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Protective Sex: How Being In-Tune with Sexuality Protects Young Women

By

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Chapter 1: Introduction

"When a woman becomes a scholar there is usually something wrong with her sexual organs."

- Frederich Nietzsche

"Women are intellectually like children … the natural reason is that she is more carnal than a man, as is clear from her many carnal abominations."

– Heinrich Kramer

"There is a moral panic in America over young women's sexuality – and it's entirely misplaced. Girls 'going wild' aren't damaging, the myth of sexual purity is. The lie of virginity – the idea that such a thing even exists – is ensuring that young womens' perception of themselves is inextricable from their bodies, and that their ability to be moral actors is absolutely dependent on their sexuality."

- Jessica Valenti

In her book, *The Purity Myth,* Jessica Valenti (2010) touches on a very important point concerning women and their sexuality: for better or for worse, the two are inextricably tied together. For centuries, the female body, particularly in the context of sexuality, has been used as the main attribute through which her worth is evaluated. A sexually "pure" woman is seen as "good" and "moral", while a sexually experienced woman is generally associated with evil and manipulation. This is illustrated clearly by archetypes found throughout literature and art, such as the evil sorceress or the wife who manipulate the king. Society's message is clear: A woman's sexuality, her body, is synonymous with her worth as a person.

Women are not the same as men. Women in Western society are often held to different standards than men, standards which tend to focus on the female body and sexual desirability, including sexual "purity" (Frederickson & Roberts, 1997). We can see these differences manifest in the different issues facing women today. For example, women are more likely to suffer from internalizing disorders such as depression, anxiety, and eating disorders (McLean et al., 2011) Furthermore, women are too often the victim of sexual violence, where sexuality is used to control women and cause them harm. In a national survey of intimate partner violence, one in two women were found to be the victims of some form of sexual violence other than rape (Breiding et al., 2014). This same survey found that one in five women had experienced sexual assault, and that one in five women had suffered severe physical violence from an intimate partner. Although they can also be victims of sexual violence, men suffer such crimes at much lower rates than women (Breiding et al., 2014), making sexual violence an issue which affects women on a much greater scale than it affects men.

Higher rates of sexual violence against women has not developed in a vacuum. In their article on sexual economics, based on social exchange theory, Baumeister and Twenge (2004) argue that sex is a commodity, one which men want and women give access to. The article assumes that women have few resources other than sex to offer to a more privileged, male consumer base. Suppression of sexuality is blamed on other women trying to keep the "market value" for sex high so that they can gain more resources from male consumers. As Rudman and Fetterolf (2014) pointed out, this viewpoint reflects an attitude held by many in Western society that places women in a position unequal to that of men and reduces their value to only what their bodies can offer

men. This has been found not to be a natural state of society, but rather a vestige of the patriarchy within which Western women live. In multiple studies, Rudman and colleagues first demonstrated that men attempted to control women's sexuality through treating sex as a commodity and enforcing sexual double standards. Men, more so than women, endorsed a sexual double standard which created negative consequences for women who engaged in sexual behavior (Rudman, Fetterolf & Sanchex, 2012). Furthermore, women were not found to view sex as a female commodity, and that men were more active in creating barriers to sexual equality in women (Rudman & Fetterolf, 2014). Taken together, these findings reveal a vast difference in the ways men and women view female sexuality: while women view sexuality as part of their experiences as human beings, men view female sexuality as a commodity which they can "purchase" at the right price (whether it be monetary or social, such as relationships) regardless of the feelings of the woman. This attitude creates a society where men feel entitled to sex and women are objectified as being only providers of sex. Thus, sexual violence is perpetuated and justified through the dehumanization of women.

Sexual violence against women has dire consequences for a woman's well-being. As well as other mental disorders, survivors of sexual violence are much more likely to suffer from PTSD (Chivers-Wilson, 2006; Golding, 1999). In most cases, sexual assault is perpetrated by someone who is known by the survivor. When such a betrayal is coupled with a societal response which blames the victim, it is unsurprising that sexual assault results in an overwhelmingly traumatic experience for the victim. This clearly demonstrates the darker side of sexuality: as sexuality is used as a weapon against women, their mental health suffers as much or more than their bodies.

If sexuality has been the strongest driver for controlling women, as can be evidenced by the high rates of sexual violence directed at women, then it stands to reason that through sexuality a woman can take back her own agency. As will be discussed in further detail, the reduction of women to sexual objects leads to many of the mental health issues experienced by women. However, if a women can define her self-worth through something other than sexual desirability, her worth is then not subject to the sexual standards imposed upon her by others. Through the ability to take agency of her sexuality, a woman is able to then take control of one of the greatest mechanisms of the oppression of women: sex.

Purpose of the Study

This study aims to explore the link between a woman's agency over her own sexuality and positive psychological outcomes, particularly resilience. In this study, sexual agency is defined through measures of sexual awareness. Positive psychological outcomes are defined through measures of psychopathology, as well as resilience. My goal is to provide practitioners with a perspective on how best to incorporate sexuality within their practice with women, specifically in the context of female empowerment and recovery from adversity, although, because sex is practiced by both genders, our findings can also be applied to men. However, I argue that female sexuality is core to a woman's concept of self and empowerment, and that, through taking control of their own sexuality, women can better reclaim their lives.

Definitions

Operationalizing abstract concepts, such as "sexual agency," can be difficult. Keeping in mind the holistic view of sexuality as a product of biological, social and

psychological factors, I therefore define “sexual agency” in terms of sexual awareness, especially positive sexual awareness. This is because sexual awareness requires assertiveness, insight, and conscientiousness; all factors necessary in taking agency over one’s sexual expression. Resilience is defined through the constructs measured by the Resilience Scale for Adults (Friborg et al., 2003), meaning that resilience will be seen as a process through which the individual uses both individual and environmental resources to overcome adversity and maintain good psychological adjustment. Psychological adjustment is defined as having the absence of symptoms of depression, anxiety, somatization and disordered eating. Through these definitions, I am able to measure and quantify constructs which are abstract in nature.

Chapter 2: Theoretical Background and Literature Review

Women, Sex, and Well-being

Sexual behavior is common. At some point in their lives, most people will engage in some form of sexual behavior. In their study, Siegel, Klein and Roghmann (1999) found that almost 90% of women had ever had sex by their fourth year of college. 69% of college women reported having oral sex, and 11% reported having anal sex. Owen et al. (2010) found that 50.9% of college women had reported "hooking up" in the past year, indicating that engaging in sexual behavior is the norm for college women. This could be for a variety of reasons, the most intuitive, perhaps, being that having sex is enjoyable.

