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Amee E. Catalano  
Queer Women's Sexual Experiences  
after Sexual Violence in a Non-  
heterosexual Relationship

### **ABSTRACT**

This quantitative study explores the sexual experiences of queer women after sexual violence perpetrated by a previous intimate partner in a non-heterosexual relationship. Sixty individuals identifying as queer women with a sexual violence experience completed an anonymous online survey consisting of questions related to help-seeking behaviors and sexual distress. The Female Sexual Distress Scale-Revised (FSDS-R) (Derogatis et al., 2008) was adapted to assess levels of sexual distress amongst the sample population.

This study found three themes: 1.) current sexual experiences carry anxiety and post-traumatic stress symptoms, 2.) sexual violence experience(s) as impacting libido, desire, and behavior, and 3.) current sexual experiences as improved. This study found no significant statistical difference or correlation in overall sexual distress by help-seeking behavior; however, the data is significant for assisting social workers provide services to this population.

**QUEER WOMEN'S SEXUAL EXPERIENCES AFTER SEXUAL VIOLENCE IN A  
NON-HETEROSEXUAL RELATIONSHIP**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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Finally, a nod to my broken ankle, for quite literally forcing me to sit down and write.

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## CHAPTER I

### Introduction

This investigation is an exploration of queer women's sexual experiences after sexual violence in a non-heterosexual relationship. Women's sexuality and sexual experiences have important historical and structural contexts. Constructs of female sexuality and desire create, maintain, and reinforce specific gendered sexual scripts. This script contains a narrative for the ideal woman. Interconnected with systems of inequality (e.g. sexism, racism, heterosexism/homophobia, ableism, classism, and so on), these scripts construct binaries that determine certain categories of identity as more privileged than others. In regards to sex and sexuality, this script's narrative requires the individual to be a heterosexual and cisgender woman. This is important because heterosexuality and womanhood, when combined like this, are constructed as perfect combination for motherhood. In other words, under this script, sex and sexuality are reduced to reproduction and motherhood.

Of course, we know that sex and sexuality exists on a spectrum. We also know that there are various, interconnected reasons why individuals engage in sex that do not have to do solely with reproduction. However, the gendered sexual script constructed by dominant narratives derived from systems of inequality is only advantageous for a very narrow group of people: cisgender, heterosexual, able-bodied, white women. All of this is important to keep in mind because deviation from this specific script may result in the pathology of women's sexual experiences.

In regards to sexual violence and intimate partner violence (IPV), this discourse creates gendered assumptions surrounding relationship violence. This discourse perpetuates two major myths: 1.) Women are not capable of being perpetrators of sexual violence or IPV, and 2.)



Sexual violence and/or IPV are exclusively a heterosexual experience. These myths are harmful for individuals in the LGBTQ+ community who have experienced or are experiencing sexual violence and/or IPV.

In 2010, the National Center for Injury Prevention and Control (NCIPV) of the Center for Disease Control (CDC) conducted a National Intimate Partner and Sexual Violence Survey (NIPSVS) with a section on sexual orientation. The key findings of this survey are startling: the lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner was significantly higher for lesbian women (43.8%) and bisexual women (61.1%) when compared to heterosexual women (35.0%) (p. 2). These statistics suggest a gender-based analysis of IPV is not enough to adequately serve and meet the mental health needs of queer women.

A gender-based lens for sexual violence and IPV derives from the lived realities and clear statistics that the majority of female-identified victims identified their perpetrator as male-identified in the NIPSVS (p. 3). The mainstream domestic violence movement has dedicated decades of hard work to end sexual violence against women and girls utilizing this gender-based analysis. This gender-based analysis “reflect[s] the nature and pattern of direct patriarchal violence against women and girls, and help us address misogynistic community- and systems-based responses to it” (Pusey and Mehrotra, 2011, p. 240). However, this lens is not an easy fit for queer relationships and communities. It is important to strengthen assessments of violence “in ways that take into account the complex gender dynamics in our communities and do not rely on gender-based violence assessment shortcuts (e.g., the primary perpetrator is the more masculine person, the bigger person, etc.)” (p. 240).

Therefore, it is not enough to utilize a gender-based framework when researching sexual violence and IPV in queer communities. In order to meet the needs of queer individuals and

communities impacted by violence, an understanding of the way sexual violence and IPV is connected to multiple, interconnected systems of inequality (e.g. racism, sexism, heterosexism, homophobia, classism, and so on).

In the past decades, there has been a great deal of literature surrounding the impact of sexual violence on the sexual functioning amongst women (see: Becker et al., 1989; Feldman-Summers et al., 1979; Orlando et al., 1983; Shapiro et al., 1997; and van Berlo et al., 2000). This body of literature has relied on gendered sexual scripts as well as the historical development of psychiatry and the Diagnostic Manual of Mental Disorders (DSM). Definitions of female sexual dysfunction and understandings of female sex and sexuality within psychiatry are historically impacted. For instance, psychoanalysis “dominated discussions of female sexuality and its problems...psychopathology involved the failure to adhere to norms of gender and femininity” (Angel, 2010, p. 2). In other words, this failure to adhere to gendered sexual scripts resulted in the pathology of women’s sexual experiences, labeled as female sexual dysfunction or neurosis and social disintegration (p. 2). Furthermore, social factors (in particular, feminism and lesbianism) were “linked to clitoral sexuality,” which in turn linked the individual to failure of adhering to the above-mentioned gendered sexual scripts (p. 2).

There is an increasing body of research regarding the lived experiences of individuals in the LGBTQ+ community who have experienced sexual violence and/or IPV; however, a gap exists in the literature regarding queer women’s sexual experiences after sexual violence perpetrated by an intimate partner(s). The research questions are: Do queer women experience changes in their sexual interest and behavior after sexual assault perpetrated by a previous intimate partner? How do queer women feel about these changes? The purposes of this investigation are to 1.) Challenge myths of the perfect victim/ideal aggressor binary of sexual

violence from queer women's lived reality of sexual violence, 2.) Increase the scope of knowledge on female sexual experiences after sexual assault through the inclusion of strictly queer women, and 3.) Utilize the proposed study's findings to assist clinical social workers in meeting the mental health needs of this population.

Chapter II will review the body of literature regarding queer women's sexual experiences after sexual violence. Chapter III will report the methodology for this investigation. Chapter IV will outline the results and findings, and Chapter V engages a discussion of the literature and this investigation's findings.

## CHAPTER II

### Literature Review

The domestic violence movement has declared many victories. Decades of hard work to end sexual violence against women and girls has resulted in the establishment of the National Domestic Violence Hotline and the National Network to End Domestic Violence (NNEDV), domestic violence shelters, the Violence against Women Act (VAWA), and so much more. Without these victories, many individuals in the United States would be without resources. With this effort, however, came gendered assumptions surrounding relationship violence. This discourse perpetuates two major myths: 1.) Women are not capable of being perpetrators of sexual violence or intimate partner violence (IPV), and 2.) Sexual violence/IPV is exclusively a heterosexual experience. Both of these myths have directed previous research to conform to this perpetrator/victim standard, thereby limiting knowledge regarding the sexual experiences of queer women after sexual assault. These gendered assumptions are not enough for the complexity of queer identity and queer experience.

Queering IPV is the central theme of this chapter. The utilization of “queer” as a verb is deliberate and will be used for the rest of this chapter as a conscious tool; *to queer something* is to take a look at its foundations and question them. By queering something, its limits, biases, and boundaries can be explored. In this way, *queering IPV* is a process of critically examining existing dominant frameworks of relationship violence. Queering IPV is exploring alternative frameworks to strengthen understandings of relationship violence. By using “queer” as a verb, this chapter becomes not only about queer IPV, but also about queering existing IPV frameworks that do not serve queer identity and queer experience.

Women's sexuality and sexual experiences have important historical and structural implications for clinical social work practice regarding the mental health treatment of survivors of IPV. Constructs of female sexuality create, maintain, and reproduce a specific sexual, gendered, racialized and maternal script for women to follow. This sexual script requires the individual to be a heterosexual and cisgender woman who has sex solely for reproduction. Clinically, deviation from this script may result in the pathology of women's sexual experiences, labeled within the field as female sexual dysfunction. Socially, women who deviate or are perceived to deviate from this script are labeled as queer, a lesbian, or gay.

The following sections of this chapter will utilize a queer framework to address these important historical implications of women's sexuality and sexual violence experiences. The first section will present with a theoretical framework for queering IPV. The second section will queer psychiatry's involvement in women's sexual experiences and sexual violence experiences. Lastly, the final section will review previous research on sexual experiences after sexual violence.

### **Queering Intimate Partner Violence**

Sexual violence within queer relationships is undoubtedly a significant issue. In 2010, the National Center for Injury Prevention and Control (NCIPV) of the Center for Disease Control (CDC) conducted a National Intimate Partner and Sexual Violence Survey (NIPSVS) in regards to victimization by sexual orientation. Key findings of this survey are startling: the lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner was significantly higher for lesbian women (43.8%) and bisexual women (61.1%) when compared to heterosexual women (35.0%) (p. 2). These statistics suggest a gender-based analysis of IPV is not enough to adequately serve and meet the mental health needs of queer women.

Utilizing a gender-based analysis of intimate partner violence and sexual violence is crucially important, especially due to the pervasiveness of male violence against women and girls. According to the NIPSVS, across all types of violence reported, the majority of female-identified victims identified their perpetrator as male-identified (p. 3). Further, 3 in 10 women who reported experiencing sexual violence and/or IPV reported at least one impact on their lives related to this experience, such as: posttraumatic stress disorder (PTSD) symptoms, being fearful for safety, need for health care, need for mental health care, need for housing services, need for legal services, need for victim advocate services, and so on (p. 4). Of this statistic, 1 in 5 women reported PTSD symptoms (p. 54). It is clear by these statistics that sexual violence and IPV prevention and intervention efforts must utilize a gender-based analysis. Pusey and Mehrotra (2011) clearly articulated this importance: “Gender-based analyses of domestic violence reflect the nature and pattern of direct patriarchal violence against women and girls, and help us address misogynistic community- and systems-based responses to it” (p. 240). However, Pusey and Mehrotra assert a gender-based analysis is not an easy fit for queer relationships and communities: “We must strengthen our assessments of violence and power within relationships in ways that take into account the complex gender dynamics in our communities and do not rely on gender-based violence assessment shortcuts (e.g., the primary perpetrator is the more masculine person, the bigger person, etc.)” (p. 240). Perez-Darby (2011) asserts:

Due in part to mainstream understandings of domestic violence, we typically equate battering with privilege. We’ve seen heterosexual men utilize male privilege to batter women, and again we’ve boiled down a complex set of dynamics to a simple idea: men batter women. While the idea that batterers are people with privilege is based on a type of battering that does exist, I’ve often seen queer and trans survivors of domestic violence

struggle to reconcile this assumption with their own reality, in which the person who battered them claims one of any number of marginalized identities. Frequently we hear batterers say, “I have a disability so I can’t batter,” “I’m genderqueer so I can’t batter,” “I’m a person of color so I can’t batter.” There is no identity that inherently bars people from being batterers—virtually all of us are capable of setting up and maintaining a pattern of power and control. (p. 109).

Therefore, it is not enough to employ a gender-based framework when researching IPV and sexual violence in queer communities. In order to meet the mental health needs of queer individuals and communities affected by violence, an understanding of the way IPV and sexual violence “is connected to homophobia, biphobia, transphobia and heterosexism along with other forms of prejudice and oppression including (but not limited to) sexism, racism, and classism” is essential (Ristock, 2005, p. 3). A gender-based analysis assumes gendered roles of sexual violence, in which the male individual is the perpetrator and the female individual is the victim. When researching and working with queer individuals and communities impacted by sexual violence and IPV, it is also important “to acknowledge that some people identify their gender outside the gender binary system of male and female, therefore finding the most accurate language to describe IPV can be difficult because language itself is not neutral and reflects many assumptions that are embedded within dominant culture” (p. 4).

Gendered sexual scripts have harmed the sexual assault experiences of queer women and queer people overall. The focus of research shifted towards the experiences of queer women in the early 1990s. Walters (2011) conducted a qualitative research study to generate theoretical explanations about same-sex IPV. Walters defines lesbian survivors of IPV as “women who have experienced violence at the hands of their female intimate partners (p. 253). Using modified

grounded theory as a foundation in the research, Walters interviewed four self-identified lesbian women who were survivors of IPV with their female partners and discovered several major themes. First, Walters discovered that 100% of participants had a history of family violence, and 50% had a history of childhood sexual abuse (p. 256). Walters concluded that lesbians who have a history of family violence are more likely to experience IPV. This seems far-fetched, given the very small population size; but possibly a topic area to be researched. Secondly, gendered beliefs about violence perpetuate the myth that lesbians neither oppress nor abuse one another. This myth strengthens “the wall of denial that continues to entrap lesbians who are battered by their partners” (p. 257). Third, this very same myth reduces the severity of violence between women as a mere “catfight” (p. 258). In fact, the range of abuse the participants of experienced included: emotional abuse, verbal abuse, stalking, throwing objects, financial abuse, physical abuse, and sexual abuse. Fourth, all of these concepts create, maintain, and reinforce barriers for help from social institutions, specifically from law enforcement. All of the participants had at one point called the police for help; all of the participants received no assistance. This took form as: police not responding to the 911 calls and treating the incident(s) as a “disturbing-the-peace [situation] than domestic violence [situation]” (p. 261). Both of these instances reinforce to the perpetrator of violence that their behavior is acceptable and not categorized as abuse. Fifth, there is an overall silence and concealment about violence taking place in lesbian relationships. Walters names this as “denial at the community level” (p. 262). Domestic violence is considered to be a private matter between intimate partners, resulting in the public sphere to adopt an “it’s none of my business” attitude (p. 265). Walters asserts there is a division between “reality and societal recognition” of violence (p. 265). Finally, all of the above themes are interlinked with heterosexism and homophobia. Both are systems of oppression, which serve as barriers for



lesbians experiencing IPV. It is clear that moving beyond a gender-based framework is essential to understanding IPV within queer relationships.

Moving beyond a gendered framework, McDonald (2012) researched the social contexts of woman-to-woman IPV. Her findings were revealing, as heterosexism impacts the social contexts an individual is involved in. First, the research indicated girls who witnessed intimate partner abuse or were themselves abused as children are more likely to experience adult intimate partner abuse (p. 641). Furthermore, participants reported their relationship violence perpetrators had also been abused as children, and this knowledge made many of the survivors feel sympathy or excuse them for the violence (p. 641). Second, the research showed negative experiences of coming out as queer left many participants feeling isolated and lonely (p. 641). McDonald posited negative experiences of coming out leaves queer women vulnerable to woman-to-woman IPV, especially if their partner has been out longer and have connections within queer communities (p. 642). These findings begin to document the ways heterosexism impacts a person's social contexts and lived experiences of violence.

Queer women's lives are shaped differently by the effects of sexism, racism, classism, and homophobia. Ristock (2005) asserted the importance of acknowledging the combined effects of sexism, racism, classism, and intimate partner violence and sexual violence in the lived realities of queer individuals and communities. Therefore, applying an intersectional framework is essential in furthering understandings of queer IPV as well as meeting the mental health needs of queer individuals and communities. Intersectionality is a lens of analysis that asserts the interconnectedness of oppressive institutions (e.g. sexism, racism, homophobia and heterosexism, classism, ableism). Ristock explains:

Intersectionality is not an additive model where we simply add LGBTQ abuse to our

current understandings of domestic violence; nor is it an approach that falsely compartmentalizes experiences of abuse into separate special cases (LGBTQ abuse/women of color abuse/people with disabilities abuse) while keeping white heterosexual women's experiences as the norm and at the forefront. This framework challenges the oversimplified either/or binaries (e.g., us/them, male/female, good/bad, victim/perpetrator) with which we work. (p. 8)

Understanding queer women's sexual experiences after sexual violence requires an intersectional framework. This is because queer women's lived experiences are subjective to their social contexts and social locations.

### **Queering Sex, Queering the DSM**

Queer women's lived experiences are also subjective to historical and structural contexts of sex, sexuality, and psychiatry. In the context of this research, queer embodies more than an identity. Suzanne Iasenza (2010) describes queer in their article as: "the potential and fluidity and multidimensionality of same and other sex/gender experience in all people...[and] embodies the confounding nature of sexuality in general with its incongruities and paradoxes in sexual behaviors, attractions, thoughts, feelings, fantasies, and sensations" (p. 292). In this way, queer is much more than relating to the LGBT+ experience. Iasenza asserts that to take a queer perspective is to challenge the dominant discourse on sex, sexuality, and gender as well as embrace the fluidity of individual/collective experience. In addition to this crucial perspective, Iasenza identifies and summarizes models of sexual behavior, such as: The Kinsey Heterosexuality-Homosexuality Scale, the Klein Sexual Orientation Grid, Lev's model, and the Human Sexual Response Cycle. The distinctions and interconnections between these theoretical models of sexual behavior are important when proceeding with this study. The first four listed

were also historically the first theoretical models of sexual behavior, as developed over time. These four models have a commonality: the linear path of sexual behavior (e.g. they posit that every person's sexual experience includes the overarching goal of achieving orgasm). On the other hand, the Human Sexual Response Cycle posits that every sexual experience is not as linear as the previous models suggested. In fact, the Human Sexual Response Cycle is the only model that includes "willingness" as a starting point for a sexual experience; it also replaced the goal of achieving orgasm with "pleasure" to better embody the fluidity of sexual experience (p. 296).

Queer women's lived experiences of sex and sexuality are impacted by historical development of psychiatry and the DSM. In exploring the sexual experiences of women after sexual assault, it became clear there was specific language to describe this. One phrase that continuously came up was "female sexual dysfunction." Angel (2010) outlines how this phrase has important historical implications and has been included in the DSM since its first publication in 1952. Prior to the first edition of the DSM, psychoanalysis "dominated discussions of female sexuality and its problems, frigidity in particular...psychopathology involved the failure to adhere to norms of gender and femininity" (p. 2). The work of Sigmund Freud accounted for the development of femininity and female sexuality, in which a transfer of erotic zones from the clitoris to the vagina occurred. According to Angel, analysts interpreted Freud's account as "a crucial part of a biological imperative to reproduction, as well as heterosexuality...the failure of vaginal orgasm became the conceptual lynchpin of 'frigidity'" (p. 2). Frigidity became defined as failure to achieve vaginal orgasm. A woman desiring clitoral stimulation (as opposed to vaginal, penetrative intercourse) became labeled as a woman who behaved like a man and denied her maternal obligations; this behavior supposedly "led to neurosis, isolation, and social

disintegration” (p. 2). Furthermore, “social and psychological ills such as feminism and lesbianism were also linked to clitoral sexuality” (p. 2). This construct of female sexuality writes a specific sexual, gendered, and maternal script for women. This sexual script requires the individual be a heterosexual woman who has sex solely for reproduction. This theory does not meet the complexities of queer lived experiences. Clinically, deviation from this script results in the pathology of women’s sexual experiences, labeled within the field as female sexual dysfunction. Socially, women who deviate or are perceived to deviate from this script are labeled as queer, a lesbian, or gay.

The first edition of the DSM, released in 1952, contained the category of “sexual deviation”. According to Angel, sexual deviation, which included homosexuality, was included with personality disorders (p. 3). Frigidity was categorized under a separate category of “psychophysiological autonomic and visceral disorders”. The DSM-II, released in 1968, is similar to the original publication. In the DSM-III, released in 1980, an overarching chapter on “psychosexual disorders” was included. According to Angel, psychosexual dysfunctions were exclusively reserved for women. The DSM-III diagnostic criteria for psychosexual dysfunctions were: inhibited sexual desire, inhibited sexual excitement, inhibited orgasm, functional dyspareunia, functional vaginismus, [and] atypical psychosexual dysfunction” (p. 4). The revision of the DSM-III in 1987 changed “psychosexual dysfunctions” to “sexual dysfunctions”, including: “sexual desire disorder, sexual aversion, female sexual arousal disorder, inhibited female orgasm, dyspareunia, vaginismus, sexual dysfunction not otherwise specified” (p. 4). In the DSM-IV, this remained the same, but added “sexual dysfunction due to a general medical condition” and “substance-induced sexual dysfunction”.

The DSM-IV (published in 1994) and DSM-IV-TR (published in 2000) diagnostic criterion of female sexual dysfunctions are different than that of the more-recent DSM-V. The DSM-IV-TR female dysfunctions were changed with the development of the DSM-V. Female hypoactive desire disorder and female arousal disorder were merged into Female Sexual Interest/Arousal Disorder (FSIAD). Female Orgasmic Disorder (FOD) remained unchanged. Dyspareunia and vaginismus merged into genito-pelvic pain/penetration disorder (GPD). Sexual aversion disorder and sexual dysfunction due to a general medical condition were removed. Sexual Dysfunction NOS was replaced by other specified dysfunctions and Unspecified Sexual Dysfunction. New exclusion criteria was added to the DSM-V in 2013; specifically, the disorder should be excluded from a diagnosis if symptoms can be better explained as a consequence of severe relationship distress, such as intimate partner violence. Furthermore, a new group of criteria added to the DSM-V (associated features), which was divided into five categories: partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, and medical factors. IsHak and Tobia (2013) asserted these changes to the diagnostic criterion for sexual dysfunction disorders in the DSM-V were made in order to “increase its validity and clinical usefulness” (p. 3). The authors concluded the changes made were successful in reflecting current research in the field of sexual disorders.

