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Psychological Distress and Relationship Satisfaction Among Survivors of Sexual Violence

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DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Agriculture, Food and Environment
at the University of Kentucky

By
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ABSTRACT OF DISSERTATION

Psychological Distress and Relationship Satisfaction Among Survivors of Sexual Violence

The World Health Organization (WHO; 2002) has indicated that sexual violence is a serious public health concern, and both the WHO and the United Nations (UN) have declared that violence against women, in particular, is a profound violation of human rights (UN General Assembly, 1993; WHO, 2017). Although the systemic and negative impact of trauma on family and intimate relationships have been well documented, the empirical literature regarding the effects of adult sexual trauma on relationship satisfaction is less robust. These studies are designed to address this gap and will do so with analyses centered on an understudied population: the experiences of lesbian, gay, bisexual, transgender, and queer individuals. Additionally, this research will add to the literature by exploring individual coping strategies (e.g., emotion-focused coping) and relational processes (e.g., decision-making) in relation to relationship satisfaction, while considering assault severity and psychological distress. Thus, this research presents opportunities for application in clinical contexts whereby clinicians can focus on creating opportunities for shared decision-making when couples in which one partner has a sexual assault history present for therapy

Study 1: Intimate relationships are critical to posttraumatic functioning; however, there is limited information concerning the association between PTSD symptoms and relationship satisfaction among individuals who have experienced sexual assault in adulthood. Inclusion criteria for this study required participants (N = 480) to be at least 18 years of age, have personal experience with sexual victimization since their 14th birthday, and to be currently involved in a romantic relationship (married or in a committed relationship). This study is designed to examine how relationship satisfaction varies according to sexual assault severity and levels of posttraumatic stress among individuals in committed relationships. Additionally, given empirical evidence suggesting that treatment for psychological distress might mitigate the association between PTSD symptoms and relationship satisfaction, t tests will also be used to assess whether relationship satisfaction statistically differs for assault survivors depending on whether or not they participated in mental health counseling following an experience of sexual violence. Finally, given the relevance of emotion-focused coping related to posttraumatic well-being and relationship functioning, I have hypothesized that behavioral emotion-

focused coping explains unique variance in relationship satisfaction, even after accounting for the variance explained by PTSD symptom severity.

Study 2: Sexual and gender minority (SGM) individuals experience disproportionately high rates of mental health problems and sexual violence compared to heterosexual adults. Given limited empirical evidence hinting at the potential for relationship involvement to buffer adverse mental health effects among SGM individuals who have experienced sexual violence, this study is designed to assess whether PTSD symptom severity differs by gender identity (cisgender vs. transgender and gender nonconforming), sexual orientation identity (sexual minority identity vs. heterosexual/straight), and relationship involvement (yes vs. no). In addition, PTSD symptom severity will be assessed in relation to sexual identity (sexual minority vs. straight) and three levels of relationship status: not currently partnered, partnered but not married, and married. Finally, relationship involvement will be explored as a potential moderator of the association between sexual violence severity and PTSD symptom severity. Participants included 322 individuals who had experienced sexual violence within the past 12 months. Previous experiences of sexual violence and length of current relationship were controlled for in the analyses.

Study 3: Romantic relationships seem to provide added benefits to SGM individuals. Moreover, how partners engage with each other appears particularly relevant for understanding relational contexts that promote psychological resilience following experiences of trauma. The positive relational processes by which SGM individuals solve problems, initiate conversation, and make decisions—often to a degree more effective than heterosexual couples (Gottman et al., 2003)—might be helpful for understanding whether and how relationships act as a protective factor for adverse mental health problems following sexual violence. Thus, this study is designed to consider the associations between relational processes (i.e., decision-making power), relationship satisfaction, and PTSD among SGM individuals who have experienced sexual violence. More specifically, I will attempt to identify what role, if any, decision-making power has in the relationship between relationship satisfaction, PTSD, and sexual violence among SGM individuals. Participants (N = 143) currently partnered SGM individuals who had reported experiences of sexual violence at some point since their 14th birthday.

KEYWORDS: Sexual Violence, Relationship Satisfaction, Posttraumatic Stress Disorder, Emotion-Focused Coping, Feminism, Sexual Minority

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Psychological Distress and Relationship Satisfaction Among Survivors of Sexual Violence

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DEDICATION

This one is for me.

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CHAPTER 1. INTRODUCTION

1.1 Sexual Violence

The World Health Organization (WHO; 2002) indicates that sexual violence is a serious public health concern, and the International Criminal Court's definition of "crimes against humanity" includes, "rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity" and applies to men and women alike (Rome Statute of the International Criminal Court, 1993, p. 7). Both the WHO and the United Nations (UN) have declared that violence against women, in particular, is a profound violation of human rights (UN General Assembly, 1993; WHO, 2017), and a multinational study by the WHO found that women's lifetime prevalence of being sexually victimized by a partner ranged from as low as 6% in Japan, Serbia, and Montenegro to as high as 59% in Ethiopia (García-Moreno et al., 2005). In the United States, the Centers for Disease Control and Prevention has asserted that sexual violence is a substantial problem (Basile et al., 2016): Approximately 11–18% of women and 1–3% of men report being sexually assaulted at some point during their lives (Tjaden & Theonnes, 2000). Another study found that nearly 1 in 5 women and 1 in 71 men in the United States have been raped at some point in their lives, and regarding sexual violence other than rape, approximately 1 in 2 women and 1 in 5 men in the United States experience sexual violence (Black et al., 2011).

Sexual violence encompasses a wide range of sexually violent acts (Canan & Levand, 2019) and has been defined as:

any sexual act, attempts to obtain a sexual act, or acts to traffic for sexual purposes, directed against a person using coercion, harassment or advances made by any person

regardless of their relationship to the victim, in any setting, including but not limited to home and work (Jewkes et al., 2002, p. 149).

Notably, this definition accounts for the different contexts in which sexual violence can occur (e.g., rape in the context of war), the wide range of victim–perpetrator relationships (e.g., sexual assault by an intimate partner), various forms of coercion (e.g., coercion via physical threat), and levels of severity (e.g., sexual harassment). It is therefore important to distinguish between different contexts, victim–perpetrator relationships, coercive tactics, and levels of severity when studying sexual violence (Dartnall & Jewkes, 2013).

Although anyone can experience sexual violence, victims tend to be female (MacKinnon, 2016; Maxwell & Scott, 2014), and the risk of sexual violence is particularly high among racial and ethnic minorities (Abbey et al., 2010; Black et al., 2011; Tjaden & Theonnes, 2006) and lesbian and bisexual women (Rothman et al., 2011; Walters et al., 2013). Increased vulnerability to sexual violence is also associated with being younger rather than older (Siddique, 2015), having previously been raped or sexually assaulted (Classen et al., 2005; Siegel & Williams, 2003), and having many sexual partners (Cook et al., 2016; Holm Bramsen et al., 2012). Among other factors influencing the risk of sexual violence, consuming drugs and alcohol is associated with elevated risk (Siegel & Williams, 2013), as is poverty (Xu et al., 2013).

Sexual violence is also associated with numerous physical and mental health consequences. For instance, sexual violence is associated with sexual and reproductive health complications (e.g., contracting sexually transmitted infections; Alvarado et al., 2018; Grose et al., 2020; Neilson et al., 2017) and sexual risk-taking behavior (Cook et al.,

2016; Kaufman et al., 2019). Regarding mental health effects, sexual violence is associated with depression, anxiety disorders, and posttraumatic stress disorder (Carlson & Oshri, 2018; Chrisler & Ferguson, 2006; Elkit & Chistiansen, 2010: Hedtke et al., 2008; Rees et al., 2011). Additionally, sexual violence is associated with an increased risk of suicidal ideation and suicide attempts (Pico-Alfonso et al., 2006; Tomasula et al., 2012). In fact, one study found that individuals with sexual assault histories were six times more likely to report a suicide attempt in the past year than those without sexual assault histories (Tomasula et al., 2012).

The economic costs of sexual violence are high; for example, the estimated costs of sexual violence in Iowa was $4.7 billion in 2009 and in Michigan was $6.5 billion in 1996 (Post et al., 2002; Yang et al., 2014). The estimated lifetime cost of rape per victim in the United States was $122,461 in 2011, with a population economic burden of $3.1 trillion dollars, which included costs associated with healthcare, the criminal justice system, and productivity (Peterson et al., 2017). Moreover, survivors of intimate partner violence, sexual violence, and stalking miss a mean of 4.9 days from work and school, which translates to $730 in losses per victim and a $110 billion productivity loss across the U.S. population (Peterson et al., 2018).

Families reproduce societal values and norms (Few-Demo, 2014; Pitre & Kushner, 2015) that likely sustain sexual violence (Randall & Venkatesh, 2015). Family scholars are uniquely situated to address the complexities of sexual violence through the study of relationships among individuals and the examination of social forces that influence the context of sexual violence (Gilgun, 2012). Indeed, family scholars have established a need to focus on the political and economic contexts in which families are

situated by intentionally examining the intersection of power, inequality, and inequity to better understand how individuals, relationships, and families function (Ferree, 2010; Few-Demo, 2014; Pitre & Kushner, 2015). Individuals are inseparable from their historical, political, and social contexts; the beliefs, assumptions, and practices of individuals are always contextualized. Thus, family scholars must consider how individuals and families interact with other systems and institutions, how individuals and families are shaping these interactive processes, and how individuals and families are being shaped by these systems and institutions (Gilgun, 2006). Family theories offer an emerging perspective for conceptualizing sexual violence because the effects of sexual trauma are multifaceted and cannot be understood at the individual level alone (Morrison, 2007). All spheres of social life must be considered to fully understand systemic and multilayered processes involved in sexual violence.

In this regard, the relational experiences associated with sexual violence victimization are addressed herein. First, in this chapter, I will overview three theories that might be particularly helpful for framing the scope needed to understand sexual violence and address both the individual and interpersonal consequences of sexual violence: human ecological theory, the life course perspective, and feminist family theory. The next three chapters comprise three research studies that examine the interplay between sexual violence, psychological distress, and intimate relationships. More specifically, I will empirically examine how relationship satisfaction varies according to sexual victimization histories and psychological distress, how psychological distress varies according to sexual victimization histories and relationship involvement, and the role of relational processes in the relationships between relationship satisfaction, psychological distress, and sexual

violence. Finally, I will conclude with suggestions for how family scientists can contribute to the field of sexual violence in an applied context.

1.2 Human Ecology Theory and the Bioecological Model

Human ecology theory provides a framework for understanding how sexual violence victimization impacts individual and familial behaviors. Notably, human ecology theory has emerged as a useful framework for considering how individuals, groups, and communities can approach sexual assault prevention efforts across ecological environments (see McMahon et al., 2019). Bronfenbrenner (1979, 1989) first conceptualized the ecosystem as an array of interconnected systems that make up the ecological environment for the purpose of stressing the interrelatedness of individuals and their various contexts, as well as the simultaneous impacts people and context have on human development. Over time and until his death, Bronfenbrenner continuously reassessed and refined his theory of human development, ultimately introducing the Process–Person–Context–Time (PPCT) model (Brofenbrenner, 2005; Bronfenbrenner & Morris, 1998). The PPCT model provides a framework for viewing the variability of developmental processes as a function of process, person, context, and time (Bronfenbrenner & Morris, 1998; Smith & Hammon, 2012), and can be used to examine the family's role in individual outcomes following sexual violence victimization.

1.2.1 Process

At the core of the PPCT model is process, which represents the dynamic ways of interaction between organisms (i.e., individuals) and their environments. Proximal processes, more specifically, encompass the reciprocal and ongoing interactions between

individuals and the objects, persons, and symbols in their external environment. As the primary mechanism for development, proximal processes reflect those processes that occur in an individual's most immediate environments over an extended period of time, which are likely to have enduring and lasting impacts (Bronfenbrenner & Morris, 1998). As these dynamic processes operate and change over time to become more complex and interrelated, the characteristics of the person (e.g., coping skills), the characteristics of the environment (e.g., availability of resources), the nature of the developmental outcomes considered (e.g., achieving resiliency following trauma), and the historicity and timing of social changes systematically influence the form, content, power, and direction of the proximal processes (Bronfenbrenner & Morris, 1998; Tudge et al., 2009). Thus, in the PPCT model, process explains the interconnection and reciprocal nature of person, context, and time.

1.2.2 Person

The person component of the PPCT model represents the personal characteristics that an individual brings to any social situation and has been classified into three categories of characteristics. Demand characteristics, such as age, gender, and personal appearance, act as immediate stimuli by influencing initial expectations in the context of a new encounter. In the context of sexual victimization, gender can have an immediate impact on one's belief as to whether an assault has occurred. For example, male survivors of sexual assault report confusion about their role as a victim of abuse and have difficulty articulating what abuse actually is from a male victim's perspective (Zverina et al., 2011). The shame experienced, compounded with the incorrect but prevalent assumption that men are not or should not be victims of sexual assault can lead male

survivors to minimize or even conceal their experiences. Furthermore, the construction of a victim identity is integral to the accessibility and focus of social assistance and resources (e.g., counseling services; Leisenring, 2006; Wood & Rennie, 1994), and male victims of sexual violence therefore experience different barriers to recovery than their female counterparts. Resource characteristics include mental and emotional resources (e.g., past experiences, intelligence, etc.) as well as social and material resources (e.g., housing, educational opportunities, etc.) and are not readily apparent but are often inferred from demand characteristics (Bronfenbrenner & Morris, 1998; Trudge et al., 2009). Adult sexual victimization is common among those who are socially disadvantaged, and compared to non-victims, victims of sexual violence are more likely to have lower incomes (Xu et al., 2012). Although sexual violence occurs across all sociodemographic statuses, lower socioeconomic status is associated with an increased risk for violent exposure (Crouch et al., 2000; Spencer et al., 2020; Yakubovich et al., 2018), indicating that resource characteristics such as socioeconomic status are associated with exposure to sexual violence. Furthermore, a lack of economic resources can contribute to the development of attitudes that facilitate violence (see Markowitz, 2003, for review). Force characteristics are dispositional characteristics that concern differences in motivation, temperament, and persistence and can impact developmental trajectories (Tudge et al., 2009). Notably, force characteristics entail components of one's character that are associated with therapeutic effectiveness, such as with Trauma-Focused Cognitive Behavioral Therapy wherein the goal is to regulate affective, behavioral, biological, and cognitive domains that may have been impacted by the trauma experienced (Cohen & Mannarina, 2015).

1.2.3 Context

Context, or the environment, is made up of four interrelated systems. The microsystem represents the immediate environment of an individual and includes the family, school, work, and church. Individuals engage in multiple microsystems at once, and mesosystems describe the interrelations among those microsystems. Although individual behavior can vary based on environment, microsystems are not independent of one another, and the various components of the developing person's environment both impact and are impacted by each additional microsystem (Tudge et al., 2009). For example, conflicting views on sex and sex education from a person's school and church may interface in ways that influence how that person might understand a nonconsensual sexual experience, ultimately shaping the type of resource characteristics that are activated. Whereas the micro- and mesosystems encompass environments in which individuals are directly embedded, settings and institutions (e.g., government agencies, informal social networks, media, etc.) that are more diffuse and yet ever-present via their indirect impact on one's development comprise the exosystem. Conceptualizations of rape and sexual assault in the media and popular culture often portray stereotypical conceptions of victim and offender identities, perpetuate rape myths, and reproduce hegemonic cultural attitudes surrounding sexual violence (Lindgren & Lundström, 2010). Thus, although an individual may not be directly or immediately impacted by the narratives portrayed about what constitutes sexual assault and who can experience sexual assault, these narratives can nonetheless have marked implications for informal or formal disclosure after a victimization experience. Finally, the macrosystem is defined by the values and belief systems (i.e., customs, values, laws, attitudes, etc.) of any given culture and encompasses

(provides context for) all of the other systems even while slowly shifting in response to changes in those other systems (Bronfenbrenner, 1993; Bronfenbrenner & Morris, 1998; Tudge et al., 2009).

1.2.4 Time

The time component of the PPCT model represents how processes, person, and context develop and change over time (Bronfenbrenner & Morris, 1998), and concerns both the relative constancy and change in all aspects of the PPCT model (Trudge et al., 2009). Micro-time represents what is occurring during a particular activity or interaction. For example, sexual assault survivors may experience guilt for not fighting back during an act of sexual violence, which may lead them to question whether what they experienced actually occurred. Relatedly, meso-time represents the degree to which activities and interactions occur. Cumulative effects at the mesosystem level can be attributed to either interactions with individuals over time (i.e., repeated sexual assault by the same individual) or consistency in interactions across multiple individuals and contexts (i.e., repeated experiences of sexual violence across the life course). Macro-time most closely resembles Bronfenbrenner's conceptualization of the chronosystem and refers to the developmental processes that vary according to specific historical events that occur at any given developmental period. Dramatic shifts in rape law, both within international courts and within the United States (Randall & Vankatesh, 2015), the grassroots efforts of women's groups (#MeToo; Jansson & Eduards, 2016), and the development of Sexual Nurse Examiner programs (Mulla, 2014), for example, have helped mobilize support and resources for survivors of sexual violence. Notably, however, the humanitarian conceptualization of rape as a form of gender-based inequality (Davidson, 2018) and the

public recognition of rape and sexual assault as an increasing public health concern (Schwartz et al., 2015) has done little to increase the reporting rates of sexually violent crimes (Randall & Venkatesh, 2015).

1.2.5 Implications

The nested structure of ecological environments in the PPCT model supports the argument that the etiology of violence is multilayered. Indeed, it is not only the experience of sexual violence that affects the individual but also the process and context through which sexual violence occurs and is experienced, including social and cultural factors that have contributed to its occurrence over time. Thus, the various and interconnected systems of influence are important for understanding how spheres of interaction cultivate sexual violence and the health and well-being of those who have experienced it. Viewing sexual violence victimization through the lens of human ecology theory places a spotlight on the risk factors, barriers, and resiliency factors within each system, and in doing so provides avenues to promote, understand, and treat survivors of sexual violence. In addition to prevention efforts in the form of bystander intervention (see Banyard, 2019, for review), an ecological approach to sexual violence victimization could include an examination of survivors' interpersonal relationships, especially given that the dissolution or avoidance of relationships following sexual violence is not uncommon (Miller, 2020; O'Callaghan et al., 2019). Moreover, the interpersonal nature of sexual violence warrants investigation into relationships at the familial, community, and societal levels because these relationships could be avenues for healing and combatting the negative effects of sexual victimization and support the notion that the social ecology surrounding survivors of sexual victimization contributes to post-assault outcomes (Campbell et al., 2009).

1.3 Life Course Perspective

Aging and human development are lifelong processes, and the life course perspective (LCP) takes into account the interplay between the social course of lives and those aging and developmental processes (Elder & Rockwell, 1979). The LCP largely emerged from decades of research that showed the impact historical events, like the Great Depression, had on families, work, and education years after the economy had recovered (Elder, 1974). In addition to locating individual developmental trajectories within social and historical contexts, the "timing, duration, spacing, and order of [life] events and [social] roles" have vast developmental implications (Elder & Rockwell, 1979, p. 2). Therefore, life stages can only be understood in relation to other stages across the lifespan and to the social mores of the historical moment. Moreover, the interplay between age and time has both social and historical meaning; chronological age represents the aging process whereas social age reflects the social roles and timing of said roles within any given society (Elder, 1994; Elder & Rockwell, 1979). Additionally, age, and more specifically birth year, places individuals within a specific cohort in which members experience historical and social changes together, locating individuals in history just as "social age locates roles in the social structure" (Elder & Rockwell, 1979, p. 3). Using the LCP, sexual violence could also be viewed as a process rather than an event, and sexual violence victimization is not only contextualized within individual life histories, but also embedded within social and historical structures. Thus, the LCP is a useful framework for considering the role social, historical, and personal factors play in both the immediate and lifelong consequences of sexual violence.

1.3.1 Historical time and place

The life course principle of historical time and place indicates that one's life course is embedded in and shaped by—that is, cannot be fully understood independent of—the historical time and location one's experiences occur (Elder, 1998). Sexual violence has a long history (Schultz et al., 2016), but contemporary social and legal views of and approaches toward sexual violence have changed over time, thereby changing the ways in which it is experienced. For example, feminist mobilization strategies have helped to shift the perception of rape from a consequence of irresponsible individual behavior toward a view that rape and sexual assault is a systemic social problem (Boyle et al., 2017). Perhaps most notably in the social media age, digital feminism (e.g., #MeToo, #TimesUp) can be a source of community, connection, and a form of solidarity in addressing rape culture (Mendes et al., 2018). The democratic grassroots nature of digital movements such as #MeToo place sexual harassment, sexism, and rape culture center stage in the public conscience and gain traction in many disparate pockets of society (Mendes et al., 2018). Furthermore, digital spaces can provide support and validation where other systems and individuals have failed (Alaggia & Wang, 2020).

Although changes within the justice system often reflect social realities (MacKinnon, 2014), and steps have been taken to combat sexual violence both domestically and internationally, reporting rates of sexual violence remain low (Randall & Venkatesh, 2015). Still, the American Law Institute's 1962 Model Penal Code, which originally included spousal immunity for rape, has undergone revisions due to the power dynamics within spousal relationships in conjunction with increasingly prevalent norms

and expectations concerning gender equality; the Code now stipulates that rape can occur between spouses and is a crime (Davidson, 2018).

Legal changes paired with the meaningful work and coalition building occurring within digital spaces has likely contributed to a change in what it means to have experienced sexual violence. For example, a study found that 69% of Americans believe the #MeToo movement has created an environment where those who are accused of sexual assault and harassment will be held accountable (Jackson et al., 2018). However, despite the consciousness raising that comes from grassroot efforts and the creation of disclosure spaces for survivors of sexual violence, experiences of sexual violence remain complicated: sexism and racism are normalized in everyday life, marginalized identities are not adequately represented in cultural narratives of sexual violence, and barriers still exist for disclosing experiences of sexual violence (Battaglia et al., 2019). Nonetheless, sexual violence today is embedded in and shaped by social, legal, and cultural challenges to narratives about sexual violence.

1.3.2 Trajectories and Transitions

Transitions and trajectories are key principles that guide life course research (Elder, 1998; George, 1993). Transitions, or changes in status, tend to be brief but can have long-term consequences (George, 1993). For many, experiencing sexual violence is a consequential life event that produces "identifiable, discrete changes in life patterns that disrupt usual behaviors and can threaten or challenge personal well-being" (George, 1989, p. 243). Indeed, research has found that sexual assault survivors are experiencing both positive (e.g., appreciation of life) and negative (e.g., psychological distress) changes 2

weeks following sexual violence (Frazier et al., 2001), highlighting the multifaceted consequences associated with sexual victimization.

Those who experience sexual victimization must make sense of their experiences and identities, and gender stereotypes and sexual scripts are influential in this regard (Boyle & McKinzie, 2015). For instance, if the assault does not follow stereotypical narratives of rape—a violent assault perpetuated by a stranger—women are less likely to label their experience as rape (Littleton et al., 2007; Wilson & Miller, 2015), which could create barriers for disclosing this event and receiving help. Moreover, a victim versus survivor identity is associated with psychological distress: Individuals who identify as "survivors" of sexual violence report less distress (i.e., negative emotions, depression, reduced self-esteem) than those who identify as "victims" or "victim/survivors" (Boyle & Rogers, 2020). The clustering of "victims" and "victim/survivors" and distinction with "survivors" in terms of distress suggests that the absence of a victim identity is associated with less distress (Boyle & Rogers, 2020). The "victim" label has also been associated with posttraumatic stress and shame whereas the "survivor" label is associated with anger and less depression (Boyle & Clay-Warner, 2018). In any case, transitions immediately following sexual victimization can have long-term consequences if those transitions hinder the access and use of support resources.

Notably, transitions are embedded within trajectories, which are "long-term patterns of stability and change" (George, 1993, p. 358). Additionally, the consequences of violence may differ based on when it occurs and how it occurs (Swartout et al., 2011; Williams, 2003). For instance, both childhood sexual assault (CSA) and witnessing domestic violence as a child are associated with elevated risk for sexual assault in

adolescence; however, whereas CSA continues to be associated with heightened risk for sexual assault in college and beyond, the risk associated with witnessing domestic violence in childhood recedes (Swartout et al., 2011). In the case of domestic violence, transitioning out of the home seems to serve as a protective factor; however, those with CSA histories remain at risk regardless of the transition and continue to be impacted over time. Women with cumulative abuse histories that started in childhood also have poorer health and fewer socioeconomic resources in later life (Davies et al., 2015).

In addition to early experiences of sexual victimization having consequences for revictimization and overall health, these experiences also appear to be important for later interpersonal relationships. For instance, rape is associated with discomfort in close relationships and is characterized by fear of abandonment, fear of intimacy, and distrust of others (Thelen et al., 1998). Furthermore, CSA is associated with the development of insecure attachment dimensions, which can indirectly lead to psychological and couple distress (Godbout et al., 2009) and is also associated with an elevated risk for experiencing physical assault in intimate relationships (Bond & Bond, 2004; Doumas et al., 2008; Sandberg et al., 2019). Perhaps this is not surprising given that childhood trauma can elicit confusion and feelings of inadequacy, ultimately shaping how individuals see themselves in relation to others. Notably, if these feelings and representations persist overtime—as is suggested by prototype models of attachment (Fraley et al., 2011; Jones et al., 2018; Stern et al., 2018)—and are possibly even reinforced through subsequent adverse events, the relationship trajectories of individuals who have experienced sexual violence will undoubtedly shift based on these violent experiences.

1.3.3 Timing in Lives

The timing in lives component suggests that the timing of life transitions has long-term consequences for individuals due to the effect on subsequent transitions (Elder, 1998). Indeed, early life experiences shape individual differences in outcomes in later life (Alwin, 2012), and sexual assault is no exception. For instance, experiencing sexual assault by 18 years of age is associated with small but statistically significant detrimental effects on global health outcomes (Kuhlman et al., 2018). Potter et al. (2018) found that, among women who were assaulted during college, physical, mental, and reproductive health problems related to the assault were self-reported as barriers to educational and career goals. Unwanted sexual experiences also appear to affect different aspects of female sexuality depending on the developmental time period in which the violence occurs. More specifically, women who experience sexual violence following puberty report more sexual distress and more difficulties with orgasm, sexual arousal, and sexual satisfaction than both those who have never experienced sexual violence and those who report CSA (Maseroli et al., 2018). Furthermore, women exposed to unwanted sexual experiences in childhood report greater body image concerns and higher depersonalization scores than those without a history of sexual violence (Maseroli et al., 2018). Although these results demonstrate that unwanted sexual experiences in adolescence have a marked impact on female sexuality, they also suggest that the timing of sexual violence might result in vastly different developmental trajectories, which are further complicated by various disadvantages and advantages.

Cumulative advantages or disadvantages can stem from circumstances such as socioeconomic status (e.g., access to resources), life experiences (e.g., adverse childhood

experiences), and social capital (e.g., holding a social position of power; Alwin, 2012). For example, sexual assault survivors are at high risk of revictimization, which is associated with adverse mental and physical health outcomes (Brown et al., 2009; Classen et al., 2005; Jozkowski & Sanders, 2012). Research also indicates that revictimization trajectories differ for those who experience sexual violence. For instance, exposure to sexual violence in adolescence makes individuals vulnerable to revictimization trajectories that either (a) persist over the early life course and beyond (i.e., chronic revictimization), or (b) are characterized by a sharp increase in revictimization in early adulthood (emerging-adulthood revictimization; Papalia et al., 2017). This is perhaps due to the onset of puberty and the associated psychosexual, social, physiological, and cognitive changes that occur during this period of development. Accordingly, poor adjustment during this period could leave individuals vulnerable to revictimization in the future.

It is also likely that CSA is interrelated with other experiences of early adversity, such as family disruptions (e.g., family imprisonment, parental maladjustment), social disadvantage (e.g., unemployment, high crime rates), and a high risk for poly-victimization (e.g., co-occurring physical abuse, domestic violence, etc.) and revictimization (Bhandari et al., 2011; Finkelhor et al., 2007; Koverola et al., 1996; Morris et al., 2019; Mustaine et al., 2014; Ports et al., 2016; Widom et al., 2008). When adverse circumstances such as family disruption and social disadvantages co-occur with sexual abuse as well as other forms of violence and neglect, the resulting cumulative disadvantage can lead to complex trauma, which most often results from repeated exposures to severe stressors and is characterized by poor self-regulation and interpersonal problems (Cohen et al., 2012;

Herman, 1992; Lawson et al., 2013). Accordingly, the LCP takes into account how family interactions and disruptions could cultivate a cycle of violence.

1.3.4 Linked Lives

The interconnected nature of human lives is referred to as linked lives in the LCP (Alwin, 2012). Considering how lives are linked helps contextualize sexual violence within shared lives and ongoing relationships (Williams, 2003). Fallout from a traumatic event can manifest in other areas of the human experience, including in attachment relationships and especially in the case of complex trauma (Cohen et al., 2012). For example, CSA perpetrated by a parent or caregiver is a deep betrayal of safety and security. In the absence of a safe, secure, and nurturing environment, internal working models of the self and others are disrupted, which can interfere with the development of secure attachment and adversely affect an individual's sense of self and trust in the world. Importantly, secure attachment mitigates both the risk of experiencing revictimization as well as the development of psychiatric symptoms often associated with traumatic experiences (Barnum & Perrone-McGovern, 2017; Cantón-Cortés et al., 2015; Smith & Stover, 2016; Stubenbort et al., 2002); however, individuals who experience complex trauma tend to report lifelong difficulties with relationships (Lawson et al., 2013) that manifest in the form of insecure attachment.

Violence within family systems requires consideration not only for those who are victimized, but also for the other family subsystems (i.e., parent–child system, spousal relationship, sibling relationships, etc.) and sociocultural systems (i.e., patriarchy, criminal justice system, etc.) in which the violence occurs. For example, CSA perpetuated by a father not only has profound implications for the parent–child relationship, but also

represents a challenge for the relationship between the husband and the wife. Additionally, patriarchal notions of power and control might reaffirm the dominance of the father and the subordination of the mother and child within the family system. Thus, the ways in which our beliefs and social systems are reflected within family relationships can contribute to and sustain family violence. The concept of linked lives also suggests that the traumatic experiences of one individual can have ripple effects for others in the family system. In another example, the development of PTSD following an experience of sexual violence could lead a mother to be irritable and explosive or withdrawn and depressed, adversely affecting the quality and nature of both marital and parenting relationships.

Social and historical forces are also expressed through shared networks of relationships (Elder, 1998). A sociopolitical analysis of sexual violence focused on gender, racial, and class inequalities can be helpful for understanding individual experiences of sexual violence. Furthermore, if sexual violence is conceptualized as a mechanism of inequality (Armstrong et al., 2018), the intersection of varying identities and social locations must be examined to better understand how to systemically address the impact of sexual violence (Gómez & Gobin, 2020). For example, sexual assault survivors who identify with racial or ethnic classifications that have a history of marginalization must navigate long-established discriminatory policies and laws that have disproportionately impacted their lived experiences (Gill, 2008; Sherman, 2016). This complex web of social inequalities might prevent individuals from accessing resources and services due to a distrust of the healthcare and criminal justice systems (Vinson & Oser, 2016; Wadsworth & Records, 2013). Moreover, social inequalities often manifest in social disadvantage, which is important in affecting the risk of being sexually victimized.

1.3.5 Human Agency

Human agency—the choices and actions individuals take based on the various opportunities and constraints afforded to them via social and historical circumstances (Elder, 1998)—can provide insight into why some who experience sexual violence do not develop interpersonal or identity problems whereas others do. Family scholars have argued that how power and agency are negotiated matters for trying to understand structural forces (Few Demo, 2014; Rossetto & Tollison, 2017) such as sexual violence. Families are uniquely situated to challenge gendered attitudes about power, agency, and sex (Rossetto & Tollison, 2017), but socialization practices that promote empowerment might not occur in families beset by interpersonal violence.

Prevention and intervention programming are often focused on those who are most susceptible to sexual violence (women and girls), but programs focused on changing the behavior of women and girls perpetuate the idea that the responsibility for ending sexual violence lies with victims rather than perpetrators, and develops a dilemma wherein women are seen both as active change agents and as to blame for sexual violence (Curchin, 2019), which can complicate experiences of sexual violence and lead to self-blame. For survivors in which such blame attributions develop, it can contribute to negative self-image and weaken the ego identity (McEwan et al., 2002), potentially hampering recovery efforts. However, recognizing vulnerability and safety are critical for negotiating consent and establishing sexual agency post sexual trauma (Mark & Vowels, 2020), and a qualitative inquiry into how men and women heal from sexual violence suggests that managing memories, regulating relationships with others, constructing safety, and restoring a sense of self all contribute to a greater sense of agency and satisfaction across

the life course (Draucker et al., 2009). Thus, as presented here, negotiating safety is both a critical component of resiliency and sexual agency post-assault and a reflection of social and cultural norms that support violence against women. So, the choices and actions that individuals take when responding to sexual violence are both contextualized within social and cultural norms and a result of internal processing tendencies and individual identity characteristics. If, by chance, institutional responses to sexual violence are culturally and socially relevant, dissemination could challenge harmful norms in a meaningful way, thereby reducing the tendency for institutions and people to victim-blame and improving the chances a survivor has to access help and live a satisfying life. Notably, there has been an increasing effort to expand the scope of institutional responses to sexual violence to one that also includes men and boys (Barker et al., 2007). The LCP concept of human agency takes into account the tension between social and cultural opportunities and constraints as well as individual choice.

1.3.6 Implications

Using the life course perspective to understand sexual violence can help address the impact of sexual violence on individual functioning over the life span by taking into account historical and social contexts, developmental trajectories, shared networks and relationships, and the actions and behaviors of those affected. Moreover, the relative contributions of multiple experiences with sexual violence and the developmental timing at which initial or subsequent acts of violence occur are areas of research well-suited for life course principles. The life course perspective can provide insights into the developmental nuances associated with sexual violence that could have policy or clinical implications in later life stages. Similarly, the life course principles of linked lives and

historical time and place bring meaning to the interpersonal and social nature of sexual violence and promote a macro-level perspective for understanding sexual violence. Engaging with the complex and multiple trajectories that occur following sexual violence can also allow practitioners to be aware of the compounding effects of sexual violence that can contribute to adverse health over the lifespan (Kuhlman et al., 2018).

1.4 Feminist Family Theory

Feminist family theory provides a framework for understanding how sexual violence is associated with gender inequality at the societal level, which exists in nearly all social institutions due to institutional sexism and discrimination. In fact, in a cross-national comparison concerning violence against women, the status of women, and fear among women indicated that the occupational and educational status of women was related to the prevalence of sexual violence against women; these factors accounted for 41% and 40% of the variance in sexual violence, respectively (Yodanis, 2004). Moreover, Yodanis' (2004) findings suggest that structural gender inequality is related to sexual violence, and that rates of sexual violence are associated with women's fear. These findings provide empirical support for feminist theory's position that violence against women is linked to structural inequalities.

The history of feminism has been largely conceptualized into three distinct and chronological waves: securing equal rights for women (Wave 1), challenging racism and sexism in established institutions (Wave 2), and focusing on multiple forms of oppressions that are experienced on an individual basis as the result of societal oppression (Wave 3; Smith & Hannon, 2012). Notably, however, the wave metaphor is viewed by some as an oversimplification of feminist praxis for understanding complex social issues such as

sexual violence because single-factor theories of rape (e.g., rape is an expression of power and control) silence alternative ways of thinking about the history of feminism (Hemmings, 2001), and how sexual violence fits into that multifaceted history. For instance, although the radical feminist theory of rape represents an important contribution to the field, the proposition that rape is an expression of power and control minimizes the importance and prevalence of other reasons sexual violence occurs. Complex positionality, alternatively, offers ways to evaluate a situation (i.e., sexual violence) from multiple standpoints, creating room to identify overlapping aspects of divergent viewpoints while also accounting for differences across those viewpoints (May, 2015).

Therefore, different feminist theory paradigms are likely a better representation of how feminist theory has influenced understandings of sexual violence. For instance, sexual violence has been interpreted as a result of insufficient economic and social opportunities for women (Liberal Feminist Theory), patriarchy (i.e., social systems that value traditional masculine social norms; Radical Feminist Theory), class inequalities (Marxist Feminism), or a gendered performance (i.e., "doing gender"; Butler, 1988; Masculinities). Most recently, McPhail's (2016) Feminist Framework Plus (FPP) has provided a more comprehensive explanation of the nature of sexual violence by knitting together aspects of the aforementioned theoretical paradigms while employing an intersectional focus. Theory-knitting accounts for the strengths and weaknesses of each theoretical framework by selectively knitting them into a single integrated framework with "internal coherence, unifying power, and explanatory depth" (McPhail, 2016, p. 321).

1.4.1 Feminist Framework Plus

The FFP utilizes five core ideas from five theoretical perspectives (radical feminism, liberal feminism, intersectionality, social construction, postmodern/queer theory): patriarchal power and control (rape is a political act to maintain male domination and female subordination); normative heterosexuality perspective (sexual violence is a continuation of heteronormativity and ensures female subjugation); at the intersections (sexual violence occurs at the intersection of various identities and social locations with varying degrees of oppression based on those interactions); doing masculinity, doing rape (rape is a way to achieve masculinity); and embodied sexual practice (rape is a specific act upon the body/self; the specific bodies and relationships matter). These core ideas reflect the salient theoretical premise of each of the five theoretical perspectives that underly the FFP, but importantly also indicate the five theories that contribute to the FFP include a feminist perspective, a focus on power relations and gender, and an acknowledgment of the cultural context (e.g., patriarchy) in which sexual violence occurs (McPhail, 2016). The theories also differ in meaningful ways—for example, embodied sexual practice differs from patriarchal power and control in that the former is concerned with intrapersonal and individual difference whereas the latter concerns macro-level constructions of gender—which provides the FFP with added complexity and explanatory power for understanding sexual violence.

1.4.1.1 Feminist Framework

The feminist framework is constructed by knitting together the five core ideas that emerged from the relevant theoretical perspectives. Specifically, five primary concepts flow from the feminist framework and reflect how the five core ideas converge and diverge

to increase the explanatory power of feminist theories of sexual violence. The first concept that emerges from the feminist framework is the acknowledgement that rape is both a violent and a sexual act "upon and by specific bodies, with sexual consequences for the survivor" (McPhail, 2016, p. 321). The second concept is an acknowledgement that sexual violence occurs due to multiple motives that can include, but are not limited to, revenge, attempts to perform masculinity, and expressions of power and control (McPhail, 2016). Thus, multiple motives—not only power and control—underlie sexual violence. The third concept, that sexual violence is both political and personal, conveys that sexual violence is present and should be understood at all levels of the sociopolitical spectrum, from the specificity of rape at the bodily level to the political level of patriarchy, as well as the multiple influences present across those levels of abstraction (McPhail, 2016). The fourth concept draws from Black feminist theorists such as Crenshaw (1991) and emphasizes the intersectionality of identities and oppression. Victims and perpetrators occupy multiple and simultaneous social identities, and these identities and positions shape life experiences, perspectives, and trajectories at personal, political, and historical levels (McPhail, 2016). Finally, the fifth concept of the feminist framework refers to the violent destabilization of the survivor's existing self and acknowledges the harm that sexual violence does to the survivor (Canan & Levand, 2019; McPhail, 2016).

1.4.1.2 Plus

The "Plus" factors of the FFP include empirically derived risk factors for sexual violence that are largely overlooked by the cultural and social explanations provided in the feminist framework aspect of the FFP (McPhail, 2016). These risk factors have been loosely divided into five categories: psychological (e.g., low self-esteem), environmental

(e.g., child sexual abuse), developmental (e.g., attachment disorders), situational (e.g., alcohol and drug use), and biological (e.g., genetic factors). As indicated by McPhail (2016) and others (Craig et al., 2006; Fulu et al., 2013; Ward et al., 2006), the Plus factors are statistically associated with sexually aggressive men. Notably, psychological (e.g., negative urgency and trait anxiety and depression; Combs et al., 2018), environmental (e.g., child sexual abuse; Ports et al., 2016), developmental (e.g., insecure attachment; Dimitrova et al., 2010; Mikulincer et al., 2011; Ogle et al., 2015), and situational (e.g., membership in fraternity or sorority; Ford & Soto-Marquez, 2016) factors have statistically significant associations with negative health effects for survivors following experiences of sexual violence. In terms of risk factors for victimization, those individuals who experience CSA have a cumulative increase in the risk of experiencing adult sexual violence with each additional adverse childhood experience (Ports et al., 2016). Additionally, Greek life has been strongly associated with high prevalence of sexual assault in college students (Ford & Soto-Marquez, 2016). Notably, there are mixed findings regarding the impact of biological factors on post-assault well-being (see Campbell et al., 2009, for review), with some research indicating that changes in cortisol levels immediately following the assault are positively associated with the development of PTSD symptoms (Resnick et al., 1997), and other research finding that changes in cortisol levels following an assault are unrelated to PTSD (Resnick et al., 1995).

1.4.2 Implications for Feminist Family Theory

The FFP offers feminist family theorists a roadmap for locating behaviors and norms in historical, political, and social contexts, while offering more explanatory potential for understanding sexual violence than single-factor feminist theories. For

instance, the patriarchal power and control perspective acknowledges the political nature of the violent act and denies the sexual component of sexual violence (McPhail, 2016). The embodied sexual practice perspective of the FFP, in contrast, acknowledges the sexual nature of the violent act and explains why survivors might have difficulty engaging in consensual sexual relations with future intimate partners. Whereas the patriarchal power and control perspective alone does not distinguish between perpetrators, the embodied sexual practice perspective brings meaning to the nature of the relationship between the victim and the perpetrator. Paired with the fact that a majority of rapes and sexual assaults are perpetrated by someone known to the survivor (Wegner et al., 2014), the nature of the relationship between the victim and the perpetrator can have profound implications for survivors who are attempting to make meaning of their assaults, especially when the prevailing power and control narrative does not fit their experience (McPhail, 2016). Additionally, at the intersections paired with the embodied sexual practice perspective emphasizes that the consequences of experiencing sexual violence differ based on social categories and positions, whether that be in relation to the victim–perpetrator relationship and the social categorical intersections of the victim and perpetrator, or in relation to the social (e.g., social support) and political (e.g., access to criminal justice system) resources available to the survivor. For example, bisexual women experience greater PTSD and depression symptoms than heterosexual women following sexual trauma, and bisexual women consistently report greater levels of PTSD and depression symptoms over time than their heterosexual counterparts (Sigurvinsdottir & Ullman, 2015).

The FFP framework is also of particular use for family science researchers. For instance, in a sample of 254 college women with sexual assault histories, 75% of the

victim–perpetrator relationships (friends, casual acquaintances, dating partner, etc.) continued following the assault (Edwards et al., 2012). Moreover, greater levels of trauma symptomology predicted relationship continuation, as did nondisclosure of the assault and limited perpetrator blame (Edwards et al., 2012). In the context of the FFP framework, these findings suggest that the nature of the victim–perpetrator relationship important, but so too is the nature of the post-assault relationship, both in terms of understanding the psychological well-being of survivors following the assault and in activating support networks. Furthermore, because the relationship between victim and perpetrator matters for post-assault recovery, and these relationships take on different meanings for individuals depending on their various social and political locations and have manifest personal and political implications, the nuances associated with sexual violence and the recovery from such an attack might be better framed within feminist frameworks such as the FFP than single-factor theories of rape.