Men, too, often engage in sexual behavior. However, researchers have noted the differences in perception between male and female sexual behavior (Baumeister & Twenge, 2002; Baumeister & Vohs, 2004; Rudman & Fetterolf, 2014). While women are often ostracized for their sexual behavior, men are encouraged to engage in sexual behavior. These double standards have been shown to exist even in college students and are favored by men more than women (Rudman, Fetterolf & Sanchez, 2012). There is little doubt that the sexual double standard affects a woman's perception of her own sexuality more than it affects a man's. While little stigma is attached to men who engage in sexual behavior, especially casual sexual behavior, women often pay a high social price (Rudman, Fetterolf & Sanchez, 2012; Baumeister & Twenge, 2002). This has led many to believe that sexual behavior is harmful to women, even though there is little evidence for such a belief.

With sexual behavior, both casual and not, becoming more common among college women, many researchers have investigated the effects of such behavior on the

mental health and well-being of women. Results from these investigations have been mixed (Vrangalova, 2014; Bersamin et al, 2014; Owen, Quirk & Fincham 2014). When "hooking up" was defined as having intercourse with a partner whom was known less than a week, Bersamin et al. (2014) found that casual sex was negatively correlated with well-being and positively correlated with psychological distress. However, sex with a virtual stranger (i.e., someone who the person has known less than a week) is rare amongst college students (Bersamin et al, 2014), making this definition of "hooking up" problematic. For example, other studies have included "friends with benefits" in their definition of "hooking up" (Owen et al., 2010; Vrangalova, 2014). Furthermore, the study could not determine whether the psychological distress was a result of "hooking up" or whether "hooking up" was another activity done by those in psychological distress.

When defined as a range of sexual behavior (from kissing to sexual intercourse) involving a partner with whom one does not have a committed relationship, other studies have found positive reactions after "hooking up" depending on sociological and personality factors. Owen, Quirk and Fincham (2014) found that many college women reported positive sexual/romantic and social/academic reactions after engaging in casual sex, though participants with higher ratings for loneliness and anxious attachment reported less positive reactions to casual sex. Similarly, Vrangalova (2014) found that those who engaged in casual sex because of autonomous reasons (i.e., they wanted to have casual sex) reported an increase in well-being after "hooking up." In contrast, those who engaged in casual sex because of external pressure or expectations had decreased psychological well-being. This finding expands on a study by Vrangalova and Ong (2014) which found that college students who had positive attitudes about casual sex

tended to reap more benefits after engaging in it than students with negative attitudes. Other psychological factors also seem to influence reactions to "hooking up." These studies demonstrate the intricacy with which attitudes about sexuality are intertwined with psychological reactions to sexual behavior. Sexuality is not only a process of the body; it is deeply connected with the mind as well.

Though the study of "hooking up" and its effects on well-being has been studied in recent years, studies which explore the benefits of sexuality on physical and mental health, as well as relationships have been ongoing for decades. A growing body of research has been finding that sexuality plays an integral role in a person's well-being, and that healthy sexuality is healthy for the mind, the body, and relationships (Diamond & Huebner, 2012; Levin, 2007; Rosen & Bachmann, 2008).

Few studies have rigorously tested the relationship between physical health and sexual health, but many findings from studies have indicated a moderate relationship between the two (Levin, 2007; Diamond & Huebner, 2012). In their review, Diamond and Huebner (2012), found several studies that supported increased longevity in both men and women. Interestingly, the effects of sex on longevity have been found to be greater for women who had a greater *enjoyment* of sexual activityq (Palmore, 1982). Levin (2007) reported that several studies have found that more frequent orgasms have been found to decrease mortality risk. Although the exact mechanisms of increased longevity are unclear, the relationship between sexual activity and longevity may be explained by improved cardiovascular health as observed in individuals with a greater frequency of sex as well as greater emotional satisfaction (Diamond & Huebner, 2012; Levin, 2007).

A relationship between longevity, cardiovascular health and sexuality has been supported in the literature, however, it is difficult to determine a causal relationship because of the variety of variables surrounding greater sexual frequency and satisfaction. For example, it may not be that sexual functioning itself improves physical health, but rather that having good physical health improves sexual functioning and increases desire to engage in sexual activities. Furthermore, relationship satisfaction has been found to have a strong link with sexual satisfaction. Because relationship satisfaction has also been found to have several benefits for long-term health, this may also explain greater sexual satisfaction (Diamond & Huebner, 2012). In both same-sex and mixed-sex relationships, greater sexual satisfaction has been found to be one of the biggest predictors of relationship well-being (Holmberg, Blair & Phillips, 2010). It could be that increased sexuality is not so much a causal factor for physical health, but rather an indicator of a satisfying intimate relationship, which has been shown to increase health and longevity. However, benefits of sexuality differ in women within different relationships. Litzinger and Gordon (2005), for example, found that have shown that couples characterized by poor communication and trust seem to use positive sexual interaction to buffer the negative aspects of their relationship and that frequent sexual contact can compensate for these aspects. Diamond and Huebner (2010) argue that meaningful sexual contact (not contact used as a means to avoid intimacy or exert power over one another) has a notably positive effect on relationship health. This indicates that sexuality alone has a causal effect on the health of a relationship.

As well as impacting physical well-being and relational well-being, healthy sexuality has been found to have a positive effect on psychological well-being and

satisfaction with life, a relationship which has been well established in the literature. In their commentary, Rosen and Bachmann (2008) stated that the relationship between sexual satisfaction and well-being in women was an important and under-studied topic in health psychology. Across studies, Rosen and Bachman (2008) noticed a strong relationship between a woman's happiness and sexual satisfaction, including the rating of sex as the highest indicator of happiness for women. This relationship has found continued support in the literature. Holmberg, Blair and Phillips (2010) reported that sexual satisfaction was a predictor of well-being in women in both same-sex and mixed-sex relationships. Donaghue (2009) found that a passionate/romantic sexual self-schema (one which indicated a greater interest and enjoyment of sex), was significantly associated with positive affect and greater life satisfaction. In one longitudinal study, sexual well-being was found to have not only a greater association with well-being over time, but also well-being from moment to moment (Stephensen & Mesten, 2015). Furthermore, this relationship has not only been found in America, but across countries. Carrobles, Gámez-Guadix and Almendros (2011) found that, in a sample of Spanish women, greater sexual assertiveness, sexual confidence, frequency of orgasm, all predicted a greater sexual satisfaction, which in turn predicted a greater perception of well-being. Lastly, in a survey of 13,882 women across 29 different countries, Laumann et al. (2006) found a positive relationship between sexual satisfaction and psychological well-being across all countries. Interestingly, a study by Owen, Fincham and Moore (2014) found that students who reported more depressive symptoms also reported improved well-being after engaging in casual sex, while students who reported fewer depressive symptoms reported decreased well-being after casual sex. This suggests that

sex has possibly been used as a tool for emotional regulation, lending further support to the relationship between sexuality and well-being. Across cultures and ages, sexual satisfaction has been found to have a strong relationship to psychological well-being.

