KISS and FSFI-Pain

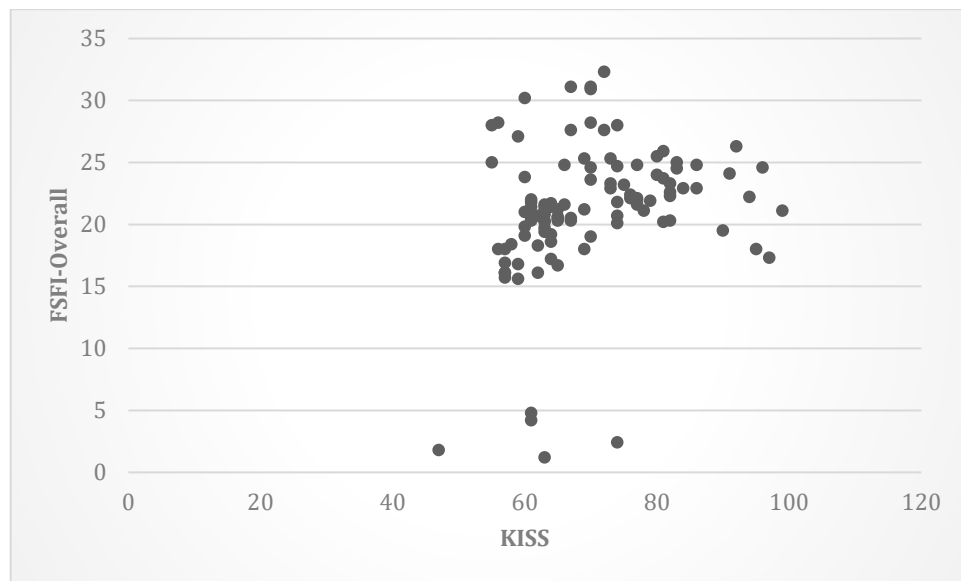


KISS and FSFI Overall Score

There was a significant positive relationship between the KISS scale and the FSFI Overall score, $r(105) = .265, p = .006$. This indicates that as the KISS scale rises, so does the score of the FSFI. Participants who reported higher levels of sexual shame also had higher overall scores of sexual functioning.

Figure 4.7

Correlation Between KISS and FSFI-Overall Score



CHAPTER V: DISCUSSION

Potential Interpretation of Results

The current study found that there was a relationship between sexual shame and sexual functioning for multiple domains on the Female Sexual Function Index (FSFI). The domains that did not have a correlation were desire and pain, while there was a positive correlation between sexual shame and the arousal, lubrication, orgasm, satisfaction, and the overall domains on the FSFI. The strongest relationship was between sexual shame and orgasm.

I introduced earlier that in studies that have looked at the relationship between sexual shame and sexual functioning in people who have experienced childhood sexual abuse, there was a strong mediating relationship between sexual shame and sexual functioning. In that research, higher levels of shame indicated lower sexual functioning. This study found the opposite relationship in women who were sexually active before experiencing sexual violence. In this study, higher levels of sexual shame were actually related to higher sexual functioning scores in the majority of domains. There may be an explanation for this. One potential explanation is that the age at which sexual abuse happens is a key factor in how sexual shame and sexual functioning are related. If sexual abuse happens before sexual health is established, it could be that sexual shame inhibits sexual functioning in the future and sexual functioning cannot develop as healthily.

Another potential explanation could be that individuals who have higher levels of sexual shame are more motivated to have positive sexual experiences in order to overcome those feelings of shame, and therefore put more work into their sexual intercourse. This could explain why the relationship is highest with the orgasm domain, which can take some effort for women to achieve. It may also explain why there was no correlation between sexual shame and pain and

desire. The desire domain looked at the frequency and level of desire, which could explain why it is not associated in the same way as the other domains; women may not work at feeling desire in order to have a sexual experience and instead focus on the sexual activity itself. Pain, likewise, would not be a part of a positive sexual experience and would not be something most women would strive for.