CHAPTER 2. RELATIONSHIP SATISFACTION AMONG SURVIVORS OF SEXUAL ASSAULT: CONSIDERING PTSD, EMOTION-FOCUSED COPING, AND MENTAL HEALTH SERVICES

Although social, intimate, and familial relationships buffer the impact of trauma (Gutermann et al., 2016; Smith et al., 2020), they can also be the source of trauma. Empirical research has consistently found a link between posttraumatic stress disorder (PTSD) and intimate relationship problems (Matsakis, 2004): Meta-analyses have found small associations between PTSD and relationship quality (r = -.24; Lambert et al., 2012) and medium associations between PTSD and relationship discord (r = .38; Taft et al., 2011). Other meta-analyses have found small (r = .28; Ozer et al., 2003) and medium (r = .40; Brewin et al., 2000) associations between a lack of social support and PTSD in adults who have experienced various types of trauma. Another meta-analysis found moderate effect sizes between PTSD and marital and partner functioning problems (z = .31) as well as between PTSD and physical or emotional intimacy problems (z = .33; Birkley et al., 2016). Moreover, empirical inquiries concerning the holistic impact of trauma suggest that trauma symptoms are negatively associated with relationship satisfaction for soldiers and their partners (Goff et al., 2007), and that greater incidences of trauma among married women predict lower relationship satisfaction for their husbands (Ruhlmann et al., 2018). Among heterosexual couples in which both partners reported previous trauma, husband's PTSD symptoms predict lower relationship satisfaction for both themselves and their spouses (Rhulmann et al., 2018).

Although the systemic and negative impact of trauma on family and intimate relationships have been well documented, the empirical literature regarding the effects of adult sexual trauma on relationship satisfaction is less robust. However, there is evidence

to suggest that adult sexual assault is associated with lower relationship satisfaction and emotional intimacy among women in heterosexual relationships (Georgia et al., 2018). Additionally, mental health symptoms (e.g., depression and anxiety) have been found to independently mediate the relationship between both adult sexual assault and child sexual abuse (CSA) and the satisfaction of both members of the dyad; however, when other variables hypothesized to indirectly influence the relationship (e.g., emotional intimacy) were entered into the model, the link between mental health and relationship satisfaction became statistically nonsignificant, likely due to the shared variance with emotional intimacy (Georgia et al., 2018). Although Georgia et al.'s findings indicate a statistical association between marital distress and mental health symptoms among female survivors of sexual assault, PTSD symptom severity and assault severity were not considered. Additionally, there is limited research on emotion-focused coping strategies among survivors of sexual violence (Classen et al., 2005), and research suggests that emotional regulation in close relationships can dampen the risk of negative psychological outcomes (Dimitrova et al., 2009). Thus, the purpose of this study is to extend these findings by considering the severity of sexual assault experiences, PTSD symptom severity, emotion-focused coping, and relationship satisfaction among married and currently partnered individuals reporting a sexual victimization experience since their 14th birthday. Before detailing the method of analysis, the existing literature regarding sexual assault and relationship satisfaction will be explored.

2.1 Background Literature

A majority of individuals who experience sexual assault are not married when victimized, but among married individuals, those who are sexually assaulted report receiving less emotional support from their spouses than do those who have not been sexually assaulted (Golding et al., 2002). Moreover, those who report experiencing multiple sexual assaults in their history report receiving less emotional support from a spouse than do those who report one instance of sexual assault (Golding et al., 2002). Given the negative association between sexual assault survivors and spousal support, and the fact that individuals with previous sexual abuse or assault histories are at a higher risk for subsequent revictimization (see Classen et al., 2005, for review), which can have negative impacts on indicators of health and sexual well-being (Jozkowski & Sanders, 2012), the nature of intimate relationships among survivors of sexual assault warrants further investigation. Although intimate relationships can certainly maintain and exacerbate personal problems, these relationships can also be "active sources of healing" (Johnson, 2002, pp. 4) for trauma survivors, and the ways in which survivors make meaning of their trauma histories is inherently social (Harvey et al., 2000; Tummala-Narra, 2012).

In the context of adverse life events, spousal support is critical for marital and psychological well-being. For example, experiencing a physical attack statistically predicts marital distress and disharmony, but this statistical relationship only holds for individuals with lower-than-mean levels of spousal support (Broman et al., 1996). Concerning psychological well-being, positive spousal support buffers against trauma symptoms for men exposed to intimate partner violence in childhood, whereas negative spousal support

exacerbates trauma symptoms (Evans et al., 2014). Notably, the buffering and potentiating effects of spousal support are less at higher levels of abuse severity (Evans et al., 2014). Women's symptoms, however, were statistically unrelated to either positive or negative spousal support (Evans et al., 2014). In sum, the amount (low vs. high) and the type (positive vs. negative) of spousal support can exacerbate or diminish the psychological and interpersonal effects of trauma, yet for individuals with multiple or severe trauma histories, the role spousal support plays in the association between trauma and support might be less pronounced. Although these findings have yet to be explored in relation to sexual violence specifically, the level of support provided in marital relationships might buffer against or exacerbate the health and well-being of survivors of sexual assault.

2.1.1 Sexual Assault and Mental Health

Many survivors of sexual violence develop symptoms of traumatic stress (Frazier et al., 2009; Paquette et al., 2019; Robinaugh & McNally, 2011). Notably, however, adult sexual assault survivors show lower levels of functioning than survivors of CSA and peer sexual abuse—unwanted and nonconsensual sexual behaviors occurring before 16 years of age with a perpetrator of a similar age—on correlates of mental health such as depression, anxiety, postsexual abuse trauma, sleep dysfunction, and dissociation (Maker et al., 2001). Furthermore, females who report being particularly distressed about sexual assault experienced during military service also report greater PTSD and disorders of extreme stress not otherwise specified (e.g., emotion regulation difficulties, interpersonal problems, dissociation, etc.) than those who report being particularly distressed about other types of traumatic experiences (e.g., robbery; Luterek et al., 2011). Thus, not only is the sequalae different for survivors of adult sexual assault than other forms of violence,

but sexual violence, especially when reported as an individual's most significant trauma, can lead to greater mental health symptoms than other types of trauma.

Relatedly, another study found a negative relationship between PTSD symptom severity and relationship satisfaction among female survivors of sexual violence who were not currently receiving treatment for psychological distress, but not among those actively receiving treatment (DiMauro & Renshaw, 2018), suggesting that treatment for psychological distress might have mitigated the association between PSTD symptoms and relationship satisfaction. Indeed, specific PTSD symptom clusters, such as negative alterations in cognition and mood, dysphoric arousal, and anhedonia, mediate the relationship between military sexual trauma and sexual satisfaction, and military sexual trauma and sexual functioning (Blais et al., 2018). Addressing mental health concerns by participating in mental health treatment that focuses on reducing symptoms of PTSD, for example, might be beneficial for sexual assault survivors and their relationships. Conversely, strengthening aspects of intimate partnerships might have a profound impact on individual mental health symptoms given that low levels of sexual and relationship satisfaction are associated with a higher likelihood of developing serious and moderate psychological distress in men and women (Patrick et al., 2013). Relationship satisfaction has also been shown to prospectively predict decreases on individual PTSD symptoms such as reliving the trauma, emotional numbing, and irritability following non-interpersonal trauma (LeBlanc et al., 2016). Given the limited information regarding the association between PTSD symptoms and relationship satisfaction in survivors of sexual violence, this study is designed to understand this association by also including assault-

specific factors, like sexual assault severity, to assess the broader impact of sexual assault.

2.1.2 Sexual Assault Severity and Relationship Satisfaction

CSA is prevalent among adults presenting for sex therapy (Berthelot et al., 2014), and individuals who report genital penetration with or without genital trauma in childhood indicate more marital dissatisfaction than those who experienced CSA without genital penetration or trauma (Liang et al., 2006). Also, among married individuals with a history of CSA, those whose CSA experiences involved attempted or completed oral, anal, or vaginal penetration report substantially worse dyadic adjustment (d = .50), lower relationship satisfaction (d = .41), and less consensus (d = .46) than their counterparts whose CSA experiences did not involve penetration (Berthelot et al., 2014). Similarly, a nationally representative survey found that men and women who reported a history of CSA involving oral, anal, or vaginal penetration reported more marital disruption and lower relationship satisfaction than those who reported CSA without penetration and those without abuse histories (Finkelhor et al., 1989). For couples in which either one or both partners report a history of CSA, there is an elevated chance of contempt and defensiveness in the relationship relative to couples without a history of CSA (Walker et al., 2011). Moreover, compared to lesbian, bisexual, and queer women without a history of CSA, women who report CSA involving attempted and completed oral, anal, or vaginal penetration tend to have lower sexual desire, lower sexual satisfaction, and more frequent negative thoughts in dating relationships in later life (Crump & Byers, 2017). Taken together, mental health functioning and relationship satisfaction seem largely

dependent on the severity of CSA experienced, and it appears that experiences of adult sexual assault may follow similar patterns.

Concerning relationship trajectories following sexual assault, unhealthy romantic relationship trajectories are similar for both low severity and high severity victims; however, trajectories among those who experience high severity sexual coercion tend to be more unhealthy than among those who experience low severity sexual coercion (Collibee & Furman, 2014). Overall, the findings from Collibee and Furman (2014) suggest that individuals who have experienced a sexual assault are at high risk of having unhealthy relationships, and although both high and low severity victims experience similar trajectories both immediately after and following the event, those who experience high-severity sexual coercion are more greatly impacted. Recent research also suggests that rape victims experience sequelae that differ in severity based on the type of coercive tactic used by the perpetrator during the assault (e.g., incapacitation, force, psychological coercion; Brown et al., 2009). Perpetrators who use incapacitation also differ in personality, attitude, and experience than perpetrators who use verbal coercion, for example (Abbey & Jacques-Tiura, 2011). These findings suggest that differentiating assaults based on tactic could aid in the prediction of post-assault psychological adjustment. Indeed, Zweig et al. (1999) found that among young adult women living in rural communities, those who had experienced sexual assault by force or psychological coercion had lower levels of psychological adjustment than women who experienced internal psychological pressure or substance-related sexual coercion. Such findings highlight the psychosocial consequences of sexual assault based on assault severity and reify the need to explore the relationship between PTSD symptoms and relationship

satisfaction following experiences of sexual assault, using information about assault severity.

H_1: PTSD statistically mediates the relationship between sexual victimization and relationship satisfaction, such that relationship satisfaction is lower among those with more severe PTSD symptoms.

H_2: Sexual assault survivors who receive mental health counseling following an assault report greater relationship satisfaction that those who do not receive mental health counseling.

2.1.3 Emotional Coping and Relationship Satisfaction

Coping is an adaptive process of responding to stress (Kraaij & Garnefski, 2019; Skinner et al., 2003), and is characterized by controlled and intentional cognitive and behavioral efforts to manage and regulate responses to stressful stimuli. Whereas problem-focused coping is focused on directly addressing a stressful stimulus, emotion-focused coping is associated with efforts to manage emotions elicited by the stressor (Garnefski et al., 2001). Meta-analyses indicate that emotional suppression is associated with lower social support, lower social satisfaction, and poorer romantic relationship quality (Chervonsky & Hunt, 2017), and that dyadic coping, or the processes through which partners cope with stressors together, also predicts relationship satisfaction (Falconier et al., 2015).

Indeed, cognitive emotion regulation strategies are related to positive dyadic coping, which in turn has been shown to be associated with relationship satisfaction (Rusu et al., 2019). Furthermore, among college aged males who experienced dating violence, psychological victimization was associated with less relationship satisfaction at

low levels of emotion-focused coping (Shorey et al., 2012). At high levels of emotion-focused coping, the association with relationship satisfaction was weaker, but negative just the same. Thus, it appears that those who exhibit high levels of emotion-focused coping might experience greater relationship satisfaction than those with low levels of emotion-focused coping; however, the extent to which emotion-focused coping impacts the association between sexual victimization and relationship satisfaction has not been fully explored.

Female sexual abuse victims appear to rely on emotion-focused strategies more than problem-focused strategies (Long & Jackson, 1993), and difficulties with emotion regulation have consistently offered unique explanatory power for understanding relational processes (e.g., sexual satisfaction) above and beyond the effects of previous maltreatment (Rellini et al., 2010; Rellini et al., 2012). In other words, emotion regulation accounts for more variance in relational processes than instances of child maltreatment, for example, although emotion regulation may not offer explanatory value for all aspects of a relationship (Rellini et al., 2012). Elevated emotion-focused coping and lower problem-focused coping has been associated with greater depressive symptoms (Matheson et al., 2007), and individuals with PTSD report greater levels of emotion dysregulation (Hanna & Orcutt, 2020). Indeed, behavioral emotion regulation, a form of emotion-focused coping, involves the controlled behavioral processes that an individual initiates when responding to stress (Kraaij & Garnefski, 2019), and plays a role in the relationship between stress and general well-being (Garnefski & Kraaij, 2006; Schroevers et al., 2007). The associations between emotion-focused coping and mental health symptoms, and the relevance of emotion regulation in relationship satisfaction and

relational processes, indicate that emotion-focused coping might interact with PTSD to explain the variance in relationship satisfaction among survivors of sexual assault.

> H_3: Behavioral emotion-focused coping explains unique variance in relationship satisfaction among survivors of sexual violence, even after accounting for the variance explained by PTSD symptom severity.

2.2 Method

2.2.1 Sampling Procedures

Participants were recruited via Amazon Mechanical Turk (MTurk), a crowdsourcing platform with a large and diverse subject pool that is representative of the U.S. population across many psychological dimensions (e.g., anxiety; McCredie & Morey, 2019). Moreover, participants recruited from MTurk are comparable in behavior (e.g., decision-making tasks) to individuals found at large universities (Mason & Suri, 2012) and demonstrate high test–retest reliabilities ($.80 < r < .92$) on various psychometric scales (e.g., The Big Five Inventory, global self-esteem, etc.) compared to other internet samples, with good to excellent internal reliability values ($.73 < \alpha < .93$; Buhrmester et al., 2011). Additionally, samples from online crowdsourcing platforms have produced reliable and valid psychometric properties on technology-assisted models, similar to those found in student samples and consumer panels (Steelman et al., 2014). Web-based surveys have also been found to be an adequate mode of data collection regarding sexual victimization and perpetration (Johnson et al., 2017).

Inclusion criteria for this study required participants to be at least 18 years of age, have personal experience with sexual victimization since their 14th birthday, and to be

currently involved in a romantic relationship (married or in a committed relationship). Eligible participants responded to questions concerning experiences of sexual violence, attachment, PTSD, emotional coping, relationship and sexual satisfaction, and decision-making within relationships. Based on the distribution of median hourly wages for human intelligence task surveys on MTurk ($4.88; Hara et al., 2018), participants were paid $2.03 to complete the roughly 25-minute survey.

Concerning the proposed mediation model (H_1), the sample size required to detect a mediated effect (R^2) depends on (a) the size of the predictor's effect on the mediator variable (path a), and (b) the size of the mediator's effect on the outcome variable when controlling for the predictor variable (path b; Fritz & MacKinnon, 2007). After accounting for missing data using listwise deletion, the analytic sample for the present study is 479 respondents, which is above the recommended sample size (N = 462) to detect mediated effects (B) of .14 and larger when using bias-corrected and accelerated bootstrapping with an alpha (α) of .05 and a beta (β) of .20. The results of a Monte Carlo power analysis for testing indirect effects (Schoemann et al., 2017)—using standardized coefficients of path a (B = .51), path b (B = -.18), and path c' (-.01) and standard deviations of study variables—indicate that the sample size available provided statistical power of .92 for direct effects and was capable of reliably detecting mediated effects (B) of 0.03 and larger. Concerning H_2, a statistical sensitivity power analysis for an independent t test using G*Power (Faul et al., 2007)—with a sample size of 479 and unequal group sizes (199 respondents participated in mental health counseling following an experience of sexual violence and 280 respondents did not), and based on a two-tailed alpha (α) of .05, a beta (β) of .20—provided sufficient power to detect effects size of d =

0.26 and larger. Concerning H_3, a statistical sensitivity power analysis using G*Power (Faul, Erdfelder, Lang, & Buchner, 2007), based on an alpha (α) value of .05, a beta (β) value of .20, a sample size of 479 respondents, and six predictor variables, provides sufficient power to detect a medium effect size (f^2) of .03 and larger.

2.2.1.1 Sample Demographics

As displayed in Table 2.1, a majority of respondents were White (73.3%) and female (60.4%). The highest level of formal education varied; most either completed some college but did not earn a college degree (24.9%), earned a bachelor's degree but nothing more (41.9%), or obtained a master's degree (17.1%). Roughly one third of respondents (30.8%) indicated they were *somewhat religious,* and nearly the same number of participants indicated they were *not at all religious* (29.2%). Regardless of religiosity, a plurality identified as Catholic (41.9%); others identified as agnostic (14.8%), evangelical Protestant (11.5%), atheist (7.7%), and Christian (6.5%). Two thirds of respondents identified as heterosexual (67.9%) and 21.9% identified as bisexual. Many respondents reported sexual violence that occurred before 14 years of age (43.5%), whereas many others did not (43.8%); some were unsure (12.7%).

Participants in the sample were slightly younger (M = 35.1, SD = 10.5) than the mean age of Americans (U.S. Census Bureau, 2013). Females and Whites were slightly overrepresented in the sample relative to the U.S. population (U.S. Census Bureau, 2012; 2013) as were lesbian, gay, bisexual, and transgender individuals (Chandra et al., 2011; Gates, 2011; Newport, 2018). These characteristics are associated with elevated risk for

experiencing sexual violence (Armstrong et al., 2018; Chen et al., 2020; Mellins et al., 2017; Newcomb et al., 2020; Tjaden & Theonnes, 2006; Walters et al., 2013).

2.2.2 Measures

2.2.2.1 Sexual Experiences Survey–Short Form Victimization

The Sexual Experiences Survey–Short Form Victimization (SES–SFV; Koss et al., 2007; see Appendix 1) was used to measure unwanted sexual experiences. More specifically, the SES–SFV comprises seven behaviorally-specific descriptions that meet legal definitions of various sex crimes (or five for male respondents; two vaginal penetration items are omitted); the instrument also has one item on aggressor gender, and one question that asks explicitly about rape. Within each type of sex crime, the instrument distinguishes among five tactics that could be used by another person to coerce the respondent to engage in the sexual act—verbal pressures, verbal criticism, incapacitation, physical threats, and physical force—creating 35 items by crossing each sexual act with each coercive tactic. Respondents indicate the number of times (0, 1, 2, or 3+) each coercive tactic was used for each item in the past 12 months and since their 14th birthday until 1 year ago; these timeframes were collapsed to consider sexual violence experiences since turning 14 years of age. In other words, the SES–SFV captured the number of times respondent's had experienced each type of sex crime according to the mode of coercive behavior the perpetrator(s) had used to commit the crime.

The six sexual victimization experiences measured by the SES–SFV are non-victim, unwanted sexual contact (e.g., "Someone fondled, kissed, or rubbed up against the private areas of my body [lips, breast/chest, crotch or butt] or removed some of my clothes without my consent [but did not attempt sexual penetration]"), attempted coercion

(e.g., “Even though it didn’t happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to”), coercion (e.g., “Someone had oral sex with me or made me have oral sex with them without my consent by telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to”), attempted rape (e.g., “Even though it didn’t happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by taking advantage of me when I was too drunk or out of it to stop what was happening”), and rape (e.g., “A man put his penis into my butt, or someone inserted fingers or objects without my consent by using force, for example holding me down with their body weight, pinning my arms, or having a weapon”), resulting in classifications along a continuum of the least to the most severe. There are three standard scoring procedures for the SES-SFV (Koss et al., 2007; 2008): scoring based on individual items, which establishes the frequency of each type of sexual assault outcome for each sexual assault tactic by calculating a percentage of individuals who reported each outcome for each tactic at the individual item level; redundant scoring in which percentages are computed for nonvictimization, sexual contact through any tactic, attempted rape through coercion, completed rape through coercion, attempted rape through incapacitation or force, and completed rape through incapacitation or force; and mutually exclusive (i.e., nonredundant) scoring, which places respondents in the category of his or her most severe type of outcome.

In a previous study with 224 college women, the SES–SFV's internal consistency (Cronbach's alpha) was .93 (Davidson & Gervais, 2015). The original SES has demonstrated good validity estimates with 1-week test–retest reliability (r = .93) and correlations with interview responses (r = .73; Koss & Gidycz, 1985). Test–retest reliability scores among male college students for the SES–SFV were statistically correlated after 2 weeks (.41 < r < .53; Anderson et al., 2018), and a 2-week test–retest reliability of the SES-SFV among 273 female undergraduate students demonstrated that 73% of women replicated their original responses concerning unwanted experiences reported in the past year (Johnson et al., 2017). In this study, additional analyses indicated that the greatest stability in category endorsed was *none;* 17% of women endorsed items that were less severe and 11% endorsed items that were more severe at the third assessment (Johnson et al., 2017).

2.2.2.1.1 SCORING

Researchers (Arata & Lindman, 2001; Brown et al., 2015; Davis et al., 2014) have utilized several different scoring methods for the SES, including nonredundant categorization by assault severity (Koss et al., 2007; 2008), nonredundant categorization of rape by severity tactic (Brown et al., 2015), and the frequency of experiences weighted in order of severity (Arata & Lindman, 2002; Davidson & Gervais, 2015). More specifically, the SES–SFV contains a wealth of information regarding sexual assault experiences such as sexual assault tactics, outcomes, and frequency; yet, the conventional scoring methods do not reflect the comprehensiveness of the measure itself. Thus, a continuous variable of sexual violence was created as an indicator of rank severity, in which participants were given a severity score that summed the severity ranks of all the

different sexual assault outcomes they reported (i.e., sum of ranks) based on a severity-ranking scheme that separated outcomes and tactics of the SES-SFV (see Davis et al., 2014). More specifically, (a) unwanted sexual contact by verbal coercion was multiplied by 1, (b) unwanted sexual contact by incapacitation was multiplied by 2, (c) unwanted sexual contact by force was multiplied by 3, (d) attempted rape by coercion was multiplied by 4, (e) attempted rape by incapacitation was multiplied by 5, (f) attempted rape by force was multiplied by 6, (g) completed rape by coercion was multiplied by 7, (h) completed rape by incapacitation was multiplied by 8, and (i) completed rape by force was multiplied by 9. The nine categories were then summed to form a total continuous score, with zero representing no sexual violence and higher numbers representing more sexual assault outcomes experienced and greater severity of sexual violence.

2.2.2.2 PTSD Checklist for DSM-5

The 20-item PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013; see Appendix 2) was used to measure PTSD symptom severity among respondents. The PCL-5 asks respondents to rate the extent to which they have experienced symptoms in the past month, with 5-point Likert-type response options anchored by *not at all* (scored as 0) and *extremely* (4). Example items include, "In the past month, how much were you bothered by blaming yourself or someone else for the stressful experience or what happened after it?" and "In the past month, how much were you bothered by repeated, disturbing, and unwanted memories of the stressful experience?" Response options are summed so that higher scores correspond with more symptom severity for diagnostic criteria (re-experiencing, avoidance, negative alterations in cognition and mood, hyperarousal) and for the whole disorder (Weathers et al., 2013). A previous study of 278

college students reported an internal consistency (Cronbach's alpha) for the PCL-5 of .94 (Blevins et al., 2015). In the same study, the PCL-5 demonstrated good test–retest reliability over a 1-week period with 53 college students (r = .82; Blevins et al., 2015). In the present study, the PCL-5's internal consistency (Cronbach's alpha) was .97.

2.2.2.3 Relationship Satisfaction

Relationship satisfaction was measured using the 5-item General Measure of Relationship Satisfaction (GMREL; Lawrance & Byers, 1992; see Appendix 3). Respondents are asked to rate their overall relationship with their partner on a 7-point semantic differential: bad–good, unpleasant–pleasant, negative–positive, unsatisfying–satisfying, worthless–valuable. Scores were summed and higher scores indicated greater relationship satisfaction. The internal consistency (Cronbach's alpha) for the GMREL in a sexually diverse sample of 955 adults was α = .97 (Mark et al., 2018). Test–retest reliability of the GMREL over periods of 3 months (r = .70; Lawrance & Byers, 1995) and 18 months (r = .61; Byers & MacNeil, 2006) was found to be acceptable. In the present study, the internal consistency (Cronbach's alpha) of the GMREL was .92.

2.2.2.4 Behavioral Emotion Regulation Questionnaire

The 20-item Behavioral Emotion Regulation Questionnaire (BERQ; Kraaii & Garnefski, 2019; see Appendix 4) was used to measure dispositional behavioral emotion regulation strategies among respondents. The BERQ has five subscales, and each scale contains 4-items: Seeking Distraction (α = .76), Withdrawal (α = .86), Actively Approaching (α = .83), Seeking Social Support, (α = .83), and Ignoring (α = .85). The BERQ uses a 5-point Likert-type response format that asks respondents to indicate what they generally do when they experience negative or unpleasant events anchored by

almost never (1) and *almost always* (5). Example items include, "I isolate myself" (withdrawal) and "I look for someone who can support me" (seeking social support). Response options are summed for each subscale such that higher scores correspond with more distraction, withdrawal, active approaching, seeking out social support, and ignoring the stressful event, respectively. The test–retest reliabilities of the scales were found to be good over a two-year period with 120 adults ($.47 < r < .75$; Kraaij & Garnefski, 2019).

2.2.2.5 Mental Health Participation

Respondents were asked whether they had ever received mental health counseling due to the sexual victimization(s) experiences described on the SES-SFV. Mental health participation was coded using dichotomous response options (no = 0; yes = 1).

2.2.3 Design and Procedures

Procedures for participation were implemented in accordance with the research protocol approved by the University of Kentucky Office of Research Integrity's Institutional Review Board. Prior to starting the survey, informed consent was obtained from participants. Participants were asked demographic information (see Appendix 5) such as age, ethnicity, race, and gender, in addition to the measures described above.

2.2.3.1 Analytic Approach

The data were analyzed for outliers using Mahalanobis distance, Cook's, and Leverage values, as suggested by Tabachnick and Fidell (2012). Additionally, correlations for multicollinearity and additivity, and plots for normality, linearity, and homogeneity were generated, and all variables were found to be normally distributed.

The Breusch–Pagan test for heteroscedasticity (Breusch & Pagan, 1979) using the Breusch–Pagan and Koenker Test Macro (Garcia-Granero, 2002) indicated heteroscedasticity in the data, χ^2 (2, N = 480) = 12.63, p = .002. Thus, heteroscedasticity-consistent standard error estimators (HC3; Davidson & MacKinnon, 1993) were implemented in the analyses to ensure greater validity and power of the ordinary least squares regression models by adjusting the standard errors associated with the beta weights of the model (Hayes & Cai, 2007; Long & Ervin, 2000).

Descriptive information was calculated for all study variables. To test H_1, a mediation model using the PROCESS macro (Version 3.5; Hayes, 2012) within SPSS (Version 27) was tested to examine the indirect effect of PTSD on the relationship between sexual victimization and relationships satisfaction. Bias-corrected and accelerated bootstrapping (BCa) was used to generate 95% confidence intervals for the effects. If the confidence intervals did not include zero, the indirect effect was considered to be statistically significant. Estimates of indirect and direct effects of the predictor(s) on the outcomes are provided in the final model (see Figure 2.1). To test H_2, an independent samples *t* test was conducted to assess whether relationship satisfaction statistically differs for assault survivors depending on whether they participated in mental health counseling following an experience of sexual violence. Finally, to test H_3, a hierarchical multiple regression model was created to predict the extent to which respondents' level of relationship satisfaction varies according to behavioral emotion-focused coping strategies and PTSD symptoms. Respondents' PTSD symptom severity was entered in Step 1, and behavioral emotion coping strategies—seeking distraction, withdrawal, actively approaching, seeking social support, ignoring—were added in Step 2.

2.3 Results

As displayed in Table 2.2, participants reported a wide range of sexually violent experiences. In total, participants reported experiencing 17,844 acts of sexual violence since their 14th birthday.[1] Notably, 68.8% of respondents reported rape (i.e., oral, anal, or vaginal penetration by a penis, fingers, or objects) by force as their most severe experience, and 10.8% of participants reported rape by incapacitation as their most severe act of sexual violence. Overall, 88.8% of respondents reported experiencing sexual contact by coercion as least once since their 14th birthday. In terms of act frequency, there were 3,031 reported instances of rape by coercion, followed by 2,991 instances of attempted rape (i.e., attempted oral, anal, or vaginal penetration by a penis, fingers, or objects) by coercion, and 2,546 instances of completed rape by force.

Descriptive statistics and intercorrelations of study variables are presented in Table 2.3. One-tailed Pearson's correlations were calculated to analyze the strength and direction of the relationships among respondents' level of sexual victimization, relationship satisfaction, PTSD symptomology, and the five behavioral emotion regulation strategies (seeking distraction, withdrawal, active approach, seeking social support, ignore). Bootstrapping was also utilized to provide confidence intervals for each correlation, effectively quantifying the precision of the effect size estimate (*r)*. Results indicated a small and negative association between sexual violence and relationship satisfaction (r = -.11). Sexual violence and PTSD were highly correlated (r = .52), whereas the five behavioral emotion regulation strategies demonstrated statistically

[1] The Sexual Experiences Survey–Short Form Victimization (SES-SFV) does not have the ability to distinguish whether endorsed outcomes or tactics occurred during multiple events or during a single event. The total number of occurrences was calculated by summing the frequency endorsed by each respondent for each outcome and tactic since their 14th birthday for the total analytic sample.

significant and positive associations with sexual violence ranging from small to moderate (.19 < *r* < .33). Relationship satisfaction and PTSD were negatively correlated (*r* = -.19); PTSD accounted for 3.6% of the variance in relationship satisfaction.

Concerning the behavioral emotion regulation strategies, withdrawal (*r* = -.20), and ignoring (*r* = -.09), were negatively correlated with relationship satisfaction, whereas actively approaching (*r* = .12), and seeking social support (*r* = .15), were positively associated with relationship satisfaction. Notably, seeking distraction was statically unrelated to relationship satisfaction (*r* = -.01). There were small correlations between PTSD and actively approaching (*r* = .15), and seeking social support (*r* = .28). PTSD and seeking distraction were moderately correlated (*r* = .30), and PTSD was highly correlated with ignoring (*r* = .51), and withdrawal (*r* = .63). Most of the behavioral emotion regulation strategies demonstrated statistically significant and positive associations with one another ranging from small to large (.08 < *r* < .56); the exception being the association between withdrawal and actively approaching, which was statistically nonsignificant (*r* = .08).

The SPSS macro PROCESS (Hayes, 2012) was used to test the mediating effect of PTSD on the association between sexual violence and relationship satisfaction. Sexual violence victimization statistically predicted PTSD, $F(1, 478) = 192.14$, $p < .001$, $R^2 = .272$. As depicted in Figure 2.1, PTSD ($B = -0.05$, $t = -3.40$, $p < .001$) statistically predicted relationship satisfaction, but sexual violence victimization ($B = -0.01$, $t = -0.29$, $p = .770$) did not statistically predict relationship satisfaction when PTSD was entered into the model, $F(2, 477) = 10.32$, $p < .001$. The direction of the coefficients indicated that relationship satisfaction was associated with low levels of PTSD symptom severity

and fewer and less severe victimization experiences. There was a statistically significant indirect association between sexual violence victimization and relationship satisfaction through PTSD, *B* = -0.03, 95% BCa CI [-0.05, -0.15].

An independent samples *t* test was conducted to evaluate differences in relationship satisfaction between those who participated in mental health services due to a sexual victimization experience and those who did not. Relationship satisfaction was slightly higher for those who did not use mental health services (*M* = 29.92, *SD* = 4.88) than those who did use mental health services (*M* = 29.52, *SD* = 5.37) in these data, but that difference cannot be assumed to exist in the population, *t*(478) = -0.85, *p* = .398, d = 0.08, and in any case the mean difference was practically meaningless (0.40, 95% CI [-1.37, 0.55]). This magnitude of difference indicates that those who did not participate in mental health services will have more relationship satisfaction in 52.3% of randomly paired individuals who did and did not participate in mental health services due to a sexual victimization experience. Notably, less than 1% of the variance in relationship satisfaction was explained by mental health participation.

Hierarchical multiple regression was used to predict relationship satisfaction (*M* = 29.76, *SD* = 5.09) using seeking distraction (*M* = 12.87, *SD* = 3.24), withdrawal (*M* = 11.58, *SD* = 3.87), actively approaching (*M* = 12.46, *SD* = 3.59), seeking social support (*M* = 12.09, *SD* = 3.74), and ignoring (*M* = 11.66, *SD* = 3.90), after controlling for PTSD (*M* = 32.82, *SD* = 20.37; see Table 2.4). PTSD was entered at Step 1 and explained 3.6% of the variance in relationship satisfaction. After seeking distraction, withdrawal, actively approaching, seeking social support, and ignoring were added in Step 2, the total variance explained by the model was 9.3%, *F*(6, 473) = 24.03, *p* < .001. Thus, the five behavioral

emotion–focused coping strategies explained an additional 5.7% in relationship satisfaction, after controlling for PTSD, F change (5, 473) = 5.93, $p < .001$. Lower levels of PTSD symptom severity statistically predicted more relationship satisfaction ($\beta = -.19$, $p < .001$). Similarly, lower levels of withdrawal predicted more relationship satisfaction ($\beta = -.14$, $p = .026$). In contrast, higher levels of seeking social support statistically predicted more relationship satisfaction ($\beta = .20$, $p < .001$). More specifically, with all other predictors held constant in the model, for every standard deviation increase in PTSD, relationship satisfaction decreased by about one point. For every one standard deviation increase in withdrawal, relationship satisfaction decreased by about 0.75 points with all other predictors held constant in the model. Finally, controlling for all other predictors in the model, a one standard deviation increase in seeking social support resulted in about a one point increase in relationship satisfaction.

2.4 Discussion

The purpose of this study was to examine the hypothesized effect of sexual violence victimization experiences on relationship satisfaction among married and currently partnered individuals who reported experiencing sexual violence since their 14th birthday. Specifically, PTSD was examined as a mediator of the association between sexual violence and relationship satisfaction, differences in relationship satisfaction were evaluated depending on respondents' participation in mental health services following acts of sexual violence, and a model including five behavioral emotion-focused coping strategies and PTSD was used to predict relationship satisfaction. Moreover, to better examine the nuanced associations among individuals who reported multiple and varying sexual victimization experiences, assault severity was ranked based on a severity-ranking

scheme that considered outcomes (i.e., unwanted sexual contact, attempted rape, completed rape) as well as the tactics (i.e., coercion, incapacitation, force) used during the assault (Davis et al., 2014).

2.4.1 Relevance of PTSD in Relationship Satisfaction

Consistent with H_1, results indicate that the relationship between sexual violence and relationship satisfaction can be explained by PTSD symptom severity. Specifically, more severe sexual violence experiences predicted higher levels of PTSD symptoms that, in turn, were associated with lower relationship satisfaction. The results of the mediation model suggest that, in the context of sexually violent experiences that occurred since one's 14^{th} birthday, PTSD symptom severity has a mediating role in the association between sexual violence and relationship satisfaction. Indeed, traumatic events may trigger psychological (Frazier et al., 2009; Paquette et al., 2019; Robinaugh & McNally, 2011) and relational distress (Goff et al., 2007; Ruhlmann et al., 2018), and the results indicate that psychological distress stemming from experiences of sexual violence may interfere with the relationship satisfaction among partnered individuals.

The extant literature indicates that those with more severe experiences of sexual violence—especially those who report experiencing vaginal, anal, or oral penetration—experience relational dissatisfaction (Berthelot et al., 2014; Finkelhor et al., 1989) and have unhealthier relationships than those who experience, for example, unwanted sexual contact (Collibee & Furman, 2014). Additionally, empirical research has demonstrated that the type of coercive tactic used by a perpetrator during an assault results in differing psychological consequences for survivors (Brown et al., 2009; Zweig et al., 1999). The results of the present study provide additional context concerning act severity and

strategies of coercion by merging these assault specific characteristics into an indicator of rank severity. For instance, the results demonstrate that those who experience more severe acts of sexual violence—determined based on outcome (from lowest to highest severity: unwanted sexual contact, attempted rape, rape) and coercive tactic (from lowest to highest severity: coercion, incapacitation, force)—are at an increased risk of developing PTSD symptoms that, in turn, are associated with lower relationship satisfaction. Additionally, the results indicate that PTSD explained a notable amount of the association between sexual violence and relationship satisfaction for those who experienced multiple acts of sexual violence, and more so at higher levels of act severity that take into account the coercive tactic used by the perpetrator. Thus, the results of the present study suggest that accounting for assault severity is an important determinant in the psychological and relational consequences following acts of sexual violence.

Given that PTSD symptom severity mediated the association between sexual violence and relationship satisfaction—that is, when PTSD symptom severity was entered into the model, the direct effect of sexual violence on relationship satisfaction was no longer statistically significant—addressing mental health concerns following acts of sexual violence would likely benefit intimate relationships among survivors of sexual violence. For instance, interventions aimed at reducing negative alterations in cognitions and mood (e.g., self-blame), dysphoric arousal (e.g., sleep problems), and anhedonia (i.e., lack of pleasure) have been suggested to improve the sexual satisfaction of individuals who experienced military sexual trauma (Blais et al., 2018). The results of the present study similarly suggest that reducing PTSD symptomology would be beneficial for sexual assault survivors and their relationships. Indeed, the results suggest that sexual

violence has very real consequences for intimate relationships, and that this relationship is explained by individual symptoms on measures of psychological distress. Thus, more research is needed to understand how specific PTSD symptom clusters interact with experiences of sexual violence to influence relationship satisfaction.

2.4.2 Relevance of Mental Health Services in Relationship Satisfaction

Although the results of the mediation model suggest that PTSD symptoms indirectly influence the association between sexual violence and relationship satisfaction, the results of the independent samples *t* test did not support the hypothesis that those receiving mental health counseling following an assault report greater relationship satisfaction than those who do not receive mental health counseling. In fact, participation in mental health services was statistically unrelated to relationship satisfaction among survivors of sexual violence. A selection effect might explain the lack of statistical association between participating in mental health services and relationship satisfaction. For instance, it might be that those who seek out mental health services (a) have more severe sexual trauma histories and (b) have more severe symptoms of psychological distress, which could result in diminished relationship satisfaction, as suggested by the mediation model. Indeed, those with severe sexual trauma histories that include vaginal, anal, and oral penetration have poorer relationship satisfaction (Berthelot et al., 2014; Finkelhor et al., 1989; Liang et al., 2006) and impaired dyadic adjustment (Berthelot et al., 2014) than those without penetration histories. Notably, however, sexual assault severity was not controlled for in the analysis and should be further explored in future studies. Additionally, given that increased social support is negatively associated with PTSD (Brewin et al., 2000; Ozer et al., 2003), perhaps those who did not participate in

treatment following sexual violence felt supported by their partners or others in their social network, thereby diminishing the need for resources and mental health services altogether.

Longitudinal analyses can provide additional context regarding the lack of statistical association between those participating in mental health services and relationship satisfaction, which have been reported here and elsewhere (e.g., DiMauro & Renshaw, 2018). For instance, a randomized control trial has demonstrated a statistically significant negative association between relationship satisfaction at 3-weeks post trauma and PTSD symptoms 5-months post trauma for those not in treatment; however, the association between relationship satisfaction at baseline and PTSD at follow-up was not statistically significant for those receiving treatment (Freedman et al., 2015). Moreover, among those not in treatment, 5-months after the trauma, PTSD symptoms had declined to a larger degree among those who had reported satisfaction with their relationships 3-weeks post trauma than those who had reported impaired relationship satisfaction 3-weeks post trauma (Freedman et al., 2015). Thus, these results on the whole indicate that natural recovery (i.e., no treatment) depends on relationship satisfaction, but that relationship satisfaction is inconsequential with regard to PTSD symptomology when treatment is utilized. Participating in treatment could reduce partner burden such that psychological distress is no longer associated with relationship satisfaction; conversely, when partners are the primary support for post trauma recovery, it appears that mental distress is very much related to relationship functioning.

Additionally, engaging in therapy could introduce unanticipated changes into the relationship, thereby requiring considerable dyadic adjustment. Developing and setting

boundaries, for example, could upset the status quo as partners are left to adjust to the needs of the individual setting those boundaries. Alternatively, treating PTSD in a dyadic format (e.g., cognitive–behavioral conjoint therapy; CBCT) can help mitigate the effects of partner accommodation, which occurs when partners modify their behaviors in response to the trauma survivors' symptoms to minimize distress in the survivor or minimize relationship conflict due to the PTSD symptoms (e.g., taking over responsibilities that cause distress, withholding true feelings to avoid anger, etc.; Fredman et al., 2016). Partner accommodation is negatively associated with relationship satisfaction for both members of the dyad (Fredmen et al., 2014); thus, if partner accommodation is not resolved via therapeutic interventions such as CBCT, there are likely to be negative implications for the trauma survivor, their partner, and the relationship as a whole. The lack of variance in relationship satisfaction explained by mental health participation in the present study, in combination with empirical research pointing to partner effects impacting both relationship satisfaction and trauma recovery, suggest that gathering information from both partners would provide a more comprehensive understanding of the interplay of treatment interventions and relationship satisfaction among survivors of sexual violence.

Importantly, this study is limited by its cross-sectional design, which prohibits any causal inferences concerning experiences of sexual violence, reports of relationship satisfaction, and the variance attributed to engaging in mental health services. Relationship satisfaction was assessed at a single time point following experiences of sexual violence, so the associated changes in relationship satisfaction to either the severity of sexual violence or the decision to seek out mental health services cannot be

determined. Moreover, among those individuals who reported engaging in mental health treatment, it is not clear how much time had passed since the sexual violence occurred before seeking services, which specific act (if any) prompted respondents to seek help, or who among them were participating in mental health services at the time of the survey. Although longitudinal research is needed to assess the relative change in relationship satisfaction among survivors of sexual violence that is associated with utilizing mental health services, or change associated with psychological and relational distress more generally, the present study serves as a first step toward assessing the relationships among these variables in a highly victimized sample of sexual assault survivors.

2.4.3 Relevance of Emotion-Focused Coping in Relationship Satisfaction

As hypothesized, results from the hierarchical regression model demonstrate that behavioral emotion-focused coping explains unique variance in relationship satisfaction among survivors of sexual violence after controlling for the variance explained by PTSD symptom severity. In combination, behavioral emotion-focused coping and PTSD symptom severity explained less than ten percent of the variance in relationship satisfaction among survivors of sexual assault in these data. Extending previous findings that indicate emotion regulation strategies offer unique explanatory power for understanding relational processes such as sexual satisfaction (Rellini et al., 2010; Rellini et al., 2012), the results of the present investigation indicate that in the context of sexual violence that occurred since one's 14th birthday, behavioral emotion-focused coping strategies play a role in the variance explained by relationship satisfaction. Indeed, the behavioral processes an individual initiates when responding to stress, such as stress resulting from symptoms of posttraumatic stress, appear relevant for the intimate

relationships among survivors of sexual violence. Specifically, withdrawal and seeking social support, in combination with PTSD symptom severity, emerged as statistically significant predictors of relationship satisfaction in the final model.

These findings are perhaps not surprising given the natural tension between patterns of withdrawal and seeking out support, both in the context of relationships and in the context of psychological distress. Concerning the former, conflict patterns such as partner demand (e.g., chastise, demand) and self-withdraw (e.g., avoid confrontation, withdraw from conflict) are prevalent in violent relationships (Feldman & Ridley, 2000) that are characterized by psychological intimate partner violence (IPV; Pickover et al., 2017). Moreover, one meta-analysis found a small, statistically significant, negative effect size between withdrawal and relationship satisfaction (d = -0.29; Woodin, 2011), suggesting that behavioral responses characterized by patterns of withdrawal have negative implications for romantic relationships and are prevalent among distressed couples. Social support, however, is positively related to relationship satisfaction (Cramer, 2004) and appears to be a protective factor against relationship dissolution (d = -0.55) to a similar effect as other relationship-level variables such as relationships satisfaction (Let et al., 2010). As demonstrated in the present study, increases in withdrawal were detrimental to relationship satisfaction, whereas increases in seeking social support promoted relationship satisfaction among survivors of sexual violence, suggesting that behavioral emotion-coping following experiences of sexual violence could have implications for intimate relationships.

