California State University, San Bernardino
CSUSB ScholarWorks

Theses Digitization Project | John M. Pfau Library

1989

The relationship of childhood sexual molestation to sexual fantasy production and sexual behavior in adult women

Mary Ambroso-Bienkowski

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project

Part of the Gender and Sexuality Commons, and the Psychology Commons

Recommended Citation

Ambroso-Bienkowski, Mary, "The relationship of childhood sexual molestation to sexual fantasy production and sexual behavior in adult women" (1989). *Theses Digitization Project*. 505.
https://scholarworks.lib.csusb.edu/etd-project/505

This Thesis is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.

THE RELATIONSHIP OF CHILDHOOD SEXUAL MOLESTATION TO SEXUAL FANTASY PRODUCTION AND SEXUAL BEHAVIOR IN ADULT WOMEN

A Thesis

Presented to the

Faculty of

California State University

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

in

Psychology

---

by

Mary Ambroso-Bienkowski

June, 1989

THE RELATIONSHIP OF CHILDHOOD SEXUAL MOLESTATION TO SEXUAL FANTASY PRODUCTION AND SEXUAL BEHAVIOR IN ADULT WOMEN

A Thesis

Presented to the

Faculty of

California State University

San Bernardino

---

by

Mary Ambroso-Bienkowski

June, 1989

Approved by:

Geraldine Stahly, PhD, Chair, Psychology — May 31, 1989 Date

Martha Kazlo, PhD

Gloria Cowan, PhD

Barbara Horton, MFCC

ABSTRACT

One hundred fifteen adult female subjects completed a questionnaire on sexual fantasy, sexual activity and sexual attitudes. The intent of the study was to test the hypothesis that there are significant differences in fantasy content, frequency of fantasy production, sexual behavior and sexual attitudes between women molested as children and non-molested women. Sexually traumatized subjects reported three fantasy scales to be significantly more exciting, four scales to be significantly more upsetting, and two scales to be "both significantly more exciting and upsetting than the non-traumatized group. Traumatized subjects reported significantly greater fantasy production overall, as well as more fantasies with childhood themes and more upsetting fantasy responses with childhood theme fantasies. The traumatized group reported significantly less sexual satisfaction and marginally less sexual activity. The hypothesis that sexually traumatized and non-traumatized women would differ in fantasy content was confirmed. Implications of the effects of molestation on sexual fantasy and sexual attitudes and behaviors are discussed.

ACKNOWLEDGEMENTS

Completing a thesis is an exercise which touches so many levels of one's life that it is almost impossible to sort out the feelings associated with finally completing such an endeavor. On an academic level I have learned to hold the research process and all that goes into a valid, reliable, ethical study in high esteem. But of much more value to me is what happened on a personal level. I was forced to deal with my lack of patience in wanting the process to flow according to my agenda. This brought up my control issues along with a great deal of frustration and anger. For one who was raised on the premise that one must always know the answers or find them out for oneself, being dependent upon others for their input and expertise was very difficult. On a more positive note, I learned that I have something to offer those with whom I have engaged even if I lack the technique. I also learned to ask for help and receive it without shame. Above all I have learned a deep respect for the process and to trust that process no matter how great the despair.

For this invaluable experience I have many people to thank. Geraldine Stahly listened to some ideas I had and set me off on a course of research to find my answers. This

thesis evolved out of our mutual interest in women and victimization and her expertise in this area of research has contributed a great deal to this study. I hope that our alliance can continue in further research. To my committee members; Martha Kazlo, Gloria Cowan, and Barbara Horton, thank you for your support and encouragement.

Maggie Dragna has been the cornerstone of this whole project. She has played many roles in the process. Maggie shared her expertise in research, challenged me as a colleague, and supported me as a friend. This thesis could not have been completed without her on an academic or personal level. Thank you!

I am deeply grateful to the women who participated in this study. It is because of their courage, honesty, and openness that this study has any meaning. I hope that what we have found helps them to understand themselves and that other survivors will be helped to understand what they are experiencing. Of utmost interest to me is that the results of this study will encourage therapists to address these issues with survivors in the recovery process.

Last, but always first, I want to thank my partner, confidante, and friend, Rick. You allowed me to grow, to discover myself, and to reach some of my goals. It is with pride, respect and love that I dedicate this thesis to you.

TABLE OF CONTENTS

Title Page.. i

Signature Page..ii

Abstract...iii

Acknowledgements..iv

Table of Contents.......................................vi

List of Tables..ix

Introduction...1

Historical Development and Early Research...............1

Current Findings on Emotional and Interpersonal Effects of Molestation..................................10

Emotional Long-Term Effects of Sexual Molestation.....11

Multiple Factors Can Influence the Effect of Molestation..22

Sexual Dysfunction Related to Molestation.............24

Sexual Fantasies: Functional and Dysfunctional.......33

Motivation for Creating Sexual Fantasy................43

Survivors Quest For Resolution of the Molestation....49

Hypothesis..52

Method..54

Subjects..54

Design..55

Introduction Procedure................................55

Consent Form Procedure................................56

Special Precautions....................................56

Fantasy Questionnaire..................................57

Results..59

Differentiating Group Information......................59

Demographic Subject Information........................60

Sexual Fantasy Scales..................................62

Hypothesis 1 Results...................................62

Hypothesis 2 Results...................................70

Hypothesis 3 Results...................................71

Hypothesis 4 Results...................................72

Hypothesis 5 Results...................................74

Additional Findings....................................75

Emotional Response Differences for 7 Child Fantasies..75

Variety of Response Differences for 52 Sexual Fantasies..77

Group Fantasy Frequency Differences By Fantasy Scale..80

Group Differences in Sexual Satisfaction and Sex Drive..81

Differences in Sexual Attitudes, Behaviors, Functioning..81

Discussion...86

Results Overview.......................................86

Implications of Results................................87

Limitations..93

Future Study...98

Appendices

A. Introduction to the Study...........................101

B. Consent Form for Non-Trauma Group..................103

C. Consent Form for Traumatized Group.................104

D. Debrief Letter for All Subjects in Study..........105

E. Questionnaire on Sexual Fantasy Production as
Related to Current Sexual Activity................106

F. Sexual Fantasy Scales.............................121

G. Scale of Sexual Activity Items....................123

H. Scale on Sexual Attitudes, Behaviors, and
Functioning.......................................124

I. Eight Sexual Fantasies Which Were Not Reported
by the Non-Traumatized Subjects...................126

References...127

LIST OF TABLES

Table 1. Responses of 42 Subjects Who Previously Self-Identified as Non-Traumatized Subjects....61

Table 2. Nine Sexual Fantasy Scales and Examples of the Sexual Fantasies Within Each Scale....... 63

Table 3. Sexual Fantasy Scale Alpha Reliability Coefficients for Exciting and Upsetting........67

Table 4. F Ratios On One-Way Analysis of Variance for Emotional Responses to Fantasy............68

Table 5. Group Means By Sexual Fantasy Scale...........69

Table 6. Responses of Group 1 (Molest) Subjects On Sexual Arousal As Related to Recapitulation of Sexual Trauma in Fantasy.......................73

Table 7. Emotional Responses For Seven Sexual Fantasies Dealing With Sexual Activity and Childhood Or Adolescence By Group..........................78

Table 8. Frequency of Exciting, Upsetting, And Both Exciting And Upsetting Responses to Seven Sexual Fantasies Dealing With Sexual Activity And Childhood or Adolescence By Group.............79

Table 9. Samples of Items in Each of Five Scales on Sexual Attitudes, Behaviors, and Functioning...83

Table 10. Sexual Attitude, Behavior And Functioning Scale

Reliability Coefficients And F Ratios On One-Way Analysis of Variance..........................85

INTRODUCTION

Historical Development and Early Research

The earliest psychological perspectives on childhood molestation were provided by Freud. Originally, Freud (1954) theorized that his hysterical patients suffered a childhood molestation which caused their hysterical disorder. Later, Freud believed that the reported experiences were memories of fantasies. Freud then developed the ideas of infantile sexuality and the oedipus complex which purported that incest fantasies were universal. The notion of actual childhood molestation trauma was discarded and the incidents reported by patients were thereafter considered to represent the inability to relinquish incestuous wishes and fantasies.

From a historical perspective, incidents of childhood sexual abuse were denied and seen as evolving out of childhood sexual fantasies (Jortner, 1985; Masson, 1984; Rush, 1977, 1980). As recently as 1962, Weiner stated in a paper on father-daughter incest that,

> the occurrence of overt sexual contact between parents and children has remained relatively rare in our society (p. 607).

A more current study by Russell (1983) involved interviewing 930 randomly selected adult women from San Francisco. Of these women, 16% reported a minimum of one

intrafamilial experience of sexual abuse prior to the age of 18. In a later study, Russell (1986) reported an incidence rate of 19%. When extrafamilial sexual abuse was considered, the figure increased to 31%. For the combined categories, the overall sexual abuse rate prior to the age of 18 was 38%. A study by Sedney and Brooks (1984) reported similar findings; in this study 16% of 301 women in a nonclinical college sample reported experiencing childhood sexual abuse.

The magnitude of the child sexual abuse problem can no longer be denied. Within the family context, however, there remains a great deal of conflict in regard to the disclosure of such abuse. In the Russell (1983) study only 2% of intrafamilial and 6% of extrafamilial sexual abuse cases were subsequently reported to law enforcement.

When the reality of sexual abuse was recognized, there began a controversy over the psychological impact of such abuse. There have been claims that children who have had sexual contact with adults could be positively affected. In the Bender and Blau (1937) study, the authors presented data which they believed indicated the experience had been emotionally satisfying to some children because they had been emotionally deprived during their early childhood and therefore received gratification from the sexual activity. Based on their observation of incest cases, Rascovsky and Rascovsky (1950) insinuated that through an incestuous act, a child increases the chance of a healthier adjustment in the

world and decreases the possibility of psychosis as compared to children who are living within an intensely incestuous situation that has not been consummated.

Similarly, Henderson (1972) proposed that within the context of father-daughter incest, if the colluding mother or incestuous father are relatively guilt and anxiety free and if the daughter is young, there will probably be a favorable prognosis. To date, empirical evidence in support of this position remains undocumented. It should be noted that these positions were taken at a time when childhood sexual abuse was still in the closet and considered very rare. It should also be noted that these positions were taken at a time before any reliable studies had been completed.

Some other researchers, while not suggesting a positive effect, took the position that the effect of sexual molestation on children is minimal. Bender and Blau (1937), in a study of 16 children ages five through twelve who had been sexually molested, reported finding that the children had not been negatively affected by the experience. The authors linked regression, prolonged developmental stages, poor academic achievement, poor social adjustment, sexual promiscuity, six cases of vaginitis and one case of syphilis, to the sexual molestation experiences of these children. The authors reasoned, however, that the children had derived some emotional satisfaction from the experience and that in some instances the child had even been the initiator thus making

the experience more positive that negative.

Fifteen years later in a follow-up study, Bender and Grugett (1952) reported that three out of four of the incest victims from the original study had attained a "moderately successful adjustment". The authors suggested that the consequence of an incestuous relationship may not be "unfailingly disastrous". Six of the children, with varying degrees of intervention including institutionalization, were reported to have, "positive responses to improved environmental influences". In reporting on four children who had unfavorable adjustment which included "persistent psychotic symptoms", Bender and Grugett attributed their difficulties to pre-existing genetic factors such as low intellect or environmental deficits rather than the molestation experience.

The early research conducted by Bender and Blau (1937) gave little attention to the pathology of the molester; rather in their study of 16 children who had been molested it is suggested that these children were the "seducers" and not the "innocently seduced". The incest or molestation then was seen as due to the child's excessive and overt sexuality. Subsequently, treatment was focused on correcting the child's compulsive sexual interests by fulfilling the child's unmet emotional needs through an adequate substitute (healthy emotional attachment) to which the child quickly adapted. Thus, these authors contended both that the molestation was

the result of the child's pathology and paradoxically that there were no traumatic effects resulting from these sexual relationships. Further, the children were reported to have benefited from the emotional satisfaction received from the experience. Where clear clinical evidence was found of behavior problems in the children, Bender and Blau maintained their belief in the benign effect of the sexual molestation experience.

The dismissal of incest as a significant factor in adjustment problems was not limited to early studies. In 1966, Yorukoglu and Kemph reported on two incest case studies and concluded that the children did not suffer serious or permanent psychological impairment. The children's immunity to the trauma was attributed to the healthy ego functioning existing prior to their incestuous experience. In contrast, a study by Russell (1986) found in a survey of 152 incest victims that only 2% described their experiences as neutral or positive.

Two studies conducted in 1979 also questioned the long-term effects of sexual molestation. Courtois (1979) studied 31 incest survivors in an effort to assess the resulting psychological impact as related to the specific variable of the experience. It was found that severity could not automatically be assumed to be directly related to the strength of a particular variable. For some women, the impact of their incest experience was rated as not severe even though

the experience had been abusive. Other women rated the impact as severe when the situation had been rated as mild. The small size of this study and the classification system of mild to severe make it difficult to judge the long-term consequences of incest. It is also possible that variables not measured would have been better predictors of the consequences.

Another study, also suffering from small sample size and design bias, was conducted by Rosenfeld (1979) who studied 18 psychiatric female patients over a one-year time period and concluded that the effects of incest were difficult to determine. Six of these women were found to have been sexually molested as children. Their social adjustment was found to be similar to that of their parents and none of these women showed evidence of being "overtly psychotic". The incest patients did show escalated levels of sexual dissatisfaction, hysterical characterological disturbance, and marital discord, but similar symptoms were shown by the 12 psychiatric patients who had not been molested. In view of these results, the actual effects of incest remain undetermined in these studies.

Gagnon (1965) reviewed the data of 333 (28% of total sample) subjects from Kinsey's study who had reported a sexual experience with an adult prior to age 13. It is interesting to note that clinicians in 1972 were estimating the occurrence of sexual abuse at one per million in spite of the widely

circulated Kinsey data showing the incidence at 28%. Gagnon reported that reactions to having had sexual contact with adult men for women were primarily negative (84%), although mixed (13%) and positive (3%) reactions were also reported. Landis (1956) in a study of 1,800 university students found 30 percent of the men and 35 percent of the women had been sexually abused. The women were asked to assess whether the experience resulted in damage to their emotional development. Three percent reported permanent damage, 30 percent reported temporary damage and 66 percent reported no damage.

Finkelhor's (1979) survey of 796 undergraduates from six colleges and universities found that males (10%) and females (15%) reported sexual experiences with siblings. One fourth of these experiences were deemed exploitive by the author because of the use of force or the age disparity between siblings. Participants' reactions were about equally divided. Thirty percent related that the experience had been negative, 20% found it positive and the rest found it neither positive or negative. For 64% of the children who had been coerced the experience was negative as it was for 54% of those children whose sibling was much older. In 82% of the coercive experiences, a female was the victim and in 70% of the age disparity cases the junior partner was female (Finkelhor, 1979, 1980).

Although some studies suggested that the effect of sexual molestation on a child were positive or minimal, early

research also proposed an adverse effect from such an experience. For example, molested children have been reported as experiencing a negative reaction emotionally, as in loss of self-esteem, withdrawal, guilt, and depression (Kaufman, Peck, & Tagiuri, 1954; Weiss, Rogers, Darwin & Dutton, 1955). Nightmares and phobias have also been linked to sexual molestation (Weiss et al, 1955).

In reviewing five cases from their patient population, Lewis and Sarrel (1969) found incest, rape and seduction to be "important contributing factors to subsequent symptom formation and characterological disorder". Several other factors influenced the eventual outcome of the sexual abuse experience: there were numerous episodes or an isolated incident; the severity of the circumstances surrounding the incident; the quality of the relationship between parent and child; how disturbed the object relations were for the child before, after, and during the molestation; the level of ego development in the child, especially the capacity to handle anxiety; the similarities between the molestation experience and the child's prevailing fantasies; and the child's ability to work through the trauma on a psychological level.

Some researchers proposed that the effects of sexual molestation were comprehensive and affected numerous aspects of one's life. In a study of 118 antisocial females, Benward and Densen-Gerber (1975) found that 52 had been sexually abused. The sexual abuse was connected as the major factor

causing the antisocial behavior to develop. Carmen, Rieker, and Mills (1984) studied 188 (65% female; 35% male) psychiatric patients and found that 43% had physical or sexual abuse in their history and 90% of the time the abuser was a family member. For this sample, sexual abuse had occurred in 19% of the cases, physical abuse in 53% of the cases, and physical and sexual abuse in 29% of the cases. Abused patients, as compared to nonabused patients, had an increased tendency to have within their histories assaultive behaviors, suicidal attempts, criminal justice system involvement, an inability to trust, impaired self-esteem, and problems coping with aggression and anger. As indicated in case studies involving adult women participating in therapy, childhood sexual trauma is offered as a significant determinant in adult psychological disturbance (Herman & Hirschman, 1977; Katan, 1973; Summit & Kryso, 1978).

The Lukianowicz (1972) study on paternal incest exemplifies the confusion and possibilities for interpretation of contradictory findings. Twenty-six female incest victims were seen in a clinical setting and the impact of the incest on the victims included: character disorders in 11 of the girls; five had an aversion to sex after marrying; four showed either depressive reactions or acute anxiety neurosis; and six manifested no apparent ill effects.

Early research concluded that the evidence was available to support the conclusion that childhood sexual abuse had few

if any long-term effects. More recent research is suggesting that there can be a multitude of long-term effects resulting from childhood sexual abuse. However, the bottom line as concluded by Henderson (1983) is that in the absence of a sufficient number of well-controlled studies it is difficult if not impossible to distinguish which effects are a direct result of sexual abuse from other variables having a high correlation with developmental trauma. Some of these variables are; poor child-rearing practices, low family income, high level of family disorganization, and a low educational level for parents. Thus according to early studies, the effects on the lives of children experiencing incest was not empirically established, although clinical evidence suggested that there was moderate to severe harm.

Current Findings on Emotional and Interpersonal Effects of Molestation

Sexual molestation has existed in the shadows for decades, however, for the past ten years it has stepped into the limelight (Browne & Finkelhor, 1986). Although many of the studies conducted in the recent past have been exploratory rather than empirical, there is a growing body of evidence which suggests that a large proportion of sexually victimized women do suffer long-term effects as a result of these experiences (Cole, 1985; Courtois, 1988; Courtois & Watts, 1982; Gelinas, 1983; Gordy, 1983; Herman, 1981; Jehu & Gazan, 1983; Jehu, Gazan & Klassen, 1984; Sedney & Brooks, 1984;

Summit, 1982). These long-term effects generally fall into three problem areas: emotional; interpersonal; and sexual. The emotional and interpersonal problems will be explored first as many of these problems have a direct affect on the more prevalent sexual problems encountered by these women. The sexual problems will be examined with an emphasis on sexual fantasy and how it may be affected by sexual molestation.