A third potential explanation is that there is a confounding variable that wasn't identified in this study. One example may be age. The majority of participants were between the ages of 25 and 34, which could be a time of life when women engage in more frequent and more satisfying sexual intercourse, while also experiencing more pressure from society to conform to certain roles that increases their sexual shame. Women may enjoy their sexual lives and feel sexual shame as a result.

This study did not look at how sexual shame might be developing for women so I cannot discuss how sexual shame develops. It does seem, however, that there is room to explore how all women are experiencing some degree of sexual shame, and yet were able to have fulfilling sexual lives. I have explored reasons for the correlation between sexual health and sexual shame, but these issues are complex. There could be compounding factors, such as accessibility to information and worldviews over the internet, that both increase sexual shame and allow women to believe that they deserve to have a healthy sex life. Social media advances have increased exposure to cultures and information from around the world. Sexual abuse survivors have been able to find communities where they can feel supported, which may have been harder in the past when people were afraid that their local communities might shame or blame them for their abuse. There have also been huge movements, such as the "Me Too" movement, that allowed sexual abuse survivors to realize just how prevalent sexual abuse was. With increased visibility comes

an increased ability to address the issues, so while women may still experience sexual shame they are also aware they aren't alone in their experiences. It may be that not feeling alone can mediate the relationship between sexual shame and sexual function. This study was not able to capture these variables, and therefore is not able to provide a complete picture of how sexual shame and sexual functioning in women who have experienced sexual violence are related.

Directions for Future Research

There was a clear relationship between sexual shame and sexual functioning in this study, that showed a positive correlation between sexual shame and multiple components of female sexual function. This study did not offer any information about what might be causing that relationship. Future studies could look further into what causes the relationship between these two variables and if there are implications of this relationship as women age. Does this relationship remain positive, or is there a time when it changes and higher sexual shame relates to lower sexual functioning? A future study could also explore if there are other variables, such as age, racial identity, sexual orientation, etc., that might influence both sexual shame and sexual functioning.

Limitations of This Study

One large limitation of this study is the limited participant pool, both in terms of the overall sample size as well as the diversity of the population. A sample of 100 participants was large enough to find a significant relationship, but it is still a very small sample. Therefore, a larger scale study would need to be run to determine if the results could be replicated. The participants were also not very diverse, in age, sexual orientation, and racial identity. The majority of participants identified as 25–34 years old (65.7%), heterosexual (87.6%), and white

(84.8%). This makes it harder to be able to draw wide conclusions about the results of the study, because there is not an indication if these results are different in diverse groups of women.

Another limitation of this study was the way in which the information was collected. Two hundred eighty-three responses were thrown out due to a variety of factors including participants not meeting the criteria, incomplete responses, and repeat submissions. As an online survey, it was challenging to ensure that the responses being collected were accurate and complete. Additionally, although measures were put in place to try to cut down on repeat responses, it is possible that people found ways around the safeguards and submitted multiple responses in order to enter the drawing for an Amazon gift card multiple times. If this were true, and respondents were putting in multiple surveys, the statistics would not be accurate and therefore the results may be unreliable. This study should be repeated, hopefully with further safeguards, so that accurate responses can be gathered.

While the results of this study are interesting and informative, they also serve to show that sexuality is a complex issue. I mentioned previously that there were limited resources about the impacts of sexual violence available that are generalized, and that could likely be due to the complexity of the issue at hand. I anticipate that as the world understands more about gender, gender identity, and sexual orientation things will become more complex. I hope that future studies will continue, because complex issues deserve thorough examination so that we can have the best information and understanding of these complex issues, which in turn enable us to offer the best support for everyone.

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APPENDIX A: KYLE INVENTORY OF SEXUAL SHAME

Kyle Inventory of Sexual Shame

Shame has been described as an “excruciating painful and contagious emotion”. It is different than feeling bad or upset about a behavior, because it relates to how you feel about yourself as a person. You might notice feelings of wanting to hide parts of yourself, or even isolate from others at times. The following are some statements related to sexual shame that may or may not describe how you are feeling right now. Please rate your agreement with each statement using the 6-point scale below.