The DSM-V diagnostic criteria and diagnostic features reveals much about the construct of sexual dysfunction in regards to women’s sexual experiences. The DSM-V outlines FOD diagnostic criterion as a “marked delay in, marked infrequency of, or absence of orgasm” and “markedly reduced intensity of orgasmic sensations” (American Psychiatric Association, 2013, p. 429). This criterion relies on linear constructs of sexual experience: the lack of or absence of an orgasm during sexual activity does not necessarily mean sexual dysfunction. Interestingly, the

DSM-V specifically states that a diagnosis of FOD should not be made if the person's sexual dysfunction appears to be associated with interpersonal factors, such as intimate partner violence and/or sexual assault. The DSM-V outlines FSIAD diagnostic criterion as:

Lack of, or significantly reduced, sexual interest/arousal, as manifested by at least three of the following:

1. Absent/reduced interest in sexual activity
2. Absent/reduced sexual/erotic thoughts or fantasies
3. No/reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate
4. Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all sexual encounters
5. Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g. written, verbal, visual)
6. Absent/reduced genital or nongenital sensations during sexual activity in almost all or all sexual encounters (American Psychiatric Association, 2013, p. 433).

This criterion also reflects a narrow lens of sexual experience; however, the DSM-V explicitly states that a diagnosis of FSIAD should not be made if the person's lack of sexual excitement, pleasure, interest, and/or arousal is found to be associated with interpersonal factors, such as intimate partner violence or sexual assault. While this exclusion criterion is an important addition to the DSM, the diagnostic criterion continues to rely on a linear model of sexual arousal.

Understanding the historical context of the DSM as it relates to women's sexual experiences is important because it illustrates the interconnectedness of psychiatry and female

sexuality. Barlow (1989) analyzed a variety of research studies about the causes of sexual dysfunction. It is important to notice the historical implication of this article in that it was written after the DSM-III edition was published in 1980 but before the DSM-IV was published in 1994. Barlow specifically analyzed the interconnections between anxiety and sexual functioning: “anxiety is considered to play a role in the development and maintenance of sexual dysfunctions for both men and women” (p. 141). For instance, there are a variety of studies that found anxiety as a contributing factor to the development of sexual dysfunction (Fenichel, 1945; Wolpe, 1958). Barlow most notably noted a series of research conducted by Masters and Johnson in 1970 and by Kaplan in 1974 and 1981. This research outlined performance fears, fears of inadequacy, fear of failure, the need to please partner(s), and performance demands as factors preventing an individual from experiencing sexual arousal (p. 141). On the other hand, there were a series research studies in the 1960s and 1970s, which noted high levels of anxiety were also associated with increased sexual arousal and/or activity. Barlow posited the role of anxiety and cognitive interference have a significant effect on sexual functioning, whether sexual arousal is decreased or increased. Barlow identified several factors differentiating sexually functional individuals and sexually dysfunctional individuals. For instance, sexually dysfunctioned individuals demonstrate a *negative* affect in sexual contexts, whereas sexually functional individuals demonstrate *positive* affect (p. 146). In addition, anxiety *inhibits* sexual arousal in sexually dysfunctional individuals and *facilitates* arousal in sexually functional individuals (p. 146). This review of the research (up to 1989) is significant because all of it was influenced by the development of gendered sexual scripts, as discussed earlier in this chapter. In addition, the associations found between anxiety and sexual functioning in Barlow’s research is an important factor to be considered in the discussion chapter of this investigation.

Barlow is not the first to test for associations between anxiety and sexual experiences. Nobre (2012) tested the cognitive-emotional model for determinants of sexual desire problems in women. Using quantitative design, Nobre surveyed over 300 women to assess for cognitive and emotional variables. It was unclear if the population under study was heterosexual women, queer women, or some combination. He hypothesized dysfunctional sexual beliefs operate as predisposing factors for negative automatic thoughts and emotions, which impair sexual functioning. According to Nobre's research findings, women experiencing sexual dysfunction tend to interpret unsuccessful sexual events as a sign of failure and personal incompetence (p. 361). During sexual activity, women experiencing sexual dysfunction reported significantly more thoughts about failure and disengagement, thoughts about being abused or disrespected by their partner, and lack of erotic thoughts (p. 362). These automatic thoughts were "associated with emotional responses of sadness, disillusion, guilt, and anger, as well as with a lack of pleasure and satisfaction" (p. 362). While these findings are important for sexual experiences after sexual assault in terms of cognitive experiences, this study failed to acknowledge and identify queer women. Because heterosexual women and queer women have markedly different social contexts due to experiences of heterosexism, this study's findings may or may not apply to queer women's sexual experiences after sexual violence.

More recently, Helleman et al. (2015) examined the prevalence and associations of IPV with non-heterosexuals with mental and sexual well-being. This quantitative study's population of focus was non-heterosexual individuals of any gender. In regards to mental well-being, the findings did not reveal an association between physical IPV and an individual's mental health status, but did reveal an association between psychological IPV and an individual's mental health status (p. 184). In addition, sexual victimization by an intimate partner was associated to lower



mental health scores, but only for male-identified participants (p. 184). In regards to sexual well-being, higher levels of psychological victimization “were negatively associated with sexual satisfaction and satisfaction with the frequency of sex, and positively associated with sexual dysfunctions with distress” (p. 184).

Cohen and Byers (2015) conducted research exploring the associations between minority stress risk factors and protective factors and the sexual functioning of sexual minority women. Their findings extended past research that found an association between relationship quality and sexual satisfaction. This research found regardless of past experiences of “external and internal minority stressors, women who were more relationally satisfied reported fewer negative thoughts during sexual interactions, better sexual esteem, less anxiety during sexual activity, more desire for sexual activity with their partner, and a higher frequency of both nongenital and genital sexual behaviors” (p. 397). Interestingly, the findings did not support the hypothesis negative events (such as sexual violence) are associated with decreased sexual functioning (p. 397). Therefore, negative events are not necessarily predictors of decreased sexual functioning.

Also notable is Cohen and Byers’ evidence that internalized heterosexism can affect the sexual functioning of sexual minority women. Their findings showed internalized heterosexism was associated with lower sexual esteem, higher sexual anxiety, and more frequent negative automatic thoughts (p. 399). In contrast, internalized homophobia was found to not be associated with sexual desire or frequency of sexual behavior. These findings may be significant in studying the sexual experiences of queer women after sexual violence perpetrated by a previous intimate partner because systems of prejudice and oppression (such as heterosexism) impact the experiences of intimate partner violence in queer relationships.

### **Previous Research: Sexual Experiences after Sexual Violence**

Early research about the sexual experiences of women after sexual assault only included heterosexual women who had been assaulted by heterosexual men. The research's findings should not extend to generalize about queer women's experiences because the research exclusively assumed their female participants were heterosexual or did not specify their female participants' sexualities as a relevant demographic. Regardless of this, the existing research is a valuable place to start for gathering information about queer women's sexual experiences after sexual assault as perpetrated by a previous partner in a non-heterosexual relationship.

Rosen et al. (2000) sought to assess the construct validity of female sexual dysfunction through development of the Female Sexual Function Index (FSFI) using quantitative method. It should be noted this study was conducted prior to the development and dissemination of the DSM-V, and as such utilizes the DSM-IV-TR. At the time of this study, the FSFI was utilized to assess and treat female sexual dysfunction; or, as categorized in the DSM-IV-TR, as FSAD. The population of focus was women between the ages of 21 and 69 years old. The population was divided into a control group (women without FSAD) and the study group (women with a diagnosis of FSAD). The authors assessed two kinds of test reliability: internal consistency and test-retest reliability. Comparing the FSAD group with the control group also assessed discriminant validity of the FSFI. As a result of this study, five domains of sexual function were identified: "(a) desire and subjective arousal, (b) lubrication, (c) orgasm, (d) satisfaction, and (e) pain discomfort" (p. 202). Based on these domains, the FSFI was developed as a 19-item questionnaire to offer a "brief, multidimensional self-report measurement for assessing the key dimensions of sexual function in women" (p. 204). One excellent factor about the FSFI is that

any person can use it as a self-report measure regardless of their sexual orientation. The five domains are useful in forming definitions of female sexual experience after sexual assault.

In response to this study, Meyer-Bahlburg and Dolezal (2007) offer a methodological critique and suggestions for improvement. The FSFI is a 19-item questionnaire; each item utilizes a five-point response scale (1 to 5) “denoting variations in frequency, intensity, or degree of satisfaction” (p. 218). Most, but not all, items contain a zero category. This zero category is used to denote “no sexual activity” in 12 of the items, and “did not attempt intercourse” in 3 of the items. This leaves four items without a zero category. The authors assert that this creates conceptual and statistical problems. Conceptually, the zero category is not a part of the response scales and therefore its presence on the item isn’t needed. Statistically, the authors carry three major critiques: 1) the zero category increases the item score range and item variance, 2) the zero category will bias domain scores towards the sexual dysfunction score, and 3) the zero category skews visual graphing of data collected using the FSFI. Ultimately, the authors recommend making modifications to the FSFI by: (a) treating all zero responses as missing values, (b) analyze the zero responses separately, (c) and adjust the items with more specific instructions for the participant.

Burgess and Holmstrom (1974) conducted a longitudinal study to explore effects of rape on sexual functioning of adult rape victims. This study consisted of three parts: 1.) interview at the time victims were first admitted at the hospital, 2.) short-term follow up period, and 3.) long-term follow up period 4-6 years after the rape. The population sample consisted of female adult victims whose rapes were reported to police and/or hospital staff. Independent variables for this study are as follows: sex life prior to rape, changes in frequency of sexual activity, and symptoms of sexual dysfunction. The dependent variable for this study is the length of time

required to feel recovered after the rape occurred. The results found that the majority of victims who were sexually active prior to the rape did alter the frequency of their sexual relations: 38% abandoned sexual activity, 33% reported delay in resuming sex, 19% reported no change in their sexual activity, and .09% reported an increase in sexual activity (p. 650). One limitation of this study was the inclusion of participants of all sexual orientations; it would be beneficial to conduct a study about the effects of rape on sexual functioning amongst only queer women rather than a mixture of both queer and heterosexual women. This is because of the marked differences in lived experiences.

Feldman-Summers et al. (1979) conducted a research study to explore the impact of rape on sexual satisfaction. The participants of this study were survivors of rape who had reported their assault to a rape crisis counselor. In order to be a study participant, the individual had to 1) have had sex prior to the rape, 2) had a steady sexual partner prior to the rape, and 3) had maintained the same partner for at least two months after the rape occurred (p. 101). The research population consisted of white women between the ages of 19 and 55 years old. It was unclear whether the participants were cisgender or transgender women. Feldman-Summers et al. compared these participants' data with a control group, the "nonvictimized sample." Participants completed a Current Sexual Behavior Questionnaire and Sexual Satisfaction Questionnaire. Based on their findings, the authors' conclusions formed the negative-association hypothesis. This hypothesis posits that rape has a strong negative impact on the aspects of women's sexual experiences.

Orlando and Koss (1983) conducted a quantitative research study in response to this negative-association hypothesis. The study's population sample were female survivors of rape and sexual assault from a university population. Participants completed the Women's Sexual

Experiences Survey and the Sexual Satisfaction Survey. The results suggested, “all levels of sexual victimization except verbal coercion were associated with reduced sexual satisfaction” (p. 105-106). The authors assert the results do not support the negative-association hypothesis.

Becker et al. (1984) conducted a mixed methods research study to determine the long-term effect of sexual assault on the sexual functioning of assault survivors. The population sample was sexual assault survivors from the Victim Treatment and Research Clinic at Columbia University. Participants were aged 18 or older with one or more experiences of sexual assault. Participants were paid \$10.00 for their participation in the study. This was the only literature reviewed that incorporated a monetary incentive for participation in the study. Becker et al. found a prevalence of sexual assaults for the majority of participants: 60% reported experiencing sexual assaults more than once. In regards to their current level of sexual functioning, 69% attributed sexual problems to the assault. Through the reports, Becker et al. were able to identify that fear of sex, arousal dysfunction, and desire dysfunction as the most common reported sexual problems. Notably, “response-inhibiting problems were experienced over three times more frequently than orgasmic problems...this data suggests that a sexual assault is less likely to interfere with a survivor’s physiological responding than to cause a survivor to perceive sexual stimuli as anxiety-provoking and to re-label her sexual feelings as either reduced or absent altogether” (p. 18).

An explanatory research study conducted by Shapiro and Schwarz (1997) aimed to explain the connection between trauma symptoms and sexual self-esteem. The population of study was female individuals enrolled as undergraduates at the University of Connecticut (p. 409). The participants were divided into two subgroups: 1) individuals who identified as experiencing date rape, and 2) individuals who identified as never experiencing date rape. These

subgroups were determined through quantitative methodology: a demographic questionnaire, the Dating and Sexual Activity Questionnaire, the Sexual Self-Esteem Inventory – Women (SSEI-W), the Trauma Symptom Inventory (TSI), the Unwanted Sexual Experiences Questionnaire, and Incident Description Forms. Interestingly, the word “rape” was not used in any data collection so as to not generate response bias from participants. The data collected from these questionnaires created the above-mentioned subgroups. Shapiro and Schwarz’s data analysis found that women who had been date raped indicated lower sexual self-esteem. Trauma symptoms reported by participants found to be significantly related with dysfunctional sexual behavior and sexual concerns. The authors posited that the lowered self-esteem of women who had been date raped meant that they experience discomfort with their sexual life and are not satisfied within their sexual relationships. Controversially, the authors inferred there is a connection between date rape experience and sexual promiscuity. The research findings and conclusions are an important addition to this study, but are lacking in one particular area of notice. The authors seemed to utilize a linear model for sexual behavior; that is, sexual behaviors and experience occur with the overall goal to achieve orgasm. Because of this, the authors seemed to arrive at the conclusion that not achieving orgasm is sexual dysfunction.

van Berlo and Ensink (2000) wrote a review of available research studies on sexual functioning after sexual assault. Despite the varying research methodologies used, the authors identified a commonality: sexual activity, sexual pleasure, and sexual satisfaction decreases after sexual assault. One notable critique that seemed present in nearly all the studies was the use of retrospective methods, meaning the survivors of sexual assault had to rely on their memory, resulting in recall bias. van Berlo and Ensink asserted that future studies should interview survivors of sexual assault “immediately after the assault and followed over a defined period of

time...[in this way,] results will be less likely to be obscured by memory processes” (p. 245).

This assertion holds tension between being an effective methodology and being insensitive to the feelings of survivors of sexual assault. There may be some survivors of sexual assault who do not want to discuss the details of their assault. Of course, they would be excluded from such a study so as to protect them as human subjects.

### **Summary**

The prevalence of sexual violence and IPV within queer communities demands a framework that meets the complexities of queer identity and experience. Sexual violence and IPV cannot be fully understood through the lens of a gender-based analysis, as this lens constructs gendered assumptions that effectively render the experiences of queer communities invisible. This invisibility is dangerous for queers in several ways: 1.) Women are fully capable of perpetrating sexual violence and/or IPV, and 2.) Sexual violence and IPV is not exclusively a heterosexual experience. In the context of research, this invisibility has historically limited the quantity and quality of studies about queer sexual violence and IPV. This means clinical social workers and professionals in the mental health field were serving queer individuals with a limited understanding of queer sexual violence and IPV. Thankfully, the literature about queer sexual violence and IPV has increased, allowing for more empirical knowledge seeking understanding among mental health professionals in order to best serve queer individuals with experiences of sexual violence and/or IPV.

On the other hand, research about queer women’s sexual experiences after sexual violence and IPV is extremely limited. Previous research (Becker et al., 1989; Feldman-Summers et al., 1979; Orlando et al., 1983; Shapiro et al., 1997; and van Berlo et al., 2000) has explored sexual experiences after sexual violence, but overall limited the population of study as

heterosexual women or failed to identify sexual orientation as a relevant demographic. This renders the collected findings irrelevant to queer experiences. It is clear, then, that proceeding research must narrow the population of study to queer individuals. There has been research of queer populations, focusing on sexual experiences, but not after sexual violence or IPV. There has also been research focusing on cognitive interference, anxiety, and sexual experiences and these findings could be useful to future research about queer women's sexual experiences after sexual violence; however, the findings may not be entirely relevant (yet) due to the broad nature of the population studied. Previous research about sexual experiences after sexual violence has clearly utilized linear models of sexual experience. This is problematic when the population under study consists of survivors of sexual violence and/or IPV because "consent" to sexual activity is not included in these models. In addition, these models assume a path of sexual activity that does not accurately depict a queer sexual experience. Future research, then, must queer these models of sexual experience.

It is essential that all future research on queer women's sexual experiences after sexual violence utilize a lens of analysis about the connections between women's sexuality, queer sexuality, and historical/structural/social contexts. The history of psychoanalysis, psychiatry, and the development of the DSM have significant implications for definitions of sex, sexuality, gender, and sexual dysfunction/function. Therefore, all future research should construct their definitions with a critical understanding in order to more accurately reflect the complexities of queer lived experiences.

This investigation is researching queer women's sexual experiences after sexual violence perpetrated by a previous intimate partner. The research questions are: Do queer women experience changes in their sexual interest and behavior after sexual assault perpetrated by a



previous intimate partner? How do queer women feel about these changes? The purposes of this investigation are to 1.) Challenge myths of the perfect victim/ideal aggressor binary of sexual violence from queer women's lived reality of sexual violence, 2.) Increase the scope of knowledge on female sexual experiences after sexual assault through the inclusion of strictly queer women, and 3.) Utilize the proposed study's findings to assist clinical social workers in meeting the mental health needs of this population. The following chapter will outline the methodology of this study.

## CHAPTER III

### Methodology

This study is an experimental investigation into queer women's sexual experiences after sexual violence as perpetrated by a previous intimate partner in a non-heterosexual relationship. This study seeks to explore the following questions:

- Do queer women experience changes in their sexual interest and behavior after sexual assault as perpetrated by a previous intimate partner?
- What are their emotional experiences of their sex lives after sexual assault?

The purposes of this study are to 1.) Challenge the myth of the perfect victim/ideal aggressor binary of sexual violence from queer women's lived reality of sexual violence; 2.) Increase the scope of knowledge on female sexual experiences after sexual assault through the inclusion of strictly queer women; and 3.) Utilize the study's findings to assist clinical social workers in meeting the mental health needs of this population. To explore the answers to these questions and to meet the identified purposes, this study utilized quantitative design. Hester and Donovan (2009) recommended the use of quantitative rather than qualitative design when researching this topic. Qualitative design relies on open-ended experiences from individuals in a selected sample and equates those experiences with truth (p. 164). However, experience is not "[capital T] Truth; experience is varying stories that hint at the Truth" (p. 164). Quantitative design is more likely to produce generalizable data, increase accuracy and objectivity of the results, and allow for the anonymity of respondents. This chapter outlines the study's methods for sampling, design, analysis, and addressing potential biases.

## **Research**

### *Definitions*

For the purposes of this study, “queer woman” is an umbrella term used to describe individuals who are cisgender, transgender or, at the time of their sexual assault experience, identified as female. It may also refer to individuals who are bisexual, lesbian, asexual, pansexual, demisexual, or queer and are female-identified. “Heterosexual” is defined as the sexual orientation of individuals who are sexually and/or romantically attracted to individuals of the opposite gender. “Non-heterosexual” is an umbrella term used to describe individuals who are not heterosexual. “Partner” and “intimate partner” are used interchangeably and are defined as: an individual with whom one has a close personal relationship that can be characterized by emotional connectedness, regular contact, ongoing physical contact and/or sexual behavior, identity as a couple, and familiarity and knowledge of each other’s lives (Breiding et al., 2015, p. 11). “Previous partner” is defined as an individual whom one has had a close personal relationship with, but no longer. “Sexual assault” and “sexual violence” are used interchangeably and are defined as sexual contact and/or activity without consent and as perpetrated by a previous intimate partner. “Consent” is defined as an informed, freely given, non-coerced, explicit “yes” to sexual contact and/or activity. “Sexual activity” and “sexual contact” are used interchangeably and are used to include penetration, unwanted touching or fondling, forcing to perform sexual acts, verbal abuse, and attempted rape.

### *Design*

A structured survey was developed and employed using the online program Qualtrics (see Appendix G). Participants followed a hyperlink to the survey, where they were greeted with an introduction to the study. This introduction outlined the study’s purposes and defined definitions

that could be useful when taking the survey. The individual clicked “NEXT” to the pre-screening page, which clearly outlined the inclusion and exclusion criterion for participation. The individual was directed to answer one of two boxes to attest they meet or do not meet the criterion provided. If they selected the box attesting to not meeting the identified criteria and clicked “NEXT”, they were led to a disqualification page and thanked for their time. If they selected the box attesting to meeting the identified criteria and clicked “NEXT”, they were directed to the informed consent document (see Appendix A) that they were asked to review. At the end of the informed consent document, individuals were asked to answer “ACCEPT” or “DECLINE” as a means of electronically signing their consent for participation in the survey. Within the informed consent document, individuals were informed that participation was optional but once their survey was submitted, their participation could not be withdrawn due to the anonymous nature of survey. Participants were provided with the option to electronically download a PDF copy of the informed consent document for their personal records.

Participants who provided informed consent were next directed to the survey questions, which was divided into five sections: demographics, previous relationship history, help-seeking, sexual experiences, and current experiences. Based on feedback provided by the Smith College Human Subjects Review Committee (SCHSRC) and due to the possibly triggering content of the survey, each section was separated by a title page with a short 1-2 sentence description of the content to come. In this way, participants would know what to expect when proceeding with answering the survey questions. In addition, a PDF document of resources was provided for optional download (see Appendix H).

