

6-2019

THE ROLE OF SEXUAL SELF-SCHEMA AND PSYCHOLOGICAL DISTRESS IN THE RELATIONSHIP BETWEEN SEXUAL VICTIMIZATION AND SEXUAL FUNCTIONING AND SATISFACTION

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THE ROLE OF SEXUAL SELF-SCHEMA AND PSYCHOLOGICAL DISTRESS
IN THE RELATIONSHIP BETWEEN SEXUAL VICTIMIZATION AND SEXUAL
FUNCTIONING AND SATISFACTION

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Psychology:
Clinical Counseling

by
Alexandra Medina

June 2019

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ABSTRACT

Sexual assault (SA) has been associated with various negative psychological consequences for survivors. Recent studies have shown an association between the history of sexual assault and sexual dysfunction among female survivors of sexual victimization. Specifically, sexual assault survivors experience difficulties with aspects of sexual functioning, sexual satisfaction, and sexual self-schemas (Rellini & Meston, 2011). The purpose of the present study was to examine the relationship between sexual victimization severity and sexual functioning and sexual satisfaction. In addition, we tested a sequential mediational model in which sexual self-schema followed by depressive and PTSD symptoms would mediate the relationship between sexual victimization severity and sexual satisfaction and sexual functioning. Seventy-three female college students with a history of sexual victimization were asked to complete a series of self-report questionnaires designed to assess the history of sexual victimization, sexual functioning, sexual satisfaction, sexual self-schemas and psychological distress levels (i.e., depression and posttraumatic stress disorder symptom severity). Results revealed no significant associations between severity of sexual victimization and sexual satisfaction and sexual functioning. Additionally, our sequential mediational models, in which sexual self-schema followed by depressive and PTSD symptoms would mediate the relationship between sexual victimization severity and sexual satisfaction and functioning were non-significant. Our findings may have been limited due to the lack of

variability in sexual victimization severity. Future studies further investigating the role of sexual self-schema, depression, and PTSD on sexual functioning and sexual satisfaction among sexual assault survivors are warranted.

ACKNOWLEDGEMENTS

I would like to sincerely express my deepest gratitude to my thesis advisor, Dr. Christina Hassija for serving as my mentor. I am tremendously appreciative for her continuous support and encouragement throughout my undergraduate and graduate education. I am very thankful to have had the opportunity of learning and developing as a researcher and clinician through Dr. Hassija guidance.

I would also like to thank my committee members, Dr. Michael Lewin and Dr. Kelly Campbell, for serving as my thesis committee members. I appreciated the constructive recommendations and support that was provided.

I want to thank my father, mother and brother for continuously supporting my academic career. My family has raised me, provided for me, laughed with me, wiped my tears, grew with me, and ultimately showed me to believe in myself. I am thankful for the motivation and encouragement provided by my best friends Amanda and Mary. Finally, I want to thank my fiancé Christopher Erich Morin for providing me unconditional emotional support and encouraging me and motivating me to complete my thesis.

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CHAPTER ONE: LITERATURE REVIEW

Introduction

The Department of Justice defines sexual assault as a sexual act that is perpetrated against an individual without their consent (Truman & Morgan, 2015). The definition of sexual assault includes unwanted sexual contact such as kissing, fondling and touching. The National Intimate Partner and Sexual Violence Survey (NISVS) classifies sexual assault into five categories: rape, being made to penetrate someone else, sexual coercion, unwanted sexual contact and non-contact unwanted sexual experiences (Black et al., 2011). Results from the NISVS indicate that 18.3% of women and 1.4% of men have experienced rape. In addition, it is estimated that 16.9% of women and 8.0% of men experienced sexual violence at some point in their lifetime (Black et al., 2011). The risk of a female experiencing sexual assault dramatically increases during the teenage years, with 30% of sexual assaults being perpetrated against females between the ages of 15 to 19 (Felson & Cundiff, 2014). Numerous studies have examined the relationship between sexual victimization and psychological distress among female college samples. The average age of first-year female college students is 17- to 19- years-olds (U.S. Department of Education, 2018). Sexual attractiveness, vulnerability, and exposure to motivated offenders accounts for the higher risks of sexual assault among adolescents and young adults (Felson & Cundiff, 2014). It is estimated that 20% to 25% of

college-aged females have experienced some form of sexual assault such as rape, attempted rape, or threat of rape or sexual assault (Fisher, Cullen, & Turner, 2000). Accordingly, sexual assault is prevalent, particularly among college populations.

Sexual assault is a widespread problem in the United States with serious consequences. Providing a better understanding of the scope and influence of sexual assault allows for improvements in medical and mental health services offered to survivors. The potential negative consequences of sexual assault can have lasting associations on sexual assault survivors. For instance, possible medical consequences include physical injuries, impaired sleep, gastrointestinal disorders, and sexually transmitted diseases (Black et al., 2011). Recent studies have shown that common psychological changes following sexual assault can include maladaptive cognitions and changes in mood and anxiety which can contribute to individuals' development of posttraumatic stress disorder (PTSD; Campbell et al., 2009). Furthermore, mental health consequences such as depression and low self-esteem (Black et al., 2011; Campbell et al., 2009) are also common outcomes. Mental health issues can contribute to sexual dysfunction and sexual dissatisfaction (Rellini & Meston, 2011). In conclusion, sexual assault can lead to a number of negative mental and physical health outcomes.

Sexual Functioning

Sexual dysfunctions are commonly comorbid with mood disturbances and can develop following exposure to sexual assault within females (Rellini & Metson, 2011; Turchik & Hassija, 2014). Sexual dysfunctions are described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013) as an individual's inability to respond to or experience sexual satisfaction. In addition, the DSM-5 indicates the relevant relationship, intrapersonal and interpersonal contexts can lead to sexual dysfunction. Furthermore, factors such as partner's sexual problems, poor communication, poor body image, history of sexual abuse and psychiatric comorbidity play a role in sexual dysfunction. There are three types of sexual dysfunctions females can experience: female orgasmic disorder, female sexual interest/arousal disorder, and genito-pelvic pain/penetration disorder. The female orgasmic disorder is characterized by difficulties in infrequency, reduced intensity or absence of orgasm. Female sexual interest/arousal disorder is characterized by the absence/reduction of sexual interest, sexual thoughts or fantasies, initiation of sexual activity and sexual arousal. Lastly, genito-pelvic pain/penetration disorder is characterized by difficulties such as pain, fear, or tension during vaginal intercourse (APA, 2013). A national probability sample found that 43% of women experience sexual dysfunction (Laumann & Rosen, 1999). However there appears to be a higher prevalence of sexual dysfunction among women who have been exposed to sexual violence (APA, 2013).

Leonard, Iverson, and Follette (2008) examined the relationship between sexual assault, on sexual functioning, sexual satisfaction and other predictor variables (e.g., psychological distress, relationship satisfaction, experiential avoidance, relationship violence, and anger) in a small sample of 22 females reporting a history of childhood sexual abuse, adolescent sexual abuse, and both childhood and adolescent sexual abuse. Participants were asked to complete an interview, sexual satisfaction index, interpersonal victimization scales, relationship satisfaction scale and psychological functioning scales. Results demonstrated that 41% of participants reported significant sexual dissatisfaction. Moreover, the results showed that 22.7% of participants' sexual functioning scores in the five domains indicated clinical levels of sexual dysfunction. Additionally, several participants' scores fell within one or more domains that indicated clinical levels of sexual dysfunction. For example, participants indicated problems in sexual thoughts, arousal, and sex drive. Within the orgasm domain, 45% of participants' scores indicated clinical dysfunction. The results demonstrated that 74% of the variance in sexual satisfaction was significantly explained by relationship satisfaction and experiential avoidance (Leonard et al., 2008). In addition, sexual satisfaction was correlated with all predictors. On the other hand, sexual functioning was only found to correlate with relationship violence. Thus, the research suggests that women with a history of CSA are more likely to experienced sexual problems. However, the sample size was small in this investigation, which may have imparted the researchers' ability to detect a

relationship between sexual satisfaction and sexual functioning. Future studies that examine the role of additional, potentially relevant mediators, such as sexual self-schema and psychological distress, may help to uncover these links.

Research suggests that an individual's experience of sexual victimization negatively predicts sexual functioning. In one recent investigation by Turchik and Hassija (2014), college females completed measures assessing severity of sexual victimization and a variety of negative health risk behaviors and sexual dysfunction. The study consisted of a sample of 309 female college participants that were placed in four victimization categories: none, sexual contact, sexual coercion, and rape, based on the reported severity of the assault experience. Results demonstrated that participants who reported sexual contact, sexual coercion or rape were more likely to indicate a lack of sexual desire. In addition, the results indicated that participants who reported rape were more likely to indicate difficulties achieving orgasm. Accordingly, individuals with higher levels of sexual victimization experienced higher levels of sexual dysfunction (Turchick & Hassija, 2014). However, one limitation is that the researchers did not examine additional factors that may have accounted for the link between sexual assault and sexual dysfunction. For example, they did not assess whether or not participants were sexually active or whether they were in a relationship. Although the study failed to assess participant's current level of sexual activity and relationship status, which may have influenced the relationship between the two variables, this study provides a compelling case for links between sexual assault

and sexual dysfunction, warranting further research on potential mediators such as sexual schemas.

Kelley and Gidycz (2017) conducted a study to examine trauma-related symptomatology as a mediator between sexual assault and sexual functioning among a sample of 501 female college students. The trauma-related symptomatology scale examined six subscales: anxiety, depression, dissociation, sexual abuse trauma index, sexual problems and sleep disturbance. The sexual functioning index assessed participants' sexual experiences in the past four weeks within six domains, which included desire, arousal, lubrication, orgasm, pain, and satisfaction. Participants reported experiencing unwanted sexual contact, sexual coercion, attempted rape, and completed rape. Results suggest that neither adult sexual assault (ASA) nor childhood sexual assault (CSA) was directly related to sexual functioning; however, trauma-related symptomatology was found to be a partial mediator. Results demonstrated that among ASA participants and CSA participants, lower sexual desire was positively associated with dissociation, anxiety, depression, sexual abuse trauma index and sleep disturbance. Results also indicated that anxiety and sexual abuse trauma mediated the relationship between history of ASA and sexual desire difficulties. Furthermore, in the lubrication category, ASA was positively related to dissociation, anxiety, depression and sexual abuse trauma index. In the orgasm category, a higher sexual abuse trauma index demonstrated a relationship between type of ASA and greater orgasm difficulties.

Lastly, within the ASA group sexual pain was associated with greater dissociation, depression, anxiety, higher sexual abuse trauma index and greater sleep difficulties. In all categories the total indirect effect of ASA was significant. Thus, trauma-related symptomatology partially mediated the relationship between sexual assault history and sexual dysfunction (Kelley & Gidycz, 2017). One limitation of the study is that women who reported no recent sexual activity were excluded from the study. It would be important to examine both sexually active and non-sexually active women, as it is possible that sexually inactive women may be inactive due to difficulties with sexual dysfunctions. In conclusion, sexual dysfunction can affect an individual's engagement in sexual activity and sexual assault experiences affect an individual's mental and sexual health.

A recent study by Lemieux and Byers (2008) examined the relationship between childhood sexual assault and sexual functioning among a sample of 272 female students. The researchers were investigating the relationship between sexual assault histories, positive and negative sexual functioning and types of sexual appraisal. Sexual appraisal was divided into appraisal of sexual self such as sexual self-schemas and sexual self-esteem, and appraisal of sexual experiences such as sexual satisfaction, and perceptions of sexual rewards and costs. Sexual rewards are defined as pleasurable and gratifying experiences with a sexual partner. Sexual costs are defined as negative sexual experiences such as feeling embarrassed, experiencing pain and anxiety.