In a recent summary article on the long-term effects of sexual molestation, Gelinas (1983) found that adults molested as children experience serious negative effects resulting from sexual abuse. Jehu and Gazan (1983) suggested that a range of sexual, interpersonal, and emotional problems frequently appear among the reported one-third of all women who have been sexually abused.

<u>Emotional Long-Term Effects of Sexual Molestation</u>

For a subgroup of previously abused women, emotional problems have been reported. Browne and Finkelhor (1986) reviewed studies which looked at the effects of childhood sexual abuse and reported that some survivors experienced long-term effects of self-destructive behavior, depression, anxiety, poor self-esteem, difficulty trusting others, substance abuse, feelings of isolation and stigma, a tendency toward revictimization, and sexual maladjustment. Courtois (1979) interviewed 30 incest victims and found that 87% of these women acknowledged a moderate to severe effect on their

families and found female survivors had the following long-term effects: a) depression, guilt, and low self-esteem; b) distrust; c) feelings of being uniquely different; d) self-destructive behavior; and e) problems with men and sex. Two smaller sample studies of incest history female outpatients reported presenting problems which were similar: anxiety; depression; social isolation; sexual difficulties; drug and alcohol abuse; and marital problems (Herman & Hirschman, 1977; Rosenfeld, 1979). In a much larger sample (301 college females), significantly greater symptoms of anxiety, self-abusive behavior, depression, trouble sleeping, being a crime victim, being an accident victim, learning problems, and emotional problems were found among the 16% of the women who had been sexually abused (Sedney & Brooks, 1984).

Gordy (1983), in her group work with adult women who were victims of incest during childhood, found several recurring themes including bouts of depression which occurred periodically, feelings of worthlessness, and low self-esteem. These women were inhibited by their guilt and shame over having been molested. As adolescents and children, they responded by total withdrawal or by acting out through alcohol or drug abuse, promiscuity, or anorexia nervosa. Almost all of these women were labeled "parentified children", meaning that they had carried out many of the responsibilities of the parent role as children. These women reported anger at their mother's for not having responded to them emotionally

and for not having been able to protect them from the molestation. Meiselman (1978) concluded from her psychotherapy sample that 60% of the victims of incest disliked their mothers and 40% continued to have strong negative feelings toward their fathers. Similarly, Benward and Densen-Gerber (1975) suggested that sexual abuse victims whose mothers were unable to protect and appropriately socialize them may have done more damage to the victim than what was done by the violating male.

According to Summit (1982), when a child is faced with a sexual molestation experience, maladaptive coping mechanisms may be developed in order to survive; these include self-mutilation (suicide attempts and promiscuity which reinforce the self-hatred and reconcile the continuing outrage), rage projection, sociopathy, delinquency, hysterical phenomena, altered consciousness, reality splitting and domestic martyrdom. It is assumed by many women that they are crazy, sick, or bad because of the helplessness and guilt they have assumed due to their childhood experiences. The internalized rage is viewed as dangerous and evil resulting in chronic fear of losing touch or control when it comes to reality and feelings. Problems with intimacy, trust, and inhibition of sexual desire and fulfillment can occur without the woman being aware of any disturbing thoughts or feelings. There can also be an uncomfortableness with the parenting role because of the residual effects of the stigma of incest.

All of the females who were victims of father-daughter incest in the Herman (1981) clinical sample reported feeling marked, branded, or stigmatized by the experience. Seventy-three percent of subjects reported moderate to severe alienation and isolation feelings in the Courtois (1979) study. Interpersonal relationships were problematic in the following areas; feelings of being different from others, alienation, and isolation accompanied by insecurity and mistrust. Moderate to severe problems were reported by 79% of the females regarding their relationships with males; these problems included mistrust, hostility, feeling betrayed, fear, and disappointment. Interestingly, although ages ranged from 22 to 50, 40% had never been married. Courtois and Watts (1982) report that it is not uncommon to find relationship problems in that they are superficial, conflictual, sexualized, and there is mistrust with parents, children, spouse, inlaws and/or male partner.

Meiselman's (1978) study of psychotherapy samples involving 26 incest victims as well as controls determined that 40% of the controls and 64% of the victims had fear of, or conflict with, the sex partner or husband. Conversely, the majority of the 40 female subjects in the Herman (1981) study of incest victims in psychotherapy tended to idealize or overvalue men whereas, only three women expressed fear or hostility. These women, however, felt anger toward women which prevented them from having supportive female friendships

and fostered in them fears of inadequacy in motherhood.

Eight females who sought therapy for prior sexual abuse comprised the subject population for the Van Buskirk and Cole (1983) study. It was found in this study that there was a significant discrepancy between the self and the idealized self-concept. The author's reported that 57% of the eight incest victims assessed themselves as being unassertive. The majority self-reported that they considered themselves helpless, undeserving, and worthless. The majority had chosen partners they judged to be like their fathers. There was also evidence that these women had difficulty with intimate relationships. They did not seem to feel that they had a right to have their needs met and subsequently often sought out relationships where they adopted the submissive role and ascribed a dominant position to the male. These dynamics recapitulated the relationship the victim had with the perpetrator.

Sexual abuse by a family member has been found to have greater negative consequences for the victim than if the abuse had happened with a perpetrator outside of the family (Sedney & Brooks, 1984). Becker, Skinner, Abel, Axelrod and Cichon (1984) found similar results in their study of 372 survivors of sexual assault; incest survivors, and incest and rape survivors particularly, had a higher incidence of sexual problems than rape only survivors. Likewise, Ruch and Chandler (1982) conducted a study of 408 females who were

treated for one of three forms of sexual assault; child incest (minor engaging in sexual activity with a person related by marriage or blood), child rape (sexual activity such as sodomy or intercourse with a nonrelative), or adult rape. It was found that the incest victims were more severely traumatized than the adult rape or child rape victims.

In an article on therapy group designs for females who were adult survivors of incest, Cole (1985) observed that many of the survivors of incest participating in group therapy reported having large memory gaps. Because memory gaps ranged from six months to several years, many survivors questioned whether they had made up their experiences. In doubting their memories, the feelings of being different, unusual, or psychotic were exacerbated. Dissociative disorders were common for these women, especially multiple personality. According to Maltz and Holman (1987), it is estimated that as many as 50% of women do not recall their incestuous experiences until they reach adulthood and something triggers their memory. Stanko (1985) discussed why sexually victimized children remain silent about their sexual abuse and attributed part of the reason to an internalized confusion due to self-doubt. This internalized confusion over time resulted in a questioning of perceptions as to whether the incidents were "real".

Dissociative disorders, in particular multiple personality, may be adaptive responses to sever trauma. Coons

and Milstein (1986) studied 20 diagnosed multiple personality patients and found an incidence rate of 75% for sexual abuse and 55% for physical abuse during childhood. In her work with adult victims of incest, Gelinas (1983) has found that some victims report conscious efforts to induce a dissociative defense while the abuse is occurring. These defenses can be in the form of self-hypnotic anesthesia experiences or dissociative behavior (multiple personality). Under stress, there remains a tendency to utilize these dissociative defenses even as adults.

Women who were sexually abused as children appear to be vulnerable to revictimization for example there is a correlation between the seriousness of the sexual abuse and the subsequent incidence of rape (Herman, 1981). Russell (1986) reported that of 930 women molested as children 33% of the "moderately abused" to 68% of the "severely abused" were subsequently raped. This is alarming when compared to the 17% incidence rate among women who had not been victimized as children. A similar relationship appeared to exist between childhood sexual abuse and domestic violence: between 38% and 48% of molestation survivors had husbands who were physically violent as compared to 17% of the women who had not been sexually abused. Additionally, 40% to 62% of the women who had been sexually abused during childhood were later sexually assaulted by their husbands compared to 21% of the non-victims.

Promiscuity has been cited in the literature as a long-term effect for victims of child sexual abuse (Courtois, 1979; Courtois, 1988; Fromuth, 1983; Herman, 1981; Lukianowicz, 1972; Meiselman, 1978). Herman (1981) stated that in her incest sample 35% reported promiscuity and the Meiselman (1978) study found that 19% of the female victims of incest had experienced a promiscuous period subsequent to incest. Lukianowicz (1972) discovered that 42% of the victims, in 26 incestuous families, became promiscuous. The promiscuity is seen as attributable to the victims' relationships with men which were masochistic and oversexualized leading to the victims' inability to establish an intimate, lasting, sexually responsive relationship (Jehu & Gazan, 1983).

There are several studies that suggest there is a connection between childhood molestation and later prostitution. One hundred thirty-six adult female prostitutes were interviewed by James and Myerding (1977) and it was found that, as children, prior to their first intercourse, 52% had experienced sexual abuse by someone ten years or more older than themselves. Of the adolescent prostitutes, 65% had been coerced into performing sexual activities and 85% of these activities had occurred prior to age 16. Similarly, in a study of 200 female street prostitutes conducted by Silbert (1982), 61% of the women were victims of child sexual abuse and incest. Of these cases, 70% reported repeated abuse with the same perpetrator which 66% of the time was a stepfather,

foster father, or natural father.

Silbert and Pines (1981) concluded that childhood sexual abuse negatively affected the attitudes, emotions, and physical health of women to the extreme, which in turn affected the decision of 70% of these women to become prostitutes. A follow-up article in 1983, (Silbert & Pines) suggested that these subjects had developed a "psychological paralysis" in that their willingness to endure an abusive relationship was seen as a result of their inability to make sense out of the earlier abuses. These women had reacted with self-blame, depression and inaction. As the abuse continued, they became less able to make any sense of it. This led to passivity, powerlessness, and a feeling of being out of control of their lives which debilitated them and led to the "psychological paralysis".

There is some evidence suggesting an increased tendency among victimized females toward homosexual relationships as compared to non-victims. Homosexuality was rare among the control group in the Meiselman (1978) study, however, 30% of the 23 incest victims in the psychotherapy sample reported significant homosexual feelings and experiences or had adopted a homosexual lifestyle. The homosexual orientation appeared to be a reaction to the heterosexual experiences which were abusive. This orientation was not apparent until after several years of unpleasant heterosexual experiences.

Gundlach (1977) conducted a questionnaire study of 233

heterosexual and 225 homosexual women. Seventeen females were victims of a strongly coerced rape or molestation by a close friend or relative prior to the age of 16. In adulthood, 94% of these victims were homosexual. Eighteen subjects endured the same circumstances, but the victimization was perpetrated by a stranger. In adulthood, 55% of these victims were homosexual. This larger discrepancy may have been due to the fact that Gundlach's sample was self-identified as almost 50% homosexual thus biasing the subject population from the onset. In the Fromuth (1986) study of 383 college females, 22% had been sexually abused, a significant relationship was found between having had a homosexual experience after age 12 and having been sexually abused as a child.

Simari and Baskin (1982) investigated the effects of heterosexual and homosexual incest experiences within male homosexual (54 subjects) and lesbian (29 subjects) populations. The authors contend that before the incestuous experience, all of the male participants had been self-identified as actively homosexual whereas this was true for only a small percentage of female subjects. Only homosexual incest was reported for the male population, whereas for the female population, the predominanat form of incest was heterosexual.

Yorukoglu and Kemph (1966) proposed that for those individuals who experienced heterosexual incest, homosexuality may be a natural escape. Conversely, Simari and Baskin (1982)

suggested that turning to homosexuality as a consequence of incest would be more of the exception than the rule. According to the authors, coping with incest by using or abusing one's sexual orientation in a defensive maneuver was likely to be discovered in an individual whose sexual orientation had not been firmly integrated. An incest experience does not cause homosexuality, but could bring forth an already present condition. From yet another perspective, Eisnitz (1984-85) postulated that most incest victims could not establish a female or male sexual identity that was firm. A female could not be masculine nor fully feminine as either choice would involve a relationship with one or the other terrifying parent. For the female incest victim, this choice was perceived as too threatening and therefore could not have been made.

Multiple Factors Can Influence the Effect of Molestation

While early studies were ambiguous, more recent studies suggest that the effect of early childhood sexual abuse is negative. Adding some ambiguity is a study by Fromuth (1986) using 383 female college students which investigated the relationship between sexual abuse in childhood and later sexual and psychological adjustment. It was found that family background (as measured by a Parental Support Scale) was a more accurate predictor of eventual psychological adjustment than was sexual abuse. Based on this study, there is the interesting possibility that the family environment has more

of an impact on psychological adjustment and that a history of childhood sexual abuse has more of an impact on sexual functioning.

There appears to be a number of factors in a survivor's history or current circumstances which can affect the impact of early childhood sexual abuse. Based on clinical experience, Groth (1978) contended that there would be greater trauma in sexual abuse that; a) involved penetration, b) was accompanied by aggression, c) occurred with a closely related person, and d) continued over a long period of time. MacFarlane (1978) added three other contingency factors; e) involved an older child who was aware of the cultural taboo violation, f) evoked an unsupportive parental reaction upon disclosure, and g) the child had been a willing participant to some degree.

Other relevant factors presented by Larson and Maddock (1983) were; h) the age discrepancy between the adult perpetrator and the child or between children, i) how capable the other parent was to nurture, j) the degree of severity of social isolation, k) what meaning the child attributed to the experience, and l) whether there was direct or indirect sexual contact. Courtois and Watts (1982) included; m) frequency of contact, and n) whether the incest was overt within the family or covert.

Browne and Finkelhor (1986) reviewed the sexual abuse empirical studies and tried to find consistent associations

between the characteristics of the experience and a resulting negative effect. It was found that there was no single contributing factor that was consistently agreed upon in the studies being associated with a more negative prognosis. There were trends cited in the studies, however. The majority of the studies indicated that abuse by stepfathers or fathers had a more negative impact for the child than abuse by other perpetrators. Genital contact experiences appeared to be more harmful. There was more trauma for the victim when there was presence of force. Male adult offenders seemed to be more threatening than female or adolescent perpetrators. Prognosis also seemed to be worse when victims were removed from their home and/or the family did not support the victim. Studies also examined age of onset, telling or not telling, and duration of abuse. These factors were not found to have any significant relation to survivors long-term adjustment. Although interesting, the findings reported by Browne and Finkelhor's review remain tentative since many of these findings are trends only and there are few replications.

Sexual Dysfunction Related to Molestation

The focus will now turn to the area of sexual dysfunctions generally, and then as specifically related to sexual molestation. Adults with sexual difficulties often have experienced cultural, family, or social influences which have inhibited sexual expression. According to Scharff (1978), it is not uncommon to find childhood incest in the

background of couples who were referred for some type of sex therapy. Sex aversion is the most commonly associated sexual dysfunction with early history of incest along with dyspareunia and vaginismus.

Marmor (1976), in a paper on female sexual responsivity, suggested that a woman's ability to be responsive was dependent upon the existence of feelings of affection, tenderness, security, intimacy, and trust with her partner. Orgasmic responsivity was found to be impaired by traumatic life events including; a misunderstanding of an early primal scene, an unpleasant initial coital experience, rape, or early molestation. The authors concluded that these experiences could result in an association being made between sex and violent aggression leading to fear of bodily harm from the penis. Loss of control or a state of potentially dangerous vulnerability could be associated with orgasm.

In 1972, O'Connor and Stern studied 96 patients (35 male and 61 female) treated for sexual disorders which consisted of various forms of frigidity and impotence. Approximately one-third of these patients had participated to some degree in bizarre sexual activity which occurred within the family structure. At least one of the parents, for 57% of the sample, evidenced severe problems in such areas as; psychosis, excessive brutality, exhibitionism, abnormal sexual behavior, incest, and alcoholism. The initial sexual experience for 35% or more of the patients was traumatic including; attempted

incest, attempted rape, intercourse in which performance was inhibited, rape, and others. Of these patients, about two-thirds were female. The severe psychopathology existing within the family system affected the patient's capacity to interact physically and emotionally with their partner.

After review of the psychiatric literature on the cause of inhibited sexual responsivity, Fisher (1973) claimed that a woman's capacity for orgasm evolved out of a long-term, complex series of conditions and was not determined by one terrifying incident in her life. A statistical analysis was conducted by Baisden and Baisden (1979) on 240 clinical records of women seeking sexual dysfunction therapy to determine what variables were inherent in women who were diagnosed with sexual problems. For these women, orgasm during intercourse was reported to occur less than 20% of the time. Orgasm was experienced, however, 31.9% of the time during oral sex or masturbation. Prior to the age of 18, 90% of these women reported sexual encounters with males at least four years older. These incidences occurred most often with a family member (38.1%) or a family friend (23.8%).

A clinical profile was developed by McGuire and Wagner (1978) containing characteristics of women who in childhood had experienced sexual trauma. These women: rarely initiate lovemaking, had trouble caressing or touching their partner and in being caressed or touched, had limited arousal during sexual contact and minimal sexual appetite prior to contact,

felt revulsion and disgust about their partner's and their own body, usually had a sexual style restricted to only intercourse, only enjoyed the sexual contact after penetration has been initiated. Surprisingly, some of these women reported being easily orgasmic through intercourse though often only through intercourse. Sexual problems for women molested during adolescence or childhood often do not appear until two to four years into their marriage. The authors suggested that up to this point; the novelty of the relationship, the increased sexual appetite during the early years of the marriage, and the need for approval, may have served to obscure the problem. After two to four years of marriage, the woman has been away from the home where the abuse occurred for a long period of time and feels secure. The authors believed that there was no longer a need for the woman to exercise emotional self-control concerning her sexual needs or concerns and therefore she was able to give herself permission to express these conflicts.

In several populations, the frequency of sexual problems for women sexually abused in adolescence or childhood has been documented as substantial. Most clinically based studies report later sexual problems for sexual abuse victims, especially for victims of incest. Meiselman's (1978) clinical study found that 87% of the sample at some time after the molestation experienced a serious difficulty with sexual adjustment as compared to only 20% of the comparison group.

Herman's (1981) study reported later sexual problems for 55% of the incest victims, but this was not significantly different when compared to women with fathers who were seductive. Although a nonclinical study (Courtois, 1979) of former incest victims, 80% reported one or more of the following conditions; being unable to relax or to enjoy activities that were sexual, abstention from or avoidance of sex, and/or a compulsive sexual desire.