In the demographics section, participants were asked to provide their age, race/ethnicity, gender identity, sexual orientation, and relationship status. In the previous relationship history

section, participants were asked to identify whether they were sexually assaulted by a previous intimate partner, if the relationship the violence occurred was considered non-heterosexual, when the first incidence of sexual violence occurred, and how long after that first incidence did the relationship end. In this section if a participant indicated they were not sexually assaulted by a previous intimate partner, and/or the relationship was not considered non-heterosexual, and/or the relationship had not ended were immediately directed to the disqualification page and thanked for their time. In the help-seeking section, participants were asked whether they sought help after their sexual violence experience. If yes, they were asked to identify what sources of help they sought and to identify its helpfulness on a Likert scale. If they replied no, they asked to identify why they did not seek help. In the sexual experiences section, participants were asked about changes in sexual behavior, interest, and frequency of sexual behavior as well as the amount of time that passed to have sex with a different partner. Participants were then presented with a list of possible feelings and problems individuals sometimes experience concerning their sexuality and sexual experiences. They were asked to identify on a Likert scale how often that specific problem has bothered them or caused them distress since the relationship ended. This list was developed after consulting the Female Sexual Distress Scale and Female Sexual Dysfunction Index, both of which will be discussed below. The final section of the survey, current experiences, asked participants to identify whether they feel they are currently satisfied with their sex life and have adequate access to local sexual violence support services. Participants were given one optional open-ended question to describe their sex life currently.

The survey took anywhere between 10 and 30 minutes to complete. With the exception of the final optional open-ended question, all of the questions were required.

## **Standardized Instruments and Measures**

Two standardized instruments inspired the development of survey. They were selected based on their relevance to the research questions, hypotheses, ease of use, and availability.

These instruments are summarized below:

1. Female Sexual Distress Scale-Revised (FSDS-R): Created by Derogatis, Rosen, Leiblum, Burnett, and Heiman (2008), the FSDS-R is a self-administered questionnaire that consists of 13 items that relate to different aspects of sex-related distress for female-identified individuals. Individuals completing the FSDS-R respond to each item on a scale of 0 to 4 (Never=0, Rarely=1, Occasionally=2, Frequently=3, Always=4). Scores greater than 11 indicates a clinical level of sexual distress.
2. Female Sexual Function Index (FSFI): Created by Rosen, Brown, Heiman, Leiblum, Meston, Shabsigh, Ferguson, and D'Agostino (2000), the FSFI is a brief self-report measure of female sexual function. Consisting of 19 questions, the FSFI measures sexual function in five domains: desire and arousal, lubrication, orgasm, satisfaction, and pain/discomfort (p. 202).

### *Female Sexual Distress Scale-Revised (FSDS-R)*

Derogatis et al. (2002) developed the FSDS in order to emphasize sexually related personal distress as a component of female sexual dysfunction. Three studies involving approximately 500 women total were conducted to evaluate reliability and validity of the FSDS. Study I was a pilot study to evaluate the items and assess the test-retest reliability and discriminative validity (p. 320). Study II was a randomized clinical trial of pharmacological therapy for female sexual arousal disorder (FSAD) (p. 322). Study III was also a clinical trial for hypoactive sexual desire disorder (HSDD) (p. 324). Their findings from each of these studies

indicated that sexual related personal distress is an essential component for the diagnosis of female sexual dysfunction. According to the researchers, the findings demonstrate the FSDDS as highly reliable, invariant and unidimensional in structure (p. 329). Furthermore, the findings indicated that the FSDDS “correlates with more general measures of mood- and symptom-oriented distress positively” (p. 329).

Derogatis et al. (2008) sought to validate a slightly revised version of the FSDDS to enhance the tool for use in measuring sexual distress among women with a diagnosis of hypoactive sexual desire disorder (HSDD). The study’s sample population was comprised of 296 women aged 18-50 years old with HSDD, another female sexual dysfunction, or none. The researchers found that the FSDDS-R demonstrated good discriminant validity, high test-retest reliability, and high degree of internal consistency in measuring sexually related personal distress amongst women with HSDD (p. 357).

The FSDDS-R was utilized as a standardized measure in the online survey. Permission for its use was obtained from Dr. Derogatis (Appendix E).

#### *Female Sexual Function Index (FSFI)*

Rosen et al. (2000) sought to assess the construct validity of female sexual dysfunction through development of the Female Sexual Function Index (FSFI) using quantitative method. It should be noted that this study was conducted prior to the development and dissemination of the DSM-V, and as such utilizes the DSM-IV-TR. At the time of this study, the FFSI was utilized to assess and treat female sexual dysfunction; or, as categorized in the DSM-IV-TR, as Female Sexual Arousal Disorder (FSAD). The population of focus was women between the ages of 21 and 69 years old. The population was divided into a control group (women without FSAD) and the study group (women with a diagnosis of FSAD). The authors assessed two kinds of test

reliability: internal consistency and test-retest reliability. Comparing the FSAD group with the control group also assessed discriminant validity of the FSFI. As a result of this study, five domains of sexual function were identified: “(a) desire and subjective arousal, (b) lubrication, (c) orgasm, (d) satisfaction, and (e) pain discomfort” (p. 202). Based on these domains, the FSFI was developed as a 19-item questionnaire to offer a “brief, multidimensional self-report measurement for assessing the key dimensions of sexual function in women” (p. 204). One excellent factor about the FSFI is that any person can use it as a self-report measure regardless of their sexual orientation. The five domains are useful in forming definitions of female sexual experience after sexual assault.

In response to this study, Meyer-Bahlburg and Dolezal (2007) offer a methodological critique and suggestions for improvement. The FSFI is a 19-item questionnaire; each item utilizes a five-point response scale (1 to 5) “denoting variations in frequency, intensity, or degree of satisfaction” (p. 218). Most, but not all, items contain a zero category. This zero category is used to denote “no sexual activity” in 12 of the items, and “did not attempt intercourse” in 3 of the items. This leaves four items without a zero category. The authors assert that this creates conceptual and statistical problems. Conceptually, the zero category is not a part of the response scales and therefore its presence on the item isn’t needed. Statistically, the authors carry three major critiques: 1) the zero category increases the item score range and item variance, 2) the zero category will bias domain scores towards the sexual dysfunction score, and 3) the zero category skews visual graphing of data collected using the FSFI. Ultimately, the authors recommend making modifications to the FSFI by: (a) treating all zero responses as missing values, (b) analyze the zero responses separately, (c) and adjust the items with more specific instructions for the participant.



Boehmer et al. (2012) conducted a study examining the effectiveness of the FSFI to sexual minority women. They evaluated the use of the FSFI with sexual minority women through modification of the tool. The researchers changed definitions to accommodate the sexual experiences of sexual minority women, specifically removing “penile penetration” and “intercourse” from the original wording of the tool and replacing it with “vaginal penetration”. The findings indicated that this change to more inclusive definitions “resulted in comparable reliability to that shown in the heterosexual sample studied by Rosen et al.” (p. 406). This led to the conclusion that the FSFI modified can be used reliably with sexual minority women.

While the FSFI was certainly relevant for this study, the Smith College Human Subjects Review Committee deemed it too graphic for study with human participants. For this reason, the FSFI served as inspiration for the research questions and hypotheses. While the FSFI was freely available for use online, it was not used in the survey.

## **Recruitment**

### *Inclusion Criteria*

Participants in this study self-identified as being queer women over the age of 18. Participants were required to be over the age of 18 years old, identify as a queer woman, and attest to having a sexual violence experience as perpetrated by a previous intimate partner in a non-heterosexual relationship.

### *Exclusion Criteria*

If participants identified as heterosexual, they were automatically excluded from participation in this study. If they indicated male gender identity, they were automatically excluded from participation. If an intimate partner was not the perpetrator of sexual violence,

they were excluded from participation. If they indicated they were in a relationship with the perpetrator, they were excluded from participation.

### *Sampling Methods*

Recruitment was conducted through use of convenience sampling and snowball sampling. Participants were obtained by three primary methods: postings on social media, emails to agencies serving the LGBTQ+ community, emails to social workers, emails to listservs, and by word-of-mouth. The researcher created a poster (see Appendix C) with information about the study, how to participate, and a link for the survey.

The following social media platforms were utilized for recruitment: Facebook, LinkedIn, Tumblr, and Reddit. There are countless Facebook groups created for LGBTQ+ Facebook users. As the researcher was already a member of several LGBTQ+ Facebook groups, the poster was uploaded to the group in order to recruit volunteers for participation. The researcher utilized their LinkedIn profile to upload the poster and request members of their LinkedIn network to share the study with their own networks. The platform Tumblr was utilized by uploading a poster to the site with accompanied “tags” (i.e. #LGBT #queer #socialwork and so on) so users searching for that tag might find it. The poster was uploaded to one Reddit group entitled r/LGBT.

Listserserv email lists are a valuable source for recruiting participants. The researcher utilized two of these lists for recruitment: the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) Information Exchange and the American Psychological Organization (APAGSLGBT) listserv. Membership of these email lists was free to join and required the user to be a student or professional in the behavioral health field (i.e. counseling, psychology, social work).

The researcher emailed agencies in their local community known to serve LGBTQ+ communities, specific members of the LGBTQ+ community that were personally known by the researcher, and colleagues in the behavioral health field. The recruitment email (see Appendix B) included information about the study, inclusion criteria, details for participation, and requested the recipient to pass the information to individuals who might be interested in participation. The recipients who were personally known by the researcher were not asked to participate due to ethical concerns.

As a member of the LGBTQ+ community, the researcher is involved in several community groups comprised of LGBTQ+ members. The researcher shared information about the study with members of these groups and requested they share the information with other individuals in their personal networks who might be interested in participation.

The survey was active online for 10 weeks, during which time 60 participants were recruited to complete the survey. Of this number, 55 participants completed the final open-ended question.

## **Ethics**

Prior to recruitment and data collection, the methodology was reviewed and approved by the SCHSRC (see Appendix D for the application and Appendix F for the HSR approval letter). Anonymity and confidentiality is assured. Individuals were not asked to provide their name to participate in this study. Additionally, Qualtrics was programmed to not record IP addresses. All data collected will be kept on a password-protected external hard drive for three years after the dissemination of the study. Participants were not offered nor did they receive any financial compensation, payment, incentives, or “gifts” for participation in this survey. Furthermore, prior

to participation in the study, individuals read and electronically signed an informed consent document.

Certain populations are considered vulnerable because of certain social conditions or life experiences. Women are a vulnerable population due to their social location as women within a culture that brings systematic marginalization. Women who experience sexual violence are a vulnerable population. As part of a larger social discourse embedded in sexism and rape culture, survivors of sexual violence are often blamed for their assault(s). Additionally, the queer community has a history of experiencing human rights violations. As part of a larger social discourse of sexism and homophobia, the queer community experiences marginalization due to their social identity.

Participation in the study could cause individuals to feel uncomfortable and distressed. The SCHSRC requested that it be made extremely clear during recruitment and in the informed consent document that participation could lead to discomfort and/or distress. This was made clear in both of these avenues. At any time during participation, the participant could choose to opt out of the survey by simply exiting out of the web browser. A packet of resources was made available via PDF download to all individuals who entered the survey. The resources included national sexual violence and domestic violence support resources, the national domestic violence hotline, queer-friendly counseling service providers, and online national queer-friendly mental health resources.

### **Data Analysis**

This study explored the sexual experiences of queer women after sexual violence as perpetrated by a previous intimate partner in a non-heterosexual relationship and examined four hypotheses. These hypotheses are as follows:

Hypothesis I: When compared to queer women who denied help-seeking behavior, queer women who reported help-seeking behavior will report decreased overall sexual distress.

Hypothesis II: Queer women who denied help-seeking behavior will report increased overall sexual distress.

Hypothesis III: Queer women who report sexual assault perpetrated by a previous intimate partner will report increased overall sexual distress.

Hypothesis IV: Queer women who report sexual assault perpetrated by a previous intimate partner will report decreased interest in sex.

Data was collected anonymously by the online software Qualtrics. Analysis of that data began immediately following the close of the survey. A statistical consult provided by the Smith College School for Social Work was utilized for assistance in analysis of the quantitative data via SPSS. All descriptive data was compiled by the researcher using SPSS.

To determine whether Hypothesis I was supported, an independent t-test was performed to analyze differences among participants who confirmed help-seeking behavior and participants who denied help-seeking behavior in regards to overall sexual distress.

To determine whether Hypotheses II, III, and IV were supported, two types of correlational tests were performed: Pearson's product moment correlation ("Pearson's r") and Spearman's rank-order correlation ("Spearman's rho"). Pearson's r was performed to evaluate the linear relationship between two continuous variables (as described in the hypotheses).

Spearman's rho was performed to evaluate the monotonic relationship between two continuous variables.

Results and findings will be discussed in the proceeding chapter.

## CHAPTER IV

### Findings

The purposes of this study are to 1.) Challenge the myth of the perfect victim/ideal aggressor binary of sexual violence from queer women's lived reality of sexual violence; 2.) Increase the scope of knowledge on female sexual experiences after sexual assault through the inclusion of strictly queer women; and 3.) Utilize the study's findings to assist clinical social workers in meeting the mental health needs of this population. Four hypotheses were developed in the course of this study:

#### Hypothesis I:

When compared to queer women who denied help-seeking behavior, queer women who reported help-seeking behavior will report decreased overall sexual distress. If this hypothesis is supported, the independent t-test will demonstrate the Sig (2-tailed) value is less than or equal to .05. If this value is less than or equal to .05, it can be concluded there is a statistically significant difference between help-seeking behavior and non-help-seeking behavior in regards to overall sexual distress.

#### Hypothesis II:

Queer women who denied help-seeking behavior will report increased overall sexual distress. If this hypothesis is supported, the results of the Spearman's rho test will demonstrate a strong monotonic relationship as shown by how close  $r_s$  is to +1.

#### Hypothesis III:

Queer women who report sexual assault perpetrated by a previous intimate partner will report increased overall sexual distress. If this hypothesis is supported, there will be a higher frequency

of scores greater than or equal to 11 and/or a higher frequency of scores in the moderate-severe categories.

A. Spearman's rho test: The monotonic relationship between the paired data is denoted by  $[-1 \leq r_s \leq 1]$ . The closer  $r_s$  is to +1, the stronger the monotonic relationship. In other words, the closer  $r_s$  is to +1, the stronger the correlation between sexual assault and increased sexual distress.

B. Pearson's r test: The correlation between two variables is denoted by r. R can range from +1 to -1. A value greater than 0 indicates a positive association; a value less than zero indicates a negative correlation. The closer r is to +1 or 1, the stronger the negative or positive correlation. In other words, if r is greater than +1, this would indicate a positive correlation between sexual assault and increased sexual distress. Further, the closer r is to 0, the stronger the correlation will be.

Hypothesis IV:

Queer women who report sexual assault perpetrated by a previous intimate partner will report decreased interest in sex.

A. Spearman's rho test: The monotonic relationship between the paired data is denoted by  $[-1 \leq r_s \leq 1]$ . The closer  $r_s$  is to +1, the stronger the monotonic relationship. In other words, the closer  $r_s$  is to +1, the stronger the correlation between sexual assault and decreased interest in sex.

B. Pearson's r test: The correlation between two variables is denoted by r. R can range from +1 to -1. A value greater than 0 indicates a positive association; a value less than zero indicates a negative correlation. The closer r is to +1 or 1, the stronger the negative or positive correlation. In other words, if r is greater than +1, this would indicate a

positive correlation between sexual assault and decreased interest in sex. Further, the closer  $r$  is to 0, the stronger the correlation will be.

## **Results**

This chapter contains a summary of the quantitative findings from this investigation. The study was conducted online using an anonymous and confidential study using Qualtrics (see Appendix G). Participants were asked the following:

- Five demographic questions
- Four questions related to sexual assault history
- If confirmed help-seeking behavior, four questions related to that help-seeking
- If denied help-seeking behavior, two questions related to barriers to help-seeking
- Nineteen questions related to sexual distress, including a standardized measure
- Two questions related to current sexual experiences
- One optional open-ended question about current sexual experiences

Sixty individuals participated in the survey. Three participants were disqualified from the study due to not meeting inclusion criteria; consequently, their individual data was removed from the collective data analysis. One participant did not answer the final optional open-ended question. In the help-seeking section of the survey, participants were shown specific questions depending on their confirmation or denial of help-seeking behavior. The results outlined in this chapter reflect the data from fifty-seven participants. The number of participants who completed each question is listed in the table below.



Table 1: Number of Participants Completing Each Measure

| Question  | Complete Responses |
|---|--------------------|
| Demographic Questions                           | 60                 |
| Sexual Assault History Section                  | 57                 |
| Help-Seeking Section (Confirmation of behavior) | 29                 |
| Help-Seeking Section (Denial of behavior)       | 28                 |
| Sexual Experiences Section                      | 57                 |
| Female Sexual Distress Scale-Revised            | 57                 |
| Current Experience                              | 57                 |
| Current Sexual Experience Optional Question     | 56                 |

The demographic findings will be presented first, followed by the quantitative findings.

### **Descriptive Data: Demographics**

Participants were asked to respond to five demographic questions at the beginning of the survey. Table 2 depicts the main demographics of survey participants, including write-in responses provided by the “Other” designation.

Overall, the majority of the sample self-identified as White or Caucasian (76.7%) between the ages of 20-29 (66.7%). The sample consisted largely of cisgender females (51.7%). In regards to sexual orientation, the majority of participants identified as queer (50.0%). Furthermore, the majority of the sample reported as currently being in a relationship (71.9%).

Table 2: Demographics of Sample Population

| Demographic Items   | Frequency                | Percentage of Sample Population         |
|---|--------------------------|---|
| Age <ul style="list-style-type: none"> <li>• 18-19</li> <li>• 20-29</li> <li>• 30-39</li> <li>• 40-49</li> </ul>  | 4<br>40<br>13<br>3       | 6.7%<br>66.7%<br>21.7%<br>5.0%          |
| Race <ul style="list-style-type: none"> <li>• Asian</li> <li>• Black/African American</li> <li>• Hispanic or Latino</li> <li>• Multiracial or Biracial</li> <li>• White or Caucasian</li> </ul>   | 2<br>1<br>4<br>7<br>46   | 3.3%<br>1.7%<br>6.7%<br>11.7%<br>76.7%  |
| Gender Identity <ul style="list-style-type: none"> <li>• Cisgender, female</li> <li>• Transgender, female</li> <li>• Gender non-conforming</li> <li>• Non-binary</li> <li>• Other (please specify): <ul style="list-style-type: none"> <li>– Cisgender Femme (1)</li> <li>– Femme (1)</li> <li>– Gender Fluid (1)</li> <li>– Genderfluid female (1)</li> <li>– Intersex (1)</li> <li>– Non-binary woman (1)</li> <li>– Queer femme (2)</li> <li>– Questioning, AFAB (1)</li> <li>– Transgender, non-binary (1)</li> </ul> </li> </ul> | 31<br>1<br>5<br>11<br>10 | 51.7%<br>1.7%<br>8.3%<br>18.3%<br>16.7% |
| Sexual Orientation <ul style="list-style-type: none"> <li>• Lesbian</li> <li>• Bisexual</li> <li>• Queer</li> <li>• Pansexual</li> <li>• Other (please specify): <ul style="list-style-type: none"> <li>– Greysexual (1)</li> </ul> </li> </ul>   | 17<br>7<br>29<br>4<br>1  | 29.3%<br>12.1%<br>50.0%<br>6.9%<br>1.7% |
| Relationship Status <ul style="list-style-type: none"> <li>• Currently in a relationship</li> <li>• Been in a relationship previously</li> </ul>  | 41<br>16                 | 71.9%<br>28.1%                          |

### **Descriptive Data: Help-Seeking Behavior**

Participants who met inclusion criteria were directed to the Help-Seeking Section of the online survey. Participants were first met with the following question: “After your sexual assault/sexual violence experience(s), did you seek support/help?” If they selected “Yes”, they were directed to a set of questions inquiring about the help they accessed. If they selected “No”, they were directed to a question regarding barriers to seeking and/or accessing help. Twenty-nine participants confirmed seeking help after their sexual violence experience(s), amounting to 50.9% of the sample population. On the other hand, twenty-eight participants denied seeking help after their sexual violence experience(s), amounting to 49.1% of the sample population.

Previous research (see: Cohen et al. 2015; Helleman et al. 2015; Hester et al. 2009; McDonald 2012; Murray et al. 2009; Ristock 2005; and Walters 2011) about same-sex intimate partner violence (SSIPV) has indicated there are barriers unique to the LGBTQ+ community to seeking and/or accessing help. Table 3 illustrates barriers to help that were identified by the twenty-eight participants who denied help-seeking behavior.

The barrier most identified by participants in this sample group was uncertainty or insecurity whether they were in an unsafe situation (64.3%). This was followed by feelings of shame (60.7%) and cognition that no one would believe them (60.7%). Fifty percent (50.0%) of participants in this sample group feared retaliation from their partner if they sought help. While not a majority in frequency, outliers in the data included no access to transportation (10.7%) and relying on the perpetrator for daily needs (14.3%).

Table 3: Barriers to Help-Seeking Identified by Non-Help-Seeking Sample Group

| Barriers*  | Frequency | Percentage of Non-Help-Seeking Participants |
|--|-----------|---|
| I didn't have transportation to access help.   | 3         | 10.7%                                       |
| I feared my partner would retaliate/do something to harm me if I sought help.  | 14        | 50.0%                                       |
| I didn't have knowledge of local sexual violence services.   | 8         | 28.6%                                       |
| I feared losing my housing if I sought help.   | 5         | 17.9%                                       |
| I feared judgment from members of my culture.  | 13        | 46.4%                                       |
| I didn't have the financial means to access help.  | 7         | 25.0%                                       |
| I was unaware or unsure if I was in an unsafe situation.   | 18        | 64.3%                                       |
| I didn't think sexual violence could happen in queer relationships.  | 12        | 42.9%                                       |
| I relied on my partner for my daily needs.   | 4         | 14.3%                                       |
| I wasn't "out" to my family or friends.  | 8         | 28.6%                                       |
| I didn't want to break up with my partner.   | 11        | 39.3%                                       |
| I felt ashamed that it happened to me.   | 17        | 60.7%                                       |
| I thought no one would believe me.   | 17        | 60.7%                                       |
| Other (please specify): <ul style="list-style-type: none"> <li>• "I didn't have knowledge of local sexual violence services for queer folx." (1)</li> <li>• "I didn't know that what I had experienced was considered sexual violence." (1)</li> <li>• "I feared for the loss of support from our community if I were to tell others. We were in high school and my parents were like her second parents (she was not getting along with her parents at the time)." (1)</li> <li>• "I kept having sex with her." (1)</li> <li>• "I thought I deserved it somehow. I also thought I was overreacting." (1)</li> <li>• "I thought it was my fault or that I deserved it."</li> </ul> | 8         | 28.6%                                       |

|  |  |  |
|--|--|--|
| <p>(1)</p> <ul style="list-style-type: none"> <li>• “I was still in love with her, and she was a trans woman who I didn’t want to isolate her. And talking about it was too painful. I missed her.” (1)</li> <li>• “I wasn’t sure it was violence, but now I realize it was because I didn’t want to have sex and was forced to.” (1)</li> </ul> |  |  |
|--|--|--|

\*Participants could choose multiple responses.