In Lemieux and Byers' (2008) sample of 270 female college students, 35% of participants reported a history of CSA. Participants were placed in one of three groups based on their CSA experiences: no CSA experiences (NO CSA group), CSA involving sexual touching only (CSA fondling group), and CSA involving attempted or completed vaginal/oral/anal sexual penetration (CSA penetration group). Results in the sexual functioning category indicated that the CSA penetration group demonstrated higher levels of sexual withdrawal and fewer sexual rewards. Within the sexual appraisal category individuals in the CSA penetration group demonstrated significantly lower sexual-self esteem when compared to the CSA fondling group and the NO CSA group. Surprisingly the results revealed that the CSA penetration group had more positive sexual self-schemas when compared to CSA fondling group. In order to determine sexual revictimization two additional groups were created: adult sexual victimization (ASV) and NO ASV group. Participants in the CSA penetration group were more likely to report sexual victimization as an adult compared to NO CSA group and CSA fondling group. The ASV group was more likely to report high levels of sexual problems, lower sexual rewards and a higher number of sexual costs.

In addition, the ASV group had lower sexual self-esteem when compared to no ASV group. Furthermore, CSA and ASV indicated more sexual problems, lower sexual rewards, higher sexual costs, lower sexual self-esteem, and lower sexual satisfaction than the non-CSA, and no ASV groups. The results demonstrated that individuals in the ASV and CSA penetration groups indicated

lower levels of sexual functioning when compared to the no CSA, NO ASV, and CSA fondling groups. The researchers examined the relationship between child sexual abuse (no CSA group and CSA penetration group) and six sexual functioning outcomes variables (e.g. ASV, casual sex, sexual withdrawal, level of sexual costs, number of sexual rewards and number of sexual costs) when mediated by self-esteem. It was concluded that sexual-self-esteem significantly mediated the relationship between CSA and ASV, casual sex, sexual withdrawal, level of sexual costs, number of sexual rewards and number of sexual costs (Lemieux & Byers, 2008). A limitation of the study was that women who reported multiple types of childhood abuse (e.g., sexual and physical abuse) were not distinguished from participants that reported only one specific form of abuse (e.g., only sexual abuse). As a result, participants who experienced multiple types of childhood abuse may have specific sexual functioning outcomes different from those who experienced only one type of childhood abuse. Separating multiple and specific types of childhood abuse would allow researchers to examine the association of specific forms of abuse on sexual functioning.

The studies reviewed suggest that women with a history of CSA experience a variety of sexual problems (Leonard et al., 2008). The greater severity of sexual assault has been associated to difficulty achieving orgasm, a lack of sexual desire, fewer sexual rewards and lower sexual self-esteem (Lemieux & Byers, 2008; Turchik & Hassija, 2014). In addition, sexual

victimization has been previously associated to higher levels of sexual withdrawal, sexual problems, and sexual costs (Lemieux & Byers, 2008). Participants who experienced ASA, reported difficulties with sexual desire, lubrication, and orgasm and ASA was positively associated with dissociation, anxiety, depression, sexual abuse trauma index and sleep disturbance (Kelley & Gidycz, 2017). Moreover, several studies have found an association between sexual victimization, relationship satisfaction, and sexual satisfaction.

Sexual Satisfaction

Closely related to sexual dysfunction is sexual satisfaction. Sexual satisfaction refers to an individual's positive evaluation of their sexual relationship, relating to sexual needs being met, and fulfilling individual and partner's expectations (Offman & Matheson, 2005). Sexual satisfaction has also been associated with sexual assault (Rellini & Meston, 2011). Orlando and Koss (1983) conducted a study on 99 female participants to determine the relationship of sexual assault severity on post-assault satisfaction. Participants were placed in one of three levels of sexual victimization, low (non-victimized and verbal coercion), moderate (attempted rape), high (rape and rape but the individual did not consider themselves a rape victim). Participants in the victimized groups were given questionnaires assessing engagement in 23 sexual activities that occurred the month before, the month after, and three months after victimization. The results showed that individuals in the non-victimized group indicated higher levels of sexual satisfaction. In addition, the results demonstrated a significant

decrease in sexual satisfaction during the month after victimization. However, at three months post-victimization, there was a significant return to original levels of sexual satisfaction. Overall, the results show that moderate and high levels of victimization were associated with lower levels of sexual satisfaction. The study was limited by the exclusion of participants who reported no sexual intercourse prior to sexual victimization, which may have influenced the researchers' ability to detect a relationship between sexual victimization and sexual satisfaction. In conclusion, the severity of victimization is associated with levels of sexual satisfaction in sexual assault survivors (Orlando & Koss, 1983).

Feldman-Summers, Gordon, and Meagher (1979) examined the relationship of rape on sexual satisfaction. After an extensive screening process, the study included 15 female rape victims and 15 female control participants. Participants were asked to complete a current sexual behavior questionnaire and a sexual satisfaction questionnaire. The non-victimized group only completed the current satisfaction section compared to the victimized group, which completed current, a two-week and two months post-rape. For the victimized group, results revealed that sexual satisfaction two weeks post-rape was less than prior rape levels. In addition, results showed that sexual satisfaction increased two months post-rape, however, sexual satisfaction levels remained lower than prior rape levels. Furthermore, the victimized group indicated significantly less satisfaction with current sexual satisfaction than the non-victimized group (Feldman-Summers et al., 1979). One limitation of the study was that sexual revictimization

was not examined within the participants. In conclusion, the highest level of victimization (rape) can have an enduring influence a survivor's sexual satisfaction.

Cohen and Byers (2015) examined the relationship between external stressors (child sexual abuse and adult sexual victimization) and protective factors (relationship satisfaction) among a sample of 569 women in a same-sex relationship of at least 12 months. Participants were asked to complete several measurements to examine child sexual abuse, adult sexual victimization, relationship satisfaction, sexual satisfaction and sexual functioning (sexual esteem, sexual anxiety, sexual desire, and sexual activities). In the study, 58% of participants reported exposure to sexual victimization, with 21% endorsing child sexual abuse and 37% endorsing adult sexual victimization. Results demonstrated that participants reporting greater relationship satisfaction also cited having improved sexual functioning. In addition, participants who reported high levels of sexual functioning indicated higher sexual satisfaction, higher sexual esteem, less anxiety, fewer negative automatic thoughts and higher frequency of both nongenital and genital sexual activity. The results revealed that sexual satisfaction was the largest contributor to sexual functioning. Thus, relationship satisfaction is associated with sexual functioning variables like sexual satisfaction, sexual esteem, sexual anxiety, sexual desire, and sexual activities. Cohen and Byers (2015) concluded that there is an association between the relationship quality and sexual satisfaction in lesbian couples.

Moreover, low or high levels of sexual functioning can predict low or high levels of sexual satisfaction. A limitation of the study was that the participants who failed to or were uncomfortable with disclosing their sexual identity were underrepresented in the results. These individuals could have demonstrated more negative attitude towards their sexuality and lower relationships satisfaction. In conclusion, this study found that the current quality of an individual's relationship was associated with reduced sexual dysfunction and sexual dissatisfaction in childhood sexual abuse and adult sexual assault survivors (Cohen & Byers, 2015).

Crump and Byers (2017) conducted a study examining the sexual well-being of sexual minority (i.e., lesbian, bisexual, and queer/unlabeled/unsure) women who reported childhood sexual abuse and/or adolescent/adult sexual victimization. The study consisted of 299 minority women in a non-cohabiting dating relationship. Participants were placed into groups based on their report of sexual abuse: No sexual abuse, adolescent and adult sexual victimization, childhood sexual abuse involving fondling, and childhood sexual abuse involving penetration. The results showed that minority women who reported childhood sexual abuse that involved fondling and penetration were more likely to report adult sexual victimization. Furthermore, minority women who reported childhood sexual abuse involving penetration reported significantly lower sexual desire and sexual satisfaction as well as an increase in negative automatic thoughts. There were no significant differences between the adolescent/adult sexual victimization

group and no sexual abuse group on sexual well-being variables. Lastly, there was no significant difference between groups on sexual esteem or sexual anxiety. In conclusion, the severity of the childhood sexual abuse was significantly associated with the survivor's sexual satisfaction. The results revealed a similar relationship between sexual victimization and sexual satisfaction among minority women compared to other studies. For example, Cohen and Byers (2015) found an association between relationship quality and sexual satisfaction in lesbian couples. A limitation of this study was that participants in the adolescent and adult sexual victimization group did not distinguish the specific forms of abuse they experienced. As a result, there was no comparison of sexual satisfaction among sexual victimization severity within the adolescent and adult sexual victimization group (Crump & Byers, 2017).

DiMauro, Renshaw, and Blais (2018) conducted a study to determine the association between sexual and non-sexual trauma on sexual satisfaction, sexual function, and mental health within female veterans. Participants were asked to complete self-reports regarding their sexual health and mental health. The study consisted of 255 female veterans who reported sexual assault and non-sexual trauma. A total of 153 participants reported sexual assault. The results demonstrated that sexual assault trauma was significantly associated with lower sexual satisfaction, greater PTSD and depression symptoms. In addition, sexual trauma and non-sexual trauma were significantly associated with sexual satisfaction. Results revealed that trauma type moderated the association

between sexual functioning and suicidality. A limitation of this study was that participants within the sexual trauma did not distinguish the specific forms of sexual assault they experienced. As a result, there was no comparison of sexual satisfaction among sexual victimization severity within the sexual trauma group.

One study reviewed indicated that sexual satisfaction levels were lower during the month after victimization. In addition, moderate and high levels of victimization were associated with lower levels of sexual satisfaction (Rellini & Meston, 2011). Sexual assault survivors are more likely to indicate significantly less satisfaction with their current sexual experiences (Feldman-Summers et al., 1979). Moreover, the level of relationship satisfaction was associated with sexual functioning, sexual esteem, sexual anxiety, and sexual desire. As a result, sexual functioning may be associated with sexual satisfaction (Cohen & Byers, 2015). Sexual assault survivors who reported childhood sexual abuse involving penetration were more likely to indicate significantly lower sexual satisfaction and an increase in negative automatic thoughts. Accordingly, sexual dissatisfaction is a frequent outcome following exposure to sexual assault, which requires further exploration, particularly in terms of factors that may contribute to this association, such as sexual self-schema.

Sexual Self-Schema

One factor that may play a role in a sexual assault survivors' likelihood of developing sexual difficulties following victimization are sexual self-schemas. Sexual self-schemas are defined as an individual's cognitive generalizations that

are perceived to be essential aspects of their sexual self. The cognitive generalizations are theorized to develop from early sexual experiences and are expressed in current sexual behaviors through sexually relevant social information. For example, a previous sexual experience that resulted in embarrassment may lead the individual to believe "I am sexually inadequate"(Andersen & Cyranowski, 1994). An individual's thoughts related to their sexual self are influenced by their observation, experiences, and discovery of their sexual behaviors, emotions, attitudes, and beliefs. In addition, women make inferences about their sexuality based on interpersonal relations.

The schematic representation of sexuality provides individuals with judgments, decisions, inferences, predictions, and behaviors about their current and future sexual self (Andersen & Cyranowski, 1994). Women can experience either positive or negative sexual self-schemas. The sexual self-schema scale (Andersen & Cyranowski, 1994) is comprised of two positive categories romantic/passionate and open/direct and one negative category embarrassment/conservatism. Positive sexual self-schemas can lead individuals to experience positive emotions and behaviors in intimate relationships. Examples of positive sexual self-schemas are loving, romantic, kind, good-natured and sympathetic. For example, positive self-schemas may lead to an increase of passionate-romantic emotions and behavioral openness to sexual experiences. Important components of positive sexual self-schema are romantic, warm, and open. Individuals with positive sexual self-schemas report higher

levels of arousability. In contrast, negative sexual self-schemas can lead individuals to experience negative emotions and behaviors in intimate relationships. Examples of negative sexual self-schemas are unromantic, cautious, uninhibited, irresponsible and broad-minded. An individual with negative self-schemas reported higher levels of embarrassment or conservatism about sexual experiences. In addition, negative self-schemas may lead individuals to describe themselves as unromantic, self-conscious and not confident in a sexual context. Sexual self-schemas can change as a result of a sexual assault because an individual generalizes the negative emotions towards future sexual experiences. Negative attitudes and values about sexual matters can lead individuals to base their self-views on the thoughts of others (Andersen & Cyranowski, 1994).