Sexual dysfunction which involved impairment of satisfaction, arousal, performance, sexual phobias, vaginismus, dyspareunia, or sexual motivation seemed to be common among sexual abuse victims (Jehu & Gazan, 1983). Causes for impaired motivation may include depression, poor physical health, fear of romantic success or intimacy, distress with or an unsatisfying female experience, avoidance of sex due to pain, or conflict between the partners. According to Courtois (1988) the roots of sexual difficulties for incest survivors are often body alienation, negative self-concept, distortions and misperceptions concerning sex-role, and sexual and interpersonal behavior.

Research was conducted by Becker, Skinner, Abel and Cichon (1986) on 372 survivors of sexual assault which included attempted rape, rape, incest and child molestation. Ninety-nine women having no sexual assault history were also part of the study. Of the 99 non-assaulted women only 17.2% reported sexual problems, whereas 58.6% of the sexual assault

survivors were experiencing sexual dysfunction. Of the survivors experiencing sexual problems, 88.2% had response inhibiting problems which were the most prevalent of the sexual problems and were composed of arousal dysfunction, desire dysfunction, and fear of sex. Post-assault sexual problems were less likely to remit spontaneously and assault-related sexual problems were reported by some survivors up to 40 years after the trauma.

In 1980, Meiselman compared MMPI records for 16 female incest survivors who were psychotherapy patients with 16 non-incest psychotherapy patients. It was confirmed that the incest history patients reported more sexual problems than the controls. Becker, Skinner, Abel and Treacy (1982) studied 83 victims of rape and/or incest and found that 43.4% reported no sexual problems, whereas, 56.6% indicated at least one sexual dysfunction, 32.4% two dysfunctions, 17.6% three dysfunctions, and 14.7% four dysfunctions. Of the dysfunctional subjects, over 70% determined that their sexual assault had preceded the onset of the sexual problems. The subjects reported sexual dysfunctions as follows; 75% feared sex, 33% lacked sexual desire, 42% had an arousal dysfunction, and 42% manifested primary or secondary nonorgasmia.

Tsai and Wagner (1978) studied 50 women involved in therapy groups for sexually molested women. The majority of these women reported difficulties in sexual functioning which fell into one of three maladaptive categories:

nonresponsivity; orgasmic, but not satisfying; and arousal which was contingent on their being in control.

In a study by Tsai, Feldman-Summers and Edgar (1979), three groups of women (thirty per group) were compared on sexual adjustment measures. The groups consisted of; a matched control group who had not been victimized, a group of sexual abuse victims who had not sought therapy and considered themselves as well-adjusted, and a group of victims of sexual abuse who were seeking therapy. The control group and the "well-adjusted" sexual abuse victims were not significantly different on overall and sexual adjustment measures, but a difference was noted for victims seeking psychotherapy. The victims seeking psychotherapy reported a greater frequency of sexual partners, expressed less satisfaction with the degree of quality in close relationships with men, received less satisfaction in sexual relationships, experienced fewer orgasms, and reported themselves as less sexually responsive.

Several clinicians reported that adult clients who were sexually abused had negative attitudes about their bodies and sexuality, experienced difficulty with sexual arousal and orgasm, had disturbing flashbacks (recapitulations) to their molestation experience, and often felt adversely about sex (Courtois, 1979; Herman, 1981; Meiselman, 1978; Tsai & Wagner, 1978). During adult sexual relations, a phenomenon of experiencing sudden flashbacks or images of the sounds, smells, feelings, sights, or other stimuli reminiscent of the

childhood abuse could occur for the incest survivor (Maltz & Holman, 1987; Tsai & Wagner, 1978). Similar to an uncontrollable nightmare, the flashback transports the survivor to the past where the abuse is mentally re-experienced. Sensations such as nausea and pain could be felt again. There could be a physiological tightening up which could result in the loss of whatever sexual arousal that had been present. A flashback could occur periodically or several times during one sexual encounter. These flashbacks have been reported during stressful, nonsexual situations as well as during nonstressful incidents. The survivor is faced with a chronic vulnerability (Maltz & Holman, 1987).

Questionnaires were administered to 542 college women and 7.7% (42) were found to have been sexually molested (Fritz, Stoll & Wagner, 1981). Of these 42 females, ten (23%) reported current sexual adjustment problems. There was one significant difference between females who had been molested and reported no problems and females who had been molested and reported problems. Negative as opposed to positive coercion seemed to correlate with an individual's self-perceived sexual adjustment as an adult. In other words, according to the authors interpretation succumbing to molestation in the absence of physical force may produce guilt which compounded the trauma that was associated with molestation and the effects on adult functioning. Apparently the victims who were physically or verbally attached were able to absolve

themselves of culpability. Summit (1982) disagreed and suggested an alternate view; he believes that many women who were sexually abused assume that they are crazy, bad or sick due to their internalized helplessness and guilt. Summit suggested that this guilt appears to emerge regardless of the use of coercion and that the rage these women feel often causes them to live in fear of losing touch with reality or losing control of their feelings. Summit found that for the survivor the long-term effect of being unaware of these feelings or thoughts was to end up having problems with intimacy, trust and sexual functioning.

Guilt as a long-term effect of sexual abuse and the affect guilt has on sexual functioning has been empirically established in the following study. Morokoff (1985) studied 62 female subjects who were randomly assigned to view erotic or nonerotic videotapes. The subjects then wrote out or imagined a sexual fantasy. Sexual arousal was measured physiologically through vaginal photoplethysmograph recordings and subjectively through self-report ratings. It was found that sex guilt has an inhibiting effect on self-report of an individual's sexual arousal. Low sex-guilt subjects expressed a higher degree of arousal by erotic stimulation than high sex-guilt subjects. However, high sex-guilt subjects actually showed a higher degree of physiological arousal during explicit erotic exposure than the low sex-guilt subjects. Sex guilt appears to function as a means of avoiding sex-related

situations which is demonstrated by the tendency of the individual with high sex-guilt to inhibit their self-awareness of arousal and perhaps thereby inhibit sexual behavior.

When there has been a traumatic sexual experience, negative connotations could become associated with sex. In a child's memory, if sexual contact was associated with negative emotions, revulsion, powerlessness, anger, or fear, all future sexual experiences could be contaminated. Because these associations could generalize to an eventual aversion to all intimacy and sex, it is not surprising that there is such a large incidence of sexual dysfunction among molestation victims (Finkelhor, 1986).

Sexual Fantasies: Functional and Dysfunctional

In order to determine whether a sexual fantasy is other than normal, it must first be determined what sexual fantasies are reported as normal. Two hundred thirty college students (114 male and 116 female) completed questionnaires in which they responded to 13 specified fantasies (Sue, 1979). The majority of the subjects reported fantasizing while engaged in sexual intercourse. Women's fantasies involved more themes with members of the same sex and being forced into sexual relationships than men's fantasies. Fantasizing was used by both sexes to enhance arousal and was found to be a typical component in sexual behavior.

Shanor (1978) presented the ten most popular sexual fantasies found for women in her study. These include; a) sex

with a man not previously involved with, b) past sexual experiences, c) sensory fantasies, d) sex with a man other than the one having intercourse with at the time, e) group sex, f) being very desirable to men, g) women's bodies, h) being coerced into having sex with a man, i) sex with more than one man, and j) sex in a public place (e.g. crowded subway, restaurant).

In a study (Grosskopf, 1983) designed to analyze sexual behaviors and attitudes of 1207 married, middle-class women, almost 75% reported that their sexual fantasies were fulfilling, enjoyable, and positive aspects of their sexual expression. Sixty percent of the women categorized their sexual fantasies as "romantic". Similarly, "seductive" fantasies were reported by almost 40% of the women. Over 50% of the women had engaged in fantasy about a famous person. Group sex was the third most popular fantasy. Other common fantasies included exhibitionism and lesbian fantasies. Rape fantasies were described by less than 10% of the subjects and the rape was qualified as being "soft" or "willing". A few women used animals in their fantasies. During masturbation, over 50% of the respondents frequently or always fantasized. Fantasy, during masturbation, was described as a mechanism utilized to take them from the plateau phase of arousal to orgasm. During sexual relations with their partner, only 16% frequently or always used fantasy, whereas, 51% occasionally did, 18% seldom did and 14% had sex without ever fantasizing.

In a study (Brown & Hart, 1977) on sexual fantasy incidence for 102 university women, it was concluded that 99% had engaged in fantasy on at least an occasional basis. Liberal attitudes, age, anxiety, independence, and sexual experience were found to be correlated with the frequency of fantasy production in this sample.

In 1983, Nutter and Condron compared 25 females from a sexual dysfunction clinic who complained of inhibited sexual desire with 30 women who reported having a satisfying sex life. It was found that women with inhibited sexual desire had fewer fantasies during general daydreaming, masturbation, coitus, and foreplay than the controls. When women from both groups fantasize, the content is similar. Women with inhibited sexual desire do not experience fewer orgasms during masturbation, nor do they masturbate less often than the controls which raises questions regarding the diagnosis of inhibited sexual desire. Since it is during intercourse alone that fewer orgasms are experienced, fear of coitus might be a better description than inhibited sexual desire.

Eight-six percent of the 300 women aged 18 to 35 who participated in the Masters, Johnson and Kolodny (1982) study were found to have erotic fantasies and 72% reported using fantasies as a means of increasing sexual arousal. The research findings support that the fantasy content is similar for each sex. Fantasy content is seen as originating normally from a movie scene, book, or an individual's actual

experience. The fantasy pleases the person and so is returned to again and again. The fantasizer plays the main character in the story, but there can be variations. A particular fantasy is replayed because it allows the fantasizer to be in control or because of its sexual arousal. Interestingly, fear of loss of control in women who were sexually abused as children accounts for a large percentage of the sexual dysfunction they report. For this group of women, the need to maintain control may manifest itself in an increase in the number and frequency of fantasies they produce and in a recapitulating effect of the sexual abuse they experienced as children. When a fantasy becomes necessary for sexual arousal to occur, the fantasizer is no longer responding to her partner. When a fantasy is drawn from past memories of a sexual experience, the fantasizer can mold or embellish the experience while retaining its essence. In this way, the real life experience can be improved or smoothed out while the passion is allowed to mount without the distractions. It is not uncommon to use a favored fantasy as a means of moving from the arousal level in the plateau phase to orgasm. Some women report being nonorgasmic without use of their fantasy in this way.

According to Masters, Johnson and Kolodny (1982), some fantasies are not pleasing or willfully conjured up. Although unwanted, these fantasies recur in an intrusive manner and can cause guilt, conflict, and fear. These fantasies can cause

the individual to shut down the sexual feelings they were experiencing because of distress or can lead to increased sexual arousal. Normally the intrusive fantasies depict sexual conduct or situations which the fantasizer considers bizarre (yet arousing) or abnormal. Although the study does not differentiate characteristics of subjects with upsetting fantasies, it is possible that this group is made up of individuals who have been sexually traumatized at some point in their life such as in the case of sexual molestation or incest. This type of trauma could account for intrusive fantasies which are disturbing, but also sexually arousing. There is usually some form of imagined injury or punishment which serves as the price being paid for sexual indulgence. The intrusive fantasies can result in sexual dysfunction, sexual guilt, or avoidance of all sexual activity.

Although based on male subjects, the Campagna (1985) study appears to support the Masters, Johnson and Kolodny (1982) study of females. Forty-five male college students were randomly selected and assigned to participate in three conditions; self-generated fantasy, vicarious fantasy, and non-erotic story. Self-generated erotic fantasies increased or sustained sexual arousal. The self-generated fantasies were altered, controlled, or molded by the individual which may account for their arousing capabilities especially as associated with erotic needs. These private sexual fantasies often recur for years.

In a study of 38 married couples, Hessellund (1976) conducted interviews to determine the personal qualitative thematic differences with respect to sexual fantasies and masturbation between men and women. Men and women showed qualitative differences in the way they thought about sex. Men exhibited an achievement and action orientation and their fantasies served to maintain their masculine self-image through the power of satisfying women. They also tended to involve several persons in their fantasies. Women stressed the emotional, tender aspects of sexuality which was demonstrated in the more person oriented content of their sexual fantasies. It was proposed that sexual fantasies and masturbation served a different function for men and women. According to Hesselund (1976), masturbation, for men, seemed to be a means of supplementing coital behavior because women tend to monitor the frequency of sexual activity. For women, masturbation appeared to be a "compensation" for coital behavior apparently involving romantic themes that may have otherwise been missing. The authors apparently did not consider the possibility that masturbation may also have been supplemental for women who were non-orgasmic in intercourse.

Sexual fantasy can be used to enhance orgasmic capacity during intercourse. Lentz and Zeiss (1984) conducted a study with 56 female college students in which they found that women who during masturbation related a high percentage of fantasies with intercourse-related content had an increased likelihood

of experiencing orgasm during intercourse.

Hariton and Singer (1974) had 141 suburban housewives complete questionnaires which involved fantasies, sexual patterns, marital adjustment, daydreaming tendencies, ideation during intercourse, and measures of personal adjustment, personality, and intelligence. The results showed 65% of the subjects reported erotic fantasy levels during intercourse as moderate to high in frequency. The most predominant fantasy themes were "submission" or "imaginary lover".

Beyond "submission" fantasies, some studies reported rape fantasies. Fifty-seven percent of 203 university females who completed questionnaires reported having conscious fantasies of rape (Kanin, 1983). Approximately 29% of these fantasies were seduction rather than rape fantasies. Almost 17% of the subjects had rape fantasies that were experienced as non-erotic and unpleasant. Although the study did not further explore the content of these non-erotic and unpleasant rape fantasies, it is possible that these women were experiencing some form of recapitulation of an earlier sexual trauma. Since these fantasies were self-reported by the subjects as being unpleasant and non-erotic, it is likely that these fantasies were intrusive, recurrent ruminations of a previous sexual trauma which had involved some form of coercion. This leaves only 12% of the subjects who reported having what has traditionally been termed "rape fantasies", which are fantasies combining both fear and sexual excitement. These

results dispute the long-standing Freudian hypothesis that female sexuality is primarily masochistic in nature and that the majority of women have positive arousal associated with rape wishes.

Questionnaires were completed by 166 females and 144 males who were sexually active, never-married, university students for a study on sexual fantasies (Davidson, 1985). Ninety-five percent of the female respondents reported having experienced sexual fantasy, and 28% reported fantasy on a frequent basis. Results suggested that males and females achieved orgasm (66%) and developed sexual arousal (80%) through fantasy production. Women fantasized more about romantic settings and prior sexual experiences. According to the authors, the findings suggested that rape fantasies were not popular among the never-married women in this sample. Interestingly, 69% of the women and 58% of the men reported the presence of guilt feelings about their sexual fantasies.

In 1980, Crepault and Couture conducted a study where 94 male subjects were interviewed regarding their erotic fantasies. A total of 45.8% of the males responded positively to having the following fantasy, "Scene where you have the impression of being raped by a woman". During heterosexual sexual activity, the fantasy content for these subjects centered around the following themes; masochistic fantasies, aggressiveness, and confirmation of sexual power. In contrast' in a study of 66 female subjects Crepault (1977)

found the fantasy content themes most prevalent for women were being with a partner other than the one currently engaged with and reviving a sexual activity from the past. It was determined that women with the greatest incidence of erotic fantasy during heterosexual activity had several traits in common: a) primarily experienced vaginal (sic) orgasms, b) were more rapidly orgasmic when engaged in sexual activities other than intercourse, c) had 16 or more years of schooling, d) began masturbating when they were young and have continued on a frequent basis, e) frequently engaged in erotic imagery outside of sexual activity, and f) experienced homosexual and heterosexual activity during puberty or childhood. Thus, these women were more sexually responsive as well as more sexually experienced. When comparing the most popular fantasies for men and women, five were found to be the same including; fantasizing about cunnilingus, fellatio, an erotic film scene, a previous sexual experience, and being with someone other than the current partner.

Although the empirical data supporting the occurrence of rape fantasy in women has been previously shown to be questionable, current researchers continue to cite old theory. Maslow (1942) correlated insecurity-security and self-esteem variable to sexual fantasies for 139 subjects of which 70 comprised the criterion group. It was determined that women with high self esteem showed stronger tendencies for promiscuity and masturbation. The fantasies they related were

liberal and varied. Rape or prostitution fantasies were reported as enjoyable and excitable. Low self-esteem women reported these same fantasies as horrifying. High self-esteem women were unrepressed and uninhibited, whereas low self-esteem women were inhibited and strongly socialized. According to Maslow, for a category of women he identified as high self-esteem and insecure, there was not much differentiation between pleasure and pain (e.g. these women reported that the idea of being the victim of rape was sexually exciting). Maslow suggested that for these women sex and power were fused and arousing themes for them included equal amounts of sadism and masochism.

Using 263 subjects, Arndt, Foehl and Good (1985) conducted a study based on the assumption that sexual fantasies were homogenous. The study found that there were "four relatively independent male and female fantasy factors, each associated with differing personality and sexual patterns, which supported the contention that sexual fantasies were multidimensional". For females, the relation between sexual satisfaction, sexual behavior and total fantasy concluded high fantasizers tended to be orgasmic both in masturbation and with partners. These women expressed satisfaction in their sexual life.

In contrast, sexual fantasy incidence related to gender and race was investigated by Price and Miller (1984) in a study involving 128 college students. They found that blacks

were more likely to use fantasy during sexual intercourse and whites were more likely to feel guilty for having fantasies. White women and men had fewer sexual fantasies than black women and men. Less reported sexual satisfaction was reported by blacks than by whites.

In a study investigating the effects of neutral, romantic, or erotic response cues and the resulting sex guilt level in the sexual fantasies reported by females, Moreault and Follingstad (1978) found that females with high sex guilt levels preferred sexual fantasy themes which indicated an irresponsibility for involvement in sexual interaction. Sexual arousal was not affected by the women's guilt levels.

In summary, the literature indicated that sexual fantasies were common for both males and females. Fantasies were used to develop and to enhance sexual arousal as well as to achieve orgasm. Male fantasies were more achievement and action oriented and served to maintain the masculine self-image by deriving a sense of power through satisfying women. In contrast, female fantasies were more person oriented and centered around romantic, seductive themes or prior sexual experiences. In contradiction to the earlier literature, females were not likely to have rape or masochistic fantasies. Women who were high fantasizers had higher levels of sexual activity and sexual satisfaction.