Despite findings of strong correlations between sexuality and psychological well-being, few studies have managed to demonstrate causation. Through its longitudinal design, Stephensen and Mesten's (2015) study was able to suggest causation, but could not confirm that sexual well-being causes psychological well-being and satisfaction with life. Throughout the literature, researchers have called for a better way to capture whether or not sexuality has a causal relationship with psychological well-being (Diamond & Huebner, 2012; Levin, 2007; Rosen & Bachmann, 2008). Although this causal relationship has not yet been established, there have been some suggestions as to the mechanism by which sexual well-being could cause psychological well-being. Levin (2007) discussed the effects of hormones released during sexual intercourse and masturbation. According to Levin (2007), prolactin and oxytocin both play roles in the calming feeling one gets after orgasm. Because of the calming effect of sexual intercourse and masturbation, it could be that either may play a role in stress reduction, thus serving to negate some of the negative effects of stress and anxiety. Oxytoxin also increases intimacy between partners, strengthening relationships (Olff et al., 2013). In support of this mechanism, Diamond and Huebner's (2012) review found some literature that indicated that sexuality is used as a means for emotional regulation. Some studies have found that those who experience depression or anxiety are more likely to engage in sexual behavior. Negative affect has also been found to *increase* arousal in some women, indicating that these women may use sex to regulate their mood (Owen, Fincham &

Moore, 2011). Though the relationship between sexual behavior and mood regulation has not yet been explored thoroughly, there is some support that this may be the case. Since mood regulation heavily influences psychological well-being, these studies suggest a possible mechanism through which sexuality influences psychological well-being.

Despite decades of study on the topic, the exact relationship between sexuality and psychological well-being, as well as the mechanisms through which such a relationship occurs, remains largely unexplored. Mechanisms through which this relationship may occur, such as increased intimacy and hormonal influences, have been identified, but not sufficiently researched. Furthermore, few studies have explored alternative explanations for the relationship between sexuality and psychological well-being which may explain other variables affecting the two. Sexuality and psychological well-being are both extremely complex processes which are affected by many variables; it is difficult to determine which factors affect which of the variables. For this reason, different perspectives concerning female sexuality and mental health are needed.

A Feminist Perspective

Feminist theory examines human behavior and the social environment within the context of a patriarchal culture. Feminist theory has made great advances in interpreting issues and research through the lens of women's experience of oppression by the patriarchy (Lay & Daily, 2007). Rooted in conflict theory, feminist theory posits that in order to maintain power, men within a patriarchal society consciously or unconsciously engage in the oppression of women, causing women to face injustice and barriers to equality with men. Since the 1950s, feminist theory and feminist literature has been in constant development, taking on new challenges and perspectives to explain culture and

its effect on human behavior. Lay & Daily (2007) write about eight branches of feminist theory spanning across issues of race, politics, economy, and sexual identity, as well as gender.

Many see these differing branches as controversies which have arisen in feminist theory. As Dietz (2003) writes, there is "no agreement in feminist theory about the meaning and status of the concept 'women' or 'gender identity,' nor even consensus about how to appropriate gender as a useful category of analysis (p. 400)." It is true that, as we have gained a better understanding of what it means to be "woman", whether that be biological sex or gender identity or other factors of female identity, we have come across new problems and new issues facing gender. Not only has our concept of gender changed over the years, but also roles assigned to genders, creating new barriers to equality for women to face. For example, first wave feminism focused on a woman's right to vote because, at the time, women were completely excluded from any societal or political discourse. As women became more included in society, entering the workforce and engaging in politics, second wave feminism was needed in order to ensure equal pay and equal opportunity for education and vocation. Today, women are still facing issues concerning support for the household, while they work, reproductive rights, and increased awareness and intervention of issues, such as sexual assault and domestic violence, issues that required a third and possibly fourth wave of feminist activism. Currently, "post-millennial" feminism (McNeil, 2010) not only acknowledges more subjective and post-modern perspectives of gender and society, but also calls for a re-examination of the role of biology and nature in feminism. However, many of the current controversies and discourse in feminist theory can also be seen as a reflection of the great diversity and

intersectionality present in feminist thought. This line of feminist thought argues that gender is not the only issue feminism should address, but also the way gender interacts with race, ethnicity, class and sexual identity (Shields, 2008).

The aspects of sexuality that encompass concepts such as sexual behavior and sexual agency are not as thoroughly discussed in feminist literature and have only recently been given attention in feminist theory. Although feminism was at the forefront of the "pro-sex" movement of the 1980s and 1990s, much of this movement was silenced and excluded from mainstream feminist discourse (Glick, 2000). Though many feminists view sexual expression as a form of liberation, there was an ironic tendency to be controlling of what kind of expression was liberating or not. This illustrates a deep-set problem with the way members of our society, even feminist activists, view sex and women: that women are sexual objects, passive beings which must express their sexuality in a way that is appealing to others.

Objectification Theory

Objectification Theory, developed by Fredrickson and Roberts (1997), uses a feminist theoretical framework to understand how a woman's experience is influenced by a culture which objectifies the female body. As an application of this framework, Objectification Theory posits that the experience of being treated as a "body" to be consumed by others (i.e., an object) results in a number of adverse psychological experiences for women (Fredrickson & Roberts, 1997). In other words, because women are often treated as consumable objects, they often evaluate themselves in terms of how attractive they are to others, rather than considering their worth in terms of the self. Objectification occurs through the over-sexualization of women's bodies through obvious

means, such as sexualization in the media, and also through more subtle means, such as the objectifying gaze (Fredrickson & Roberts, 1997). Through this process, the woman not only loses her inherent worth as a person capable of acting and thinking in her own right, but also her agency to influence the world around her. Furthermore, through the process of self-objectification (Fredrickson & Roberts, 1997), women internalize objectifying and sexualizing messages from the media and society. This causes the woman to minimize her own self-worth, seeing herself only in terms of her attractiveness to others and denying her personal attributes.