At the end of the survey, all 57 participants were asked to identify on a Likert scale (Strongly disagree-Strongly agree) whether they felt they had adequate access to local sexual violence services for support. The majority of participants in the sample population agreed (33.3%) that they had adequate access to local sexual violence services for support. About 31.6% strongly agreed that they had access to local services; 17.5% were undecided; 12.3% disagreed; and 5.3% strongly disagreed.

Participants in the sample population who confirmed help-seeking behavior were directed to a set of questions about the type of help they accessed (e.g. friends, family, professional mental health) and whether they found the support helpful to them. Table 4 illustrates the type of help accessed by the twenty-nine participants who confirmed they sought support after their sexual violence experience(s).

The top two sources of support were friends (79.3%) and professional mental health (75.9%). In the “other” specification box, two participants indicated law enforcement as a source of support. Two participants indicated online support groups and/or social media networking as a source of support. Two participants indicated psychiatric hospitalization and use of the emergency room as a source of support. In addition to identifying the sources of support, participants in the help-seeking sample group were asked to identify what type of professional

mental health services they accessed (if at all). Table 5 depicts the mental health intervention these participants identified.

Table 4: Sources of Support Identified by Help-Seeking Sample Group

| Source of Support*   | Frequency | Percentage of Help-Seeking Participants Sample Group |
|--|-----------|--|
| Friends  | 23        | 79.3%  |
| Family   | 5         | 17.2%  |
| Domestic Violence Shelter  | 6         | 20.7%  |
| LGBTQ Resource Center  | 5         | 17.2%  |
| Professional Mental Health (e.g. therapist, social worker, counselor)  | 22        | 75.9%  |
| Hotline  | 8         | 27.6%  |
| Other (please specify): <ul style="list-style-type: none"> <li>• “Domestic violence agency, court/restraining order, police” (1)</li> <li>• “Emergency Room” (1)</li> <li>• “Hotlines, online support groups and webforums, in person trauma survivor support groups, psychiatric hospitalization, women’s center, etc.” (1)</li> <li>• “Police” (1)</li> <li>• “Social Media” (1)</li> <li>• Submitting writing to a zine on the topic” (1)</li> <li>• “Survivor support group at my university” (1)</li> <li>• “YWCA domestic violence counselor” (1)</li> </ul> | 8         | 27.6%  |

\*Participants could choose multiple responses.

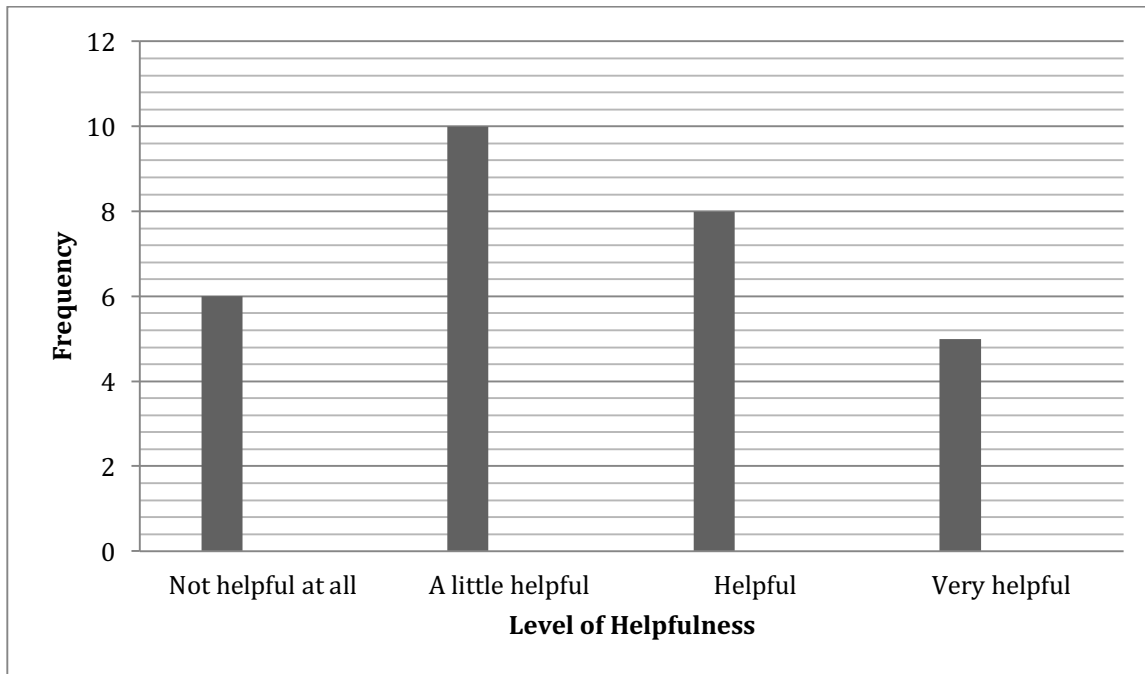
Table 5: Mental Health Interventions Accessed by Help-Seeking Sample Group

| Intervention Type* | Frequency | Percentage of Help-Seeking Participants Sample Group |
|--------------------|-----------|--|
| Individual Therapy | 21        | 72.4%  |
| Group Therapy      | 5         | 17.2%  |
| Case Management    | 2         | 6.9%   |

\*Participants could choose multiple responses.

Participants in the help-seeking sample group indicated seeking individual therapy (72.4%). Of the help-seeking sample group, participants were asked to rate on a Likert scale (Not helpful at all-Very helpful, 1-4) how helpful their source(s) of support were for them. The histogram in Figure 1 illustrates their responses, revealing a bell curve.

Figure 1: Identified Helpfulness of Sources of Support by Help-Seeking Sample Group

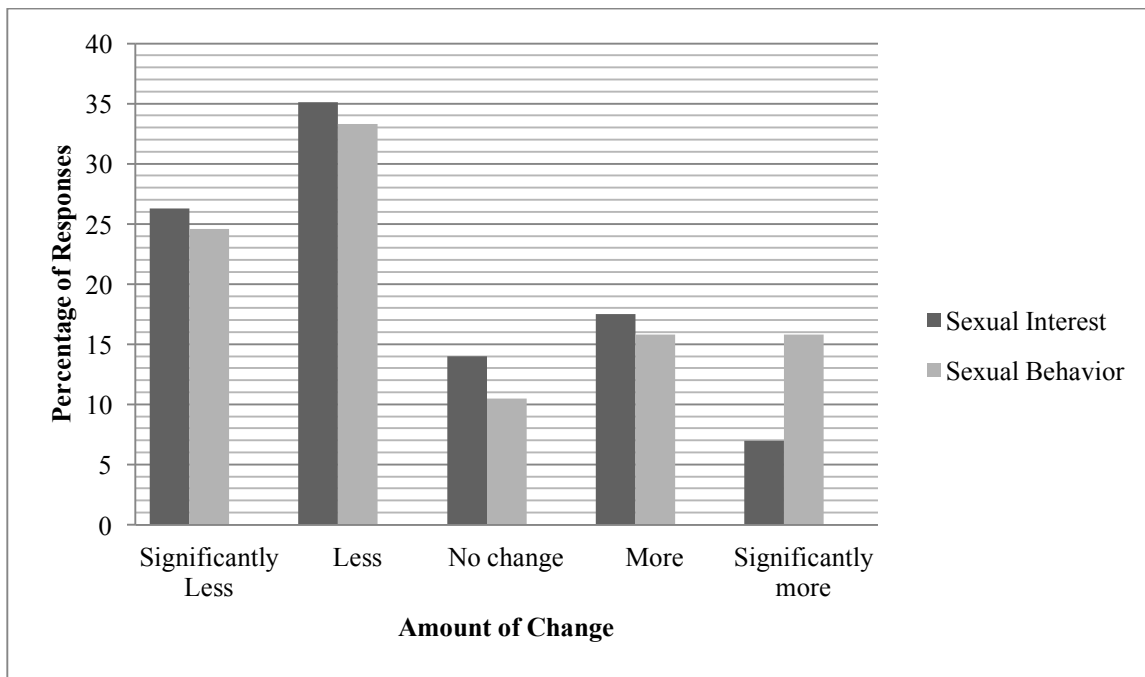


The help-seeking sample group’s average is 2.45, indicating the sample group responded that their source(s) of support were a little helpful to helpful on average.

### Descriptive Data: Sexual Activity after Sexual Violence

After the help-seeking section of the online survey, participants were asked questions regarding their sexual activity after their sexual violence experience(s). Participants were first asked to identify if there were any changes in their sexual interest and sexual behavior after their sexual violence experience(s) and after their relationship with the perpetrator ended. The percentage of responses for reported change in sexual interest and sexual behavior are illustrated in Figure 2.

Figure 2: Changes in Sexual Interest and Behavior After Sexual Violence

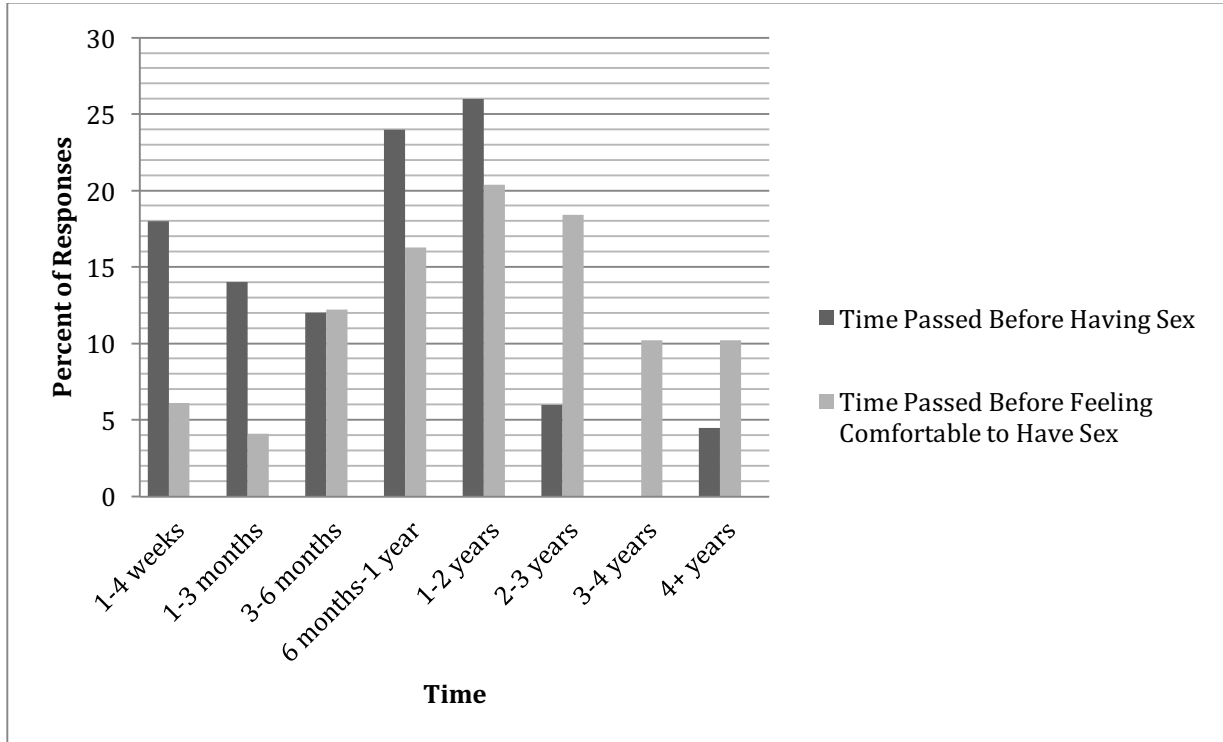


As shown in Figure 2, the majority of responses identified less sexual behavior (33.3%) and sexual interest (35.1%) after sexual violence perpetrated by a previous intimate partner. Participants also identified significantly less sexual behavior (24.6%) and sexual interest (24.6%). On the other hand, participants also identified more sexual behavior (15.8%) and sexual interest (17.5%).



After identifying changes in sexual interest and sexual behavior, participants were asked to identify the amount of time that passed before they first had sex and when they first felt comfortable to have sex. Figure 3 compares the percentage of responses reported for the amount of time that passed before first having sex and first feeling comfortable to have sex.

Figure 3: Engaging in Sexual Activity: Having Sex versus Feeling Comfortable to Have Sex



The data outlined in Figure 3 revealed that the majority of participants reported 1-2 years before having sex after their sexual violence experience(s) perpetrated by a previous intimate partner (26.0%). The data also revealed that the majority of participants reported 1-2 years before feeling comfortable to have sex again (20.4%).

#### **Descriptive Data: Overall Sexual Distress**

By use of the Female Sexual Distress Scale-Revised (DeRogatis et al. 2008), participants were given a list of feelings and problems that people sometimes experience regarding sex and sexuality. Using a Likert scale (Never-Always/0-4), participants were asked to check the number

that best described how often that problem bothered them/caused them distress since the relationship with the perpetrator of sexual violence ended. Table 6 outlines the frequency and percentage of responses for each of these problems.

Table 6: Frequency and Percentage of Reported Feelings and Problems Related to Sex

| Descriptive Item                          | Never       | Rarely      | Occasionally | Frequently  | Always      |
|---|-------------|-------------|--------------|-------------|-------------|
| Distressed about your sex life            | N/A         | 7<br>12.3%  | 17<br>29.8%  | 27<br>47.4% | 6<br>10.5%  |
| Unhappy about your sexual relationship(s) | 2<br>3.5%   | 15<br>26.3% | 18<br>31.6%  | 17<br>29.8% | 5<br>8.8%   |
| Guilty about sexual difficulties          | 8<br>14.0%  | 4<br>7.0%   | 13<br>22.8%  | 24<br>42.1% | 8<br>14.0%  |
| Frustrated by your sexual problems        | 5<br>8.8%   | 6<br>10.5%  | 12<br>21.1%  | 27<br>47.4% | 7<br>12.3%  |
| Stressed about sex                        | 2<br>3.5%   | 5<br>8.8%   | 24<br>42.1%  | 22<br>38.6% | 4<br>7.0%   |
| Inferior because of sexual problems       | 8<br>14.0%  | 13<br>22.8% | 15<br>26.3%  | 18<br>31.6% | 3<br>5.3%   |
| Worried about sex                         | 4<br>7.0%   | 4<br>7.0%   | 21<br>36.8%  | 25<br>43.9% | 3<br>5.3%   |
| Scared to have sex                        | 8<br>14.0%  | 12<br>21.1% | 18<br>31.6%  | 12<br>21.1% | 7<br>12.3%  |
| Regrets about your sexuality              | 24<br>42.1% | 6<br>10.5%  | 13<br>22.8%  | 12<br>21.1% | 2<br>3.5%   |
| Sexually inadequate                       | 12<br>21.1% | 7<br>12.3%  | 13<br>22.8%  | 16<br>28.1% | 9<br>15.8%  |
| Embarrassed about sexual problems         | 7<br>12.3%  | 9<br>15.8%  | 18<br>31.6%  | 16<br>28.1% | 7<br>12.3%  |
| Dissatisfied with your sex life           | 5<br>8.8%   | 16<br>28.1% | 15<br>26.3%  | 17<br>29.8% | 4<br>7.0%   |
| Angry about your sex life                 | 11<br>19.3% | 12<br>21.1% | 22<br>38.6%  | 9<br>15.8%  | 3<br>5.3%   |
| Bothered by low desire                    | 8<br>14.0%  | 13<br>22.8% | 15<br>26.3%  | 11<br>19.3% | 19<br>33.6% |

Each participant's individual score was calculated by the sum of each response. The total score represented the participant's overall sexual distress. Each participant's individual score was interpreted according to the scoring instructions developed by Derogatis et al. (2008). According to Derogatis et al., scores greater than 11 indicate a clinical level of sexual distress. The bell curve in Figure 4 illustrates the population sample's FSDS-R scores.

The histogram in Figure 4 illustrates a normal distribution of the data. This shows that the highest point on the curve represents the most probable event in the data. Participants in the sample population scored on average 29.26, indicative of a clinical level of sexual distress. It is significant to note that all except two participants scored above greater than or equal to 11; this indicates that 96.5% of the sample population scored within a clinical level of sexual distress.

#### **Statistical Tests: Analyzing Difference**

An independent t-test was performed to test Hypothesis I and analyze the differences in overall sexual distress by help-seeking behavior. Table 7 outlines the group statistics about the group comparisons while Table 8 outlines the independent samples test, which includes Lavene's Test for Equality of Variances and the t-test for Equality of Means.

Figure 4: FSDS-R Scores Amongst Population Sample

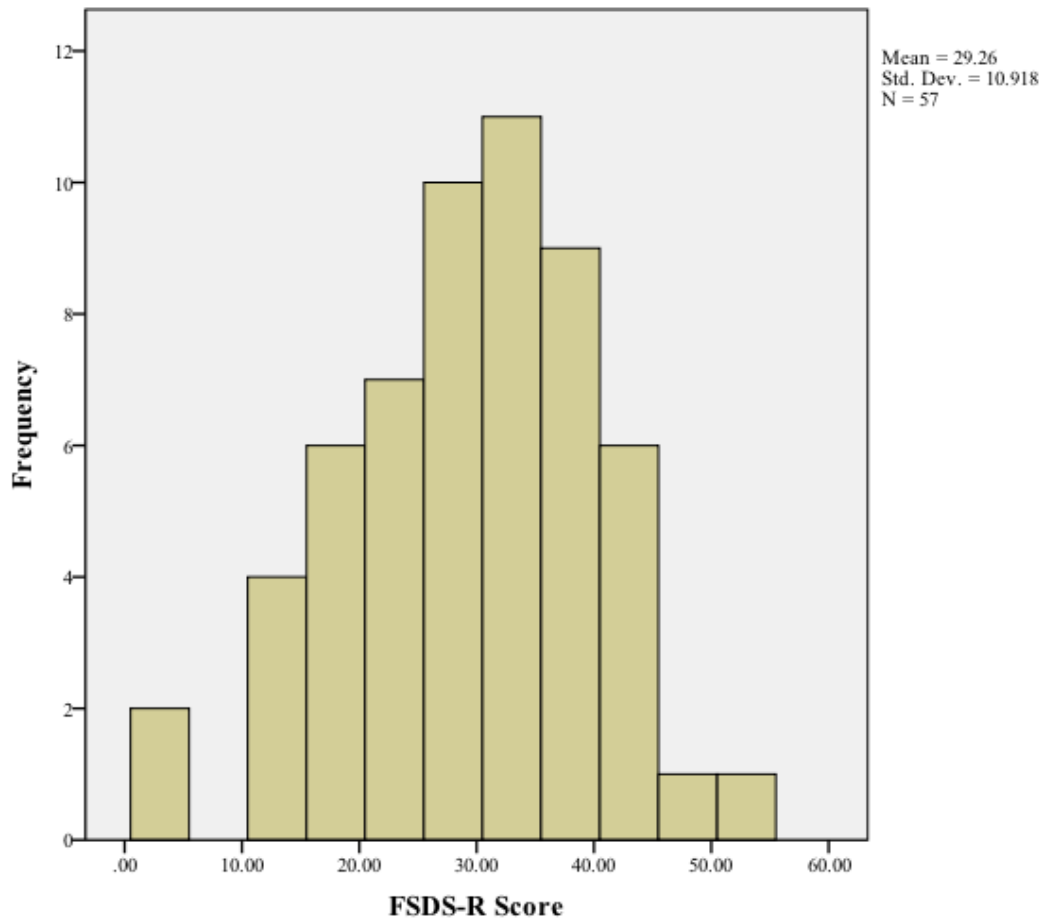


Table 7: Group Statistics for Overall Sexual Distress by Help-Seeking Behavior

|                               | After your sexual violence experience(s), did you seek support/help? | N  | Mean    | Std. Deviation | Std. Error Mean |
|-------------------------------|--|----|---------|----------------|-----------------|
| Overall Sexual Distress score | Yes  | 29 | 28.7586 | 10.68930       | 1.98495         |
|                               | No   | 28 | 29.7857 | 11.32142       | 2.13955         |

Table 8: Independent Samples Test for Overall Sexual Distress by Help-Seeking Behavior

|                               |                            | Levene's Test for Quality of Variances |       | t-test for Equality of Means |        |                 |                 |                       |   |         |
|-------------------------------|----------------------------|--|-------|------------------------------|--------|-----------------|-----------------|-----------------------|---|---------|
|                               |                            | F                                      | Sig.  | t                            | df     | Sig. (2-tailed) | Mean Difference | Std. Error Difference | 95% Confidence Interval of the Difference |         |
|                               |                            |  |       |                              |        |                 |                 |                       | Lower                                     | Upper   |
| Overall Sexual Distress score | Equal variance assumed     | 0.050                                  | 0.824 | -0.352                       | 55     | 0.726           | -1.02709        | 2.91552               | -6.86993                                  | 4.81574 |
|                               | Equal variance not assumed |  |       | -0.352                       | 54.528 | 0.726           | -1.02709        | 2.91851               | -6.87706                                  | 4.82287 |

The results of Levene's Test for Quality of Variances shows the variances are not significantly different from one another. The results of the t-test do not prove a statistically significant difference between help-seeking behavior and non-help-seeking behavior in regards to overall sexual distress. This is shown in the Sig (2-tailed) column in which the value is greater than .05.