Motivation for Creating Sexual Fantasy

Although there has been little argument that sexual

fantasies exist and are related in some important way to sexual behavior, there seems to be a variety of theories as to the meaning or function of such fantasies. Hollender (1970) in an article on women's fantasies during intercourse spoke of the use of fantasy as a means of converting sexual intercourse into a form of masturbation (perhaps, mutual) and the interpersonal relationship into a more intrapersonal one. According to Hollender, fantasies during coitus made it possible to experience orgasm which may not have been possible without fantasy. Gratification could only have been derived when the childhood notion of sexual excitability was consonant with what was occurring in the fantasy. A woman who used coital fantasies was seen by Hollender to have been remaining emotionally isolated and was also seen as deriving gratification from her masturbatory fantasies as though she were denying actually engaging in coitus with her husband. This was seen as a manifestation of the woman's inability to form an intimate relationship with a man and her need to maintain a detached position.

Sullivan (1969) postulated that in and of themselves sexual fantasies are harmless and universal. It is when fantasies encourage behavior that is inappropriate, cause the individual to suffer extreme guilt, and become a substitute for a normal, active sex life that they can lead to psychopathology. In this regard, he seemed to support Hollender above. Sullivan also contended that after a

traumatic occurrence an individual could imagine variations of the event or relive it in the form of a painful fantasy. Reliving the experience through recurrent fantasies helped the individual become desensitized to the painful event and served to insulate the individual from the overwhelming horror of the incident.

Stoller (1979) hypothesized that hostility, the hidden or overt desire to harm another, generates and enhances one's sexual excitement. Sexual indifference resulted from the absence of hostility. The hostility of eroticism was seen as a repetitive attempt to undo the frustrations and traumas from childhood which threatened one's masculine or feminine development. The function of sexual fantasy was to reverse trauma to triumph and maintain the details of the childhood frustration or trauma while converting the painful experiences to pleasure. Sexual excitement was sharpened by the vacillation between one's hope that this time there would be a pleasurable conclusion and that the anxiety of the original trauma would not be repeated. The sexual fantasy was played out in the form of an autobiography whose plot originated in childhood experiences. Through the use of safety factors and elements of risk, screen memories of actual incidents and hidden intrapsychic conflicts were resolved through orgasm.

According to Kaplan (1985), normal sexual fantasy was postulated to include numerous forms of perverse sexual and genital fantasy as well as tolerance of and the capacity for

the corresponding behaviors. These behaviors and fantasies were expected to endure a degree of aggression which allowed the normal individual to integrate and tolerate masochistic and sadistic behaviors and fantasies in sexual intercourse. A fantasy considered to be typical involved using another person as the "object", or of the self being "used" as the object which satisfied that masochistic (second case) or sadistic (first case) impulse. This allowed an individual to remain secure in the love relationship that provided a holding environment where the total sexual relation was safeguarded.

Along the same lines, Dally (1975) stipulated that sexual fantasies were either sadistic, where the person was humiliated or overpowered, or masochistic, which involved one person submitting to someone else. According to Dally, by age five, the basis of all future fantasy had been formed. These sexual fantasies were seen as evolving within the child's world during early childhood, becoming fixed during adolescence or sometime in early adulthood, and staying with the person until they die. What experiences the child had in the nature of her relationships with others close to her; how her needs were met by those upon whom she depended for gratification; and how she reacted to anger, anxiety, and frustrations would determine what sexual fantasies developed and the eventual pattern of sexual behavior in adulthood.

Shainess and Greenwald (1971) participated in a debate which questioned whether fantasies during sexual activity were

a sign of some difficulty. Shainess stated, "Many women who have rape fantasies, often have cruel, violent sexual experiences as well as experiences of other violence in their early childhood". These early experiences were seen by the authors as having conditioned the victims to passivity. They suggested such victims were no longer capable of relating in an assertive, active way. The authors further speculated that because rape constituted sex under cruel, painful, and violent circumstances, rape fantasies may allow these victims to express their passivity, termed "masochistic needs" by the authors. These fantasies were seen as a denial of responsibility in the sexual act and symptomatic of a sexual dysfunction. Shainess saw sexual fantasies as symbolic of sexual alienation and a recapitulation of the sexual alienation that occurred in the rape. The fantasies were not seen as something that the fantasizer controlled, but rather as obsessive-compulsive manifestations. While interesting or important points were made regarding the connection between sexual fantasy and rape, it seemed inappropriate to refer to these fantasies as fulfilling a "masochistic need" in the rape survivor. Such a characterization may constitute a further victimization of the survivor by psychoanalytic theorists.

Incest fantasies according to Werman (1977) can occur with nonpsychotic patients prior to diminishing resistance in psychoanalytic treatment and are not indicative of severe superego or ego distortions. The author found there were four

factors correlated with incest fantasy production: repression of some oedipal complex aspects, defensive mechanisms used to keep super-ego tensions tolerable, increased drive tension, and excessive sexual stimulation (incest and/or observing adult sexual activities) at an early age.

Larson and Maddock (1983) examined the psychological signals that could be recognized in adult victims of incest or childhood sexual abuse. Among adult victims the most prevalent recurring dream or fantasy seemed to involve themselves as children, normally in bed, with an ominous, dark creature coming toward them, although the creature's identity was unknown. Another signal involved sadomasochistic fantasies or behaviors which victims of incest reported as necessary to become sexually aroused.

In her book on female sexual fantasy, Friday (1973) wrote about the necessity of specific characters for some females to enjoy their fantasy to its fullest. For some women, the initial sexual imagery involving brothers, fathers, etc. became their most lasting and potent sexual fantasy. These first fantasies were presumed to have originated in childhood as "tiny seeds" which grew and expanded over the years. These fantasies often prevailed over time because of the association between sexual arousal and the prohibition and secrecy of the content of that first fantasy. The author did not specifically address the relationship between the origin of fantasy and childhood sexual experience, however it was

possible that sexual fantasy originated out of actual experiences the child had had such as in incest and sexual molestation.

As the research presented suggested, some subjects experienced fantasies of a disturbing nature; childhood experiences may have been the root of sexual fantasy, and it was possible that incest and sexual molestation experience in childhood may have formed the basis of fantasy, especially disturbing fantasy production. Although there remained differing perspectives as to the purpose or needs being met through sexual fantasy production, this study will attempt to clarify one subgroup's need for such fantasy.

<u>Survivors Quest for Resolution of the Molestation</u>

Many sexual molestation survivors report a need to understand and explain their early childhood experience, apparently related to their desire to take control and resolve the traumatic event. Silver, Boon and Stones (1983) studied survivors of father-daughter incest and how they handled the search for resolution, termed by the authors "a search for meaning". Over 80% of the subjects reported that it was still important to make sense of the incest by asking such questions as, "why it happened, why didn't I say no, why didn't my mother do more about it" even though the experience had ended 20 years ago on the average. The more actively the survivors appeared to be asking questions about the experience the more disruptive, intrusive, recurrent the ruminations (mental

pictures, memories, or thoughts) they reported. The direction of causality is unclear (e.g. do ruminations lead to long-term disruptions or are they a reminder of the severity of the incident and subsequent long-term adjustment problems or are they a healthy survival strategy that avoids denial and repression). The authors reported more than 80% of the subjects found that engaging in sex reactivated incest experience memories. Further, over 50% of the respondents actively engaged in what the authors termed "a search for meaning" but had nevertheless been unable to make any sense of the molestation even after 20 years. These women experienced significantly more disruptive, intrusive, painful, and recurrent ruminations, greater psychological distress levels and lower levels of self-esteem, social functioning, and self-reported resolution of the overall experience. Even for the women who according to the authors had made "some sense" of their victimization, over 90% continued the so called "search for meaning", and 65% of them were still experiencing intrusive ruminations.

Gelinas (1983) found in her work with adult incest victims that there was a concerted effort to maintain denial, but repetitive intrusions occurred nonetheless. These intrusions were involuntary compulsive tendencies to repeat an aspect of the trauma while at the same time there was a conscious effort to suppress and avoid it. According to Freud (1920), intrusive experiences often alternated with

avoidance or denial states and were essential elements for post-traumatic disorders. There was a need for mastery of the trauma (avoidance of harm) and to return things to a pre-trauma condition (pleasure) which could only be accomplished through active repetition of the event.

Efforts to resolve one's traumatic experience or the "search for meaning" could cause the thought processes to be filled with repeated ruminations consisting of the "unfinished business" (Horowitz, 1979, Parkes, 1972). Theorists, beginning with Freud (1920), saw the repeated reviewing of a traumatic experience motivated by a need for gaining mastery over the negative life events (Horowitz, 1973, 1975, 1979, 1986).

Bibring (1943) theorized that there were two aspects to the repetition compulsion; a) the reproductive or repetitive tendency to repeat or preserve the traumatic incident (ID), and b) the restitutive tendency which was the effort to reestablish a pretraumatic environment (EGO).

Parkes (1972) in discussing the process of grief work in regard to a traumatic event wrote of a conscious need to explain the event, to make sense of the traumatic event, to be able to classify it along with similar events, and to fit the event into one's expectations of the world. Monotonous repetitive remembering of the exact sequence of events which led up to the trauma, trying out different end results to the trauma, and searching for meaning or clues which would

explain, "Why did it happen to me?" are all part of the process of grief work. The search for resolution and mastery of victimization with survivors of molestation and the recapitulation of molestation in sexual fantasy may both be forms of grief work.

Hypothesis

Overall the findings of this literature review suggested that; 1) childhood sexual trauma resulted in adult fantasy during sexual activities and/or daydreams which may have included flashbacks of the actual molestation as well as fantasies of topics related to the molestation, 2) such sexual fantasy was sometimes disturbing to molestation survivors and their disturbing sexual fantasies may have been related to the sexual dysfunction that has generally been found in molestation survivors. Based on this literature review, the following hypothesis were generated: 1) Female subjects who were sexually molested during childhood or adolescence would report different emotional responses to the sexual fantasy scales than subjects who were not sexually molested during childhood or adolescence; 2) The sexual fantasies experienced by female subjects who were sexually molested during childhood or adolescence are often a recapitulation of their earlier sexual molestation; 3) A significant number of subjects who were sexually molested during childhood or adolescence will report recapitulation of their earlier sexual molestation in their sexual fantasies as associated with sexual arousal; 4)

Female subjects who were sexually molested during childhood or adolescence have fewer sexual fantasies than female subjects who were not sexually molested during childhood or adolescence; 5) Female subjects who were sexually molested during childhood or adolescence engage in less sexual activity than female subjects who were not sexually molested during childhood or adolescence.

METHOD

Subjects

Subjects for this study were 115 female volunteers who were at least 25 years of age or older. The age range was 25 to 69. The sample was divided into five age groups; 25 to 30 (N = 27), 31 to 39 (N = 41), 40 to 49 (N = 38), 50 to 59 (N = 8), and 60 to 69 (N = 1). Subjects were self-identified either as survivors of childhood sexual molestation or as having had no experience with childhood molestation or other sexual trauma as an adult. Subjects were recruited through a variety of contacts and included: 1) participants in groups for Adults Molested as Children, 2) clients of private therapists, 3) students from various classes at California State University-San Bernardino, 4) friends and acquaintances contacted by letter as potential participants, and 5) former graduates of the M.S. Clinical Counseling Psychology Program at California State University-San Bernardino contacted in a mail solicitation. Approximately 400 questionnaires were printed and distributed; 115 were returned. One hundred twenty-three subjects signed consent forms and received questionnaires for the non-traumatized group; 85 questionnaires were returned completed. Forty-six subjects signed consent

forms self-identifying as having been sexually traumatized and 30 questionnaires were returned completed.

Design

The subjects were self-identified via the consent form as either having experienced sexual trauma as a child or as never having had either such an experience as a child or adult sexual trauma. Sexual trauma was defined as rape, incest or sexual molestation. For those women who self-identified as having been sexually traumatized as a child, there was an additional requirement that they currently be in therapy or a support group for incest/molestation survivors. A few subjects who self-identified as having been sexually traumatized as a child were allowed to participate in the study if they had previously been in therapy and currently had support available to them. To double check subjects' self-identification, questions on experience with sexual trauma were included again at the end of the questionnaire and were answered by all subjects.

Introduction Procedure

Subjects were solicited either by the researcher in person or by a letter. Subjects were told that the study was designed to investigate sexual fantasy production and its impact on women and that they must be age 25 or older (see Appendix A). The extreme personal nature of the questionnaire was discussed as well as the difficulty in

being open and honest. Potential subjects were advised as to the precautions being taken to assure the anonymity of the questionnaire and confidentiality of the consent forms. Subjects solicited in person were asked to identify if they would be interested in further information about the study at which time they were given a description of the study as well as consent forms for each of the groups (see Appendix B & C).

Consent Form Procedure

Upon signing the appropriate consent form, the subject was given a manila envelope which was pre-addressed to the researcher and contained the questionnaire corresponding to the consent form signed, and a debriefing letter (see Appendix D). Subjects solicited by mail were sent a letter which included the introduction to the study as well as both consent forms. Upon mailing the appropriate consent form back to the researcher, the corresponding questionnaire was then mailed to the subject with an enclosed addressed, postage paid return envelope. No tracking system was used to identify which consent form corresponded to which questionnaire.

Special Precautions

Since there was the possibility of a participant becoming emotionally upset by the questions contained in the questionnaire, the introductory letter to the study as

well as the debriefing letter contained the researcher's name and telephone number, two names, addresses and telephone numbers of therapy groups for women molested as children, and a suicide and crisis prevention hotline number. Additionally, participants were asked in the introductory letter to the study to discontinue the questionnaire and contact the researcher if they felt upset in any way. One participant contacted the researcher to express distress.

Fantasy Questionnaire

In order to examine differences in sexual fantasy production between women who were sexually traumatized in childhood or adolescence and women who were never sexually traumatized a questionnaire was developed for this study entitled, The Questionnaire on Sexual Fantasy Production as Related to Current Sexual Activity (see Appendix E). Questions were based on the literature review of sexual fantasy and molestation research. No standardized measures were utilized. The instrument administered to all subjects covered topics including demographics, current sexual activity, sexual attitudes, sexual behavior, and sexual fantasy content, and included 184 items. Several questions regarding past sexual trauma were included at the end of the questionnaire to confirm the subjects' self-identification as either a molestation survivor or a

subject with no past history of sexual trauma as a child or an adult.

Subjects self-identified as molestation survivors completed 87 additional questions on their molestation experience. Areas covered in this additional section of the questionnaire included: the relationship of the molester to the subject, type and length of the molestation, family dynamics existing at the time of the molestation and disclosure, questions regarding how the molestation has affected the subject's sexual functioning and questions regarding the extent to which the subject continues to think about the experience.

The fantasy content section of the questionnaire used in this study had 52 sexual fantasies which had been put into a priori categories; the nine different categories were based on previous studies cited in the literature and the judgment of the experimenter and her committee members. The nine categories were as follows: 1) Romance, 2) Pain, 3) Dominating Someone or Someone Dominating You, 4) Childhood or Child Related, 5) Performing Sexually in Front of Others, 6) Unknown Identity, 7) Being More or Other Than Yourself, 8) Risk Taking, and 9) Fantasies That Do Not Fit Elsewhere. Initially the categories contained five to seven items. Subjects scored each sexual fantasy for its occurrence and identified the sexual fantasy as either exciting, upsetting, or both exciting and upsetting.

RESULTS

Differentiating Group Information

Eighty-five subjects self-identified as never having been sexually traumatized and signed consent forms to that effect; while completing the double check questions at the end of the questionnaire, 42 of those subjects marked "yes" to one of the double check questions asking if they had ever been sexually traumatized as a child or an adult (see Table I). Since these 42 subjects could not be considered as never having been sexually traumatized, data from these subjects was analyzed separately. This resulted in the subject pool being split into three groups rather than two.

In group one (N = 30) subjects were self-identified as having been sexually molested as a child. Subjects in group two (N = 43) were self-identified as having experienced no trauma as a child or an adult. Subjects in group three (N = 42) were self-identified as having experienced no trauma as a child or an adult, but subsequently answered at least one double check question indicating that they had been sexually traumatized as a child, an adult, or both as a child and an adult. Of these subjects, nine recalled a sexually traumatizing event during the course of completing the questionnaire that they were unaware of at the time of

signing the consent form. The remaining 33 subjects apparently did not initially define as sexual trauma events such as being forced to have sex or sexual trauma as we defined it. This group will be identified as the "rollover" group. Data from the study was then analyzed in these three groups and subjects will be referred to hereafter as Group 1 (molest), Group 2 (no trauma), and Group 3 (rollover), as defined above.

Demographic Subject Information

Subjects were asked to specify their current status according to these categories; student, housewife, unemployed, labor, office or professional. The subjects responded as follows: 82 students, 60 housewives, 40 unemployed, 6 labor, 18 office, and 42 professional. Relationship status for the population was distributed into six categories; 56.5% were married, 2.6% separated, 19.1% divorced, 13.9% single, 6.1% live with lover, and 1.7% widowed. For ethnicity the sample was identified as 86% Caucasian, 4.4% Hispanic, 4.4% Black and 5.3% other. The sample was well-educated; 4.4% high school graduates, 49.6% some college, 20.4% college graduates, and 25.7% graduate school. The sample was primarily heterosexual (91.2%), but included 4.4% homosexual, .9% asexual, and 3.5% bisexual subjects. There were no demographic differences between the three groups.

TABLE I

RESPONSES OF 42 SUBJECTS WHO PREVIOUSLY SELF-IDENTIFIED AS NON-TRAUMATIZED SUBJECTS

Trauma Questions	Number of Subjects Who Checked "Yes"
Were you ever forced to have sex as an adult?	16
Were you ever raped or the victim of an attempted rape as an adult?	5
Were you ever forced to participate in sexual activity as a child or adolescent?	5
Were you ever the victim of a rape or an attempted rape as a child or adolescent?	3
Were you ever sexually molested (touched by someone, asked or made to touch or observe someone in a way which made you feel uncomfortable) as a child or adolescent?	24
While completing this questionnaire, did you recall a sexual trauma from the past that you had forgotten about?	8
While completing this questionnaire, did you remember a sexual trauma from the past that had not been previously known to you?	1

Sexual Fantasy Scales

Sexual fantasies had been put into nine a priori scales when the questionnaire was constructed (see Table II). A reliability analysis was conducted using the Pearson product-moment correlation coefficients on the items of each scale and items with low reliabilities on either the exciting or upsetting variable were deleted from further analysis. The deletion of unreliable items resulted in eight scales with number of items ranging from two to eight (see Appendix F). Cronback's reliability alphas for exciting and upsetting are presented for each sexual fantasy scale in Table III.