Increasing evidence has shown that self-objectification negatively affects a woman's mental health (Tiggeman & Williams, 2012). In their comprehensive study of objectification theory, Tiggeman and Williams (2012) found that self-objectification strongly predicted depressed mood and disordered eating in young women as well as, though less strongly, predicting sexual dysfunction. Other studies have supported this finding. Self-objectification has been found to significantly predict the development of disordered eating in both adolescent girls and young women (Calogero, Davis & Thompson, 2005; Tiggeman & Slater, 2015). The body shame and appearance anxiety caused by self-objectification have been shown to increase depressed mood (Szymanski & Henning, 2007). Furthermore, Carr, Green and Ponce (2015) argue that objectification of women's bodies can also exacerbate serious mental illnesses, such as schizophrenia and borderline personality disorder, by further marginalizing women whose mental illness has already marginalized them. To support this assertion, Carr, Greene and Ponce (2015) cite several studies which have demonstrated a possible link between objectification and serious mental illness.

As well as having a serious effect on women's mental health, the objectification of women has the consequence of dehumanizing women, thus putting them at increased risk for sexual victimization and intimate partner violence. About one in five American women has survived rape in her lifetime (Breiding et al., 2011), and the rampant objectification of women in Western society is likely a large contributor to this number. In a series of three studies, Vaes, Paldino and Puvia (2011) examined the relationship between sexual objectification and dehumanization of women. The first study in the series verified that women who are sexually objectified are dehumanized by both men and women. The second study demonstrated that women tend to distance themselves from sexually objectified women, creating a sub-group of dehumanized women, while men dehumanize sexually objectified women towards whom they feel sexual attraction. The second study also found that men dehumanize personalized women they are sexually attracted to, indicating that sexual attraction to a women is linked to objectification of that woman. The third and final study found that, when primed with sexual stimuli, men are likely to objectify women and attend mostly to their physical attractiveness rather than personal attributes. Taken together, these findings indicate that sexual objectification dehumanizes women and reduces them to sexual objects to be consumed by men. When a woman is dehumanized, she it is easier to victimize. Rudman and Mescher (2012) found that men who objectify women are more willing to rape or sexually harassed them, and have more negative attitudes towards survivors of rape. Though this study could not establish a causal relationship between objectifying women and the proclivity to sexually assault them, it does demonstrate a strong relationship between the two. Because survivors of sexual assault are likely to suffer from disorders such as anxiety and PTSD

(Chivers-Wilson, 2006), this creates another pathway through which objectification of women leads to mental illness.

Transcending Objectification: Linking Sexuality and Resilience

Mental health is one of the most pertinent issues facing women today. Though women suffer from most mental illness at the same rates as men, some mental illnesses, such as depression, anxiety and disordered eating, are diagnosed in women at nearly twice the amount as in men (American Psychiatric Association, 2013; McLean et al, 2011). Trauma also seems to impact women more than men; though women report fewer traumatic events, they have greater instances of PTSD (Tolin & Foa, 2006). The increase of PTSD experienced by women can be explained in part (though not in full) by the higher instances of sexual trauma that women experience. However, sexual activity seems to have a mitigating effect on mental health in women. As discussed before, some studies have suggested that sex is used as a tool for emotional regulation, increasing feelings of well-being after experiencing negative affect (Owen, Fincham & Moore, 2014; Diamond & Huebner, 2012). However, the reason why sex can be used as a regulatory tool remains unexplored.

One possibility is a connection between female sexual agency and resilience which protects women from mental illness. As Fredrickson and Roberts (1997) have stated, to objectify a women is to take away her agency and strip her of her personal attributes, including strengths. A large body of literature has supported this assertion through demonstrating increased shame, depression and anxiety among women who have been exposed to objectification (Calogero, Davis & Thompson, 2005; Szymanski & Henning, 2007; Tiggeman & Williams, 2012; Tiggeman & Slater, 2015). On the other

hand, women who demonstrate healthy and assertive sexuality have been shown to exhibit better psychological adjustment (Carrobles, Gámez-Guadix and Almendros, 2011; Stephensen and Mesten, 2015). This could be because healthy and assertive sexuality requires a woman to take control of her own sexuality, thus de-objectifying herself and becoming an agent in her own right. The literature on resilience has demonstrated a similar process, where an individual, despite suffering trauma and extreme stress, is able to take control of his/her life, overcoming adversity and developing into a well-adjusted adult (Zolkoski & Bullock, 2012).

Though the study of resilience has been ongoing for several decades, the most influential work was a study done by Werner (1992), where infants of Hawaiian and Asian descent were studied from birth to adulthood. Although these children suffered a fair amount of hardship, many of them were able to develop into functional, healthy adults. From this study, resilience found its first constructs. Resilience has generally been defined as achieving functional outcomes despite exposure to adversity (Smith-Osborne, 2007). Though there is some disagreement in the literature over the precise mechanisms of resilience, resilience generally occurs in the context of risk factors, such as poverty and poor social support, and protective factors, such as personal competence and family cohesion (Smith-Osborne, 2007; Zolkoski & Bullock, 2012). To be resilient is to "bounce back" from adversity in the presence of these risk and protective factors, achieving a normal state of development rather than remaining in a state of dysfunction (Smith-Osborne, 2007). Much of the resilience literature focuses on resilience as either a process through which one overcomes adversity, or as a set of traits that protect one from adversity (Zolkoski & Bullock, 2012). Both perspectives have been shown to explain

good mental health outcomes despite adversity. In a meta-analysis of sixty studies, Hu, Zhang and Wang (2015) confirmed that trait resilience, the intrapsychic properties of resilient people, was related to positive mental health outcomes. However, Froborg et al. (2003) found that external factors, such as family cohesion and interpersonal competence, also proved to be protective against poor mental health outcomes.

In social work, the study of resilience focuses on resilience as a process, rather than a set of traits a person is born with. Resilience cannot be studied outside of the context of adversity (Rutter, 2007; Zolkoski & Bullock, 2012). In his review, Rutter (2012) examines different mechanisms through which resilient outcomes are attained in the face of adversity. While Rutter acknowledges the role of gene X environment interactions, he specifies that resilience is unique to the situation in which it is developed. There is a distinction between coping skills and resilience; coping skills are skills that a person has to cope with adversity, while resilience is the processes that person uses to overcome adversity. Coping skills can build resilience, but resilience is not coping in itself (Rutter, 2007). The study of resilience is the study of how a person uses resources, including coping skills and interpersonal skills, available to him/her to overcome adversity. Here, self-efficacy also plays a huge role. When a person has a sense of control over his/her environment, they are more likely to be resilient.