In addition to the t-test, a crosstabulation of help-seeking behavior and overall sexual distress was compiled. For this crosstabulation, the researcher divided the FSDS-R scores into four categories:

- Score of 0-14 = Minimal overall sexual distress
- Score of 15-28 = Mild overall sexual distress
- Score of 29-42 = Moderate overall sexual distress
- Score of 43-56 = Severe overall sexual distress

The FSDS-R scores were divided into four categories in order to gauge minimal to severe levels of overall sexual distress. Table 9 illustrates the frequencies for each overall sexual distress category. Table 10 is a crosstabulation of help-seeking behavior by overall sexual distress categories.

The results of the independent samples test could not statistically prove significant differences between help-seeking behaviors and overall sexual distress. More individuals in the help-seeking sample scored within the mild overall sexual distress category, while more individuals in the no help-seeking sample scored within the moderate overall sexual distress category. The chi-square test of difference test shown in Table 11 shows no significant difference was found between help-seeking behavior and overall sexual distress.

Table 9: Frequencies of Overall Sexual Distress by Category

|          | Frequency | Percent |
|----------|-----------|---------|
| Minimal  | 4         | 7.0     |
| Mild     | 22        | 38.6    |
| Moderate | 25        | 43.9    |
| Severe   | 6         | 10.5    |
| Total    | 57        | 100.0   |

Table 10: Crosstabulation of Help-Seeking Behavior and Overall Sexual Distress Categories

|                               |                    |                       | After your sexual violence experience(s), did you seek support/help? |        | Total  |
|-------------------------------|--------------------|-----------------------|--|--------|--------|
|                               |                    |                       | Yes  | No     |        |
| Overall Sexual Distress Score | Minimal or Mild    | Count                 | 15   | 11     | 26     |
|                               |                    | % within Score        | 57.7%  | 42.3%  | 100.0% |
|                               |                    | % within help-seeking | 51.7%  | 39.3%  | 45.6%  |
|                               | Moderate or Severe | Count                 | 14   | 17     | 31     |
|                               |                    | % within Score        | 45.2%  | 54.8%  | 100.0% |
|                               |                    | % within help-seeking | 48.3%  | 60.7%  | 54.4%  |
| Total                         |                    | Count                 | 29   | 28     | 57     |
|                               |                    | % within Score        | 50.9%  | 49.1%  | 100.0% |
|                               |                    | % within help-seeking | 100.0%   | 100.0% | 100.0% |

Table 11: Chi-Square Tests for Help-Seeking Behavior and Overall Sexual Distress

|                                    | Value             | df | Asymptotic Significance (2-sided) | Exact Sig. (2-sided) | Exact Sig. (1-sided) |
|------------------------------------|-------------------|----|-----------------------------------|----------------------|----------------------|
| Pearson Chi-Square                 | .888 <sup>a</sup> | 1  | 0.346                             |                      |                      |
| Continuity Correction <sup>b</sup> | 0.458             | 1  | 0.499                             |                      |                      |
| Likelihood Ratio                   | 0.891             | 1  | 0.345                             |                      |                      |
| Fisher's Exact Test                |                   |    |                                   | 0.429                | 0.250                |
| Linear-by-Linear Association       | 0.873             | 1  | 0.350                             |                      |                      |
| N of Valid Cases                   | 57                |    |                                   |                      |                      |

a. Zero cells (0.0%) have expected count less than 5. The minimum expected count is 12.77.

b. Computed only for a 2x2 table.

The independent samples test and chi-square test of difference found no significant difference was found between help-seeking behaviors and overall sexual distress scores.

### **Correlational Tests: Analyzing Relationships**

Pearson's r and Spearman's rho tests were performed to analyze relationships between: 1.) non-help-seeking behavior and overall sexual distress, 2.) sexual assault and overall sexual distress, and 3.) sexual assault and sexual interest. Spearman's rho was chosen to evaluate the monotonic relationship between the paired data. Pearson's r was chosen to evaluate the linear relationship between the continuous variables. Table 12 illustrates the Spearman's rho test to examine any correlations between help-seeking behavior and overall sexual distress.

Table 12: Correlational Test Between Help-Seeking Behavior and Overall Sexual Distress

|                |   |                         | After your sexual violence experience(s) did you seek support/help? | Overall Sexual Distress score |
|----------------|---|-------------------------|---|-------------------------------|
| Spearman's rho | After your sexual violence experience(s) did you seek support/help? | Correlation Coefficient | 1.000   | 0.069                         |
|                |   | Sig. (2-tailed)         |   | 0.608                         |
|                |   | N                       | 57  | 57                            |
|                | Overall Sexual Distress score                                       | Correlation Coefficient | 0.069   | 1.000                         |
|                |   | Sig. (2-tailed)         | 0.608   |                               |
|                |   | N                       | 57  | 57                            |

The correlational test depicted in the above table shows no significant correlation found between help-seeking behavior and overall sexual distress [ $r=0.069$ ,  $n=57$ ,  $p=0.608$ ].

During the course of data analysis, it became clear that Pearson's  $r$  could *not* be conducted for several reasons. First, relationships between help-seeking behavior and overall sexual distress could not be analyzed due to the help-seeking variable being nominal rather than interval. Secondly, relationships between sexual assault experience(s) and sexual interest or overall sexual distress could not be analyzed because there was not another group (e.g. individuals who do not have a sexual assault experience) within the sample to compare with.

### **Descriptive Data: Current Sexual Experience**

At the end of the online survey, participants had the option to write in their own words to describe their current sexual experiences. These responses were coded for common themes, as shown in Table 13. Note that one participant opted out of this question, which means the data in Table 13 depicts 56 participants in the sample population.



Table 13: Current Sexual Experiences Reported by Sample Population

| Theme*  | Frequency | Percentage of Sample Population |
|---|-----------|---------------------------------|
| Anxiety                                       | 13        | 23.2%                           |
| Better, good                                  | 12        | 21.4%                           |
| Comfortable                                   | 4         | 7.1%                            |
| Consent                                       | 16        | 28.6%                           |
| Healthy                                       | 6         | 10.7%                           |
| Less Desire                                   | 4         | 7.1%                            |
| Less Satisfying                               | 3         | 5.4%                            |
| Loving  | 12        | 21.4%                           |
| Nonviolent                                    | 3         | 5.4%                            |
| No sexual activity                            | 15        | 26.8%                           |
| Partner is understanding, patient, respectful | 11        | 19.6%                           |
| Safe  | 8         | 14.3%                           |
| Satisfying                                    | 4         | 7.1%                            |

\*Open-ended responses provided by participants were coded with multiple themes.

The majority of participants (28.6%) identified their current sexual experiences as now being consensual. On the other hand, 26.8% of participants denied any sexual activity at the time of taking the survey. Participants also identified anxiety (23.2%) as a present emotion in their current sexual experiences. Not insignificant to the sample population’s lived experiences, the outliers of this open-ended question were the responses “nonviolent” (5.4%) and “less satisfying” (5.4%).

## Findings

### Hypothesis I

The researcher hypothesized when compared to queer women who denied help-seeking behavior, queer women who reported help-seeking behavior will report decreased overall sexual distress.

The independent t-test demonstrates the Sig (2-tailed) value as 0.726. Because this value is

greater than .05, it can be concluded there is no significant difference found in overall sexual distress by help-seeking behavior after the sexual violence experience(s).

### **Hypothesis II**

The researcher hypothesized queer women who denied help-seeking behavior would report increased overall sexual distress. A Spearman's rho test was conducted and found a weak association between the two variables [ $r=0.069$ ]. Consequently, this hypothesis was not statistically proven for correlation.

### **Hypothesis III**

The researcher hypothesized queer women who report sexual assault perpetrated by a previous intimate partner would report increased overall sexual distress. The Pearson's r and Spearman's rho tests could not be conducted because there were no individuals in the population sample who reported "no" to a sexual assault experience. Consequently, this hypothesis could not be statistically tested for relationships. However, the descriptive data shows

### **Hypothesis IV**

The researcher hypothesized queer women who report sexual assault perpetrated by a previous intimate partner would report decreased interest in sex. The Pearson's r and Spearman's rho tests could not be conducted because there were no individuals in the population sample who reported "no" to a sexual assault experience. Consequently, this hypothesis could not be statistically tested for relationships.

### **Current Sexual Experiences: Open-Ended Responses**

In the results section of this chapter, Table 7 described common themes that derived from the data coded from the final optional open-ended question. The final section of this chapter will

outline in more detail three main themes that derived from the final optional open-ended question. Only one participant opted out of responding to this final question.

### **Theme 1: Current sexual experiences carry anxiety and triggers**

The first prominent theme that appeared from the data was that of anxiety, nervousness, triggers, and post-traumatic stress symptoms. About 23.2% of the sample population identified themselves as currently experiencing anxiety and post-traumatic stress symptoms in regards to their sexual experiences.

- “I frequently feel anxious about my lack of libido and feel guilty I can’t give to my partner more.”
- “I am triggered when my partner initiates sex and feel very shut down which is frustrating for me and rejecting for her—which I then feel guilty about.”
- “I definitely have triggers and PTSD. I would describe myself as more cautious, maybe asexual.”
- “I haven’t had sex for a while and probably won’t.”
- “I don’t think I could ever be monogamous again.”
- “I haven’t had sex since leaving my sexually abusive partner because I don’t have the support I need to be able to and this is frustrating to me.”
- “Anxiety-provoking”
- “I have periods of nervousness around sex”

### **Theme 2: Sexual violence experience(s) as impacting libido, desire, and behavior**

The second theme that appeared from the open-ended question data was sexual violence experience(s) as having an impact on libido, desire, satisfaction, and behavior.

- “My libido is way lower”

- “Infrequent sexual experiences”
- “Minimal sex”
- “I’m not having sex at all”
- “I haven’t had sex since leaving my sexually abusive partner because I don’t have the support I need to feel able to”
- “I don’t want to have sex at all”
- “I probably won’t have sex again”
- “I frequently feel anxious about my lack of libido”

### **Theme 3: Current sexual experiences as improved**

The third theme that appeared was describing current sexual experiences as improved when compared with the relationship with their previous intimate partner who had perpetrated sexual violence. About 21.4% of the sample population specifically reported their current sex life as “better” than before.

- “Much better”; “much better these days!”
- “100000% better. Apples and oranges”
- “Entirely different and better”
- “I have the support I need”
- “My sex life is honestly ideal now”
- “My sex life is my own now”
- “significantly better and healthier”

Specifically, 28.6% of the sample population identified their current sexual experience as embodying consent for sex. Participants also described their current sexual partner(s) as supportive, respectful, and understanding.

- “better communication and mutual respect”
- “an abundance of communication and consent”
- my partner is understanding and loving—the opposite of my ex who assaulted me numerous times”
- “consensual and loving”
- “My current partner knows my history, is an excellent communicator, and is very patient when it comes to our sex life.”
- “I am in a loving and secure relationship and I feel open and free with my sexuality. It took a while to heal and come to that point.”
- “I’m in a nonabusive relationship with an understanding woman who is patient if I don’t want sex. I actually occasionally initiate sex, which is not something I’ve really done before.”
- “I’m not being actively gaslit and manipulated and my partner is also a survivor of sexual abuse so not only am I have fulfilling sex, I am having sex wherein both of us are communicating and acknowledging each other’s boundaries.”
- “My current partner is kind and understanding about the impact that my last partner had on my feelings around sex and always makes sure that we communicate effectively and that I feel safe.”

### **Limitations and Biases**

A significant limitation of this study is the makeup of the sample population. Because the majority of the sample population was white cisgender women between the ages of 20 and 29, this study represents a small and homogenous sample. The results of these findings cannot be

generalized due to this homogenous sample as well as due to the sample size containing less than 60 people.

During recruitment of participants for this study, the researcher realized there was a flaw in the inclusion criteria in regards to gender identity. The recruitment materials specified that individuals must be female-identified to participate in the study. However, the online survey was programmed to exclude individuals who selected the “Transgender, male” gender identity designation in the demographics section. Consequently, any individual with female-lived experience but not currently identifying as female were excluded. Two individuals attempted to participate in this study chose this gender identity designation, and were consequently led to the disqualification page of the online survey before being able to complete it. This is a flaw that should *not* be overlooked for future research within the LGBTQ population. Individuals can have female-lived experience but not identify as female. The researcher realizes this was a limitation in this study, possibly excluding individuals for participation. The researcher encourages future researchers to employ the use of a “fill-in-the-blank” choice for gender identity, giving individuals the ability to name their identity in their own words. The spectrum of gender identity should be considered and used as a lens of analysis when developing future research (e.g. the inclusion and exclusion criteria) regarding the LGBTQ community.

Another significant limitation was discovered during the data analysis process. Because the online survey software, Qualtrics, had been programmed to automatically disqualify individuals not meeting the inclusion criteria, Hypotheses III and IV were not able to be statistically tested.

While quantitative design has several benefits (as discussed in the previous chapter), the format does not allow for follow-up questions or questions of clarification for items on the online

survey. This is a limitation because it leads to limited outcomes; in other words, *the results of this study cannot be generalized*. The use of an online survey with closed-ended questions provides participants with limited options of responses. For instance, when asked to indicate level of helpfulness of sources of support, the majority of participants in the sample group identified the sources of support as “a little helpful.” The nature and design of the anonymous online survey could not ask participants to elaborate on their answers, such as asking how/why the source(s) of support were helpful or not helpful for them or which source(s) of support were most helpful. In addition, the researcher ultimately selects and edits these responses, and thereby carry their own bias based on their personal background.

Lastly, this study was not developed nor reported without bias. As a member of the LGBTQ community, the development and reports of this study may be impacted by the researcher’s queer identity and lived experience. Furthermore, as a white cisgender woman, the development and reports of this study are certainly impacted from the researcher’s place of white privilege and cisgender privilege. The researcher’s place of privilege has the potential to influence the interpretation of the results, which were already representative of a homogenous sample. These experiences both contributed positively to the way the researcher developed the study as well as potentially negatively in that the researcher did not want to interpret the results based on personal experience and social location.

These results and findings will be discussed in the following chapter.

## CHAPTER V

### Discussion

The purposes of this study are to 1.) Challenge the myth of the perfect victim/ideal aggressor binary of sexual violence from queer women's lived reality of sexual violence; 2.) Increase the scope of knowledge on female sexual experiences after sexual assault through the inclusion of strictly queer women; and 3.) Utilize the study's findings to assist clinical social workers in meeting the mental health needs of this population.

#### Queering Sexual Violence

Women's sexuality and sexual experiences carry the weight of historical and structural implications. Constructs of female sexuality create, maintain, and reproduce specific sexual, gendered, racialized and maternal scripts. Traditionally, this script outlines for individuals to be a heterosexual, cisgender white woman who has sex solely for reproductive purposes. As reviewed in Chapter II, Iasenza (2010) described queer as "the potential and fluidity and multidimensionality of same and other sex/gender experience in all people...[and] embodies the confounding nature of sexuality in general with its incongruities and paradoxes in sexual behaviors, attractions, thoughts, feelings, fantasies, and sensations" (p. 292). In this way, queer is much more than relating to the LGBTQ+ experience; it is to challenge dominant discourse on sex, sexuality, and gender as well as to embrace the fluidity of individual/collective experience. Further, the utilization of "queer" as a verb is deliberate; to queer something is to take a look at its foundations and question them. By queering something, its limits, biases, and boundaries can be explored. In this way, queering IPV becomes a process of critically examining existing dominant frameworks of relationship violence. The research being presented in this investigation is not immune to these critical examinations.



Dominant narratives of sex and sexuality are rooted in systems of inequality, such as sexism, racism and white supremacy, heterosexism/homophobia, ableism, and so on. These systems of inequality bring forth constructs of power, privilege, and oppression. For instance, whiteness is a privilege granted by racism and white supremacy; consequently, people and communities of color are systematically disadvantaged. Cisgender is a privilege granted by transphobia and sexism. Heterosexuality is a privilege granted by heterosexism and homophobia. These concepts of power and privilege must be taken into account when conducting research with human subjects who are members of marginalized communities from the above-mentioned systems of inequality.

It is extremely important that one takes notice of the narrow population sample this investigation has brought forth. As reviewed in Chapter IV, the population sample is overwhelmingly comprised of white, cisgender, lesbian women between the ages of 20 and 29. Consequently, the results and findings of this study are more so reflective of this population sample. As previously mentioned, whiteness is a privilege and is reflective of dominant narratives in the United States. Because the population sample is overwhelmingly white, the results and findings this investigation brings forth cannot and should not be generalized to communities of color. Due to systems of inequality, the experiences of queer people of color will be drastically different than the experiences of white queer people. This is not to say that the experiences of white queer people is not important to research; this is to say that simply studying the experiences of white queer people is a significant limitation.

In addition to the population sample consisting of mostly white individuals, the sample also contains mostly cisgender women. This is important to note because the experience of cisgender individuals is rooted in systems of inequality, such as transphobia and sexism.

Cisgender individuals are granted privilege while transgender individuals are systematically disadvantaged. In the LGBTQ+ community, gender is not necessarily constructed in a binary fashion (male/female). Gender is a spectrum and not necessarily limited to two possibilities. This investigation asked individuals to indicate their gender identity. Their responses were indicative of a spectrum: cisgender female, transgender female, gender non-conforming, non-binary, cisgender femme, femme, gender fluid, genderfluid female, intersex, non-binary woman, queer femme, questioning, and trans non-binary. While these responses are not an exhaustive list, it shows that the population sample has a variety of gender identities beyond the gender binary of male/female. While a little over fifty percent of the sample identified as cisgender, the other gender identities reported by the sample is important when continuing to read, understand, and conceptualize the discussion brought forth in this chapter.

### **Queering Sex, Sexuality, and Mental Health**

#### *Queering Historical Contexts*

Queer women's lived experiences are subjective to historical and structural contexts of sex, sexuality, and psychiatry. While this researcher utilized the Female Sexual Distress Scale-Revised (FSDS-R), developed by Derogatis et al. (2008), it is important to critically analyze the historical and structural contexts associated with female sexual dysfunction, female sexual distress, and sexual violence that ultimately impact the lived experiences of survivors. While these historical and structural contexts were reviewed in Chapter II, it is crucial when engaging in discussion of queer women's sexual experiences after sexual violence to keep these contexts as a frame of reference for understanding the lived experiences of queer survivors.

The intersections of systems of inequality--particularly sexism, heterosexism/homophobia, transphobia, racism, ableism, and classism—are intricately connected

with the historical development of female sexuality in psychiatry. Recall in Chapter II that psychoanalysis “dominated discussions of female sexuality and its problems...psychopathology involved the failure to adhere to norms of gender and femininity” (Angel, 2010, p. 2). In other words, this failure to adhere to gendered sexual scripts resulted in the pathology of women’s sexual experiences, labeled as female sexual dysfunction or neurosis and social disintegration (p. 2). Furthermore, social factors (in particular, feminism and lesbianism) were “linked to clitoral sexuality,” which in turn linked the individual to failure of adhering to the above-mentioned gendered sexual scripts (p. 2). As the present chapter continues forward, keep in mind these significant historical and structural contexts that do not adequately serve or represent the lived experiences of queer women, especially when reviewing the data regarding the FSDS-R scores.

The researcher chose to utilize the FSDS-R (Derogatis et al., 2008) to test for reported feelings and problems related to sex and sexuality after a sexual violence experience(s). The FSDS-R is a self-administered questionnaire that consists of 13 items that relate to different aspects of sex-related distress for female-identified individuals. Individuals completing the FSDS-R respond to each item on a scale of 0 to 4 (Never=0, Rarely=1, Occasionally=2, Frequently=3, Always=4). Scores greater than 11 indicates a clinical level of sexual distress. The data demonstrated that 93% of respondents scored within a clinical level sexual distress.

While the qualitative data does not statistically support hypotheses, the themes that emerged from the narrative accounts are powerful and worth noting. As reviewed in Chapter IV, three themes emerged from the qualitative data: 1.) presence of anxiety and post-traumatic stress symptoms, 2.) impact of SSIPV on libido, desire, and sexual behavior, and 3.) an overall improved sex life.

### *Theme 1: Presence of Anxiety and Post-Traumatic Stress Symptoms*

The first theme that appeared in the qualitative data was current sexual experiences carry anxiety, nervousness, triggers, and post-traumatic stress symptoms. Due to the nature of qualitative data, it is difficult to prove an association between their experiences of anxiety and a sexual assault experience perpetrated by a previous intimate partner. However, the responses hold significance because they are the exact language employed by queer survivors of SSIPV.

Some responses to note:

- “I would describe myself as more cautious”
- “I frequently feel anxious...and feel guilty I can’t give to my partner more”
- “I have periods of nervousness around sex”
- “I am triggered when my partner initiates sex and feel very shut down”

Furthermore, 93% of respondents scored on the FSDS-R within clinical levels of sexual distress, with the majority of respondents scoring in a range of mild to moderate overall sexual distress. In addition to this, Becker et al. (1984) found that “ a sexual assault is more likely to cause a survivor to perceive sexual stimuli as anxiety-provoking” (p. 18).

Cohen and Byers (2015) conducted a research study to test for associations between internalized heterosexism and the sexual functioning of sexual minority women. While their findings did not support their hypothesis that negative events (such as sexual violence) are associated with decreased sexual functioning, they did find that internalized heterosexism could affect the sexual functioning of queer women in the form of lower sexual self-esteem, higher sexual anxiety, and more frequent negative automatic thoughts (p. 399). This finding provides some insight onto this first theme that emerged in the presently discussed study. While this study did not ask participants about internalized heterosexism, it can be safely assumed that

participants have experienced some form of heterosexism and homophobia due to their social locations as sexual minority women. This cannot be proven, but certainly this can provide insight on the current sexual experiences of queer women after sexual violence by a previous intimate partner.