Hypothesis 1 Results

It was hypothesized that female subjects who were sexually traumatized during childhood or adolescence would report different emotional responses to the sexual fantasy scales than female subjects who were not sexually traumatized during childhood or adolescence. In order to test the hypothesis an emotional response scale score was acquired by summing the number of reported responses of exciting, upsetting, or both exciting and upsetting to the items in each sexual fantasy scale. A one-way analysis of variance was conducted on each emotional response scale score for each sexual fantasy scale by group to determine whether there were significant differences in the way the groups responded emotionally to the fantasies in each scale.

TABLE II

NINE SEXUAL FANTASY SCALES AND EXAMPLES OF THE SEXUAL FANTASIES WITHIN EACH SCALE

Scale 1 - Romance
1. I imagine a romantic setting and being seduced by a stranger.
2. I relive a previous enjoyable sexual experience.
3. I make oral contact with my partner's genitalia and/or masturbate him/her and he/she does the same for me.

Scale 2 - Pain
1. I relive a previous unpleasant or disturbing sexual experience which has left me marked or branded.
2. I imagine my partner strips me, lays me over his/her lap, and spanks me.
3. I imagine I am being whipped and beaten and/or violently raped.

Scale 3 - Dominating Someone or Someone Dominating You
1. I pretend to resist being overpowered and forced to undress and perform sexually, but I am actually aroused.
2. I imagine I kidnap a man/woman and make him/her do as I order.
3. I imagine my partner urinates or defecates on me.

Scale 4 - Childhood or Child Related
1. I imagine a man/woman is teaching me about sex.
2. I imagine I am engaged in sexual activity with a family member.
3. I pretend to be a sleeping child or to passively resist a woman/man who is trying to sexually arouse me.

TABLE II CONTINUED

Scale 5 - Performing Sexually In Front Of Others
1. I imagine I observe myself or others having sex.
2. I imagine myself as a striptease dancer, harem girl, porno queen, or some other performer.
3. I imagine a man/woman is watching me masturbate.

Scale 6 - Unknown Identity
1. I imagine I am having sex with a man/woman whose face I cannot see.
2. I imagine I am a child and an unknown, scary creature is coming toward me.
3. I imagine a masked person who has an enormous penis is going to try to have sex with me.

Scale 7 - Being Other Or More Than You Are
1. I pretend to be an irresistible woman who delights many men.
2. I imagine I am participating in an orgy.
3. I imagine I am being made love to by several partners at the same time.

Scale 8 - Taking Risks
1. I enjoy pretending I am doing something wicked or forbidden.
2. I imagine I engage in sex without birth control.
3. I imagine I am having an affair with my best friend's partner, my partner's boss, or my neighbor.

Scale 9 - Fantasies That Do Not Fit Elsewhere
1. I imagine I am engaged in sexual activity with animals.
2. I imagine I am having sex with a handicapped person.
3. I imagine I am having sex with a man/woman whose ethnic origin is not the same as mine.

This provided a measure of the affective responses to the fantasies included in each sexual fantasy scale. The F ratios for the exciting, upsetting, and "both exciting and upsetting" variables are presented in Table IV. The group means calculated in one-way analyses of variance using sexual fantasy scale by emotional response (exciting, upsetting, and both exciting and upsetting) are presented in Table V.

Hypothesis one is supported: significant differences among the three groups were found for the exciting emotional response to sexual fantasy scales on three scales. For the Domination Scale, Group 1 (molest) reported significantly more of the fantasies described in this scale as exciting ($M = 1.433$; $F = 6.480$; $p < .01$) than Group 2 (no trauma; $M = .628$) or Group 3 (rollover; $M = .667$). For the Performing Sexually in Front of Others Scale, Group 1 (molest) reported significantly more of the fantasies described in this scale as exciting ($M = 2.500$; $F = 3.993$; $p < .05$) than Group 2 (no trauma; $M = 1.209$). For the Being More or Other Than You Are Scale, Group 1 (molest; $M = 2.633$; $F = 5.577$; $p < .01$) and Group 3 (rollover; $M = 2.634$) reported significantly more of the fantasies described in this scale as exciting than Group 2 (no trauma; $M = 1.279$).

Significant differences were found among the three groups for the upsetting emotional response to sexual fantasy scales on four scales. For the Pain Scale, Group 1

(molest) reported significantly more of the fantasies described in this scale as upsetting ($M = .667$; $F = 5.612$; $p < .01$) than Group 2 (no trauma; $M = .070$) or Group 3 (rollover; $M = .262$). For the Domination Scale, Group 1 (molest) reported significantly more of the fantasies described in this scale as upsetting ($M = .367$; $F = 3.204$; $p < .05$) than Group 2 (no trauma; $M = .047$). For the Unknown Identity Scale, Group 1 (molest) reported significantly more of the fantasies described in this scale as upsetting ($M = .667$; $F = 7.151$; $p < .01$) than Group 2 (no trauma; $M = .047$) or Group 3 (rollover; $M = .073$). For the Being Other or More Than You Are Scale, Group 1 (molest) reported significantly more of the fantasies described in this scale as upsetting ($M = .500$; $F = 4.995$; $p < .01$) than Group 2 (no trauma; $M = .047$). Although not statistically significant, but perhaps of clinical importance there was a trend for the Child Related Scale, Group 1 (molest) reported more of the fantasies described in this scale as upsetting ($M = .300$; $F = 2.570$; $p < .10$) than Group 2 (no trauma; $M = .023$).

Significant differences were found among the three groups for the "both exciting and upsetting" emotional response to sexual fantasy scales on two scales. For the Domination Scale, Group 1 (molest) reported significantly more of the items in this scale as "both exciting and upsetting" ($M = .367$; $F = .4.189$; $p < .018$) than Group 2 (no trauma; $M = .023$). For the Being More or Other Than

TABLE III

SEXUAL FANTASY SCALE ALPHA RELIABILITY COEFFICIENTS FOR EXCITING AND UPSETTING

Scale	Reliability Alphas	
	Exciting	Upsetting
1. Romance	.7133	.2412
2. Pain	.6290	.7446
3. Domination	.7356	.7734
4. Child	.7467	.6360
5. Performance	.8270	.7943
6. Identity	.6701	.8350
7. Other Self	.7885	.5298
8. Risk Taking	.8512	.3205

TABLE IV

F RATIOS ON ONE-WAY ANALYSIS OF VARIANCE FOR EMOTIONAL RESPONSES TO FANTASY

	ANOVA F Ratios		
Scale	Exciting	Upsetting	Both Exciting And Upsetting
1. Romance	0.372	1.490	2.090
2. Pain	1.926	5.612**	2.122
3. Domination	6.480**	3.204*	4.189**
4. Child	1.335	2.570+	.501
5. Performance	3.993*	1.831	1.252
6. Identity	1.419	7.151**	1.681
7. Other Self	5.577**	4.995**	5.114**
8. Risk Taking	0.096	0.708	.708

+p < .10 *p < .05 **p <.01

TABLE V

GROUP MEANS BY SEXUAL FANTASY SCALE

Scale	Group 1	Group 2	Group 3
	Exciting	Exciting	Exciting
1. Romance	2.533	2.861	2.643
2. Pain	.633	.256	.405
3. Domination	1.433	.628	.667
4. Child	.233	.163	.452
5. Performance	2.500	1.209	1.786
6. Identity	.667	.419	.805
7. Other Self	2.633	1.279	2.634
8. Risk Taking	.800	.767	.707
	Upsetting	Upsetting	Upsetting
1. Romance	.233	.070	.191
2. Pain	.667	.070	.262
3. Domination	.367	.047	.119
4. Child	.300	.023	.119
5. Performance	.600	.186	.262
6. Identity	.667	.047	.073
7. Other Self	.500	.047	.220
8. Risk Taking	.133	.070	.049
	Both Upsetting and Exciting		
1. Romance	.233	.047	.191
2. Pain	.400	.070	.238
3. Domination	.367	.023	.095
4. Child	.100	.023	.071
5. Performance	.467	.140	.262
6. Identity	.233	.047	.049
7. Other Self	.500	.047	.195
8. Risk Taking	.133	.070	.049

You Are Scale, Group 1 (molest) reported significantly more of the items in this scale as "both exciting and upsetting" (M = .500; $F = 5.114$; $p < .008$) than Group 2 (no trauma; M = .047).

Hypothesis 2 Results

It was hypothesized that the sexual fantasies experienced by female subjects who were sexually molested during childhood or adolescence are often a recapitulation of their earlier sexual molestation. This hypothesis dealt specifically with women who were sexually molested as children or adolescents. The intent therefore, was to determine if this group engaged in more recapitulation fantasies than women in the other two groups. To make such a determination it was necessary to compare the group's frequency of occurrence responses to these fantasies. Seven of the 52 fantasies included in the questionnaire had content which focused on sexual activity and childhood or adolescence. To test this hypothesis the frequency of occurrence of these seven fantasies during daydreaming, masturbation, and sexual relations were summed and compared by group using a one-way analysis of variance.

Hypothesis two was not supported: significant differences were not found among the three groups. A marginal trend was found in frequency of occurrence for these seven child related fantasies in that Group 1 (molest)

produced more of these fantasies (M = 22.035; F = 2.318; P < .10) than Group 2 (no trauma; M = 21.092) or Group 3 (rollover; M = 21.846).

Hypothesis 3 Results

It was hypothesized that a significant number of subjects who were sexually molested during childhood or adolescence would report a recapitulation of their earlier molestation as associated with sexual arousal. To assess whether subjects who were sexually traumatized in childhood use the recapitulation of their trauma in sexual fantasy to attain sexual arousal, questions were included in the questionnaire which looked specifically at this issue. These questions were only responded to by those women in Group one (molest) who self-identified in the consent form as having been sexually traumatized in childhood or adolescence. Table VI presents the frequency of occurrence responses to these questions.

Hypothesis three was not supported: forty-one per cent reported never experiencing flashbacks to their molestation during masturbation or sexual activities, however 58% were experiencing flashbacks. During sexual activities 52% never relived their sexual molestation; however, 48% did relive their molestation at least occasionally. The percentage of subjects reporting flashbacks (10% frequently; 31% sometimes; 17% rarely) was somewhat similar to the percentage reporting recapitulation of their molestation

during their sexual activities (3% frequently; 14% sometimes; 31% rarely). Eighty-three per cent report never becoming sexually aroused when thinking about their sexualmolestation during masturbation or sexual activities; 14% report rarely and 3% report sometimes becoming sexually aroused. In response to a similar question, 39% report always becoming less sexually aroused when thinking about molestation during masturbation and sexual relations, however, 29% report never and 14% report rarely becoming less sexually aroused. It appears that some subjects do become sexually aroused when recapitulating their molestation. This number is relatively small. This data does not show whether the subjects who recapitulate their molestation can become sexually aroused without recapitulating. While this finding is not statistically significant, it may have important clinical implications for those women who report these experiences.

Hypothesis 4 Results

It was hypothesized that women who had been sexually molested during childhood or adolescence would have fewer sexual fantasies than women who had never been sexually molested during childhood or adolescence. This hypothesis was based on the suggestion in the literature that such traumatic experiences often lead to denial and repression of sexual feelings. To test this hypothesis the frequency of

TABLE VI

RESPONSES OF GROUP 1 (MOLEST) SUBJECTS ON SEXUAL AROUSAL AS RELATED TO RECAPITULATION OF SEXUAL TRAUMA IN FANTASY

Key: N = Never, R = Rarely, S = Sometimes, F = Frequently, A = Always

	Percentage* of Valid Responses				
	%N	%R	%S	%F	%A
During masturbation or sexual relations, I experience flashbacks to my molestation.	41	17	31	10	0
I relive my sexual molestation during sexual activities.	52	31	14	3	0
I become sexually aroused during masturbation or sexual relations when I think about my molestation experience.	83	14	3	0	0
I become less sexually aroused when I think about my molestation experience during masturbation and sexual relations.	29	14	0	18	39
I am orgasmic when I fantasize about being molested.	71	4	14	7	7

*All percentages have been rounded to the nearest whole percent.

occurrence responses to daydreaming, masturbation, and/or sexual relations for each fantasy were summed to obtain a frequency of fantasy occurrence score for each fantasy. These scores were then summed to create a total fantasy frequency of occurrence score.

To test for significant differences in total fantasy frequency of occurrence by group a one-way analysis of variance was conducted. Hypothesis four was not supported: it was found that subjects in Group 1 (molest) produce fantasies more frequently (M = 224.393; $F = 3.847$; $p < .025$) than subjects in Group 2 (no trauma; M = 193.725). This finding is in the opposite direction of hypothesis 4 of this study that women who were molested during childhood or adolescence would engage in significantly fewer sexual fantasies than women who were never traumatized.

Hypothesis 5 Results

The last hypothesis stated that female subjects who had been sexually traumatized during childhood or adolescence would engage in less sexual activity than women who had never been sexually traumatized. The sexual activity section of the questionnaire was assessed by taking the ten items (e.g. self-masturbation, vaginal intercourse, etc.) and looking at the frequency with which the subjects engaged in each of the sexual activities listed. The items were then summed forming a scale (see Appendix G) and a reliability analysis was conducted upon the scale.

Cronback's reliability alpha for the scale was .8727.

To determine whether there was a significant difference between the groups on how they responded to the sexual activity scale, a one-way analysis of variance was conducted. Hypothesis five was supported: a significant difference was found in the frequency of sexual activity. Group 2 (no trauma) reported engaging in significantly more of the activities in the sexual activity scale (M = 40.233; $F = 3.705$; $p < .05$) than Group 3 (rollover; M = 32.881). Interestingly, the subjects in Group 3 (rollover) engage in even less sexual activity than the subjects in Group 1 (molest).

Additional Findings

Emotional Response Differences for 7 Child Fantasies

The emotional responses reported by subjects in all three groups for the 7 fantasies that dealt with sexual activity and childhood or adolescence were assessed. Eighteen subjects in Group 1 (molest), five subjects in Group 2 (no trauma), and sixteen subjects in Group 3 (rollover) reported being upset, excited, or "both upset and excited" by one of the seven fantasies whose content dealt with sexual activities and childhood or adolescence (see Table VII). The frequency of response on exciting, upsetting, and "both exciting and upsetting" for these seven fantasies are presented in Table VIII. Seventeen subjects

report excitement for these fantasies and split out by group as follows; Group 1 (molest) = 3, Group 2 (no trauma) = 4, Group 3 (rollover) = 10. Fourteen subjects report being upset by these fantasies and split out by group as follows; Group 1 (molest) = 11, Group 2 (no trauma) = 0, Group 3 (rollover) = 3. Eight subjects report being "both excited and upset" by these fantasies and split out by group as follows; Group 1 (molest) = 4, Group 2 (no trauma) = 1, and Group 3 (rollover) = 3.

It was assessed whether there were significant differences among the groups in the exciting, upsetting, or "both exciting and upsetting" responses generated for the seven child related fantasies. The differences in exciting responses were assessed first by summing the exciting responses for the seven child related fantasies to create a total exciting response score. A one-way analysis of variance was conducted on the total exciting response score by group. A significant difference was not found.

Next the differences in upsetting responses were assessed by summing the upsetting responses to the seven child related fantasies to create a total upsetting response score. A one-way analysis of variance was conducted on the total upsetting response score by group. A significant difference was found in the total upsetting responses by group for the seven child related fantasies. Subjects in Group 1 (molest) report significantly more upsetting

responses to the seven child related fantasies (*M* = .500; F = 4.708; p < .011) than subjects in Group 2 (no trauma; *M* = .023).

The differences in "both exciting and upsetting" responses to the seven child related fantasies were assessed by summing the responses to create a total "both exciting and upsetting" response score. A one-way analysis of variance was conducted on the total "both upsetting and exciting" response score for seven child related fantasies by group. A significant difference was not found for total "both upsetting and exciting" responses by group.

Variety of Response Differences for 52 Sexual Fantasies

The total variety of responses to the 52 sexual fantasies included in the questionnaire were assessed. A total variety of sexual fantasy response scale was created by summing the exciting, upsetting, and "both exciting and upsetting" responses to each fantasy. A one-way analysis of variance was performed using total variety of sexual fantasy response by group. A significant difference was found for the total variety of sexual fantasy response between two groups. Group 1 (molest) reported a significantly greater variety of sexual fantasy response (*M* = 15.250; F = 3.992; p < .05) than Group 2 (no trauma; *M* = 9.293). Interestingly, Group 3 (rollover) reported a total variety of sexual fantasy response (*M* = 12.300) which was midway between the total variety of sexual fantasy responses reported by Group

TABLE VII

EMOTIONAL RESPONSES FOR SEVEN SEXUAL FANTASIES DEALING WITH SEXUAL ACTIVITY AND CHILDHOOD OR ADOLESCENCE BY GROUP

	Subject Responses to 7 Child Related Fantasies		
Group	Excite	Upset	Both Excite And Upset
Group 1 (molest)	3	11	4
Group 2 (no trauma)	4	0	1
Group 3 (rollover)	10	3	3

TABLE VIII

FREQUENCY OF EXCITING, UPSETTING, AND "BOTH EXCITING AND UPSETTING" RESPONSES TO SEVEN SEXUAL FANTASIES DEALING WITH SEXUAL ACTIVITY AND CHILDHOOD OR ADOLESCENCE BY GROUP

Sexual Fantasy	Excite			Upset			Both Excite And Upset		
Group	1	2	3	1	2	3	1	2	3
I imagine I am a teenager who is babysitting and the man or couple I babysit for seduce me.	1	1	4	1	0	1	0	1	0
I pretend to be a sleeping child or to passively resist a woman/man who is trying to sexually arouse me.	0	2	4	1	0	1	1	0	1
I imagine I am engaged in a sexual activity with a male or female child.	0	0	0	0	0	0	1	0	0
I imagine I am a child being molested by an adult.	1	1	1	1	0	0	0	0	0
I imagine I am engaged in sexual activity with a family member.	0	0	1	2	0	0	1	0	1
I imagine I am a child and an unknown, scary creature is coming toward me.	0	0	0	5	0	1	0	0	1
I imagine I am a child and a faceless man/woman is engaged in sexual activity with me.	1	0	0	1	0	0	1	0	0

1 (molest) and Group 2 (no trauma).