Regarding psychological distress, demand/withdraw conflict patterns are associated with generalized anxiety disorder, but not PTSD, following experiences of

IPV (Pickover et al., 2017); however, demand/withdraw communication patterns have been shown to moderate the association between attachment avoidance and depression, as well as the association between attachment avoidance and posttraumatic stress symptoms among service members and veterans (Riggs et al., 2020). More specifically, at high levels of attachment avoidance, higher demand/withdraw patterns increased the risk for psychological distress but had little effect on symptoms for individuals with low attachment avoidance (Riggs et al., 2020). Certainly, behavioral strategies associated with attachment avoidance (e.g., conflict avoidance) are likely to cultivate withdrawal patterns, which could translate into an individual's reluctance to seek help following traumatic events. Notably, a lack of social support is a strong predictor concerning the development and maintenance of PTSD symptoms (Brewin et al., 2000; Ozer et al., 2003), and PTSD was likewise a statistical predictor of relationship satisfaction in the present study. The results of the present study, in combination with previous research, suggest that behavioral emotion-focused coping responses of withdrawal and seeking social support, interact with PTSD in such a way to explain some of the variance in relationship satisfaction among individuals who have previously experienced sexual violence.

More research is needed to understand the lack of statistical significance regarding the other three behavioral emotion-focused coping strategies (i.e., ignoring, seeking distraction, actively approaching) as individual predictors in the model. Importantly, ignoring, actively approaching, and seeking distraction explained 56%, 30%, and 8% of the variance in seeking social support, whereas ignoring and seeking distraction explained 36% and 12% of the variance in withdrawal; the associations

between actively approaching and withdraw were statistically nonsignificant. The small to large associations between the three nonsignificant individual predictors of relationship satisfaction and withdrawal and seeking social support, respectively, may point to presence of multicollinearity in the data, though collinearity statistics ($1.54 < VIF < 2.13$) did not indicate bias in the regression model. Still, researchers should be aware of potential suppressor effects when evaluating behavioral emotion-focused coping strategies in relation to relationship satisfaction in future studies. Additionally, some research indicates that gender differences may explain additional variance in relationship satisfaction when considering behavioral emotion-focused coping strategies (see Woodin, 2011), but more research is needed to understand how this is enacted for survivors of sexual violence and is beyond the scope of this study.

2.4.4 Limitations and Future Directions

In addition to the limitations already discussed, it is not clear when after the sexual violence occurred that individuals (a) started experiencing symptoms of PTSD, (b) participated in mental health services, and (c) entered into their current romantic relationships. For instance, a supportive relationship via an intimate partnership or through a supportive alliance with a therapist could provide a foundational corrective experience in which symptoms of distress are mitigated and healing can take place. Conversely, if sexual violence occurs within the relationship (i.e., perpetrated by an intimate partner), there are likely to be manifest implications regarding mental, emotional, and relational well-being. Unfortunately, information regarding respondents' relationship(s) to the perpetrator(s) was not collected. Longitudinal research designs and more explicit information regarding assault-level characteristics can help circumvent

these limitations. Additionally, most participants in the study experienced multiple occurrences of sexual violence through multiple tactics, and without participant confirmation of their most severe experience, and perhaps additional confirmation concerning which specific experience led to the development of PTSD symptoms, we can only speculate that sexual assault severity aligned with the severity-ranking scheme used in the present study. Other researchers (e.g., Luterek et al., 2011) have demonstrated that when sexual violence is reported as an individual's most significant trauma, the psychological toll is meaningfully different than when, for example, a natural disaster is reported as their most significant trauma. Thus, it might be that there are meaningful differences regarding individual instances of sexual violence in terms of psychological and relational impact, in addition to the adverse health implications already established within the extant literature concerning sexual revictimization (Brown et al., 2009; Classen et al., 2005; Jozkowski & Sanders, 2012). Additionally, researchers should be cautioned against generalizing these findings to individuals who are currently experiencing sexual violence as that is beyond the scope of this study.

In consideration of these limitations, the results of the present study have practical implications and point to various avenues of future study. In addition to those already discussed, these findings suggest that behavioral emotion-focused coping and PTSD symptoms have implications for the relationships among individuals who have previously experienced sexual violence. Although relationship satisfaction did not statistically differ among those who did and did not participate in mental health services due to their sexual trauma histories, it seems likely that interventions aimed at decreasing withdrawal responses and increasing individual support networks, while simultaneously addressing

symptoms of PTSD, could promote relationship satisfaction while also addressing symptoms of traumatic stress related to the sexual violence. Moreover, previous research has shown that dyadic interventions for PTSD, regardless of the state of the relationship at the start of therapy, can lead to substantial improvements in relationship quality, and that these effects are more pronounced for those who began treatment in distressed relationships (Shnaider et al., 2015). Future studies should be designed to extend these findings by evaluating the relative change in relationship satisfaction over the course of couple's therapy when behavioral emotion-focused coping strategies are directly addressed in relation to trauma symptoms stemming from experiences of sexual violence.

2.5 Conclusion

This investigation was designed to examine predictors of relationship satisfaction among individuals who had previously experienced sexual violence. More specifically, relationship satisfaction was investigated with respect to PTSD symptom severity, behavioral emotion-focused coping strategies, and the relevance of participating in mental health services. This study begins to fill critical gaps in the literature by linking experiences of sexual violence to relationship satisfaction through PTSD symptom severity. Given that PTSD symptoms fully mediated the relationship between sexual violence and relationship satisfaction among married and currently partnered individuals who have experienced sexual violence, focusing on decreasing symptoms of psychological distress is likely to benefit both individuals and their relationships. Furthermore, behavioral emotion-focused strategies explained unique variance in relationship satisfaction when controlling for PTSD symptom severity. Specifically, withdrawal and seeking social support emerged as individual predictors of relationship

satisfaction in addition to the predictive ability of PTSD. Additionally, relationship satisfaction did not differ based on whether respondents participated in mental health services following experiences of sexual violence. In sum, the findings suggest that relationship satisfaction among individuals with a history of sexual violence depends on levels of psychological distress and the use of emotion-focused coping strategies.

Table 2.1

*Demographic Characteristics of Participants (*N = *480)*

Characteristic	*n*	%
Gender		
Female	290	60.4
Male	157	32.7
Trans FTM	18	3.8
Trans MTF	12	2.5
Non-binary	2	0.4
Trans non-binary	1	0.2
Race or ethnicity		
White, non-Hispanic	352	73.3
Black, non-Hispanic	33	6.9
Asian	32	6.7
Mixed	24	5.0
American Indian/Alaska Native	19	4.0
Hispanic	15	3.1
Another, unspecified	5	1.0
Education		
Less than high school diploma	1	0.2
High school diploma	37	7.7
Some college	120	24.9
Associate's degree	30	6.3
Bachelor's degree	201	41.9
Master's degree	82	17.1
Doctorate	9	1.9
Religion		
Catholic	201	41.9
Agnostic	71	14.8
Protestant, Evangelical	55	11.5
Atheist	37	7.7
Christianity, unspecified	31	6.5
Protestant, Mainline	28	5.8
No religious preference	23	4.8
Other, spirituality	17	3.5
Islamic	9	1.9
Jewish	8	1.7
Religiosity		
Very religious	103	21.5
Somewhat religious	148	30.8
Slightly religious	89	18.5
Not at all religious	140	29.2
Respondent relationship status		
Married	282	58.8
In a relationship, not married	198	41.2
Sexual orientation		
Straight/Heterosexual	326	67.9
Bisexual	105	21.9
Gay or Lesbian/Homosexual	17	3.5
Asexual	16	3.3
Pansexual	10	2.1
Prefer not to say	6	1.3
Childhood Sexual Abuse		
No	210	43.8
Yes	209	43.5
Unsure	61	12.7
	M	*SD*
Age (years)	35.1	10.5

Table 2.2

*Sexual Assault Severity Scores for Respondents since the Age of 14 (*N = *480)*

Separated outcome and tactic	Highest Severity Rank [a]	Redundant [b]	Total frequency [c]
Sexual contact by coercion	10 (2.1)	426 (88.8)	1,810 (10.1)
Sexual contact by incapacitation	11 (2.3)	357 (74.4)	795 (4.5)
Sexual contact by force	15 (3.1)	372 (77.5)	1,327 (7.4)
Attempted rape by coercion	6 (1.3)	350 (72.9)	2,992 (16.8)
Attempted rape by incapacitation	14 (2.9)	312 (65.0)	1,431 (8.0)
Attempted rape by force	21 (4.4)	302 (62.9)	2,455 (13.8)
Rape by coercion	21 (4.4)	357 (74.4)	3,031 (17.0)
Rape by incapacitation	52 (10.8)	325 (67.7)	1,457 (8.2)
Rape by force	330 (68.8)	330 (68.8)	2,546 (14.2)

Note. Percentages are presented in parentheses.

[a] Reflects scoring based on the highest severity rank, in which participants were placed in the category of their most severe experience, ignoring all less severe outcomes. [b] Reflects redundant scores for each outcome and tactic in that if a participant experienced both unwanted sexual contact by coercion and by force, they would be counted in both categories. [c] Reflects the total number of times respondents in the sample reported experiencing the corresponding outcome and tactic.

Table 2.3

*Means, Standard Deviations, and Intercorrelations for Study Variables (*N = *480)*

Variable	*M*	*SD*	Range	1	2	3	4	5	6	7
1. Sexual violence	31.45	14.93	1−45	–						
2. Relationship satisfaction	29.76	5.09	5−35	-.11 [-.21, -.02]**	–					
3. PTSD	32.82	20.37	0−79	.52 [.45, .59]***	-.19 [-.27, -.11]**	–				
4. Seeking distraction	12.87	3.24	5−20	.19 [.09, .27]***	-.01 [-.11, .09]	.30 [.20, .39]***	–			
5. Withdraw	11.58	3.87	4−20	.33 [.25, .40]***	-.20 [-.28, -.12]***	.63 [.57, .69]***	.35 [.25, .45]***	–		
6. Active approach	12.46	3.59	4−20	.23 [.13, .32]***	.12 [.02, .19]**	.15 [.05, .25]***	.37 [.27, .46]***	.08 [-.04, .19]	–	
7. Seeking social support	12.09	3.74	4−20	.24 [.15, .32]***	.15 [.06, .25]***	.28 [.18, .37]***	.29 [.19, .38]***	.10 [.00, .20]**	.55 [.46, .62]***	–
8. Ignore	11.66	3.90	4−20	.28 [.19, .34]***	-.09 [-.18, .00]*	.51 [.43, .59]***	.56 [49, .63]***	.60 [.51, .67]***	.10 [.00, .20]**	.08 [-.03, .17]*

Note. Numbers in brackets are 95% bias corrected and accelerated (BCa) intervals of the correlation coefficients.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 2.4

*Hierarchical Multiple Regression Analysis for Predicting Relationship Satisfaction (*N = *480)*

Step and predictor variables	R^2	ΔR^2	*B*	95% CI	β	*t*	*p*
Step 1	.04	.04					< .001
PTSD			-0.05	[-0.07, -0.03]	-.19	-4.26	< .001
Step 2	.09	.06					
Seeking distraction			-0.04	[-0.21, 0.14]	-.02	-0.39	.700
Withdrawal			-0.18	[-0.34, -0.02]	-.14	-2.23	.026
Actively approaching			0.06	[-0.09, 0.21]	.04	0.75	.456
Seeking social support			0.27	[0.13, 0.42]	.20	3.65	< .001
Ignoring			0.12	[-0.04, 0.29]	.09	1.47	.144

Note. Reference category in parentheses. CI = confidence interval for *B*.

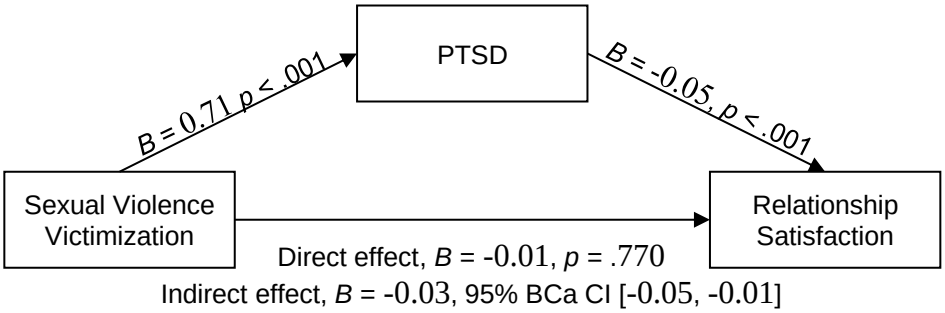

Figure 2.1 Model of sexual violence victimization as a predictor of relationship satisfaction, mediated by PTSD

CHAPTER 3. RELATIONSHIPS, PTSD, AND SEXUAL VIOLENCE: THE EXPERIENCES OF SEXUAL AND GENDER MINORITIES

Sexual and gender minority (SGM) individuals experience disproportionately high rates of mental health problems, including depression, suicide ideation, anxiety, eating disorders, substance use, and posttraumatic stress (Gonzales & Henning-Smith, 2017; Institute of Medicine, 2011; Lipson et al., 2019; Meyer et al., 2008; Newcomb et al., 2020; Pitoňák, 2017; Ross et al., 2018), and there is evidence to suggest that these risks differ based on sexual orientation and gender identity. For example, transgender and gender nonconforming (TGNC) individuals are more than two times as likely to report poor mental health than cisgender lesbian, gay, and bisexual (LGB) individuals (Schnarrs et al., 2019). These health disparities persist across the life course (Fredriksen-Goldsen et al., 2013; Fredriksen-Goldsen et al., 2017; McLaughlin et al., 2012), and are further complicated by other sociodemographic variables and identity statuses (e.g., race; Kerridge et al., 2017; Rimes et al., 2019b), experiences of minority stress (Dürrbaum & Sattler, 2020; la Roi et al., 2020; Valentine & Shiperd, 2018), and trauma (Balsam et al., 2015; Charak et al., 2019; Schnarr et al., 2020).

LGB and TGNC individuals also experience disproportionately high rates of sexual violence (SV) compared to heterosexual adults (Armstrong et al., 2018; Chen et al., 2020; Mellins et al., 2017; Newcomb et al., 2020; Rothman et al., 2011; Walters et al., 2013). Approximately one in eight lesbian women, four in ten gay men, and about half of bisexual men (47.4%) and bisexual women (46.1%) have experienced SV at some point in their lives (Walters et al., 2013). Bisexual women, in particular, have the highest lifetime rates of SV across female sexual orientation classifications, and both gay and

bisexual men report greater lifetime prevalence of SV than heterosexual men (Chen et al., 2020). According to a systematic review (Stotzer, 2009), the prevalence of rape and sexual assault among TGNC individuals ranges from 10% to 86%, whereas findings from the 2015 U.S. Transgender Survey (James et al., 2016) suggest that nearly half (47%) of transgender individuals have experienced SV at some point in their lifetime. Transgender individuals also report prevalence rates more than twice that of their cisgender LGB counterparts (Langenderfer-Magruder et al., 2016). Plainly, the prevalence rates of SV among SGM individuals are alarmingly high; TGNC individuals experience higher rates of SV than their cisgender counterparts, and bisexuality also seems to be positively associated with experiencing SV across one's lifetime.

The mental health disparities and high rates of SV among SGM individuals begs for the identification of factors that help to protect SGM individuals from adverse health outcomes, especially given the limited access this population has to resources that support positive health outcomes because of sexual- and gender-based stigma and discrimination (White Hughto et al., 2015). Furthermore, SGM individuals who have experienced SV are more likely to report a history of suicide ideation, suicide attempts, and self-harming behaviors than those who have not experienced SV (Rimes et al., 2019a; Ross-Reed et al., 2019; Testa et al., 2012), thereby exacerbating the already high rates of suicide attempts among this population (Mak et al., 2020; Marshall et al., 2011; Miranda-Mendizábal et al., 2017; Testa et al., 2017). Particularly among heterosexual adults, romantic relationships have consistently emerged as a protective factor for mental distress (Kamp Dush & Amato, 2005; Vanassche et al., 2013), and relationship involvement appears to buffer the effect of violence motivated by sexual minority status

and psychological distress among racially diverse sexual minority youth (Whitton et al., 2018).

Among individuals with PTSD, those who are married and cohabitating have higher levels of life satisfaction than those who are single or divorced (Karatzias et al., 2013), although findings from a meta-analysis indicate that the level of emotional support received from a spouse is lower among individuals who have been sexually assaulted than those who have not (Golding et al., 2002). The same meta-analysis did not find a statistical difference among unmarried individuals according to sexual assault history, but this was likely due to a smaller sample of unmarried sexual assault survivors (i.e., lower power to statistically detect a difference). Notably, among partnered women who have experienced sexual assault, the odds of receiving emotional support from one's partner are similar for both married and unmarried women (Golding et al., 2002). Taken together, these findings suggest that the differences between those who have and have not been sexually assaulted are similar for both married and unmarried-but-partnered women. Additionally, that the type of support received within these relationships could have implications for both the development of PTSD symptoms and overall relationship satisfaction.

Despite empirical evidence that suggests differing outcomes based on relationship status for those who have been sexually assaulted and those who have developed PTSD, these dynamics have not been fully explored among SGM individuals who have experienced sexual assault. Moreover, it appears critical to understand whether and how different relationship statuses among SGM individuals protect (or exacerbate) mental health problems following SV, especially given the high rates of SV victimization within

this population (Armstrong et al., 2018; Chen et al., 2020; Mellins et al., 2017; Newcomb et al., 2020; Rothman et al., 2011; Walters et al., 2013), the co-occurrence of multiple forms of violence (psychological, sexual, physical) in same-sex relationships (see Longobardi & Badenes-Ribera, 2017, for a review), and the prevalence of polyvictimization within the population as a whole (Sterzing et al., 2017a; Sterzing et al., 2017b). Alternatively, same-sex couples are particularly advantaged compared to heterosexual couples in areas of conflict initiation (Gottman et al., 2006) and conflict resolution (Kurdek, 2005), which might mean that SGM relationships are better suited to address the deleterious effects of SV and could promote a buffering effect over and above that of their heterosexual and cisgender counterparts. Thus, research is needed to understand how romantic relationships intersect with gender and sexual identity statuses following SV to promote mental well-being.

3.1 Timing of Assault

Early life experiences shape individual outcome differences in later life (Alwin, 2012), and the impact of abusive experiences likely varies based on the life stage in which the abuse occurs. For instance, Ziobrowski et al. (2020) conducted a series of latent class analyses to classify maltreatment based on the developmental timing, duration, and co-occurrence of abuse types that occurred before 17 years of age and found that the latent classes were uniquely associated with a range of adverse health outcomes (e.g., high depressive symptoms, substance use, binge drinking, etc.). Importantly, these results highlight the value of considering the developmental timing of abuse, especially given that abuse sustained across both developmental periods (i.e.,

childhood and adolescence) tended to have the strongest associations with health indicators (Ziobrowski et al., 2020). Furthermore, women who were abused in childhood are less likely to be married or in cohabiting relationships; however, CSA, specifically, is associated with a higher risk of cohabiting versus being married: One study found that women who experienced sexual abuse in childhood were three times more likely to be cohabiting rather than married compared to women who were not sexually abused in childhood (Cherline et al., 2004). Additionally, a meta-analysis indicated that overall, people who had been sexually assaulted were less likely to be married and less likely to receive support from their friends and family (Golding et al., 2002). Together, these results demonstrate that both the timing and the form of abuse is associated with various psychosocial consequences later in life.

Indeed, CSA is associated with negative intimate relationship outcomes, and research demonstrates that exposure to CSA has long-lasting effects on relationship outcomes in adulthood, such as relationship dissatisfaction (Friesen et al., 2009; Liang et al., 2006) and a 40–50% increased risk of reporting marital problems than individuals without CSA histories (Dube et al., 2005). Some research findings have suggested that relationship characteristics (e.g., communication patterns) do little to alter the impact that CSA histories have on relationship satisfaction (Nguyen, 2019). Instead, assault-specific factors, like the nature of the victim–perpetrator relationship, are associated with outcomes. For example, CSA perpetrated by a family member presents a higher risk for relationship problems later in life than CSA perpetrated by either a friend or a stranger (Watson & Halford, 2010), but there has not been comparable research regarding the

nature of the victim–perpetrator relationship and subsequent relationship satisfaction for survivors of adult sexual assault.

It is known, however, that sexual assault experienced in adulthood impacts how survivors perceive their intimate relationships. Murphy et al. (1988) found that in the immediate weeks following rape, survivors have lower self-esteem, less hope for the future, and are less satisfied in their relationships with others than nonvictims. Although there are few differences in reported self-esteem between victims and nonvictims a year later, at 2-years post-rape victims had statistically lower satisfaction in their relationships, indicating that relationship issues in the aftermath of rape might persist over time, even if temporarily absent due to victim suppression or a period of heightened support. Indeed, Elliot et al. (2004) found that adult sexual assault victims had more trauma symptoms a mean of 14 years post-victimization than individuals who were not assaulted. Moreover, despite a relative scarcity of information about the consequences of sexual assault on relationship formation after childhood and adolescence, sexual violence following puberty is associated with greater sexual distress and sexual difficulties than if the assault occurred in childhood or not at all (Maseroli et al., 2018).

3.2 Relationships and Sexual Violence

Across cultures, people who are married are more satisfied with their life than those who cohabit (Diener et al., 2000), and predictors of life satisfaction vary by gender: marital status and interpersonal relationships contribute to life satisfaction for women, whereas sociopolitical variables such as employment and education are important

determinants for life satisfaction in men (Joshanloo, 2018). Perceived social support partially mediates the relationship between having a romantic partner and high well-being (Stronge et al., 2019). Longitudinal data indicates that people who get married have short-term increases in subjective well-being, but the potentiating effect of marriage on happiness does not last (Lucas et al., 2003; Lucas & Clark, 2006), whereas other cross-sectional (Haring-Hidore et al., 1995) and panel research (Easterlin, 2003) suggest that marriage is associated with a lasting increase in subjective happiness. Beyond the protective effects of marriage, selection effects might also explain some of these conflicting results (e.g., DeMaris, 2018). For instance, happy individuals may be more successful at finding a mate and staying married, whereas unhappy individuals may be more likely to suffer from psychological issues that prevent them from entering into intimate relationships or lead to relationship dissolution.

One such psychological problem that stems from interpersonal trauma is the development of PTSD. Dissociation, an intrapsychic process and way of relating to others, is associated with an individual's ability to stay emotionally present (Lyons-Ruth, 2008), and can contribute to relationship difficulties, including preoccupation and a fear of relationships in general (Dorahy et al., 2013). The interpersonal nature of sexual assault might also reaffirm the idea that relationships should be regarded with fear and worry (Ornduff et al., 2001). Moreover, Dorahy et al. (2013) found that those high in dissociation also exhibit heightened self-criticism. Thus, individuals who develop symptoms of PTSD and have particularly high levels of dissociation may have a tendency to internalize relationship issues or avoid intimate relationships altogether. Notably, self-criticism mediates the association between CSA and romantic relationship satisfaction,

and attachment avoidance is prospectively related to decreased levels of romantic relationship satisfaction (Lassri et al., 2018). Heightened self-criticism, then, might indirectly lead to unsatisfying relationships, which can increase attachment avoidance, leading to subsequent decreases in relationship satisfaction over time, ultimately creating a vicious cycle of relationship functioning. Attachment anxiety and attachment avoidance are negatively related to relationship satisfaction (Candel & Turliuc, 2019), and secure attachment relationships can buffer the impact of sexual trauma (Cantón-Cortés et al., 2015; Stubenbort et al., 2002). Therefore, preoccupation with relational issues or an avoidance of relationships altogether could stem from insecurities regarding internal working models of the self and of others and could be exacerbated by sexually violent experiences. Notably, the relation between attachment insecurity and relationship satisfaction is stronger for relationships longer in length and among those who are older (Candel & Turliuc, 2019).

Given limited empirical evidence hinting at the potential for relationship involvement to buffer adverse mental health effects among SGM individuals who have experienced SV, the present study was designed to assess whether PTSD symptom severity differs by gender identity (cisgender vs. TGNC), sexual orientation identity (sexual minority identity vs. heterosexual), and relationship involvement (partnered vs. not partnered). In addition, PTSD symptom severity will be assessed in relation to sexual identity (sexual minority vs. heterosexual) and three levels of relationship status: not currently partnered, partnered but not married, and married. Finally, relationship involvement will be explored as a potential moderator of the association between SV

severity and PTSD symptom severity. Previous experiences of sexual violence and the length of current relationship will be controlled for in the analyses.

H_1: PTSD symptom severity is greater among TGNC individuals than cisgender individuals.

H_2: PTSD symptom severity is greater among sexual minority individuals than heterosexual individuals.

H_3: PTSD symptom severity is greater among those individuals not in relationship than those in relationships.

H_4: PTSD symptom severity is greatest among TGNC, sexual minority individuals who are not in relationships.

H_5: PTSD symptom severity is greater among those not currently partnered than among those who are currently partnered, including those who are married and those who are not.

H_6: PTSD symptom severity is greater among those currently partnered but not married than among those who are currently married.

H_7: PTSD symptom severity is greater for sexual minority individuals than for heterosexual individuals at lower levels of relationship status; from highest to lowest: not currently partnered, partnered but not married, married.

H_8: Involvement in romantic relationships will moderate the relationship between SV and PTSD symptom severity such that those who are currently in a romantic relationship have less severe PTSD symptoms than those who are not in a romantic relationship.

3.3 Method

3.3.1 Sampling Procedures

Participants were recruited via Amazon Mechanical Turk (MTurk)—a crowdsourcing platform with a large and diverse subject pool that is representative of the U.S. population across many psychological dimensions (e.g., anxiety; McCredie & Morey, 2019)—in June of 2020. Inclusion criteria for the study required participants to be at least 18 years of age, have personal experience with sexual victimization since their 14th birthday, and have been in at least one romantic relationship (e.g., spouse, boyfriend, girlfriend, etc.). Eligible participants responded to questions concerning experiences of sexual violence, attachment, PTSD, emotional coping, relationship and sexual satisfaction, and decision-making within relationships. Attention checks were scattered throughout the survey, and 688 respondents correctly answered the three attention check questions. Participants were paid $2.03 to complete the roughly 25-minute survey, based on the distribution of median hourly wages for human intelligence task surveys on MTurk ($4.88; Hara et al., 2018).

The present study required that respondents have sexual victimization experiences that occurred within the past year and those respondents who refused to provide information on their sexual orientation were removed from the sample, which left a sample size of 322 respondents. For H_1–H_4, a statistical sensitivity power analysis for a factorial ANOVA using G*Power (Faul et al., 2007)—based on a sample size of 321, an alpha (α) of .05, a beta (β) of .20, six groups, one degree of freedom, and three covariates—provided sufficient power to detect an effect size of $F = 0.16$ and larger, which is equivalent to a Cohen's d of 0.32 and larger. For H_5–H_7, a statistical sensitivity

power analysis for a factorial ANOVA using G*Power (Faul et al., 2007)—based on a sample size of 322, an alpha (α) of .05, a beta (β) of .20, six groups, two degrees of freedom, and three covariates—provided sufficient power to detect an effect size of F = 0.17 and larger, which is equivalent to a Cohen's d of 0.34 and larger.

3.3.1.1 Sample Demographics

As displayed in Table 3.1, most respondents were White (70.2%), heterosexual (61.5%), and female (54.0%); 10.3% of the sample identified as transgender. The highest level of formal education varied but those in this sample were slightly more educated relative to the U.S. population (U.S. Census Bureau, 2020); most respondents either completed some college but did not earn a bachelor's degree (19.9%), earned a bachelor's degree but nothing more (48.8%), or obtained a master's degree (18.3%). Some respondents indicated that they were *not religious* (19.6%), or *slightly religious* (18.6%), whereas roughly one third of respondents indicated they were *somewhat religious* (35.1%), and about a quarter of respondents reported that they were *very religious* (26.7%). Regarding religious preference, over half of respondents identified as Catholic (53.7%); others identified as Evangelical Protestant (9.9%) or Agnostic (9.0%). A little over half of respondents (53.1%) indicated they had experienced childhood sexual abuse; 33.5% of respondents did not, and others were unsure (13.4%). Most respondents were either married (53.7%) or in a committed but nonmarital relationship (30.1%); 15.2% of respondents were single.

Females and Whites were overrepresented in the sample compared to the U.S. population as a whole (Statista Research Department, 2021; U.S. Census Bureau, 2012; 2013), as were transgender, lesbian, gay, and bisexual individuals (Gates, 2011; Newport,

2018), which was to be expected given that these groups are particularly vulnerable to experiences of sexual violence (Armstrong et al., 2018; Chen et al., 2020; Cortina & Kubiak, 2006; Tjaden & Theonnes, 2006). These groups are also at a heightened risk for experiencing psychological distress (Gonzales & Henning-Smith, 2017; Grenier et al., 2019; Lipson et al., 2019; Newcomb et al., 2020; Pitoňák, 2017; Ross et al., 2018).

3.3.2 Measures

3.3.2.1 Sexual Experiences Survey–Short Form Victimization

The Sexual Experiences Survey–Short Form Victimization (SES–SFV; Koss et al., 2007; see Appendix 1) was used to measure unwanted sexual experiences. More specifically, the SES–SFV comprises seven behaviorally-specific descriptions that meet legal definitions of various sex crimes (or five for male respondents; two vaginal penetration items are omitted for male respondents); the instrument also has one item on aggressor gender, and one question that asks explicitly about rape. Within each type of sex crime, the instrument distinguishes among five tactics that could be used by another person to coerce the respondent to engage in the sexual act—verbal pressures, verbal criticism, incapacitation, physical threats, and physical force—creating 35 items by crossing each sexual act with each coercive tactic. Respondents indicate the number of times (0, 1, 2, and 3+) each coercive tactic was used for each item in the past 12 months and since 14 years of age until 1 year ago; only experiences of sexual violence that occurred over the past 12 months were retained for analysis. In other words, the SES–SFV captured the number of times respondent's had experienced each type of sex crime according to the mode of coercive behavior the perpetrator(s) had used to commit the crime.

The six sexual victimization experiences measured by the SES–SFV are non-victim; unwanted sexual contact (e.g., “Someone fondled, kissed, or rubbed up against the private areas of my body [lips, breast/chest, crotch or butt] or removed some of my clothes without my consent [but did not attempt sexual penetration]”); attempted coercion (e.g., “Even though it didn’t happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to”); coercion (e.g., “Someone had oral sex with me or made me have oral sex with them without my consent by telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn’t want to”); attempted rape (e.g., “Even though it didn’t happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by taking advantage of me when I was too drunk or out of it to stop what was happening”); and rape (e.g., “A man put his penis into my butt, or someone inserted fingers or objects without my consent by using force, for example holding me down with their body weight, pinning my arms, or having a weapon”), resulting in classifications along a continuum of the least to the most severe. There are three standard scoring procedures for the SES-SFV (Koss et al., 2007; 2008): (a) scoring based on individual items, which establishes the frequency of each type of sexual assault outcome for each sexual assault tactic by calculating a percentage of individuals who reported each outcome for each tactic at the individual item level; (b) redundant scoring in which percentages are computed for nonvictimization, sexual contact through any tactic,

attempted rape through coercion, completed rape through coercion, attempted rape through incapacitation or force, and completed rape through incapacitation or force; and (c) mutually exclusive (i.e., nonredundant) scoring, which places respondents in the category of his or her most severe type of outcome.

In a previous study with 224 college women, the SES–SFV's internal consistency (Cronbach's alpha) was .93 (Davidson & Gervais, 2015). The original SES has demonstrated good validity estimates with 1-week test–retest reliability (r = .93) and correlations with interview responses (r = .73; Koss & Gidycz, 1985). Test–retest reliability scores among male college students for the SES–SFV were statistically correlated after 2 weeks (.41 < r < .53; Anderson et al., 2018), and a 2-week test–retest reliability of the SES-SFV among 273 female undergraduate students demonstrated that 73% of women replicated their original responses concerning unwanted experiences reported in the past year (Johnson et al., 2017). In this study, additional analyses indicated that the greatest stability in category endorsed was *none;* 17% of women endorsed items that were less severe and 11% endorsed items that were more severe at the third assessment (Johnson et al., 2017).

3.3.2.1.1 SCORING

Researchers (Arata & Lindman, 2002; Brown et al., 2015; Davis et al., 2014) have utilized several different scoring methods for the SES, including nonredundant categorization by assault severity (Koss et al., 2007; 2008), nonredundant categorization of rape by severity tactic (Brown et al., 2015), and the frequency of experiences weighted in order of severity (Arata & Lindman, 2002; Davidson & Gervais, 2015). More specifically, the SES–SFV contains a wealth of information regarding sexual assault

experiences such as sexual assault tactics, outcomes, and frequency; yet, the conventional scoring methods do not reflect the comprehensiveness of the measure itself. Thus, a continuous variable of sexual violence was created as an indicator of rank severity, in which participants were given a severity score that summed the severity ranks of all the different sexual assault outcomes they reported (i.e., sum of ranks) based on a severity-ranking scheme that separated outcomes and tactics of the SES-SFV (see Davis et al., 2014). More specifically, (a) unwanted sexual contact by verbal coercion was multiplied by 1, (b) unwanted sexual contact by incapacitation was multiplied by 2, (c) unwanted sexual contact by force was multiplied by 3, (d) attempted rape by coercion was multiplied by 4, (e) attempted rape by incapacitation was multiplied by 5, (f) attempted rape by force was multiplied by 6, (g) completed rape by coercion was multiplied by 7, (h) completed rape by incapacitation was multiplied by 8, and (i) completed rape by force was multiplied by 9. The nine categories were then summed to form a total continuous score, with zero representing no sexual violence and higher numbers representing more sexual assault outcomes experienced and greater severity of sexual violence.

3.3.2.2 PTSD Checklist for DSM-5

The 20-item PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013; see Appendix 2) was used to measure PTSD symptom severity among respondents. The PCL-5 asks respondents to rate the extent to which they have experienced symptoms in the past month, with 5-point Likert-type response options anchored by *not at all* (scored as 0) and *extremely* (4). Example items include, “In the past month, how much were you bothered by blaming yourself or someone else for the stressful experience or what happened after it?” and “In the past month, how much were you bothered by repeated,

disturbing, and unwanted memories of the stressful experience?" Response options are summed so that higher scores correspond with more symptom severity for diagnostic criteria (re-experiencing, avoidance, negative alterations in cognition and mood, hyperarousal) and for the whole disorder (Weathers et al., 2013). A previous study of 278 college students reported an internal consistency (Cronbach's alpha) for the PCL-5 of .94 (Blevins et al., 2015). In the same study, the PCL-5 demonstrated good test–retest reliability over a 1-week period with 53 college students (r = .82; Blevins et al., 2015). In the present study, the PCL-5's internal consistency (Cronbach's alpha) was .97.

3.3.2.3 Gender Identity

Gender identity was measured using three questions from the survey. First, participants were asked, "With which of the following gender identities do you most closely identify?" Response options were *female*, *male*, *non-binary/third gender*, *prefer to self-describe,* and *prefer not to say*. Then participants were asked, "Do you identify as transgender?" Response options were *yes* and *no*. Finally, participants were also asked, "What is your biological sex (i.e., the sex you were assigned at birth)?" Response options were *female* and *male*. Items were recoded and grouped into a new variable labelled gender identity. Affirmative responses to the question about transgender identification, those who selected *non-binary/third gender*, and those who selected a biological sex that differed from their preferred gender identity were grouped into *TGNC* (0). Those who selected the gender identity that aligned with their reported biological sex were collapsed into a single grouping category that was labeled *cisgender* (1).

3.3.2.4 Sexual Orientation

Respondents reported their sexual orientation. Specifically, respondents were asked, "What is your sexual orientation?" with *asexual, bisexual, gay or lesbian/homosexual, pansexual, straight/heterosexual, prefer to self-describe* (open-ended response), and *prefer not to say* as response options. Qualitative responses for those who preferred to self-describe were analyzed and recoded into available categories (e.g., "Sex-positive asexual panromantic" recoded into *asexual*), and those who did not provide a response were excluded from the sample. The original responses *bisexual, gay/lesbian, asexual* and *pansexual* were collapsed into a single grouping category that was labeled *SGM* (1)*;* others retained the *heterosexual* (2) classification.

3.3.2.5 Relationship Status

Respondents were asked to, "Please describe your current relationship status." Response options were *single, in a relationship but not married*, *married, separated, divorced,* and *widowed*. Response options were recoded and grouped into new categories, *not currently partnered* (1), *in a relationship but not married* (2), and *married* (3), with the *not currently partnered* group comprising *single, separated,* and *divorced* respondents.

3.3.2.5.1 Relationship Involvement

Response options for relationship status were also recoded and grouped into a dummy variable describing relationship involvement (*no* = 0, *yes* = 1). The original responses *in a relationship but not married* and *married* were collapsed into a single category and indicated that a respondent was currently involved in a romantic relationship, whereas original response options *single, divorced,* and *separated* were collapsed into the grouping category *no*.

3.3.2.5.2 RELATIONSHIP LENGTH

Respondents were asked to "Please indicate how long you've been in your current relationship." Respondents provided the length of their relationship (in years) by rounding to the nearest year.

3.3.2.6 Childhood Sexual Abuse

The extant literature indicates that the developmental period in which sexual assault occurs can have varying effects on mental health and relationship outcomes. Although the focus of this study was on experiences of sexual assault that occurred after one's 14th birthday, respondents were also asked, "Did you ever have a similar experience to those described (on the SES-SFV) prior to your 14th birthday?" Response options were *yes*, *no*, and *unsure*. Regarding PTSD, it might be that respondents who selected *unsure* are either (a) unaware of experiences of CSA, and therefore are not psychologically impacted by this uncertainty, or (b) unaware of experiences of CSA, and therefore the uncertainty of a history of CSA contributes to psychological distress. For the purposes of this study, response options were coded so that original responses options of *no* and *unsure* were collapsed into a single grouping category *no* (1), whereas original response options of *yes* (2) remained in its own category. This decision was supported by statistical analyses (see Appendix 6 for supplemental information).

3.3.3 Design and Procedures

Procedures for participation were implemented in accordance with the research protocol approved by the University of Kentucky Office of Research Integrity's Institutional Review Board. Prior to starting the survey, informed consent was obtained

from participants. Participants were asked demographic information such as age, ethnicity, race, and gender, in addition to the measures described above.

3.3.3.1 Analytic Approach

The data were analyzed for outliers using Mahalanobis distance, Cook's, and Leverage values, as suggested by Tabachnick and Fidell (2012). Additionally, correlations for multicollinearity and additivity, and plots for normality, linearity, and homogeneity were generated. All variables were found to be normally distributed. The Breusch–Pagan test for heteroscedasticity (Breusch & Pagan, 1979) using the Breusch–Pagan and Koenker Test Macro (Garcia-Granero, 2002) indicated heteroscedasticity in the data, χ^2 (2, N = 322) = 16.93, p < .001, so heteroscedasticity-consistent standard error estimators (HC3; Davidson & MacKinnon, 1993) were implemented in the final models.

Descriptive statistics and intercorrelations were analyzed using Pearson *r* correlations. To test H_1–H_4, a three-way ANCOVA was conducted to examine the difference in PTSD symptom severity based on gender identity, sexual orientation, and relationship involvement. Bias-corrected and accelerated bootstrapping (BCa) was used to equalize the variances when the data violated the assumption of homogeneity. To test H_5–H_7, a two-way ANCOVA was conducted to estimate the effect of respondent sexual identity statuses and relationship status on PTSD symptom severity, where respondent sexual identity (sexual minority, heterosexual) and relationship status (not currently partnered, partnered but not married, married) are the independent variables and PTSD symptom severity is the outcome variable. Finally, to test H_8, a moderation model using the PROCESS macro (Version 3.5; Hayes, 2012) within SPSS (Version 27) was conducted to examine whether the strength and direction of the relationship between SV

severity and PSTD symptom severity is affected by relationship involvement (see Figure 3.1 for conceptual model). BCa bootstrapping was utilized to generate 95% confidence intervals for each interaction and main effect.

3.4 Results

Descriptive statistics for sexual violence experiences that occurred over the past year are displayed in Table 3.2. In total, 90.4% (n = 291) of participants reported more than one experience of sexual violence in the past 12 months. Notably, 67.7% of participants reported rape by force as their most severe experience and 7.8% of respondents reported rape by incapacitation as their most severe experience. Overall, 82.9% of respondents reported sexual contact by coercion at least once in the past year (M = 2.49 times, SD = 1.77), 68.6% of participants reported sexual contact by incapacitation (M = 1.19 times, SD = 1.10), and 77.5% of participants reported sexual contact by force (M = 2.13 times, SD = 1.90). In terms of attempted rape, 73.6% of respondents reported attempted rape by coercion (M = 5.04 times, SD = 2.35), 64.3% of participants reported attempted rape by incapacitation (M = 2.35 times, SD = 2.38), and 64.6% of participants reported attempted rape by force (M = 4.43 times, SD = 4.65). For completed rape, 73.9% of participants reported rape by coercion (M = 5.05 times, SD = 4.48), 65.8% of participants reported rape by incapacitation (M = 2.37 times, SD = 2.35), and 67.7% of participants reported rape by force (M = 4.57 times, SD = 4.58). Sexual violence (M = 30.74, SD = 17.07, range = 1–45) and PTSD (M = 40.97, SD = 18.05, range = 0–79) were moderately correlated, r = .41, 95% BCa CI [.31, .50], p < .001. In other words, 16.8% of the variance in PTSD was explained by respondents' experience of sexual violence in the past 12 months.

3.4.1 Three-way Factorial ANCOVA

To test hypotheses 1–4, a 2 x 2 x 2 factorial ANCOVA was conducted to assess the role that gender identity (TGNC vs. cisgender), sexual orientation (sexual minority vs. heterosexual), and relationship involvement (in relationship vs. not in relationship) play in predicting one's PTSD symptoms after controlling for length of the current relationship, experiences of CSA, and previous experiences of sexual violence that occurred since 14 years of age until 1 year ago. Levene's test was not statistically significant ($p = .086$) indicating that the groups could be assumed to have homogeneity of variance. Mean scores for each group are presented in Table 3.3. The covariate, sexual violence since turning 14 years of age, was statistically related to PTSD symptom severity, $F(1, 321) = 35.73$, $p < .001$, $\eta^2 = .09$, experiences of CSA were also statistically related to PTSD symptom severity, $F(1, 321) = 16.11$, $p < .001$, $\eta^2 = .04$. Relationship length was statistically unrelated to PTSD symptom severity, $F(1, 321) = 0.06$, $p = .802$, $\eta^2 < .01$. After controlling for previous experiences of sexual violence, CSA, and relationship length, there was not a statistically significant interaction effect between gender identity and sexual orientation, $F(1, 321) = 0.17$, $p = .680$, $\eta^2 < 01$, gender identity and relationship involvement, $F(1, 321) = 0.23$, $p = .629$, $\eta^2 < .01$, or sexual orientation and relationship involvement, $F(1, 321) = 1.01$, $p = .316$, $\eta^2 < .01$, suggesting that H_4 was not supported.

Main effects were examined to determine if PTSD symptom severity is greater among TGNC individuals than cisgender individuals (H_1), if PTSD symptom severity is greater among sexual minority individuals than heterosexual individuals (H_2), and if PTSD symptom severity is greater among individuals not in relationships than those in

relationships (H_3). PTSD symptom severity did not statistically differ between TGNC (M = 48.52, SD = 15.00) and cisgender (M = 39.09, SD = 18.30) respondents, $F(1,321)$ = 1.86, p = .174, $\eta^2 < .01$. Similarly, PTSD symptom severity did not statistically differ between those who identified with a sexual minority status (M = 43.97, SD = 18.78) and those who identified as heterosexual (M = 39.04, SD = 17.39), $F(1, 321) = 0.02$, p = .904, $\eta^2 < .01$. PTSD symptom severity also did not statistically differ between those who were in a relationship (M = 41.16, SD = 17.98) and those who were not (M = 39.80, SD = 18.30), F (1, 321) = 0.06, p = .814, $\eta^2 < .01$. See Table 3.4 for detailed results of the omnibus ANCOVA.