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
1. I think people would look down on me if they knew about my sexual experiences.						
2. I scold myself and put myself down when I think of myself in past sexual situations.						
3. Overall, I feel satisfied with my current and past sexual choices and experiences.						
4. When I think of my sexual past, I feel defective as a person, like something is						

inherently wrong with me.						
5. I feel ashamed about having sex with someone when I didn't want to.						
6. I feel like I am never quite good enough when it comes to sexuality.						
7. I sometimes try to conceal the kind of person I am with regard to sexuality.						
8. I feel ashamed of my sexual abilities.						
9. I feel ashamed about having sexual or kinky fantasies.						
10. I feel ashamed of something about my body when I am in a sexual situation.						

11. I sometimes avoid certain people because of my past sexual choices or experiences.						
12. I feel good about myself with regard to my sexual choices and experiences.						
13. I replay painful events from my sexual past over and over in my mind.						
14. I have an overpowering dread that my sexual past will be revealed in front of others.						
15. I feel ashamed about a time when I had sex that was not totally consensual. 16. When it comes to sexuality, I feel like I am a worthy person who is at least equal to others.						

17. I feel ashamed about having an affair/being unfaithful/being sexually promiscuous.						
18. I feel afraid other people will find out about my sexual defects.						
19. I feel ashamed about having same-sex attractions.						
20. I feel empty and unfulfilled when I think of my current or past sexual experiences.						

APPENDIX B: PERMISSION TO USE KYLE INVENTORY OF SEXUAL SHAME

Re: Form Submission - New Form

Dr. Sarah Kyle [REDACTED]

Mon, Jul 10, 2023 at 7:31 PM

To: Aili Jones [REDACTED]

Hi Dr. Aili,
Congratulations on finishing and defending your dissertation! The measure is not copyrighted, so feel free to include it in your appendix (but please include me in your citations). :)

Take care,
SK

SARAH E. KYLE, PH.D., LCSW

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[Quoted text hidden]

APPENDIX C: DEMOGRAPHIC INFORMATION

Demographic Information

The following questions are designed to help us get further information about the individuals who are completing the surveys. If a question is not relevant, please write N/A. No data will be saved with any of your identifying information, in order to protect your privacy.

How old are you?	<input type="checkbox"/> 18–24 <input type="checkbox"/> 25–34 <input type="checkbox"/> 35–44 <input type="checkbox"/> 45–54 <input type="checkbox"/> 55–60
How old were you when you became sexually active?	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18–24 <input type="checkbox"/> 25–34 <input type="checkbox"/> 35–44 <input type="checkbox"/> 45–54 <input type="checkbox"/> 55–60
How old were you when you were sexually assaulted? If you have been sexually assaulted more than once, please indicate the earliest sexual assault.	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18–24 <input type="checkbox"/> 25–34 <input type="checkbox"/> 35–44 <input type="checkbox"/> 45–54 <input type="checkbox"/> 55–60
What is your sexual orientation?	<input type="checkbox"/> Bisexual <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Other _____ <input type="checkbox"/> Prefer not to answer
Are you of Hispanic, Latino or Spanish origin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your identified race?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>What is your religious affiliation?</p>	<ul style="list-style-type: none"><input type="checkbox"/> American Indian or Alaska Native<input type="checkbox"/> Asian<input type="checkbox"/> Black or African American<input type="checkbox"/> Native Hawaiian or Other Pacific Islander<input type="checkbox"/> White<input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Asian Folk Religion<input type="checkbox"/> Christian (Catholic, Protestant or Other Christian religion)<input type="checkbox"/> Hindu<input type="checkbox"/> Jewish<input type="checkbox"/> Muslim<input type="checkbox"/> No Religious Affiliation<input type="checkbox"/> Other _____<input type="checkbox"/> Prefer not to answer
--	---