The relationship between resilience and sexuality has not been widely studied, though self-efficacy has also been discussed in the literature concerning sexuality and resilience. So far, much of the current literature seems to focus on resilience after the occurrence of sexual trauma (Domhardt et al., 2015). Such studies have found that resilience after surviving sexual trauma often include factors such as interpersonal

competence, active coping and control beliefs. In a qualitative study of abuse survivors, Bogar and Hulse-Killacky (2006) found that resilient survivors reported taking an active role in their environment, either through educational achievement, creativity or personal competence. In this case, it can be argued that resilience for women is achieved though increasing her self-efficacy, and thus empowering her to take agency.

These studies indicated that a link can be drawn between sexuality and resilience. Sexuality, through the mechanisms of rape, violence, and abuse, is used to strip a woman of her individual characteristics and agency. However, through taking back sexual agency, a woman may able to overcome adversity and gain more confidence in herself as an individual. Society uses a woman's sexuality to objectify her, and thus makes her into a passive recipient of its actions. However, if a woman is able to take control of her sexuality and gain agency in her sexuality, she is less susceptible to the effects of objectification and can thus become a stronger agent in the society around her. This sense of agency may be the key to a woman's ability to be resilient. Once she finds her agency, she can become an active participant in her environment and be empowered to use the resources at her disposal, resources she can then use to overcome difficult times.

Hypotheses

The purpose of the present study is to explore the possibility that sexuality can be used as a protective factor which increases a woman's resilience. To the author's knowledge, no previous study has examined this possibility. Therefore, I hypothesized that, through resilience, healthy sexuality, as defined by good sexual functioning, sexual awareness and a lack of guilt surrounding sexuality, will improve a woman's

psychological adjustment despite the presence of stress and traumatic events. In this study, I tested the following hypotheses:

Hypothesis 1: Comfort with sexuality will be positively related to resilience and negatively related to depression, anxiety, and eating disorders.

Hypothesis 2: The relationships between stress and traumatic life events with depression, anxiety, somatization, and eating disorders will be moderated by resilience and sexual awareness, such that higher resilience and sexual awareness attenuates the relationships between stress and traumatic life events with depression, anxiety, somatization, and eating disorders.

Hypothesis 3: The moderating effects of sexual awareness on the relationships between stress and traumatic life events with depression, anxiety, somatization, and eating disorders will be stronger for women than for men.

Chapter 3: Methods

Our correlational study tested a model demonstrating the relationships between Adverse Childhood Experiences, sexual awareness, resilience and psychological adjustment. Data were collected from a convenience sample of undergraduate students at the University of Texas at Arlington who were administered a questionnaire covering the variables explored in this study. All questionnaires and collection procedures were approved by the University's Institutional Review Board.

Independent Variables

As discussed, healthy sexuality has been found to be positively correlated with psychological adjustment (Bachman & Rosen, 2008). In this study, we further define healthy sexuality not through sexual functioning, but through awareness of sexuality, using the Sexual Awareness Questionnaire (Snell, Fisher & Miller, 1991).

Measuring resilience requires the presence of some sort of trauma within the participants' lifetime (Zolkoski & Bullock, 2012). Therefore, the Adverse Childhood Experiences scale was used as an independent variable to differentiate between participants who are at highest risk for psychological maladjustment and who may exhibit the most resilience.

Moderating Factors

It was expected that the relationship between Adverse Childhood Experiences and psychological adjustment will be moderated by resilience. Therefore, resilience was used as moderating factor within the present model. Resilience was assessed by the Resilience Scale for Adults (Friborg et al., 2003). This study sought to further understand the

relationship between sexuality and resilience by examining how sexuality influences psychological adjustment through the mechanism of resilience.

Dependent Variables

Through measuring psychological adjustment as the dependent variable, this study explored how sexual awareness, through increasing resilience, results in improved psychological adjustment. Psychological adjustment was measured using the Patient Health Questionnaire (Spitzer, Kroenke & Williams, 1999), a questionnaire which assesses symptoms of psychological disorders such as depression, anxiety, eating disorders, and somatization.

Participants

Four hundred thirteen undergraduate psychology students (283 female, 127 male, 1 other, 2 not reported) at a large southwestern state university completed an anonymous online survey for research participation credit. The majority of the participants identified as straight (90.1%), followed by bisexual (5.8%), gay or lesbian (2.7%), and other (1.2%). The mean age of the sample was 19.4 years (SD = 2.7) for women and 20.0 years (SD = 3.0) for men. The race/ethnicity of the sample was 38.0% Caucasian/White, 26.6% Hispanic/Latino, 20.1% Asian/Pacific Islander, 11.1% African American/Black, and 3.6% other. Almost half of the participants (45.4%) defined themselves as not currently dating, followed by steady or exclusive daters at 38.3%, occasionally dating at 10.9%, married 2.4%, and engaged 2.7%.

Measures

Reported Cronbach's alphas are based on the present sample.

Somatization was measured by the Patient Health Questionnaire PHQ-15 Somatic Symptom Severity scale (Kroenke, Spitzer, & Williams, 2002; Spitzer, Kroenke, & Williams, 1999; α = .77), which consists of 15 questions asking about how often one has been bothered by somatization symptoms, such as "stomach pain" and "dizziness," in the past two weeks. Responses are coded 0 = "Not Bothered," 1 = "Bothered A Little," and 2 = "Bothered A Lot." Scores are the sum of the responses across the 15 items.

Depression was measured by the Patient Health Questionnaire PHQ-9 Depression scale (Kroenke & Sprizer, 2002; α = .85), which consists of 9 questions asking about the frequency of depressive symptoms one has experienced in the past two weeks, with items such as "Little interest or pleasure in doing things" and "Feeling down, depressed, or hopeless." Responses are coded 0 = "Not at all," 1 = "Several days," 2 = "More than half the days," and 3 = "Nearly every day." Scores are the sum of the responses across the 9 items.

Anxiety was measured by the Patient Health Questionnaire GAD-7 Anxiety scale (Spitzer, Kroenke, Williams, & Lowe, 2006; α = .82), which consists of 7 questions asking about the frequency of anxiety symptoms one has experienced in the past four weeks, with items such as "Feeling nervous, anxious, on edge, or worrying a lot about different things." Responses are coded 0 = "Not at all," 1 = "Several days," 2 = "More than half the days," and 3 = "Nearly every day." Scores are the sum of the responses across the 7 items.

Eating disorder symptoms were measured by the Patient Health Questionnaire PHQ-ED Eating Disorder scale (Spitzer, Kroenke, & Williams, 1999; α = .70), which consists of 8 yes-no questions asking about the occurrence of behaviors indicative of a

binge eating disorder. An example item is "Do you often feel that you can't control what or how much you eat?" Scores are the number of yes responses across the 8 items.