Andersen and Cyranowski (1994) conducted a study to provide support for their construct of the sexual schema scale. The study consisted of 400 women completing several measurements to examine several schema hypotheses. In order to examine sexual schema generalization about sexual self, participants were asked to complete the sexual arousability index (SAI), sexual opinion survey (SOS), sociosexual orientation inventory (SOI), and global sexuality rating scales. Positive sexual self-schemas were positively associated with SAI, SOS, SOI and global sexuality ratings. Thus, participants with positive sexual self-schemas stated that they were more likely to become sexually aroused than women with a negative sexual self-schema. Participants with a positive sexual

schema indicated that they experienced sexual arousal in appropriate sexual events, were willing to engage in uncommitted sexual relationships and viewed themselves as more sexual (Andersen & Cyranowski, 1994).

Furthermore, Anderson and Cyranowski (1994) examined the relationship between sexual and romantic experiences to determine how sexual schemas are developed from past experiences. The results showed that positive sexual self-schema were significantly associated with having more sexual experiences, greater number of lifetime partners, and a higher frequency of sexual encounters when compared to participants with negative sexual schemas. Lastly, participants completed a current sexual experience scale to determine the influence of sexual self-schemas between two levels of relationship status such as women currently sexually involved and women currently not sexually involved. Results demonstrated that SAI scores among participants with positive schema were consistent and high between both relationship statuses. On the other hand, SAI scores among participants with negative schema were inconsistent and lower between both relationship statuses compared to positive schema. Overall, the results demonstrated that sexual schemas are a generalization about an individual's sexual self, are influenced by past sexual experiences and are expressed in current sexual experiences (Andersen & Cyranowski, 1994). A limitation of this study was that sexual schema only examined intrapersonal and interpersonal aspects of sexuality, and did not take into account the role of sexual victimization. In conclusion, important implications of sexual schemas can

help understand the relationship between sexual functioning and sexual satisfaction.

Additional research has found that women with a history of sexual abuse express greater negative sexual schemas (Meston, Rellini & Heiman, 2006). In a study, 48 females with CSA and 71 control participants were asked to complete the sexual self-schema scale, measures of depressive and anxiety symptoms, the Brief Sexual Functioning Questionnaire (BSFQ; Taylor, Rosen, & Leiblum, 1994) and the Sexual Abuse Questionnaire (Carlin & Ward, 1992). Results demonstrated that CSA was significantly associated with the romantic/passionate schema independently from other factors. As a result, the CSA group showed significantly lower scores in the romantic/passionate schema. When the researchers added depression and anxiety symptom severity to the model, the prediction of romantic/passionate schema increased from 6% to 18%. Thus, when looking at depression and the romantic/passionate schema independently the results demonstrated a moderate inverse relationship. Lastly, results showed that CSA group scored significantly higher on depression, anxiety, and negative sexual affect during sexual activities. A limitation of this study was that prior to participating, the participants were aware that the purpose of the study was to examine potential relations between CSA and adult sexuality, which may have lead to a self-selection bias. As a result, participants may have been motivated to participate in the study if they had been severely negatively affected by their childhood sexual abuse and wished to disclosure their distress. This study

provides a compelling case for links between sexual assault and negative sexual schemas (Meston et al., 2006).

Alternatively, sexual self-schemas have been studied to understand the relationship between sexual behaviors and sexual assault. Niehaus, Jackson, and Davies (2010) conducted a study to determine the reliability of a new sexual self-schemas factor (immoral/irresponsible). The results demonstrated that the modified sexual self-schema scale demonstrated good internal consistency and reliability. In Niehaus et al.'s (2010), second study the new sexual self-schemas factor was included. In the study, participants' sexual self-schemas were used to evaluate their engagement in sexual behaviors and possible risk of sexual assault in adolescence. The results demonstrated a significant difference among participants with and without CSA history within the sexual self-schemas. CSA survivors demonstrated more openness and immoral/irresponsible sexual self-cognitions than individuals with no CSA history. However, CSA survivors reported less embarrassment and less passionate/romantic sexual self-cognitions than those without CSA history. Severity of CSA was significantly associated with all sexual self-schemas factors such as immoral/irresponsible (e.g., individuals view their sexuality as immoral, irresponsible and bad), open/direct (e.g. individuals are open, direct, revealing and straightforward regarding their sexuality), passionate/romantic (e.g., individuals express less love and passion) and embarrassed/conservative (e.g., individuals are less cautious and self-consciousness) factors. In addition, CSA survivors significantly endorse

higher levels immoral/irresponsible factor, endorse higher levels of open/direct factors, and endorse passionate/romantic and embarrassed/conservative factors significantly less when compared to the control group. Furthermore, CSA survivors demonstrated less embarrassment and passionate/romantic sexual self-cognitions. In addition, the results indicated that CSA severity was significantly associated with the number of consensual sexual partners. Further results demonstrated that the addition of the immoral/irresponsible factors increased the variance of consensual sexual partners from 10.6% to 19.7% among CSA survivors. Results demonstrated that CSA survivors were less likely to avoid sexual situations and were more likely to consume alcohol than participants with no sexual assault history. Lastly, the results indicated that risky sexual behaviors (e.g., consensual sexual partners and alcohol consumption) contributed significantly to adolescent sexual assault experiences (Niehaus et al., 2010). In fact, CSA severity, risky sexual behaviors, and sexual self-schemas simultaneously accounted for 53% variance in adolescent sexual assault experiences. Lastly, CSA survivors were more likely to engage in sexual situations than participants with no sexual assault history. A limitation of this study is that only childhood sexual abuse survivors were included in the study. Examining childhood sexual abuse survivors, and adult sexual abuse survivors would demonstrate the association of sexual assault on sexual self-schemas. In conclusion, sexual self-schemas play an important role in examining the

relationship between childhood sexual assault and the heightened risk of adolescent sexual assault.

Research suggests that sexual self-schema plays a role in sexual functioning and sexual satisfaction among sexual assault survivors (Rellini & Meston, 2011). The study sample consisted of 48 women with a history of childhood sexual abuse (CSA) and 48 women with no history of abuse (NSA). In the study, participants completed a sexual psychophysiological assessment to measure sexual arousal response towards sexual stimuli. In addition, participants completed a variety of questionnaires to identify their effective responses prior to sexual stimuli, sexual arousal function, sexual satisfaction, sexual self-schema, and child sexual abuse. Results demonstrated that participants in the CSA group reported significantly less arousal, less satisfaction, and negative affect prior to sexual stimuli. In addition, the results demonstrated that when examining the mediation of negative affect in the relationship between schemas and sexual functioning the relationship between embarrassed/conservative and satisfaction was fully mediated. Thus, higher levels of embarrassed/conservative were associated with higher levels of negative affect and lower sexual satisfaction. In conclusion, sexual self-schemas were associated with an individual's level of sexual satisfaction. In contrast, higher levels of romantic/passionate were associated with lower negative affect and higher levels of sexual satisfaction. Lastly, the results demonstrated that the CSA group was within one SD from a clinical sample of females with sexual arousal dysfunction. A limitation of the

study was that sexual revictimization was not separately examined within the participants. Women with a history of childhood sexual abuse are more likely to experience revictimization of sexual abuse. As a result, the association of sexual revictimization can affect the severity of sexual self-schema, and sexual dysfunction (Rellini & Meston, 2011).

The studies discussed have indicated that sexual schemas are influenced by past sexual experiences and are expressed in current sexual experiences (Andersen & Cyranowski, 1994). Sexual assault survivors are more likely to report significantly lower scores in the romantic/passionate schema (Meston et al., 2006; Niehaus et al., 2010). Furthermore, sexual assault survivors reported more openness and immoral/irresponsible sexual and fewer embarrassment self-cognitions (Niehaus et al., 2010). Thus, sexual assault history is associated with an individual's positive and negative sexual self-schemas.

The Present Study

The proposed study was an attempt to delineate potential variables through which sexual assault may be associated with the quality of the survivor's sexual health and satisfaction. Specifically, the proposed study attempted to expand on previous research by examining the relationship between sexual victimization, sexual satisfaction, and sexual functioning and examined the mediational influence of sexual self-schemas. Previous research indicated that sexual self-schemas is associated with an individual's level of sexual satisfaction (Rellini & Meston, 2011). In addition, research indicated that sexual

revictimization is related to the severity of sexual self-schema, and sexual dysfunction (Rellini & Meston, 2011). Previous studies have neglected to examine the role of sexual self-schemas in the association between sexual victimization severity (i.e., sexual revictimization, childhood sexual victimization, and adult childhood sexual victimization) and sexual satisfaction and sexual functioning. In addition, some studies failed to examine whether or not participants were currently sexually active or whether they were in a relationship. The proposed study examined the relationship of sexual self-schemas on sexual victimization, sexual satisfaction, and sexual functioning on both sexually active and non-sexually active women. Lastly, separating multiple and specific types of sexual assault would allow to examine the association of specific forms of abuse on sexual functioning, sexual self-schemas and sexual satisfaction. Conducting a study examining the role of sexual self-schema may help to further understand the relationship between sexual victimization severity and sexual satisfaction, and sexual functioning.

Purpose

The purpose of the current study was to examine the role of sexual self-schema in the relationship between sexual victimization severity and two dependent variables, sexual functioning and sexual satisfaction. Specifically, we aimed to determine if sexual victimization severity would influence sexual self-schemas, which in turn, influence sexual functioning and sexual satisfaction.

Hypotheses

Our hypotheses were as follows:

- 1) Sexual victimization severity would be negatively associated with sexual satisfaction.
- 2) Severity of sexual victimization would be negatively associated with sexual functioning.
- 3) We hypothesized a sequential mediational model in which sexual self-schema followed by depression and PTSD mediated the relationship between sexual victimization severity and sexual satisfaction.
- 4) We hypothesized a sequential mediational model in which sexual self-schema followed by depression and PTSD mediated the relationship of sexual victimization severity and sexual functioning.

CHAPTER TWO: METHODS

Participants

Our sample consisted of 73 undergraduate female students with a mean age of 25.51 (SD = 8.104) that reported a history of sexual victimization. In terms of race, 39% ($n=29$) of respondents identified as Caucasian, followed by Asian American ($n = 4$; 5.5%), American Indian or Alaskan Native ($n = 4$; 5.5%) and African-American ($n = 2$; 2.7%). In terms of ethnicity, 79.5% ($n = 58$) of the participants identified as Hispanic, while 19.2% ($n = 14$) identified as Not Hispanic and 1.4% ($n = 1$) identified as Unknown. In regard to participants' year in college, the majority of the sample were juniors 34.2% ($n = 25$) or seniors 47.5% ($n = 35$). The majority of respondents reported being in a committed relationship 45.1% ($n = 33$, 45.1%), followed by being single 26% ($n = 19$), married 16.4% ($n = 12$), living with a significant other ($n = 8$; 11%), and divorced or widowed ($n = 1$; 1.4%). The majority of participants reported a yearly income of less than \$15,000 ($n = 54$; 71.2%), followed by \$15,000-29,999 ($n = 12$; 16.4%), \$30,000-44,999 ($n = 6$; 8.2%), \$45,000-59,999 ($n = 1$; 1.4%), and \$60,000-74,999 ($n = 2$; 2.7%).

Measures

Demographic Questionnaire

Participants completed a brief demographic questionnaire that assessed their age, gender, race, ethnicity, marital status, college year, and income.

Sexual Self-Schema-Women (SSSS-W; Andersen & Cyranowski, 1994)

The SSSS-W assesses participants' perceptions about sexual aspects of oneself. The scale consists of 50 trait adjectives (e.g., generous, uninhibited, romantic, embarrassed, and, irresponsible) and asks participants to rate to what extent the term describes them on a scale from 0 (*not at all descriptive of me*) to 6 (*very much descriptive of me*). The items are subdivided into three statistically determined domains: two positive schemas (Open/Direct, and Passionate/Romantic), and one negative schema (Embarrassed/Conservative). Sexual self-schema score is calculated by subtracting the negative factor score from the sum of the two positive factors. In other words, the total score is calculated by adding passionate-romantic and open-direct factor scores and subtracting the embarrassed-conservative factor score. The inter-item correlations were Cronbach's $\alpha = 0.82$, 0.83 , and 0.68 for Romantic/ Passionate, Open/Direct and the Embarrassed/ Conservative domains (Rellini & Meston, 2011). The maximum possible score is 156, scores range from 0 to 156. The reported internal consistency is $\alpha = 0.82$ and test-retest reliability is $r = .91$ (Andersen & Cyranowski, 1994). In our sample, the SSSS-W had an alpha of .872.