Group Fantasy Frequency Differences By Fantasy Scale

The differences among the groups in the frequency of fantasy occurrence within fantasy scales was assessed. To do so a total frequency of fantasy occurrence score for each individual fantasy was obtained by summing the frequency of fantasy occurrence responses for daydreaming, masturbation and sexual relations. The total frequency of fantasy scores for the fantasies belonging in each sexual fantasy scale were summed to create a total frequency of fantasy scale score. A one-way analysis of variance was then conducted on the total frequency of fantasy scale scores by group. It was found that there were significant differences in the frequency of fantasy occurrence for three sexual fantasy scales. For the Domination Scale, Group 1 (molest) reported significantly greater frequency of fantasy occurrence (M = 15.433; $F = 5.470$; $p < .005$) than Group 2 (no trauma; M = 11.762) or Group 3 (rollover; M = 11.683). For the Performing Sexually in Front of Others Scale, Group 1 (molest) reported significantly greater frequency of fantasy occurrence (M = 29.800; $F = 3.690$; $p < .028$) than Group 2 (no trauma; M = 23.167). For the Being More or Other Than You Are Scale, Group 1 (molest) reported significantly greater frequency of fantasy occurrence (M = 36.207; F = 3.672; $p < .029$) than Group 2 (no trauma; M = 29.381).

Group Differences in Sexual Satisfaction and Sex Drive

Two questions were included in the questionnaire which looked at sexual satisfaction and sex drive. A one-way analysis of variance was done on the question, "How satisfied are you with your sex life"? Responses could be chosen from very, somewhat, or not very. A significant difference was found between two groups in response to the question, "How satisfied are you with your sex drive?". Subjects in Group 2 (no trauma) reported significantly greater satisfaction with their sex life (M = 2.163; F = 4.455; $p < .01$) than Group 1 (molest; M = 1.586). Subjects in Group 3 (rollover; M = 1.846) reported a satisfaction with their sex life which was midway between that reported by subjects in Group 2 (no trauma) and Group 1 (molest). For the question, "How satisfied are you with your sex drive?", the groups did not report a significant difference.

Differences in Sexual Attitudes, Behaviors, Functioning

Under the sexual activity section of the fantasy questionnaire a subsection combined 36 questions that dealt with sexual attitudes, behaviors and functioning. The 36 items were placed into a priori categories that formed five scales: 1) Positive and Negative General Sexual Attitudes; 2) Positive and Negative Sexual Attitudes Toward Partner; 3) Physical Discomfort During Sexual Activity, 4) Intensity and Extent of Orgasm During Sexual Activity; and 5) Extent of

Sexual Fantasy During Sexual Activity (see Appendix H; Table IX). The number of items in each scale varied from three to ten. A reliability analysis was then conducted on the devised scales. Four items that contributed negatively to the scale reliabilities were deleted from further analysis. Scale revisions were made and the reliability analysis was rerun (see Table X). The minimum inter-item reliability was .6047. Each item was scored by the subject on a five point scale from "Never" to "Always". The subject response to each item was summed by scale. All items that were written to score in an opposing direction were recoded so that all scale items were scored in the same direction. The scale item responses were summed to get a scale score.

To determine if there was a significant difference in group response to the five scales one-way analyses of variance were conducted. These results are presented in Table X. Significant differences among the three groups were found for the sexual attitudes, behaviors, and functioning subsection for two scales. For the Negative/Positive General Sexual Attitude Scale, subjects in Group 1 (molest) reported a greater number of negative responses for the items described in the scale ($\underline{M}$ = 20.92; F = 10.45; $p < .01$) than Group 2 (no trauma; $\underline{M}$ = 16.20) or Group 3 (rollover; $\underline{M}$ = 18.28. For the Negative/Positive Sexual Attitudes Toward Partner Scale, subjects in Group 3 (rollover) reported a greater number of negative responses

TABLE IX

SAMPLES OF ITEMS IN EACH OF FIVE SCALES ON SEXUAL ATTITUDES, BEHAVIORS, AND FUNCTIONING

Scale 1 - Positive/Negative General Sexual Attitudes
1. I have little interest in sex and could go on indefinitely without it.
2. I feel guilty when I experience sexual pleasure.
3. When I masturbate, I worry about being caught.

Scale 2 - Positive/Negative Sexual Attitudes Toward Partner
1. I am happy when my partner approaches me for sex.
2. After sexual relations with my partner I feel relaxed and contented.
3.I have sex with my partner out of a sense of obligation, not desire.

Scale 3 - Physical Discomfort During Sexual Activity
1. Insufficient vaginal lubrication is a problem for me.
2. I sometimes become physically ill (nausea, vomiting, panicked, etc.) during sexual activity.
3. I experience genital pain during or after intercourse.

Scale 4 - Intensity and Extent of Orgasm During Sexual Activity
1. My orgasms are very intense.
2. I have multiple orgasms.
3. During sexual relations, I am orgasmic.

Scale 5 - Extent of Fantasy During Sexual Activity
1. I fantasize as part of my regular sex routine like kissing, petting, hugging, etc..
2. I have a favorite recurring fantasy that arouses me during sex.
3. During masturbation, I fantasize.

---

to the items described in the scale ($\underline{M}$ = 27.07; F = 3.346; p < .05) than Group 2 (no trauma; $\underline{M}$ = 22.46). Of clinical significance is the greater number of positive responses to the Intensity and Extent of Orgasm During Sexual Activity Scale reported by Group 2 (no trauma; $\underline{M}$ = 10.02) than reported by Group 1 (molest; $\underline{M}$ = 8.75).

TABLE X

SEXUAL ATTITUDE, BEHAVIOR AND FUNCTIONING SCALE RELIABILITY COEFFICIENTS AND F RATIOS ON ONE-WAY ANALYSIS OF VARIANCE

Scale	ANOVA Reliability Alphas	ANOVA F Ratio
Attitude	.6047	10.450 **
Partner	.6854	1.195 *
Physical	.5990	2.104
Orgasm	.7087	2.551 +
Fantasy	.7764	1.912

+ $p < .10$ * $p < .05$ ** $p < .01$

For individual items in each scale refer to Appendix H.

DISCUSSION

Results Overview

Some of the most striking findings of the study were the differences in the frequency and variety of fantasy production between women who were sexually traumatized in childhood and women who were never sexually traumatized. Women who were never sexually traumatized reported having the least variety of sexual fantasies and also reported fewer sexual fantasies that were either exciting or upaetting. However, the no trauma group also reported more sexual satisfaction and sexual activity than women who were sexually traumatized.

Women who had self-identified as having been sexually traumatized in childhood or adolescence reported having sexual fantasies more frequently and of a greater variety also reported the greatest frequency of sexual fantasy, both exciting and upsetting. This group reported the least amount of sexual satisfaction, and was found to engage in less sexual activity than the no trauma group, but were more sexual activity than the rollover group. Women in the traumatized group expressed the most negative general sexual attitudes. The traumatized group also reported more upsetting responses to child related fantasies. These

findings contradict the expectation that traumatized women deal with childhood molestation primarily through denial and repression, but are consistent with the literature that suggests that childhood molestation interferes with sexual pleasure and healthy sexual adjustment in adulthood.

Implications of Results

The findings of the study not only support the notion that childhood sexual trauma has important implications for adult sexual functioning, but invites speculation about the reason for the increased frequency and variety of sexual fantasy production in adults molested as children. When differences in emotional response to sexual fantasy are considered, it is interesting to note that the differences found for the exciting variable were on the Domination, Performing Sexually in Front of Others, and Being Other or More Than You Are Scales. The items included in these scales reflected the scenario of many self-reported sexual molestations (e.g. "I imagine my partner says crude or obscene words to me during sexual relations; I imagine a man/woman is watching me engage in sex with another man/woman; I imagine I am having sex with an older, experienced lover"). Although not tested by this study, excitement on these scales may have resulted from physical arousal that became associated with sexual molestation. It is possible that the subject's fantasies were more

psychologically acceptable forms of the dynamics which occurred in their molestation (e.g. "I imagine I have been tied up by several men/women who are sexually stimulating me").

The emotional response differences found between the traumatized and non-traumatized groups on the upsetting variable was expected based on the content of the fantasy items found in the scales (Pain; Domination; Unknown Identity; Being Other or More Than You Are scales). The fantasy items included in these scales could have caused subjects to ruminate about their molestation experience or could have caused the activation of a flashback experience. Either of these experiences could have caused the subject to become upset. It also possible that women who were subjected to abusive experiences in childhood are more sensitive to fantasy content which could be perceived as threatening, unpleasant or harmful. Some of the traumatized subjects reported a negative physical reaction (headaches, nausea, dizziness, etc.) while completing the questionnaire. It may be possible to attribute part of the physical reaction to the associations (between fantasy content and the molestation experience) being experienced by the subjects while completing the questionnaire.

An emotional response of "both upsetting and exciting" to fantasy items in the Domination and Being More or Other Than You Are Scales was reported more frequently by

traumatized subjects. This study does not address why traumatized women were reporting more "both exciting and upsetting" responses to the items in these two scales. The following tentative explanation will be explored in a future study.

Traumatized subjects may have experienced an exciting emotional response during sexual fantasy involving content similar to the items from these two scales. The excitement they experienced was probably normal sexual arousal that became associated on a physiological level with the childhood molestation experience and was being reactivated by fantasies similar in content to that experience. It is possible that even though the traumatized subjects were experiencing a physiological sexual arousal, they were also upset by the excitement they were experiencing over fantasy items that were similar to their molestation. Traumatized subjects therefore could have been excited as well as upset when experiencing fantasies similar in content to their molestation experience. The end result of this dual phenomenon could have been either increased sexual arousal or disruption of the arousal process. It is possible that subjects who report being "both excited and upset" are experiencing an emotional/psychological split between the sexual arousal they enjoy and disgust or shame over the means being used to obtain sexual arousal.

The above explanation appears to support the trend

found for traumatized women to engage in more fantasies involving sexual activity and childhood. Clinically this is important because of the potential negative emotional effects that are likely to accompany such fantasies whether these women are finding the fantasies emotionally exciting, upsetting, or both exciting and upsetting.

The literature to date has not addressed sexual fantasy production as linked to sexual molestation either positively or negatively. The results of this study supported that there was a connection between the two especially since women who had been sexually traumatized were engaging in more sexual fantasy production than non-traumatized subjects. The results of this study lead to the question of what function increased sexual fantasy production may serve for traumatized subjects.

It is possible that some traumatized women may use sexual fantasy production to do their grief work or as a means of resolving their childhood trauma on a psychological level. Sexual fantasy may allow traumatized women to relive their molestation in order to gain mastery over the event; recapitulating memories of a frightening and exploitative experience over which they had no control as a child in an adult context in which they have complete control. Thus, sexual fantasy may be allowing traumatized women to resolve their molestation in a safe way, something they may have been unable to do elsewhere.

Perhaps sexual fantasy provides safety for traumatized women to act out the emotions connected to their molestation. Through fantasy production traumatized women can act out their aggression, anger, confusion, shame, etc. feelings that may have been too threatening or overwhelming to deal with in other ways. Another possibility is that sexual fantasy may allow some traumatized women to rescript what took place during their molestation thus restoring to these survivors the power and self-esteem lost during the trauma.

Sexual fantasy production may allow them some traumatized women to become sexually aroused by reliving their earliest association with arousal. Or, paradoxically, sexual fantasy may offer an escape allowing some molestation survivors to engage in sexual activity that otherwise may have been too psychologically or physically painful. The reverse may also be possible. Traumatized women may experience intrusive, recurrent fantasies that interrupt their sexual functioning. Experiencing fantasies which are out of control and unpleasant may cause the survivors additional trauma. Engaging in less sexual activity is a predictable result of such fantasy production and this explanation would support the findings that traumatized women reported less sexual satisfied.

The role sexual fantasy plays in the sexual functioning and adjustment of traumatized women should be further

explored in future studies. The literature to date has suggested that sexual fantasy production was a normal, healthy means of sexual expression. Since this study showed that traumatized women produced significantly more sexual fantasies than non-traumatized women, previous studies that contented sexual fantasy production signified healthy sexuality may be called into question since it seems doubtful that traumatized women can be considered sexually healthier than non-traumatized women. This point is reinforced by the findings that traumatized women engaged in less sexual activity, expressed less sexual satisfaction, had a more negative attitude toward sexuality overall, and produced marginally more negative responses to items regarding sexual pleasure as measured physically by the intensity and extent of orgasm.

Perhaps women who have never been sexually traumatized have less need for sexual fantasy, especially if traumatized women are using their sexual fantasies as a means of distorting reality or as an escape from reality. It is possible then that traumatized women produce more sexual fantasy because they have a greater need for the escape such fantasy production provides. This need may also be greater for traumatized women because they are less comfortable engaging in overt forms of sexual expression (sexual intercourse, fellatio, etc.). Interesting, it is in these activities that several studies have reported adults

molested as children experience the greatest sexual dysfunction (inhibited sexual desire, vaginismus, dyspareunia, etc.). There may be a correlation between degree of trauma and degree of sexual fantasy production.

Limitations

The subjects who initially identified themselves as not traumatized and subsequently answered a double check question indicating some sexual trauma (Group 3; rollovers) were not a useful group except as part of the screening process. When treated as a group for analysis, this group appeared to have a bi-modal distribution on a number of factors in the data, at times looking like the traumatized subjects and at other times looking like the non-traumatized subjects. These findings are consistent with the fact that Group 3 (rollovers) was composed both of women who reported having been forced to have sex as an adult, but were apparently never sexually traumatized as a child or adolescent, and of women who were raped and sexually molested as a child or an adolescent. One could argue that these different experiences, although both traumatic, may have had different long-term effects on the individual experiencing them, depending upon many different variables (e.g. age of the victim, who the perpetrator was, degree of abuse, length of abuse, etc.). It is quite possible then that Group 3 (rollovers) was composed of women who had experienced trauma in a wide range of severity from minimal

to severe. If this is the case, the differences in range of trauma then may have caused the group to swing from aligning with the traumatized subjects to aligning with the non-traumatized subjects. It is also possible that the bi-modal distribution could be explained by the denial and cognitive dissonance being experienced by the subjects in this group, indicated by their initial self-classification as non-traumatized, inspite of subsequently admitted experience to the contrary.

Subjects in the sexually traumatized group were solicited through a large number of therapists which resulted in difficulty estimating the number of subjects asked to participate in the study. Numerous questionnaires were sent to therapists who then determined whether their clients would be asked to participate. The number of questionnaires that were actually distributed can be accounted for only by the number of consent forms signed. The number of potential subjects who were asked to participate and subsequently refused is unknown, which made it impossible to gauge the refusal rate. Also, with no information about refusers, it is difficult to judge how representative this sample was, even of survivors in therapy.

For the subjects in this study who self-identified as having been molested in childhood or adolescence, there is no way of knowing how representative they were as a sample

of traumatized women. Those who agreed to participate may have been less traumatized than those who did not agree to participate. Likewise, women who agreed to participate, but who subsequently never returned the questionnaire may be different from the subjects who's responses were used in this study. The therapy requirement for the traumatized subjects necessarily excluded a large number of traumatized women who may have provided a very different set of responses to the questionnaire. Considering all of these concerns it is clear that the findings of this study can not necesarily be generalized to sexually traumatized women in general.

In soliciting subjects for this study, several therapists expressed concern that their clients would be further victimized by the questionnaire. Interestingly, therapists who disclosed that they had been sexually traumatized were the most reluctant to involve their clients in the study. This is a legitimate concern however, especially since from the onset of the study a few women who said that they had been sexually abused also reported physical reactions (e.g. nausea, headache, dizzy, loss of sleep, anxiety, etc.) while completing the questionnaire; these symptoms were very different from the most frequently reported physical reaction for subjects in the other two groups who reported sexual arousal).

Several therapists who conducted Adults Molested as

Children therapy groups in Los Angeles, Orange, Riverside and San Bernardino counties were contacted as a potential source for a subject pool in the sexually traumatized group. Only a few therapists were willing to present the study to their clients because of concerns about the emotional impact of the instrument. Concern was expressed by some therapists that their clients were not be ready to deal with what the questionnaire could potentially bring up for them. Even those therapists who believed their clients would benefit from completing the questionnaire, had clients who refused to participate, (reported in at least three cases). In one county, the instrument was deemed to be too sophisticated for the clientele in the therapy groups. One member of an Adults Molested as Children therapy group, who participated in the study, reported that several group members had refused to participate due to the requirement that they sign their name to a consent form. In spite of the above probems, all therapist who were contacted expressed interest and support for the study.

Ethical and legal considerations required the implementation of some prerequisites to participate which may have eliminated willing subjects from participating. Subjects were required to be 25 years of age or older. All subjects were required to sign a consent form self-identifying as either having been sexually traumatized in childhood or adolescence or as never having been sexually

traumatized. The additional therapy requirement for traumatized subjects eliminated many potential subjects, but was instituted for their protection in the event of negative effects from participating in the study. This study was designed with other safeguards for volunteer subjects who experienced any discomfort during or after completing the questionnaire. For all subjects, the researcher's name and telephone number were provided, as well as the name, address and telephone numbers of two therapy groups and the telephone number of a 24 hour crisis line.

Conducting studies of this type are not without risk. In this author's mind, however, it does not seem possible to understand the long-term effects of sexual abuse on sexual functioning without asking detailed information on how subjects function in sexual areas (e.g. fantasy content, sexual activity, sexual attitudes, etc.). It is the survivors themselves who must disclose what is happening to them so that they can help each other heal. Educational efforts are being made to work toward prevention of sexual trauma, but efforts must also be made to help survivors with the recovery process.

One of the main limitations of this study was the limited number of subjects who participated. Obtaining volunteer subjects for this questionnaire was difficult regardless of whether the potential subject had been abused or not. In spite of the "sexual revolution", sex is

apparently still a taboo topic in our society, perhaps a remnant of the Victorian era where sexuality was not talked about between intimate partners much less recorded on a questionnaire being sent to an absolute stranger. It is possible that there is a whole response set which has remained untapped because of this social taboo. The subjects who participated in this study may be different from the subjects who refused to participate. The limited number of subjects also precluded, in some cases more sophisticated statistical analysis.

Future Study

This study has paved the way for a follow-up study which could more clearly differentiate the differences between traumatized and non-traumatized women in sexual fantasy production. Determining why traumatized women report engaging in more sexual fantasy production while finding sexual activity less satisfying than non-traumatized women is an important factor to be looked at in future studies. Further analysis of the content of sexual fantasy is also needed. When more subjects are obtained, a factor analysis can be performed on the sexual fantasy scale to determine if the scales that were constructed will hold up in replication.