Adverse childhood experiences (ACE; Centers for Disease Control, 2015; α = .70) were measured by 10 yes/no questions asking about potentially traumatic experiences from one's childhood. These experiences included childhood physical, emotional, and sexual abuse, neglect, domestic violence, poverty, substance abuse of a parent, mental illness in a parent, incarceration of a household member and separation of parents. These 10 childhood experiences were found to be associated with negative outcomes, including increased risk for mental illness, substance abuse and early death (Felitti et al, 1998; Edwards et al., 2003). Scores are the number of yes responses across the 10 items.

Resilience was measured by the Resilience Scale for Adults (RSA; Friborg et al., 2003), a 33 item scale developed to assess protective factors within an individual and within the environment. Each item requires completing a sentence with two separate choices (e.g., participants can answer "strong" or "weak" to finish the sentence, "The bonds among my friends are…"). Participants indicate the degree to which they identify with one answer or the other on a seven point scale. The RSA assesses resilience through six factors: positive perception of self (α = .80), positive perception of future (α = .82), social competence (α = .78), structured style (α = .53), family cohesion (α = .83), and social resources (α = .83). The 6 factor subscales were all positively correlated with each other and were combined (averaged) to form a total resilience score (α = .83). The RSA has been shown to be predictive of psychological adjustment (Friborg et al., 2003).

Sexual awareness was measured by the Sexual Awareness Questionnaire (Snell, Fisher & Miller, 1991), a 36-item self-report measure designed to measure four

personality traits associated with sexual awareness and assertiveness: *sexual consciousness* (the tendency to think about one's own sexuality; α = .85), *sexual monitoring* (the awareness one has of the impression one's sexuality makes on others; α = .76), *sexual assertiveness* (the tendency to be assertive in one's sexual desires; α = .80), and *sex appeal consciousness* (α = .93). Participants are asked to indicate, on a scale of zero to four, how characteristic of him/her each statement is. Subscale scores are the sum of the responses on the relevant items. Sexual consciousness correlated .64 with sexual assertiveness in the present sample, so these 2 scales were combined (averaged) to form a positive sexual awareness scale, in contrast to the sexual monitoring scale, which may reflect one's acceptance of being sexually objectified. The Sexual Awareness Questionnaire has been validated on a population of undergraduate students.

Chapter 4: Results

Independent sample t-tests compared sex differences in somatization, depression, anxiety, eating disorder symptoms, adverse childhood experiences, resilience, sexual consciousness/assertiveness, and sexual monitoring (Table 1). Women scored significantly higher than men on somatization and anxiety, while men scored higher than women on both sexual consciousness/assertiveness and sexual monitoring.

Table 2 presents the correlations among somatization, depression, anxiety, eating disorder symptoms, adverse childhood experiences, resilience, sexual consciousness/assertiveness, and sexual monitoring, separately by gender. For both women and men, somatization, depression, anxiety, and eating disorders were significantly positively correlated with each other. As expected, all of these disorders were positively correlated with adverse childhood events and negatively correlated with resilience. Contrary to hypotheses, however, these disorders were not significantly negatively correlated with positive sexual awareness (consciousness + assertiveness). These disorders were, on the other hand, significantly positively correlated with sexual monitoring for women, perhaps reflecting the effects of objectification. As expected, for both women and men, positive sexual awareness was significantly positively correlated with resilience, while sexual monitoring was non-significantly negatively correlated with resilience. Another unexpected finding was the positive correlations between the sexual awareness scales tested and adverse childhood experiences.

Hierarchical multiple regressions were conducted to test whether resilience, positive sexual awareness (consciousness + assertiveness), or sexual monitoring moderated the relationship between adverse childhood experiences and psychological

maladjustment. For each of the disorders (somatization, depression, anxiety, eating disorder symptoms), the steps in the hierarchical multiple regressions for testing resilience were: 1) gender, 2) adverse childhood experiences, 3) resilience, 4) centered interaction terms of gender by ACE and gender by resilience, 5) centered interaction term of ACE by resilience, 6) centered 3-way interaction term. For these analyses, none of the ACE by resilience nor the 3-way interaction terms were significant.

For each of the disorders (somatization, depression, anxiety, eating disorder symptoms), the steps in the hierarchical multiple regressions for testing positive sexual awareness or sexual monitoring were: 1) gender, 2) adverse childhood experiences, 3) resilience, 4) sexual awareness (positive or monitoring) 5) centered interaction terms of gender by ACE and gender by sexual awareness, 6) centered interaction term of ACE by sexual awareness, 7) centered 3-way interaction term. For these analyses, none of the ACE by positive sexual awareness nor the 3-way interaction terms were significant. None of the ACE by sexual monitoring nor the 3-way interaction terms were significant, with the exception of a significant ACE by sexual monitoring interaction for eating disorders (R^2 change = .013, $F(1, 295) = 4.192$, $p < .05$). As shown in Figure 1, this interaction resulted from the positive ACE-eating disorder relationship being attenuated for individuals high in sexual monitoring. It should be noted that, while the 3-way interaction was not significant, the 2-way interaction is largely driven by the women in the sample, as indicated by this interaction remaining significant when only the women participants are analyzed, which was not the case for the male sample.

Chapter 5: Discussion

Findings and Implications

Mean levels of adverse childhood experiences were comparably experienced by participants of both sexes, as were levels of resilience and symptomology of depression, anxiety, and eating disorders, although women reported higher levels of somatization than men. ACEs did not correlate significantly with negative psychological adjustment in men, but it did in women, confirming studies which have shown stronger reactions to trauma in women than in men (Tolin & Foa, 2006). Depression, anxiety and somatization were found to also correlate significantly with negative sexual awareness (sexual monitoring) for women, but not men. This finding supports objectification theory in that it demonstrates that, when women are more conscientious of their attractiveness to others, they exhibit more symptoms of internalizing disorders, such as depression, anxiety and disordered eating.

Interestingly, resilience in women was more strongly negatively correlated with psychological maladjustment than resilience in men, indicating that resilience may, in women, have a stronger effect on ameliorating symptoms of somatization, depression, anxiety and disordered eating than it does in men. In both sexes, positive sexual awareness (consciousness and assertiveness) was positively correlated with resilience, while negative sexual awareness was not. This finding provides support for the hypothesis that positive sexual awareness is positively related to resilience through its correlation with other protective factors in resilience. However, future research is needed to support sexuality as a protective factor in resilience. Another interesting finding was that the number of ACEs experienced by the participants was positively correlated with

both positive and negative sexual awareness. It is not clear why this finding occurred, though it is possible that adversity increases sexual awareness. This relationship should be explored further in future research.