Sexual Experiences Survey – Short Form (SES-SFV; Koss et al., 2007)

The SES-SFV is comprised of seven items designed to measure the severity of sexual victimization in both heterosexual and same-sex encounters. The items provide behaviorally specific descriptions of unwanted sexual acts (e.g. sexual touching, such as kissing or fondling, completed or attempted forms of sexual intercourse, anal sex, oral sex). Each item comprises behavioral descriptions of different aggressive strategies: verbal pressure, exploitation of the victim's incapacitated state (e.g. alcohol or substance intoxication), and use or threat of physical violence. Three additional questions assess the participants' age, number of sexual assault incidents, the sex of the perpetrator and if rape had occurred. The SES-SFV has displayed adequate internal consistency ($\alpha = 0.70$; Koss et al., 2007). In our sample, the SES-SFV had an alpha of .932.

Life Events Checklist for DSM-5 (LEC-5; Weathers, Blake, Schnurr, Kaloupek, Marx, & Keane, 2013)

The LEC-5 assesses exposure to seventeen potentially traumatic life events. The LEC-5 was used to assess participant's history of sexual victimization in order to determine their eligibility to participate in the present study. Participants are asked to consider their entire life when going through the list of potential traumatic life events. For example, participants are asked if any of the following events have occurred: natural disaster, transportation accident, physical assault, and sexual assault. Responses are; happened to me, witnessed it, learned about it, part of my job, not sure and doesn't apply. In the modified

version that was used in this study, participants only had the option of checking whether or not they directly experienced any of the events listed. Additional items were included to assess which event was the worst event experienced, if they experienced the event within the last five years, and if at the time of the event they experienced extreme helplessness and horror. In the current study, participants that reported experiencing “sexual assault” and/or an “other unwanted or uncomfortable sexual experience” were considered eligible for the study. The LEC-5 has been validated for test-retest reliability ($r = .82$, $p < .001$) and strong convergence ($kappa = .76$). In our sample, the LEC-5 had an alpha of .766.

Center for Epidemiologic Studies-Depression Scale (CES-D; Radloff, 1977)

Participants’ depressive symptoms within the last week were assessed with the CES-D questionnaire. Participants were asked to answer 20 questions concerning how they felt or behaved. Responses ranged on a four-point scale from 0 = *rarely or none of the time (less than 1 day)* to 3 = *most or all of the time (5-7 days)*. Total scores range from 0–60, with higher scores indicating the presence of more symptomatology. High internal consistency has been reported ranging from .85 to .90 (Radloff, 1977). In our sample, the CES-D had an alpha of .927.

Post-Traumatic Stress Disorder Checklist for DSM-5 (PCL-5; Blevins, Weathers, Davis, Witte, & Domino, 2015)

PTSD symptom severity was assessed using the Post-traumatic Stress Disorder Checklist for DSM-5, which asks individuals 20 questions that assess the degree of PTSD symptoms. Participants are asked to indicate how much they were bothered by the problems provided in the PCL-5 in the past month. The responses range from 0 (*not at all*) to 4 (*extremely*). The PCL-5 has been validated with well-established psychometric properties such as strong internal consistency ($\alpha = .94$), test-retest reliability ($r = .82$), convergent ($r_s = .74$ to $.85$) and discriminant ($r_s = .31$ to $.60$) validity (Blevins, Weathers, Davis, Witte, & Domino, 2015). In our sample, the PCL-5 had an alpha of .946.

Female Sexual Function Index (FSFI; Rosen et al., 2000)

The FSFI assesses female sexual activity, sexual intercourse, and sexual stimulation within the last four weeks. The FSFI consists of 19 items which participants are asked to rate on a 5 point Likert-type scale. The range of total scores is 1.2 to 36. A score ≤ 26.55 is classified as FSD. The individual items are summed into six subscales (desire, arousal, lubrication, orgasm, satisfaction, and pain). The score range for the six subscales are as following 1-5 for interest/desire, 0-5 for sexual arousal, 0-5 for lubrication, 0-5 for orgasm, 0 (or 1)-5 for sexual satisfaction, and 0-5 for sexual pain. The FSFI has been validated with acceptable psychometric properties such as test–retest reliability (Pearson's

$r = .79 - .86$), and internal consistency (Cronbach's $\alpha = .82 - 0.92$; Rosen et al., 2000). In our sample, the FSFI had an alpha of .954.

Sexual Satisfaction Scale-Women (SSS-W; Meston & Trapnell, 2005)

The SSS-W consists of 30-items that assess sexual satisfaction and sexual distress. Sexual satisfaction is separated in five domains: ease and comfort discussing sexual and emotional issues (communication), compatibility between partners in terms of sexual beliefs, preferences, desires, and attraction (compatibility), contentment with emotional and sexual aspects of the relationship (contentment), personal distress concerning sexual problems (personal distress), and distress regarding the influence of their sexual problems on their partners and relationships at large (relational distress). For example, participants are asked if they feel content with the way their present sex life is, their sexual difficulties are frustrating them, and they often feel something is missing from their present sex life. The responses ranged from 1 (*Strongly disagree*) to 5 (*Strongly agree*). For each domain the total score ranges from 6–30, with higher scores indicating better sexual functioning. In the present study, the full scale score of contentment, communication, compatibility, concern-relational, and concern-personal was utilized. The SSS-W scale has acceptable internal consistency (Cronbach's $\alpha \geq 0.74$) and test–retest reliability ($r = .58-.79$; Meston & Trapnell, 2005). In our sample, the SSS-W had an alpha of .943.

Procedure

The study was conducted in two phases. In the first phase, participants were pre-screened as part of a mass-testing procedure for history of sexual assault. Participants were recruited through the Department of Psychology SONA system from psychology and social science courses. Eligible participants who consented to participate in the present study were asked to complete a series of self-report questionnaires designed to assess severity of sexual victimization, sexual functioning, sexual satisfaction, and sexual self-schemas online using an online survey management tool. Then, participants completed a demographics questionnaire designed to assess age, gender, ethnicity, marital status, college year, and income. Lastly, participants completed the SSSS, SES-SFV, LEC-5, and FSFI measures. The following scales were administered in a random order to control for priming effects: SSS-W, FSFI, CESD-R, SES, PCL-5 and SSSS. At the end of the study, participants received post-study information. In exchange for their participation, students were awarded credit that could be applied towards extra credit in participating courses. All participants were treated in accordance with the Ethical Principles of Psychologist and Code of Conducts (American Psychological Association, 2010).

Data Analysis

The present study had one independent variable (IV) and two dependent variables (DV). The IV was severity of sexual victimization. The DVs were sexual functioning and sexual satisfaction. The mediating variables were sexual self-

schemas and psychological distress (i.e., depressive and PTSD symptom severity).

IBM SPSS 24 was used to calculate bivariate correlations to evaluate our first two hypotheses. We conducted mediational analyses using PROCESS macro version 3.1 with IBM SPSS version 25 (see Hayes, 2018). Specifically, we conducted sequential mediation analyses using PROCESS model six to evaluate two sequential mediation models, with sexual schema followed by psychological distress (i.e., depressive and PTSD symptom severity) as intervening variables between participants' sexual victimization severity and sexual functioning and sexual satisfaction.

CHAPTER THREE:

RESULTS

Data cleaning and screening were conducted prior to testing the hypotheses in SPSS. A total of eight participants did not complete the survey and an additional two participants were male participants and were therefore removed from further analyses. Outliers were screened on sexual victimization severity, sexual satisfaction, and sexual functioning. For sexual victimization, sexual satisfaction and sexual functioning, no values were outside of the ± 3.3 z-score range meaning there were no extreme scores. The final sample size of our data set consisted of 73 participants ($N = 73$).

Correlational Analyses

Bivariate correlations were computed to determine associations between all variables of interest and to test Hypotheses 1 and 2. Correlations are reported in Table 2. Hypothesis 1 predicted that sexual victimization severity would be negatively associated with sexual satisfaction. Results showed a non-significant association between sexual victimization severity and sexual satisfaction, $r = -.23$, $p = .051$. Hypothesis 2 predicted that the severity of sexual victimization would negatively be associated with sexual functioning. Results revealed no significant correlation between sexual victimization severity and sexual functioning, $r = -.07$, $p = .56$.

Sequential Mediation

Sequential mediation analyses were computed to determine associations between all variables of interest and to test Hypotheses 3 and 4. Hypothesis 3 predicted that the paths between sexual self-schema, through depression and finally, PTSD served as an intervening variable between participants' sexual victimization severity and sexual satisfaction. The model summary was non-significant, $R = .35$, $R^2 = .12$, $MSE = 393.68$, $F(4, 67) = 2.32$, $p = .07$. Thus, the hypothesis was not supported. Regarding sexual satisfaction as the outcome, it was determined that PTSD, depression, sexual self-schema, and sexual victimization severity were not associated with sexual satisfaction. The mediators were non-significant; as evidenced by the total indirect effect, $b = -.02$, CI [-1.24, .93]. Further, the completely standardized indirect effect yielded a value of $b = -.002$, CI [-.06, .05]. See Figure 1 for a visual depiction and see Table 3 for additional details.

Hypothesis 4 predicted that sexual self-schema followed by depression and PTSD served as an intervening variable between participants' sexual victimization severity and sexual functioning. The model summary was non-significant, $R = .31$, $R^2 = .09$, $MSE = 67.03$, $F(4, 68) = 1.85$, $p = .13$. Thus, the hypothesis was not supported. Regarding sexual functioning as the outcome, PTSD, depression, sexual self-schema, and sexual victimization severity were not statistically significant associated with sexual functioning. The mediators were non-significant; as evidenced by the total indirect effect, $b = -.08$, CI [-.59,

.32]. Further, the standardized indirect effect yielded a value of $b = -.02$, CI [-.15, .08]. See Figure 2 for a visual deception and see Table 4 for additional details.

CHAPTER FOUR: DISCUSSION

The goal of the present study was to examine the role of sexual self-schema in the relationship between sexual victimization severity and sexual functioning and sexual satisfaction. Further, we predicted that sexual self-schemas, followed by depression and PTSD, would mediate the relationship between sexual victimization severity and sexual satisfaction and sexual functioning. This study sought to expand current research by examining sexual self-schemas as an additional psychological consequence of sexual assault.

Summary and Interpretations of Findings

Our first hypothesis, that sexual victimization severity and sexual satisfaction would be associated, was not supported. Findings showed no significant correlation between sexual victimization severity and sexual satisfaction. This was surprising, as previous research conducted by Offman and Matheson (2005) determined that sexual assault survivors that reported moderate and high levels of victimization reported lower levels of sexual satisfaction. Crump and Byers' (2017) study provided support for the association between sexual victimization severity and sexual satisfaction. Results revealed that women who reported childhood sexual abuse involving penetration reported significantly lower sexual satisfaction. Also, Rellini and Meston (2011) found an association between sexual assault and sexual satisfaction. Furthermore,

Feldman-Summers et al., (1979) found that sexual satisfaction levels two weeks post-rape were less than prior rape levels. In addition, results showed that sexual satisfaction increased two months post-rape. However, sexual satisfaction levels remained lower than prior rape levels. In other words, the studies demonstrated that sexual satisfaction levels are affected by sexual victimization severity and the time post sexual assault. In the present study, the amount of time post-victimization could influence participants' endorsement of sexual satisfaction levels. That is, it is possible that the timing (i.e., CSA vs. ASA) of experiencing sexual assault predicts sexual satisfaction. In the present study, the timing in which participants experienced SA was not evaluated, which may have limited our ability to detect significant associations between victimization and sexual satisfaction.