As indicated in this study, it is entirely possible that there are sexual fantasies which are unique to women

who have been molested as children. Eight sexual fantasies in this study were not reported by women in the non-traumatized group (e.g. "I relive a previous unpleasant or disturbing sexual experience which has left me marked or branded"; see Appendix I). If this can be further demonstrated with a larger sample, then the sexual fantasy questionnaire may be a useful diagnostic or clinical tool which could be used to detect sexual trauma in the early stages of therapy or to help the therapist and client where the client appears resistant. The purpose of such a diagnostic tool would be to help the client open some doors which are blocked and to direct the therapist in a treatment plan which would be in the client's best interests.

The questionnaire used in this study definitely brought up blocked material for many of the subjects in the trauma and rollover groups. The subjects who experienced this while completing the questionnaire expressed appreciation for having volunteered to participate in the study and felt they had grown from the experience even though it was uncomfortable for some of them. A similar reaction was expressed by the women in the non-trauma group in that many of them had not focused or assessed their sexuality prior to participating in this study. For some women, participating in this study and being exposed to the various sexual attitudes, behaviors, and functions, actually resulted in an opportunity to compare their experience of sexuality with

other people's experience. Subjects comments to this effect included, "the questionnaire made me more aware that I'm sexually repressed"; "that my sex life is pretty routine and not too exciting"; "I must be boring"; and "I was surprised by some of the fantasies and again realize how 'Victorian' I must be". It is gratifying that the study apparently served a positive educational and growth experience for some participants.

APPENDIX A

Introduction to the Study

Dear Volunteer,

Thank you for expressing an interest in this project. This study was designed to investigate the sexual fantasy production and its impact on women, age 25 or older, who were sexually traumatized as children or adolescents. A number of studies show sexual dysfunction in some incest and/or sexual molestation survivors. Some survivors also report disturbing flashbacks and a wide range of sexual fantasies that may or may not be disturbing. However, very little concrete information is available on this important topic to assist survivors and their therapists in the healing process. It is for this reason that I have chosen this topic for further study.

Having worked with incest victims, I realize how difficult it is to disclose information about such personal matters. Through therapy, incest victims are able to explore many of the issues surrounding their molestation/s even though some of the details or incidents remain blocked from their conscious memory. It takes a tremendous amount of strength and courage to face these issues, deal with them, and move past them.

I believe that the more we can learn about the dynamics that surround sexual abuse the better able we will be to aid "survivors" in the healing process. There is still much to be learned about the impact on "survivors". One reason sexual abuse has remained in the closet for so many years and that so little remains known about it today is that talking about sexual matters has been and remains a cultural taboo.

I am requesting your help in shedding some light on one aspect of the unknown. This may or may not be difficult for you to do. Through the "survivors" disclosure we may come to know the full impact of victimization which may help reduce further victimization of adult survivors by enhancing the treatment tools currently available. Your honest participation in this study may aid in this process.

I want you to understand that completing this questionnaire is not without risks. Some subjects, who participated in our pilot study, were unable to complete the questionnaire or were only able to partially complete the questionnaire. Some subjects initially felt threatened by the questionnaire and were unable to complete it in their first attempt. By putting it aside, however, they found that they were able to complete it in their second attempt. Others found that completing the questionnaire caused them to become emotionally upset, physically distressed, and/or to recall incidents of sexual trauma they had forgotten or that had not previously been known to them. These reactions occurred even though they had dealt with or were dealing with their molestation issues in therapy. Although the subjects discovered

Appendix A (cont'd)

some valuable insights through their reactions and/or recollections, itis important that you are aware that something similar could happen to you. If you find this possibility threatening or upsetting in any way, please feel free to discontinue now.

While completing this questionnaire, if you should recall an incident you had forgotten about or that had not been previously known to you or if you become disturbed for any other reason, discontinue the questionnaire after noting at that point on the questionnaire what is happening for you. In any event, the questionnaire (whether completed or incomplete) should be placed in the envelope provided and returned to the researcher.

If you do not complete the questionnaire for any reason or if you find that the questionnaire causes you to become upset at some point after completing the questionnaire, please contact one of the following for support and/or referral for additional help dealing with the issues raised:

a) the researcher - Mary Bienkowski - (714)-880-1255
b) a current or previous therapist or support group
c) an Adults Molested As Children Support Group

Family Services	For CSUSB Students:
1661 North E Street	CSUSB Counseling Center
San Bernardino, CA	Physical Science 227
(714)-886-6502	(714)-887-7437

d) Suicide & Crisis Prevention - (714)-886-4889

There are no right or wrong answers to anything included in the questionnaire. All of your individual responses are anonymous and to further assure confidentiality only the group responses will be disclosed. This information will be available to you in approximately six months. If you are interested in obtaining a copy of the results, address the enclosed envelope and return it with the questionnaire.

We'd like to leave you with one last thought. How you respond to this study in no way reflects where you are at as a person. Each of us is coming from a different place and each of us will react differently to the material contained in the questionnaire. It is of vital importance to us that you feel free to do what is best for you at this place in time. Your interest in this study is appreciated.

Sincerely,

Mary Ambroso-Bienkowksi
M.S. Candidate, Department of Psychology
California State University, San Bernardino
Geraldine Stahly, Ph.D.
California State University, San Bernardino

APPENDIX B

Consent Form for Non-Trauma Group

Department of Psychology
California State University, San Bernardino
Participation Consent - C -

This study is designed to investigate the phenomenon of sexual fantasy production in women age 25 or older. **Do not complete this questionnaire if you experienced sexual trauma (rape, incest, sexual molestation) as a child or as an adult.**

I agree to participate in the study on sexual fantasy and I understand the following:

1) I understand my participation will consist of completing a questionnaire on my sexual behavior and fantasies.

2) I understand the questions are personal and may be upsetting and that I am free to discontinue my participation in the study at any time with no negative consequence.

3) I understand that my answers in this questionnaire will be treated in strict confidence and that I will remain anonymous. Within these restrictions, group results of this study will be made available to me at my request.

4) I understand that my participation in the study does not guarantee any beneficial results to me.

Print Name:

Signature:

Date:

APPENDIX C

Consent Form for Traumatized Group

Department of Psychology
California State University, San Bernardino
Participation Consent - E -

This study is designed to investigate the phenomenon of sexual fantasy production in women age 25 or older. **Only incest and/or molestation survivors who are currently in therapy or in a support group for molestation survivors should complete this questionnaire.**

I agree to participate in the study on sexual fantasy and I understand the following:

1) I understand my participation will consist of completing a questionnaire on my sexual behavior and fantasies.

2) I understand the questions are personal and may be upsetting and that I am free to discontinue my participation in the study at any time with no negative consequence.

3) I understand that the answers on this questionnaire will be treated in strict confidence and that I will remain anonymous. Within these restrictions, group results of the study will be made available to me at my request.

4) I understand that my participation in the study does not guarantee any beneficial results to me.

Print Name:

Signature:

Date:

APPENDIX D

<u>Debrief Letter for All Subjects in Study</u>

Dear Volunteer,

Thank you for participating in this project. This study was designed to investigate whether there are sexual fantasy differences for women, age 25 or older, who were sexually traumatized as children or adolescents as compared to women of the same age who have not had those experiences. We wanted to find out what those differences were, if any, and what effect those differences may or may not have on overall sexual functioning.

Some literature exists on the sexual fantasies for women who have not been molested. There is also literature available on the long-term sexual dysfunctions found in some women who have been sexually abused as children or adolescents. There were no studies found, however, which looked at the differences in sexual fantasies between women who were and women who were not molested and the relationship of such fantasies to sexual functioning.

This information may assist sexual molestation survivors and their therapists in facilitating the healing process. Preliminary group results from this study will be available in approximately six months. If you are interested in our findings, please contact the researcher:

Mary Ambroso-Bienkowski
% Geraldine Stahly, Ph. D., Department of Psychology
5500 University Parkway
California State University, San Bernardino, CA 92407-2397
Re: Sexual Fantasy Study

If you became upset and were unable to complete the questionnaire or if you find that you become upset in the future as a result of completing this questionnaire or dealing with the subject matter contained therein, please contact one of the following:

a) the researcher - Mary Bienkowski - (714)-880-1255
b) a current or previous therapist or support group
c) an Adults Molested As children Support Group

Family Services
1661 North E Street
San Bernardino, CA
(714)-886-6502 or 881-2691

For CSUSB Students:
CSUSB Counseling Center
Physical Science 227
(714)-887-743

d) Suicide & Crisis Prevention - (714)-886-4889

Sincerely,

Mary Ambroso-Bienkowski
M.S. Candidate, Department of Psychology
California State University, San Bernardino
Geraldine Stahly, Ph.D.
Assistant Professor, Department of Psychology
California State University, San Bernardino

APPENDIX E

QUESTIONNAIRE ON SEXUAL FANTASY PRODUCTION AS RELATED TO CURRENT SEXUAL ACTIVITY

This questionnaire is designed to provide information about sexual fantasies, how an individual feels about sexual fantasies, and how sexual fantasies affect current sexual functioning. Some of the questions may require sharing thoughts and feelings which are highly personal. **Once again, if you should become upset while completing this questionnaire, please discontinue.** Please think carefully about each question before answering and try to answer each one as honestly as you can. Your candid response to each item will be greatly appreciated.

SECTION A. DEMOGRAPHICS **(Please check or fill in the correct answer.)**

DI. My current age is:
(1) 25-30 ____________
(2) 31-39 ____________
(3) 40-49 ____________
(4) 50-59 ____________
(5) 60-69 ____________
(6) 70+ ____________

DII. Check all that apply:
(1) Student ____________
(2) Housewife ____________
(3) Unemployed ____________
(4) Labor ____________
(5) Office ____________
(6) Professional ____________

DIII. Ethnicity:
(1) Caucasian ____________
(2) Hispanic ____________
(3) Asian ____________
(4) Black ____________
(5) Indian ____________
(6) Other ____________

DIV. Childhood Religion:
(1) Catholic ____________
(2) Protestant ____________
(3) Jewish ____________
(4) Adventist ____________
(5) Born Again Christ._
(6) Atheist ____________
(7) Other ____________

DV. Current Religion:
(1) Catholic ____________
(2) Protestant ____________
(3) Jewish ____________
(4) Adventist ____________
(5) Born Again Christ.__
(6) Atheist ____________
(7) Other ____________

DVI. Formal Schooling:
(1) 8th grade/less _____
(2) Some high school ___
(3) High school grad ___
(4) Some college ______
(5) College grad _______
(6) Grad school _______
(7) Other ____________

DVII. Relationship Status
(1) Married ____________
(2) Separated ____________
(3) Divorced ____________
(4) Single ____________
(5) Live with lover ___
(6) Widowed ____________

DVIII. For How Long?
(1) 0-3 Months ________
(2) 4-12 Months ______
(3) 1-2 Years ________
(4) 3-5 Years ________
(5) 6-12 Years ________
(6) 13+ Years ________

DIX. Sexual Preference:
(1) Heterosexual _______
(2) Homosexual ________
(3) Asexual ____________
(4) Bisexual ____________
(5) Pedophile ____________
(6) Other ____________

DX. Childhood Family Economic Status:
(1) Couldn't make ends meet ____________
(2) Got by with some help ____________
(3) Comfortable ______
(4) More than enough to get by on _______
(5) Wealthy ____________

DXI. Current Yearly Income For Self:
(1) $0-8,000 ____________
(2) $9-17,000 ____________
(3) $18-26,000 ____________
(4) $27-35,000 ____________
(5) $36-44,000 ____________
(6) $45-60,000 ____________
(7) $61-80,000 ____________
(8) Over $81,000 ______

DXII. Yearly Income For Family w/o self:
(1) $0-8,000 ____________
(2) $9-17,000 ____________
(3) $18-26,000 ____________
(4) $27-35,000 ____________
(5) $36-44,000 ____________
(6) $45-60,000 ____________
(7) $61-80,000 ____________
(8) Over $81,000 _______

Appendix E (cont'd)

DXIII. When You Were 12, Did You Have:

(1) Many good friends ___
(2) Few good friends ___
(3) 1-2 good friends ___
(4) No good friends ___
(5) Adult friends ___
(6) Other ___

DXIV. Before Age 12, My Parents' Marriage Was:

(1) Unhappy ___
(2) Not very happy ___
(3) Somewhat happy ___
(4) Happy ___
(5) Very happy ___
(6) Other ___

DXV. Family Members I Lived With At Age 12:

(1) Father ___
(2) Mother ___
(3) # of brothers ___
(4) # of sisters ___
(5) Other-who? ___
(6) Other-who? ___

DXVI. In My Family I Was The:

(1) Oldest ___
(2) Born second ___
(3) Born third ___
(4) Born fourth ___
(5) Youngest ___
(6) Only ___
(7) Other ___

DXVII. Number of Siblings: (Natural or Step)

(1) None ___
(2) 1 ___
(3) 2 ___
(4) 3 ___
(5) 4 ___
(6) 5 ___
(7) Other ___

DXVIII. Place I Lived The Longest Before Age 12:

(1) Farm ___
(2) Unincorporated area___
(3) Village ___
(4) Small town ___
(5) Suburbs ___
(6) City ___
(7) Other ___

SECTION B. Sexual Activity

How Often I Engage In: (X=Times)

SI. I Generally Engage In:	4-7X Week	2-3X Week	1X Week	2X Month	1X Month	Less 1X Month
(1) Self-masturbation	___	___	___	___	___	___
(2) Vaginal intercourse	___	___	___	___	___	___
(3) Oral female contact with male genitalia	___	___	___	___	___	___
(4) Oral male contact with female genitalia	___	___	___	___	___	___
(5) Anal intercourse	___	___	___	___	___	___
(6) Masturbation by partner	___	___	___	___	___	___
(7) Masturbation of partner	___	___	___	___	___	___
(8) Affectionate fondling	___	___	___	___	___	___
(9) Kissing	___	___	___	___	___	___
(10) Hugging	___	___	___	___	___	___
(11) Other___	___	___	___	___	___	___

SII. Please check the correct answer:	Very	Somewhat	Not Very
(1) How important is sex in your life?	___	___	___
(2) How satisfied are you with your sex life?	___	___	___
(3) Rate partner's satisfaction in sex life with you.	___	___	___
(4) How satisfied are you with your sex drive?	___	___	___

(5) How compatible are your sexual frequency needs with your current partner's needs?

I want more than he\she does ___
I want less than he\she does ___
We want the same ___
Varies ___

Appendix E (cont'd)

For the following you may check more than one if applicable.

SIII. Typically, when I am uninterested in having sex, it is usually because I am:

(1) Tired ____________
(2) Angry ____________
(3) Partner unavailable ________
(4) Feel bad about self ________
(5) Punishing partner ________
(6) Sick ____________
(7) Depressed ____________
(8) Hurt ____________
(9) Anxious ____________
(10) Feeling coerced ________
(11) Resentful ____________
(12) Not turned on ________
(13) Other ____________

SIV. When I am interested in having sex, it is usually because I am:

(1) In love with partner ________
(2) Sexually aroused ____________
(3) Needing affection ____________
(4) Stressed; need to relax ________
(5) Feeling guilty ____________
(6) Want to get it over with ________
(7) Think it's time ____________
(8) Want a favor in return ________
(9) Want to get pregnant ________
(10) Fear of losing partner ________
(11) Don't want a scene ________
(12) Need validation ________
(13) Other ____________

SV. Following each statement, select the number that best represents your answer from 1 (Never) to 5 (Always).

Never	Rarely	Sometimes	Frequently	Always
1	2	3	4	5

(1) I am happy when my partner approaches me for sex. _____
(2) After sexual relations with my partner I feel relaxed and contented. _____
(3) I desire sexual relations and encourage my partner to have sex. _____
(4) I have little interest in sex and could go on indefinitely without it. _____
(5) I have sex with my partner out of a sense of obligation, not desire. _____
(6) I feel my partner is pressuring me sexually. _____
(7) I feel guilty when I experience sexual pleasure. _____
(8) Insufficient vaginal lubrication is a problem for me. _____
(9) When my partner is being affectionate, I usually assume he/she is making a sexual overture when in fact he\she is just being affectionate. _____
(10) I sometimes become physically ill (nausea, vomiting, panicked, etc.) during sexual activity. _____
(11) I think I have sexual fantasies because I am tired of my partner. _____
(12) I experience genital pain during or after intercourse. _____
(13) I experience vaginal muscle spasms which interrupt intercourse. _____
(14) I have engaged in a pattern of sexual encounters where I sexually use men. _____
(15) I am ashamed of my body. _____
(16) I have engaged in same-sex sexual activities. _____
(17) Sex is more enjoyable when I am in control. _____
(18) I have used drugs (alcohol, marijuana, LSD, cocaine, hashish, heroin, uppers, downers, etc.) in conjunction with sexual activity. _____
(19) Sex without the use of drugs occurs _____.
(20) As an adult (over 21 years of age), I have engaged in sexual activity with a minor (under 18 years of age). _____

Appendix E (cont'd)

DXIII. When You Were 12, Did You Have:
(1) Many good friends ____
(2) Few good friends ____
(3) 1-2 good friends ____
(4) No good friends ____
(5) Adult friends ____
(6) Other ____

DXIV. Before Age 12, My Parents' Marriage Was:
(1) Unhappy ____
(2) Not very happy ____
(3) Somewhat happy ____
(4) Happy ____
(5) Very happy ____
(6) Other ____

DXV. Family Members I Lived With At Age 12:
(1) Father ____
(2) Mother ____
(3) # of brothers ____
(4) # of sisters ____
(5) Other-who? ____
(6) Other-who? ____

DXVI. In My Family I Was The:
(1) Oldest ____
(2) Born second ____
(3) Born third ____
(4) Born fourth ____
(5) Youngest ____
(6) Only ____
(7) Other ____

DXVII. Number of Siblings: (Natural or Step)
(1) None ____
(2) 1 ____
(3) 2 ____
(4) 3 ____
(5) 4 ____
(6) 5 ____
(7) Other ____

DXVIII. Place I Lived The Longest Before Age 12:
(1) Farm ____
(2) Unincorporated area__
(3) Village ____
(4) Small town ____
(5) Suburbs ____
(6) City ____
(7) Other ____

SECTION B. Sexual Activity

SI. I Generally Engage In:	**How Often I Engage In:** (X=Times) 4-7X Week	2-3X Week	1X Week	2X Month	1X Month	Less 1X Month
(1) Self-masturbation	____	____	____	____	____	____
(2) Vaginal intercourse	____	____	____	____	____	____
(3) Oral female contact with male genitalia	____	____	____	____	____	____
(4) Oral male contact with female genitalia	____	____	____	____	____	____
(5) Anal intercourse	____	____	____	____	____	____
(6) Masturbation by partner	____	____	____	____	____	____
(7) Masturbation of partner	____	____	____	____	____	____
(8) Affectionate fondling	____	____	____	____	____	____
(9) Kissing	____	____	____	____	____	____
(10) Hugging	____	____	____	____	____	____
(11) Other____	____	____	____	____	____	____

SII. Please check the correct answer:	Very	Somewhat	Not Very
(1) How important is sex in your life?	____	____	____
(2) How satisfied are you with your sex life?	____	____	____
(3) Rate partner's satisfaction in sex life with you.	____	____	____
(4) How satisfied are you with your sex drive?	____	____	____

(5) How compatible are your sexual frequency needs with your current partner's needs?