3.4.2 Two-way Factorial ANCOVA

To test hypotheses 5–7, a 2 x 3 factorial ANCOVA was conducted to assess the role that sexual orientation (sexual minority vs. heterosexual) and relationship status (not currently partnered vs. partnered but not married vs. married) play in predicting PTSD symptom severity, when controlling for previous experiences of sexual violence, CSA, and length of current relationship. Levene's test was statistically significant (p = .041), so bootstrapping was used to equalize the variances. Mean scores for each group are displayed in Table 3.5. The covariate, sexual violence since turning 14 years of age, was statistically related to PTSD symptom severity, $F(1, 322) = 36.28$, $p < .001$, $\eta^2 = .09$, as were experiences of CSA, $F(1, 322) = 16.13$, $p < .001$, $\eta^2 = .04$. Notably, the covariate, relationship length, was not statistically related to PTSD symptom severity, $F(1, 322)$ = 1.17, p = .280, $\eta^2 < .01$.

There was not a statistically significant interaction effect between sexual orientation and relationship status on PTSD symptom severity after controlling for

previous SV experiences and relationship length, $F(2, 322) = 0.58$, $p = .561$, $\eta^2 < .01$, which failed to support H_7, so main effects were examined. PTSD symptom severity did not statistically differ between those individuals who hold a sexual minority status (M = 43.97, SD = 18.78) and those who identify as heterosexual (M = 39.09, SD = 17.36), $F(1, 313) = 0.39$, $p = .535$, $\eta^2 < .01$. Additionally, PTSD symptom severity did not statistically differ among those who were not currently partnered (M = 39.98, SD = 18.51), currently partnered but not married (M = 35.56, SD = 18.97), and married (M = 44.30, SD = 16.65), $F(2, 313) = 1.77$, $p = .172$, $\eta^2 = .01$., which did not support H_5 or H_6. See Table 3.6 for detailed results of the omnibus ANCOVA.

3.4.3 Moderation Model

Finally, to test H_8, the SPSS macro PROCESS (Hayes, 2020) was used to test whether and the extent to which relationship involvement moderates the relationship between sexual violence that occurred within the past year and PTSD symptom severity (see Table 3.8). The model with the predictor (sexual violence) and the moderator (relationship involvement) statistically enhanced the prediction of PTSD when controlling for previous experiences of sexual violence and the length (in years) of current relationships, $F(6, 315) = 16.22$, $p < .001$, $R^2 = .23$; however, results indicated that relationship involvement did not statistically moderate the effect of sexual violence on PTSD, B = -0.05, 95% CI [-0.21, 0.32], $t = 0.39$, $p = .700$. Said differently, neither the strength nor the direction of the effect of sexual violence on PTSD symptom severity changed according to relationship involvement. In fact, the addition of the interaction effect in the model did not statistically change the model, $F(1, 315) = 0.14$, $p = .700$, R^2

change < .001, and accounted for less than 1% of the variance in PTSD symptom severity.

3.5 Discussion

Over the past few decades, a substantial amount of attention has been placed on the role of social support in the development of PTSD. It is not surprising that romantic relationships have emerged as a protective factor for mental distress (Kamp Dush & Amato, 2005; Vanassche et al., 2013) given that having a supportive environment in which to process a traumatic event is important in determining the likelihood of developing symptoms of posttraumatic stress. In the case of sexual violence, however, the interpersonal nature of the act itself might make the buffering effects of romantic relationships more nuanced and could also be exacerbated by minority stress. Indeed, minority stress theory indicates that stigma, prejudice, and discrimination can create stressful social environments that then elevate the risk for developing psychopathology (Hatzenbuehler, 2009; Meyers, 2013). In this regard, the present study was designed to investigate whether being in a relationship explains differences in PTSD symptoms among survivors of sexual violence and how sexual orientation and gender identity interact with relationship involvement and levels of relationship status to understand differences in PTSD symptoms. Counter to expectations, neither relationship involvement, SGM status, nor relationship status contributed to differences in PTSD symptom severity for individuals who reported SV experiences in the past year. Although the absence of any meaningful or statistical differences regarding these variables and their relationship to PTSD was unanticipated, there are several possible explanations ripe for investigation.

3.5.1 Convergence and Divergence with Previous Research

Bivariate correlations between sexual assault severity and PTSD symptom severity were largely consistent with previous research (Brown et al., 2009; Davies et al., 2014). Namely, increases in SV severity were linked to moderate increases in PTSD symptoms. Although the measure of association between sexual violence and PTSD was stronger in the present study than in previous studies (Davies et al., 2014), this is likely due to the focused recruitment of individuals based on their victimization histories. Regarding respondents' sexual victimization histories, an examination of sexual victimization frequency and act severity indicated that highest severity rankings for unwanted sexual contact and attempted rape were similar, albeit slightly higher, than what has been found in previous work using internet samples (Johnson et al., 2017). Of note, 75% of respondents in the present study reported some form of rape as their most severe experience, compared to 13% in previous studies (Johnson et al., 2017); however, it should be noted that Johnson et al. (2017) recruited participants through an online undergraduate psychology course and did not focus on victimization histories. Moreover, the authors did not separate outcomes by tactics, precluding a comparison of outcomes (i.e., unwanted sexual contact, attempted rape, rape) based on tactic (i.e., coercion, incapacitation, force). Although the rates of sexual violence reported in the present study exceed the rates reported in other samples (e.g., Davies et al., 2014; Johnson et al., 2017), these differences are likely due to recruitment methods focused on sexual victimization histories. These discrepancies suggest that future researchers may need to distinguish between outcomes and tactics when sampling participants based on victimization

histories in order to account for the nuanced associations with mental health that exist within highly victimized groups.

3.5.2 Gender Identity, Sexual Orientation, and Relationship Involvement

Notably, the results of this study indicated that PTSD symptom severity did not differ based on gender identity, sexual orientation identity, and relationship involvement, either separately or together, when accounting for relationship length and previous experiences of sexual violence, including a history of CSA. Once the influence of the covariates on PTSD were accounted for in the three-way ANCOVA, the variance explained by the predictors were not statistically meaningful in these data. Furthermore, the covariates—specifically previous experiences of sexual violence since 14 years of age and CSA—were strong predictors of PTSD, as anticipated, and the primary predictor variables explained nothing meaningful beyond what the covariates explained. One possible explanation for this finding aligns with Roberts et al. (2012), who reported that sexual minorities have a greater risk of developing PTSD than their heterosexual counterparts, and that child abuse accounted for 32.3% to 48.4% of the elevated risk of developing PTSD among sexual minorities. Further, gender nonconformity partially mediated the high prevalence of PTSD for heterosexual individuals who had previously had same-sex experiences, over and above the effect of child abuse, indicating that stress due to gender identity put gender nonconforming sexual minority individuals at elevated risk for PTSD (Roberts et al., 2012). In the context of the present study, controlling for previous experiences of sexual violence appeared to mitigate the risk of severe PTSD symptoms for all study participants; however, an examination of the adjusted means,

which account for the presence of the covariates, likely provide additional context and point to additional directions for future research.

For instance, PTSD scores among TGNC and sexual minority individuals were lower after than before accounting for the presence of the covariates in the model. Interestingly, the opposite was true for individuals who identified as heterosexual or cisgender, although those who were cisgender and indicated a sexual minority status had lower relative mean PTSD scores when accounting for the presence of the covariates. Thus, previous experiences of sexual violence seem to have explained more of the variance in PTSD symptom severity for sexual minority and TGNC individuals than it explained for cisgender heterosexual individuals, corroborating the findings from Roberts et al.'s (2019) study. Said differently, it might be that SV history is a stronger predictor of mental health outcomes for SGM individuals than for cisgender or heterosexual individuals. Consequently, researchers might need to account for previous SV experiences in order to meaningfully understand the ways minority statuses contribute to mental health outcomes in similar and dissimilar fashion when compared to other dominant groups in society. That said, these findings should be interpreted with caution, especially given the small effect sizes.

Concerning relationship involvement and SGM status, recent research suggests that family social support independently predicts PTSD and depression among racial minority LGB individuals, whereas social support from friends and significant others does not (Wise et al., 2019). Additionally, Wise et al. (2019) found that age interacted with social support from family and friends—but not significant others—to predict PTSD. More specifically, family support predicted PTSD in late adolescence (16–19

years), whereas friend social support predicted PTSD during the transition to adulthood (21–24 years). Although Wise et al. did not focus on experiences of sexual violence, the results suggest that the sources of support that are most meaningful for LGB individuals varies by developmental period, and that support from significant others does not explain additional variance in PTSD symptoms.

In the context of the present study, it is clear that the level of PTSD symptom severity did not vary for SGM individuals based on relationship involvement, and it might be that other types of relationships are more influential concerning the health and well-being of SGM individuals following experiences of trauma. This is perhaps not surprising given that five common network types—diverse, diverse/no children, family-focused, friend-centered/restricted, and fully restricted— that remain relatively stable across the life course have been documented among LGBT adults, and that each type has been identified as statistically related to mental health outcomes (i.e., positive affect, negative affect, self-esteem, etc.; Kim et al., 2017). Similar to The Convey Model of Social Relations (Antonucci et al., 2014), which describes how individuals develop social ties that, essentially, move with them across the life course and how those social ties are associated with mental health, those who have restricted support networks often have the worst mental health outcomes (Kim et al., 2017). Thus, it seems that other forms of social support from friends and family could play a more meaningful role in understanding the discrepancies in mental health between and among SGM individuals than a single indicator of relationship status. Notably, however, these findings could also be attributed to selection effects, wherein those with less severe psychological issues are more successful at entering intimate relationships and those with more severe mental health

concerns are unable (or choose not to) enter into intimate relationships. Inclusion criteria for the present study required that participants had at least one previous romantic relationship, so perhaps those who hold an SGM status but were not eligible to participate due to relationship history differ from those individuals who have been in a romantic relationship.

Notably, this study was not designed to examine the predictive ability of either social support received from partners or social network characteristics. However, the existing literature concerning the relevance of other forms of social support for SGM individuals might explain why those who were not in relationships did not differ in PTSD symptom severity; that is, they might have had ample support in other forms. Future studies examining how PTSD symptoms differ for SGM individuals who have experienced sexual violence based on an analysis of social networks could uncover social pathways to mental health within this population. Moreover, due to sample size constraints in the present study, respondents with bisexual, gay/lesbian, asexual, and pansexual identities were combined into a single group to represent sexual minorities despite evidence indicating health disparities and inequalities within the population as a whole (King et al., 2008; Macapagal et al., 2016; Zeeman et al., 2019). Future researchers should focus on recruiting more robust samples of individuals with specific sexual orientation statuses. It is important to note that sexual orientation and gender identity are separate constructs and that these identities were not conflated in the present study. Because of the empirical research indicating that transgender and gender nonconforming individuals have different experiences of both sexual violence and mental health outcomes than cisgender LGB individuals, future researchers should continue to

recognize these identities as separate constructs when studying sexual violence and make efforts to examine the intersections between them.

3.5.3 Sexual Orientation and Relationship Status

The results of the two-way ANCOVA indicated that there were no differences in PTSD symptom severity based on sexual orientation or relationship status, nor were there statistically significant interaction effects between sexual orientation and relationship status when controlling for previous experiences of sexual violence and the length of relationships for those who were currently partnered. Similar to the preceding discussion, the covariates concerning previous experiences of SV, including CSA, appeared to explain the difference in PTSD scores such that the presence of the predictors were not statistically meaningful, once again indicating the importance of accounting for previous experiences of SV. Notably, however, previous research using population-level data found that married lesbian and gay individuals tended to report the best health (i.e., mental health, general health, healthcare access), followed respectively by partnered, single, and post-married (i.e., divorced, separated, and widowed) individuals (Du Bois et al., 2019). Du Bois et al., however, only used two indicators of mental health (i.e., number of days mental health was not good, ever had a depressive disorder) and did not focus exclusively on experiences of trauma, let alone experiences of sexual violence. Nonetheless, the proposed linear trend indicating that married individuals were the healthiest, followed by partnered individuals, then single individuals, was not confirmed by the present analysis. In fact, in the presence of covariates, single sexual minority individuals had the lowest mean PTSD scores, followed by partnered and married

individuals, respectively, whereas heterosexual married individuals had the highest mean PTSD scores, followed by single individuals and those who were currently partnered.

One possible explanation for these discrepancies and divergence from the extant empirical literature could be that the mere presence of a partnership does not confer mental health benefits for survivors of sexual violence. Whereas Du Bois et al. (2019) found moderate effects between relationship status and mental health among sexual minority individuals ($.30 < d < .33$), previous research also indicates that the effect marital quality has on indicators of health is practically meaningful ($.07 < r < .21$; Robles, 2014; Robles et al., 2014) given that increasing marital quality, even a little, could have meaningful impacts on quality of health. Moreover, meta-analyses have found small associations between PTSD and relationship quality ($r = -.24$; Lambert et al., 2012), potentially indicating that studies examining the relationship quality would uncover meaningful differences in PTSD symptom severity that were not identified in the present study. Given that PTSD is negatively associated with marital quality, and that marital quality has small, but meaningful, associations with health indicators, perhaps it is not surprising that married heterosexual and sexual minority individuals had the highest scores on PTSD symptom severity, although marital quality was not controlled for in the present study. To understand the discrepancies between the findings from Du Bois et al. (2019) and the results presented here, future researchers should focus on investigating marital quality in addition to relationship status to better understand mental health outcomes within this population.

Research concerning marital status and suicidal behavior could also provide additional context for the null findings. For instance, a study found that thwarted

belongingness, or an extreme sense of social isolation and disconnection stemming from an unmet need to belong, mediated the relationship between relationship status (a risk factor for suicide) and suicidal behavior among gay men, such that being unpartnered was associated with higher levels of thwarted belongingness, which were in turn associated with higher levels of suicidal behavior than when individuals were partnered (Riley & McLaren, 2019). Concerning sexual violence, self-blame is associated with higher distress following experiences of sexual violence (Frazier, 2003), and subjective factors (e.g., self-blame) have twice the effect of objective factors (e.g., use of threat during assault) on psychological distress (Weaver & Clum, 1995). In light of the body of literature suggesting that a lack of social support contributes to psychological distress (Brewin et al., 2000; Ozer et al., 2003), it might be that examining other risk factors, such as self-blame, in combination with relationship status would identify differences in PTSD symptoms. Moreover, longitudinal designs that can temporally locate SV experiences with respect to singlehood, relationship formation, and relationship dissolution would provide additional context concerning the relationships of SV survivors and the associated impact on PTSD. Although inclusion criteria for the present study required that participants had experienced SV in the past year, and all participants indicated that their relationships had been at least one year in length—meaning that respondents had likely been in their current relationship at the time of their most recent experience of sexual violence—this study is limited by its cross-sectional design. Moreover, although controlling for previous experiences of SV is a strength in that it removes noise from the analyses, these experiences could have occurred over a broad range of ages (i.e., since the

age of 14 until 1 year ago), thereby clouding the potential strength of observed statistical relationships.

3.5.4 Sexual Victimization, Relationship Involvement, and PTSD

Contrary to the hypotheses, results indicate that relationship involvement did not statistically moderate the relationship between sexual violence experiences within the past year and PTSD symptom severity. Although about 23% of the variance in PTSD symptom severity was explained by recent sexual violence experiences and relationship involvement when controlling for previous experiences of sexual violence and the relationship length of those involved in relationships at the time of the survey, the variance explained did not change depending on whether respondents were in a relationship. Previous research indicates that individuals who experience adverse life events have an increased likelihood of being divorced or unmarried (Anderson, 2017). Thus, although adverse life experiences, such as sexual violence, can certainly influence relational outcomes later in life, these findings suggest that those outcomes do little to alter the association between SV and PTSD. Although these data suggest that neither the direction or magnitude of the association between SV and PTSD vary according to whether one is partnered, one area in which being partnered appears particularly advantageous to SV survivors is when they are receiving treatment for PTSD (Fredman et al., 2016). Therefore, future researchers might examine how relationship involvement moderates the relationship between SV and PTSD among those receiving mental health treatment.

Other research has found that found that high social support has an equal and negative association on functional impairment and somatization for sexual minority and

nonsexual minority women, whereas low social support is more closely associated with more severe symptoms for sexual minority women than among nonsexual minority women (Weiss, et al., 2015). Indeed, among women who perceived low social support from their partners, the negative association between PTSD symptoms and relationship satisfaction was more prominent for lesbian women than for heterosexual women (Caska-Wallace et al., 2016). The opposite was true when receiving high support from their partners such that the negative association between PTSD and relationship was less drastic for lesbian women than heterosexual women (Caska-Wallace et al., 2016). Thus, partner support appeared to play a more prominent role in predicting lesbian than heterosexual women's relationship satisfaction in the presence of PTSD symptoms. In combination with the previous research cited herein, it seems that relationship processes, such as social support or relationship satisfaction, play a more meaningful role than relationship status in understanding mental health discrepancies among SGM individuals. Importantly, this study was not designed to measure social support received from intimate partners and does not explain why those who were unpartnered did not have associations between SV severity and PTSD symptom severity that differed from those who were partnered.

3.6 Conclusion

Although previous research indicates that there is a heightened risk for psychological distress in SGM individuals (Gonzales & Henning-Smith, 2017; Institute of Medicine, 2011; Lipson et al., 2019; Meyer et al., 2008; Newcomb et al., 2020; Pitoňák, 2017; Ross et al., 2018; Solomon et al., 2021), previous research has also found few differences in abuse history (e.g., adult sexual assault, childhood physical abuse, etc.)

and mental health outcomes (PTSD severity, depression symptom severity, etc.) between heterosexual and sexual minority women (Weiss et al., 2015). The results of the present study provide support for the latter and expand these findings to TGNC individuals and relationship statuses, such that there were no discernable differences in PTSD symptomology based on gender identity, sexual orientation, and relationship involvement. Moreover, PTSD symptom severity did not differ based on sexual orientation and relationship status (single, in a relationship, married), and relationship involvement did not moderate the association between SV experiences and PTSD symptom severity. Although these findings should be interpreted with caution given the various limitations discussed herein, perhaps most importantly, these findings suggests that previous experiences of sexual violence that also include experiences of CSA play an important role in explaining the differences in PTSD symptom severity for those with recent SV experiences, and that the unexplained variance in PTSD may not be attributable to gender identity, sexual orientation, or relationship statuses. Such results reveal that individuals who have SV histories, and more specifically SV experiences that occurred in the past year, likely do not differ in terms of PTSD symptom severity based solely on empirically derived identity statuses. Instead, it seems that contextualizing PTSD for survivors of SV within broader social and relational contexts that focus on processes of support that are inherent within relationships would be more beneficial for uncovering differences in PTSD outcomes.

Table 3.1

*Demographic Characteristics of Participants (*N = *322)*

Characteristic	*n*	%
Gender		
Female [a]	174	54.0
Male [b]	114	35.4
Trans FTM	16	5.0
Trans MTF	15	4.7
Trans non-binary/third gender	2	0.6
Non-binary/third gender	1	0.3
Race or Ethnicity		
White	226	70.2
Black, non-Hispanic	27	8.4
Asian	22	6.8
Mixed	16	4.7
American Indian/Alaskan Native	15	4.7
Hispanic	14	4.3
Another, unspecified	2	0.6
Education		
High school diploma	20	6.2
Some college	64	19.9
Associate's degree	19	5.9
Bachelor's degree	157	48.8
Master's degree	59	18.3
Doctorate	3	0.9
Religion		
Catholic	173	53.7
Protestant, Evangelical	32	9.9
Agnostic	29	9.0
Protestant, Mainline	20	6.2
Atheist	18	5.6
Christianity, unspecified	13	4.0
No religious preference	12	3.7
Other, spirituality	11	3.4
Islamic	9	2.8
Jewish	5	1.6
Religiosity		
Very religious	86	26.7
Somewhat religious	113	35.1
Slightly religious	60	18.6
Not religious	63	19.6
Respondent relationship status		
Married	173	53.7
In a relationship, not married	97	30.1
Single	49	15.2
Separated	2	0.6
Divorced	1	0.3
Sexual Orientation		
Heterosexual	198	61.5
Bisexual	92	28.6
Asexual	16	5.0
Gay/lesbian	9	2.8
Pansexual	7	2.2
Childhood sexual abuse		
Yes	171	53.1
No	108	33.5
Unsure	43	13.4
	M	*SD*
Age (years)	33.0	10.0

Table 3.2

*Sexual Assault Severity Scores for Respondents since 14 Years of Age (*N = *322)*

Separated outcome and tactic	*M*	*SD*	Range	Highest Severity Rank [a]	Redundant [b]
Sexual contact by coercion	2.49	1.77	0–6	22 (6.8)	267 (82.9)
Sexual contact by incapacitation	1.19	1.10	0–3	8 (2.5)	207 (68.6)
Sexual contact by force	2.13	1.90	0–6	7 (2.1)	221 (77.5)
Attempted rape by coercion	5.04	4.67	0–18	8 (2.5)	237 (73.6)
Attempted rape by incapacitation	2.35	2.38	0–9	5 (1.6)	207 (64.3)
Attempted rape by force	4.43	4.65	0–18	8 (2.5)	208 (64.6)
Rape by coercion	5.05	4.48	0–18	21 (6.5)	238 (73.9)
Rape by incapacitation	2.38	2.35	0–9	25 (7.8)	212 (65.8)
Rape by force	4.57	4.58	0–18	218 (67.7)	218 (67.7)

Note. Percentages are presented in parentheses.

[a] Reflects scoring based on the highest severity rank, in which participants were placed in the category of their most severe experience, ignoring all less severe outcomes. [b] Reflects redundant scores for each outcome and tactic in that if a participant experienced both unwanted sexual contact by coercion and by force, they would be counted in both categories.

Table 3.3

Means, Adjusted Means, Standard Deviations, Standard Errors, and Confidence Intervals for PTSD according to Sexual Orientation, Relationship Involvement, Gender Identity and Gender Identity and Sexual Orientation as a Function of Relationship Involvement (N = 321)

Variable	*n*	*M*	*SD*	M_{adj} [a]	*SE* [b]	95% CI
PTSD	321 (100.0)	40.94	18.07	41.65	1.31	[39.08, 42.99]
Sexual orientation						
Sexual minority	124 (38.6)	43.97	18.78	41.99	1.89	[40.99, 47.12]
Heterosexual	197 (61.4)	39.04	17.39	41.19	1.73	[36.77, 41.57]
Relationship involvement						
Single, not partnered	51 (15.9)	39.80	18.30	41.31	2.54	[34.86, 44.91]
In a relationship	270 (84.1)	41.16	17.98	41.90	1.39	[39.00, 43.41]
Gender identity						
TGNC	63 (19.6)	48.52	15.00	43.91	2.36	[45.27, 51.74]
Cisgender	258 (80.4)	39.09	18.30	39.95	1.55	[36.89, 41.45]
Sexual minority						
Gender Identity						
TGNC	46 (14.3)	49.22	15.13	44.96	2.87	[44.94, 53.04]
Cisgender	78 (24.3)	40.87	20.09	39.03	2.49	[36.79, 45.65]
Heterosexual						
Gender Identity						
TGNC	17 (5.3)	46.65	14.95	41.80	4.00	[39.65, 53.36]
Cisgender	180 (56.1)	38.32	17.46	40.88	1.76	[35.93, 40.95]
Single, not partnered						
Sexual orientation						
Sexual minority	24 (7.5)	42.29	19.54	40.97	3.40	[33.69, 49.70]
Heterosexual	27 (8.4)	37.59	17.90	41.99	3.25	[30.54, 44.88]
Gender Identity						
TGNC	11 (3.4)	51.82	8.90	44.83	4.98	[47.11, 56.69]
Cisgender	40 (12.5)	36.50	19.33	39.56	2.87	[30.32, 42.61]
In a relationship						
Sexual Orientation						
Sexual minority	100 (31.1)	44.37	18.67	43.01	1.74	[41.19, 47.75]
Heterosexual	170 (53.0)	39.27	17.35	40.78	2.10	[30.06, 38.60]
Gender Identity						
TGNC	52 (16.2)	47.83	15.98	43.45	2.49	[43.70, 51.79]
Cisgender	218 (67.9)	39.57	18.10	40.35	1.20	[37.14, 42.16]
Single, not partnered						
TGNC						
Sexual minority	11 (3.4)	51.82	8.90	44.83	4.98	[47.11, 56.69]
Heterosexual	-	-	-	-	-	-
Cisgender						
Sexual minority	13 (4.0)	34.23	22.63	37.12	4.58	[21.66, 46.13]
Heterosexual	27 (8.4)	37.59	17.90	41.99	3.25	[30.54, 44.88]
In a relationship						
TGNC						
Sexual minority	35 (10.9)	48.40	16.63	45.09	2.80	[43.11, 53.28]
Heterosexual	17 (5.3)	46.65	14.95	41.80	4.00	[39.65, 53.36]
Cisgender						
Sexual minority	65 (20.2)	42.20	19.46	40.93	2.02	[37.51, 47.15]
Heterosexual	153 (47.7)	38.45	17.44	39.77	1.32	[35.70, 41.28]

Note. Percentages are presented in parentheses. Numbers in brackets are 95% bias corrected accelerated (BCa) intervals for the mean.

[a] Means adjusted for the presence of covariates. [b] Standard error for adjusted means.

Table 3.4

Summary Table for Three-Way Analysis of Variance of the Effects of Gender Identity, Sexual Orientation, and Relationship Involvement on PTSD

Variable	*df*	*SS*	*MS*	*F*	*p*	$\hat{\eta}_p^2$	η^2
Gender identity	1	487.82	487.82	1.86	.174	.01	< .01
Sexual orientation	1	3.83	3.83	0.02	.904	< .01	< .01
Relationship involvement	1	14.64	14.64	0.06	.814	< .01	< .01
Gender identity x Sexual orientation	1	44.67	44.67	0.17	.680	< .01	< .01
Gender identity x Relationship involvement	1	61.34	61.34	0.23	.629	< .01	< .01
Sexual Orientation x Relationship involvement	1	265.44	265.44	1.01	.316	< .01	< .01
Within cells	311	81,722.99	262.94				
Total	321	642,607.00					

Note. $\hat{\eta}_p^2$ = partial eta squared. η^2 = eta squared.

Table 3.5

Means, Adjusted Means, Standard Deviations, Standard Errors, and Confidence Intervals for PTSD according to Sexual Orientation, Relationship Status, and Relationship Status as a Function of Sexual Orientation (N = 322)

Variable	*n*	*M*	*SD*	M_{adj} [a]	*SE* [b]	95% CI
PTSD	322	40.70	18.05	40.70	1.06	[39.05, 42.86]
Sexual Orientation						
Sexual minority	124 (38.5)	43.97	18.78	41.35	1.63	[40.74, 47.38]
Heterosexual	198 (61.5)	39.09	17.36	40.04	1.35	[36.69, 41.41]
Relationship status						
Not partnered	52 (16.1)	39.98	18.51	40.74	2.35	[34.73, 44.84]
Currently partnered, not married	97 (30.1)	35.56	18.97	38.20	1.85	[31.92, 39.25]
Married	173(53.7)	44.30	16.65	43.16	1.33	[41.92, 46.91]
Sexual minority						
Relationship status						
Not partnered	24 (7.5)	42.29	19.54	40.18	3.36	[34.40, 50.42]
Currently partnered, not married	28 (8.7)	38.68	22.49	40.48	3.05	[30.16, 47.27]
Married	72 (22.4)	46.58	16.62	43.41	1.98	[42.87, 50.20]
Heterosexual						
Relationship status						
Not partnered	28 (8.7)	38.00	17.70	41.31	3.17	[31.65, 44.06]
Currently partnered, not married	69 (21.4)	34.29	17.37	35.92	1.99	[30.06, 38.60]
Married	101 (31.4)	42.67	16.57	42.91	1.66	[39.41, 45.73]

Note. Numbers in brackets are 95% bias corrected accelerated (BCa) intervals for the mean.

[a] Means adjusted for the presence of covariates. [b] Standard error for adjusted means.

Table 3.6

Summary Table for Two-Way Analysis of Variance of the Effects of Sexual Orientation, and Relationship Status on PTSD

Variable	df	SS	MS	F	p	$\widehat{\eta}_P^2$	η^2
Sexual orientation	1	99.61	99.61	0.39	.535	< .01	< .01
Relationship status	2	916.42	458.21	1.77	.172	.01	.01
Sexual orientation x relationship status	2	299.61	149.80	0.51	.561	< .01	< .01
Within cells	313	80,981.88	258.73				
Total	322	645,008.00					

Note. $\widehat{\eta}_P^2$ = partial eta squared. η^2 = eta squared.

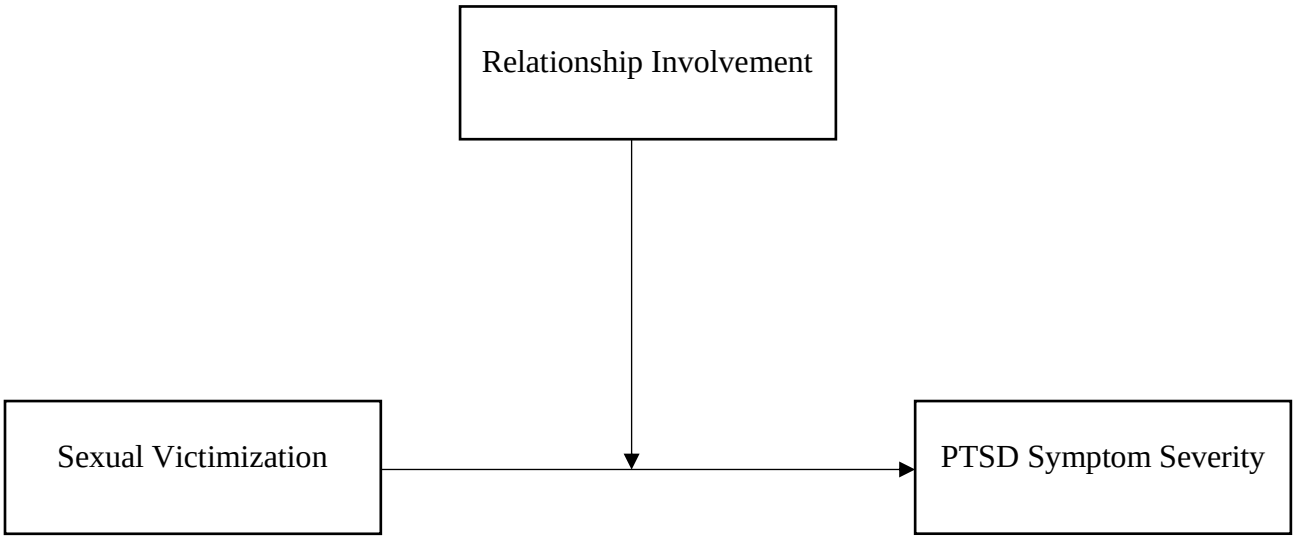

Figure 3.1 Moderation model for Hypothesis 7

CHAPTER 4. SEXUAL VIOLENCE, DECISION-MAKING, RELATIONSHIP SATISFACTION, AND PTSD AMONG SEXUAL AND GENDER MINORITY INDIVIDUALS

Relationship involvement is a well-established protective factor for adverse mental health problems (Kamp Dush & Amato, 2005; Smith et al., 2020; Vanassche et al., 2013; Whitton et al., 2018), and relationship satisfaction has also been shown to prospectively predict decreases of individual posttraumatic stress disorder (PTSD) symptoms such as reliving the trauma, emotional numbing, and irritability (LeBlanc et al., 2016). Research suggests that romantic involvement has a stress-buffering effect in racially diverse sexual minorities (Witton et al., 2018), but the protective effects of support among those exposed to violence are thought to be less pronounced for gender minority youth than for cisgender youth (Rosse-Reed et al., 2019). Nonetheless, the factors that predict relationship quality and stability are relatively the same for heterosexual and same-sex couples (Kurdek, 2005). For instance, depression, relationship dissatisfaction, destructive couple conflict, and low social support are associated with relationship instability among same-sex couples (Khaddouma et al., 2015), and depressive symptoms and low levels of social support are predictive of lower relationship satisfaction in both female same-sex couples (Terrell & Dugger, 2018) and partnered bisexual individuals (Vencill et al., 2018). Relationship resources help to explain unique variation in relationship satisfaction for same-sex couples beyond the explanatory power of personal and contextual resources alone (Pope et al., 2010), and there is evidence to suggest that relationship functioning in same-sex couples is particularly healthy in areas such as division of household labor (Kurdek, 2004, 2006, 2007), conflict resolution (Kurdek, 2005), and communication (Gottman et al., 2003).

Those in committed relationships also experience added mental health benefits. For example, sexual and gender minority (SGM) individuals who are partnered report fewer depressive and anxiety symptoms (Whitton, 2020) and better psychological well-being (Parsons et al., 2013; Wayment & Peplau, 1995) than their single counterparts. Notably, however, minority stressors can negatively impact psychological adjustment, and ultimately the relationship satisfaction of same-sex partners (Balsam & Szymanski, 2005; Rotosky et al., 2004).

In sum, romantic relationships seem to provide added benefits to SGM individuals, and how partners engage with each other appears particularly relevant for understanding relational contexts that promote psychological resilience following experiences of trauma. Further, the positive relational processes by which SGM individuals solve problems, initiate conversation, and make decisions—often to a degree more effective than heterosexual couples (Gottman et al., 2003)—might be helpful for understanding whether and how relationships act as a protective factor for adverse mental health problems following sexual violence. Yet, there is a dearth of research on the buffering effects of relationship processes among SGM individuals who have experienced sexual violence (SV). Additionally, there is not adequate insight into the relational processes that might promote the mental well-being of individuals who have experienced SV. Thus, this study is designed to fill those gaps by considering the associations between relational processes, relationship satisfaction, and PTSD among SGM individuals who have experienced SV. Before detailing the method employed, relevant scholarship will be reviewed.

4.1 Relationship Satisfaction and Trauma

Gender and sexual-orientation related discrimination (Sullivan et al., 2017), internalized homonegativity, and sexual identity (Pepping et al., 2019) have been explored as potential explanatory variables in the link between trauma and relationship satisfaction among SGM individuals. Discrimination is associated with increased relationship satisfaction and commitment for lesbian, gay, and bisexual (LGB) young adults with low trauma exposure, but discrimination is not associated with changes in relationship satisfaction among those with more robust trauma histories (Sullivan et al., 2017), indicating that the determinants of relationship satisfaction and commitment might vary based on trauma history. Relatedly, LGB individuals who have experienced SV tend to score lower on attachment avoidance than those who are not victimized, with the difference being smaller for those with low than high internalized homophobia, and their romantic relationship functioning is positively associated with having a secure LGB identity (Gemberling et al., 2015). These findings suggest that internalized homophobia can indirectly lead to more avoidance in relationships following SV; however, the results also suggest that romantic relationships could buffer against the adverse effects of SV for SGM individuals.

Additionally, it could be that the strengths observed in same-sex couples, like the tendency to engage in healthy conflict (Gottman et al., 2003), might facilitate closeness and communication while reducing avoidance. Clearly, having both engagement and support in one's intimate relationship is beneficial to the recovery process following sexual trauma, particularly given that PTSD symptoms tend to be exacerbated by avoidance of stimuli that remind individuals of their trauma (American Psychiatric Association, 2013). SGM individuals and their relationships appear particularly well

situated to combat the deleterious effects of sexual trauma because LGB individuals with SV histories might be less likely to withdraw from and more likely to engage with romantic partners. Furthermore, the effects of gender- and sexual-related discrimination on relationship satisfaction and commitment appear to be inconsequential with additional experiences of trauma, suggesting that, perhaps, other aspects of SGM relationship functioning better explain the association between SV and relationships satisfaction regardless of SV severity.

Emotional intimacy mediates the association between internalized homonegativity and relationship satisfaction for married lesbian and gay individuals (Guschlbauer et al., 2019), highlighting the importance of cultivating emotional intimacy in same-sex relationships to buffer against discrimination and stigma. Sexual minority women who experience satisfaction in their relationships report greater sexual functioning than those with lower relationship satisfaction regardless of their sexual or criminal victimization history, suggesting characteristics of one's relationship have a great deal of impact on sexual functioning even when minority stressors are held constant (Cohen & Byers, 2015). Partner support has also emerged as an important predictor of relationship satisfaction among military veteran women with PTSD (Caska-Wallace et al., 2016). More specifically, military veteran women with PTSD experience impaired relationship satisfaction, and this association is more pronounced for lesbian women than heterosexual women, and when receiving low than high partner support (Caska-Wallace et al., 2016). Although there are similarities between same-sex and heterosexual relationship functioning, it also appears that experiences of trauma impact relationship functioning differently for same-sex and heterosexual couples. Furthermore, relationship

satisfaction, in particular, seems to promote positive outcomes in other areas of the relationship, such as sexual satisfaction and intimacy, and this holds true regardless of victimization histories.

4.1.1 Relationship Satisfaction and Mental Well-Being

Relationship satisfaction also promotes positive mental health outcomes (LeBlanc et al., 2016), and the abovementioned findings suggest that various aspects of relationships play a role in the mental health of SGM individuals who have experienced SV, likely operating through the relative influence these relational processes have on relationship satisfaction. Indeed, mental health symptoms are inversely related to relationship satisfaction (Edwards-Stewart et al., 2018; Terrell & Dugger, 2018), and higher levels of marital satisfaction are associated with better overall well-being (Proulx et al., 2007; Robles et al., 2014). A longitudinal study that followed active-duty military personnel over the course of individual therapy provides additional insight into the dynamic nature of the association between relationship satisfaction and mental health: Individuals who reported a change in relationship satisfaction over the course of therapy experienced a reduction in PTSD symptoms and general distress (Edwards-Stewart et al., 2018). Although the direction of causality between relationship satisfaction and mental health are unclear, the findings from Edwards-Stewart et al. (2018) might actually indicate a dynamic, iterative relationship between the two variables. Furthermore, individual mental health is associated with partner's perception of relationship satisfaction among female same-sex couples, above the effects of the partner's own mental health (Otis et al., 2006). Overall, these findings point to the recursive nature of relationship satisfaction and mental health, but do not account for experiences of trauma.

It is notable, however, that adults presenting for sex therapy with childhood sexual abuse histories are more likely to report relationship and psychological issues than those without (Berthelot et al., 2014).

4.1.1.1 Relationship Processes and Satisfaction

Containing conflict and promoting psychologically intimate communication have emerged as important predictors of relationship satisfaction in both heterosexual and same-sex couples who have been together for 30 years or more (Mackey et al., 2004). Although research suggests that same-sex couples experience similar levels of satisfaction, emotional intimacy, and commitment as heterosexual couples (Joyner et al., 2019), relative to heterosexual couples, same-sex couples tend to take healthier approaches toward addressing conflict, power, and equality in their relationships (Gottman et al., 2003; Kurdek, 2004). This is important because lesbian women and gay men report greater relationship satisfaction when they believe that the decision-making power within the relationship is relatively equal (Eldridge & Gilbert, 1990; Peplau & Fingerhut, 2007; Peplau & Spalding, 2000). Furthermore, lesbians value interdependence in financial decision-making, which is in turn predictive of relationship satisfaction (Mock & Cornelius, 2007). Additionally, equality in managing household chores is also associated with relationship stability for gay men and lesbian women (Gotta et al., 2011). Therefore, shared decision making within one's relationship might also promote healthy functioning in the context of SV, which in turn affects the well-being of survivors.

4.1.1.2 Decision-Making and PTSD

Much of the extant literature surrounding decision-making and sexual violence concerns three interrelated areas of interest: the decision to report the experience to law

enforcement (Marchetti, 2012; United States Department of Justice, 2011; Wolitzsky-Taylor et al., 2011), or to universities (Boyle et al., 2017; Lindquist et al., 2016; Spencer et al., 2017; Spencer et al., 2020), and the decision to disclose experiences to friends and family (Dworkin et al., 2016; Orchowski & Gidycz, 2015; Ullman et al., 2020). PTSD symptoms have been found to account for meaningful variance in reporting behavior among sexual assault survivors such that for every 1-unit increase in hyperarousal symptoms, individuals were 11 times more likely to make a police report, whereas individuals were about 7% less likely to make a report to police with each unit increase in avoidance symptoms (Walsh & Bruce, 2014). Additionally, negative social reactions to SV disclosure were associated with higher levels of paranoia, interpersonal sensitivity, hostility, and phobic anxiety at 7-month follow-up in a study that followed college women during their first year at university ($.43 < r < .52$; Orchowski & Gidyc, 2015). Given that the decision to make a report is associated with post-assault sequela of avoidance and hyperarousal, for example, and that negative reactions to disclosure heighten the risk for mental and relational issues later on, it seems that the associations between decision-making and PTSD are meaningful among survivors of sexual violence, especially when these decisions are connected to reporting and disclosing SV experiences.

More broadly, shared decision-making among individuals seeking treatment for PTSD and healthcare providers has also gained traction in the empirical literature (Etingen et al., 2019; Mott et al., 2014). From a healthcare provider's perspective, provider clinical expertise as well as patient factors (e.g., goals, treatment preferences) are important considerations for negotiating and establishing treatment plans (Etingen et

al., 2019). Additionally, veterans who were randomized into a condition in which they participated in a 30-minute shared-decision making session prior to the start of therapy not only preferred an evidence-based treatment, but also received a more adequate dose of psychotherapy (i.e., attended more than 9 sessions) than those in the control condition who completed treatment planning during intake and in alignment with clinic protocols (Mott et al., 2014). A similar study found that veterans who received the intervention (i.e., shared decision-making with provider) initiated evidence-based treatment sooner than controls but did not differ from individuals in the control condition in treatment attendance or completion (Hessinger et al., 2018). Regarding sexual assault, individuals who perceive that they have greater control over their recovery process have fewer symptoms of PTSD than those who did not (Ullman et al., 2007). Moreover, one path analysis indicated that positive social reactions to SV disclosure was positively associated with more perceived control over treatment, which was in turn related to lower PTSD symptom severity (Ullman & Peter-Hagene, 2014), suggesting the tension between social support and control in the context of SV as it relates to PTSD symptomology. In combination with the previously described research indicating that shared decision-making can promote overall well-being and interpersonal functioning, these findings suggest shared decision-making in relationships might be particularly meaningful for SV survivors as it relates to managing PTSD symptomology. What has yet to be identified in the literature is the relevance of decision-making within intimate relationships and how that might be related to subsequent evaluations of posttraumatic stress symptoms.

The purpose of this study is multifaceted: (a) to establish a direct connection between SV and PTSD symptoms; (b) to establish a direct connection between SV and

relationship satisfaction; and (c) to ascertain whether relational decision-making plays a role in the associations between SV and PTSD symptom severity, and SV and relationship satisfaction.

H_1: Sexual violence severity is positively correlated with PTSD symptom severity.

H_2: Sexual violence severity is negatively correlated with relationship satisfaction.

H_3: Decision-making power mediates the relationship between SV and PTSD symptom severity, such that PTSD symptoms are less severe for those with high levels of shared decision-making in their romantic relationships.

H_4: Decision-making power mediates the relationship between SV and relationship satisfaction, such that relationship satisfaction are greater for those with high levels of shared-decision-making in their romantic relationships.

4.2 Method

4.2.1 Sampling Procedures

Participants were recruited via Amazon Mechanical Turk (MTurk)—a crowdsourcing platform with a large and diverse subject pool that is representative of the U.S. population across many psychological dimensions (e.g., anxiety; McCredie & Morey, 2019)—in June of 2020. Inclusion criteria for the study required participants to be at least 18 years of age, have personal experience with sexual victimization since their 14th birthday, and have been in at least one romantic relationship. Eligible participants responded to questions concerning experiences of sexual violence, attachment, PTSD,

emotional coping, relationship and sexual satisfaction, and decision-making within relationships. Attention checks were scattered throughout the survey, and 688 respondents correctly answered the three attention check questions. Participants were paid $2.03 to complete the roughly 25-minute survey, based on the distribution of median hourly wages for human intelligence task surveys on MTurk ($4.88; Hara et al., 2018). Only currently partnered sexual minority respondents were included in the present study.