Our second hypothesis, that sexual victimization severity and sexual functioning would be associated was not supported. This is contrary to what several studies have found. For example, Turchick and Hassija (2014) demonstrated that individuals with higher levels of sexual victimization experienced higher levels of sexual dysfunction. Furthermore, Kelley and Gidycz (2017) found that a history of sexual abuse was positively associated with sexual pain and negatively associated with sexual desire. Additionally, Rellini and Metson (2011) and Leonard and colleagues (2008) found an association between sexual assault and sexual dysfunctions. For example, Leonard et al. found that 22.7% of participants' sexual functioning scores across five domains

were at clinical levels of sexual dysfunction. Lastly, DiMauro et al. (2018) revealed that sexual assault is negatively related to sexual satisfaction. Thus, the studies mentioned provide support for the relationship between sexual victimization severity and sexual functioning.

When looking at the sexual victimization scale, it ranges from non-sexual contact to rape. In other words, the sexual victimization scale was a categorical measure of victimization severity. Most of the participants in the study were endorsing rape in terms of SA. The larger proportion of those indicating they were raped may have limited the range of SA severity. In other words, a relationship was not detected because the range of SA severity was not represented in the study's sample. In addition to that, the scale doesn't examine the intensity of the specific type of sexual assault. For example, extreme types of rape such as multiple rapes at once or multiple perpetrators are not included in this scale. It is possible we're not detecting a relationship between sexual victimization severity and sexual satisfaction and sexual functioning because our sample did not include participants with a range of SA severity.

Our third hypothesis, tested via a sequential mediational model, in which sexual schema followed by depression and PTSD would mediate the relationship between sexual victimization severity and sexual satisfaction, was not supported. Our findings were contrary to a prior study conducted by DiMauro (2018), which revealed that sexual assault trauma was significantly associated with lower sexual satisfaction, greater PTSD symptoms, and depression. A possible

explanation of the results may be that not all symptoms of PTSD result in sexual dissatisfaction (Balis et al., 2018). In other words, specific clusters of PTSD (i.e., re-experiencing, avoidance, negative alternation in cognitions and mood) may be related to sexual satisfaction, while other clusters (e.g., hyper-arousal) may not. Within the present study, we examined severity of the full diagnosis of PTSD as opposed to specific symptom clusters.

Previous studies have also supported the link between sexual schemas and sexual victimization and satisfaction. For example, Meston et al. (2006) demonstrated that CSA survivors showed significantly lower scores in the romantic/passionate schema. Additionally, results demonstrated that women with a history of sexual abuse expressed greater negative sexual schemas. Furthermore, Meston (2011) revealed that higher levels of embarrassment/conservative sexual self-schemas were associated with lower levels of sexual satisfaction. Thus, higher levels of embarrassment/conservative and lower levels of romantic/passionate schemas were associated with levels of sexual satisfaction. Lastly, Niehaus, Jackson, and Davies (2010) revealed that CSA survivors reported more openness and immoral/irresponsible self-cognitions, and fewer embarrassment and passionate/romantic sexual self-cognitions than those without CSA history. It is possible our lack of significant findings may have been due to our use of the total score of sexual self-schema scale, which may have diminished the influence of the negative sexual self-schema (Meston et al., 2006).

Lastly, our fourth hypothesis, that predicted a sequential mediational model in which sexual self-schema followed by depression and PTSD would mediate the relationship of sexual victimization severity and sexual functioning was not supported. This was surprising, as previous research conducted by Balis, Geiser, and Cruz (2018) determined that specific PTSD clusters, such as anhedonia and dysphoria, mediated the relationship between sexual assault and sexual functioning. The present study used the full PTSD scale. As a result, the associations between specific symptom clusters of PTSD and our variables of interest were not evaluated, which may account for the discrepancy in our results within sexual functioning. Furthermore, a study conducted by Rellini and Meston (2011) determined that the history of sexual victimization severity was not a significant predictor of arousal-function. However, the study failed to examine all domains of sexual functioning. Moreover, results demonstrated that participants in the CSA group reported significantly less arousal (Rellini & Meston, 2011). The lack of mediation results in the current study suggests that the relationship between sexual victimization severity and sexual functioning may be independent of the influence of sexual self-schema, depression and PTSD. In the present study we examined the relationship between sexual victimization severity and sexual functioning, using the full scale. Thus, the specific domains of sexual functioning were not examined or reported. As a result, there could have been significant associations with specific types of dysfunction, which we were unable to examine due to a small sample size.

In conclusion, there have been several studies that have provided support for the variables of interest. However, in the current study there was no support for our hypotheses. We suspect this may have been due to a design error. Specifically, we had limited variability in our measure of sexual victimization severity, as most participants reported attempted rape or rape, which are the highest levels of victimization. This is likely because we recruited participants with a history of victimization. In addition, the current study used the full PTSD, sexual functioning and sexual satisfaction scales. As a result, the specific domains of the scales were not examined or reported, which could account for the discrepancy in results.

Implications for Theory

Although the findings from the current study revealed non-significant results, there are some implications to consider. For example, sexual-self schema and psychological distress did not mediate relationships between sexual victimization severity and sexual satisfaction and functioning. This lack of significance may indicate there are other variables to consider as potential mediators. For example, it would be important to examine the relationship between sexual victimization and PTSD specific clusters and additional psychological distress (e.g., dissociation and anxiety). Additionally, while there may be other variables to consider, it is also possible that the extreme dynamics of psychological distress and the contemplation of sexual self-schemas would

emerge as mediators. Essentially, the theoretical implication is that there may be other more pressing variables to consider for this type of relationship.

Implications for Clinical Practice

There are also implications for clinical practice to consider. In this study, we found that sexual self-schemas did not mediate the relationship between sexual victimization severity and sexual satisfaction and sexual functioning. In cognitive-behavioral therapy, clinicians typically examine the thoughts and feelings of their clients who are experiencing psychological distress resulting from SA. Perhaps there are other factors outside of sexual self-schemas that warrant exploration in terms of treatment. For example, rather than the sexual self-schemas, we could examine social support, disclosure, and security within relationships as mediators. Altogether, there may be other avenues to pursue in therapy, outside of sexual self-schemas.

Psychological distress did not mediate the relationship between sexual victimization severity and sexual satisfaction and sexual functioning. While examining psychological distress within therapy would be critical to the improvement of the client, it appears to not be involved in terms of mediation. In other words, therapy aimed at helping SA populations might benefit from examining other factors that may be influencing clients' sexual satisfaction and functioning, in addition to psychological distress. That is, perhaps clinicians could examine and integrate mental and sexual health care among individuals with a

history of sexual assault. For example, clinicians can facilitate client's development of healthy sexual and relationship boundaries.,

The findings have potential implications for efforts to improve sexual satisfaction, sexual function, sexual self-schemas, and psychological distress among sexual assault survivors. These implications apply to both clinicians and researchers. Overall, the results suggest that it is important for researchers to continue to explore the role of sexual self-schemas on sexual functioning, sexual satisfaction, and psychological distress as a way to reduce psychological distress and sexual distress, but to also consider other variables at play.

Limitations

Our sample was comprised of female undergraduate students, most with a history of SA, which may have limited our ability to detect significant relationships between sexual victimization severity and variables of interest. Potentially with a larger sample size and more power we could have detected a significant relationship. In addition, having variability within the range of sexual victimization severity may have enhanced our ability to detect relationships between sexual victimization severity and the outcome variables. Thus, future studies should include participants with and without a history of victimization to elucidate the relationship between severity of victimization and sexual satisfaction and functioning. Hence, our results may not be generalizable to other trauma populations or male SA survivors. In addition, our study relied upon self-report measures as a primary means of data collection, which is prone to participant

response bias, as well as under-or-over reporting of psychological symptoms and other variables. Despite participants having anonymity when completing the survey, some individuals may have not felt comfortable reporting their sexuality and/or sexual functioning and/or sexual satisfaction and/or sexual abuse experiences. Also, our study was cross-sectional in nature, which makes it impossible to determine causal relationships between variables.

Despite these limitations, the results of this study provided additional information regarding the role of sexual self-schema in an emerging area of research. Research examining the role of sexual self-schema is limited. As a result, additional studies should be conducted, in order to better understand the influence of sexual self-schemas on SA survivors. Future research should also include variability within sexual victimization severity. For example, studies should recruit participants with a greater range of victimization experiences (e.g., non-victims, those reporting only sexual contact, those reporting only sexual coercion). In addition, future studies could look at subscales of functioning in association with sexual victimization severity and sexual self-schema and psychological distress. Thus, it is hoped that future work will continue to investigate this important topic.

APPENDIX A:
INFORMED CONSENT

Project Title: Sexual Health Survey

INVESTIGATOR:

Christina Hassija
Department of Psychology
California State University, San Bernardino
909-537-5481
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APPROVAL STATEMENT:

This study has been approved by the Department of Psychology Institutional Review Board Sub-Committee of the California State University, San Bernardino, and a copy of the official Psychology IRB stamp of approval should appear on this consent form. The University required that you give your consent before participating in this study.

DESCRIPTION:

The purpose of our study is to investigate the impact of traumatic life events on individuals' psychological, sexual, and relational well-being. In this manner, it may be possible to identify factors that may need to be addressed in order to improve psychological, physical, and relationship functioning among adults who experience traumatic life events. Based on your responses on the SONA pre-screen, you are eligible to participate in the present study. Participation in this study will require no more than 45 minutes. You will be asked to complete surveys about stressful life experiences, emotional and sexual difficulties that you may be experiencing and personal characteristics. Please note that there is no deception in this study, and we could not make this statement if there were any deception.

RISKS AND BENEFITS:

The benefits of participation include the gratifying experience of assisting in research which might have implications for the treatment of psychological, physical, and relationship functioning. You will also receive a list of campus and community resources that may help you with emotional difficulties that you may be experiencing. Your participation will enable you to earn 1.5 units of research participation credit in a selected Psychology class at your instructor's discretion. Minimal risks are possible with your participation in this study and include the possibility of short-term emotional distress resulting from recalling and completing surveys about stressful life experiences. It is very unlikely that any psychological harm will result from participation in this study. However, if you would like to discuss any distress you have experienced, do not hesitate to contact the CSUSB Psychological Counseling Center (909 537-5040).

VOLUNTARY PARTICIPATION:

Your participation in this study is entirely voluntary. You are free to withdraw your participation at any time during the study or refuse to answer any specific questions, without penalty or withdrawal of benefits to which you are otherwise entitled.

CONFIDENTIALITY STATEMENT:

As no identifying information will be collected, your name cannot be connected with your responses and hence your data will remain completely anonymous. All information gained from this research will be kept confidential. The results from this study will be submitted for professional research presentations and/or publication to a scientific journal. When the study results are presented or published, they will be in the form of group averages as opposed to individual responses so again, your responses will not be identifiable. Results from this study will be available from Dr. Christina Hassija, after June 2019. Your anonymous data will be sent to the researcher in an electronic data file and stored for a period of 5 years on a password-protected computer in a locked office and may only be accessed by researchers associated with this project.

RIGHT TO WITHDRAW:

You are free to refuse to participate in this study or to withdraw at any time. Your decision to withdraw will not result in any penalty or loss of benefits to which you are entitled. You may withdraw your participation by simply clicking the appropriate button to exit the study. If you choose to withdraw from the study you will still receive credit for your participation. Alternatively, you may also choose to leave objectionable items or inventories blank.

QUESTIONS OR CONCERNS:

If you have any questions or concerns regarding this study, please feel free to contact the Department of Psychology IRB Subcommittee at Psych.irb@csusb.edu. You may also contact the Human Subjects office at California State University, San Bernardino (909) 537-7588 if you have any further questions or concerns about this study.

I acknowledge that I have been informed of, and understand the purpose of this study, and I freely consent to participate.

I acknowledge that I am at least 18 years of age. Please indicate your desire to participate by placing an "X" on the line below.

