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Sexual Assault Disclosure and Sexual Functioning: The Role of Trauma Symptomatology

Jennifer M. Staples, MS,[1] Danielle Eakins, MS,[1] Elizabeth C. Neilson, MSW, MPH,[1] William H. George, PhD,[1] Kelly Cue Davis, PhD,[2] and Jeanette Norris, PhD[3]

ABSTRACT

Introduction: Previous research has demonstrated that a history of adult sexual assault (ASA) is associated with negative outcomes, including trauma symptomatology and fear of sexual intimacy. Disclosing sexual assault might be protective against such negative outcomes.

Aim: To examine the indirect effect of trauma symptomatology on the association between disclosing ASA and current sexual functioning.

Methods: Participants included 652 women 21 to 30 years old with a history of ASA recruited from the community. Participants completed self-report measurements on a computer.

Main Outcome Measures: Separate models were performed, with sexual functioning divided into sexual desire, orgasm, and pain during sex.

Results: ASA disclosure was indirectly associated with sexual orgasm and pain during sex by trauma symptomatology. However, there was no indirect effect of trauma symptomatology on the relation between ASA disclosure and sexual desire.

Conclusion: Disclosing experiences of ASA could serve a protective function by lessening trauma symptomatology, thereby mitigating impacts on aspects of sexual functioning, such as orgasm and pain.

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Key Words: Sexual Assault; Sexual Assault Disclosure; Sexual Functioning; Trauma; Women

INTRODUCTION

Adult sexual assault (ASA)—any unwanted or nonconsensual sexual experience occurring after 14 years of age—is a significant public health issue, with numerous studies suggesting 13% to 45% of women will experience ASA during their lifetime.[1–4] Research has consistently shown an association between ASA and subsequent sexual difficulties.[5,6] At least 65% of women disclose their sexual assault experiences to friends, family, or health care providers,[7] and it remains unclear whether disclosure is associated with positive or negative health outcomes. There has been sparse research on whether disclosure of sexual assault is associated with sexual functioning. Furthermore, evidence has indicated that post-traumatic stress disorder (PTSD) symptoms, according to *Diagnostic and Statistical Manual of Mental Disorders* criteria, are negatively related to sexual functioning.[8] To our knowledge, no study has investigated the intersection of ASA disclosure, trauma symptomatology, and sexual functioning. In this study, we investigated associations between ASA disclosure and sexual functioning in women with a history of ASA, including indirect associations by trauma symptomatology.

Research has indicated that women with a history of ASA are more likely than women without ASA to experience sexual arousal and desire problems, anorgasmia, and pain during sex.[9,10] Becker et al[10] found that 59% of the ASA survivors in their sample reported having at least one sexual problem compared with only 17.2% of the non-assaulted women. Furthermore, sexual difficulties after ASA are enduring. In a prospective study of ASA survivors who were women, 61% experienced some disruption of sexual functioning immediately after the assault and up to 20% reported having sexual problems at 1-year follow-up.[11] Another longitudinal study with ASA survivors interviewed 4 to 6 years after the assault found that most women reported

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[1]Department of Psychology, University of Washington, Seattle, WA, USA;

[2]School of Social Work, University of Washington, Seattle, WA, USA;

[3]Alcohol and Drug Abuse Institute, University of Washington, Seattle, WA, USA

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that their sexual functioning took years to return to normal or that they still had not recovered sexually.[12]

Relation Among Sexual Assault, PTSD, and Sexual Functioning

Empirical evidence has supported an association between ASA and PTSD symptoms.[3,13–15] In a nationally representative sample, ASA was associated with all 10 subscales of the Trauma Symptom Inventory,[3] including anxious arousal, intrusive experiences, dissociation, and impaired self-reference, despite an average of 14 years having passed since the assault. Another study found that some women with an ASA history continued to experience post-traumatic symptoms up to 3 years after the assault,[16] suggesting that the trauma symptoms are long lasting for some individuals.