4.2.1.1 Sample Demographics

As displayed in Table 4.1, most respondents were White (72.0%), bisexual (71.3%), and female (55.9%); 14.0% of the sample identified as transgender. The highest level of formal education varied, but a majority had either completed some college (22.4%), earned a bachelor's degree (48.3%), or earned a master's degree (16.1%). Respondents indicated they were either *very religious* (25.9%), *somewhat religious* (32.2%), *slightly religious* (14.7%), or *not at all religious* (27.3%). Regarding religious preference, most identified as Catholic (48.3%); others identified as agnostic (13.3%) or atheist (10.5%). A slight majority indicated they had experienced childhood sexual abuse (51.7%); 36.4% of respondents indicated that they had not, and 11.9% were unsure. Most respondents were married (60.1%), and 39.9% were not married but were in a committed relationship.

The sample was more racially diverse than the U.S. population (Jensen et al., 2020), which is not surprising because those who are not White are at heightened risk for experiencing SV (Garcia & Rivera, 2014; Sigurvinsdottir et al., 2016) and adverse mental health outcomes (Pahl et al., 2020). There were more married SGM individuals in the sample relative to the U.S. population (Walker & Taylor, 2021), and respondents were

less educated than same-sex householders in the United States (Statista, 2021). According to a report from the Williams Institute, nearly half of LGBT adults in the United States are religious: 17.1% are highly religious and 23.5% are moderately religious (Conron et al., 2020), making this sample slightly more religious than the LGBT population as a whole. Protestants were underrepresented in the sample relative to the LGBT population, whereas Catholics, Atheists, and Agnostic were overrepresented (Conron et al., 2020).

4.2.2 Measures

4.2.2.1 Sexual Experiences Survey–Short Form Victimization

The Sexual Experiences Survey–Short Form Victimization (SES–SFV; Koss et al., 2007; see Appendix 1) was used to measure unwanted sexual experiences. More specifically, the SES–SFV comprises seven behaviorally-specific descriptions that meet legal definitions of various sex crimes (or five for male respondents; two vaginal penetration items are omitted); the instrument also has one item on aggressor gender, and one question that asks explicitly about rape. Within each type of sex crime, the instrument distinguishes among five tactics that could be used by another person to coerce the respondent to engage in the sexual act—verbal pressures, verbal criticism, incapacitation, physical threats, and physical force—creating 35 items by crossing each sexual act with each coercive tactic. Respondents indicate the number of times (0, 1, 2, and 3+) each coercive tactic was used for each item in the past 12 months and since their 14th birthday until 1 year ago; these timeframes were collapsed to consider sexual violence during the participants' entire life since they turned 14 years of age. In other words, the SES–SFV captured the number of times respondent's had experienced each

type of sex crime according to the mode of coercive behavior the perpetrator(s) had used to commit the crime.

The six sexual victimization experiences measured by the SES–SFV are non-victim, unwanted sexual contact (e.g., "Someone fondled, kissed, or rubbed up against the private areas of my body [lips, breast/chest, crotch or butt] or removed some of my clothes without my consent [but did not attempt sexual penetration]"); attempted coercion (e.g., "Even though it didn't happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to"); coercion (e.g., "Someone had oral sex with me or made me have oral sex with them without my consent by telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to"); attempted rape (e.g., "Even though it didn't happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by taking advantage of me when I was too drunk or out of it to stop what was happening"); and rape (e.g., "A man put his penis into my butt, or someone inserted fingers or objects without my consent by using force, for example holding me down with their body weight, pinning my arms, or having a weapon"), resulting in classifications along a continuum of the least to the most severe. There are three standard scoring procedures for the SES-SFV (Koss et al., 2007; 2008): scoring based on individual items, which establishes the frequency of each type of sexual assault outcome for each sexual assault tactic by calculating a percentage of individuals who reported each outcome for

each tactic at the individual item level; redundant scoring in which percentages are computed for nonvictimization, sexual contact through any tactic, attempted rape through coercion, completed rape through coercion, attempted rape through incapacitation or force, and completed rape through incapacitation or force; and mutually exclusive (i.e., nonredundant) scoring, which places respondents in the category of his or her most severe type of outcome.

In a previous study with 224 college women, the SES–SFV's internal consistency (Cronbach's alpha) was .93 (Davidson & Gervais, 2015). The original SES has demonstrated good validity estimates with 1-week test–retest reliability (r = .93) and correlations with interview responses (r = .73; Koss & Gidycz, 1985). Test–retest reliability scores among male college students for the SES–SFV were statistically correlated after 2 weeks (.41 < r < .53; Anderson et al., 2018), and a 2-week test–retest reliability of the SES-SFV among 273 female undergraduate students demonstrated that 73% of women replicated their original responses for unwanted experiences reported in the past year (Johnson et al., 2017). In the Johnson et al. study, additional analyses indicated that the greatest stability in category endorsed was *none;* 17% of women endorsed items that were less severe and 11% endorsed items that were more severe at the third assessment.

4.2.2.1.1 SCORING

Researchers (Arata & Lindman, 2002; Brown et al., 2015; Davis et al., 2014) have utilized several different scoring methods for the SES, including nonredundant categorization by assault severity (Koss et al., 2007; 2008), nonredundant categorization of rape by severity tactic (Brown et al., 2015), and the frequency of experiences weighted

in order of severity (Arata & Lindman, 2002; Davidson & Gervais, 2015). More specifically, the SES–SFV contains a wealth of information regarding sexual assault experiences such as sexual assault tactics, outcomes, and frequency; yet, the conventional scoring methods do not reflect the comprehensiveness of the measure itself. Thus, a continuous variable of sexual violence was created as an indicator of rank severity, in which participants were given a severity score that summed the severity ranks of all the different sexual assault outcomes they reported (i.e., sum of ranks) based on a severity-ranking scheme that separated outcomes and tactics of the SES-SFV (see Davis et al., 2014). More specifically, (a) unwanted sexual contact by verbal coercion was multiplied by 1, (b) unwanted sexual contact by incapacitation was multiplied by 2, (c) unwanted sexual contact by force was multiplied by 3, (d) attempted rape by coercion was multiplied by 4, (e) attempted rape by incapacitation was multiplied by 5, (f) attempted rape by force was multiplied by 6, (g) completed rape by coercion was multiplied by 7, (h) completed rape by incapacitation was multiplied by 8, and (i) completed rape by force was multiplied by 9. The nine categories were then summed to form a total continuous score, with zero representing no sexual violence and higher numbers representing more sexual assault outcomes experienced and greater severity of sexual violence.

4.2.2.2 PTSD Checklist for DSM-5

The 20-item PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013; see Appendix 2) was used to measure PTSD symptom severity among respondents. The PCL-5 asks respondents to rate the extent to which they have experienced symptoms in the past month, with 5-point Likert-type response options anchored by *not at all* (scored as 0) and *extremely* (4). Example items include, “In the past month, how much were you

bothered by blaming yourself or someone else for the stressful experience or what happened after it?" and "In the past month, how much were you bothered by repeated, disturbing, and unwanted memories of the stressful experience?" Response options are summed so that higher scores correspond with more symptom severity for diagnostic criteria (re-experiencing, avoidance, negative alterations in cognition and mood, hyperarousal) and for the whole disorder (Weathers et al., 2013). A previous study of 278 college students reported an internal consistency (Cronbach's alpha) for the PCL-5 of .94 (Blevins et al., 2015). In the same study, the PCL-5 demonstrated good test–retest reliability over a 1-week period with 53 college students (r = .82; Blevins et al., 2015).

4.2.2.3 Global Measure of Relationship Satisfaction

Relationship satisfaction was measured using the General Measure of Relationship Satisfaction (GMREL; Lawrance & Byers, 1992; see Appendix 3). Respondents were asked to rate their overall relationship with their partner on five 7-point semantic differentials: bad–good, unpleasant–pleasant, negative–positive, unsatisfying–satisfying, worthless–valuable. Scores are summed and higher scores are indicative of greater relationship satisfaction. The internal consistency (Cronbach's alpha) for the GMREL in a sexually diverse sample of 955 adults was α = .97 (Mark et al., 2018). Test–retest reliability of the GMREL over periods of 3 months (r = .70; Lawrance & Byers, 1995) and 18 months (r = .61; Byers & MacNeil, 2006) was found to be acceptable.

4.2.2.4 Decision-Making

Decision-making was measured by asking respondents to think about the main person making decisions in their current relationship in five key areas: healthcare,

making large household purchases, making purchases for daily household needs, visiting family, and deciding household activities (see Appendix 7). Example questions include, "Who is most likely to make decisions about obtaining healthcare?" and "Who is most likely to make decisions about deciding household activities?" Response options were *mainly myself* (1), *mainly my partner* (2), *myself and my partner* (3), and *does not apply* (4). Response options were recoded and grouped into a new variable *does not apply* (0), *individual decision-making* (1), and *shared decision-making* (2). Original response options *mainly myself* and *mainly my partner* were collapsed into the grouping category *individual decision-making*, and the response option of *myself and my partner* was collapsed into *shared decision-making*. Responses to the five questions were summed to create a total continuous score of decision-making, with zero representing an absence of decision-making in the relationship and higher numbers representing more shared decision-making power.

4.2.3 Design and Procedures

Procedures for participation were implemented in accordance with the research protocol approved by the University of Kentucky Office of Research Integrity's Institutional Review Board. Prior to starting the survey, informed consent was obtained from participants. Participants were asked demographic information such as age, ethnicity, race, and gender, in addition to the measures described above.

4.2.3.1 Analytic Approach

Preliminary statistical analyses were conducted using SPSS (Version 27). Missing data for all study variables ranged from 0.6% for various items on the SES–SFV and PCL-5 (e.g., How much were you bothered by repeated disturbing dreams of the stressful

experience over the past month?) to 2.8% on one item of the PCL-5 (i.e., How much were you bothered by being "super alert" or watchful or on guard over the past month?).[2] Little's MCAR test (1988) indicated that data were missing completely at random, χ^2 (1647, N = 178) = 1731.65, p = .072. Therefore, listwise deletion was utilized to handle missing data. Data were inspected for outliers using Mahalanobis distance, Cook's, and Leverage values, as suggested by Tabachnick and Fidell (2012). Five outliers were removed. Correlations for multicollinearity and additivity, and plots for normality, linearity, and homogeneity were generated. All variables were found to be normally distributed upon visual inspection, and the strength of associations among study variables ranged from small to medium, so the likelihood of multicollinearity biasing the results was determined to be low. The Breusch–Pagan test for heteroscedasticity (Breusch & Pagan, 1979) using the Breusch–Pagan and Koenker Test Macro (Garcia-Granero, 2002) indicated homoskedasticity in the data, χ^2 (2, N = 143) = 1.07, p = .587, meaning that the errors associated with the beta weights of the model remained consistent as the value of the predictors (i.e., SV, decision-making power) changed.

Descriptive statistics and intercorrelations were calculated for all study variables using Pearson *r* correlations, and bias-corrected and accelerated (BCa) bootstrapping quantified the precision of the effect size estimate (*r*). A path analysis using AMOS (Version 27) was constructed to test the direct effects of SV on decision-making power,

[2] An analysis of the frequency of missing values also indicated that 20 items on the SES–SFV had a considerably high percentage of missing values, ranging from 34.3–34.8%, and included 61–62 participants with missing data, respectively; however, further examination determined that these items were associated with vaginal penetration, thus those participants who identified as *male* were not presented these questions. Additional examination of the range of missingness indicated that among cases in which 34.8% were missing, only 1 participant who should have responded (i.e., *female* participant) did not, which would ultimately indicate that missing data for these items would be 0.6% and aligned with the results of Little's (2003) MCAR test.

PTSD symptom severity, and relationship satisfaction, and the indirect effects of SV on PTSD symptom severity and relationship satisfaction through decision-making power. Path analysis in structural equation modeling allows for a simultaneous test of direct and indirect (i.e., mediating) effects and allows for the assessment of the magnitude and statistical significance of the relations among exogenous (i.e., predictor) and endogenous (i.e., mediator, outcome, or both) variables included in the model. In the tested model, sexual violence served as the exogenous variable, and decision-making power, PTSD, and relationship satisfaction served as endogenous variables. Paths from sexual violence to the endogenous variables, and paths from decision-making power to PTSD and relationship satisfaction were included and freely estimated in the model (see Figure 4.1 for model).

Model fit was evaluated using recommendations from Kline (2015), and included the χ^2 test of model fit, Steiger's root mean square error of approximation (RMSEA; Steiger & Lind, 1980; Steiger, 1990), the standardized root mean square residual (SRMR; Maydeu-Oliveres, 2017), and the comparative fit index (CFI; Bentler, 1990; Hu & Bentler, 1999). Statistically non-significant χ^2 values indicate acceptable model fit; however, statistical significance is confounded by sample size, such that large sample sizes with high power almost always result in *p* values below the alpha criterion (Crowley & Fan, 1997). The RMSEA is an absolute fit index that indicates the "degree of misspecification" in the model (Hoyle, 2012, p. 352), wherein a value of zero denotes a perfect model, values between .05 and .08 suggest reasonable error of specification, and RMSEA values greater than or equal to .10 suggest poor model fit (Browne & Cudeck, 1993). The RMSEA is an unstandardized effect size of model misfit (Maydeau-Olivares,

2017), and is presented as a 90% confidence interval. A non-zero upper confidence limit of the RMSEA indicates that the model "cannot be regarded as correct" when the lower confidence limit is zero (Browne & Cudeck, 1993, p. 240), indicating that models with RMSEA values that follow this trend may not necessarily fit population values. The SRMR, which differs from the RMSEA such that it can be interpreted as the mean standardized residual covariance, demonstrates higher power to reject poor model fit than the RMSEA, especially in small samples (i.e., $N \leq 200$; Maydeu-Olivares et al., 2018; Shi et al., 2020). SRMR values of zero indicate perfect model fit, and values less than .08 indicate good fit (Hu & Bentler, 1999). The CFI is a relative fit index that indicates the improvement of the CFA model over the null model and is measured on a 0–1 scale. Specifically, higher CFI values indicate close approximate fit, and the cutoff value for an acceptable model is .95 (Hu & Bentler, 1999). In the present study, model fit indices suggested good fit for the model ($\chi^2 = 0.23$, $p = .635$; RMSEA = 0.00, 90% BCa CI [0.00, 0.17], $p = .690$; CFI = 1.00; SRMR =.01), so there was no need to inspect modification indices.

4.3 Results

Descriptive statistics concerning sexual assault severity scores are displayed in Table 4.2. Scoring using the highest rank severity, which puts participants in the category of their most severe SV experience, indicated that 75.5% of participants had been raped by force at some point since their 14th birthday. Concerning redundant scoring categorizations, almost all participants (92.3%) had experienced unwanted sexual contact through coercion at least once since their 14th birthday; many others reported unwanted sexual contact through incapacitation (82.5%) or force (81.8%), whereas 81.1%

participants reported at least one instance of rape by coercion. Overall, this was a highly victimized sample with 6,832 single occurrences of SV reported among participants. In terms of greatest frequency based on the separated outcomes and tactics coding scheme, attempted rape by coercion accounted for 16.7% of total SV occurrences, whereas rape by coercion and rape by force accounted for 16.5% and 15.1% of total SV occurrences, respectively.

Correlations between variables were tested using Pearson's correlation coefficients (see Table 4.3). Results indicated that sexual violence and PTSD were moderately correlated (r = .43), but sexual violence was not statistically associated with relationship satisfaction (r = .07), or decision-making power (r = .04). Sexual violence explained 18.5% of the variance in PTSD. Decision-making power was positively correlated with increases in relationship satisfaction (r = .23), with decision-making power explaining 5.3% of the variance in relationship satisfaction; however, decision-making power was not meaningfully correlated with PTSD (r = -.10). Also, relationship satisfaction was not statistically correlated with PTSD (r = -.03).

A path analysis model was created in AMOS to test both the direct and indirect relationships between sexual violence, decision-making power, and PTSD and relationship satisfaction, respectively (see Table 4.4). Direct effects of sexual violence on PTSD remained statistically significant in the model (B = 0.66, SEB = .11, β = .43), indicating that PTSD symptom severity is associated with more severe forms of sexual violence. More specifically, a one standard deviation increase in sexual violence was associated with a 0.43 standard deviation increase on PTSD. Direct effects of decision-making power on relationship satisfaction were also statistically significant in the model

(*B* = 0.54, *SEB* = .21, β = .23), suggesting that shared decision making was associated with high scores on relationship satisfaction. Said differently, if decision-making power increased by one standard deviation, relationship satisfaction would be expected to increase by 0.23 standard deviations. Direct effects of sexual violence on decision-making power (*B* = 0.01, *SEB* = .01, β = .04), sexual violence on relationship satisfaction (*B* = 0.02, *SEB* = .04, β = .06), and decision-making power on PTSD (*B* = -1.19, *SEB* = .76, β = -.11) were not statistically significant in the model. Indirect effects of sexual violence on PTSD symptom severity through decision-making power were not statistically significant in the model (*B* = -0.01, *SEB* = .02, β = .00), nor was the indirect effect of sexual violence on relationship satisfaction through decision-making power statistically significant (*B* = 0.00, *SEB* = .01, β = .01). Overall, sexual violence and decision-making power explained 19.5% of the variance in PTSD and 5.8% of the variance in relationship satisfaction. whereas sexual violence accounted for 0.1% of the variance in decision-making power.

4.4 Discussion

The present study was designed to examine the associations among sexual violence, relational decision-making power, PTSD symptom severity, and relationship satisfaction among a sample of currently partnered sexual minority individuals who reported sexual violence since their 14th birthday. Addressing multiple gaps in the extant literature within this population, decision-making power within relationships was assessed as a possible mediator of the relationship between sexual violence and PTSD, as well as between sexual violence and relationship satisfaction. A novel severity ranking

scheme that measured specific experiences of unwanted sexual contact in terms of the coercive tactic used during the assault was implemented to examine the possible variations in mental health and relational outcomes within the sample. Moreover, a measure concerning shared and individual decision-making across different aspects of relationships (e.g., daily household needs, healthcare decision-making, purchasing, etc.) provided an assessment of various relational processes that contribute to overall relationship functioning.

The first notable finding to emerge was the statistical association between sexual violence and PTSD, and the lack of a statistical relationship between sexual violence and relationship satisfaction, either directly or indirectly. Similarly, results indicated that the indirect effect of sexual violence on PTSD through decision-making power was not supported by the model. Finally, another notable finding to emerge was the association between decision-making power and relationship satisfaction contrasted with statistically nonsignificant findings for PTSD symptomology. Although the results of the present study are not the first to indicate positive statistical relationships between experiences of trauma and symptoms of posttraumatic stress, these results appear to indicate that the variance explained in PTSD symptom severity by relational decision-making power is negligible. To my knowledge, this is the first study to examine shared decision-making within relationships as it relates to PTSD symptom severity. These results are also the first to suggest that decision-making power (or lack thereof) is a meaningful contributor of relationship satisfaction for those with sexual violence histories and among participants with diverse sexual orientations.

4.4.1 Sexual Violence and PTSD

Consistent with previous research (Davis et al., 2014), and as expected, experiences of SV were positively associated with PTSD symptom severity. More specifically, in these data, a one standard deviation increase in SV resulted in 9.18 additional points on the PCL-5. Although the SES–SFV lacks the ability to differentiate between endorsed outcomes and tactics that have occurred over multiple events or during a single event, these findings suggest that repeated experiences of assault, at higher levels of SV severity, have a meaningful impact on the severity of PTSD individuals experience. Indeed, the interpersonal nature of SV has been described as a "traumata of human agency" (Collimore et al., 2009, p. 240), and although about 8–20% of traumatized individuals develop PTSD (Breslau et al., 1998, 2004; Kessler et al., 2005), assaultive traumatic events have been shown to result in substantially higher risk for developing PTSD, with some estimates putting the conditional risk of developing PTSD at upwards of 15% (Breslau, 2002; Breslau et al., 2004; Kessler, 1995). Furthermore, individuals who report experiencing more than one traumatic event are more likely to develop PTSD than nonassaulted controls (Breslau et al., 2000; Kessler et al., 1995) and this pattern is evidenced among SV survivors as well (see Cividanes et al., 2019, for review; Goodman-Williams & Ullman, 2020; Ullman & Peter-Hagene, 2016). The results of the present study add further support to these previous findings; however, the factor loadings were smaller in the present study than those found in another study that also recruited participants based on previous or current dating relationships as part of inclusion criteria ($.63 < \beta < .64$; Pegram & Abbey, 2019).

4.4.1.1 Indirect Effects of Shared Decision-making

Contrary to what was hypothesized, shared decision-making was not a statistically significant mediator of the relationship between SV and PTSD symptom severity, although the path coefficient was in the expected direction such that shared decision-making was negatively associated with PTSD symptom severity. Despite the lack of a statistical association, these results suggest that decision-making not associated with the trauma is unlikely to be meaningfully relevant when it comes to mental health and psychological distress. Moreover, although relational decision-making was not implemented as a proxy for egalitarian beliefs or as an assessment of gendered stereotypes within romantic relationships, future researchers might consider how these systemic issues play a role in mental health symptomology following experiences of SV. For instance, much of the research concerning rape myth acceptance—stereotyped beliefs about SV that exonerate the perpetrator, blame the victim, and trivialize the incident (Burt, 1980; Lonsway & Fitzgerald, 1994)—has not been primarily conducted among individuals with SV histories themselves (Lonsway & Fitzgerald, 1994; Turchik & Edwards, 2011) despite feminist and social ecological theoretical framings that suggest the cultural norms and inequalities within our society not only condone SV, but also adversely affect recovery from the same (Campbell et al., 2009; Rozee & Koss, 2001; cf. Voller et al., 2015, & Wilson et al., 2017). Moreover, attending to issues of homophobia, transphobia, and discrimination might also uncover important correlates that promote (or hinder) SV recovery among the population centered within the present study. For instance, how might internalized homonegativity interact with rape myth acceptance to disenfranchise those with sexual trauma histories and negatively affect recovery efforts? In what ways do partner attitudes and beliefs contribute to PTSD symptomology? How

do partners in same-sex relationships come together after experiences of trauma to promote healing? These are important questions that need to be addressed in addition to the work that is already in motion (e.g., Aolsved et al., 2006; Gemberling et al., 2015; Gold et al., 2009).

4.4.2 Sexual Violence and Relationship Satisfaction

The lack of statistical association between SV and relationship satisfaction could be due to the high rates of SV within the sample as a whole, and these unanticipated findings might be explained by previous research on trauma, discrimination, and romantic functioning. Whereas some partnered sexual minority individuals may come together in the face of discrimination such that relationship satisfaction is bolstered, those with extensive trauma exposure do not experience changes in relationship satisfaction following discrimination (Sullivan et al., 2017). It could be that those with cumulative trauma histories are either less likely to engage in adaptive coping, or have become desensitized to life's stressors. Moreover, greater life stress has been found to be associated with low adaptation among married couples (Neff & Karney, 2009), and research indicates that race moderates the bidirectional relationship between sexual stress and marital quality such that stress more adversely affects marital quality for African American men than for European American men (Blumenstock & Papp, 2017). Further, transitional periods for same-sex couples are embedded within the context of heterosexual sociocultural norms and involve adaptivity within multiple social and relational locations, which can be further complicated by contextual factors such as race, ethnicity, and class statuses (Cao et al., 2016). In the context of the present study, stress due to institutionalized homophobia might create an environment in which cumulative

SV histories (i.e., high scores on SES–SFV) override any of the protective factors that could cultivate relationship satisfaction, resulting in a lack of statistical significance between these two constructs. Future work should seek to clarify the nature of the association between SV and relationship satisfaction. Clarifying this association may be particularly important when attempting to identify the consequences of SV on relationship satisfaction, especially given the relevance of intimate partners as a support network for those experiencing psychological distress. Better understanding on this point could help SV survivors access the treatment they might need.

4.4.2.1 Shared Decision-Making and Relationship Satisfaction

The results of the present study converge with previous findings (Eldridge & Gilbert, 1990; Mock & Cornelius, 2017; Peplau & Fingerhut, 2007; Peplau & Spalding, 2000) indicating that relationship satisfaction is greater for individuals who have greater levels of shared decision-making within their relationship. Importantly, this study is one of the first to indicate that shared decision-making power is beneficial to relationship satisfaction among partnered sexual minority individuals who have experienced SV. More specifically, a one standard deviation increase in shared decision-making resulted in approximately one additional point on relationship satisfaction. Although the direct effect between decision-making power and relationship satisfaction is small, these findings suggest that cultivating shared decision-making within a relationship could contribute to greater relationship satisfaction, although longitudinal data is needed to confirm the temporal order of this association. Nonetheless, interventions that focus on building equity when it comes to decision making could have meaningful impacts for relationship satisfaction when at least one individual has experienced a form of SV.

Although egalitarian couples are typically more satisfied with their relationships than are couples with power discrepancies (Gray-Little et al., 1983), among gay men in same-sex relationships, those in with more power reported lower relationship satisfaction than those with less relative power within the relationship (Perry et al., 2016), giving credibility to the adage that with great power comes great responsibility. In addition to higher income and older age being positively associated with greater decision-making power for gay men, HIV-positive men had higher levels of decision-making power within the relationship, although HIV-negative men in concordant relationships (i.e., partnered with other HIV-negative men) reported greater satisfaction than HIV-positive men in concordant relationships (i.e., partnered with other HIV-positive men; Perry et al., 2016). There was no difference in relationship satisfaction between partners in HIV-serodiscordant relationships (Perry et al., 2016). In this context, it seems that not only managing a serious chronic condition is associated with lower relationship satisfaction overall, but in cases in which the chronic condition is specific to one individual, the burden of managing that condition can create more responsibility, which is then in turn related to lower satisfaction.

Following SV, it is not uncommon for survivors to exert control over recovery; in fact, present and future control is associated with better adjustment (Frazier et al., 2004) and greater perceived control over recovery is associated with posttraumatic growth (Kirkner & Ullman, 2020). It would not be surprising if this desire for control spills over into intimate relationships. In the context of the present study, shared decision-making power was positively associated with relationship satisfaction; however, dyadic data could be beneficial for understanding the relative difference in relationship satisfaction

between both members of the relationship. In addition to only reporting on one partner's perspective of decision-making power in the relationship, albeit this partner had a history of SV, relative power within the relationship was not examined. Further, it might also be possible that in response to traumatic experiences, couples need to adjust their dyadic coping strategies to account for the needs of the one who experienced the trauma, thus creating space in which the survivor has more control over decisions made in the relationship. As such, these questions are beyond the focus of the present study and will require longitudinal designs that incorporate dyadic data.

4.4.3 Limitations and Future Directions

The cross-sectional design of the study precludes causal inferences regarding the impact of SV on decision-making power, PTSD symptoms, or relationship satisfaction. Although these data do not allow a determination concerning whether PTSD symptoms emerged following SV, the heightened risk of developing PTSD following experiences of trauma is well-documented (Brewin et al., 2000; Ozer et al., 2003), as is the heightened risk for developing PTSD after SV relative to other forms of interpersonal violence (Gilboa-Schectman & Foa, 2001). Symptoms of avoidance and emotional numbing exert the strongest cross-lagged effects on developing a full PTSD diagnosis 3-months post-trauma among treatment-seeking survivors of sexual assault (Hyland et al., 2016). Moreover, a longitudinal study indicated that interpersonal trauma heightens the risk for developing posttraumatic stress symptoms as compared to nonassualtive trauma, which then increases the risk for exposure to nonassaultive traumatic events in urban contexts (Lowe et al., 2014). Bolstered by empirical data suggesting that racially diverse women who develop PTSD from assaultive events experienced PTSD for longer durations than

those who experienced nonassaultive events (Gill et al., 2008), these findings suggest a cycle of adversity wherein exposure to interpersonal trauma, such as sexual violence, can prospectively determine adverse and long-lasting mental health symptoms. Moreover, these symptoms can lead to revictimization, especially among minority individuals. Although there is a growing body of empirical literature concerning trajectories of dating and intimate partner violence among sexual minority individuals (Alexander et al., 2016; Martin-Shorey & Fromme, 2016; Szalacha et al., 2017), more research is needed to understand the associated impacts of SV on PTSD within this population.

The causal inferences regarding the effects of SV on relationship satisfaction and decision-making are less clear, and selection effects could have also biased these data. Nonetheless, longitudinal findings suggest that more severe experiences of CSA correlated with greater marital dissatisfaction approximately 17 years after CSA occurred (Liang et al., 2006). Dynamic communication also benefits marriages, such that positive communication tactics as well as decreases in both men's and women's negative communication is linked to higher relationship satisfaction (Leuchtmann et al., 2019). Additionally, dealing with stress as a unit and perceiving a partner as helpful in dealing with stress benefits relationship satisfaction for both members of the dyad (Rusu et al., 2020). Thus, it seems that shared and productive relationship processes contribute to relationship satisfaction overtime; however, the results of the present study did not indicate an indirect statistical association between sexual violence and relationship satisfaction through shared decision-making. Longitudinal research is needed to understand the temporal relations between sexual violence and relationship satisfaction,

and how some of these relational processes (i.e., communication, dyadic coping, etc.) contribute to relationship satisfaction for individuals who have experienced trauma.

More generally, the present study was underpowered (power = .22, $df = 1$, $\alpha = .05$, $N = 137$, $\varepsilon_a = 0.10$) relative to Cohen's (1988) 4:1 tolerance ratio for Type II to Type I errors, which has been generally accepted as the appropriate ratio (Lakens, 2013, for review). Although low statistical power is not uncommon for path analyses in the field of education (.05 < power < .92; Fadlelmula, 2011), and a priori power analyses are often underreported (Fadlelmula, 2011; Gaskin & Happell, 2013, 2014), reviews have found that the statistical power needed to detect small, medium, and large effects was, respectively, .26, .71, and .95 in nursing research (Polit & Sherman, 1990), and .27, .74, and .92 in applied psychology (Mone et al., 1996). Thus, the statistical power in the present study was not out of step with the larger body of published research and, importantly, statistical relationships were found among the study variables, with statistically significant standardized path coefficients ranging from small to medium. Moreover, with sufficient power to detect small effects (based on previous reviews of the literature), it would be reasonable to expect that the small effects that were identified would have reached statistical significance if those effects existed in the population. Nonetheless, sufficiently powered studies that either (a) base estimates of effect size from previous studies, or (b) achieve standardized, albeit arbitrary (Correll et al., 2020, for review), effect size metrics (i.e., small, medium, large) are needed, especially given that the indirect effects found in the present study were not statistically significant, despite the fact that fewer participants are needed to have sufficient statistical power for tests of indirect effects than in the test of total effects (Kenny, 2019).

Although a statistical relationship that emerged between decision-making power and relationship satisfaction, the measure concerning decision-making did not assess other types of power beyond relational decision-making (e.g., sexual power, financial power, etc.) and was not specific to gay, lesbian, bisexual, pansexual, or asexual relationships. Another scale, the General Decision-Making Style Inventory (Scott & Bruce, 1995), assesses different decision-making styles (i.e., rational, intuitive, dependent, avoidant, spontaneous) that might better reflect dispositional styles of decision-making and therefore could be helpful both in the context of relationship satisfaction and PTSD. Regardless, this study is one of the first to look at partner decision-making in the context of PTSD symptomology, and the findings suggest that relational decision-making power may not be relevant to PTSD symptomology among SV survivors in the same way that shared decision-making is important in other contexts (e.g., treatment for PTSD; Ullman et al., 2007).

4.5 Conclusions

The present study was designed to consider the associations between relational decision-making, relationship satisfaction, and PTSD among partnered SGM individuals who have experienced SV using path analysis in structural equation modeling. Although direct effects of SV on PTSD and shared decision making on relationship emerged, indirect effects of SV on PTSD through decision making power, and SV on relationship satisfaction through decision-making power were not supported by the model in these data. In sum, the findings indicate the SV is associated with elevated psychological distress, and that shared decision-making is related to greater overall relationship satisfaction among SGM individuals who have experienced SV. Although most of the

extant literature has focused on shared decision-making in the context of PTSD treatment with mental health providers (Etingen et al., 2019; Mott et al., 2014), the present study was the first to consider how relational decision-making power mediates the relationship between with SV and PTSD. Even with statistically nonsignificant indirect effects, these findings suggest that the perception of shared decision-making is an important contributor to relationship satisfaction for SGM SV survivors, and interventions that focus on promoting more shared decision-making are likely to be clinically and meaningfully relevant for those within this population.

Table 4.1

*Demographic Characteristics of Participants (*N = *143)*

Characteristic	*n*	%
Gender		
Female	80	55.9
Male	41	28.7
Trans FTM	10	7.0
Trans MTF	9	6.3
Non-binary/third gender	2	1.4
Trans, non-binary/third gender	1	0.7
Race or ethnicity		
White, non-Hispanic	103	72.0
Mixed	12	8.4
Black, non Hispanic	9	6.3
Asian	8	5.6
Hispanic	5	3.5
American Indian or Alaska Native	3	2.1
Another, unspecified	3	2.1
Education		
High school diploma	9	6.3
Some college	32	22.4
Associate's degree	7	4.9
Bachelor's degree	69	48.3
Master's degree	23	16.1
Doctorate	3	2.1
Religion		
Catholic	69	48.3
Agnostic	19	13.3
Atheist	15	10.5
Protestant, Mainline	8	5.6
Protestant, Evangelical	7	4.9
Islamic	6	4.2
Other, spirituality	6	4.2
No religious preference	5	3.5
Christianity, unspecified	4	2.8
Jewish	4	2.8
Religiosity		
Very religious	37	25.9
Somewhat religious	46	32.2
Slightly religious	21	14.7
Not religious	39	27.3
Respondent relationship status		
Married	86	60.1
In a relationship, not married	57	39.9
Sexual orientation		
Bisexual	102	71.3
Gay or lesbian/homosexual	16	11.2
Asexual	15	10.5
Pansexual	10	7.0
Childhood sexual abuse		
Yes	74	51.7
No	52	36.4
Unsure	17	11.9
	M	*SD*
Age (years)	34.7	10.7
Length of relationship (years)	8.0	7.0

Table 4.2

*Sexual Assault Severity Scores for Respondents since the Age of 14 (*N = *143)*

Separated outcome and tactic	Highest Severity Rank [a]	Redundant [b]	Total frequency [c]
Sexual contact by coercion	2 (1.4)	132 (92.3)	616 (9.0)
Sexual contact by incapacitation	1 (0.7)	118 (82.5)	281 (4.1)
Sexual contact by force	2 (1.4)	117 (81.8)	483 (7.1)
Attempted rape by coercion	2 (1.4)	113 (79.0)	1,141 (16.7)
Attempted rape by incapacitation	4 (2.8)	111 (77.6)	576 (8.4)
Attempted rape by force	7 (4.9)	105 (73.4)	1,000 (14.6)
Rape by coercion	3 (2.1)	116 (81.1)	1,130 (16.5)
Rape by incapacitation	14 (9.8)	111 (77.6)	575 (8.5)
Rape by force	108 (75.5)	108 (75.5)	1,030 (15.1)

Note. Percentages are presented in parentheses.

[a] Reflects scoring based on the highest severity rank, in which participants were placed in the category of their most severe experience, ignoring all less severe outcomes. [b] Reflects redundant scores for each outcome and tactic in that if a participant experienced both unwanted sexual contact by coercion and by force, they would be counted in both categories. [c] Reflects the total number of times respondents in the sample reported experiencing the corresponding outcome and tactic.

Table 4.3

*Means, Standard Deviations, and Intercorrelations for Study Variables (*N *= 143)*

Variable	*M*	*SD*	Range	1	2	3
1. Sexual violence	35.16	14.12	1−45	−		
2. Relationship satisfaction	29.65	4.71	9−35	.07 [-0.14, 0.25]	−	
3. Decision-making power	7.15	2.00	0−10	.04 [-0.14, 0.20]	.23 [0.08, 0.38]**	−
4. PTSD	38.58	21.36	0−79	.43 [0.26, 0.59]***	-.03 [-0.20, 0.13]	-.10 [-0.26, 0.06]

Note. Numbers in brackets are 95% bias corrected and accelerated (BCa) intervals of the correlation coefficients.
* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4.4

Unstandardized (B) and Standardized (β) Total, Direct, and Indirect Effects of Predictors Decision-making Power, PTSD, and Relationship Satisfaction (N = 143)

	Total Effects				Direct Effects				Indirect Effects			
Parameter Estimate	*B*	*β*	95% BCa CI	*p*	*B*	*β*	*t*	*p*	*B*	*β*	*95% BCa CI*	*p*
Predictors on decision-making power												
Sexual violence	0.01	0.04	[-0.16, 0.21]	.722	0.01	0.04	0.45	.651				
Predictors on PTSD												
Sexual violence	0.65	0.43	[0.26, 0.56]	.003	0.66	0.43	5.76	< .001	-0.01	0.00	[-0.04, 0.02]	.592
Decision-making power	-1.19	0.11	[-0.24, 0.01]	.084	-1.19	-0.11	-1.48	.139				
Predictors on relationship satisfaction												
Sexual violence	0.02	0.07	[-0.17, 0.27]	.498	0.02	0.06	0.75	.451	0.00	0.01	[-0.03, 0.60]	.473
Decision-making power	0.54	0.43	[0.07, 0.38]	.005	0.54	0.23	2.82	.005				

Note. $\chi^2 = 0.23$, $p = .635$; RMSEA = 0.00, 95% BCa CI [0.00, 0.17], $p = .690$; CFI = 1.00. CI = confidence interval. PTSD = posttraumatic stress disorder.

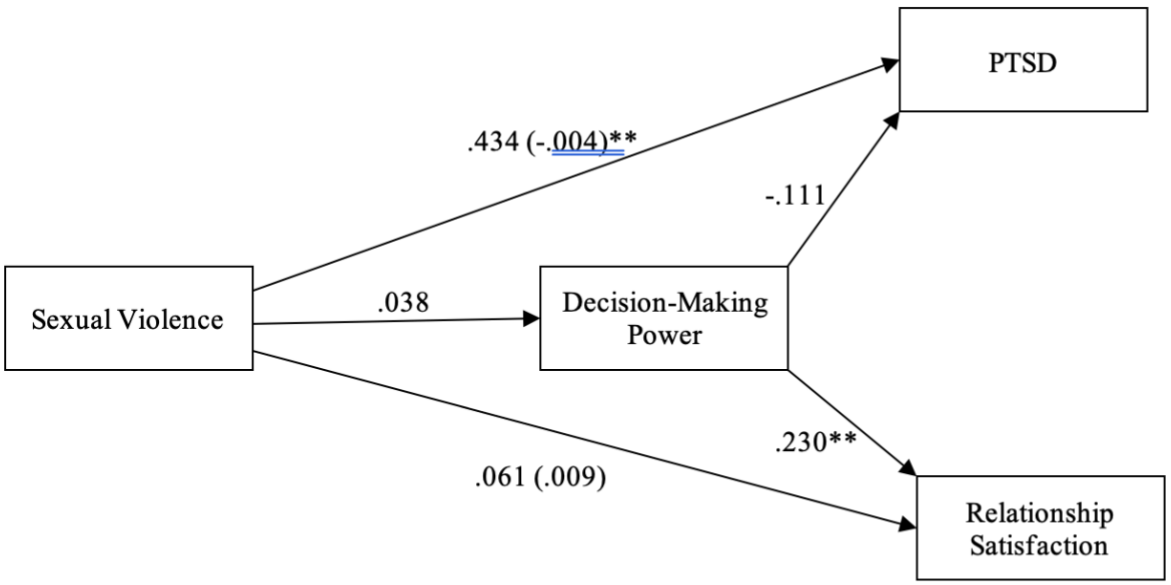

Figure 4.1 AMOS model of direct effects of predictor on PTSD and relationship satisfaction and indirect effects of predictor on PTSD and relationship satisfaction through decision-making power, respectively

Note. Values reflect standardized path coefficients. The coefficients in parentheses reflect the indirect relationships between sexual violence and PTSD and relationship satisfaction through decision-making power, respectively. *p < .05, ** p < .01, ***p < .001.

CHAPTER 5. CONCLUSION

This dissertation was designed to examine the mental health and relational sequalae among survivors of sexual violence. In the first study, PTSD symptom severity emerged as a mediator of the association between sexual violence severity and relationship satisfaction. Behavioral emotion-focused coping strategies explained unique variance in relationship satisfaction when controlling for PTSD symptom severity, and withdrawal and seeking social support, specifically, emerged as individual predictors of relationship satisfaction in addition to the variance explained by PTSD symptom severity. Additionally, a paired-samples *t* test revealed that relationship satisfaction did not differ based on whether respondents participated in mental health services due to previous assault experiences.

For the second study, I investigated how romantic relationships intersected with gender and sexual identity statuses following sexual violence to promote psychological well-being. Findings indicated that there were no statistical differences in PTSD symptomology based on gender identity, sexual orientation, and relationship involvement. Moreover, PTSD symptom severity did not differ based on sexual orientation and relationship status. Additionally, neither the strength nor the direction of the association between sexual violence and PTSD symptom severity differed based on whether respondents were partnered.

Finally, in the third study, I created a path analysis in AMOS (Version 27) to examine the direct and indirect associations of sexual violence on PTSD and relationship satisfaction through relational decision-making among partnered sexual minority individuals. Direct effects between sexual violence and PTSD, as well as between

relational decision-making and relationship satisfaction, were supported by the model. Despite good model fit, indirect effects of sexual violence on PTSD through relational decision-making, and indirect effects of sexual violence on relationship satisfaction through relational decision-making, were not supported by the model.

In addition to identifying the similarities and differences in mental health among survivors, these results highlight the importance of psychological well-being as it concerns relationship satisfaction for survivors of sexual violence. Additionally, these findings demonstrate that emotion-focused coping and interventions that promote shared decision-making among couples are clinically relevant strategies for promoting relationship functioning among survivors. Despite null findings concerning PTSD, identity, and relationship statuses, and a lack of statistical difference in relationship satisfaction based on mental health participation, family scientists, and specifically marriage and family therapists, appear well-positioned to attend to the psychological and relational needs of individuals who have experienced sexual violence. Furthermore, these findings bolster the theoretical frameworks upon which the field of family science has emerged; plainly, the trauma experienced by one has rippling effects beyond the individual. Although it cannot be determined based on these studies whether the emotional-coping strategies endorsed by the respondents or the level of shared decision-making changed explicitly because of the sexual violence, the emotional and relational processes involved in determining relationship satisfaction are very much apparent within the data. Said differently, the emotional and relational processes by which an individual copes and partners has meaningful implications for survivors of sexual violence, and

together highlight the need for clinical interventions that not only support survivors but also facilitate happy and healthy relationships.

5.1 Supporting Survivors: An Applied Context

Marriage and family therapists (MFTs) are trained in psychotherapy and family systems to treat wide range of clinical problems, including individual psychological problems and marital issues (American Association of Marriage and Family Therapy; AAMFT, 2021). For MFTs, conceptualizing the presenting problem includes an assessment of the relationships and systems in which clients are embedded (AAMFT, 2021). The results of this dissertation project indicate that the psychological impacts of sexual trauma are linked to relationship satisfaction, which likely makes marriage and family therapy an effective treatment strategy for survivors given the clinical focus on both mental health and relational processes within the profession. On the one hand, clinicians can attend to the psychological distress experienced by the client with care given to the potential impacts the distress is imposing in other spheres of life, including romantic relationships. On the other hand, clinicians can attend to relationship issues with the understanding of how experiences of trauma can show up in couple issues.