In research conducted by Nobre (2012), findings illustrated that women experiencing sexual dysfunction tend to interpret unsuccessful sexual events as a sign of failure and personal incompetence (p. 361). Furthermore, these automatic thoughts were found to be associated with emotional responses of “sadness, disillusion, guilt, and anger” (p. 362). Items on the FSDS-R can be compared to Nobre’s findings. More respondents reported frequently feeling guilty about sexual difficulties (42.1%), frequently feeling inferior because of sexual problems (31.6%), and frequently feeling sexually inadequate (28.1%). These reports, combined with the knowledge of the overall FSDS-R scores, could indicate support of Nobre’s findings.

A study conducted by Barlow (1989) tested for associations between anxiety and sexual arousal and/or activity. Barlow found that anxiety can inhibit sexual arousal and/or activity in sexually dysfunctional individuals or anxiety can facilitate arousal and/or activity in sexually functional individuals (p. 146). The anxiety reported by the respondents in the qualitative data certainly impacted their current sexual arousal and/or activity in a variety of ways, whether as inhibitors or facilitators. For instance, one respondent reported, “I am triggered when my partner initiates sex and feel very shut down.” While the nature of the online survey could not pose follow-up questions, this respondent’s report seems to illustrate anxiety as inhibiting their sexual arousal and/or activity with their current partner(s), which supports a component of Barlow’s findings. Furthermore, respondents were asked to identify the amount of time that passed before they had sex and the amount of time that passed before they felt comfortable to have sex. The

majority of participants reported 1-2 years before having sex; some also revealed having sex within 1 week to 1 year of their sexual violence experience(s). Alternatively, more respondents reported 1-2 years before feeling comfortable having sex. Does this data support Barlow's findings about anxiety as inhibiting or facilitating sex? The fact that there is a reported difference between first having sex and feeling comfortable having sex (regardless of the amount of time) could show that anxiety derived from the sexual assault experience(s) is acting as either an inhibitor or facilitator for sex.

*Theme 2: Sexual violence experience(s) as impacting libido, desire, and behavior*

Barlow's research ties in with the second theme emerging from the qualitative data: sexual violence experience(s) impacting libido, desire, and behavior. Respondents reported less desire, less satisfaction, lower libido, and decreased or no sexual activity. One respondent reported, "I frequently feel anxious about my lack of libido." This indicates that this respondent's anxiety inhibits sexual arousal and/or behavior rather than facilitates it. On the other hand, other respondents noted decreased libido, infrequent sexual behavior or minimal sex, decreased desire for sex, or not having sex at all. These respondents did not indicate whether these current sexual experiences were impacted by anxiety derived from their sexual violence experience(s). Based on Barlow's findings, one can speculate that anxiety derived from their sexual violence experience(s) did facilitate their current experiences.

Research by Becker et al. (1984) about the long-term effect of sexual assault on the sexual functioning of survivors found that most respondents attributed their sexual problems to the assault. Notably, the researchers found that "response-inhibiting problems were experienced over three times more frequently than orgasmic problems...this data suggests that a sexual assault is less likely to interfere with a survivor's physiological responding than to cause a

survivor to perceive sexual stimuli as anxiety-provoking and to re-label her sexual feelings as reduced or absent altogether” (p. 18). These findings pose the question whether the respondents in the currently discussed study perceive sexual stimuli as anxiety-provoking and consequently relabeling their sexual feelings.

The current investigation was unable to test for correlations between sexual violence perpetrated by a previous intimate partner and overall sexual distress; however, 93% of the population sample, all of whom reported were survivors of SSIPV, scored within clinical levels of sexual distress. The question at this point is whether a sexual assault experience can be correlated with higher levels of sexual distress. Feldman-Summers et al. (1979) found that rape has a strong negative impact on aspects of women’s sexual experiences, labeling this the negative association hypothesis. Becker et al. (1984) found that the majority of their population sample attributed sexual problems to their sexual assault, and the most common problems reported were fear of sex, arousal dysfunction, and desire dysfunction. On average, respondents in the present study reported that after their sexual violence experience(s), they had less sexual interest and sexual behavior.

Could the overall FSDS-R scores reflect sexual self-esteem? Perhaps higher scores on the FSDS-R are reflective of lower sexual self-esteem and lower scores on the FSDS-R are reflective of higher sexual self-esteem. If that is the case, could it be said that 93% of the sample population (which scored in clinical levels of sexual distress) has lower sexual self-esteem? If that is the case, then the average FSDS-R score of 29.26 (out of a possible 56) indicates moderate overall sexual distress and therefore moderately low sexual self-esteem. Additionally, Shapiro and Schwarz (1997) found that women who had been date raped had lower sexual self-esteem. While unable to test for correlations on the present study, the fact that the data reflects an

overwhelming majority of the sample population being within clinical levels of sexual distress seems significant. An association between a sexual assault experience and lower sexual self-esteem can be speculated.

*Theme 3: Current sexual experiences as improved*

Barlow's research findings about anxiety facilitating sexual arousal and/or sexual activity may connect with the third theme that emerged from the qualitative data: current sexual experiences as improved. About 21.4% of the sample population specifically reported their current sex life as "better" than before. One respondent reported, "My sex life is honestly ideal right now." Of significant note, 28.6% of the sample population specifically identified their current sexual experiences as having explicit experiences of consent. One can speculate whether this reported improvement in their sex lives is due to anxiety acting as a facilitator to sexual arousal and/or sexual activity, as Barlow's research found. Did their sexual violence experience(s) trigger anxiety? If yes, does this anxiety act as a facilitator? Is the presence of consent, reported improved communication with current sexual partner(s), and reported overall improved sex lives due to their sexual violence experience(s) and derived anxiety? Alternatively, one cannot assume that a negative event (such a sexual violence experience) results in anxiety. Research conducted by Cohen and Byers (2015) found that negative events are not necessarily associated with decreased sexual functioning or activity (p. 397). On the other hand, research conducted by Feldman-Summers et al. (1979) found the negative association hypothesis, which theorized that rape has a strong negative impact on aspects of women's sexual experiences.



## **Barriers to Help-Seeking After Sexual Violence**

As illustrated in the previous chapter, the population sample was divided between two groups: individuals who confirmed they sought help after their sexual violence experience(s) and individuals who denied help-seeking after their sexual violence experience(s).

Twenty-eight individuals denied help-seeking after their sexual violence experience(s), amounting to 49.1% of the sample population. Previous research (Cohen et al., 2015; Helleman et al., 2015; Hester et al., 2009; McDonald, 2012; Murray et al., 2009; Ristock, 2005; and Walters, 2011) about same-sex IPV (SSIPV) has indicated there are unique barriers unique to the LGBTQ+ community to seeking and or accessing help.

The research findings support components of Walters' (2011) qualitative research about same-sex IPV (SSIPV). In the research, Walters found there is an overall silence and concealment about violence taking place in same-sex relationships, naming this as "denial at the community level" (p. 262). This community-level denial is not only in place in the dominant culture, created and reinforced by systems of inequality (e.g. homophobia, sexism, etc.), this denial is also active within the LGBTQ+ community, reinforced systems of inequality and the internalization of those systems. This community-level denial was represented in the investigation: 46.4% of the non-help-seeking individuals reported fearing judgment from members of their culture and 42.9% reported they did not think sexual violence could happen in queer relationships.

About 28.6% of the non-help-seeking sample reported a barrier to help-seeking was not being "out" to family or friends. In their research, McDonald (2012) theorized the coming out process leaves queer women vulnerable to SSIPV, especially if their partner has been out longer and has connections within queer communities (p. 642). This investigation does not significantly

support McDonald's theorization, but the existence of data shows this is something to be explored further. One participant stated, "I feared for the loss of support from our community if I were to tell others." Another: "She was a trans woman and I didn't want to isolate her." This second statements hints that not only does the survivor of SSIPV fear isolation from the community for themselves, but also for the perpetrator. This may be indicative of not wanting to "betray" members of a historically marginalized community even if that member is a perpetrator of violence.

Evidence suggests that individuals in the LGBTQ+ community are especially susceptible to being placed at a socioeconomic disadvantage (American Psychological Association, 2017). Scherzer (1998) found that the single most frequently identified barrier to accessing assistance among lesbian women was money. Other research (Ard et al., 2011; Goodmark, 2013) has shown that LGBTQ+ individuals have the risk of rejection and isolation from "family, friends, and society, and dependence on social networks that provide support and stability may make efforts to separate from abusers and seek help more costly" (p. 17). The data in this investigation revealed socioeconomic status as a barrier to help-seeking, supporting this evidence. For instance, the data showed 25.0% of individuals in the non-help-seeking group did not have the financial means to access help, 17.9% feared loss of housing if they sought help, and 10.7% didn't have transportation to access help.

Survivors of SSIPV may also encounter barriers on intra- and interpersonal levels. For instance, survivors of SSIPV may experience feelings of shame, embarrassment, guilt, sadness and fear (p. 18). In this investigation, individuals in the non-help-seeking sample group reported examples of these types of barriers. About 60.7% of individuals in the sample group reported feelings of shame and 60.7% reported fear no one would believe them. One respondent reported:

“I thought I deserved it somehow. I also thought I was overreacting.” Another respondent reported: “I thought it was my fault or that I deserved it.” Another respondent reported: “Talking about it was too painful.”

Dominant narratives and understandings of what constitutes SSIPV may even prevent survivors from recognizing incidents of abuse and/or that their partners are abusive. Hassouneh et al. (2008) found that women who experienced violence from a same-sex intimate partner did not initially consider these incidents to be violence (p. 313). This is reflective in the data discovered in this investigation: 64.3% of individuals in the non-help-seeking group reported they were unaware or unsure if they were in an unsafe situation and 42.9% reported they didn't think sexual violence could happen in queer relationships. One respondent reported: “I didn't know that what I had experienced was considered sexual violence.” Another reported: “I wasn't sure it was violence, but now I realize it was because I didn't want to have sex and was forced to.” This also really speaks to the changeover in terminology from “domestic violence” to “intimate partner violence” in which society needs to catch up with the limited scope of domestic violence to include all people, not just heterosexual couples.

Barriers may also take form on the institutional level. Scherzer (1998) and Girschik (2002) found that queer women might have a limited knowledge of LGBT-specific and/or LGBT-friendly assistance providers in their local areas. This barrier is shown in the data: 28.6% of individuals in the non-help-seeking group reported not having knowledge of local sexual violence services. One respondent specifically elaborated, “I didn't know about local sexual violence services for queer folks.” Furthermore, individuals who confirmed they sought help were more likely to seek help from friends rather than institutional sources, such as professional mental health or a domestic violence shelter. Four respondents identified the following

institutional supports utilized: law enforcement, judicial system, and the emergency room. This outlying data within the help-seeking sample group suggests that the institutional barriers described by both Scherzer and Girschik carries relevance to queer women experiencing SSIPV.

### **Help-Seeking Behavior**

When individuals in the LGBTQ+ community do seek help, research has indicated that they are more likely to draw upon support from their personal social networks (Renzetti, 1988; Turrell, 2000; Merrill et al., 2000; McClennen et al., 2002). This is reflected in the sources of support identified by the help-seeking sample group in the currently discussed study: 79.3% of respondents in the help-seeking sample group reported they sought friends for support.

Sometimes individuals in the LGBTQ+ community seek help from professional mental health, such as from therapists, psychologists, counselors, or social workers. About 75.9% of the help-seeking sample group reported they sought professional mental health after their sexual violence experience(s). Interestingly, more individuals identified individual therapy (72.4%) than group therapy (17.2%). This is interesting due to the evidence that posits individuals in the queer community are more likely to rely on personal support networks within their communities.

Additionally, research shows that queer people cite law enforcement as an unhelpful source of assistance for sexual violence (Renzetti, 1988; Turrell, 2000; McClennen, 2002). Two people in the help-seeking sample group sought assistance from law enforcement. This data is reflective of the previous research that cites the unhelpfulness of law enforcement.

Several studies suggest that individuals in the queer community who are survivors of SSIPV have low confidence in their health care providers' ability to help (Brown et al., 2015). Individuals in the help-seeking sample group were asked to identify the quality of help of their

source(s) of support. The average response indicated their source(s) of support were a little helpful to helpful.

### **Implications for Social Work**

The currently presented investigation presents with several implications for the field of social work. First, while statistical tests of correlation could not be conducted, the data illustrated clinical levels of sexual distress for 93% of the population sample. This data is significant for social workers serving queer women who are survivors of SSIPV. It tells social workers that there may be a correlation between a sexual assault experience(s) perpetrated by an intimate partner and sexual distress. With this knowledge, social workers may be able to better serve individuals in this population.

This investigation also illustrates what previous research has shown: individuals in the LGBTQ+ community face barriers to seeking help that are unique to their sexual orientation and gender identity. When working with this population, it is crucially important to not only foresee what those barriers are, but to understand that these barriers are put in place by systems of inequality (sexism, homophobia, heterosexism, and so on). Therefore, when developing and providing interventions, social workers can ethically provide those interventions to the population.

This investigation also highlights help-seeking patterns among this population: queer women in this population are more likely to rely on informal, personal networks for assistance, such as friends. Queer women who reported seeking professional mental health services were more likely to report seeking individual therapy rather than group therapy, which poses the question: in a population that has historically gathered together and sought comfort/acceptance in community spaces, how and why are mental health spaces not seeing enrollment in group

therapy? Are there therapy groups catered for this population? Are they accessible? If they exist, why is this population not enrolling and attending in them? Perhaps this investigation will help social workers create and develop groups specifically for queer women who are survivors of SSIPV, or to make existing groups for IPV survivors more inclusive for queer women utilizing the knowledge about the unique barriers this population faces.

### **Recommendations for Future Research**

The prevalence of sexual violence and intimate partner violence (IPV) within queer communities demands a framework that meets the complexities of queer identity and experience. Sexual violence and IPV cannot be fully understood through the lens of a gender-based analysis, as this lens constructs gendered assumptions that effectively render the experiences of queer communities invisible. Future research about sexual violence and IPV within queer communities should move past a gendered framework and adapt an intersectional framework. Future research about the sexual experiences of queer people should adapt a framework that does not adhere to gendered sexual scripts.

As discussed earlier, the present investigation had a limited population sample. Others who wish to continue the exploration of sexual experiences of queer women after sexual violence should consider expanding the demographics of their population sample. Utilize recruitment techniques not solely in white LGBTQ+ communities and expand the search to queer communities of color.

As discussed in Chapter II and in this chapter, previous research has explored the impact of sexual violence on sexual functioning; however, the previous research operated with a gendered sexual script as lens for the development and interpretation of the data collected. Much of the previous research did not note the sexual orientations of participants within their

population sample. This could have been due to the interconnectedness of the historical development of psychiatry and gendered sexual scripts. Future research on the topic of sexual functioning after sexual assault should critically examine the ways gendered sexual scripts impact understandings of sexual functioning. Future research on the topic of sexual functioning after sexual assault should continue to recruit for their population sample within the LGBTQ+ community, as this present investigation highlights some significance for the population.

Initially, the present investigation sought to examine sexual functioning through utilization of the Female Sexual Function Index (FSFI) (Rosen et al. 2000). The FSFI is a self-report questionnaire measuring female sexual function. Consisting of 19 questions, the FSFI measure sexual function in five domains: desire and arousal, lubrication, orgasm, satisfaction, and pain/discomfort (p. 202). When the present researcher presented the initial plan to utilize the FSFI with queer women with sexual violence experience(s) to the Smith College Human Subjects Review Committee (SCHSRC), it was rejected due to the graphic content of the measure. While the researcher holds appreciation to the SCHSRC for its commitment to protecting human subjects, this rejection was unprecedented. In order to effectively serve queer women experiencing sexual distress, there needs to be research to provide data and evidence for mental health professionals to learn from. Research cannot be watered down because it is too graphic. Sex and sexuality are part of the lived experiences of many individuals; to reject questions about sex and sexuality because they are too graphic limits the research, is a disservice to the clients served by mental health professionals, and frankly perpetuates systems of inequality (sexism, heterosexism/homophobia, classism, racism, and so on).

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**Appendix A**

**Informed Consent**



**Consent to Participate in a Research Study**

**Smith College School for Social Work • Northampton, MA**

.....

**Title of Study:** Queer women’s sexual experience after sexual assault in a non-heterosexual relationship

**Investigator(s):** Amee Catalano, [acatalano@smith.edu](mailto:acatalano@smith.edu)

.....

**Introduction**

You are being asked to participate in a research study about the sexual experiences of queer women after a sexual assault experience. You were selected as a possible participant because you identified as a queer woman with a sexual assault experience from a previous intimate partner in a non-heterosexual relationship. Due to the complexity of queer identity, queer woman may include: lesbian woman, bisexual woman, asexual woman, demisexual woman, pansexual woman, cisgender woman, and/or transgender woman. Sexual assault is defined as any sexual contact/activity occurring without your consent. If you are currently in a relationship with the intimate partner perpetrating sexual violence, you will be automatically excluded from participating in this study. I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

## **Purpose of Study**

The purposes of the study are:

- 1.) To challenge the myth that sexual violence does not occur within queer relationships;
- 2.) To expand the scope of knowledge of queer women's sexual experiences after sexual assault;  
and
- 3.) To use the data collected to assist clinical social workers in meeting the mental health needs of queer women after sexual violence perpetrated by an intimate partner.

This study is being conducted as a research requirement for my Master's in Social Work degree. Ultimately, this research may be published or presented at professional conferences.

## **Description of the Study Procedures**

If you agree to be in this study, you will be asked to do the following things:

- Complete an online survey about your experiences after sexual violence.

## **Risks/Discomforts of Being in this Study**

Participation in this study could result in discomfort and/or emotional distress due to the highly sensitive and intimate nature of the survey questions.

Should you experience these potential risks, I have compiled a packet of resources for you to access. You can download this packet of resources [HERE](#). *[A link to the packet of resources to download will be inserted here.]*

## **Benefits of Being in the Study**

The benefits of participation are: 1.) Having the opportunity to share your personal story, and 2.) the knowledge that your personal story may be used to fill a gap in existing research and literature. The benefits to social work/society are: 1.) Expanding the scope of knowledge

regarding the sexual experiences of queer women after sexual assault, 2.) Gathering more data about queer women's experiences of sexual violence, and 3.) Assisting clinical social workers in providing more informed and quality services to queer women.

### **Confidentiality**

Your participation will be kept confidential and anonymous. I will not collect names, email addresses or other identifying data. The survey software, Qualtrics, is programmed to not record IP addresses. Survey responses will be encrypted to ensure that the data is private and confidential. The data gathered will be kept confidential, accessible only by me, my research advisor, and the data analyst.

In addition, the records of this study will be kept strictly confidential. All research materials including analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. I will not include any information in any report I may publish that would make it possible to identify you.

### **Payments/gift**

You will not receive a payment/gift for participation in this study.

### **Right to Refuse or Withdraw**

The decision to participate in this study is entirely up to you. You may choose not to answer any question or withdraw from the study at any time before the end of the survey by exiting your web browser window. If you exit before clicking the "Done" button at the end of the survey, any data you entered will be eliminated. Once you click "Done" however, I will not be able to remove

your data because the anonymous nature of the survey will make it impossible to identify which responses are yours.

### **Right to Ask Questions and Report Concerns**

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Ameer Catalano at [acatalano@smith.edu](mailto:acatalano@smith.edu) or by telephone at (xxx) xxx-xxxx. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

### **Consent**

Your electronic signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be provided the option to download a PDF copy of this form to keep, which I suggest you save and print for your records. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

I AGREE

I DISAGREE *[If checked, participants will be led to disqualification page.]*



**Appendix B**  
**Recruitment Email**

**[DATE HERE]**

Dear **[NAME OF RECIPIENT= key community leader of queer community]**

I am writing about my Master's level thesis. My thesis explores the sexual experiences of queer women after sexual violence perpetrated by a previous intimate partner in a non-heterosexual relationship. Previous research has focused on women's sexual experiences after sexual assault as perpetrated by men, leaving a significant gap in the literature. My goal is to begin filling this research gap by examining the sexual experiences of exclusively queer women after sexual violence perpetrated by a previous intimate partner. In addition, my goal is to challenge the myth that queer relationships are immune to sexual violence. I also hope to use this study's findings to assist clinical social workers in meeting the needs of queer women after sexual violence.

Participation in the study consists of completing an anonymous, online survey. It will take between 10 minutes to 30 minutes to complete. Participants will be asked a series of personal and sensitive questions about their sexual life after their sexual violence experience. At any point prior to submitting the survey, a participant may opt out by simply exiting the page.

Will you please help me find individuals to participate in thesis? I am looking for participants who meet the following criteria:

- Identify as queer and female-identified
- Aged 18+ over
- Experienced sexual violence as perpetrated by an intimate partner

- Not currently in a relationship with the perpetrator of sexual violence
- The relationship the violence occurred in is considered non-heterosexual

Will you please forward this email to anyone who might be interested in participating in my study? I have attached the recruitment flyer to this email for your reference. Interested individuals may proceed directly to the survey link at **[insert hyperlink to the online survey here.]** or contact me via email ([acatalano@smith.edu](mailto:acatalano@smith.edu)) or phone (xxx-xxx-xxxx) with questions they may have about participation in the study.

Thank you for your time and help!

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Best,

Amea Catalano, B.A.

Master's of Social Work Candidate

Smith College School for Social Work

[NOTE: This text is for social media postings. The post will include the following text as well as a copy of the recruitment flyer.]