Research also has supported a negative association between trauma symptoms and sexual functioning. Sexual problems (operationalized as experiencing at least one of the following six sexual problems in their lifetime for at least 2 weeks: lack of interest in sex, fear of sex, inability to become sexually excited or aroused, inability to stay sexually excited or aroused, not able to have an orgasm, and painful vaginal intercourse) were more likely to be reported by ASA survivors who had PTSD symptoms and non-sexual trauma survivors who had PTSD symptoms than individuals without PTSD symptoms.[8] As many as 40% of ASA survivors who reported experiencing at least one of six sexual problems also had experienced post-traumatic symptomatology compared with fewer than 10% reporting no sexual problems. Furthermore, 40% of survivors who reported a sexual problem had experienced ASA compared with 15% who reported no sexual problems. Moreover, PTSD was found to contribute significantly to sexual problems after accounting for criminal victimization, completed rape, physical injury during the crime, and depression, suggesting that PTSD symptoms could play a key role in the development of sexual problems in women with a history of ASA.[8] In a study with women veterans and active duty personnel (93% of whom had experienced sexual trauma), recovering from a previous PTSD diagnosis after treatment was associated with improved sexual outcomes.[17] However, we do not know why some women with a history of ASA develop trauma symptoms and sexual disturbances and others do not.

Sexual Assault Disclosure

Disclosure is an important factor in the aftermath of sexual assault. Disclosure refers to the act of telling and/or discussing an experience of sexual assault with someone, regardless of whether it was officially reported.[18] Disclosure can involve reporting to formal sources (eg, police, campus services) and informal sources (eg, friends, family).[19] Rates of disclosure after ASA vary greatly, with as many as 66% to 92% of ASA survivors telling at least one person about their assault.[20] In general, approximately 15% of survivors disclose their assault to formal sources, such as health service providers, and approximately 65% of survivors disclose to informal sources, such as friends or family members.[7]

Anti–sexual assault movements have historically emphasized the importance of disclosure of sexual assault[21]; however, investigations of the consequences of disclosure have yielded conflicting findings. Negative reactions to an ASA disclosure, such as blaming the victim, focusing on one's own feelings rather than the victim's, and forcing the victim to go to the police, have been consistently associated with negative outcomes, including increased PTSD symptoms.[22] Interestingly, positive social reactions to sexual assault disclosure have been weakly but positively associated with more severe PTSD symptoms—operationalized as a summed score of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* PTSD criteria including re-experiencing, numbing and avoidance, and arousal symptoms; however, this could occur because survivors with more severe symptoms might seek help more often than survivors with few or no symptoms.[23] However, previous research found that positive reactions to disclosure were related to higher perceived control over recovery, which was protective against PTSD symptoms,[24] and emotionally supporting reactions were associated with increased efforts to seek support.[25] Disclosure also was found to be unrelated to short-term psychological adjustment, unless the disclosure was met with a negative reaction, in which case there was an association with poor adjustment.[18] In addition, other research found no differences in depression and PTSD diagnoses for women who disclosed vs those who did not, prompting the investigators to speculate that ASA-related trauma occurs irrespective of disclosure.[26] The large proportion of women who report ASA to an informal source points to disclosure as potentially important in post-assault functioning; however, the association between sexual assault disclosure and sexual functioning—a possible outcome of ASA—has not been investigated.

The research cited earlier consistently indicates an association between ASA and problems with sexual functioning. Although disclosure is an important focus of research, the bulk of research has focused on responses to the disclosure, with less research examining whether disclosure per se plays a pivotal role in post-ASA functioning. There also is limited research on the role of disclosure in the association between ASA and sexual functioning. The purpose of this study was to investigate how disclosing ASA is related to sexual functioning. Taken together, previous research has suggested that trauma symptoms could serve as a potential pathway from disclosure of ASA to subsequent sexual outcomes.[8,23] Therefore, we specifically investigated the indirect association between ASA disclosure and sexual functioning using trauma symptomatology.

METHODS

Participants

Participants were women 21 and 30 years old (N = 652) recruited from an urban community. Participants' average age was 24.78 years (SD = 2.66). The sample was 69.9% Caucasian (n = 456), 6.9% Black or African American (n = 45), 14.3% multiracial (n = 93), 4.9% Asian American (n = 32), 0.9%