Findings reported in this dissertation emphasize the important role that psychological distress has on relationship satisfaction following sexual violence, and perhaps underscores the relevance that certain coping strategies have in mitigating the psychological sequalae, above and beyond the effects of PTSD symptom severity that, in turn, impact relationship satisfaction. For instance, psychological distress has an important impact on perceived relationship satisfaction reported by survivors; however, findings indicate that how individuals generally cope with negative or unpleasant events

explained more variance in relationship satisfaction than PTSD symptoms. In a clinical context, this information is important for mental health providers, especially when individuals with sexual trauma histories engage in couples counseling. Not only should clinicians be assessing for trauma histories, but when individuals report sexual trauma, clinicians should be paying attention to how clients are generally coping with those experiences, especially when it comes to patterns of withdrawal and seeking social support.

Indeed, feelings of detachment or estrangement with others and a markedly diminished interest or participation in activities underly symptoms of PTSD (American Psychological Association, 2015). Patterns of withdrawal within couple contexts can also cultivate a rigid negative cycle of interaction, which can contribute to less satisfaction and worse conflict-affective recoveries over time (Laurent et al., 2008; Prager et al., 2019; Sasaki & Overall, 2021). Withdrawal reactions typically leave neither partner feeling secure or satisfied in relationships, and if sustained cycles of withdraw/pursue or attack/defend persist, it can leave clients feeling like their partner will not be there for them when they really need them (MacIntosh, 2017). Thus, not only is withdrawal a symptom associated with psychological distress, but when individuals withdraw from their partners, they are also engaging in adverse behaviors that create dissatisfaction in relationships. Seeking out social support via a romantic partner is likely both an antidote to psychological distress and a buffer against low levels of relationship satisfaction; however, positive support seeking (e.g., recognizing partner as support, expresses feelings related to problem, etc.) can be hard to do, especially among distressed couples (Verhofstadt et al., 2013). Moreover, research indicates higher levels of negative support

seeking (e.g., rejecting help, making demands for help, etc.) in distressed couples than non-distressed couples (Verhosfstadt et al., 2013). Taken together, withdrawal may not only be associated with poor relational interactions, but individuals might also be resistant to seeking support for distress once these negative patterns are already in place. Furthermore, if individuals are experiencing symptoms of posttraumatic stress, disengagement is likely, which only perpetuates negative couple dynamics.

Following sexual trauma, individuals may struggle to communicate attachment needs and partners may be unlikely to know how to respond, thus the couple oscillates between periods of intense emotion followed by periods of shutdown and possibly dissociation. In fact, cycles of arousal and avoidance can lead to—and can certainly feel like—reenactments of past trauma (Buttenheim & Levendosky, 1994), and have been conceptualized as attempts to resolve past traumatic relationships (MacIntosh, 2017). When these repeated attempts fail, the intensity of interaction begins to dominate couple experiences of each other and can lead to "rigid polarization" (MacIntosh, 2017, p. 346). Therapy can help bring a new perspective to these interactions. Clinicians can attend to the deep emotional pain and fear embedded in these cycles, while also working directly with the emotions and emotional processes stemming from the trauma (Mlotek & Paivio, 2017). Clinicians can help clients practice emotion regulation skills within sessions, while also providing psychoeducation about trauma and PTSD so that partners can better understand signs of escalation and dissociation (Wen et al., 2020). Emotion regulation helps individuals develop skills for managing symptoms of posttraumatic stress, whereas psychoeducation helps partners understand that what they experience as withdrawal is likely a symptom of the trauma and may have nothing to do with them, although partner

responses can certainly contribute to withdrawal patterns within the relationship, and if present should also be addressed. In this way, therapy serves as a corrective emotional experience (Wen et al., 2020) and reestablishes safety and security with the dyad.

Although the results cited within the dissertation did not evidence direct links between sexual violence and relationship satisfaction, the results did demonstrate that shared relational decision-making power was positively related to relationship satisfaction among survivors of sexual violence. Thus, helping clients adjust their communication skills to promote shared decision-making could be relevant in these contexts. MFTs might also consider how egalitarian views are limiting or promoting shared decision-making, given that women who perceive themselves to be in egalitarian marriages tend to report higher levels of happiness both in the present and 15 years later (LeBaron et al., 2014). Knudson-Martin et al. (2015) have recommended seven clinical competencies for attending to power imbalances within relationships that range from identifying enactments of cultural discourses and attuning to underlying sociocultural emotions, to fostering relational safety and facilitating shared relationship responsibility. Clinicians who organize their therapeutic responses in ways that attend to power imbalances can help identify and track the often imperceptible cultural discourses that are prevalent within relationships and "identify alternatives consistent with goals of mutual support" (Knudson-Martin et al., 2015). In the same way that medical models of shared decision making empower autonomy and choice in recovery and treatment among sexually exploited youth (Sahl & Knoepke, 2018), shared decision-making within relationships can cultivate mutual respect and reciprocity that ultimately encourages active participation in relationships (i.e., the opposite of withdrawal), cultivates an active

voice in naming attachment needs (i.e., seeking support), and can contribute to healing. Moreover, regaining control in any way is crucial and can facilitate survivor empowerment (Ullman & Townsend, 2008) and posttraumatic growth (Kirkner & Ullman, 2020).

Although no differences in PTSD symptoms were found based on gender, relationship, or sexual orientation statuses, MFTs operating from feminist, intersectional, and anti-violence frameworks should be mindful of inequities and disparities experienced by different groups (Few-Demo & Allen, 2020). However, being mindful of sociocultural and institutional constraints resulting in disparities of health and well-being is not enough. Therapists must do the work, so to speak, and the work is not and cannot be neutral. Not only can neutrality inadvertently reinforce systems that support violence, but perhaps equally as problematic, can also ignore the role that this profession has played in pathologizing lesbian, gay, bisexual, transgender, and queer (LGBTQ) identities. Borrowed and adapted from Samuel's (2020) vision of systemic therapists' role in dismantling systemic racism, therapists must critically examine their own biases concerning homophobia, transphobia, sexism, classism, ableism, and racism; after all, interpersonal violence is embedded in systems of oppression and power. If MFTs are to be agents of systemic change, a collective consciousness raising must happen within the field, but not in ways that burden our LGBTQ clients or colleagues. Moreover, the profession must also advocate for the abolishment of laws and policies that have historically disadvantaged marginalized communities (Samuel, 2020), which include the very communities that we serve every day. Additionally, diversity and cultural competency training must also evolve into practices of diversity and cultural competence

within the therapeutic space because being culturally sensitive is not the same as doing culturally sensitive work (D'Aniello et al., 2016). Perhaps this is not the time or space to reflect on how the field of marriage and family therapy has contributed to and perpetuated systems of oppression and disadvantage that cultivate sexual violence, and in no way does this serve as an exhaustive review concerning the scope of the problem. But perhaps not doing so would only reinforce systems of violence, which are ultimately antithetical to the pursuit of the field at large. Samuel (2020), I argue, said it best, "As MFTs, we have committed to acknowledging that human suffering is a reflection of the systems in which they endure and improving such systems" (p. 12), and at this juncture, in the present moment, MFTs can no longer be complacent.

Finally, in conclusion, sexual violence encompasses a wide range of sexually violent acts (Canan & Levand, 2019) that are perpetuated onto individuals at staggering rates, and it has the capacity to disrupt interpersonal relationships. Psychological distress, coping strategies, and relational decision-making cannot be ignored when it comes to relationship satisfaction among survivors of sexual violence. To help understand how to help individuals who have previously experienced sexual violence, researchers and clinicians across disciplines should be aware of the psychological and relational impacts of sexual violence and not ignore how psychological distress contributes to relationship satisfaction.

APPENDICES

APPENDIX 1. SEXUAL EXPERIENCES SURVEY–SHORT FORM VICTIMIZATION

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

	Sexual Experiences	**How many times in the past 12 months?**	**How many times since age 14?**
1.	Someone fondled, kissed, or rubbed up against the private areas of my body (lips, breast/chest, crotch or butt) or removed some of my clothes without my consent *(but did not attempt sexual penetration)* by:	0 1 2 3+	0 1 2 3+
	a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	c. Taking advantage of me when I was too drunk or out of it to stop what was happening.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	d. Threatening to physically harm me or someone close to me.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

2.	**Someone had oral sex with me or made me have oral sex with them without my consent by:**	0 1 2 3+	0 1 2 3+
	a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	c. Taking advantage of me when I was too drunk or out of it to stop what was happening.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	d. Threatening to physically harm me or someone close to me.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

3.	**If you are a male, check box and skip to item 4. A man put his penis into my vagina, or someone inserted fingers or objects without my consent by:**	0 1 2 3+	0 1 2 3+
	a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	c. Taking advantage of me when I was too drunk or out of it to stop what was happening.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	d. Threatening to physically harm me or someone close to me.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

	e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

4.	**A man put his penis into my butt, or someone inserted fingers or objects without my consent by:**	0 1 2 3+	0 1 2 3+
	a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	c. Taking advantage of me when I was too drunk or out of it to stop what was happening.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	d. Threatening to physically harm me or someone close to me.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

5.	Even though it didn't happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by:	0 1 2 3+	0 1 2 3+
	a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

	b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	c. Taking advantage of me when I was too drunk or out of it to stop what was happening.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	d. Threatening to physically harm me or someone close to me.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

6.	**If you are male, check this box and skip to item. Even though it didn't happen, a man TRIED to put his penis into my vagina, or someone tried to stick in fingers or objects without my consent by:**	0 1 2 3+	0 1 2 3+
	a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	c. Taking advantage of me when I was too drunk or out of it to stop what was happening.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	d. Threatening to physically harm me or someone close to me.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

7.	**Even though it didn't happen, a man TRIED to put his penis into my butt, or someone tried to stick in objects or fingers without my consent by:**	0 1 2 3+	0 1 2 3+
	a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	c. Taking advantage of me when I was too drunk or out of it to stop what was happening.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	d. Threatening to physically harm me or someone close to me.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

8. Did any of the experiences described in this survey happen to you 1 or more times?
   Yes ☐ No ☐
9. What was the sex of the person or persons who did them to you?

   Female only ☐

   Male only ☐

   Both females and males ☐

   I reported no experiences ☐

10. Have you ever been raped? Yes No

APPENDIX 2. PTSD Checklist for DSM-5 (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4

14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

APPENDIX 3. GLOBAL MEASURE OF RELATIONSHIP SATISFACTION

Overall, how would you describe your overall relationship with your partner?

1.

1	2	3	4	5	6	7
Very Bad						Very Good

2.

1	2	3	4	5	6	7
Very Unpleasant						Very Pleasant

3.

1	2	3	4	5	6	7
Very Negative						Very Positive

4.

1	2	3	4	5	6	7
Very Unsatisfying						Very Satisfying

5.

1	2	3	4	5	6	7
Worthless						Very Valuable

APPENDIX 4. BEHAVIORAL EMOTION REGULATION QUESTIONNAIRE

1. I engage in other, unrelated activities

1	2	3	4	5
Almost Never				Almost Always

2. I set my worries aside by doing something else

1	2	3	4	5
Almost Never				Almost Always

3. I do other things to distract myself

1	2	3	4	5
Almost Never				Almost Always

4. I engage in an activity which makes me feel good

1	2	3	4	5
Almost Never				Almost Always

5. I avoid other people

1	2	3	4	5
Almost Never				Almost Always

6. I withdraw

1	2	3	4	5
Almost Never				Almost Always

7. I isolate myself

1	2	3	4	5
Almost Never				Almost Always

8. I close myself off to others

1	2	3	4	5

Almost Never				Almost Always

9. I try to do something about it

1	2	3	4	5
Almost Never				Almost Always

10. I get to work on it

1	2	3	4	5
Almost Never				Almost Always

11. I take action to deal with it

1	2	3	4	5
Almost Never				Almost Always

12. I do whatever is required to deal with it

1	2	3	4	5
Almost Never				Almost Always

13. I look for someone to comfort me

1	2	3	4	5
Almost Never				Almost Always

14. I ask someone for advice

1	2	3	4	5
Almost Never				Almost Always

15. I share my feelings with someone

1	2	3	4	5
Almost Never				Almost Always

16. I look for someone who can support me

1	2	3	4	5
Almost Never				Almost Always

17. I move on and pretend that nothing happened

1	2	3	4	5
Almost Never				Almost Always

18. I repress it and pretend it never happened

1	2	3	4	5
Almost Never				Almost Always

19. I behave as if nothing is going on

1	2	3	4	5
Almost Never				Almost Always

20. I block it out

1	2	3	4	5
Almost Never				Almost Always

APPENDIX 5. DEMOGRAPHIC QUESTIONNAIRE

1. With which of the following gender identities do you most closely identify?
    a. Female
    b. Male
    c. Non-binary/third gender
    d. Prefer to self-describe (please specify)
    e. Prefer not to say

2. Do you identify as transgender?
    a. Yes
    b. No
    c. Prefer not to say

3. What is your sexual orientation?
    a. Asexual
    b. Bisexual
    c. Gay or Lesbian/Homosexual
    d. Pansexual
    e. Straight/Heterosexual
    f. Prefer to self-describe (please specify)
    g. Prefer not to say

4. Select your birth month
    a. January
    b. February
    c. March
    d. April
    e. May
    f. June
    g. July
    h. August
    i. September
    j. October
    k. November
    l. December

5. Select your birth year

6. With which of the following racial and ethnic classifications do you identity? Select all that apply.
    a. American Indian or Alaska Native

b. Asian
c. Black or African American
d. Hispanic or Latino
e. Native Hawaiian or Pacific Islander
f. White or Caucasian
g. Another racial or ethnic identification (please identify)

7. Which of the following best describes your religious preference?
    a. Catholic
    b. Protestant
    c. Islamic
    d. Jewish
    e. Something else

8. How would you describe your religious preference?
    a. Agnostic
    b. Atheist
    c. Baptist – Unspecified
    d. Baptist – Northern
    e. Baptist – Southern
    f. Buddhism
    g. Congregational
    h. Episcopalian-Anglican
    i. Fundamentalist
    j. Hinduism
    k. Jehovah's Witness
    l. Jainism
    m. Lutheran
    n. Methodist
    o. Muslim
    p. Latter-Day Saints
    q. Non-Denominational
    r. Pentecostal
    s. Presbyterian
    t. Quaker
    u. RLDS
    v. Seventh Day Adventist
    w. Sikhism
    x. Unitarian
    y. Wiccan
    z. None

9. Which denomination?
    a. Baptist – Unspecified

b. Baptist – Northern
c. Baptist – Southern
d. Congregational
e. Episcopalian-Anglican
f. Fundamentalist
g. Jehovah's Witness
h. Lutheran
i. Methodist
j. Mormon/LDS
k. Non-Denominational
l. Pentecostal
m. Presbyterian
n. Quaker
o. RLDS
p. Seventh Day Adventist
q. Something else

10. Would you say that you are . . .
    a. Very religious
    b. Somewhat religious
    c. Slightly religious
    d. Not religious

11. To what degree do your religious beliefs inform your day to day decisions?
    a. A great deal
    b. Somewhat
    c. Slightly
    d. Not at all

12. Please describe your current relationship status
    a. Single
    b. In a relationship but not married
    c. Married
    d. Separated
    e. Divorced
    f. Widowed

13. Please indicate which of the following most closely resembles your current intimate partnership. If you are not currently in an intimate partnership, please indicate which of the following most closely resembles your most recent intimate partnership.
    a. Monogamous relationship (one sexual/intimate partner at a time)
    b. Polyamorous relationship (more than one sexual/intimate partner at a time)

14. Please indicate how long you've been in your current relationship. If you are not currently in a relationship, please indicate how long your previous relationship lasted.
    a. [open-ending response]

15. Please indicate the highest level of education you have achieved
    a. Did not complete high school
    b. High school diploma (or GED)
    c. 1 year of college (but no degree)
    d. 2 years of college (but no degree)
    e. Associates degree
    f. 3 years of college (but no degree)
    g. 4 years of college (but no degree)
    h. Bachelor's degree
    i. Master's degree
    j. Doctorate

APPENDIX 6. ONE-WAY ANOVA SUPPORTING THE DECISION TO GROUP EXPERIENCES OF CSA

Table 9
*Means, Standard Deviations, and One-Way ANOVA for PTSD Symptom Severity According to Childhood Sexual Abuse (*N = *322)*

	Groups							
	1. Yes (n = 171)		2. No (n = 108)		3. Unsure (n = 43)		ANOVA test	
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*
PTSD	46.08	16.51	34.08	18.99	37.95	15.14	15.89	< .001

Table 10
Means, Standard Errors, and Planned Contrasts for the Effects of Childhood Sexual Abuse on PTSD Symptom Severity

Contrast	Value Contrast	*SE*	*t*	df	*p*	*d*
Yes CSA vs No/Unsure CSA	-20.12	3.88	-5.19	221.95	< .001	0.63
No CSA vs. Unsure CSA	3.87	2.94	1.31	96.28	.192	0.24

An ANOVA was conducted to assess the differences in PTSD symptoms among three different childhood sexual abuse experiences: yes, no, unsure. The Levene's statistic was statistically significant (p = .013) indicating that homogeneity of variance could not be assumed across these groups. Thus, Welch's adjusted F ratio was used, which indicated that at least two of the groups were statistically different from one another and that CSA experiences had moderate effects on PTSD symptoms severity, Welch's F(2,118) = 15.89, p < .001, □□2 = .09. See Table 10 for means, standard deviations, and results of the one-way ANOVA. Planned contrasts revealed that reporting an experience of CSA (M = 46.08, SD = 16.51) statistically increased PTSD symptoms compared to having no reported experiences of CSA or being unsure about experiences of CSA (M = 35.19, SD = 18.08), t(221.95) = -5.19, p < .001, d = 0.63. However, PTSD symptoms did not statistically differ between having no CSA experiences (M = 34.08, SD = 18.99), and being unsure of CSA (M = 37.95, SD = 15.14), t(96.28) = 1.31, p = .192, d = 0.24. Thus, because those who reported experiences of CSA exhibited moderate differences on PTSD scores than those who did not or were unsure of CSA experiences, but those who did not report CSA and those who were unsure about CSA did not have statistically different PTSD scores, the decision was made to group those without CSA histories and those who were unsure of CSA into one category labeled no (scored as 1), retaining those who reported a history of CSA into a single category labelled yes (2).

APPENDIX 7. DECISION-MAKING

For the following questions, please think about the main person making decisions in your current relationship. If you are not in a relationship at the time, please think about who made decisions in your previous relationship(s).

1. Who makes the decisions about obtaining healthcare?
    a. Mainly myself
    b. Mainly my partner
    c. Mainly myself and my partner jointly
    d. Decisions about obtaining healthcare did not apply to my current or previous relationship(s)
2. Who makes the decisions about making large household purchases?
    a. Mainly myself
    b. Mainly my partner
    c. Mainly myself and my partner jointly
    d. Decisions about making large household purchases did not apply to my current or previous relationship(s)
3. Who makes the decisions about making purchases for daily household needs?
    a. Mainly myself
    b. Mainly my partner
    c. Mainly myself and my partner jointly
    d. Decisions about making purchases for daily household needs did not apply to my current or previous relationship(s)
4. Who makes the decisions about visiting family relatives?
    a. Mainly myself
    b. Mainly my partner
    c. Mainly myself and my partner jointly
    d. Decisions about visiting family relatives did not apply to my current or previous relationship(s)
5. Who makes the decisions about deciding household activities?
    a. Mainly myself
    b. Mainly my partner
    c. Mainly myself and my partner jointly
    d. Decisions about deciding household activities did not apply to my current or previous relationship(s)

REFERENCES

Abbey, A., & Jacques-Tiura, A. J. (2011). Sexual assault perpetrators' tactics: Associations with their personal characteristics and aspects of the incident. *Journal of Interpersonal Violence, 26*(14), 2866–2889. https://doi.org/10.1177/0886260510390955

Abbey, A. D., Jacques-Tiura, A. J., & Parkhill, M. R. (2009). Violence and Harassment. In H. Landrine, & F. Russo (Eds), *Handbook of Diversity in Feminist Psychology* (pp. 389–476). Springer.

Alaggia, R., & Wang, S. (2020). "I've never told anyone until the #metoo movement": What can we learn from sexual abuse and sexual assault disclosures made through social media? *Child Abuse and Neglect, 103*. https://doi.org/10.1016/j.chiabu.2019.104312

Alexander, K. A., Volpe, E. M., Abboud, S., & Campbell, J. C. (2016). Reproductive coercion, sexual risk behaviours and mental health symptoms among low-income behaviourally bisexual women: Implications for nursing practice. *Journal of Clinical Nursing, 25*(23–24), 3533–3544. https://doi.org/10.1111/jocn.13238

Alvarado, G., Fenny, A. P., Dakey, S., Mueller, J. L., O'Brien-Milne, L., Crentsil, A. O., Duvvury, N., Seriver, S., & Schwenke, C. (2018). The health-related impacts and costs of violence against women and girls on survivors, households and communities in Ghana. *Journal of Public Health in Africa, 9*(860), 110–114. https://doi.org/10.4081/jphia.2018.860

Alwin, D. F. (2012). Integrating varieties of life course concepts. *The Journals of Gerontology: Series B: Psychological Sciences and Social Sciences, 67B*(2), 206–220. https://doi.org/10.1093/geronb/gbr146

American Association for Marriage and Family Therapy. (2021). *About Marriage and Family Therapists.* American Association for Marriage and Family Therapy. https://www.aamft.org/About_AAMFT/About_Marriage_and_Family_Therapists.aspx?hkey=1c77b71c-0331-417b-b59b-34358d32b909

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

Anderson, K. G. (2017). Adverse childhood environment: Relationship with sexual risk behaviors and marital status in a large American sample. *Evolutionary Psychology, 15*(2), 1–11. https://doi.org/10.1177/1474704917710115

Anderson, R. E., Cahill, S. P., & Delahanty, D. L. (2018). The psychometric properties of the Sexual Experiences Survey–Short Form Victimization (SES–SFV) and characteristics of sexual victimization experiences in college men. *Psychology of Men and Masculinity, 19*(1), 25–34. https://doi.org/10.1037/men0000073

Antonucci, T. C., Ajrouch, K. J., & Birditt, K. S. (2014). The convoy mode: Explaining social relations from a multidisciplinary perspective. *The Gerontologist, 54*(1), 82–92. https://doi.org/10.1093/geront.gnt118

Aolsved, A. C., & Long, P. J. (2006). Co-occurrence of rape myth acceptance, sexism, racism, homophobia, ageism, classism, and religious intolerance. *Sex Roles, 55*(7–8), 481–492. https://doi.org/10.1007/s11199-006-9101-4.

Arata, C. M., & Lindman, L. (2002). Marriage, child abuse, and sexual victimization. *Journal of Interpersonal Violence, 17*(9), 953–971. https://doi.org/10.1177/0886260502017009003

Armstrong, E. A., Gleckman-Krut, M., & Johnson, L. (2018). Silence, power, and inequality: An intersectional approach to sexual violence. *Annual Review of Sociology, 44*, 99–122. https://doi.org/10.1146/annurev-soc-073117-041410

Balsam, K. F., & Szymanski, D. M. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *Psychology of Women Quarterly, 29*(3), 258–259. https://doi.org/10.1111/j.1471-6402.2005.00220.x

Balsam, K. F., Molina, Y., Blayney, J. A., Dillworth, T., Zimmerman, L., & Kaysen, D. (2015). Ethnic differences in identity and mental health outcomes among young sexual minority women. *Cultural Diversity and Ethnic Minority Psychology, 21*(3), 380–390. https://doi.org/10.1037/a0028680

Banyard, V. L. (2011). Who will help prevent sexual violence: Creating an ecological model of bystander intervention. *Psychology of Violence, 1*(3), 216–229. https://doi.org/10.1037/a0023739

Barker, G., Ricardo, C., & Nascimento, M. (2007). *Engaging men and boys in changing gender-based inequality in health: Evidence from programme interventions.* World Health Organization. https://www.who.int/gender/documents/Engaging_men_boys.pdf

Barnum, E. L., & Perrone-McGovern, K. M. (2017). Attachment, self-esteem and subjective well-being among trauma survivors of childhood sexual trauma. *Journal of Mental Health Counseling, 39*(1), 39–55. https://doi.oirg/10.17744/mehc.39.1.04

Basile, K. C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S. G., & Raiford, J. L. (2016). *Stop SV: A technical package to prevent sexual violence.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/SV-Prevention-Technical-Package.pdf

Battaglia, J. E., Edley, P. P., & Newsom, V. A. (2019). Intersectional feminisms and sexual violence in the era of me too, Trump, and Kavanaugh. *Women & Language, 42*(1), 133–143. https://doi.org/10.34036/WI.2019.014

Behrmester, M., Kwang, T., & Gosling, S. D. (2011). Amazon's mechanical turk: A new source of inexpensive, yet high-quality, data? *Perspectives of Psychological Science, 61*(1), 3–5. https://doi.org/10.1177/1745691610393980

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological Bulletin, 107*(2), 238–246. https://doi.org/10.1037/0033-2909.107.2.238

Berthelot, N., Godbout, N., Hébert, M., Goulet, M., & Bergeron, S. (2014). Prevalence and correlates of childhood sexual abuse in adults consulting for sexual problems. *Journal of Sex & Marital Therapy, 40*(5), 434–443. https://doi.org/10.1080/009263X.2013.772548

Bhandari, S., Winter, D., Messer, D., & Metcalfe, C. (2011). Family characteristics and long-term effects of childhood sexual abuse. *British Journal of Clinical Psychology, 50*(4), 435–451. https://doi.org/10.111/j.2044-8260.2010.02006.x

Birkley, E. L., Eckhardt, C. I., & Dykstra, R. E. (2016). Posttraumatic stress disorder symptoms, intimate partner violence, and relationship functioning: A meta-analytic review. *Journal of Traumatic Stress, 29*(5), 397–405. https://doi.org/10.1002/jts.22129

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., Chen, J., & Stevens, M. R. (2011). *The national intimate partner and sexual violence survey (NISVS): 2010 summary report.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf

Blais, R. K., Geiser, C., & Cruz, R. A. (2018). Specific PTSD symptom clusters mediate the association of military sexual trauma severity and sexual function and satisfaction in family service members/veterans. *Journal of Affective Disorders, 238*, 680–688. https://doi.org/10.1016/j.jad.2018.05.052

Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). Posttraumatic stress disorder checklist for *DSM-5* (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*(6), 489–498, https://doi.org/10.1002/jts.22059

Blumenstock, S. M., & Papp, L. M. (2017). Distress and marital quality of newlyweds: Investigation of sociodemographic moderators. *Family Relations, 66*(5), 794–808. https://doi.org/10.1111/fare.12285

Bond, S., B., & Bond, M. (2004). Attachment styles and violence within couples. *The Journal of Nervous and Mental Disease, 192*(12), 857–863. https://doi.org/10.1097/01.nmd.0000146879.33957.ec

Boyle, K. M., Barr, A., & Clay-Warner, J. (2017). The effects of feminist mobilization and women's status on universities' reporting of rape. *Journal of School Violence, 16*(3), 317–330. https://doi.org/10.1080/15388220.2017.1318580

Boyle, K. M., Barr, A., & Clay-Warner, J. (2018). Shameful "victims" and angry "survivors": Emotion, mental health, and labeling sexual assault. *Violence and Victims, 33*(3), 436–452. https://doi.org/10.1891/0886-6708.v33.i3.436

Boyle, K. M., & McKinzie, A. E. (2015). Resolving negative affect and restoring meaning: Responses to deflection produced by unwanted sexual experiences. *Social Psychology Quarterly, 78*(2), 151–172. https://doi.org/10.1177/0190272514564073

Boyle, K. M. & Rogers, K. B. (2020). Beyond the rape "victim"–"survivor" binary: How race, gender, and identity processes interact too shape distress. *Sociological Forum, 35*(2), 323–345. https://doi.org/10.1111/socf.12584

Brenan, M. (2019, March 18). *U.S. men less concerned than in 2017 about sexual harassment.* Gallup. https://news.gallup.com/poll/247823/men-less-concerned-2017-sexual-harassment.aspx

Breslau, N. (2002). Epidemiologic studies of trauma, posttraumatic stress disorder, and other psychiatric disorders. *Canadian Journal of Psychiatry, 47*(10), 923–929. https://doi.org/10.1177/070674370204701003

Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davic, G. C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit area survey of trauma. *Archives of General Psychiatry, 55*(7), 626–632. https://doi.org/10.1001/archpsych.56.7.626

Breslau, N., Wilcox, H. C., Storr, C. L., Lucia, V. C., & Anthony, J. C. (2004). Trauma exposure and posttraumatic stress disorder: A study of youths in urban America. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 81*(4), 530–544. https://doi.org/10.1093/jurban/jth138

Breusch, T. S., & Pagan, A. R. (1979). A simple test for heteroscedasticity and random coefficient variation. *Econometric, 47*(5), 1287–1294). https://doi.org/10.2307/1911963

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology, 68*(5), 748–766. https://doi.org/10.1037//0022-006X.68.5.748

Broman, C. L., Riba, M. L., & Trahan, M. R. (1996). Traumatic events and marital well-being. *Journal oof Marriage and Family, 58*(4), 908–916. https://doi.org/10.2307/353979

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Harvard University Press.

Bronfenbrenner, U. (1989). Ecological systems theory. In R. Vasta (Ed.), *Annals of child development* (pp. 187–249). JAI.

Bronfenbrenner, U. (2005). *Making human beings: Biological perspectives on human development.* Sage.

Bronfenbrenner, U., & Morris, P. A. (1998). The ecological developmental processes. In D. William & R. M. Lerner (Eds.), *Handbook of child psychology: Theoretical models of human development* (pp. 993–1028). John Wiley & Sons Inc.

Brown, A. L., Testa, M., & Messman-Moore, T. L. (2009). Psychological consequences of sexual victimization resulting from force, incapacitation, or verbal coercion. *Violence Against Women, 15*(8), 898–919. https://doi.org/10.1177/1077801209335491

Brown, M. W., & Cudeck, R. (1992). Alternative ways of assessing model fit. *Sociological Methods & Research, 21*(2), 230–258. https://doi.org/10.1177/0049124192021002005

Buttenheim, M., & Levendosky, A. (1994). Couples treatment for incest survivors. *Psychotherapy: Theory, Research, Practice & Training, 31*(3), 407–414. https://doi.org/10.1037/0033-3204.31.3.407

Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse, 10*(3), 225–246. https://doi.org.10.1177/1524838009334456

Canan, S. N., & Levand, M. A. (2019). A feminist perspective on sexual assault. In In W. T. O'Donohue & P. A. Schewe (Eds.), *Handbook of sexual assault and sexual assault prevention* (pp. 383–397). Springer. https://doi.org/10.1007/978-3-030-23645-8

Candel, O., & Turliuc, M. N. (2019). Insecure attachment and relationship satisfaction: A meta-analysis of actor and partner associations. *Personality and Individual Differences, 147*, 190–199. https://doi.org/10.1016/j.paid.2019.04.037

Cantón-Cortés, D., Cortés, M. R., & Cantón, J. (2015). Child sexual abuse, attachment style, and depression: The role of the characteristics of abuse. *Journal of*

Interpersonal Violence, 30(3), 420–436. https://doi.org/10.1177/088626051435101
Cao, H., Mills-Koonce, W. R., Wood, C., & Fine, M. A. (2016). Identity transformation during the transition to parenthood among same-sex couples: An ecological, stress-strategy-adaptation perspective. *Journal of Family Theory and Review, 8*(1), 30–59. https://doi.org/10.1111/jftr.12124
Carlson, M. W., & Oshri, A. (2018). Depressive symptom trajectories among sexually abused youth: Examining the effects of parental perpetration and age of abuse onset. *Child Maltreatment, 23*(4), 387–398. https://doi.org/10.1177/1077559518779755
Caska-Wallace, C. M., Katon, J. G., Lehavot, K., McGinn, M. M., & Simpson, T. L. (2016). Posttraumatic stress disorder symptom severity and relationship functioning among partnered heterosexual and lesbian women veterans. *LGBT Health, 3*(3), 186–192. https://doi.org/10.1089/lgbt.2015.0097
Chandra, A., Mosher, W. D., Copen, C., & Sionean, C. (2011). *Sexual behavior, sexual attraction, and sexual identity in the United States: Data from the 2006–2008 National Survey of Family Growth*. (National Health Statistics Reports No. 36). National Center for Health Statistics. https://www.cdc.gov/nchs/data/nhsr/nhsr036.pdf
Charak, R., DiLillo, D., Messman-Moore, T. L., & Gratz, K. L. (2017). Latent classes of lifetime sexual victimization characteristics in women in emerging adulthood: Differential relationship with emotion dysregulation. *Psychology of Violence, 8*(5), 570–579. https://doii.org/10.1037/vio0000154
Chen, J., Walters, M. L., Gilbert, L. K., & Patel, N. (2020). Sexual violence, stalking, and intimate partner violence by sexual orientation, United States. *Psychology of Violence, 10*(1), 110–119. https://doi.org/10.1037/vio0000252
Cherlin, A. J., Burton, L. M., Hurt, T. R., & Purvin, D. M. (2004). The influence of physical and sexual abuse on marriage and cohabitation. *American Sociological Review, 69*(6), 768–789). https://doi.org/10.1177/000312240406900602
Chervonsky, E., & Hunt, C. (2017). Suppression and expression of emotion in social and interpersonal outcomes: A meta-analysis. *Emotion, 17*(4), 669–683. https://doi.org/10.1037/emo0000270
Chrisler, J. C., & Ferguson, S. (2006). Violence against women as a public health issue. *Annals of the New York Academy of Sciences, 1087*(1), 235–249. https://doi.org/10.1196/annals.1385.009
Cividanes, J. C., mellow, A. F., & Mello, M. F., (2019). Revictimization as a high-risk factor for development of posttraumatic stress disorder: A systematic review of the literature. *Brazilian Journal of Psychiatry, 41*(1), 82–89. https://doi.org/10.1590/1516-4446-2017-0013
Classen, C. C., Palesh, O. G., & Aggarwal, R. Sexual revictimization: A review of the empirical literature. *Trauma, Violence, & Abuse, 6*(2), 103–129. https://doi.org/10/1177/152438005275087
Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. (2nd Edition). Lawrence Erlbaum Associates.

Cohen, J. A., & Mannarino, A. P. (2015). Trauma-focused cognitive behavior therapy for traumatized children and families. *Child and Adolescent Psychiatric Clinics of North America, 24*(3), 557–570. https://doi.org/10.1016/j.chc.2015.02.005

Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child Abuse & Neglect, 36,* 528–541. https://doi.org/10.1016/j.chiabu.2012.03.007

Cohen, J. N., & Byers, E. S. (2015). Minority stress, protective factors, and sexual functioning of women in a same-sex relationship. *Psychology of Sexual Orientation and Gender Diversity, 2*(4), 391–403. https://doi.org/10.1037/sgd0000108

Collibee, C., & Furman, W. (2014). Impact of sexual coercion on romantic experiences of adolescents and young adults. *Archives of Sexual Behavior, 43*(7), 1431–1441. https://doi.org/10.1007/s1058-013-0256-0

Collimore, K. C., Asmundson, G. J. G., Taylor, S., & Jang, K. L. (2009). Socially related fears following exposure to trauma: environmental and genetic influences. *Journal of Anxiety Disorders, 23*(2), 240–246. https://doi.org/10.1016/j.janxdis.2008.07.006

Combs, J. L., Riley, E. N., Peterson, S. J., Jordan, C. E., & Smith, G. T. (2018). Pre-assault personality predicts the nature of adverse outcomes among sexual assault victims. *Journals of Studies on Alcohol and Drugs, 79*(2), 258–269. https://doi.org/10.15288/jsad.2018.79.258

Conron, K. J., Goldberg, S. K., & O'Neill, K. (2020). *Religiosity among LGBT adults.* UCLA School of Law, Williams Institute. https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Religiosity-Oct-2020.pdf

Cook, M. C., Morisky, D. E., Williams, J. K., Ford, C. L., & Gee, G. C. (2016). Sexual risk behaviors and substance use among men physically victimized by women. *American Journal of Public Health, 106*(7), 1263–1269. https://doi.org/10.2105/AJPH.2016.303136

Cortina, L. M., & Kubiak, S. P. (2006). Gender and posttraumatic stress: Sexual violence as an explanation for women's increased risk. *Journal of Abnormal Psychology, 115*(4), 753–759. https://doi.org/10.1037/0021-843X.115.4.753

Correll, J., Mellinger, C., McClelland, G. H., & Judd, C. M. (2020). Avoid Cohen's 'small', 'medium', and 'large' for power analysis. *Trends in Cognitive Science, 24*(3), 200–207. https;//doi.org/10.1016/j.tics.2019.12.009

Craig, L. A., Browne, K. D., Beech, A. R., & Stringer, I. (2006). Differences in personality and risk characteristics in sex, violent and general offenders. *Criminal Behavior and Mental Health, 16*(3), 183–194. https://doio/org/10.1002/cbm.618

Cramer, D. (2004). Emotional support, conflict, depression, and relationship satisfaction in a romantic partner. *The Journal of Psychology, 138*(6), 532–542. https://doi.org/10.3200/JRLP.138.6.532-542

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Crouch, J. L., Hanson, R. F., Saunders, B. E., Kilpatrick, D. G., & Resnick, H. S. (2000). Income, race/ethnicity, and exposure to violence in youth: Results from the

national survey of adolescents. *Journal of Community Psychology, 28*(6), 625–641. https://doi.org/10.1002/1520-6629(2000011)28:6<625::AID-JCOP6>3.0.CO;2-R

Crowley, S. L., & Fan, X. (1997). Structural equation modeling: Basic concepts and applications in personality assessment research. *Journal of Personality Assessment, 68*(3), 508–531. https://doi.org/10.1207/s15327752jpa6803_4

Crump, L., & Byers, E. S. (2017). Sexual well-being of sexual minority women in dating relationships who have experienced childhood sexual abuse and/or adolescent and adult sexual victimization. *Canadian Journal of Human Sexuality, 26*(2), 163–173. https://doi.org/10.31138/cjhs.262-a4

Curchin, K. (2019). The dilemma of rape avoidance advice: Acknowledging women's agency without blaming victims of sexual assault. *Women's Studies International Forum, 75*, 102240. https://doi.org/10.1016/j.wsif.2019.102240

D'Aniello, C., Nguyen, H. N., & Piercy, F. P. (2016). Cultural sensitivity as an MFT common factor. *The American Journal of Family Therapy, 44*(5), 234–244. https://doi.org/10.1080/01926187.2016.1223565

Dartnall, E., & Jewkes, R. (2013). Violence against women: The scope of the problem. *Best Practice & Research Clinical Obstetrics and Gynaecology, 27*(), 3–13. https://doi.org/10.1016/j.bpobgyn.2012.08.002

Davidson, C. (2018). Rape in context: Lessons for the United States from the international criminal court. *Cardozo Law Review, 39*(4), 1191–1238.

Davidson, M. M., & Gervais, S. J. (2015). Violence against women through the lens of objectification theory. *Violence Against Women, 21*(3), 330–354. https://doi.org/10.1177/1077801214568031

Davidson, R., & MacKinnon, J. G. (1993). *Estimation and inference in econometrics*. Oxford University Press.

Davies, L., Ford-Bilboe, M., Willson, A., Varcoe, C., Wuest, J., Campbell, J., & Scott-Storey, K. (2015). Patterns of cumulative abuse among female survivors of intimate partner violence: Links to women's health and socioeconomic status. *Violence Against Women, 21* (1), 30–48. http://doi.org/10/1177/1077801214564076

Davis, K. C., Gilmore, A. K., Stappenbeck, C. A., Balsan, M. J., George, W. H., & Norris, J. (2014). How to score the sexual experiences survey? A comparison of nine methods. *Psychology of Violence, 4*(4), 445–461. https://doi.org/10.1037/a0037494

DeMaris, A. (2018). Marriage advantage in subjective well-being: Causal effect of unmeasured heterogeneity? *Marriage and Family Review, 54*(4), 335–350. https://doi.org/10.1080/01494929.2017.1359812

Diener, E., Gohm, C. L., Suh, E., & Oishi, S. (2000). Similarity of the relations between marital status and subjective well-being across cultures. *Journal of Cross-Cultural Psychology, 31*(4), 419–436. https://doi.org/10.1177/0022022100031004001

Dimitrova, N., Pierrehumbert, B., Glatz, N., Torrisi, R., Heinrichs, M., Halfon, O., & Chouchena. (2010). Closeness in relationships as a mediator between sexual abuse in childhood or adolescence and psychopathological outcome in adulthood. *Clinical Psychology and Psychotherapy, 17*(3), 183–195. https://doi.org/10.1002/cpp.650

Dorahy, M. J., Corry, M., Shannon, M., Webb, K., McDermott, B., Ryan, M., & Dyer, K. F. W. (2013). Complex trauma and intimate relationships: The impact of shame, guilt and dissociation. *Journal of Affective Disorders, 147*(1–3), 72–79. https://doi.og/10.1016/j.jad.2012.10.010

Doumas, D. M., Pearson, C. L., Elgin, J. E., & McKinley, L. L. (2008). Adult attachment as a risk factor for intimate partner violence. *Journal of Interpersonal Violence, 23*(5), 616–634. https://doi.org/10.1177/088620507313526

Drauker, C. B., Martsolf, D. S., Ross, R., Cook, C. B., Stidham, A. W. & Mweemba, P. (2009). The essence of healing from sexual violence: A qualitative metasynthesis. *Research in Nursing & Health, 32*(), 366–378. https://doi.org/10.1002/nur.20333

Du Bois, S. N., Legate, N., & Kendall, A. D. (2019). Examining partnership–health associations among lesbian women and gay men using population-level data. *LGBT Health, 6*(1), 23–33. https://doi.org/10.1089/lgbt.2018.0158

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). *American Journal of Preventive Medicine, 28*(5), 430–437. https://doi.org/10.1016/j.amepre.2005.01.015

Dürrbaum, T., & Sattler, F. A. (2020). Minority stress and mental health in lesbian, gay, and bisexual youths: A meta-analysis. *Journal of LGBT Youth, 17*(3), 298–314. https://doi.org/10.1080/19361653.2019.1586615

Dworkin, E. R., Pittenger, S. L., & Allen, N. E. (2015). Disclosing sexual assault within social networks: A mixed-method investigation. *American Journal of Community Psychology, 57*(1–2), 216–228. https://doi.org/10.1002/ajcp.12033

Easterlin, R. A. (2003). Explaining happiness. *Proceedings of the National Academy of Sciences of the United States of America, 100*(19), 11176–11183. https://doi.rog/10.1073/pnas.1633144100

Edwards, K. M., Kearns, M. C., Gidycz, C. A., & Calhoun, K. S. (2012). Predictor of victim-perpetrator relationship stability following a sexual assault: A brief report. *Violence and Victims, 27*(1), 25–32. https://doi.org/10.1891/0886-6708.27.1.25

Edwards-Stewart, A., Rennebohn, S. B., DeSimone, J., Willey, B., Smolenski, D. J., & Hoyt, T. (2018). Relationship satisfaction and mental health treatment among active-duty military. *Couple and Family Psychology: Research and Practice, 7*(3), 201–211. https://doi.org/10.1037/cfp0000108

Elder, G. H. (1974). *Children of the great depression: Study in social structure and personality.* University of Chicago Press.