To members of [**SOCIAL MEDIA GROUP NAME HERE**]

I am writing about my Master's level thesis. My thesis explores the sexual experiences of queer women after sexual violence perpetrated by a previous intimate partner in a non-heterosexual relationship. Previous research has focused on women's sexual experiences after sexual assault as perpetrated by men, leaving a significant gap in the literature. My goal is to begin filling this research gap by examining the sexual experiences of exclusively queer women after sexual violence perpetrated by a previous intimate partner. In addition, my goal is to challenge the myth that queer relationships are immune to sexual violence. I also hope to use this study's findings to assist clinical social workers in meeting the needs of queer women after sexual violence.

Participation in the study consists of completing an anonymous, online survey. It will take between 10 minutes to 30 minutes to complete. Participants will be asked a series of personal and sensitive questions about their sexual life after their sexual violence experience. At any point prior to submitting the survey, a participant may opt out by simply exiting the page.

Are you interested in participating in my thesis? Or, do you know anyone who may be interested in participating? I am looking for participants who meet the following criteria:

- Identify as queer and female-identified
- Aged 18+ over
- Experienced sexual violence as perpetrated by an intimate partner
- Not currently in a relationship with the perpetrator of sexual violence
- The relationship the violence occurred in is considered non-heterosexual

I have attached the recruitment flyer to this post for your reference. Interested individuals may proceed directly to the survey link at **[insert hyperlink to the online survey here.]** or contact me via email ([acatalano@smith.edu](mailto:acatalano@smith.edu)) or phone (xxx-xxx-xxxx) with questions they may have about participation in the study.

Thank you for your time and help!

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Best,

Amee Catalano, B.A.

Master's of Social Work Candidate

Smith College School for Social Work

## Appendix C

### Recruitment Flyer

**Queer Women's Sexual Experiences after Sexual Violence**

Please consider participating in my research study.

**Qualifications for Participation**

- o You are a member of the LGBTQ+ community
- o You are female-identified or have female lived experience
- o You are age 18 or older
- o You have a sexual violence experience as perpetrated by an intimate partner
- o The relationship the sexual violence occurred is considered non-heterosexual
- o You are no longer in this relationship

**Purposes of this study:**

1. Challenge the myth that violence does not occur in queer relationships
2. Gather information about queer women's sexual experiences after sexual violence perpetrated by an intimate partner
3. Use the findings to assist clinical social workers in meeting the mental health needs of queer women survivors of sexual violence.

**Participation involves taking a confidential and anonymous online survey answering a series of highly sensitive questions about your sexual experiences after sexual violence.**

**You will be automatically excluded if any of the following apply to you:**

a.) you are not a member of the LGBTQ+ community, b.) you are not female-identified or do not have female lived experience, c.) you are under the age of 18, d.) you do not have a sexual violence experience as perpetrated by an intimate partner, and e.) you are currently in a relationship with the person who perpetrated sexual violence against you.

**If you meet the qualifications for participation and do not have experiences noted in the exclusion criteria, you may access the survey here: <LINK>**

Questions? Contact Ameer Catalano at [acatalano@smith.edu](mailto:acatalano@smith.edu) or ~~919.919.9199~~

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

## Appendix D

### Human Subject Review (HSR) Application

2016-2017

Smith College School for Social Work

Human Subjects Review Application

Project title: Queer women's sexual experience after sexual assault in a non-heterosexual relationship

Is this a joint project (more than one researcher working on this study)?  No  Yes

Name of researcher(s): Ameer Catalano

Check one:  MSW  PhD

Phone (include contact researcher for joint projects): (916) 402-1484

Email (include email for contact researcher for joint projects): acatalano@smith.edu

Research advisor: Mariko Ono

The signature below testifies that I, as the researcher, pledge to conform to the following: As one engaged in research utilizing human subjects, I acknowledge the rights and welfare of the participants involved. I acknowledge my responsibility as a researcher to secure the informed consent of the participants by explaining the procedures and by describing the risks and benefits of the study. I assure the Committee that all procedures performed under the study will be conducted in accordance with those federal regulations and Smith School for Social Work policies that govern research involving human subjects.

**Any deviation from the study (e.g.: change in researcher, research methodology, participant recruitment procedures, data collection procedures, etc.) will be submitted to the Committee by submitting a Protocol Change Form for which you MUST receive**

approval *prior* to implementation. I agree to report all deviations to the study protocol or adverse events IMMEDIATELY to the Committee.

Researcher: \_\_\_\_\_Amee Catalano,

11/18/2016\_12/19/2016\_\_\_\_\_

Name(s)

(Date)

Research Advisor/Committee Chair\_\_\_\_Mariko Ono,

9/20/16\_\_\_\_11/23/16\_12/19/16\_\_\_\_\_

(Date)

**IN THE SECTIONS BELOW WHERE DESCRIPTIONS ARE REQUESTED, BE SURE TO  
PROVIDE SUFFICIENT DETAIL TO ENABLE THE COMMITTEE TO EVALUATE  
YOUR PROCEDURES AND RESPONSES.**

**1. DESCRIPTION OF RESEARCH PROJECT INVOLVING HUMAN PARTICIPANTS**

Briefly summarize the purpose of the study, the over-arching research question, the specific research design you will use and why you have chosen it for this study, and the planned use of human participants, and a brief synopsis of relevant literature that points to need for further study (NO MORE THAN A HANDFUL OF ARTICLES) **with sufficient detail and in clear, concise language** (*space will expand in all sections as you enter your information*):

Women's sexuality and sexual experiences have important historical and structural implications for clinical social work practice regarding the treatment of female sexual dysfunction after sexual assault. Constructs of female sexuality create, maintain, and reproduce a specific sexual, gendered, and maternal script for women to follow; further, this sexual script inevitably requires the individual to be a heterosexual and cisgender woman who has sex solely for reproduction in order to be a mother (Angel, 2010). Deviation from this script results in pathology of women's sexual experience, labeled as female sexual dysfunction. Previous literature (Burgess and Holmstrom, 1974; Feldman-Summers et al., 1979; Orlando and Koss, 1983; Becker et al., 1984) has focused on sexual dysfunction experienced by women after a sexual assault perpetrated by a man. The women's anti-violence movement in the 1970s framed a perpetrator/victim binary in which only a cisgender man could be the perpetrator and only a white, heterosexual, middle-class, cisgender woman could be the victim. This discourse perpetuates two major myths: 1.) Women are not capable of being perpetrators of sexual violence, and 2.) Sexual violence is



exclusively a heterosexual experience (Angel,2010). Both of these myths have directed previous research to conform to this perpetrator/victim standard, thereby limiting knowledge regarding the sexual experiences of queer women after sexual assault. For the purposes of this study, queer women may include individuals who are cisgender, transgender or, at the time of their sexual assault experience, identified as female. Queer women may also refer to individuals who are bisexual, lesbian, asexual, pansexual, demiseual, or queer and are female-identified. For the purposes of this study, sexual assault/violence is defined as sexual contact/activity without consent and as perpetrated by an intimate partner. In this study, the terms “sexual assault” and “sexual violence” will be used interchangeably. Consent is defined as an informed, freely given, non-coerced, explicit “yes” to sexual contact/activity. Sexual contact/activity is defined to include, but not limited to, penetration, unwanted sexual touching or fondling, forcing of the victim to perform sexual acts, verbal abuse, and attempted rape/sexual assault.

The proposed study seeks to explore the following questions: Do queer women experience changes in their sexual interest and behavior after sexual assault perpetrated by a previous intimate partner? How do queer women feel about these changes? For the purposes of this study, “partner” and “intimate partner” will be used interchangeably, and are defined as: an individual with whom one has a close personal relationship that can be characterized by emotional connectedness, regular contact, ongoing physical contact and/or sexual behavior, identity as a couple, and familiarity and knowledge of each other’s lives (Center for Disease Control and Prevention, 2015). “Previous partner” is defined as an individual whom one has had a close personal relationship with, but no longer. The purposes of the proposed study are to 1.) challenge myths of the perfect victim/ideal aggressor binary of sexual violence from queer women’s lived reality of sexual violence, 2.) increase the scope of knowledge on female sexual experiences after

sexual assault through the inclusion of strictly queer women, and 3.) utilize the proposed study's findings to assist clinical social workers in meeting the mental health needs of this population. The proposed study will utilize a quantitative design to answer the proposed research question. Hester and Donovan (2009) recommended the use of quantitative rather than qualitative design when researching this topic. This is because experience is not "Truth" experience is varying stories that hint at the Truth (p. 164). For this reason, I will employ quantitative design to increase accuracy and objectivity of the results. Individuals will participate in the study via online survey. Since the topic of this study may be emotionally triggering for participants, a survey can provide emotional distance from the topic, as opposed to an interview in which a participant speaks at length regarding a topic. Participants will follow the instructions and answer a series of open-ended and closed-ended questions. Participants will not have direct contact with the researcher. The researcher developed the online survey content based on the literature reviewed on the topic and adaptation of existing assessment tools (e.g. the Female Sexual Function Index and the Female Sexual Distress Scale).

**2. PARTICIPANTS:** if you are only observing public behavior, skip to question d in this section.

a). How many participants will be involved in the study?

    12-15        X    $\geq 50$           Other (how many do you anticipate)

b). List specific eligibility requirements for participants (or describe screening procedures), including exclusionary and inclusionary criteria. For example, if including only male participants, say so, and *explain why*. If using data from a secondary de-identified source, skip to question e in this section.

A participant must identify as a queer woman. Due to the complexity and fluidity of queer identity, a queer woman identity may include: lesbian woman, bisexual woman, asexual woman, demisexual woman, pansexual woman, cisgender woman, and/or transgender woman.

Participants will be excluded from the study if they identify as a heterosexual woman (heterosexual is defined to be an individual who is sexually and/or romantically attracted to individuals of the opposite gender). Participants must have a sexual violence experience as perpetrated by a previous partner. For the purposes of this study, sexual assault/violence is defined as sexual contact/activity without consent and as perpetrated by an intimate partner. For the purposes of this study, “partner” and “intimate partner” will be used interchangeably, and are defined as: an individual with whom one has a close personal relationship that can be characterized by emotional connectedness, regular contact, ongoing physical contact and/or sexual behavior, identity as a couple, and familiarity and knowledge of each other’s lives (Center for Disease Control and Prevention, 2015). “Previous partner” is defined as an individual whom one has had a close personal relationship with, but no longer. If currently in a relationship with the partner perpetrating sexual violence, participants will be automatically excluded from the study in order to protect the wellbeing of the participant. The previous relationship the sexual violence occurred in must be considered non-heterosexual. If the relationship is considered heterosexual, the participant will be excluded from the study.

All participants will receive a copy of a resource packet at the beginning and completion of their participation. This copy will be accessible via a PDF download. Please see Attachment A for a copy of this resource packet.

c). Describe how participants will be recruited. ***Be specific: give step-by-step description of the entire recruitment process, including getting permission to post flyers or post messages on***

**internet sites.** *Attach all flyers, letters, announcement, email messages etc. that will be used to recruit. **Include the following statement on any/all recruitment materials/emails/internet postings, etc:*** This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

The population sample will consist of at least 50 participants who meet inclusion criteria and currently reside in the United States. The proposed study will utilize snowball sampling and convenience sampling for the recruitment of participants. The researcher will utilize social media platforms for recruitment, posting a flyer and accompanied letter. These social media platforms include: Facebook groups for the queer community, LinkedIn groups for queer-identified individuals, Reddit group for queer sexual assault survivors, and Tumblr posting with tags related to the queer community (e.g. #queer #LGBT and so on). This writer is a member of these groups and does not need permission to post. Despite the researcher being a member of these groups, the researcher is not personally acquainted with every member of them.

The researcher will send a recruitment letter to key leaders of the queer community in their own locale. In this case, this locale would be Arcata, California and Seattle, Washington. These key leaders have been identified based on their involvement in Pride (annual month of LGBTQ+ pride), queer community resource centers, and personal connection with the researcher. Key leaders with personal connection will not be eligible to participate in the study, but will be utilized as a starting point for snowball sampling. These key leaders are only expected to forward the information to individuals they believe meet criteria and would be interested in participating.

When potential participants click the hyperlink on the recruitment email they received or on the social media posting, they will immediately be directed to the online survey.

Please see Attachments B1 and B2 for a copy of the recruitment text and Attachment B2 for a copy of the recruitment flyer.

d). Is there any relationship between you as the researcher and the participants (e.g. teacher/student, superintendent/principal/teacher; supervisor/clinician; clinician/client, etc.) that might lead to the appearance of coercion? If so, what steps will you take to avoid this situation. For example: “I will not interview individuals who have been direct clients.”

The researcher is a member of the queer community. Individuals with whom the researcher has had a personal relationship will be excluded from participating in the study.

e). Are the study *target subjects* members of any of the following federally defined vulnerable populations? (ONLY check if the study focus area is SPECIFICALLY based on any of the listed groups. For instance, if your study is about how persons who are economically disadvantaged access services, you DO check ‘Economically disadvantaged’ category below. DO NOT CHECK IF SOME OF THESE FOLKS MAY BY CHANCE BE IN A MIXED SAMPLE – EXCEPT IF THERE ARE CHILDREN/UNDER 18 YEAR OLDS. Thus: if you are asking about how individuals who live in inner city locations get to services, you DO NOT check any of the categories below, because there is a range of types of people who live in these environments who may wish to participate, and you do not define the population as ‘economically disadvantaged’).

Be aware that checking ‘yes’ **automatically requires the HSR Full Review.**

Yes     No

If 'Yes', check the group(s) all that apply in your study:

minors (under 18 years of age) Please indicate the approximate age range of minors to be involved. Participants under age 18 require participant assent AND written consent from the parent/legal guardian. Please use related forms.

prisoners

pregnant women

persons with physical disabilities

persons with diagnosed mental disabilities

economically disadvantaged

educationally disadvantaged

### **3. RESEARCH METHODS:**

(Check which applies)

Interview, focus group, non-anonymous questionnaire

Anonymous questionnaire/survey

Observation of public behavior

Analysis of de-identified data collected elsewhere ('secondary data')

( ) Where did these data come from originally?

---

---

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---

Did this original research get IRB approval?  Yes  No

(Skip to BENEFITS section)

\_\_\_ Other (describe)

---

---

Describe the nature of the interaction between you and the participants. Additionally, if applicable, include a description of the ways in which different subjects or groups of participants will receive different treatment (e.g., control group vs comparison group, etc.).

a). Please describe, with sufficient detail, the procedure/plan/research methodology to be followed in your research (e.g. this is a quantitative, survey based study; tell us what participants will do; etc).

The proposed study will utilize quantitative method. During data collection, participants will answer a series of open-ended and closed-ended questions via online survey.

Participants will click the link to the online survey. There will be a introduction to the study, followed by the pre screening page, then the appropriate informed consent documents for the participant to review, followed by the ‘I agree to participate in this study’ box. Once they click on the ‘I agree to participate’ box, participants will be led to the survey. First, participants will enter their demographic information. The demographic information will be used to describe the sample. Then, participants will answer a series of open-ended and closed-ended questions.

Participants may withdraw from the study at any time by simply exiting out of the survey. All responses will be anonymous and confidential.

b). How many times will you meet/interact with participants? (***If you are only observing public behavior, SKIP to question d in this section.***)

The researcher will not directly meet with participants. Should a participant have questions regarding their participation and/or the study itself, the researcher's email and phone number will be provided for contact. Using email may break anonymity, and the participant will be informed of this risk. Should a participant email the researcher, the email will be stored separate from the data.

c). How much total time will be required of each participant?

Participants should expect to spend between 10 minutes to 30 minutes of time for completion of the online survey.

d). Where will the data collection occur (please provide sufficient detail)?

Data collection will occur on their personal computer with Internet access. The survey is online via Qualtrics and can only be accessed with an Internet connection.

e). If you are conducting surveys, attach a copy of the survey instrument to this application. If you are conducting individual interviews or focus groups, including ethnographies or oral histories, attach a list of the interview questions as an "Attachment". Label attachments alphabetically, with descriptive titles (e.g.: *Attachment A: Interview Questions*).

For a copy of the online survey questions, please see Attachment C: Online Survey.

**4. INFORMED CONSENT: (If you are only observing public behavior, SKIP to next section)**

a). What categories of consent documentation will you be obtaining from your participants?

(Check all that apply)

written participant consent

written parent/guardian consent

Child assent 14-17

Child assent, assent 6-13



Adult with guardian consent

b). Attach original consent documents. \*note: be advised that, electronic signatures and faxed, signed consents ARE allowed. Please describe how you will gain consent.

Please see Attachment D for a copy of the original consent documents. When entering the online survey, participants will be presented on their screen with a copy of the informed consent document. Participants will read the document and electronically sign for consent by clicking “I AGREE” and submitting the online form. Participants will be asked to print a copy of their consent form for their records.

#### **5. COLLECTION /RETENTION OF INFORMATION:**

a). With sufficient detail, describe the method(s) of recording participant responses (e.g., audiotape, videotape, written notes, surveys, etc.)

Participant responses will be recorded via online survey as accessed through their personal computer.

b). Include the following statement to describe where and for how long will these materials will be stored and the precautions being taken to ensure the security and safety of the materials,.

All research materials including analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

c). Will the recordings of participant responses be coded for subsequent analysis? ***If you are only observing public behavior, SKIP to next section.***

Yes

No

## **6. CONFIDENTIALITY:**

a). What assurances about maintaining privacy will be given to participants about the information collected?

1. Anonymity is assured (data cannot be linked to participant identities)

2. Confidentiality is assured (names and identifying information are protected, i.e., stored separately from data).

3. Neither anonymity nor confidentiality is assured

b). If you checked (2) above, describe methods to protect confidentiality with sufficient detail.

Describe how you will maintain privacy of the participant as well as the data.

Individuals will not have to provide their name to participate in this study. Additionally,

Qualtrics will be programmed not to record IP addresses. All identifying information will be removed from the data and will not be used in the results/findings section of the thesis. All data collected will be kept on a password-protected external hard drive for three years after the dissemination of the study.

c). If you checked (3) above, explain, with sufficient detail, why confidentiality is not assured.

N/A

d). If you checked (3) above, provide sufficient detail that describes measures you will take to assure participants understand how their information will be used. Describe and attach any permissions/releases that will be requested from participants.

N/A

## **7. RISKS:**

a). Could participation in this study cause participants to feel uncomfortable or distressed?

Yes

No

If yes, provide a detailed description of *what steps* you will take to protect them.

Participation in this study could cause individuals to feel uncomfortable or distressed. This will be made clear to the participant during the informed consent process. At any time during participation in the survey, the individual may choose to opt out of the study simply by exiting out of the web browser. A packet of resources will be made available via PDF download to all individuals who enter the survey. This resource will include, but is not limited to: national sexual violence/domestic violence resources, national domestic violence hotline, queer-friendly resource center(s), queer-friendly counseling service providers, and online national queer-friendly mental health resources.

b). Are there any other risks associated with participation (e.g. financial, social, legal, etc.)?

Yes

No

If yes, provide a detailed description of the measures you will take to mitigate these additional risks.

Participants face the potential of experiencing risks during participation in this study.

Participants who are currently in a relationship with the perpetrator of sexual violence could result in interpersonal repercussions from the perpetrator. As such, individuals currently in a relationship with the perpetrator will be automatically excluded from participation. This exclusion criterion will be made clear on the recruitment materials (the flyer and social media postings) as well as on the online survey. There will be screening questions at the beginning of the online survey to determine eligibility of the individual. Additionally, participants also face the potential of experiencing emotional risks during participation in this study. The topic area of

this study is sensitive and may cause emotional distress. Prior to the survey questions and after completion of the survey, participants will be given a list of national resources to seek support. These resources will include: the national domestic violence hotline, transgender lifeline, the national suicide hopeline, the Trevor Project support line, the national domestic violence coalition website, and the national sexual assault coalition website.

**8. COMPENSATION: (If you are only observing public behavior, SKIP to the next section)**

Describe any cash or ‘gifts’ (e.g.: coffee shop gift card) that participants will receive for participating in this research (see guidance about payment/gift compensation in the Smith School for Social Work Human Subjects Review Guideline, at the HSR site in the SSW website).

Participants will not receive compensation for participation in this research study.

**9. BENEFITS:**

a). Describe the potential benefits for you, the researcher, in conducting this study.

This research will assist the researcher in fulfilling their thesis requirement for their Master’s degree in Social Work.

b). Describe the potential benefits for individuals who participate as subjects, EXCLUDING payment/gift compensations.

Sharing personal stories can be an empowering experience for survivors of sexual violence. This study will provide participants with the opportunity to share their personal experiences.

c). Describe the potential benefits to the field of clinical social work from this research?

Previous research has primarily focused on the sexual experiences of heterosexual, cisgender women after sexual assault by men, leaving a gap in knowledge regarding the sexual experiences of queer women after sexual assault by an intimate partner. This study will begin to fill in this knowledge gap by providing a quantitative data analysis. Knowing more about the experiences

of this specific population will assist clinical social workers in providing more informed and quality mental health services to queer women.

**10. FINAL APPLICATION ELEMENTS:**

a. Include the following statement to describe the intended uses of the data:

The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis. The results of the study may also be used in publications and presentations.

b. If there are Co- Researchers, cooperating departments, and/or cooperating institutions, follow the following instructions:

If you are working with/conducting your research with a researcher working at another institution or organization, include a letter of approval from that institution's IRB or agency administrator. If there are multiple researchers, indicate only one person on the Documentation of Review and Approval as the researcher; others should be designated as "Co-Researcher(s)" here.

N/A

c. TRAINING: Include the following statement to describe training:

I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.

## **Appendix E**

### **Permission to Use Standardized Measure**

This study utilized the standardized measure, the Female Sexual Distress Scale-Revised (FSDS-R) on the anonymous online survey. The FSDS-R was developed by Derogatis, Pyke, McCormack, Hunter, and Harding in 2008 as a self-administered questionnaire. Containing thirteen items related to different aspects of sexual distress in women, a score greater than 11 indicates a clinical level of sexual distress.