Few interactions were found in this study. Neither resilience nor sexual awareness moderated the relationship between ACEs experienced by the participants and negative psychological adjustment. In accordance with past studies, resilience should have moderated the relationship between childhood adversity and negative psychological outcomes (Zolkoski & Bullock, 2012), which is why I expected to find an interaction. No interaction was found; a deviation from other studies of resilience. However, sexual monitoring was found to have a moderating effect between ACEs and high levels of disordered eating. This was an unexpected finding, and demonstrated that there is a relationship between ACEs, disordered eating and negative sexual awareness, such that higher sexual monitoring attenuates the relationship between adverse childhood experiences and disordered eating. No other studies have explored sexual awareness as having any relation to resilience, so there is nothing to suggest that sexual awareness should make one more resilient. Because attenuation effect was expected for resilience and positive sexual awareness, and sexual monitoring is uncorrelated with resilience, this interaction is anomalous.

Results indicate that there is a relationship between childhood adversity, resilience, sexual awareness (positive and negative) and psychological outcomes. Though the hypotheses were not entirely supported, data demonstrate a relationship between positive sexual awareness and resilience which provides a basis for believing that sexual awareness could be a protective factor in overcoming adversity for both sexes. This study

also provided interesting findings that warrant future investigation. The increased sexual awareness resulting from experiencing ACEs was an unexpected finding. However, it could be that increased sexual behavior, a behavior of those who have experienced adversity, could have the effect of increasing one's sexual awareness, both positively and negatively. However, it is also possible that increased sexual awareness resulting from ACEs increases sexual behavior. Furthermore, because sex has been found to be used as a tool for self-regulation (Owen, Fincham & Moore, 2014), it is also possible that sexual awareness developed as a result of experience with sexual behaviors which participants engaged in as a tool for emotional regulation. Further research is needed to determine the relationship between childhood adversity, sexual behavior and sexual awareness.

The moderating effects of negative sexual awareness on the relationship between ACEs and disordered eating was also a surprising result that warrants further investigation. It is unclear why this relationship was found in the data. While the positive correlation between ACEs and disordered eating was expected in this study, the moderating effect of negative sexual awareness on disordered eating was not. Disordered eating has been found to result from objectification (Tiggeman & Slater, 2015), and sexual self-monitoring (i.e., conscientiousness about one's level of sexual appeal) is an indication of self-objectification. It is possible that conscientiousness of one's sexual appeal to others may discourage high levels of disordered eating resulting from the experience of childhood adversity. Moderating effects were found only in women, indicating that men do not experience this same concern with one's body. Future research should further explore the relationship between sexual awareness and eating disorders in

order to discern why negative sexual awareness seems to be a protective factor against developing high levels of disordered eating after experiencing childhood adversity.

Limitations of Study

Perhaps one of the most unexpected findings present in this study was the lack of moderating effects resilience had on the relationship between childhood trauma and negative psychological outcomes. Many studies have confirmed that resilience does moderate the effects of trauma on psychological adjustment (Zolkoski & Bullock, 2012; Hu, Zhang & Wang, 2015). However, in this study, resilience was not found to have any moderating effects on the relationship between childhood trauma and psychological outcomes. This could be because the population we tested had relatively low ACEs scores (M = 1.45 for women, M = 1.36 in men), indicating that there were not high levels of traumatic experiences in this population. Because resilience can only be truly measured in the presence of adversity, the low levels of adversity experienced by the population in the present study may not have yielded accurate results on resilience. Furthermore, because of the low levels of adversity in the current samples, a different measure of resilience may have been more successful in capturing the relationship between adversity and the ability to overcome adversity in this population. Lastly, adversity may not have been properly defined by the ACEs measure; because adversity is experienced differently by different people, the ACEs measure may not have been able to completely capture this population's experience of adversity. Further investigation would benefit from measures of resilience and adversity more appropriate to the population being studied.

Furthermore, although positive sexual awareness was demonstrated to correlate positively with resilience, the determination of sexual awareness as a protective factor cannot be made. Because this study did not use an experimental design, causality cannot be certain. Because ACEs also demonstrated a positive correlation with sexual awareness, it is difficult to determine the exact effect sexual awareness has on resilience, or whether sexual awareness results from the adversity from which resilience is normally developed. Future studies would benefit from incorporating sexual awareness into interventions to determine whether or not sexual awareness improves resilience in clients.

Conclusion

This study may have raised more questions than provided answers. While the data suggest that sexual awareness may serve as a protective factor because of its relationship with resilience, such an assertion cannot be made because resilience was not shown to mediate the relationship between trauma and psychopathology, a relationship that is inconsistent with in the literature. The positive correlation of sexual awareness with the experience of adversity also raises questions about how the two are related. Though none of the hypothesized interactions were found, this study did find moderating effects of negative sexual awareness on the relationship between ACEs and disordered eating, a finding that warrants an investigation to better understand why such effects were found. However, despite surprising findings, this study succeeded in providing support for both objectification theory and the possibility of sexual awareness being a protective factor. To the author's knowledge, no previous study has demonstrated this possibility.

The intent of this study was to contribute to the feminist literature and provide a basis for incorporating sexuality into intervention research. Although feminist literature is

rich in writing and rhetoric, there is a dearth of empirical studies done from a feminist perspective and even less evidence supporting the efficacy of feminist theory in interventions (Lay & Daley, 2007; Israeli & Santor, 2000). Through demonstrating support for objectification theory, this study was successful in adding empirical evidence to the body of feminist literature. This study also takes a new perspective on the use of sexuality in interventions. Though women are most affected by objectification and societal pressures surrounding sexuality, feminist therapy does little to incorporate sexual awareness and sexual agency into interventions. This study demonstrated that there may be a basis to change that. For both men and women, positive sexual awareness was shown to correlate positively with resilience, and sexual awareness of both types was shown to relate to the experience of adversity in childhood, suggesting that sexuality could be incorporated into interventions. In direct practice, such interventions could work with women to raise awareness of objectification and its effects on a woman's mental health. Following awareness raising, the therapist can then encourage the client to explore her own sexuality and deepen her awareness of sexual feelings and needs. At a macro level, interventions can be done through raising awareness of the negative effects of objectification and the positive effects of sexual awareness so that women can gain relief from the societal pressures of "purity" and sexual objectification. Sexuality should be normalized as a healthy part of what it means to be human, not something that determines the woman's worth. Through such an intervention, women can overcome the effects of objectification and become stronger agents in the world around them. At a macro level, interventions can be done through raising awareness of the negative effects of

objectification and the positive effects of sexual awareness so that women can gain relief from the societal pressures of "purity" and sexual objectification.