Elder, G. H. (1994). Time, human agency, and social change: Perspectives on the life course. *Social Psychology Quarterly, 57*(1), 4–15. https://doi.org/10.2307/2786971

Elder, G. H. (1998). The life course as developmental theory. *Child Development, 69*(1), 1–12. https://doi.org/10.2307.1132065

Elder, G. H., & Rockwell, R. C. (1979). The life-course and human development: An ecological perspective. *International Journal of Behavioral Development, 2*(1), 1–21. https://doi.org/10.1177/016502547900200101

Eldridge, N. S., & Gilbert, L. A. (1990). Correlates of relationship satisfaction in lesbian couples. *Psychology of Women Quarterly, 14*(1), 43–64. https://doi.org/10.1111/j.1471-6402.1990.tb00004.x

Elkit, A., & Christiansen, D. M. (2010). ASD and PTSD in rape victims. *Journal of Interpersonal Violence, 25*(8), 1470–1488. https://doi.org/10.1177/0886260509354587

Elliot, D. M., Mok, D. S., & Briere, J. (2004). Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. *Journal of Traumatic Stress, 17*(3), 203–211. https://doi.org/10.1023/B:JOTS.0000029263.11104.23

Etingen, B., Hill, J. N., Miller, L. J., Schwartz, A., LaVela, S. L., & Jordan, N. (2019). An exploratory pilot study to describe shared decision-making for PTSD treatment planning: The provider perspective. *Military Medicine, 184*(3–4), 467–475. https://doi.org/10.1093/milmed/usy407

Evans, S. E., Steel, A. L., Watkins, L. E., & DiLillo, D. (2014). Childhood exposure to family violence and adult trauma symptoms: The importance of social support from a spouse. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(5), 527–536. https://doi.org/10.1037/a0036940

Falconier, M. K., Jackson, J. B., Hilpert, P., & Bodenmann, G. (2015). Dyadic coping and relationship satisfaction: A meta-analysis. *Clinical Psychology Review, 42*, 28–46. https://doi.org/10.1016/j.cpr.2015.07.002

Faul, F., Erdfelder, E., Lang, A., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39*(2), 175–191. https://doi.org/https://doi.org/10.3758/bf03193146

Feldman, C. M., & Ridley, C. A. (2000). The role of conflict-based communication responses and outcomes in male domestic violence toward female partners. *Journal of Social and Personal Relationships, 17*(4–5). 552–573. https://doi.org/10.1177/0265407500174005

Ferree, M. M. (2010). Filling the glass: Gender perspectives on families. *Journal of Marriage and Family, 72*(3), 420–439. https://doi.org/10.1111/j.1741-3737.2010.00711.x

Few-Demo, A. L. (2014). Intersectionality as the "new" critical approach to feminist family studies: Evolving racial/ethnic feminisms and critical race theories. *Journal of Family Theory & Review, 6*(2), 169–183. https://doi.org./10.1111/jftr.12039

Few-Demo, A. L., & Allen, K. R. (2020). Gender, feminist, and intersectional perspectives on families: A decade in review. *Journal of Marriage and Family, 82*(1), 326–345. https://doi.org/10.1111/jomf.12638

Finkelhor, D., Hotaling, G. T., Lewis, I. A., & Smith, C. (1989). Sexual abuse and its relationship to later sexual satisfaction, marital status, religion, and attitudes. *Journal of Interpersonal Violence, 4*(4), 379–399. https://doi.org/10.1177/088626089004004001

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Re-victimization patterns in a national longitudinal sample of children and youth. *Child Abuse & Neglect, 31*, 479–502. https://doi.org/10.1016/j.chiabu.2006.03.012

Ford, J., & Soto-Morquez, J. (2016). Sexual assault victimization among straight, gay/lesbian, and bisexual college students. *Violence and Gender, 3*(2), 107–115. https://doi.org/10.1089/vio.2015.0030

Fraley, C. R., Vicary, A. M., Brumbaugh, C. C., & Roisman, G. I. (2011). Patterns of stability in adult attachment: Empirical test of two models of continuity and change. *Journal of Personality and Social Psychology, 101*(5), 974–992. https://doi.org/10.1037/a0024150

Frazier, P. A. (2003). Perceived control and distress following sexual assault: A longitudinal test of a new model. *Journal of Personality and Social Psychology, 84*(6), 1257–1269. https://doi.org/10.1037/0022-3514.84.6.1257

Frazier, P., Anders, S., Perera, S., Tomich, P., Tennen, H., Park, C., & Tashiro, T. (2009). Traumatic events among undergraduate students: Prevalence and associated symptoms. *Journal of Counseling Psychology, 56*(3), 450–460. https://doi.org/10.1037/a0016412

Frazier, P., Conlon, A., & Glaser, T. (2001). Positive and negative life changes following sexual assault. *Journal of Consulting and Clinical Psychology, 69*(6), 1048–1055. https://doi.org/10.1037//0022-006X.69.6.1048

Frazier, P., Steward, J., & Mortensen, H. (2004). Perceived control and adjustment to trauma: A comparison across events. *Journal of Social and Clinical Psychology, 23*(3), 303–324. https://doi.org/10.1521/jscp.23.3.303.35452

Fredman, S. J., Pukay-Martin, N. D., Macdonald, A., Wagner, A. C., Vorstenbosch, V., & Monson, C. M. (2016). Partner accommodation moderates treatment outcomes for couple therapy for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 84*(1), 79–87. https://doi.org/10.1037/ccp0000061

Fredman, S. J., Pukay-Martin, N. D., Macdonald, A., Wagner, A. C., Vorstenbosch, V., & Monson, C. M. (2016). Partner accommodation moderates treatment outcomes for couples therapy for posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology, 84*(1), 79–87. https://doi.org/10.1037/ccp0000061

Fredman, S. J., Vorstenbosch, V., Wagner, A. C., Macdonald, A., & Monson, C. M. (2014). Partner accommodation in posttraumatic stress disorder: Initial testing of the significant others' responses to trauma scale (SORTS). *Journal of Anxiety Disorders, 28*(4), 372–381. https://doi.org/10.1016/j.janxdis.2014.04.001

Fredriksen-Goldsen, K. I., Kim, H., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health, 103*(10), 1802–1809. https://doi.org/10.2105/AJPH.2012.301110

Fredriksen-Goldsen, K. I., Shiu, C., Bryan, A. E. B., Goldsen, J., & Kim, H. (2017). Health equity and aging of bisexual older adults: Pathways of risk and resilience. *Journals of Gerontology: Social Sciences, 72*(3), 468–478. https://doi.org/10.1093/geroonb/gbw120

Freedman, S. A., Gilad, M., Ankri, Y., Roziner, I., & Shalev, A. Y. (2015). Social relationship satisfaction and PTSD: Which is the chicken and which is the egg? *European Journal of Psychotraumatology, 6,* Article 28864. https://doi.org/10.3402.ejpt.v6.28864

Friesen, M. D., Woodward, L. J., Horwood, L. J., & Fergusson, D. M. (2009). Childhood exposure to sexual abuse and partnership outcomes at age 30. *Psychological Medicine, 40*(4), 679–688. https://doi.org/10.1017/S0033291709990389

Fritz, M. S., & MacKinnon, D. P. (2007). Required sample size to detect the mediated effect. Psychological Science, *18*(3), 233–239. https://doi.org/10.1111/j.1467-9280.2007.01882.x

Fulu, E., Jewkew, R., Roselli, T., & Moreno, C. G. (2013). Prevalence of and factors associated with male perpetration of intimate partner violence: Findings from the UN multi-country cross-sectional study on men and violence in Asia and the pacific. *Lancet Global Health, 1,* e208–e218. https://doi.org/10.1016/S2214-109X(13)70074-3

Garcia, G., & Rivera, M. (2014). Is race a factor of disparate health problems associated with violence against women? *Journal of Health Disparities Research & Practice, 7*(2), 10–23. https://doi.org/10.1092/ije/dyv096.573

Garcia-Granero, M. (2002). Breusch-Pagan & Koenker Test Macro. Raynald's SPSS Tools. http://spsstools.net/en/syntax/syntax-index/regression-repeated-measures/breusch-pagan-amp-koenker-test/

García-Moreno, C., Jansen, H. A. F. M., Watts, C., Ellsberg, M., & Heise, L. (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes, and women's responses.* World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/43310/9241593512_eng.pdf?sequence=1

Garnefski, N., & Kraaij, V. (2006). Relationships between cognitive emotion regulation and depressive symptoms: A comparative study of five specific samples. *Personality and Individual Differences, 40*(8), 1659–1669. https://doi.org/10.1016/j.paid.2005.12.2009

Garnefski, N., Kraaij, V., & Spinhoven, P. (2001). Negative life events, cognitive emotion regulation and emotional problems. *Personality and Individual Differences, 30*(8), 1311–1327. https://doi.org/10.1016/S0191-8869(00)00113-6

Gary-Little, B., & Burks, N. (1983). Power and satisfaction in marriage: A review and critique. *Psychological bulletin, 93*(3), 513–538. https://doi.org/10.1037/0033-2909.93.3.513

Gates, G. J. (2011). *How many people are lesbian, gay, bisexual, and transgender?* The Williams Institute, UCLA School of Law. https://escholarship.org/uc/item/09h684x2

Gaskin, C. J., & Happell, B. (2013). Power of mental health nursing research: A statistical analysis of studies in the International Journal of Mental Health Nursing. *International Journal of Mental Health Nursing, 22*(1), 69–75. https://doi.org/10.1111/j.1447-0349.2012.00845.x

Gaskin, C. J., & Happell, B. (2014). Power, effects, confidence, and significance: An investigation of statistical practices in nursing research. *International Journal of Nursing Studies, 51*(5), 795–806. https://doi.org/10.1016/j.ijnurstu.2013.09.014

Gemberling, T. M., Cramer, R. J., Miller, R. S., Stroud, C. H., Noland, R. M., & Graham, J. (2015). Lesbian, gay, and bisexual identity as a moderator of relationship functioning after sexual assault. *Journal of Interpersonal Violence, 30*(20), 3431–3452. https://doi.org/10.1177/08862605145638834

George, L. K. (1989). Stress, social support, and depression over the life-course. In K. S. Markides, & C. L. Cooper (Eds.) *Aging, Stress, and Health* (pp. 241–267). Wiley.

George, L. K. (1993). Sociological perspectives on life transitions. *Annual Review of Sociology, 19,* (), 353–373. https://doi.org/10.1146/annurev.so.19.080193.002033
Georgia, E. J., Roddy, M. K., & Doss, B. D. (2018). Sexual assault and dyadic relationship satisfaction: Direct associations through intimacy and mental health. *Violence Against Women, 24*(2), 936–951. https://doi.org/10/1177/1077801217727371
Gilboa-Schectman, E., & Foa, E. B. (2001). Patterns of recovery from trauma: The use of intraindividual analysis. *Journal of Abnormal Psychology, 110*(3), 392–400. https://doi.org/10.1037//0021-843x.110.3.392
Gilgun, J. F. (2006). Enduring themes of qualitative family research. *Journal of Family Theory & Review, 4*(2), 90–95. https://doi.org/10.1111/j.1756-2012.00118.x
Gill, A. (2018). Survivor-centered research: Towards an intersectional gender-based violence movement. *Journal of Family Violence, 33*(6), 559–562. https://doi.org/10/100/s10896-018-9993-0
Gill, J. M., Page, G. G., Sharps, P., & Campbell, J. C. (2008). Experiences of traumatic events and associations with PTSD and depression in urban health care-seeking women. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 85*(5), 693–706. https://doi.org/10.1007/s11524-008-9290-y
Godbout, N., Sabourin, S., & Lussier, Y. (2009). Child sexual abuse and adult romantic adjustment: Comparison of single- and multiple-indicator measures. *Journal of Interpersonal Violence, 24*(4), 692–705. https://doi.org/10.1177/0886260508317179
Gold, S. D., Dickstein, B. D., Marx, B. P., & Lexington, J. M. (2009). Psychological outcomes among lesbian sexual assault survivors: An examination of the roles of internalized homophobia and experiential avoidance. *Psychology of Women Quarterly, 33*(1), 54–66. https://doi.org/10.1111/j.1471-6402.2008.01474.x
Golding, J. M., Wilsnack, S. C., & Cooper, M. L. (2002). Sexual assault history and social support: Six general population studies. *Journal of Traumatic Stress, 15*(3), 187–197. https://doi.org/10.1023/A:1015247110020
Gómez, J. M., Gobin, R. L. (2020). Black women and girls & #MeToo: Rape, cultural betrayal, & healing. *Sex Roles, 82,* 1–12. https://doi.org/10.1007/s11199-019-01040-0
Gonzales, G., & Henning-Smith, C. (2017). Health disparities by sexual orientation: Results and implications from the behavioral risk fact surveillance system. *Journal of Community Health, 42*(6), 1163–1172. https://doi.org/10.1007/s10900-017-0366-z
Goodman-Williams, R., & Ullman, S. E. (2020). Posttraumatic stress disorder and measurement invariance in a sample of sexual assault survivors: Are symptom clusters stable over time? *Psychological Trauma: Theory, research, practice, and policy, 12*(4), 389–396. https://doi.org/10.1037/tra0000509
Gotta, G., Green, R-J., Rothblum, E., Solomon, S., Balsam, K., & Schwartz, P. (2011). Heterosexual, lesbian, and gay male relationships: A comparison of couples in 1975 and 2000. *Family Process, 50*(3), 353–376. https://doi.org/10.1111/j.1545-5300.2011.01365
Gottman, J. M., Levenson, R. W., Swanson, C., Swanson, K., Tyson, R., & Yoshimoto, D. (2003). Observing gay, lesbian and heterosexual couples' relationships:

Mathematical modeling of conflict resolution. *Journal of Homosexuality, 45*(1), 65–91. https://doi.org/10.1300/J082v45n01_04

Grenier, S., Payette, M., Gunther, B., Askari, S., Desjardins, F. F., Raymond, B., & Berbiche, D. (2019). Association of age and gender with anxiety disorders in older adults: A systematic review and meta-analysis. *International Journal of Geriatric Psychiatry, 34*(), 397–407. https://doi.org/10.1002/gps.5035

Grose, R. G., Chen, J. S., Roof, K. A., Rachel, S., & Yount, K. M. (2020). Sexual and reproductive health outcomes of violence against women and girls in lower-income countries: A review of reviews. *The Journal of Sex Research,* 1–20. https://doi.org/10.1080/00224499.2019.1707466

Guschlbauer, A., Grant Smith, N., DeStefano, J., & Soltis, D. E. (2019). Minority stress and emotional intimacy among individuals in lesbian and gay couples: Implications for relationship satisfaction and health. *Journal of Social and Personal Relationship, 36*(3), 855–878. https://doi.org/10.1177/0265407517746787

Gutermann, J., Schreiber, F., Matulis, S., Schwartzkopff, Deppe, J., & Steil, R. (2016). Psychological treatments for symptoms of posttraumatic stress disorder in children, adolescents, and young adults: A meta-analysis. *Clinical Child and Family Psychology Review, 19*(2), 77–93. https://doi.org/10.1007/s10567-016-0202-5

Hannan, S. M., & Orcutt, H, K. (2020). Emotion regulation in undergraduate students with posttraumatic stress symptoms: A multimethod study. *Psychological Trauma: Theory, Research, Practices, and Policy*, *12*(6), 643–650. https://doi.org/10.1037/tra0000577

Hara, K., Adams, A., Milland, K., Savage, S., Callison-Burch, C., & Bigham, J. P. (2018, April). *A data-driven analysis of workers' earnings on Amazon Mechanical Turk.* [Conference proceedings] *CHI-19: Proceedings of the 2018 CHI Conference on Human Factors in Computing Systems*. https://doi.org/10.1145/3173574.3174023

Haring-Hidore, M., Stock, W. A., Okun, M. A., & Witter, R. A. (1985). Marital status and subjective well-being: A research synthesis. *Journal of Marriage and Family, 47*(4), 947–953. https://doi.org/10.2307/352338

Harvey, M. R., Mishler, E. G., Koenen, K., & Harney, P. A. (2000). In the aftermath of sexual abuse: Making and remaking meaning in narratives of trauma and recovery. *Narrative Inquiry, 10*(2), 291–311. https://doi.org/10.1075/ni.10.2.02har

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707–730. https://doi.org/10.1037/a0016441

Hayes, A. F. (2012). PROCESS: A versatile computational tool for observed variable mediation, moderation, and conditional process modeling [White paper]. Retrieved from http://www.afhayes.com/public/process2012.pdf

Hayes, A. F., & Cai, L. (2007). Using heteroskedasticity-consistent standard error estimators in OLS regress: An introduction and software implementation. *Behavior Research Methods, 39*(4), 709–722. https://doi.org/10.3758/BF03192961

Hedtke, K. A., Ruggiero, K. J., Fitzgerald, M. M., Zinzow, H. M., Saunders, B. E., Resnick, H. S., & Kilpatrick, D. G. (2008). A longitudinal investigation of

interpersonal violence in relation to mental health and substance use. *Journal of Consulting and Clinical Psychology, 76*(4), 633–647. https://doi.org/10.1037/0022-006X.76.4.633

Hemmings, C. (2011). Why stories matter: The political grammar of feminist theory. Duke University Press.

Herman, J. (1992). *Trauma and Recovery*. BasicBooks

Hessinger, J. D., Longdon, M. J., & Baer, S. M. (2018). Evaluation of a shared decision-making intervention on the utilization of evidence-based psychotherapy in a VA outpatient PTSD clinic. *Psychological Sciences, 15*(4), 437–441. https://doi.org/10.1037/ser0000141

Holm Bramsen, R., Lasgaard, M., Koss, M. P., Elklit, A., & Banner, J. (2012). Adolescent sexual victimization: A prospective study on risk factors for first time sexual assault. *European Child & Adolescent Psychiatry, 21*(9), 521–526. https://doi.org/10.1007/s00787-012-0290-0

Hoyle, R. H. (2012). Path analysis and structural equation modeling with latent variables. In P. M. Camic, D. L. Long, A.T. Panter, D. Rindskopf, & K.J. Sher (Eds.), *APA handbook of research methods in psychology: Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 333–367). American Psychological Association. https://doi.org/10.1037/13620-000

Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural Equation Modeling: A Multidisciplinary Journal, 6*(1), 1–55. https://doi.org/10.1080/10705519909540118

Hyland, P., Shevlin, M., Hansen, M., Vallières, F., Murphy, H., & Elkit, A. (2016). The temporal relations of PTSD symptoms among treatment-seking victims of sexual assault: A longitudinal study. *Journal of Loss and Trauma, 21*(6), 492–506. https://doi.org/10.1080/15325024.2915.1117933

Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, & Board on the Health of Select Populations Staff. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. National Academies Press.

Jackson, C., Newall, M., & Chen, E. (2018, October 31). *Sexual assault: A new divided era of understanding*. IPSOS. https://www.ipsos.com/sites/default/files/2018-10/ipsos_npr_sexual_assault_topline_103118_final.pdf

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. National Center for Transgender Equality. https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF

Jansson, M., & Eduards, M. (2016). The politics of gender in the UN Security Council resolutions on women, peace and security. *International Feminist Journal of Politics, 18*(4), 590–604. https://doi.org/10.1080/14616742.2016.1189669

Jensen, E. B., Knapp, A., King, H., Armstrong, D., Johnson, S. L., Sink, L., & Miller, E. (2020, December). *Methodology for the 2020 demographic analysis estimates.* U.S. Census Bureau. https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/2020da_methodology.pdf

Jewkes, R., Sen, P., & García-Moreno, C. (2002). Sexual violence. In E. G. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), *World report on violence and health* (pp. 147–181). World Health Organization.

Johnson, S. M. (2002). *Emotionally Focused Couple Therapy with Trauma Survivors*. Guilford Press.

Johnson, S. M., Murphy, M. J., & Gidycz, C. A. (2017). Reliability and validity of the sexual experiences survey–short forms victimization and perpetration. *Violence and Victims, 32*(1), 78–92. https://doi.org/10.1891/0886-6708.VV-D-1500110

Jones, J. D., Fraley, R. C., Ehrlich, K. B., Stern, J. A., Lejuez, C. W., Shaver, P. R., & Cassidy, J. (2018). Stability of attachment style in adolescence: An empirical test of alternative developmental processes. *Child Development, 89*(3), 871–880. https://doi.org/10.1111/cdev.12775

Joshanloo, M. (2018). Gender differences in the predictors of life satisfaction across 150 nations. *Personality and Individual Differences, 135*, 312–315. https://doi.org/10.1016/j.paid.2018.07.043

Joyner, K., Manning, W., Prince, B. (2019). The qualities of same-sex and different-sex couples in young adulthood. *Journal of Marriage and Family, 81*(2), 487–505. https://doi.org/10.1111/jomf.12535

Jozkowski, K. N., & Sanders, S. A. (2012). Health and sexual outcomes of women who have experience forced or coercive sex. *Women & Health, 52*(2), 101–118. https://doi.org/10.1080/03630242.2011.649397

Kamp Dush, C. M., & Amato, P. R. (2005). Consequences of relationship status and quality for subjective well-being. *Journal of Social and Personal Relationships, 22*(5), 607–627. https://doi.org/10.1177/0265407505056438

Karatzias, T., Chouliara, Z., Power, K., Brown, K., Begum, M., McGoldrick, T., & Maclean, R. (2013). Life satisfaction in people with post-traumatic stress disorder. *Journal of Mental Health, 22*(6), 501–508. https://doi.org/10.3109/09638237.2013.819418

Kaufman, M. R., Tsang, S. W., Sabri, B., Budhathoki, C., & Campbell, J. (2019). Health and academic consequences of sexual victimization experiences among students in a university setting. *Psychology of Sexuality, 10*(1), 56–68. https://doi.org/10/1080/19419899.2018.1552184

Kayan Fadlelmula, F. (2011). Assessing power of structural equation modeling studies: A meta-analysis. *Education Research Journal, 1*(3), 37–42.

Kenny, D. A. (2019). Enhancing validity in psychological research. *American Psychologist, 74*(9), 1018–1028. https:/doi.org/10.1037/amp0000531

Kerridge, B. T., Pickering, R. P., Saha, T. D., Ruan, W. J., Chou, S. P., Zhang, H., Jung, J., & Hasin, D. S. (2017). Prevalence, sociodemographic correlates and DAM-5 substance use disorders and other psychiatric disorders among sexual minorities in the United States. *Drug and Alcohol Dependence, 170*, 82–92. https://doi.org/10.1016/j.drugalcdep.2016.10.038

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. e. (2005). Lifetime prevalence and age-of-onset distribution of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*(), 592–602. https://doi.org/10.1001/archpsych.62.6.593

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry, 52*(12), 1048–1060. https://doi.org/10.1002/archpsyc.1995.03950240066012

Khaddouma, A., Norona, J. C., & Whitton, S. W. (2015). Individual, couple, and contextual factors associated with same-sex relationship instability. *Couple and Family Psychology: Research and Practice, 4*(2), 106–125. https://doi.org/10.1037/cfp0000043

Kim, H., Fredriksen-Goldsen, K. I., Bryan, A. E. B., & Muraco, A. (2017). Social network types and mental health among LGBT older adults. *The Gerontologist, 57*, S84–S94. https://doi.org/10.1093/geront/gnw169

King, M., Semlyen, J., See Tai, S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8*, Article 70. https://doi.org/10.1186/1471-244X-8-70

Kirkner, A., & Ullman, S. E. (2020). Sexual assault survivors' post-traumatic growth: Individual and community-level differences. *Violence Against Women, 26*(15–16), 1987–2003. https://doi.org/10.1177/1077801219888019

Kline, R. (2015). *Principles and Practice in Structural Equation Modeling* (4th ed.). The Guilford Press.

Knudson-Martin, C., Huenergardt, D., Lafontant, K., Schaepper, J., Bishop, L., & Wells, M. (2015). Competencies for addressing gender and power in couple therapy: A socio emotional approach. *Journal of Marital and Family Therapy, 41*(2), 205–220. https://doi.org/10.1111/jmft,12068

Koss, M. P., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M. Ullman, S., West, C., & White, J. (2007). Revising the SES: A collaborative process to improve assessment of sexual aggression and victimization. *Psychology of Women Quarterly, 31*(4), 357–370. https://doi.org/10.1111/j.1471-6402.2007.00385.x

Koss, M. P., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M., Ullman, S., West, C., & White, J. (2008). Erratum: Revising the SES: A collaborative process to improve assessment of sexual aggression and victimization. *Psychology of Women Quarterly, 32*(4), 493. https://doi.org/10.1111/j.1471-6402.2008.00468

Koss, M. P., & Gidycz, C. A. (1985). Sexual experiences survey: Reliability and validity. *Journal of Consulting and Clinical Psychology, 53*(3), 422–423. https://doi.org/10.1037/0022-006X.53.3.422

Koverola, C., Proulx, J., & Battle, P. (1996). Family functioning as predictors of distress in revictimized sexual abuse survivors. *Journal of Interpersonal Violence, 11*(2), 263–280. https://doi.org/10.1177/088626096011002009

Kraaij, V., & Garnefski, N. (2019). The behavioral emotion regulation questionnaire: Development, psychometric properties and relationships with emotional problems and the cognitive emotion regulation questionnaire. *Personality and Individual Differences, 137*, 56–61. https://doi.org/10.1016/j.paid.2018.07.036

Kuhlman, K. R., Robles, T. F., Bower, J. E., & Carroll. (2018). Screening for childhood adversity: the what and when of identifying individuals at risk for lifespan health disparities. *Journal of Behavioral Medicine, 41*, 516–527. https://doi.org/10.007/s10865-018-9921-z

Kurdek, L. A. (2004). Are gay and lesbian cohabiting couples really different from heterosexual married couples? *Journal of Marriage and Family, 68*(4), 880–900. https://doi.org/10.1111/j.0022-2445.2004.00060.x

Kurdek, L. A. (2005). What do we know about gay and lesbian couples? *Current Directions in Psychological Science, 14*(5), 251–254. https://doi.org/10.1111/j.0963-7214.2005.00375.x

Kurdek, L. A. (2006). Differences between partners from heterosexual, gay, and lesbian cohabiting couples. *Journal of Marriage and Family, 68*(2), 509–528. https://doi.org/10.1111/j.1741-3737.2006.00268.x

Kurdek, L. A. (2007). The allocation of household labor by partners in gay and lesbian couples. *Journal of Family Issues, 28*(1), 132–148. https://doi.org/10.1177/0192513X06292019

Lakens, D. (2013). Calculating and reporting effect sizes to facilitate cumulative science: A practical primer for *t*-tests and ANOVAs. *Frontiers in Psychology, 4*, 863. https://doi.org/10.3389/fpsyg.2013.00863

Lambert, J. E., Holzer, J., & Hasbun, A. (2015). Association between parents' PTSD severity and children's psychological distress: A meta-analysis. *Journal of Traumatic Stress, 27*(1), 9–17. https://doi.org/10.1002/jts.21891

Langenderfer-Magruder, L., Walls, N. E., Kattari, S. K., Whitfield, D. L., Ramos, D. (2016). Sexual victimization and subsequent police reporting by gender identity among lesbian, gay, bisexual, transgender, and queer adults. *Violence and Victims, 31*(2), 320–331. https://doi.org/10.1891/0886-6708

Lassri, D., Luyten, P., Fonagy, P., & Shahar, G. (2018). Undetected scars? Self-criticism, attachment, and romantic relationships among otherwise well-functioning childhood sexual abuse survivors. *Psychological Trauma: Theory, Research, Practice, and Policy, 10*(1), 121–129. https://doi.org/10.1037/tra0000271

la Roi, C. L., Meyer, I. H., & Frost, D. M. (2019). Differences in sexual identity dimensions between bisexual and other sexual minority individuals: Implications for minority stress and mental health. *American Journal of Orthopsychiatry, 89*(1), 40–51. https://doi.org/10.1037/ort0000369

Laurent, H. K., Kim, H. K., & Capaldi, D. M. (2008). Interaction and relationship development in stable young couples: Effects of positive engagement, psychological aggression, and withdrawal. *Journal of Adolescence, 31*(6), 815–835. https://doi.org/10.1016/j.adolescence.2007.11.001

Lawson, D. M., Davis, D., Brandon, S. (2013). Treating complex trauma: Critical interventions with adults who experienced ongoing trauma in childhood. *Psychotherapy, 50*(3), 331–335. https://doi.org/10/1037/a0032677

Le, B., Dove, N. L., Agnew, C. R., Korn, M. S., & Mutso, A. A. (2010). Predicting nonmarital romantic relationship dissolution: a meta-analytic synthesis. *Personal Relationship, 17*(3), 377–390. https://doi.org/10.1111/j.1475-6811.2010.01285.x

LeBaron, C. D. L., Miller, R. B., Yorgason, J. B. (2014). A longitudinal examination of women's perceptions of marital power and marital happiness in midlife marriages. *Journal of Couple & Relationship Therapy, 13*(2), 93–113. https://doi.org/10.1080/15332691.2013.852492

LeBlanc, N. J., Dixon, L., Robinaugh, D. J., Valentinne, S. E., Bosley, H. G., Gerber, M. Q., & Marques, L. (2016). PTSD and romantic relationship satisfaction: Cluster-

and symptom-level analyses. *Journal of Traumatic Stress, 29*(3), 259–267. https://doi.org/10.1002/jts.22100

Leisenring, A. (2006). Confronting "victim" discourses: The identity work of battered women. *Symbolic Interaction, 29*(3), 307–330. https://doi.org/10.1525/si.2006.29.3.307

Leuchtmann, L., Milek, A., Bernecker, K., Nussbeck, F. W., Backes, S., Martine, M., Zemp, M., Brandstätter, & Bodenmann, G. (2019). Temporal dynamics of couples' communication behaviors in conflict discussions: A longitudinal analysis. *Journal of Social and Personal Relationships, 36*(9), 2937–2960. https://doi.org/10.1177/0265407518806582

Liang, B., Williams, L. M., & Siegel, J. A. (2006). Relational outcomes of childhood sexual trauma in female survivors: A longitudinal study. *Journal of Interpersonal Violence, 21*(1), 42–57. https://doi.org/10.1177/0886260505281603

Lindgren, S., & Lundström, R. (2010). Inside victims and outside offenders: Dislocation and intervention in the discourse of rape. *Social Semiotics, 20*(3), 309–324. https://doi.org/10.1080/10350331003722885

Lindquist, C. H., Crosby, C. M., Barrick, K., Krebs, C. P., & Settles-Reaves, B. (2016). Disclosure of sexual assault experiences among undergraduate women at historical black colleges and universities (HBCUs). *Journal of American College Health, 64*(6), 469–480. https://doi.org/10.1080/07448481.2016.1181635

Little, R. A. (1988). A test of missing completely at random for multivariate data with missing values. *Journal of the American Statistical association, 83*(404), 1198–1202. https://doi.og/10.2307/2290157

Littleton, H. L., Rhatigan, D. L., & Axsom, D. (2007). Unacknowledged rape: How much do we know about the hidden rape victim. *Journal of Aggression, Maltreatment & Trauma, 14*(4), 57–74. https://doi.org/10.1300/J146v14n04_04

Lipson, S. K., Raifman, J., Abelson, S., Reisner, S. L. (2019). Gender minority mental health in the U.S.: Results of a national survey on college campuses. *American Journal of Preventative Medicine, 57*(3), 293–301. https://doi.org/10.1016/j.amepre.2019.04.025

Long J. S., & Ervin, L. H. (2000). Using heteroscedasticity consistent standard errors in the linear regression model. *The American Statistician, 54*(3), 217–224. https://doi.org/10.2307/2685594

Long, P. J., & Jackson, J. L. (1993). Childhood coping strategies and the adult adjustment of female sexual abuse victims. *Journal of Child Sexual Abuse, 2*(2), 23–39. https://doi.org/10.1300/J070v02n02_03

Longobardi, C., & Badenes-Ribera, L. (2017). Intimate partner violence in same-sex relationships and the role of sexual minority stressors: A systematic review of the past 10 years. *Journal of Child and Family Studies, 26*(8), 2039–2049. https://doi.org/10.1007/s10826-017-0734-4

Lonsway, K. A., & Fitzgerald, L. F. (1994). Rape myths: In review. *Psychology of Women Quarterly, 18*(2), 133–164. https://doi.org/10.1111/j.1471-6402.1994.tb00448.x

Lowe, S. R., Walsh, K., Uddin, M., Galea, S., & Koenen, K. C. (2014). Bidirectional relationships between trauma exposure and posttraumatic stress: A longitudinal

study of Detroit residents. *Journal of Abnormal Psychology, 23*(3), 533–544. https://doi.org/10.1037/a0037046

Lucas, R. E., & Clark, A. E. (2006). Do people really adapt to marriage? *Journal of Happiness Studies, 7,* 405–426. https://doi.org/10.1007/s10902-006-9001-x

Lucas, R. E., Clark, A. E., Georgellis, Y., & Diener, E. (2003). Reexamining adaptation and the set point model of happiness: Reactions to changes in marital status. *Journal of Personality and Social Psychology, 84*(3), 527–539. https://doi.org/10.1037/0022-3154.84.3.527

Luterek, J. A., Bittinger, J. N., & Simpson, T. L. (2011). Posttraumatic sequelae associated with military sexual trauma in female veterans enrolled in VA outpatient mental health clinics. *Journal of Trauma and Dissociation, 12*(3), 261–274. https://doi.org/10.1080/15299732.2011.551504

Lyons-Ruth, K. (2003). Dissociation and the parent-infant dialogue: A longitudinal perspective from attachment research. *Journal of the American Psychoanalytic Association, 51*(3), 883–911. https://doi.org/10.1177/00030651030510031501

Macapagal, K., Bhatia, R., & Greene, G. J. (2016). Differences in healthcare access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health, 3*(6), 434–442. https://doi.org/10.1089/lgbt.2015.0124.

MacIntosh, H. B. (2017). Dyadic traumatic reenactment: An integration of psychoanalytic approaches to working with negative interaction cycles in couple therapy with childhood sexual abuse survivors. *Clinical Social Work Journal, 45*(4), 344–353. https://doi.org/10.1007/s10615-016-0607-0

Mackey, R. A., Diemer, M. A., & O'Brien, B. A. (2004). Relational factors in understanding satisfaction in the lasting relationships of same-sex and heterosexual couples. *Journal of Homosexuality, 47*(1), 111–136. htttps://doi.org/10.1200/J082v47n01_07

MacKinnon, C. A. (2014). Toward a renewed equal rights amendment: Now more than ever. *Harvard Journal of Law and Gender, 37,* 569–579.

MacKinnon, C. A. (2016). Rape redefined. *Harvard Law & Policy Review, 10*(2), 431–477.

Mak, J., Shires, D. A., Zhang, Q., Prieto, L. R., Ahmedani, B. K., Kattari, L., Becerra-Culqui, T. A., Bradlyn, A., Flanders, D., Getahun, D., Giammattei, S. V., Hunkeler, E. M., Lash, T. L., Nach, R., Quinn, V. P., Robinson, B., Roblin, D., Silverberg, M. J., Solvis, J, . . . Goodman, M. (2020). Suicide attempts among a cohort of transgender and gender diverse people. *American Journal of Preventative Medicine, 59*(4), 570–577. https://doi.org/10.1016/j.amepre.2020.03.026

Maker, A. H., Kemmelmeier, M., & Peterson, C. (2001). Child sexual abuse, peer sexual abuse, and sexual assault in adulthood: A multi-risk model of revictimization. *Journal of Traumatic Stress, 14*(2), 351–368. https://doi.org/10.1023/A:1011173103684

Marchetti, C. A. (2012). Regret and police reporting among individuals who have experienced sexual assault. *Journal of the American Psychiatric Nurses Association, 18*(1), 32–39. https://doi.org/10.1177/1078390311431889

Mark, K. P., & Vowels, L. M. (2020). Sexual consent and sexual agency of women in healthy relationships following a history of sexual trauma. *Psychology & Sexuality, 11*(4), 315–328. https://doi.org/10.1080/19419899.2020.1769157

Mark, K. P., Vowels, L. M., & Murray, S. H. (2018). The impact of attachment style on sexual satisfaction and sexual desire in sexually diverse sample. *Journal of Sex & Marital Therapy, 44*(4), 450–458. https://doi.org/10.1080/0092623X.2017.1405310

Markowitz, F. E. (2003). Socioeconomic disadvantage and violence: Recent research on culture and neighborhood control as explanatory mechanisms. *Aggression and Violent Behavior, 8*(2), 145–154. https://doi.org/10.1016/S1359-1789(01)00049-3

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., Thoma, B. C., Murray, P. J., D'Augelli, A. R., & Brent, D. A. (2011). Anxiety and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health, 49,* 115–123. https://doi.org/10.1016/j.adohealth.2011.02.005

Martin-Shorey, A., & Fromme, K. (2016). Trajectories of dating violence: Differences by sexual minority status and gender. *Journal of Adolescence, 49,* 28–37. httpd://doi.org/10.1016/j.adolescence.2016.02/008

Maseroli, E., Scavello, I., Campone, B., Di Stasi, V., Cipriani, S., Felciai, F., Camartini, V., Magini, A., Castellini, G., Ricca, V., Maggi, M., & Vignozzi, L. (2018). Psychosexual correlates of unwanted sexual experiences in women consulting for female sexual dysfunction according to their timing across the life span. *Journal of Sexual Medicine, 15*(12), 1789–1751. https://doi.org/10/1016/j.jsxm.2018.10.004

Matheson, K., Skomorovsky, A., Fiocco, A., & Anisman, H. (2007). The limits of 'adaptive' coping: Well-being and mood reactions to stressors among women in abusive dating relationships. *Stress, 10*(1), 75–95. https://doi.org/10.1080/10253890701208313

Matsakis, A. (2004). Trauma and its impact on families. In D. R. Catherall (Ed.) *Handbook of Stress, Trauma, and the Family* (pp. 15–31). Brunner-Routledge.

Maxwell, L., & Scott, G. (2014). A review of the role of radical feminist theories in the understanding of rape myth acceptance. *Journal of Sexual Aggression, 20*(1), 40–54. https://doi.org/10.1080/13552600/2013.773384

Maydeu-Olivares, A. (2017). Assessing the size of model misfit in structural equation models. *Psychometrika, 82*(3), 533–558. https://doi.org/10.1007/s11336-016-9552-7

Maydeu-Olivares, A., Shi, D., & Rosseel, Y. (2018). Assessing fit in structural equation models: A monte-carlo evaluation of RMSEA versus SRMR confidence intervals and tests of close fit. *Structural Equation Modeling: A Multidisciplinary Journal, 25*(3), 389–402. https://doi.org/10.1080/10705511.2017.1389611

McCredie, M. N., & Morey, L. C. (2019). Who are the turkers? A characterization of MTurk workers using the personality assessment inventory. *Assessment, 26*(5), 759–766. https:/doi.org/10.1177/1073191118760709

McEwan, S. L., de Man, A. F., & Simpson-Houseley, P. (2002). Ego-identity achievement and perception of risk in intimacy in survivors of stranger and

acquaintance rape. *Sex Roles, 47*(5/6), 281–287. https://doi.org/10.1023/A:1021390828178

McLaughlin, k. a., Hatzenbuehler, M. L., Xuan, Z., & Conron, K. J. (2012). Disproportionate exposure to early-life adversity and sexual orientation disparities in psychiatric morbidity. *Child Abuse & Neglects, 36*(9), 645–655. https://doi.org/10.1016/j.chiabu.2012.07.004

McMahon, S., Wood, L., & Cusano, J. (2019). Theories of sexual violence prevention. In W. T. O'Donohue & P. A. Schewe (Eds.), *Handbook of sexual assault and sexual assault prevention* (pp. 383–397). Springer. https://doi.org/10.1007/978-3-030-23645-8

McPhail, B. A. Feminist framework plus: Knitting feminist theories of rape etiology into a comprehensive model. *Trauma, Violence, & Abuse, 17*(3), 314–329. https://doi.org/10.1177/1524838015584367

Mellins, C. A., Walsh, K., Sarvet, A., Wall, M., Gilbert, L., Santelli, J. S., Thompson, M., Wilson, P. A., Khan, S., Benson, S., Bah, K., Kaufman, K. A., Reardon, L., & Hirsch, J. S. (2017). Sexual assault incidents among college undergraduates: Prevalence and factors associated with risk. *PLoS ONE, 12*(11), Article e0186471. https://doi.org/10.1371/journal.pone.0186471

Mendes, K., Ringrose, J., & Keller, J. (2018). #MeToo and the promise and pitfalls of challenging rape culture through digital feminist activism. *European Journal of Women's Studies, 25*(2), 236–246. https://doi.org/10/1177/1350506818765319

Mendizábal-Miranda, A., Castellvi, P., Parés-Badell, O., Almenara, J., Alonso, I., Blasco, M. J., Cabriá, A., Gabilondo, A., Gili, M., Lagares, C., Piqueras, J. A., Roca, M., Rodriguez-Marín, J., Rodríguez-Jiménez, T., Soto-Sanz, V., Vilagut, G., & Alonso, J. (2017). Sexual orientation and suicidal behaviour in adolescents and young adults: Systematic review and meta-analysis. *The British Journal of Psychiatry, 211*, 77–87. https://doi.org/10.1192/bjp.bp.116.196345

Meyer, I. H., Dietrich, J., & Schwartz, S. (2008). Lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay, and bisexual populations. *American Journal of Public Health, 98*(6), 1004–1006. https://doi.org/10.2105/AJPH.2006.096826

Miller, L. R. (2020). Single women's sexualities across the life course: The role of major events, transitions, and turning points. *Sexualities, 24*(1–2), 226–251. https://doi.org/10.1177/1363460720922754

Mlotek, A. E., & Paivio, S. C. (2017). Emotion-focused therapy for complex trauma. *Person-Centered & Experiential Psychotherapies, 16*(3), 198–214. https://doi.org/10.1080/14779757.2017.1330704

Mock, S. E., & Cornelius, S. W. (2007). Profiles of interdependence: The retirement planning of married, cohabiting, and lesbian couples. *Sex Roles, 56*(11–12), 793–800. https://doi.org/10.1007/s11199-007-9243-z

Mone, M. A., Mueller, G. C., & Mauland, W. (1996). The perceptions and usage of statistical power in applied psychology and management research. *Personnel Psychology, 49*(1), 103–120. https://doi.org/10.1111/j.1744-6570.tbt01793.x