Participant's X
Date

APPENDIX B:
TABLES

Table 1. Demographic and other characteristics of the sample (N=73)

Variable	M(SD)	n(%)	Range
Gender			
Female		73(100%)	
Age	25.51(8.104)	73	18-56
Years of education			
Freshman		1(1.4%)	
Sophomore		12(16.4%)	
Junior		25(34.2%)	
Senior		35(47.9%)	
Marital status			
Single		19(26%)	
In a committed relationship		33(45.02%)	
Living with significant other		8(11%)	
Married		12(16.4%)	
Divorced or Widowed		1(1.4%)	
Ethnic background			
Hispanic or Latino		58(79.5%)	
Not Hispanic or Latino		14(19.2%)	
Unknown		1(1.4%)	
Racial background			
Caucasian or White		29(39.7%)	
Asian (Asian American)		4(5.5%)	
African American		2(2.7%)	
American Indian or Alaskan Native		4(5.5%)	
Other		31(42.5%)	
Income			
\$0-14,999		52(71.2%)	
\$15,000-\$29,999		12(16.4%)	
\$30,000-\$44,999		6(8.2%)	
\$45,000-\$59,999		1(1.4%)	
\$60-000-\$74,999		2(2.7%)	
Trauma history			
Sexual assault		57(78.1%)	
Other unwanted uncomfortable		2(2.7%)	

sexual experience		
-------------------	--	--

Sexual Satisfaction Scale for Women		
Contentment	19.46(6.64)	6-30
Communication	23.87(5.03)	6-30
Compatibility	21.16(6.56)	6-30
Concern-Relational	22.43(6.90)	6-30
Concern-Personal	22.04(7.23)	6-30
Full Scale Score	86.80(20.56)	6-135
Female Sexual Function Index		
Desire	3.99(1.19)	1-5
Arousal	4.04(1.71)	0-5
Lubrication	4.18(1.91)	0-5
Orgasm	4.02(1.97)	0-5
Satisfaction	4.12(1.46)	0(or 1)-5
Pain	4.30(2.03)	0-5
Full Scale Score	24.56(8.37)	1.2-36
Sexual Self-Schema-Women	45.72(13.74)	0-156
Sexual Victimization Severity	4.12(2.06)	1-6
Non-Victim	16(21.9%)	
Sexual Contact	6(8.2%)	
Attempted	3(4.1%)	
Coercion	9(12.3%)	
Attempted Rape	6(8.2%)	
Rape	33(45.2%)	
Psychological Distress		
PTSD Symptom Severity	31.60(19.40)	0-80
Depression Symptom Severity	21.71(13.20)	0-63

Table 2. Pearson correlations between sexual assault severity, sexual self-schema, measures of psychological distress, and other variables of interest ($n = 73$).

	Sexual Victimization Severity	Sexual Self- Schema	Sexual Satisfaction Scale	Female Sexual Function Index	Depression Symptoms	PTSD Symptoms
Sexual Victimization Severity						
<i>r</i>	1.00					
Sig. (2-tailed)	.					
Sexual Self-Schema						
<i>r</i>	.124	1.00				
Sig. (2-tailed)	.294	.				
Sexual Satisfaction Scale						
<i>r</i>	-.231	.197	1.00			
Sig. (2-tailed)	.051	.098	.			
Female Sexual Function Index						
<i>r</i>	-.070	.244*	.605**	1.00		
Sig. (2-tailed)	.558	.038	.000	.		
Depression Symptoms						
<i>r</i>	.245*	-.216	-.219	.68	1.00	
Sig. (2-tailed)	.036	.066	.064	.00**	.	
PTSD Symptoms						
<i>r</i>	.267*	-.022	-.086	-.11	.656**	1.00
Sig. (2-tailed)	.023	.856	.471	.33	.00	.

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

Table 3. Sequential mediation effect of sexual self-schema, depression, and PTSD in the relationship between sexual victimization severity and sexual satisfaction

Outcome variable	<i>b</i>	<i>SE</i>	95% CI		<i>df</i>	<i>t</i>	<i>F</i>	<i>R</i> ²	<i>p</i>
			Lower	Upper					
Sexual Self-Schema									
<i>Model</i>							1.02	.01	.32
<i>Constant</i>	42.44	3.71	35.03	49.85	70	11.43			.000**
<i>Sexual Victimization Severity</i>	.80	.80	-.79	2.40	70	1.00			.32
Depression									
<i>Model</i>							5.33	.13	.007*
<i>Constant</i>	24.43	5.68	13.09	35.76	69	4.30			.000**
<i>Sexual Victimization Severity</i>	1.93	.73	.4773	3.38	69	2.65			.01*
<i>Sexual Self-Schema</i>	-.24	.11	-.45	-.02	69	-2.21			.03*
PTSD									
<i>Model</i>							19.75	.46	.000**
<i>Constant</i>	.61	7.45	-14.26	15.48	68	.08			.93
<i>Sexual Victimization Severity</i>	.59	.89	-1.18	2.37	68	.66			.51
<i>Sexual Self-Schema</i>	.16	.13	-.10	.42	68	1.21			.23
<i>Depression</i>	.99	.14	.72	1.28	68	7.09			.000**
Sexual Satisfaction									
<i>Model</i>							2.32	.12	.07
<i>Constant</i>	86.48	10.16	66.19	106.76	67	8.51			.000**
<i>Sexual Victimization Severity</i>	-2.30	1.22	-4.74	.13	67	-1.89			.06
<i>Sexual Self-Schema</i>	.28	.18	-.08	.64	67	1.55			.13
<i>Depression</i>	-.29	.25	-.79	.21	67	-1.14			.26
<i>PTSD</i>	.11	.17	-.22	.44	67	.65			.52
Total Effect Model									
<i>Model</i>							3.94	.05	.051
<i>Constant</i>	96.46	5.41	85.67	107.26	70	17.82			.000**
<i>Sexual Victimization Severity</i>	-2.32	1.17	-4.65	.01	70	-1.99			.051
Indirect Effects									
	<i>Effect</i>	<i>SE</i>	95% CI						
Sexual Victimization Severity→ Sexual Self-Schema→ Sexual Satisfaction	.22	.25	-.23	.76					
	-.56	.59	-1.89	.45					

Sexual Victimization Severity→ Depression → Sexual Satisfaction				
Sexual Victimization Severity → PTSD → Sexual Satisfaction	.06	.23	-.47	.52
Sexual Victimization Severity → Sexual Self- Schema→ Depression→ Sexual Satisfaction	.06	.09	-.08	.30
Sexual Victimization Severity → Sexual Self- Schema→ PTSD→ Sexual Satisfaction	.01	.04	-.05	.10
Sexual Victimization Severity → Depression → PTSD→ Sexual Satisfaction	.21	.35	-.44	1.02
Sexual Victimization Severity → Sexual Self- Schema→ Depression→ PTSD → Sexual Satisfaction	-.02	.05	-.14	.07

Note: * $p < .05$. ** $p < .001$. $N = 73$. $b =$ unstandardized beta, $SE =$ standard error, $df =$ degrees of freedom, $CI =$ confidence interval.

Table 4. Sequential mediation effect of sexual self-schema, depression, and PTSD in the relationship between sexual victimization severity and sexual functioning

Outcome variable	<i>b</i>	<i>SE</i>	95% CI		<i>df</i>	<i>t</i>	<i>F</i>	<i>R</i> ²	<i>p</i>
			Lower	Upper					
Sexual Self-Schema									
<i>Model</i>							1.12	.02	.29
<i>Constant</i>	42.32	3.60	35.13	49.51	71	11.74			.000**
<i>Sexual Victimization Severity</i>	.83	.78	-.73	2.40	71	1.06			.29
Depression									
<i>Model</i>							4.87	.12	.01*
<i>Constant</i>	25.45	5.65	14.18	36.72	70	4.51			.000**
<i>Sexual Victimization Severity</i>	1.76	.72	.3293	3.20	70	2.45			.02*
<i>Sexual Self-Schema</i>	-.24	.11	-.46	-.02	70	-2.22			.03*
PTSD									
<i>Model</i>							19.03	.45	.000**
<i>Constant</i>	.04	7.49	-14.91	15.01	69	.01			.93
<i>Sexual Victimization Severity</i>	.86	.88	-.89	2.61	69	.98			.51
<i>Sexual Self-Schema</i>	.15	.13	-.11	.42	69	1.17			.23
<i>Depression</i>	.97	.14	.69	1.24	69	6.91			.000**
Sexual Functioning									
<i>Model</i>							1.85	.09	.13
<i>Constant</i>	22.01	4.19	13.66	30.37	68	5.26			.000**
<i>Sexual Victimization Severity</i>	-.21	.49	-1.19	.78	68	-.42			.78
<i>Sexual Self-Schema</i>	.13	.07	-.02	.28	68	1.75			.08
<i>Depression</i>	-.11	.10	-.31	.09	68	-1.08			.09
<i>PTSD</i>	-.00	.07	-.14	.13	68	-.07			.13
Total Effect Model									
<i>Model</i>							.35	.00	.56
<i>Constant</i>	25.73	2.21	21.33	30.14	71	11.64			.000**
<i>Sexual Victimization Severity</i>	-.28	.48	-1.24	.67	71	-.59			.56
<hr/>									
Indirect Effects	<i>Effect</i>	<i>SE</i>	95% CI						
			Lower	Upper					
Sexual Victimization Severity→ Sexual Self-Schema→ Sexual Functioning	.11	.11	-.10	.36					

Sexual Victimization Severity → Depression → Sexual Functioning	- .19	.25	-.75	.25
Sexual Victimization Severity → PTSD → Sexual Functioning	.00	.10	-.30	.16
Sexual Victimization Severity → Sexual Self- Schema → Depression → Sexual Functioning	.02	.04	-.04	.13
Sexual Victimization Severity → Sexual Self- Schema → PTSD → Sexual Functioning	-.00	.01	-.03	.03
Sexual Victimization Severity → Depression → PTSD → Sexual Functioning	-.01	.14	-.32	.24
Sexual Victimization Severity → Sexual Self- Schema → Depression → PTSD → Sexual Functioning	.00	.02	-.04	.05

Note: * $p < .05$. ** $p < .001$. $N = 73$. $b =$ unstandardized beta, $SE =$ standard error, $df =$ degrees of freedom, $CI =$ confidence interval.