On May 15, 2017, this writer received verbal permission from Dr. Leonard R. Derogatis to use components of the FSDS-R in this current research study.

## Appendix F

### HSR Approval Letter



---

**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-  
7994

December 22, 2016

Amee Catalano

Dear Amee,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D., Co-Chair, Human Subjects Review Committee  
CC: Mariko Ono, Research Advisor

## Appendix G

### Copy of Survey

*[Bold horizontal lines signal a new page in the questionnaire. Content without a line between them will appear on the same page.]*

#### INTRODUCTION

##### Queer women's sexual experiences after sexual assault in a non-heterosexual relationship

Study designed by Ameer Catalano, MSW Candidate at Smith College School for Social Work

You have entered the anonymous and confidential online survey for a quantitative study that explores the sexual experiences of queer women after sexual violence perpetrated by a previous intimate partner in a non-heterosexual relationship.

Previous research on this topic has primarily focused on women's sexual experiences after sexual assault as perpetrated by men, leaving a significant gap in the literature regarding queer women's experiences. This study seeks to begin filling this research gap by examining the sexual experiences of exclusively queer women after sexual violence as perpetrated by a previous intimate partner. In addition, this study seeks to challenge the harmful myth that violence does not occur in queer relationships. This study also seeks to use the findings to assist clinical social workers in meeting the mental health needs of queer women after sexual violence.

The following terms are defined to help you navigate the content of this survey:

- **Sexual violence/sexual assault:** Sexual contact/activity without consent and as perpetrated by an intimate partner. *During the course of this survey, the terms "sexual assault" and "sexual violence" will be used interchangeably.*
- **Partner/Intimate partner:** An individual with whom one has a close personal relationship that can be characterized by emotional connectedness, regular contact,



ongoing physical contact and/or sexual behavior, identity as a couple, and familiarity and knowledge of each other's lives. *During the course of this survey, the terms "partner" and "intimate partner" will be used interchangeably.*

- **Previous intimate partner:** An individual whom one has had a close personal relationship with, but no longer.
- **Queer women:** Umbrella term used to describe individuals who are cisgender, transgender or, at the time of their sexual assault experience, identified as female. May also refer to individuals who are bisexual, lesbian, asexual, pansexual, demisexual, or queer and are female-identified.
- **Heterosexual:** Sexual orientation of individuals who are sexually and/or romantically attracted to individuals of the opposite gender.
- **Non-heterosexual:** Umbrella term used to describe individuals who are not heterosexual.
- **Consent:** An informed, freely given, non-coerced, explicit "yes" to sexual contact/activity.

Should you encounter discomfort during the course of completing this survey, the researcher encourages you to access your personal support network and/or review the list of resources **HERE**. *[Insert link to PDF download of resource packet.]*

Clicking "next" will lead you to the pre-screening page.

Thank you for your interest in participating in this study.

---

PRE-SCREENING

This is the pre-screening page. Please read through the following criteria to determine if you qualify to participate in this study.

In order to participate in this study, the following criteria must be met:

- You are a member of the LGBTQ+ community
- You are female-identified or have female-lived experience
- You are aged 18+
- You have a sexual violence experience as perpetrated by an intimate partner
- The relationship the sexual violence occurred is considered non-heterosexual
- You are no longer in this relationship

If any of the following criteria applies to you, you will be automatically excluded from participation in this study:

- You are not a member of the LGBTQ+ community
- You are not female-identified or you do not have female lived experience
- You are under the age of 18
- You do not have a sexual violence experience as perpetrated by an intimate partner
- The relationship the sexual violence occurred is heterosexual
- You are currently in this same relationship

If you meet all of the above, and do not have experiences noted in the exclusion criteria and wish to proceed, please check the box provided. *(If checked and the individual clicks “next”, they will be led to the Informed Consent section of the survey.)*

\_\_\_ If you do not meet the above criteria, thank you for your interest and I ask that you exit the survey at this time. *(If checked and the individual clicks “next”, they will be led to the Disqualification Page section of the survey. Individuals may also just exit the web browser.)*

---

#### INFORMED CONSENT

[Please see Attachment D for informed consent document.]

---

#### DOWNLOAD INFORMED CONSENT DOCUMENT

*[Participants who electronically signed the consent form will have the option to download a PDF of the document on this page. Participants who indicate disagreement with the terms of the informed consent document will be automatically directed to the disqualification page. Please see last page of this attachment for the disqualification page text.]*

---

#### NOTICE OF SENSITIVITY

During the course of this survey, you will encounter questions that are highly sensitive and personal in nature. At any time, you may opt out of the study by exiting from the browser window.

Should you encounter discomfort during the course of completing this survey, the researcher encourages you to access your personal support network for support and/or review the list of resources [HERE](#). *[insert link to PDF download of resource packet.]*

In this first section, you will be asked about your demographic information.

---

#### DEMOGRAPHICS SECTION

- Age
  - 18-19
  - 20-29
  - 30-39
  - 40-49
  - 50+
- Race/Ethnicity
  - American Indian or Alaskan Native
  - Asian
  - Black/African American
  - Hispanic or Latino
  - Middle Eastern
  - Multiracial or Biracial
  - Native Hawaiian or Pacific Islander
  - White
  - Other (please specify): \_\_\_\_\_
- Gender Identity
  - Cisgender, female
  - Cisgender, male
    - *If this answer is selected, participant is automatically excluded from the study and will be automatically directed to the disqualification page.*
  - Transgender, female
  - Transgender, male

- *If this answer is selected, participant is automatically excluded from the study and will be automatically directed to the disqualification page.*
  - Gender non-conforming
  - Nonbinary
  - Other (Please specify) \_\_\_\_\_
  - Sexual Orientation
    - Lesbian
    - Bisexual
    - Heterosexual
      - *If this answer is selected, participant is automatically excluded from the study and will be automatically directed to the disqualification page.*
    - Queer
    - Asexual
    - Demisexual
    - Pansexual
    - Other (Please specify) \_\_\_\_\_
  - Relationship Status
    - I am currently in a relationship.
    - I have been in a relationship previously.
    - I have never been in a relationship.
      - *If this answer is selected, participant is automatically excluded from the study and will be automatically directed to the disqualification page.*
-

## PREVIOUS RELATIONSHIP HISTORY

This next section asks questions about your previous relationship in which sexual violence occurred.

Should you encounter discomfort during the course of completing this section, the researcher encourages you to access your personal support network for support and/or review the list of resources [HERE](#) *[insert link to PDF download of resource packet.]*

---

- Sexual Assault/Violence History
  - My previous partner did NOT force me to have sex and/or perform other sexual activities without my consent.
    - *If this answer is selected, participant is automatically excluded from the study and will be automatically directed to the disqualification page.*
  - My previous partner forced me to have sex and/or perform other sexual activities without my consent.
- Was this previous relationship considered non-heterosexual?
  - Yes
  - No
    - *If this answer is selected, participant is automatically excluded from the study and will be automatically directed to the disqualification page.*
- When did the first incidence of sexual violence occur?
  - Less than 6 months ago
  - Less than 1 year ago
  - 1 year ago

- 2 years ago
- 3 years ago
- 4 years ago
- 5+ years ago
- How long ago did the relationship end?
  - Less than 6 months ago
  - Less than 1 year ago
  - 1 year ago
  - 2 years ago
  - 3 years ago
  - 4 years ago
  - 5+ years ago
  - It has not ended.
    - *If this answer is selected, participant is automatically excluded from the study and will be automatically directed to the disqualification page.*

---

## HELP-SEEKING SECTION

This next section asks questions about the ways you may have sought support after your sexual violence experience(s).

Should you encounter discomfort during the course of completing this section, the researcher encourages you to access your personal support network for support and/or review the list of resources **HERE** *[insert link to PDF download of resource packet.]*

---

- After your sexual violence experience(s), did you seek support/help?
  - Yes
    - *If selected, Qualtrics will automatically skip the next question.*
  - No
- If NO, why not? Check all that apply.
  - I feared losing my housing if I sought help.
  - I feared judgment from members of my culture.
  - I didn't have the financial means to seek help.
  - I didn't have transportation to access help.
  - I was unaware or unsure if I was in an unsafe situation.
  - I didn't think sexual violence could happen in queer relationships.
  - I didn't have knowledge of local sexual violence services.
  - I feared my partner would retaliate/do something to harm me if I sought help.
  - I relied on my partner for my daily needs.
  - I wasn't "out" to my family or friends.
  - I didn't want to break up with my partner.
  - I felt ashamed that it happened to me.
  - I thought no one would believe me.
  - Other (please specify) \_\_\_\_\_
    - *Regardless of the selection, after continuing to next page the participant will be directed to the next section (Sexual Experiences Section) (meaning, they will skip the next three questions).*
- If YES, which source(s) of support did you seek? Check all that apply.



- Friends
  - Family
  - Domestic Violence shelter
  - LGBTQ Resource Center
  - Professional mental health (Therapist, Social Worker, Counselor)
  - Hotline
  - Other (please specify) \_\_\_\_\_
- If you received mental health service(s) from a professional (counselor, social worker, and/or therapist), what kind of service did you receive? Check all that apply. If no, please check “N/A.”
    - Individual therapy
    - Group therapy
    - Couples therapy
    - Case management
    - N/A
- Regardless of the type of support you received, how helpful was it for you?
    - Not helpful at all
    - A little helpful
    - Very helpful

---

## SEXUAL EXPERIENCES SECTION

This next section asks questions about your sexual experiences, including...

- Changes in your sexual interest, sexual behavior, and frequency of sexual behavior you may or may not have experienced
- Your feelings about your sexual experiences after the relationship ended

Should you encounter discomfort during the course of completing this section, the researcher encourages you to access your personal support network for support and/or review the list of resources [HERE](#) *[insert link to PDF download of resource packet.]*

The table below asks you about changes in your sexual interest, behavior, and frequency of sexual behavior both **after** your sexual violence experience **and after** the relationship ended. Sexual behavior is defined as your sexual practices (e.g. whether or not you engage in sexual activity, such as intercourse, foreplay, etc.). Frequency of sexual behavior is defined as how often you engage in sexual activity.

AFTER your sexual violence experience AND AFTER the relationship ended, did you notice...?

|   | Significantly less | Less | No change | More | Significantly more |
|---|--------------------|------|-----------|------|--------------------|
| ...a change in your interest in sex?                  |                    |      |           |      |                    |
| ...a change in your sexual behavior?                  |                    |      |           |      |                    |
| ...a change in the frequency of your sexual behavior? |                    |      |           |      |                    |

The following questions are concerning the amount of time that passed before you had sex with a different partner **and** the amount of time that passed before you felt comfortable having sex with a different partner.

How long after the relationship ended did you...

|   | 1-4<br>weeks | 1-3<br>months | 3-6<br>months | 6<br>months-<br>1 year | 1-2<br>years | 2-3<br>years | 3-4<br>years | 4+<br>years<br><br>(Please<br>specify) | N/A  |
|---|--------------|---------------|---------------|------------------------|--------------|--------------|--------------|--|--|
| ...have sex<br>with a<br>different<br>partner?                          |              |               |               |                        |              |              |              |  | I have not<br>had sex<br>since the<br>relationship<br>ended.                           |
| ...feel<br>comfortable<br>having sex<br>with a<br>different<br>partner? |              |               |               |                        |              |              |              |  | I have not<br>felt<br>comfortable<br>having sex<br>since the<br>relationship<br>ended. |

---

Below is a list of feelings and problems that individuals sometimes have concerning their sexuality. Please read and check the number that best describes **how often that problem has bothered you or caused you distress since the relationship ended.**

Since the relationship ended, how often have you felt...?

|   | Never (0) | Rarely (1) | Occasionally<br>(2) | Frequently (3) | Always (4) |
|---|-----------|------------|---------------------|----------------|------------|
| Distressed about your sex life            |           |            |                     |                |            |
| Unhappy about your sexual relationship(s) |           |            |                     |                |            |
| Guilty about sexual difficulties          |           |            |                     |                |            |
| Frustrated by your sexual problems        |           |            |                     |                |            |
| Stressed about sex                        |           |            |                     |                |            |
| Inferior because of sexual problems       |           |            |                     |                |            |
| Worried about sex                         |           |            |                     |                |            |
| Scared to have                            |           |            |                     |                |            |

|                                   |  |  |  |  |  |
|-----------------------------------|--|--|--|--|--|
| sex                               |  |  |  |  |  |
| Regrets about your sexuality      |  |  |  |  |  |
| Sexually inadequate               |  |  |  |  |  |
| Embarrassed about sexual problems |  |  |  |  |  |
| Dissatisfied with your sex life   |  |  |  |  |  |
| Angry about your sex life         |  |  |  |  |  |
| Bothered by low desire            |  |  |  |  |  |

---

### CURRENT EXPERIENCE

This next section asks questions about your current experiences, as of **today**.

Should you encounter discomfort during the course of completing this section, the researcher encourages you to access your personal support network for support and/or review the list of resources [HERE](#) *[insert link to PDF download of resource packet.]*

---

The following questions refer to your current experience, **as of today**.

- I am satisfied with my sex life.
  - Strongly Agree
  - Agree
  - Undecided
  - Disagree
  - Strongly Disagree
  
- I have adequate access to information and services for sexual violence.
  - Strongly Agree
  - Agree
  - Undecided
  - Disagree
  - Strongly Disagree
  
- When compared with your previous partner, how would you describe your sex life now?
  - *(Open-ended, participant writes in answer)*

---

You have reached the end of the survey, but your answers have NOT been submitted. This is your last opportunity to opt out of participation in the study. To opt out, simply exit out of the page; none of your responses will be recorded.

To continue and submit your responses, please click “Submit.”

---

Your responses have been recorded. Thank you for participating in my research study.

Due to the highly sensitive nature of this study, I encourage you to reach out to your personal support network, engage in self-care, and/or access the resources packet I have compiled here

***[Link to the resource packet in PDF download here.]***

### Disqualification Page

***[If an individual does not meet eligibility for the study, they will be directed to this page.]***

Unfortunately, you do not meet eligibility criteria for participating in this study. Thank you for your interest in my research. Please close your browser window; any responses you submitted will not be recorded.

Download a packet of resources in PDF. ***[A link to resource packet will be here for participants to download]***

## Appendix H

### Copy of Resource Packet

# Resource Packet

Compiled by Amee Catalano, MSW Candidate  
Smith College School for Social Work

| Resource   | Phone Number  | Address  | Notes   |
|--|---|--|---|
| <p style="text-align: center;">API Chaya</p> <p><a href="http://www.apichaya.org">http://www.apichaya.org</a></p>  | <p style="text-align: center;">Helpline<br/>(available Mon-Fri): 206-325-0325<br/>Or toll-free at 1-877-922-4292</p> <p style="text-align: center;">Staff and advocates speak around a dozen languages including: Gujarati, Hindi, Urdu, Japanese, Marathi, Tagalog, and Vietnamese. Additional professional interpreters are also available.</p> | <p style="text-align: center;">Mailing address:<br/>API Chaya<br/>PO Box 14047<br/>Seattle, WA 98114</p> | <p>Seattle-based organization that supports Asian, South Asian, and Pacific Islander survivors and families impacted by domestic violence and sexual assault, as well as human trafficking survivors from all communities. Offers survivor support services in the form of a helpline, resources and referrals, advocacy-based counseling, safety and support planning, basic legal advocacy, and support groups.</p> <p>If you live outside of Seattle, they can help you connect to resources in your local area.</p> |
| <p style="text-align: center;">The Asian/Pacific Islander Domestic Violence Resource Project (DVRP)</p> <p><a href="http://dvrp.org">http://dvrp.org</a><br/>(website available for translation in Japanese, Chinese, Hindi, Thai, Vietnamese)</p> | <p style="text-align: center;">Confidential Helpline<br/>(available Mon-Fri): 202-833-2233</p> <p style="text-align: center;">Trained staff and advocates speak over 20 Asian languages.</p>  | <p style="text-align: center;">PO Box 14268<br/>Washington, DC 20044</p>                                 | <p>Non-profit organization dedicated to addressing, preventing, and ending domestic violence and sexual assault in Asian/Pacific Islander communities while empowering survivors to rebuild their lives after abuse.</p>  |
| <p style="text-align: center;">Casa de Esperanza</p> <p><a href="http://www.casadeesperanza.org">http://www.casadeesperanza.org</a></p>  | <p style="text-align: center;">24-hour bilingual domestic violence helpline:</p>  | <p style="text-align: center;">Mailing address:<br/>PO Box 40115<br/>St. Paul, MN 55104</p>              | <p>A national resource center dedicated to supporting the prevention and intervention efforts across the county to</p>  |



|   |  |   |  |
|---|--|---|--|
|   | 651-772-1611   |   | end domestic and dating violence.  |
| Gay and Lesbian Medical Association<br><a href="http://www.glma.org">http://www.glma.org</a>                                | 202-600-8037   | 1326 18 <sup>th</sup> Street NW<br>Suite 22<br>Washington, DC<br>20036      | Advocates for the needs of LGBTQ medical professionals and patients. Offers online phone referrals to LGBTQ friendly healthcare professionals.   |
| GLBT National Help Center<br><a href="http://www.glbtnationalhelpcenter.org">http://www.glbtnationalhelpcenter.org</a>      | 888-843-4564   | 2261 Market St #296<br>San Francisco, CA<br>94114                           | Provides free and anonymous information, referrals, and peer counseling to gay, lesbian, bisexual, transgender, and questioning callers.   |
| GLMA: Health Professionals Advancing LGBT Equality<br><a href="http://www.glma.org">http://www.glma.org</a>                 | 202-600-8037<br><a href="mailto:info@glma.org">info@glma.org</a> | 1100 H Street NW<br>Suite 540<br>Washington DC,<br>20005                    | National organization dedicated to LGBT healthcare equality. Services include policy advocacy, a growing LGBT-friendly healthcare provider membership, and education. Users can search for an LGBT-friendly healthcare provider through their website. |
| National Alliance to End Sexual Violence<br><a href="http://www.endsexualviolence.org">http://www.endsexualviolence.org</a> | N/A  | 1129 20 <sup>th</sup> Street NW<br>Suite 801<br>Washington, DC<br>20036     | Alliance of statewide organizations to end sexual violence. Visit website to find your state's sexual violence resource agency, as well as sexual assault agencies and local domestic violence shelters in your area.                                  |
| National Black Justice Coalition<br><a href="http://nbjc.org">http://nbjc.org</a>   | Office: 202-319-1552   | PO Box 71395<br>Washington, DC<br>20024                                     | Civil rights organization dedicated to empowering black LGBT individuals. The Coalition works with communities and allies for social justice, equality, and an end to racism and homophobia.   |
| National Resource Center on Domestic Violence   | Use the National Domestic Violence Hotline: 1-800-               | Offices located at:<br>6041 Linglestown Rd.,<br>Harrisburg, PA 17112<br>And | National organization to ensure that policy, practice, and research is grounded in and guided by the voices and  |

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| <a href="http://www.nrcdv.org">http://www.nrcdv.org</a>   | 799-7233   | 1101 Vermont Ave.<br>NW, Suite 400,<br>Washington DC 20005 | experiences of domestic violence survivors and advocates.  |
| National Domestic Violence Hotline<br><a href="http://www.thehotline.org">http://www.thehotline.org</a>                               | 1-800-799-7233<br>TTY 1-800-787-3224<br>Deaf Domestic Violence Hotline: 1-855-812-1001   | N/A  | Provides lifesaving tools and immediate support to enable victims to find safety and live lives free of abuse. Provides support, crisis intervention information, and referral services. Established in 1996 with the Violence Against Women Act (VAWA). |
| National Sexual Violence Resource Center (NSVRC)<br><a href="http://www.nsvrc.org">http://www.nsvrc.org</a>                           | 1-717-909-0710<br>TTY: 1-717-909-0715<br>Toll Free: 1-877-739-3895   | 123 North Enola Drive<br>Enola, PA 17025                   | The NSVRC's Mission is to provide leadership in preventing and responding to sexual violence through collaboration, sharing and creating resources, and promoting research.  |
| National Suicide Prevention Lifeline<br><a href="http://www.suicidpreventionlifeline.org">http://www.suicidpreventionlifeline.org</a> | Free, confidential 24/7 hotline: 1-800-273-8255<br>In Spanish: 1-888-628-9454<br>TTY: 1-800-799-4889   | N/A  | National network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24/7.  |
| Rape, Abuse, and Incest National Network (RAINN)<br><a href="http://www.rainn.org">http://www.rainn.org</a>                           | 24/7 Hotline: 1-800-656-HOPE<br>Online chat: <a href="http://online.rainn.org">http://online.rainn.org</a><br>Spanish: <a href="http://rainn.org/es">http://rainn.org/es</a> | N/A.<br>See website for resources in your area.            | Anti-sexual violence organization operating the National Sexual Assault Hotline. Carries out programs to prevent sexual violence, help victims and ensure that perpetrators are brought to justice.  |
| Trans Lifeline  | (877) 565-8860   | Mailing address:   | This line is primarily for   |

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| <p><a href="http://www.translifeline.org">http://www.translifeline.org</a></p>                              |                                     | <p>TransLifeline<br/>2443 Fillmore St.<br/>#380-9468, San Francisco, CA 94115</p> | <p>transgender people experiencing a crisis. The lifeline is staffed by transgender people with the explicit goal to support callers, connect callers with services local to them, and will only call emergency services with the caller's expressed consent.</p> |
| <p>The Trevor Project<br/><a href="http://www.thetrevorproject.org">http://www.thetrevorproject.org</a></p> | <p>24/7 Hotline: 1-866-488-7386</p> | <p>Mailing address:<br/>PO Box 69232<br/>West Hollywood, CA 90069</p>             | <p>National organization providing crisis intervention and suicide prevention services to LGBTQ young people ages 13-24.</p>  |