Still, before the aforementioned interventions can be designed and implemented, further research is needed. Using a cross-sectional design, this study focused on a sample of mostly young college students who had not suffered large amounts of adversity as children. Because of this, it could not be a true study of resilience. The results do not fully substantiate the hypotheses, but they do encourage a line of future research on the connection between sexual awareness and resilience. Such research should use populations which have suffered more adversity in childhood, or are currently suffering adversity, such as domestic violence populations or those recovering from incest. Such populations are particularly appropriate for a feminist perspective because they are most affected by patriarchal societal constructs. Furthermore, because of the developmental nature of resilience (Smith-Osborne, 2007), a longitudinal design on a population which has suffered or is currently suffering adversity would be better able to capture resilience in those individuals, as well as the way sexual awareness plays into resilience.

Sexuality, including sexual awareness, sexual agency, and sexual expression, is inextricable from the human experience. One cannot separate this experience from the environment surrounding it, which makes a person-in-environment perspective necessary to be able to understand the deeper context of our attitudes on sexuality. While individual differences in attitudes, coping skills and psychopathology can be studied and measured, the picture is incomplete without taking into account the deeper societal issues which have created these attitudes. Sexuality and gender do not develop in a vacuum. Societal standards, such as standards of beauty, sexual behavior, and gender roles, shape the way

women view sexuality and respond to it, which is why this issue must be examined not only from an individual perspective, but as part of a greater system.

A social work perspective achieves this. Objectification theory, supported by the current data, serves to give an explanation for the higher instances of internalization disorders in women as being caused by societal attitudes on women and sexuality. However, resilience serves to give a solution to this issue. By addressing strengths in both the individual and the environment, resilience provides women with both kinds of resources to overcome the adversity many of them face. Through resilience, a problem that is perpetuated through both individual and societal attitudes is also solved using individual and societal resources. In this way, social work can pool the perspectives of psychology, sociology and gender studies to understand sexuality and design interventions concerning this incredibly complex issue.

Often, sexuality is seen in terms of "risky" sexual behavior or sexual dysfunction, however, it does not have to be seen as either positive or negative in order to understand the impact it has on a person's identity and well-being. The taboo around sexuality may prevent this very important topic from being discussed in interventions, however, it is clear that such a discussion must take place. As researchers and therapists, we, too, must become aware of the impact sexuality has on those we serve.

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Table 1

Means and Standard Deviations by Gender

	Gender		*t*
	Female	Male	
	M (*SD*)	*M* (*SD*)	
Somatization	6.37 (3.94)	3.88 (3.55)	-5.711***
Depression	6.92 (5.38)	6.24 (4.89)	-1.183
Anxiety	5.82 (3.62)	4.65 (3.31)	-3.035**
Eating disorder	0.89 (1.40)	0.87 (1.33)	-0.135
Adverse childhood experiences	1.45 (1.76)	1.36 (1.72)	-0.420
Resilience	5.16 (0.82)	5.01 (0.78)	-1.651
Positive sexual awareness	13.78 (5.47)	15.22 (4.88)	2.340*
Sexual monitoring	17.50 (7.25)	19.26 (6.28)	2.255*

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

Table 2

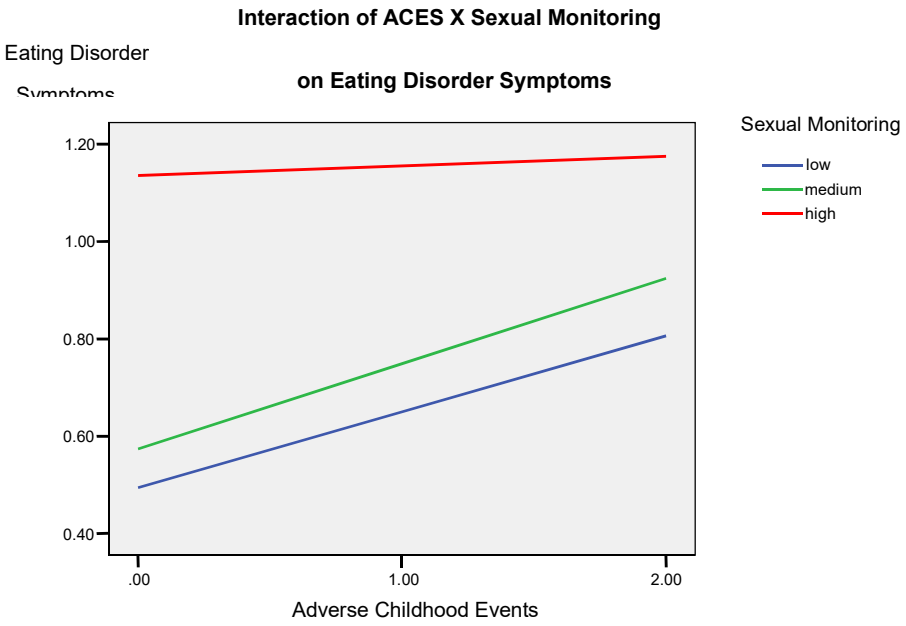
Correlations among Variables[a]

	Som.	Dep.	Anx.	ED	ACE	Resil.	Pos. sex. Aware.	Sex. Mon.
Somatization		.479***	.517**	.189**	.183**	-.192**	.040	.143*
Depression	.602***		.792***	.298***	.213***	-.553***	-.042	.186**
Anxiety	.496***	.746***		.225***	.262***	-.456***	.095	.138*
Eating disorder	.303**	.311***	.245**		.158*	-.149*	.022	.119
Adverse childhood experiences	.282**	.149	.128	.139		-.147*	.261***	.080
Resilience	-.101	-.209*	-.198*	-.198*	-.040		.191**	-.107
Positive sexual awareness	.049	-.077	-.017	.008	.256**	.423***		.196**
Sexual monitoring	.173	.027	.097	.129	.203*	-.051	.326***	

Note. [a.] Women above the diagonal and men below the diagonal.

*p<.05 **p<.01 ***p<.0

Figure 1


Interaction of ACES X Sexual Monitoring
on Eating Disorder Symptoms
Eating Disorder
Symptoms
1.20
1.00
0.80
0.60
0.40
.00
1.00
2.00
Adverse Childhood Events
Sexual Monitoring
low
medium
high