Morris, M. C., Marco, M., Maguire-Jack, K., Kouros, C. D., Baily, B., Ruiz, E., & Im, W. (2019). Connecting child maltreatment risk with crime and neighborhood

disadvantage across time and place: A bayesian spatiotemporal analysis. *Child Maltreatment, 24*(2), 181–192. https://doi.org/10.1177/1077559518814364
Morrison, Z. (2007). Caring about sexual assault: The effects of sexual assault on families, and the effects on victim/survivors of family responses to sexual assault. *Family Matters, 76*(7), 55–63.
Mott, J. M., Stanley, M. A., Street, R. L., Grady, R. H., & Teng, E. J. (2014). Increasing engagement in nevidence-based PTSD treatment through shared decision-making: A pilot study. *Military Medicine, 179*(2), 143–149. https://doi.org/10.7205/MILMED-D-13-00363
Mulla, S. (2014). *The violence of care: Rape victims, forensic nurses, and sexual assault intervention.* New York University Press
Murphy, S. M., Amick-McMullan, A. E., Kilpatrick, D. G., Haskett, M. E., Veronen, L. J., Best, C. L., & Saunders, B. E. (1988). Rape victims' self-esteem: A longitudinal analysis. *Journal of Interpersonal Violence, 3*(4), 355–370. https://doi.org/10.1177/088626088003004001
Mustaine, E. E., Tewksbury, R., Huff-Corzine, L., Corzine, J., & Marshall, H. (2014). Community characteristics and child sexual assault: Social disorganization and age. *Journal of Criminal Justice, 42*(2), 173–183. https://doi.org/10.1016/j.jcrimjust.2013.06.016
Neff, L. A., & Karney, B. R. (2009). Stress reactivity to daily relationship experiences: How stress hinders adaptive processes in marriage. *Journal of Personality and Social Psychology, 97*(3), 435–450. https://doi.org/10.1037/a0015663
Neilson, E. C., Norris, J., Bryan, A. E. B., Stappenbeck, C. A. (2017). Sexual assault severity and depressive symptoms as longitudinal predictors of the quality of women's sexual experiences. *Journal of Sex & Marital Therapy, 43*(5), 463–478. https://doi.org/10.1080/0092623X.2016.1208127
Nelson Goff, B. S., Crow, J. R., Reisbig, A. M. J., & Hamilton, S. (2007). The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *Journal of Family Psychology, 21*(3). https://doi.org/10.1037/0893-3200.21.3.344
Newcomb, M. E., Hill, R., Buehler, K., Ryan, D. T., Whitton, S. W., & Mustanski, B. (2020). High burden of mental health problems, substance use, violence, and related psychosocial factors in transgender, non-binary and gender diverse youth and young adults. *Archives of Sexual Behavior, 49*(2), 645–659. https://doi.org/10.1007/s10508-019-01533-9
Newport, F. (2018, May 18). In U.S., Estimate of LGBT population rises to 4.5%. Gallup. https://news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx
Nguyen, T. P., Karney, B. R., & Bradbury, T. N. (2016). Childhood abuse and later marital outcomes: Do partner characteristics moderate the association? *Journal of Family Psycholoogy, 31*(1), 82–92. https://doi.org/10.1037/fam0000208
O'Callaghan, E., Shepp, V., Ullman, S. E., & Kirkner, A. (2019). Navigating sex and sexuality after sexual assault: A qualitative study of survivors of informal support providers. *Journal of Sex Research, 56*(8), 1045–1057. https://doi.or/g10.1080/00224499.2018.1506731
Orchowski, L. M., & Gidycz, C. A. (2015). Psychological consequences associated with positive and negative responses to disclosure of sexual assault among college

women: A prospective study. *Violence Against Women, 21*(7), 803–823. https://doi.org/10.1177/1077801215584068
Ornduff, S. R., Kelsey, R. M., & O'Leary, D. (2001). Childhood physical abuse, personality, and adult relationship violence: A model of vulnerability to victimization. *American Journal of Orthopsychiatry, 71*(3), 322–331. https://doi.org/10.1037/0002-9432.71.3.322
Otis, M. D., Riggle, E. D. B., & Rostosky, S. S. (2006). Impact of mental health on perceptions of relationship satisfaction and quality among female same-sex couples. *Journal of Lesbian Studies, 10*(1–2), 267–283. https://doi.org/10.1300/j155v10n01_14
Ozer, E. J., Best, S. R., Lipsey, T. L., Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin, 129*(1), 52–73. https://doi.org/10.1037.0033-2909.129.1.52
Pahl, K., Williams, S. Z., Lee, J. Y., Joseph, A., & Blau, C. (2020). Trajectories of violent victimization predicting PTSD and comorbidities among urban/ethnic/racial minorities. *Journal of Consulting and Clinical Psychology, 88*(1), 39–47. https://doi.org/10.1037/ccp0000449
Papalia, N. L., Luebbers, S., Ogloff, J. R. P., Cutajar, M., Mullen, P. E., & Mann, E. (2017). Further victimization of child sexual abuse victims: A laten class typology of re-victimization trajectories. *Child Abuse and Neglect, 66*, 112–129. https://doi.org/10.1016/j.chiabu.2017.02.040
Paquette, G., Martin-Storey, A., Bergeron, M., Dion, J., Daigneault, I., Hébert, M., Ricci, S., & Castonguay-Khounsombath, S. (2019). Trauma symptoms resulting from sexual violence among undergraduate student: Differences across gender and sexual minority status. *Journal of Interpersonal Violence*. https://doi.org/10.1080/10926771.2019.1710634
Parsons, J. T., Starks, T. J., DuBois, S., Grov, C., & Golub, S. A. (2013). Alternatives to monogamy among gay male couples in a community survey: Implications for mental health and sexual risk. *Archives of Sexual Behavior, 42*(2), 303–312. https://doi.org/10.1007/s10508-011-9885-3
Patrick, K., Heywood, W., Smith, A. M. A., Simpson, J. M., Shelley, J. M., Richters, J., & Pitts, M. K. (2013). A population-based study investigating the association between sexual and relationship satisfaction and psychological distress among heterosexuals. *Journal of Sex & Marital Therapy, 39*(1), 56–70. https://doi.org/10.1080/0092623X.2012.665819
Pegram, S. E., & Abbey, A. (2019). Associations between sexual assault severity and psychological and physical health outcome: Similarities and differences among African American and Caucasian survivors. *Journal of Interpersonal Violence, 34*(19), 4020–4040. https://doi.org/10.1177/0886260516673626
Peplau, L. A., & Fingerhut, A. W. (2007). The close relationship of lesbians and gay men. *Annual Review of Psychology, 58*, 405–424. https://doi.org/10.1146/annurev.psych.58.110405.085701
Peplau, L. A., & Spalding, L. R. (2003). The close relationships of lesbians, gay men, and bisexuals. In L. Garnets, & D. Kimmel (Eds.), *Psychological Perspectives on Lesbian, gay, and bisexual experiences* (pp.449–475), Columbia University Press

Pepping, C. A., Cronin, T. J., Halford, W. K., Lyons, A. (2019). Minority stress and same sex relationship satisfaction: The role of concealment motivation. *Family Process, 58*(2), 496–508. https://doi.org/10.1111/famp.12365

Perlman, M. R., Dawson, A. E., Dardis, C. M., Egan, T., & Anderson, T. (2016). The association between childhood maltreatment and coping strategies: The indirect effect through attachment. *The Journal of Genetic Psychology, 177*(5), 156–171. https://doi.org/10.1080/00221325.2016.1220912Peterson, C., DeGue, S., Florence, C., & Lokey, C. N. (2017). Lifetime economic burden of rape among U.S. adults. *American Journal of Preventive Medicine, 52*(6), 691–701. https://doi.org/10.1016/j.amepre.2016.11.014

Perry, N. S., Huebner, D. M., Baucom, B. R. W. & Hoff, C. C. (2016). The complex contribution of sociodemographics to decision-making power in gay male couples. *Journal of Family Psychology, 30*(8), 977–986. https://doi.org/10.1037/fam0000234

Peterson, C., Liu, Y., Kresnow, M., Florence, C., Merrick, M. T., DeGue, S., & Lokey, C. (2018). Short-term lost productivity per victim: Intimate partner violence, sexual violence, or stalking. *American Journal of Preventive Medicine, 55*(1), 106–110. https://doi.org/10.1016/j.amepre.2018.03.007

Pickover, A. M., Lipinksi, A. J., Dodson, T. S., Tran, H. N., Woodward, M. J., & Beck, J. G. (2014). Demand/withdraw communication in the context of intimate partner violence: Implications for psychological outcomes. *Journal of Anxiety Disorders 52*, 95–102. https://doi.org/10.1016/j.janxdis.2017.07.002

Pico-Alfonso, M. A., Garcia-Linares, I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E., & Martinez, M. (2006). The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health, 15*(5), 559–611. https://doi.org/10.1089/jwh.2006.15.599

Pitoňák, M. (2017). Mental health in non-heterosexuals: Minority stress theory and related explanation frameworks review. *Mental Health & Prevention, 5*, 63–73. https://doi.org/10.1016/j.mhp.2016.10.002

Pitre, N. Y., & Kushner, K. E. (2015). Theoretical triangulation as an extension of feminist intersectionality in qualitative family research. *Journal of Family Theory & Review, 7*(3), 284–298. https://doi.org/10.1111/jftr.12084

Polit, D. F., Sherman, R. E. (1990). Statistical power in nursing research. *39*(6), 365–369.

Pope, A. L., Murray, C. E., & Mobley, A. K. (2010). Personal, relational, and contextual resources and relationship satisfaction in same-sex couples. *The Family Journal: Counseling and Therapy for Couples and Families, 18*(2), 163–168. https://doi.org/10.1177/1066480710364501

Ports, K. A., Ford, D. C., & Merrick, M. T. (2016). Adverse childhood experiences and sexual victimization in adulthood. *Child Abuse & Neglect, 51*, 313–322. https://doi.org/10.1016/j.chiabu.2015.08.017

Post, L. A., Mezey, N. J., Maxwell, C., & Novalés Wibert, W. (2002). The rape tax: Tangible and intangible costs of sexual violence. *Journal of Interpersonal Violence, 17*(7), 773–782. https://doi.org/10.1177/088626050201700700 5

Potter, S., Howard, R., Murphy, S., & Moynihan, M. M. (2018). Long-term impacts of college sexual assaults on women survivors' educational and career attainments.

Journal of American College Health, 66(6), 496–507. https://doi.org/10.1080/07448481.2018.1440574

Prager, K. J., Pourcher, J., Shirvani, F. K., Parsons, J. A., & Allam, Z. (2019). Withdrawal, attachment security, and recovery from conflict in couple relationships. *Journal of Social and Personal Relationships, 36*(2), 573–598. https://doi.org/10.1177/0265407517737387

Preacher, K. J., Rucker, D. D., & Hayes, A. F. (2007). Addressing moderated mediation hypotheses: Theory, methods, and prescriptions. *Multivariate Behavioral Research, 42*(1), 185–227. https://doi.org/10.1080/00273170701341316

Proulx, C. M., & Buehler, C. (2007). Marital quality and personal well-being: A meta-analysis. *Journal of Marriage and Family, 69*(3), 576–593. https://doi.org/10.1111/j.1741-3737.2007.00393

Randall, M., & Venkatesh, V. (2015). The right to no: The crime of marital rape, women's human rights, and international law. *Brooklyn Journal of International Law, 41*(1), 153–202.

Raymond, N. M., & Hutchison, A. N. (2019). A pilot test of the effectiveness of an integrated sex positive education program. *American Journal of Sexuality Education, 14*(3), 315–341. https://doi.org./10.1080/15546128.2019.1584870

Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., Teesson, M., Bryant, R., McFarlane, A. C., Mills, K. L., Slade, T., Carragher, N., O'Donnell, M., & Forbes, D. (2011). Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *Journal of the American Medical Association, 306*(5), 513–521. https://doi.org/10.1001/jama.2011.1098

Rellini, A. H., Vujanovic, A. A., Gilbert, M., & Zvolensky, M. J. (2012). Childhood maltreatment and difficulties in emotion regulation: Associations with sexual and relationship satisfaction among young adult women. *Journal of Sex Research, 49*(5), 434–442. https://doi.org/10.1080/00224499.2011.56430

Rellini, A. H., Vujanovic, A. A., & Zvolensky, M. J. (2010). Emotional dysregulation: Concurrent relation to sexual problems among trauma-exposed adult cigarette smokers. *Journal of Sex & Marital Therapy, 36*(2), 137–153. https://doi.org/10.1080/00926230903554545

Resnick, H. S., Yehuda, R., & Acierno, R. (1997). Acute post-rape plasma cortisol, alcohol use, and PTSD symptom profile among recent rape victims. *Annals New York Academy of Sciences, 821,* 433–436. https://doi.org/10.1111/j.1749-6632.1997.tb48298.x

Resnick, H. S., Yehuda, R., Pitman, R. K., & Foy, D. W. (1995). Effect of previous trauma on acute plasma cortisol level following rape. *American Journal of Psychiatry, 152*(11), 1675–1677. https://doi.org/10.1176/ajp.152.11.1675

Riggs, S. A., Raiche, E., Creech, Z. K., McGuffin, J., & Romero, D. H. (2020). Attachment, couple communication, and family functioning in relation to psychological distress among service members and veterans. *Couple and Family Psychology: Research and Practice, 9*(4), 239–255. https://doi.org/10.1037/cfp0000154

Riley, K., & McLaren, S. (2019). Relationship status and suicidal behavior in gay men: The role of thwarted belongingness and hope. *Suicide and Life-Threatening Behavior, 49*(5), 1452–1462. https://doi.org/10.1111/sltb.12532

Rimes, K. A., Ion, D., Wingrove, J., & Carter, B. (2019). Sexual orientation differences in psychological treatment outcomes for depression and anxiety: National cohort study. *Journal of Consulting and Clinical Psychology, 87*(7), 577–589. https://doi.org/10.1037/ccp0000416

Rimes, K. A., Shivakumar, S., Ussher, G., Baker, D., Rahman, Q., & West, E. (2019). Psychosocial factors associated with suicide attempts, ideation, and future risk in lesbian, gay, and bisexual youth: The youth chances study. *Research Trends, 40*(2), 83–92. https://doi.org/10.1027/0227-5910/a000527

Roberts, A. L., Rosario, M., Corliss, H. L., Koenen, K. C., & Austin, S. B. (2012). Elevate risk of posttraumatic stress in sexual minority youths: Mediation by childhood abuse and gender nonconformity. *American Journal of Public Health, 102*(8), 1587–1593. https://doi.org/10.2105/AJPH.2011.300530

Robinaugh, R. J., & McNally, R. J. (2011). Trauma centrality and PTSD symptom severity in adult survivors of childhood sexual abuse. *Journal of Traumatic Stress, 24*(4), 483–486. https://doi.org/10.1002/jts.20656

Robles, T. F., Slatcher, R. B., Trombello, S. M., McGinn, M. M. (2014). Marital quality and health: A meta-analytic review. *Psychological Bulletin, 140*(1), 140–187. https://doi.org/10.1037/a0031859

Rome Statute of the International Criminal Court, A/Conf.183/9. (1993). https://iccforum.com/background/sgbv

Ross, L. E., Salway, T., Tarasoff, L. A., MacKay, J. M., Hawkins, B. W., & Fehr, C. P. (2018). Prevalence of depression and anxiety among bisexual people compared to gay, lesbian, and heterosexual individuals: A systematic review and meta-analysis. *The Journal of Sex Research, 55*(4–5), 435–456. https://doi.org/10.1080/00224499.2017.1387755

Rosse-Reed, D. E., Reno, J., Peñaloza, L., Green, D., & FitzGerald, C. (2019). Family, school, and peer support are associated with rates of violence victimization and self-harm among gender minority and cisgender youth. *Journal of Adolescent Health, 65*(6), 776–783. https://doi.org/10.1016/j.jadohealth.2019.07.013

Rossetto, K. R., & Tollison, A. C. (2017). Feminist agency, sexual scripts, and sexual violence: Developing a model for postgendered family communication. *Family Relations, 66*(1), 61–74. https://doi.org/10.1111/fare.12232

Rostosky, S. S., Korfhage, B. A., Duhigg, J. M., Stern, A. J., Bennett, L., & Riggle, E. D. B. (2004). Same-sex couple perceptions of family support: Consensual qualitative study. *Family Processes, 43*(1), 43–57. https://doi.org/10.1111/j.1545-5300.2004.04301005.x.

Rothman, E. F., Exner, D., & Baughman, A. L. (2011). The prevalence of sexual assault against people who identify as gay, lesbian, or bisexual in the United States: A systemic review. *Trauma, Violence, & Abuse, 12*(2), 55–66. https://doi.org/10.1177/1524838010390707

Rozee, P. D., & Koss, M. P. (2001). Rape: A century of resistance. *Psychology of Women Quarterly, 25*(4), 295–311. https;//doi.org/10.1111/1471-6402.00030

Rusu, P. P., Bodenmann, G., & Kayser, K. (2019). Cognitive emotion regulation and positive dyadic outcomes in married couples. *Journal of Social and Personal Relationship, 36*(1), 359–376. https://doi.org/10.1177/0265407517751664

Rusu, P. P., Nussbeck, F. W., Leuchtmann, L., & Bodenmann, G. (2020). Stress, dyadic coping, and relationship satisfaction: A longitudinal study disentangling timely stable from yearly fluctuations. *PLoS ONE, 15*(4), e0231133. https://doi.org/10.1371/journal.pone.0231133

Ruhlman, L. M., Gallus, K. L., & Durtschi, J. A. (2018). Exploring relationship satisfaction and attachment behaviors in single- and dual-trauma couples: A pilot study. *Traumatology, 24*(1), 27–35. https://doi.org/10.1037/trm0000129

Sahl, S., & Knoepke, C. (2018). Using shared decision making to empower sexually exploited youth. *Journal of the American Academy of Child and Adolescent Psychiatry, 57*(11), 809–812. https://doi.org/10.1016/j.jaac.2018.07.873

Samuel, D. (2020, July/August). Our role as systemic therapists in dismantling systemic racism. *Family Therapy Magazine*, 1–14.

Sandberg, D. A., Valdez, C. E., Engle, J. L., & Menghrajani, E. (2019). Attachment anxiety as a risk factor for subsequent intimate partner violence victimization: A 6-month prospective study among college women. *Journal of Interpersonal Violence, 37*(7), 1410–1427. https://doi.org/10.1177/0886260516651314

Sasaki, E., & Overall, N. (2021). Partners' withdrawal when actors behavior destructively: Implications for perceptions of partners' responsiveness and relationship satisfaction. *Personality and Social Psychology Bulletin, 47*(2), 307–323. https://doi.org/10.1177/0146167220926820

Schnarrs, P. W., Stone, A. L., Salcido, R., Georgiou, C., Zhou, X., & Nemeroff, C. B. (2020). The moderating effect of resilience on the relationship between adverse childhood experiences (ACEs) and quality of physical and mental health among adult sexual and gender minorities. *Behavioral Medicine, 46*(3–4), 366–374. https://do.org/10.1080.08964289.2020.1727406

Schoemann, A. M., Boulton, A. J., & Short, S. D. (2017). Determining power and sample size for simple and complex mediation models. *Social Psychological and Personality Science, 8*(4), 379–386. https://doi.org/10.1177/1948550617715068

Schroevers, M., Kraaij, V., & Garnefski, N. (2007). Goal disturbance, cognitive coping strategies, and psychological adjustment to different types of stressful life event. *Personality and Individual Differences, 43*(2), 413–423. https://doi.org/10.1016/j.paid.2006.12.099

Schultz, K., Cattaneo, L. B., Sabina, C., Brunner, L., Jackson, S., & Serrata, J. V. (2016). Key roles of community connectedness in healing from trauma. Psychology of Violence, 6(1), 42–48. https://doi.org/10.1037/vio0000025

Schwartz, R., McMahon, S., & Broadnax, J. (2015). A review of sexual assault information on college web sites. *Health Social Work, 40*(4), 275–282. https://doi.org/10.1093/hsw/hlvo64

Sherman, F. T. (2016). *Unintended consequences: Addressing the impact of domestic violence mandatory and pro-arrest policies and practices on girls and young women.* The National Crittenton Foundation. https://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=2050&context=lsfp

Shi, D., Maydeau-Olivares, A., & Rosseel, Y. (2020). Assessing fit in ordinal factor analysis models: SMSR vs. RMSEA. *Structural Equation Modeling: A Multidisciplinary Journal, 27*(1), 1–15. https://doi.org/10.1080/10705511.2019.1611434

Shnaider, P., Pukay-Martin, N. D., Sharma, S., Jenzer, T., Fredman, S. J., Macdonald, A., & Monson. (2015). A preliminary examination of the effects of pretreatment relationship satisfaction on treatment outcomes in cognitive-behavioral conjoint therapy for PTSD. *Couple and Family Psychology: Research and Practice, 4*(4), 229–238. https://doi.org/10.1037/cfp0000050

Shorey, R. C., Ferbes, J., Brasfield, H., & Stuart, G. L. (2012). Male dating violence victimization and adjustment: The moderating role of coping. *American Journal of Men's Health, 6*(3), 218–228. https://doi.org/10.1177/1557988311429194

Siddique, J. A. (2015). Age, marital status, and risk of sexual victimization: Similarities and differences across victim–offender relationships. *Journal of Interpersonal Violence, 31*(15), 2556–2575. https://doi.org/10.1177/0886260515579507

Siegel, J. A., & Williams, L. M. (2003). Risk factors for sexual victimization of women: Results from a prospective study. *Violence Against Women, 9*(8), 902–930. https://doi.org/10.1177/1077801203255130

Sigurvinsdottir, R., & Ullman, S. E. (2016). Sexual orientation, race, and trauma as predictors of sexual assault recovery. *Journal of Family Violence, 31*(7), 1–9. https://doi.org/10.1007/s10896-015-97938

Skinner, E. A., Edge, K., Altman, J., & Sherwood, H. (2003). Searching for the structure of coping: A review and critique of category systems for classifying ways of coping. *Psychological Bulletin, 129*(2), 216–269. https://doi.org/10.1037/0033-2909.129.2.216

Smith S. R., & Hamon, R. R. (2012). *Exploring family theories*. Oxford University Press.

Smith, J. R., Wokneh, A., & Yaya, S. (2020). Barriers and facilitators to help-seeking for individuals with posttraumatic stress disorder: A systematic review. *Journal of Traumatic Stress, 33*(2), 137–150. https://doi.org/10.1002/jts.22456

Smith, L. S., Stover, C. S. (2016). The moderating role of attachment on the relationship between history of trauma and intimate partner violence victimization. *Violence Against Women, 22*(6), 745–764. https://doi.org/10/1177/1077801215610863

Solomon, D. T., Combs, E. M., Allen, K., Roles, S., DiCarlo, S., Reed, O., Klaver, S. J. (2021). The impact of minority stress and gender identity on PTSD outcomes in sexual minority survivors of interpersonal trauma. *Psychology & Sexuality, 12*(1–2), 64–78. https://doi.org/10.1080/19419899.2019.1690033

Spencer, C., Mallory, A., Toews, M., Stith, S., & Wood, L. (2017). Why sexual assault survivors do not report to universities: A feminist analysis. *Family Relations, 66*(1), 166–179. https//doi.org/10.1111/fare.12241

Spencer, C., Stiith, S., Durtschi, J., & Toews, M. (2020). Factors related to college students' decision to report sexual assault. *Journal of Interpersonal Violence, 35*(21–22), 4666–4685. https://doi.org/10.1177/08862660517717490

Spencer, C. M., Anders, K. M., Toews, M. L., & Emanuels, S. K. (2020). Risk markers for physical teen dating violence victimization in the United States: A meta-analysis. *Journal of Youth and Adolescence, 49*(3), 575–589. https://doi.org/10.1007/s10964-020-01194-1

Statista. (2020, September). Percentage of same-sex couples in the United States in 2019, sorted by educational attainment. https://www.statista.com/statistics/325076/same-sex-couples-in-the-us-by-educational-attainment-of-householder/

Statista Research Department. (2021, January 20). Total population of the United States by gender 2010–2025. https://www.statista.com/statistics/737923/us-population-by-gender/

Steiger, J. H. (1990). Structural model evaluation and modification: An internal estimate approach. *Multivariate Behavioral Research, 25*(2), 173–180. https://doi.org/10.1207/s15327906mbr2501_4

Steiger, J. H., & Lind, J. C. (1980, May 28). *Statistically based tests for the number of common factors* [Paper presentation]. Annual Spring Meeting of the Psychometric Society, Iowa City, IA.

Stern, J. A., Fraley, R. C., Jones, J. D., Gross, J. T., Shaver, P. R., & Cassidy, J. (2018). Developmental processes across the first two years of parenthood: Stability and change in adult attachment style. *Developmental Psychology, 54*(5), 975–988. https://doi.10.1037/dev0000481

Sterzing, P. R., Edleson, J., Fisher, A., & Gartner, R. E. (2017). Polyvictimization prevalence rates for sexual and gender minority adolescents: Breaking down the silos of victimization research (ICPSR 36775). *National Institutes of Justice.*

Sterzing, P. R., Ratliff, G. A., Gartner, R. E., McGeough, B. L., & Johnson, K. C. (2017). Social ecological correlates of polyvictimization among a national sample of transgender, genderqueer, and cisgender sexual minority adolescents. *Child Abuse and Neglect, 67*(), 1–12. https://doi.org/10.1016/j.chiabu.2017.02.017

Stotzer, R. L. (2009). Violence against transgender people: A review of United States data. *Aggression and Violent Behavior, 14*, 170–179. https://doi.org/10.1016/j.avb.2009.01.006

Stronge, S., Overall, N. C., & Sibley, C. G. (2019). Gender differences in the associations between relationship status, social support, and wellbeing. *Journal of Family Psychology, 33*(7), 819–829. https://doi.org/10.1037/fam0000540

Stubenbort, K., Greeno, C., Mannarino, A. P., & Cohen, J. A. (2002). Attachment quality and post-treatment functioning following sexual trauma in young adolescents: A case series presentation. *Clinical Social Work Journal, 30*(1), 23–39. https://doi.org/10.1023/A:1014222327357

Sullivan, T. J., Feinstein, B. A., Marshall, A. D., & Mustanski, B. (2017). Trauma exposures, discrimination, and romantic relationship functioning: A longitudinal investigation among LGB young adults. *Psychology of Sexual Orientation and Gender Diversity, 4*(4), 481–490. https://doi.org/10.1037/sgd0000249

Swartout, K. M., Swartout, A. G., & White, J. W. (2011). A person-centered, longitudinal approach to sexual violence. *Psychology of Violence, 1*(1), 29–40. https://doi.org/10.1037/a0022069

Szalacha, L. A., Hughes, T. L., McNair, R., & Loxton, D. (2017). Mental health, sexual identity, and interpersonal violence: Findings from the Australian longitudinal women's health study. *BMC Women's Health, 17*, 1–11. https://doi.org/10.1186/s12905-017-0452-5

Tabachnick, B. G., & Fidell, L. S. (2012). Using multivariate statistics. (6th edition). Pearson Education.

Taft, C. T., Watkins, L. E., Stafford, J., Street, A. E., & Monson, C. M. (2011). Posttraumatic stress disorder and intimate relationship problems: A meta-analysis. *Journal of Consulting and Clinical Psychology, 79*(1), 22–23. https://doi.org/10.1037/a0022196Thelen, M. H., Sherman, M. D., & Borst, T. S. (1998). Fear of intimacy and attachment among rape survivors. *Behavior Modification, 22*(1), 108–116. https://doi.org/10.1177/01454455980221007

Terrell, K. R., Dugger, S. M. (2018). Exploring the relationship among mental health concerns, social support, and relationship satisfaction in female same-sex couples. *Journal of LGBT Issues in Counseling, 12*(1), 51–65. https://doi.org/10.1080/15538605.2018.1421113

Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology, 126*(1), 125–136. https://doi.org/10.1037/abn0000234

Testa, R. J., Sciacca, L. M., Hendricks, M. L., Goldblum, P., Bradford, J., & Bognar, B. (2012). Effects of violence on transgender people. *Professional Psychology: Research and Practice, 43*(5), 452–459. https://doi.org/10.1037/a0029604

Tjaden, P., & Theonnes, N. (2000). *Full report of the prevalence, incidence, and consequences of violence against women.* National Institute of Justice and the Centers for Disease Control and Prevention (NCJ 183781). Washington, DC: Government Printing Office.

Tjaden, P., & Theonnes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey*. National Institute of Justice. https://www.ncjrs.gov/pdffiles1/nij/210346.pdf

Tomasula, J. L., Anderson, L. M., Littleton, H. L., & Riley-Tillman, T. C. (2012). The association between sexual assault and suicidal activity in a national sample. *School Psychology Quarterly, 27*(2), 109–119. https://doi.org/10/1037/a0029162

Tudge, J. R. H., Mokrova, I., Hatfield, B. E., & Karnik, R. B. (2009). Uses and misuses of Bronfenbrenner's theory of human development. *Journal of Family Theory & Review, 1*(1), 198–210. https://doi.org/10.1111/j.1756-2589.2009.00026.x

Tummala-Narra, P., Kallivayalil, D., Singer, R., & Andreini, R. (2012). Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(6), 640–648. https://doi.org/10.1037/a0024929

Turchik, J. A., & Edwards, K. M. (2012). Myths about male rape: A literature review. *Psychology of Men & Masculinity, 13*(2), 211–226. https://doi.org/10.1037/a0023207

Ullman, S. E., Filipas, H. H., Townsend, S. m., & Starzynski, L. L. (2007). Psychosocial correlates of PTSD symptom severity in sexual assault survivors. *Journal of Traumatic Stress, 20*(5), 821–831. https://doi.org/10.1002/jts.20290

Ullman, S. E., O'Callaghan, E., Shepp, V., & Harris, C. (2020). Reasons for and experiences of sexual assault nondisclosure in a diverse community sample. *Journal of Family Violence, 35*(3–4), 839–851. https://doi.org/10.1007/s10896-020-00141-9

Ullman, S. E., & Peter-Hagene, L. (2014). Social reactions to sexual assault disclosure, coping, perceived control and PTSD symptoms in sexual assault victims. *Journal of Community Psychology, 42*(4), 495–508. https://doi.org/10.1002/jcop.21624

Ullman, S. E., & Peter-Hagene, L. (2016). Longitudinal relationships of social reactions, PTSD, and revictimization in sexual assault survivors. *Journal of Interpersonal Violence, 31*(6), 1074–1094. https://doi.org/10.1177/0886260514565069

Ullman, S. E., & Townsend, S. M. (2008). What is an empowerment approach to working with sexual assault survivors? *Journal of Community Psychology, 36*(3), 299–312. https://doi.org/10.1002/jcop.20198

United Nations General Assembly (1993, December 20). *Declaration of the Elimination of Violence Against Women*, A/RES/48/104.

United States Department of Justice (2011). *Criminal victimization in the United States, 2008 statistical tables: National crime victimization survey.* https://www.bjs.gov/content/pub/pdf/cvus08.pdf

U.S. Census Bureau. (2012). Statistical abstract of the United States: Section 1, population. https://www2.census.gov/library/publications/2011/compendia/statab/131ed/tables/pop.pdf

U.S. Census Bureau. (2013). 2010 Census of population and housing, summary population and housing characteristics, CPH-1-1. https://www2.census.gov/library/publications/2012/dec/cph-1-1.pdf

U.S. Census Bureau. (2020). Educational attainment in the United State: 2019. https://www.census.gov/content/census/en/data/tables/2019/demo/educational-attainment/cps-detailed-tables.html

Valente, P. K., Scrimshaw, E. W., Dolezal, C., LeBlanc, A. J., Singh, A. A., Bockting, W. O. (2020). Stigmatization, resilience, and mental health among a diverse community sample of transgender and gender nonbinary individuals in the U.S. *Archives of Sexual Behavior, 49*(7), 2649–2660. https://doi.org/10.1007/s10508-020-01761-4

Valentine, S. E., Shipherd, J. C. (2018). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clinical Psychology, Review, 66,* 24–38. https://doi.org/10.1016/j.cpr.2018/03.003

Vanassche, S., Swicegood, G., & Matthijs, K. (2013). Marriage and children as a key to happiness? Cross-national differences in the effects of marital status and children on well-being. *Journal of Happiness Studies, 14*(2), 501–524. https://ddoi.org/10.1007/s10902-012-9340-8

Vencill, J. A., Carlsoon, S., Iantaffi, A., & Miner, M. (2018). Mental health, relationships, and sex: Exploring patterns among bisexual individuals in mixed orientation relationship. *Sexual and Relationship Therapy, 33*(1–2), 14–33. https://doi.org/10.1080/14681994.2017.1419570

Verhofstadt, L. L. L., Lemmens, G. M. D., & Busse, A. (2013). Support-seeking, support-provision and support-perception in distressed married couples: A multi-method analysis. *Journal of Family Therapy, 35*(3), 320–339. https://doi.org/10.1111/1467-6427.12001

Vinson, E. S., & Oser, C. B. (2016). Risk and protective factors for suicidal ideation in African American women with a history of sexual violence as a minor. *Violence Against Women, 22*(14), 1770–1787. https://doi.org/10.1177/1077801216632614

Voller, E., Polusny, M. A., Noorbaloochi, S., Street, A., Grill, J., & Murdoch, M. (2015). Self0-efficacy, male rape myth acceptance, and devaluation of emotions in sexual trauma sequelae: Findings from a sample of male veterans. *Psychological Bulletin, 12*(4), 420–427. https://doi.org/10.1037/ser0000046

Wadsworth, P., & Records, K. (2013). A review of the health effects of sexual assault on African American women and adolescents. *Journal of Obstetric, Gynecological & Neonatal Nursing, 42*(3), 249–273. https://doi.org/10.1111/1552-6909.12041

Walker, E. C., Sheffield, R., Larson, J. H., & Holman, T. B. (2011). Contempt and defensiveness in couple relationships related to childhood sexual abuse histories for self and partner. *Journal of Marital and Family Therapy, 37*(1), 37–50. https://doi.org/10.1111/j.1752-0606.2009.00153

Walker, L., & Taylor, D. (2021, February). *Same-sex couple households: 2019* (ACSBR-005). United States Census Bureau.

Walsh, R. M., & Bruce, S. E. (2014). Reporting decisions after sexual assault: The impact of mental health variables. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(6), 691–699. https://doi.org/10.1037/a0036592

Walters, M. L., Chen, J., & Breiding, M. J. (2013). *The national intimate partner and sexual violence survey (NISCS): 2010 findings on victimization by sexual orientation.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/nisvs_sofindings.pdf

Ward, T., Polaschek, D. L. L., & Beech, A. R. (2006). *Theories of Sexual Offending.* Wiley

Warner, R. M. (2013). *Applied statistics: From bivariate through multivariate techniques* (2nd ed.). Sage.

Watson, B., & Halford, W. K. (2010). Classes of childhood sexual abuse and women's adult couple relationships. *Violence and Victims, 25*(4), 518–535. https://doi.org/10.1891/0886-6708.25.4.518

Wayment, H. A., & Peplau, L. A. (1995). Social support and well-being among lesbian and heterosexual women: A structural modeling approach. *Personality and Social Psychology Bulletin, 21*(11), 1189–1199. https://doi.org/10.1177/01461672952111007

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). The PTSD Checklist for DSM-5 (PCL-5). https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Weaver, T. L., & Clum, G. A. (1995). Psychological distress associated with interpersonal violence: A meta-analysis. *Clinical Psychology Review, 15*(2), 115–140. https://doi.org/10.1016/0272-7358(95)00004-9

Weiss, B. J., Garvert, D. Wi., & Cloitre, M. (2015). PTSD and trauma-related difficulties in sexual minority women: The impact of perceived social support. *Journal of Traumatic Stress, 28*(6), 563–571. https://doi.org/10.1002/jts.22061

Wen, I., Price, L. E., Spray, A. M., & Marmar, C. R. (2020). Mending broken bonds in military couples using emotionally focused therapy for couples: Tips and

discoveries. *Journal of Clinical Psychology, 76*(5), 865–870. https://doi.org/10.1002/jclp.22921
White-Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine, 147*, 222–231. https://doi.org/10.1016/j.socscimed.2015.11.010
Whitton, S. W., Dyar, C., Newcomb, M. E., & Mustanski, B. (2018). Romantic involvement: A protective factor for psychological health in racially-diverse young sexual minorities. *Journal of Abnormal Psychology, 127*(3), 265–275. https://doi.org/10.1037/abn0000332
Whitton, S. W., Godfrey, L. M., Crosby, S., & Newcomb, N. E. (2020). Romantic involvements and mental health in sexual and gender minority emerging adults assigned female at birth. *Journal of Social and Personal Relationships, 37*(4), 1340–1361. https://doi.org/10.1177/0265407519898000
Widom, C. P., Czaja, S. J., Dutton, M. A. (2008). Childhood victimization and lifetime revictimization. *Child Abuse & Neglect, 32*(8), 785–796. https://doi.org/10.1016/j.chiabu.2007.12.006
Williams, L. M. (2003). Understanding child abuse and violence against women. *Journal of Interpersonal Violence, 18*(4), 441–451. https://doi.org/10.1177/0886260502250842
Wilson, L. C., & Miller, K. E. (2015). Meta-analysis of the prevalence of unacknowledged rape. *Trauma, Violence, & Abuse,17*(2), 149–159. https://doi.org/10.1177/1524838015576391
Wilson, L. C., Newins, A. R., & White, S. W. (2017). The impact of rape acknowledgement on survivor outcomes: The moderating effects of rape my acceptance. *Journal of Clinical Psychology, 74*(6), 926–939. https://doi.org/10.1002/jclp.22556
Wise, A. E., Smith, B. C., Armelie, A. P., Boarts, J. M., & Delahanty, D. L. (2019). Age moderates the relationship between source of social support and mental health in racial minority lesbian, gay, and bisexual youth. *Journal of Health Psychology, 24*(7), 888–897. https://doi.org/10.1177/1359105316686667
Wolitzky-Taylor, K. B., Resnick, H. S., Armstadter, A. B., McCauley, j. l., Ruggiero, K. L., & Kilpatrick, D. G. (2012). Reporting rape in a national sample of college women. *Journal of American College Health, 59*(7), 582–587. https://doi.org/10.1080/07448481.2010.515634
Wood, L. A., & Rennie, H. (1994). Formulating rape: The discursive construction of victims and villains. *Discourse & Society, 5*(1), 125–148. https://10.1177/0957926594005001006
Woodin, E. M. (2011). A two-dimensional approach to relationship conflict: Meta-analytic findings. *Journal of Family Psychology, 25*(3), 325–335. https://doi.org/10.1037/a0023791
World Health Organization. (2002). *World report on violence and health.* https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf;jsessionid=769280F7355CD0066D75CFCBFFC92DD0?sequence=1
World Health Organization. (2017, November 29). Violence against women: Key facts. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

Xu, Y., Olfson, M., Villegas, L., Okuda, M., Wang, W., Liu, S., & Blanco, C. (2013). A characterization of adult victims of sexual violence: Results from the national epidemiological survey for alcohol and related conditions. *Psychiatry: Interpersonal and Biological Process*, *76*(3), 223–240. https://doi.org/10.1521/psyc.2013.76.3.223

Yakubovich, A. R., Stöckl, H., Murrary, J., Melendez-Torres, G. J., Steinert, J. I., Glavin, C. E. Y., & Humphreys, D. K. (2018). Risk and protective factors for intimate partner violence against women: Systematic review and meta-analyses of prospective-longitudinal studies. *American Journal of Public Health, 108*(7), e1–e11. https://doi.org/10.2105/AJPH.2018.304428

Yang, J., Miller, T. R., Zhang, N., LeHew, B., & Peek-Asa, C. (2014). Incidence and cost of sexual violence in Iowa. *American Journal of Preventive Medicine, 47*(2), 198–202. https://doi.org/10.1016/j.amepre.2014.04.005

Zeeman, L., Sherrif, N., Browne, K., McGlynn, N., Mirandola, M., Gios, L., Davis, R., Sanchez-Lambert, J., Aujean, S., Pinto, N., Farinella, F., Donisi, V., Niedźwiedzka-Stadnik, M., Rosińska, M., Pierson, A., Amaddeo, F., & the Health4LGBTI Network. (2019). A review of lesbian, gay, bisexual, trans, and intersex (LGBTI) health and healthcare inequalities. *European Journal of Public Health, 29*(5), 974–980. https://doi.org/10.1093/eurpub/cky226

Zhang, Z. (2014). Monte Carlo based statistical power analysis for mediation models: Methods and software. *Behavioral Research Methods, 46*(4), 1184–1198. https://doi.org/10.3758/s13428-013-0424-0

Ziobrowski, H. N., Buka, S. L., Bryn Austin, S., Sullivan, A. J., Horton, N. J., Simone, M., & Field, A. E. (2020). Using latent class analysis to empirically classify maltreatment according to the developmental timing, duration, and cooccurrence of abuse types. *Child Abuse & Neglect, 107*(), 104574. https://doi.org/10.1016/j.chiabu.2020.104574

Zverina, M., Stam, H. J., & Babins-Wagner, R. (2011). Managing victim status in group therapy for men: A discourse analysis. *Journal of Interpersonal Violence,* 26(14), 2834–2855. https://doi.org/10.1177/0886260510390949

Zweig, J. M., Crockett, L. J., Sayer, A., & Vicary, J. R. (1999). A longitudinal examination of the consequences of sexual victimization for rural young adult women. *Journal of Sex Research, 36*(4), 396–409. https://doi.org/10.1080/00224499909552012

VITA

1. EDUCATION

Doctor of Philosophy — FAMILY SCIENCES, FAMILY PROCESSES
Graduate Certificate: Gender and Women's Studies
University of Kentucky
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Master of Science — FAMILY SCIENCES, COUPLE & FAMILY THERAPY
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August 2017

Bachelor of Science — PSYCHOLOGICAL SCIENCES
Minors: Business Administration, Conflict Analysis and Trauma Studies
Undergraduate Certificate: Conflict Resolution
Kansas State University
Manhattan, Kansas
May 2015

CLINICAL EXPERIENCE

2018 – Present — THERAPIST
Parker Relationship Center
Lexington, Kentucky
Supervisor: Dr. Trent Parker

2015 – 2017 — INTERN THERAPIST
University of Kentucky Family Center
Lexington, Kentucky

2015 – 2017 — INTERN THERAPIST
William Wells Brown Elementary, Lansdowne Elementary
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2. PROFFESIONAL POSITIONS HELD

2021 – 2023 — POSTDOCTORAL CLINICAL FELLOW
The Family Institute at
Northwestern University, Evanston, Illinois

2018 – Fall 2020 — FAMILY SCIENCES REPRESENTATIVE Graduate Student Congress
University of Kentucky, Lexington, KY

2017 – 2020	EDITORIAL ASSISTANT *Family Relations: Interdisciplinary Journal of Applied Family Sciences* National Council on Family Relations, Minneapolis, Minnesota Editor: Dr. Jason Hans
2015 – Present	GRADUATE ASSISTANT Department of Family Sciences University of Kentucky, Lexington, Kentucky Major Professor: Dr. Jason Hans

3. SCHOLASTIC AND PROFESSIONAL HONORS

Fall 2019	2019–2020 GRADUATE STUDENT RESEARCH ACTIVITY AWARD, $750 Phil Richards Endowment Fund College of Agriculture, Food and Environment University of Kentucky, Lexington, Kentucky
2018	2018 HES GRADUATE STUDENT RESEARCH DAY, $50 School of Human Environmental Sciences University of Kentucky, Lexington, Kentucky
2019 – Fall 2020	STUDENT REPRESENTATIVE Curriculum Committee Department of Family Sciences University of Kentucky, Lexington, Kentucky
2019 – Fall 2020	DIRECTOR OF NATIONAL LEGISLATIVE AFFAIRS External Affairs Committee Graduate Student Congress University of Kentucky, Lexington, Kentucky
2018 – Fall 2020	EXTERNAL AFFAIRS COMMITTEE Graduate Student Congress University of Kentucky, Lexington, Kentucky
2018	2018 HES GRADUATE STUDENT RESEARCH DAY, $50 School of Human Environmental Sciences University of Kentucky, Lexington, Kentucky
Spring 2019	STUDENT REPRESENTATIVE Faculty Search Committee Department of Family Sciences University of Kentucky, Lexington, Kentucky
2016 – 2017	PRESIDENT Student Association of Couple and Family Therapy Department of Family Sciences University of Kentucky, Lexington, Kentucky

2015 – 2017 TREASURER
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4. PROFESSIONAL PUBLICATIONS

REFEREED JOURNAL ARTICLES

Butterbaugh, S. M., Ross, B. D., & **Campbell, A. M.** (2020). My money and me: Attaining financial independence in emerging adulthood through a conceptual model of identity capital theory. *Contemporary Family Therapy: An International Journal, 42*(1), 33–45. https://doi.org/10.1007/s10591-019-09515-8

Summers, K., **Campbell, A. M.,** Gray, H., Zetmeir, L. A., & Nelson Goff, B. S. (2017). A comparison study of low trauma disclosure participants and their partners in army couples. *Marriage and Family Review, 53*(6), 556–575. https://doi.org/10.1080/01494929.2016.1247762

NON-ACADEMIC PUBLICATIONS

Campbell, A. M. (Feb 2019). UK Graduate Student Congress opposes proposed change to the definition of sex. *University of Kentucky Graduate Student Digest*.

MANUSCRIPTS IN PREPARATION

Smith, A. G., **Campbell, A. M.,** Elswick, A., & Kostelic, A. (in preparation). Sex, drugs, and long-term care: Perceptions of preparedness among long-term care administrators working in Kentucky.

Campbell, A. M., Hans, J. D. (in preparation). Perceptions of victim responsibility: Rape myth acceptance among college students, military personnel, and general population respondents.

Campbell, A. M., Hans, J. D. (in preparation). Adult attachment dimensions and disorganization mediate the link between sexual violence and PTSD symptom severity.

5. ALYSSA CAMPBELL