APPENDIX C:
FIGURES

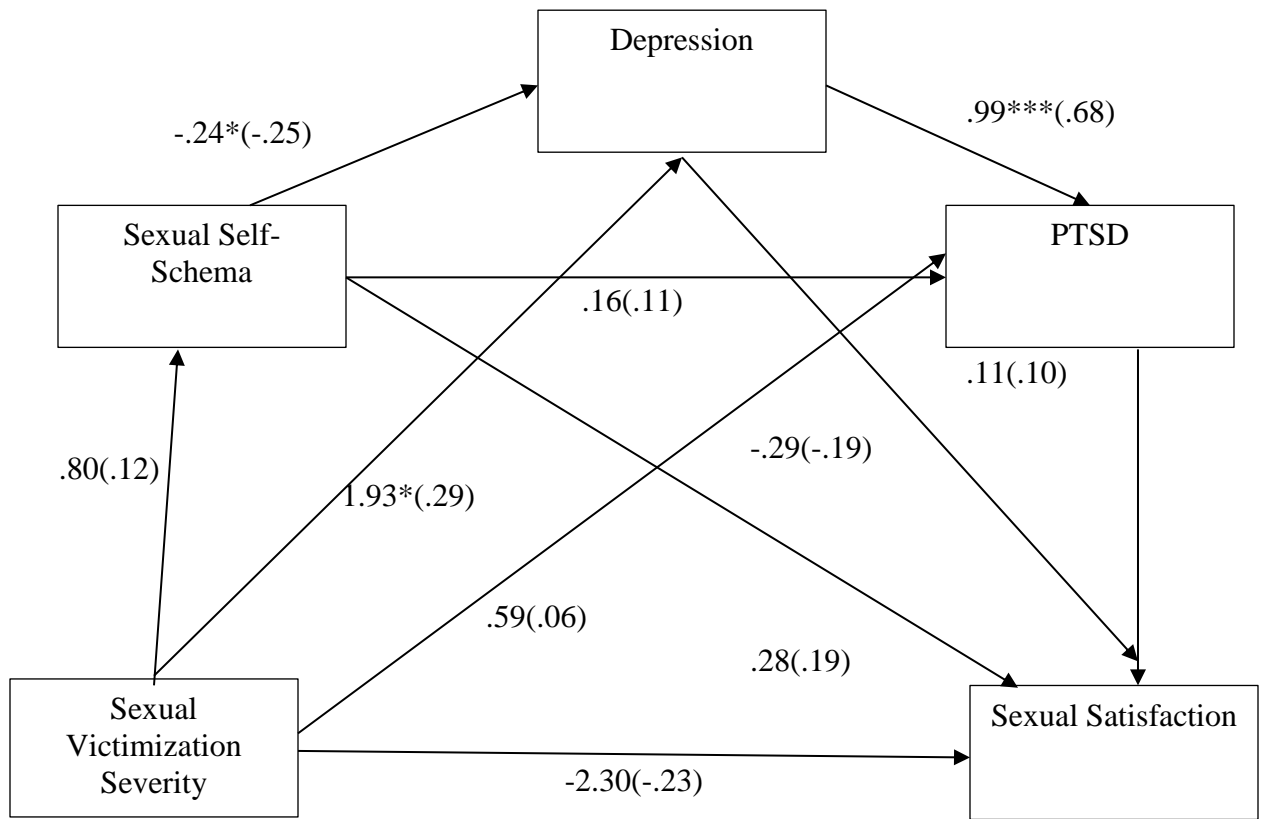


Figure 1. Sequential Path Analysis Model Demonstrated Sexual Self-Schema, Depression, and PTSD As Intervening Variables Between Sexual Victimization Severity And Sexual Satisfaction. Unstandardized effects are presents outside the parentheses with standardized effects in the parentheses. * $p < .05$. ** $p < .001$.

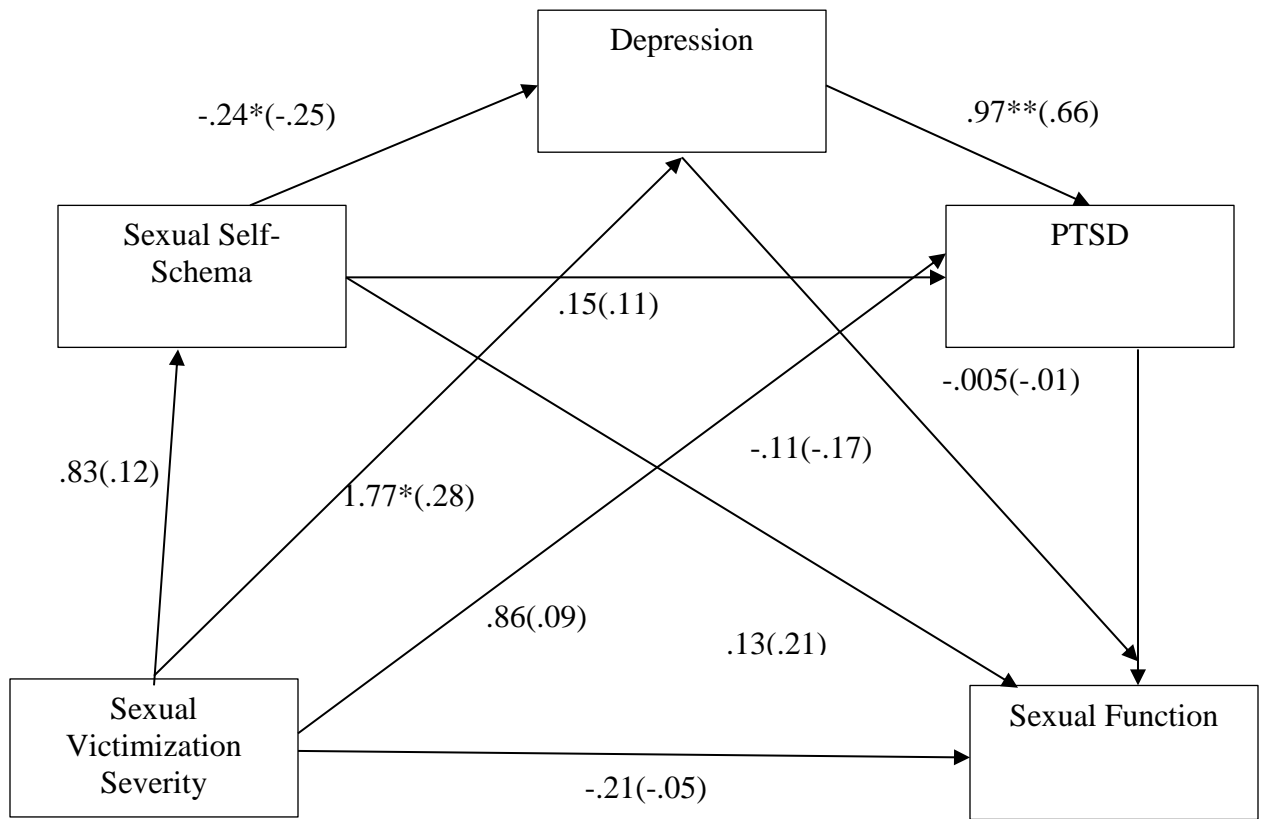


Figure 2. Sequential Path Analysis Model Demonstrated Sexual Self-Schema, Depression, and PTSD as Intervening Variables Between Sexual Victimization Severity and Sexual Functioning. Unstandardized effects are presents outside the parentheses with standardized effects in the parentheses. * $p < .05$. ** $p < .001$.

APPENDIX D:
MEASURES

Please answer each question to the best of your knowledge.

1. Age: _____
2. Gender: M F (please check only one)
3. What is your ethnic background:
 Hispanic
 Not Hispanic
 Unknown
4. What is your racial background?
Caucasian (White) _____
Asian (Asian American) _____
African American (Black) _____
American Indian or Alaskan Native _____
Native Hawaiian/other Pacific Islander _____
Other _____ (please specify) _____
5. What is your current marital status? (please choose only one)
 Single
 In a committed relationship
 Living with a significant other
 Married
 Divorced or Widowed
6. Student Yearly Income: \$0 - \$14,999 _____ \$15,000-\$29,999 _____
_____ \$30,000-\$44,999 _____ \$45,000-\$59,999 _____
_____ \$60,000-\$74,999 _____ \$75,000-\$89,999 _____
_____ \$90,000-\$99,999 _____ Over \$100,000 _____
8. Year in College: Freshman Sophomore Junior Senior

Sexual Experiences SES-SFV

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.

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: How many times in the past 12 months? 0 1 2 3+ How many times since age 14? 0 1 2 3 +

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: How many times in the past 12 months? 0 1 2 3+ How many times since age 14? 0 1 2 3 +

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.

If you are a male, check box and skip to item 4

3. If you are a male, check box and skip to item 4

A man put his penis into my vagina, or someone inserted fingers or objects without my consent by: How many times in the past 12 months? 0 1 2 3+

How many times since age 14? 0 1 2 3+

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: How many times in the past 12 months? 0 1 2 3+ How many times since age 14? 0 1 2 3+

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 didn't happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by: How many times in the past 12 months? 0 1 2 3+ How many times since age 14? 0 1 2 3+

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. If you are male, check this box and skip to item 7.

Even though it didn't happen, a man TRIED to put his penis into my vagina, or someone tried to stick in fingers or objects without my consent by: How many times in the past 12 months? 0 1 2 3+ How many times since age 14? 0 1 2 3+

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 didn't happen, a man TRIED to put his penis into my butt, or someone tried to stick in objects or fingers without my consent by: How many

times in the past 12 months? 0 1 2 3+ How many times since age 14? 0
1 2 3+

- 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. I am: Female Male My age is _____ years and _____ months.

9. Did any of the experiences described in this survey happen to you 1 or more times? Yes No

What was the sex of the person or persons who did them to you?

Female only, Male only ,Both females and males ,I reported no experiences.

10. Have you ever been raped? Yes No

Koss, M.P., Abbey, A., Campbell, R., Cook, S; Norris, J., Testa, C., Ullman, S.,

West, C., & White, J. (2007). Revising the SES: A collaborative process to improve assessment of sexual aggression and victimization. *Psychology of Women Quarterly*, 31, 357-370.

Sexual Self-Schema (SSSS)

Directions: Below is a listing of 50 adjectives. For each word, consider whether or not the term describes you. Each adjective is to be rated on a scale ranging from 0 = not at all descriptive of me to 6 = very much descriptive of me. Choose a number of each adjective to indicate how accurately the adjective describes you. There are no right or wrong answers. Please be thoughtful and honest.

Question: To what extent does the term _____ describe me?

1. generous
2. uninhibited
3. cautious
4. helpful
5. loving
6. open-minded
7. shallow
8. timid

9. frank
10. clean-cut
11. stimulating
12. unpleasant
13. experienced
14. short-tempered
15. irresponsible
16. direct
17. logical
18. broad-minded
19. kind
20. arousable
21. practical
22. self-conscious
23. dull
24. straightforward
25. casual
26. disagreeable
27. serious
28. prudent
29. humorous
30. sensible
31. embarrassed
32. outspoken
33. level-headed
34. responsible
35. romantic
36. polite
37. sympathetic
38. conservative
39. passionate
40. wise
41. inexperienced
42. stingy
43. superficial
44. warm
45. unromantic
46. good-natured
47. rude
48. revealing
49. bossy
50. feeling

Andersen, B. L., & Cyranowski, J. M. (1994). Women's sexual self-schema. *Journal Of Personality & Social Psychology*, 67(6), 1079-1100.

Life Events Checklist (LEC-5)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; © you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you. Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

1. Natural disaster (i.e., flood, hurricane, tornado, earthquake).
2. Fire or explosion.
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash).
4. Serious accident at work, home, or during a recreational activity.
5. Exposure to toxic substance (for example, dangerous chemicals, radiation).
6. Physical assault (for example, being attacked, hit, slapped, beaten up, kicked).
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb).
8. Sexual assault (rape, made to perform any type of sexual act through force or threat of harm).
9. Other unwanted or uncomfortable sexual experience.
10. Combat or exposure to a war zone (in the military or as a civilian).
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war).
12. Life threatening illness or injury.
13. Severe human suffering.
14. Sudden, violent death (for example, homicide, suicide).
15. Sudden accidental death.
16. Serious injury, harm, or death you caused to someone else.
17. Any other stressful event or experience. (Specify: _____)

a) Which was the WORST event?

b) Did this event happen within the last 5 years?

YES (1)

NO (2)

- c) Did you experience extreme fear, helplessness or horror during this event?
YES (1) NO (2)

Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., &

Keane, T.M. (2013). *The Life Events Checklist for DSM-5 (LEC-5)*.

Instrument available from the National Center for PTSD at

www.ptsd.va.gov.

Female Sexual Function Index (FSFI)

These questions ask about your sexual feelings and responses during the past 4 weeks. Please answer the following questions as honestly and clearly as possible. Your responses will be kept completely confidential. In answering these questions the following definitions apply: Sexual activity can include caressing, foreplay, masturbation, and vaginal intercourse. Sexual intercourse is defined as penile penetration (entry) of the vagina. Sexual stimulation includes situations like foreplay with a partner, self-stimulation (masturbation), or sexual fantasy. CHECK ONLY ONE BOX PER QUESTION.

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

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

- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never

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

- 5 = Very high
- 4 = High

- 3 = Moderate
- 2 = Low
- 1 = Very low or none at all

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

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

- 0 = No sexual activity
- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never

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

- 0 = No sexual activity
- 5 = Very high
- 4 = High
- 3 = Moderate
- 2 = Low
- 1 = Very low or none at all

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

- 0 = No sexual activity
- 5 = Very high confidence
- 4 = High confidence
- 3 = Moderate confidence
- 2 = Low confidence
- 1 = Very low or no confidence

6. Over the past 4 weeks, how often have

you been satisfied with your arousal (excitement) during sexual activity or intercourse?

- 0 = No sexual activity
- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never

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

- 0 = No sexual activity
- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never

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

- 0 = No sexual activity
- 1 = Extremely difficult or impossible
- 2 = Very difficult
- 3 = Difficult
- 4 = Slightly difficult
- 5 = Not difficult

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

- 0 = No sexual activity
- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never

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

- 0 = No sexual activity
- 1 = Extremely difficult or impossible
- 2 = Very difficult
- 3 = Difficult
- 4 = Slightly difficult
- 5 = Not difficult

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

- 0 = No sexual activity
- 5 = Almost always or always
- 4 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 2 = A few times (less than half the time)
- 1 = Almost never or never

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

- 0 = No sexual activity
- 1 = Extremely difficult or impossible
- 2 = Very difficult
- 3 = Difficult
- 4 = Slightly difficult
- 5 = Not difficult

13. Over the past 4 weeks, how satisfied were you with your ability to reach orgasm (climax) during sexual activity or intercourse?

- 0 = No sexual activity
- 5 = Very satisfied
- 4 = Moderately satisfied
- 3 = About equally satisfied and dissatisfied

- 2 = Moderately dissatisfied
- 1 = Very dissatisfied

14. Over the past 4 weeks, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner?

- 0 = No sexual activity
- 5 = Very satisfied
- 4 = Moderately satisfied
- 3 = About equally satisfied and dissatisfied
- 2 = Moderately dissatisfied
- 1 = Very dissatisfied

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

- 5 = Very satisfied
- 4 = Moderately satisfied
- 3 = About equally satisfied and dissatisfied
- 2 = Moderately dissatisfied
- 1 = Very dissatisfied

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

- 5 = Very satisfied
- 4 = Moderately satisfied
- 3 = About equally satisfied and dissatisfied
- 2 = Moderately dissatisfied
- 1 = Very dissatisfied

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

- 0 = Did not attempt intercourse
- 1 = Almost always or always
- 2 = Most times (more than half the time)
- 3 = Sometimes (about half the time)
- 4 = A few times (less than half the time)

5 = Almost never or never

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

0 = Did not attempt intercourse

1 = Almost always or always

2 = Most times (more than half the time)

3 = Sometimes (about half the time)

4 = A few times (less than half the time)

5 = Almost never or never

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

0 = Did not attempt intercourse

1 = Very high

2 = High

3 = Moderate

4 = Low

5 = Very low or none at all

Rosen, R., Brown, C., Heiman, J., Leiblum, S., Meston, C., Shabsigh, R., . . .

D'Agostino, R., Jr. (2000). The Female Sexual Function Index (FSFI): A multidimensional self-report instrument for the assessment of female sexual function. *Journal of Sex & Marital Therapy, 26*(2), 191-

208. doi:10.1080/009262300278597

The Sexual Satisfaction Scale for Women (SSS-W)

The SSS-W consists of a 30-item that assesses sexual satisfaction and sexual distress. The responses ranged from 1 (Strongly disagree) to 5 (Strongly agree).

Q1: I feel content with the way my present sex life is.

Q2: I often feel something is missing from my present sex life.

Q3: I often feel I don't have enough emotional closeness in my sex life.

Q4: I feel content with how often I presently have sexual intimacy (kissing, intercourse, etc.) in my life.

Q5: I don't have any important problems or concerns about sex (arousal, orgasm, frequency, compatibility, communication, etc.).

Q6: Overall, how satisfactory or unsatisfactory is your present sex life?

Q7: My partner often gets defensive when I try discussing sex.

Q8: My partner and I do not discuss sex openly enough with each other, or do not discuss sex often enough.

Q9: I usually feel completely comfortable discussing sex whenever my partner wants to.

Q10: My partner usually feels completely comfortable discussing sex whenever I want to.

Q11: I have no difficulty talking about my deepest feelings and emotions when my partner wants me to.

Q12: My partner has no difficulty talking about their deepest feelings and emotions when I want him to.

Q13: I often feel my partner isn't sensitive or aware enough about my sexual likes and desires.

Q14: I often feel that my partner and I are not sexually compatible enough.

Q15: I often feel that my partner's beliefs and attitudes about sex are too different from mine.

Q16: I sometimes think my partner and I are mismatched in needs and desires concerning sexual intimacy.

Q17: I sometimes feel that my partner and I might not be physically attracted to each other enough.

Q18: I sometimes think my partner and I are mismatched in our sexual styles and preferences.

Q19: I'm worried that my partner will become frustrated with my sexual difficulties.

Q20: I'm worried that my sexual difficulties will adversely affect my relationship.

Q21: I'm worried that my partner may have an affair because of my sexual difficulties.

Q22: I'm worried that my partner is sexually unfulfilled.

Q23: I'm worried that my partner views me as less of a woman because of my sexual difficulties.

Q24: I feel like I've disappointed my partner by having sexual difficulties.

Q25: My sexual difficulties are frustrating to me.

Q26: My sexual difficulties make me feel sexually unfulfilled.

Q27: I'm worried that my sexual difficulties might cause me to seek sexual fulfillment outside my relationship.

Q28: I'm so distressed about my sexual difficulties that it affects the way I feel about myself.

Q29: I'm so distressed about my sexual difficulties that it affects my own well-being.

Q30: My sexual difficulties annoy and anger me.

Meston, C., & Trapnell, P. (2005). Development and Validation of a Five-Factor

Sexual Satisfaction and Distress Scale for Women: The Sexual

Satisfaction Scale for Women (SSS-W). *The Journal of Sexual*

Medicine, 2(1), 66–81. <http://doi.org/10.1111/j.1743-6109.2005.20107.x>

Posttraumatic Stress Disorder Checklist-5 (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to very stressful life experiences. Think about the impact that YOUR MOST stressful life event (from the last survey) has had on you and respond to the following items as they relate to that event. Please read each one carefully and

then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit
4 = Extremely

1. Repeated, disturbing and unwanted memories of the stressful experience?
2. Repeated, disturbing dreams of the stressful experience?
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?
4. Feeling very upset when something reminded you of the stressful experience?
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
6. Avoiding memories, thoughts, or feelings related to the stressful experience?
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?
8. Trouble remembering important parts of the stressful experience?
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as : I am bad, theres is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?
10. Blaming yourself or someone else for the stressful experience or what happened after it?
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?
12. Loss of interest in activities that you used to enjoy?
13. Feeling distant or cut off from other people?
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?
15. Irritable behavior, angry outbursts, or acting aggressively?
16. Taking too much risks or doing things that could cause you harm?
17. Being "superalert" or watchful or on guard?
18. Feeling jumpy or easily startled?
19. Having difficulty concentrating?
20. Trouble falling or staying asleep?

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for *DSM-5* (PCL-5). Scale available from the National Center for PTSD at www.ptsd.va.gov.

Center for Epidemiological Studies Depression Scale (CESD-R)

INSTRUCTIONS FOR QUESTIONS: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week. Please circle the response that best describes how you have felt.

- 1 Rarely or none of the time (less than one day)
- 2 Some or a little of the time (1-2 days)
- 3 Occasionally or a moderate amount of time (3-4 days)
- 4 Most or all of the time (5-7 days)

During the past week:

- | | | | | |
|---|---|---|---|---|
| 1. I was bothered by things that don't usually bother me | 1 | 2 | 3 | 4 |
| 2. I did not feel like eating; my appetite was poor. | 1 | 2 | 3 | 4 |
| 3. I felt that I could not shake off my blues even with help from my family or friends. | 1 | 2 | 3 | 4 |
| 4. I felt that I was just as good as other people. | 1 | 2 | 3 | 4 |
| 5. I had trouble keeping my mind on what I was doing. | 1 | 2 | 3 | 4 |
| 6. I felt depressed. | 1 | 2 | 3 | 4 |
| 7. I felt that everything I did was an effort. | 1 | 2 | 3 | 4 |
| 8. I felt hopeful about the future. | 1 | 2 | 3 | 4 |
| 9. I thought my life had been a failure. | 1 | 2 | 3 | 4 |
| 10. I felt fearful. | 1 | 2 | 3 | 4 |
| 11. My sleep was restless. | 1 | 2 | 3 | 4 |
| 12. I was happy. | 1 | 2 | 3 | 4 |
| 13. I talked less than usual. | 1 | 2 | 3 | 4 |
| 14. I felt lonely. | 1 | 2 | 3 | 4 |
| 15. People were unfriendly. | 1 | 2 | 3 | 4 |
| 16. I enjoyed life. | 1 | 2 | 3 | 4 |
| 17. I had crying spells. | 1 | 2 | 3 | 4 |
| 18. I felt sad. | 1 | 2 | 3 | 4 |
| 19. I felt that people dislike me. | 1 | 2 | 3 | 4 |
| 20. I could not get "going." | 1 | 2 | 3 | 4 |

Radloff, L. S. (1977). The CES-D scale: A self report depression scale for research in the general population. *Applied Psychological Measurements*, 1, 385-401.

APPENDIX E:
DEBRIEFING INFORMATION

Post-study Information Form

Some individuals who experience stressful life events adjust fairly well, while others have more emotional difficulties. The purpose of our study is to explore sexual functioning and satisfaction among individuals exposed to varying levels of sexual victimization. The benefits of participation include the gratifying experience of assisting in research, which might have implications for the treatment of sexual and mental health issues resulting from exposure to sexual victimization.

There was no deception in this study, and we could not make this statement if there were any deception. Minimal risks are possible with your participation in this study and include the possibility of short-term emotional distress resulting from recalling and completing surveys about stressful life experiences. If you would like to discuss any distress you have experienced, do not hesitate to contact the CSUSB Psychological Counseling Center (909 537-5040).

Results from this study will be available from Dr. Christina Hassija, after June 2019. Any further questions concerning this study may be answered by Dr. Hassija at chassija@csusb.edu or 909-537-5481, or the Department of Psychology IRB Subcommittee at Psych.irb@csusb.edu. You may also contact the Human Subjects office at California State University, San Bernardino (909) 537-7588. Please do not discuss your participation in this study with other students as data collection is ongoing.

APPENDIX F:
INSTITUTIONAL REVIEW BOARD APPROVAL

10/22/2018

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2019-52

Christina Hassija
Department of Psychology
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Dr. Christina Hassija :

Your application to use human subjects, titled “The Role of Sexual Self-Schema and Psychological Distress in the Relationship between Sexual Victimization on Sexual Functioning and Satisfaction” has been reviewed and approved by the Chair of the Institutional Review Board (IRB) of California State University, San Bernardino has determined that your application meets the requirements for exemption from IRB review Federal requirements under 45 CFR 46. As the researcher under the exempt category you do not have to follow the requirements under 45 CFR 46 which requires annual renewal and documentation of written informed consent which are not required for the exempt category. However, exempt status still requires you to attain consent from participants before conducting your research as needed. Please ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.

Your IRB proposal (IRB-FY2019-52 - The Role of Sexual Self-Schema and Psychological Distress in the Relationship between Sexual Victimization on Sexual Functioning and Satisfaction) is approved. You are permitted to collect information from 101 Participants for 1.5 Sona Units from Sona. This approval is valid from 10/22/18 to 10/22/19.

The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval notice does not replace any departmental or additional approvals, which may be required.

Your responsibilities as the researcher/investigator include reporting to the IRB Committee the following three requirements highlighted below. Please note failure of the investigator to notify the IRB of the below requirements may result in disciplinary action.

- Submit a protocol modification (change) form if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before implemented in your study to ensure the risk level to participants has not increased,
- If any unanticipated/adverse events are experienced by subjects during your research, and
- Submit a study closure through the Cayuse IRB submission system when your study has ended.

The protocol modification, adverse/unanticipated event, and closure forms are located in the Cayuse IRB System. If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval identification number (listed at the top) in all correspondence.

Best of luck with your research.

Sincerely,

Donna Garcia

Donna Garcia, Ph.D., IRB Chair
CSUSB Institutional Review Board

DG/MG

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