I want more than he\she does ____
I want less than he\she does ____
We want the same ____
Varies ____

Appendix E (cont'd)

Select the number that best represents your answer from 1 (Never) to 5 (Always).

(21) When I masturbate, I worry about being caught. _____
(22) I fantasize as part of my regular sex routine like kissing, petting, hugging, etc.. _____
(23) I have sexual feelings toward children. _____
(24) I fantasize to put me in the mood for sex when I'm not ready. _____
(25) I have a favorite recurring fantasy that arouses me during sex. _____
(26) When I have sexual fantasies, I feel detached from my partner. _____
(27) My orgasms are very intense. _____
(28) I fantasize to overcome temporary feelings of boredom or anger toward my partner that might interfere with sexual pleasure. _____
(29) I have multiple orgasms. _____
(30) During masturbation, I am orgasmic _____.
(31) During sexual relations, I am orgasmic _____.
(32) During masturbation, I fantasize _____.
(33) During sexual relations, I fantasize _____.
(34) I experience intense anxiety during sexual activities. _____
(35) The content of my sexual fantasies remains the same over time. _____
(36) I tell my partner about my sexual fantasies. _____

SVI. The following statement\s would describe how openly I feel I deal with sexual matters today:

(1) I discuss sexual matters openly with my partner. _____
(2) I only discuss certain sexual matters openly. _____
(3) I do not discuss sexual matters with anyone. _____
(4) I only discuss sexual matters with certain people. _____
(5) I wish I could be more open in discussing sexual matters. _____

SECTION C. Sexual Fantasy Content

Below you will find several categories of sexual fantasies. Because fantasy production is so subjective, you may not find your exact fantasy included. An area has been included within each category for you to briefly describe your sexual fantasies if they are different from those within the category. **There are three things requested for each fantasy that you have; how frequently you have the fantasy, what you are doing when you have the fantasy, and how it affects you.** Please log this information according to the letter or number assigned to the correct answer.

Arousal Capability: When I have this fantasy it:	**Fantasy Type: I have this fantasy while I am:**	**Frequency: How often I have this fantasy:**
N = Neither - I do not have this fantasy.	D = Daydreaming	1 = Never
Ex = Excites me.	M = Masturbating	2 = Rarely
Up = Upsets me.	S = Engaged in Sexual Relations	3 = Sometimes
B = Both upsets and excites me.	O = Other - specify ________________	4 = Frequently
		5 = Always

Appendix E (cont'd)

Arousal Capability: N=Don't have, Ex=Excites, Up=Upsets, B=Both excites/upsets

Type: D=Daydreaming, M=Masturbating, S=Sexual Relations, O=Other

Frequency: 1=Never, 2=Rarely, 3=Sometimes, 4=Frequently, 5=Always

	Arousal Capability				Frequency of Fantasy			
	N	Ex	Up	B	D	M	S	O
EXAMPLE: I imagine I am having sex in a hot tub.	___	___	___	___	___	___	___	___

FI. If you have sexual fantasies that are romantic (i.e. candlelight dinners, sex on the beach, etc.), see if any of the fantasies in this category are similar to yours and complete the information requested. If not, go on to FII.

	Arousal Capability				Frequency of Fantasy			
	N	Ex	Up	B	D	M	S	O
(1) I imagine a romantic setting and being seduced by a stranger.	___	___	___	___	___	___	___	___
(2) I imagine having sex (vaginal or anal) with my partner in a different location.	___	___	___	___	___	___	___	___
(3) I relive a previous enjoyable sexual experience.	___	___	___	___	___	___	___	___
(4) I make oral contact with my partner's genitalia and/or masturbate him/her and he/she does the same for me.	___	___	___	___	___	___	___	___
(5) I imagine that my partner and I are experimenting with numerous coital positions/sex toys and that I am having multiple orgasms.	___	___	___	___	___	___	___	___
(6) I imagine someone is kissing and sucking my breasts.	___	___	___	___	___	___	___	___

(7) For this category, the fantasies I'd like to share are:

____

____

____

____

____

FII. If you have fantasies which involve pain, complete this category to see if any of these fantasies are similar to yours. If not, go on to FIII.

	Arousal Capability				Frequency of Fantasy			
	N	Ex	Up	B	D	M	S	O
(1) I relive a previous unpleasant or disturbing sexual experience which has left me marked or branded.	___	___	___	___	___	___	___	___
(2) I imagine I'm a slave who must obey my partner's every whim.	___	___	___	___	___	___	___	___

Appendix E (cont'd)

Arousal Capability: N=Don't have, Ex=Excites, Up=Upsets, B=Both excites/upsets
Type: D=Daydreaming, M=Masturbating, S=Sexual Relations, O=Other
Frequency: 1=Never, 2=Rarely, 3=Sometimes, 4=Frequently, 5=Always

	N	Ex	Up	B	D	M	S	O
(3) I imagine my partner strips me, lays me over his/her lap, and spanks me.	___	___	___	___	___	___	___	___
(4) I imagine I am being whipped and beaten and/or violently raped.	___	___	___	___	___	___	___	___
(5) I am sexually aroused when I observe someone being physically harmed while I engage in sexual activities.	___	___	___	___	___	___	___	___

(6) For this category, the fantasies I'd like to share are:

____
____
____
____
____

FIII. If you have sexual fantasies which involve dominating someone or someone dominating you, complete this category to see if any of the fantasies are similar to yours. If not, go on to FIV.

	N	Ex	Up	B	D	M	S	O
(1) I pretend to resist being overpowered and forced to undress and perform sexually, but I am actually aroused.	___	___	___	___	___	___	___	___
(2) I imagine I have been tied up by several men/women who are sexually stimulating me.	___	___	___	___	___	___	___	___
(3) I imagine I am a prostitute.	___	___	___	___	___	___	___	___
(4) I imagine I humiliate or torture my partner.	___	___	___	___	___	___	___	___
(5) I imagine I kidnap a man/woman and make him/her do as I order.	___	___	___	___	___	___	___	___
(6) I imagine my partner says crude or obscene words to me during sexual relations.	___	___	___	___	___	___	___	___
(7) I imagine that my partner urinates or defecates on me.	___	___	___	___	___	___	___	___

(8) For this category, the fantasies I'd like to share are:

____
____
____
____

Appendix E (cont'd)

Arousal Capability: N=Don't have, Ex=Excites, Up=Upsets, **B=Both excites/upsets**
Type: D=Daydreaming, M=Masturbating, S=Sexual Relations, **O=Other**
Frequency: 1=Never, 2=Rarely, 3=Sometimes, 4=Frequently, 5=Always

FIV. If you have sexual fantasies involving childhood or **being a child, complete this category. If not go on to FV.**

	Arousal Capability				Frequency of Fantasy			
	N	Ex	Up	B	D	M	S	O
(1) I imagine a man/woman is teaching me about sex.								
(2) I imagine I am a teenager who is babysitting and the man or couple I am babysitting for seduce me.								
(3) I pretend to be a sleeping child or to passively resist a woman/man who is trying to sexually arouse me.								
(4) I imagine I am engaged in a sexual activity with a female or male child.								
(5) I imagine I am a child being molested by an adult.								
(6) I imagine I am engaged in sexual activity with a family member.								

(7) For this category, the fantasies I'd like to share are:

FV. If you have sexual fantasies which involve you performing sexually in front of others, complete this category. If not, go on to FVI.

	N	Ex	Up	B	D	M	S	O
(1) I imagine I observe myself or others having sex.								
(2) I imagine myself as a striptease dancer, harem girl, porno queen, or some other performer.								
(3) I imagine things I've read or seen in books/magazines or watched in a film.								
(4) I imagine a man/woman is watching me masturbate.								
(5) I imagine a man/woman is watching me engage in sex with another man/woman.								
(6) I imagine another woman and I are having sex and being observed by or joined by a man/woman.								

Appendix E (cont'd)

Arousal Capabilities: N=Don't Have, Ex=Excites, Up=Upsets, B=Both excites/upsets
Type: D=Daydreaming, M=Masturbating, S=Sexual Relations, O=Other
Frequency: 1=Never, 2=Rarely, 3=Sometimes, 4=Frequently, 5=Always

(7) For this category, the fantasies I'd like to share are:

____
____
____
____
____

FVI. If you have sexual fantasies which involve a partner whose identity cannot be determined, complete this category. If not, go on to FVII.

	Arousal Capability				Frequency of Fantasy			
	N	Ex	Up	B	D	M	S	O
(1) I imagine I am having sex with a man/woman whose face I can't see.	___	___	___	___	___	___	___	___
(2) I imagine I am a child and an unknown, scary creature is coming toward me.	___	___	___	___	___	___	___	___
(3) I imagine a masked person who has an enormous penis is going to try to have sex with me.	___	___	___	___	___	___	___	___
(4) I imagine I am being seduced by a man/woman whose face I cannot see.	___	___	___	___	___	___	___	___
(5) I imagine I am a child and a faceless man/woman is engaged in sexual activity with me.	___	___	___	___	___	___	___	___

(6) For this category, the fantasies I'd like to share are:

____
____
____
____
____

FVII. If you have sexual fantasies which involve you being other or more than you are, complete this category. If not, go on to FVIII.

	N	Ex	Up	B	D	M	S	O
(1) I pretend I am an irresistible woman who delights many women/men.	___	___	___	___	___	___	___	___
(2) I imagine I am participating in an orgy.	___	___	___	___	___	___	___	___
(3) I imagine I am being made love to by several partners at the same time.	___	___	___	___	___	___	___	___

Appendix E (cont'd)

Arousal Capability: N=Don't have, Ex=Excites, Up=Upsets, B=Both excites/upsets
Type: D=Daydreaming, M=Masturbation, S=Sexual Relations, O=Other
Frequency: 1=Never, 2=Rarely, 3=Sometimes, 4=Frequently, 5=Always

(4) I imagine I have larger breasts which cause men/women to stare at me when I wear tight clothing.	___	___	___	___	___	___	___	___
(5) I imagine I am having sex with an older, experienced lover.	___	___	___	___	___	___	___	___
(6) I imagine I have a blind date who is turned on by my body.	___	___	___	___	___	___	___	___

(7) For this category, the fantasies I'd like to share are:

____
____
____
____
____

FVIII. If you have sexual fantasies which involve taking risks, complete this section. If not, go on to FIX.

	Arousal Capability				Frequency of Fantasy			
	N	Ex	Up	B	D	M	S	O
(1) I enjoy pretending I am doing something wicked or forbidden.	___	___	___	___	___	___	___	___
(2) I imagine I am engaged in sexual activity with my partner who is driving the car.	___	___	___	___	___	___	___	___
(3) I imagine my partner and I are engaged in sexual activity in a public place (i.e. elevator).	___	___	___	___	___	___	___	___
(4) I imagine I am engaged in sexual activity with a partner who I know may have been exposed to AIDS.	___	___	___	___	___	___	___	___
(5) I imagine I engage in sex without birth control.	___	___	___	___	___	___	___	___
(6) I imagine I am having an affair with my best friend's partner, my partner's boss, or my neighbor.	___	___	___	___	___	___	___	___

(7) For this category, the fantasies I'd like to share are:

____
____
____
____
____

Appendix E (cont'd)

Arousal Capability: N=Don't have, Ex=Excites, Up=Upsets, B=Both excites/upsets

Type: D=Daydreaming, M=Masturbation, S=Sexual Relations, O=Others

Frequency: 1=Never, 2=Rarely, 3=Sometimes, 4=Frequently, 5=Always

FIX. Below are some sexual fantasies which do not seem to fit into any other category. Please complete this section.

	N	Ex	Up	B	D	M	S	O
(1) I imagine I engage in sexual activity with animals.	___	___	___	___	___	___	___	___
(2) I engage in or observe other women engage in lesbian sexual activities.	___	___	___	___	___	___	___	___
(3) I imagine I am having sex with a man/woman whose ethnic origin is not the same as mine.	___	___	___	___	___	___	___	___
(4) I imagine I am having sex with a handicapped person.	___	___	___	___	___	___	___	___
(5) I imagine I am engaged in sexual activity with any of the following: screen actor/actress, a millionaire.	___	___	___	___	___	___	___	___

(7) For this category, the fantasies I'd like to share are:

____
____
____
____
____

FX. **The sexual fantasies I have most frequently are: (If any are the same as the above fantasies, please note category and number.)**

____
____
____
____
____

FXI. **The sexual fantasies I have and enjoy the most are: (If any are the same as the above fantasies, please note category and number.)**

____
____
____
____
____

FXII. **The sexual fantasies I have that I find most disturbing are: (If any are the same as the above fantasies, please note category and number.)**

____
____
____

Appendix E (cont'd)

FXIII. The following statement\s would accurately describe how openly sexual matters were dealt with in my family of origin:

(1) No one discussed sexual matters openly _____.

(2) Only certain types of sexual matters could be discussed openly _____.
Please specify type: ____

(3) All sexual matters could be discussed openly _____.

(4) All sexual matters could be discussed with certain members of my family _____.
Please specify who: ____

(5) There were certain members of my family who I knew I could never discuss sexual matters with _____.
Please specify who: ____

FXIV. Please check the answer\s which best describes what is true for you: In completing this portion of the questionnaire, I found that:

(1) I did not find the questions upsetting and was able to be very honest about my thoughts and experiences _____.

(2) The questions made me uncomfortable, but I was able to be honest about my thoughts and experiences _____.

(3) I was unable to be completely honest, but did not find that I was extremely upset by the questions _____.

(4) I was extremely upset by the questions and was unable to be completely honest about my thoughts and experiences _____.

(5) I was able to face some issues that I had not previously been able to deal with _____.

(6) I had a physical reaction including the following symptoms:
____
____
____

FXV. Please check either "Yes" or "No" for the following questions:

	YES	NO
(1) Were you ever forced to have sex as an adult?	____	____
(2) Were you ever raped or the victim of an attempted rape as an adult?	____	____
(3) Were you ever forced to participate in sexual activity as a child or adolescent?	____	____
(4) Were you ever the victim of a rape or an attempted rape as a child or adolescent?	____	____
(5) Were you ever sexually molested (touched by someone, asked or made to touch or observe someone in a way which made you feel uncomfortable) as a child or adolescent?	____	____
(6) While completing this questionnaire, did you recall a sexual trauma from the past that you had forgotten about?	____	____
(7) While completing this questionnaire, did you remember a sexual trauma from the past that had not been previously known to you?	____	____

Appendix E (cont'd)

SECTION D. Sexual Molestation

This section deals with the forced sexual encounters you experienced as a child or adolescent. Though some people find the word uncomfortable, for the purposes of this questionnaire we will refer to all forced sexual experiences as "molestation". Many sexual molestation survivors report having been molested by more than one person, therefore we have made it possible to document information regarding multiple molestations. **Please answer this section by checking the appropriate answer or filling in information as requested.**

MI. I was molested by: **Number of Times the Molestation Occurred:**

Relationship of person to you (step-uncle, father, etc.)	1	2-5	6-20	21-50	51-100	101+
(1) ____________	___	___	___	___	___	___
(2) ____________	___	___	___	___	___	___
(3) ____________	___	___	___	___	___	___
(4) ____________	___	___	___	___	___	___

MII. For each of the persons named above, hereafter referred to as "Molestation #1", #2, etc., please complete the following information.

Length of Time the Abuse Lasted:

	1 Day	1 Week	1 Month	2-6 Months	7-12 Months	1-2 Years	3-5 Years	6+ Years
(1) Molestation #1	___	___	___	___	___	___	___	___
(2) Molestation #2	___	___	___	___	___	___	___	___
(3) Molestation #3	___	___	___	___	___	___	___	___
(4) Molestation #4	___	___	___	___	___	___	___	___

MIII.	Age I was when abuse began:	Age I was when abuse ended:	Age of offender when abuse began:
(1) Molestation #1	________	________	________
(2) Molestation #2	________	________	________
(3) Molestation #3	________	________	________
(4) Molestation #4	________	________	________

MIV. Type of Molestation: **Check all behaviors that you are aware of:**

	Molestation #1	#2	#3	#4
(1) An invitation or request to do something sexual.	___	___	___	___
(2) Kissing and hugging in a sexual way.	___	___	___	___
(3) Other person showing his/her sexual organ to you.	___	___	___	___
(4) You showing your sex organs to other person.	___	___	___	___
(5) Other person fondling you in a sexual way with clothing on both.	___	___	___	___
(6) You fondling other person in a sexual way with clothing on both.	___	___	___	___

Appendix E (cont'd)

Type of Molestation: **Check all behaviors that apply:**

	Molestation #1	#2	#3	#4
(7) Other person fondling you in a sexual way without clothing.	____	____	____	____
(8) You fondling other person in a sexual way without clothing.	____	____	____	____
(9) Simulated intercourse with clothing on.	____	____	____	____
(10) Intercourse	____	____	____	____
(11) Vaginal or anal penetration with tongue, finger, object, etc..	____	____	____	____
(12) Oral contact between other person's mouth and your genitals.	____	____	____	____
(13) Oral contact between your mouth and other person's genitals.	____	____	____	____
(14) Other - specify ____________	____	____	____	____

MV. In terms of percentages, in retrospect, I would say that my molestation experience has been: (i.e. 100% negative, 100% positive, 80% neg. & 20% pos.)

	Negative	Mostly Negative	Neutral	Mostly Positive	Positive
(1) Molestation #1	________	________	________	________	________
(2) Molestation #2	________	________	________	________	________
(3) Molestation #3	________	________	________	________	________
(4) Molestation #4	________	________	________	________	________

MVI. Check the correct answer for each molestation: (as you see it now)

	Molestation #1 Yes	#1 No	#2 Yes	#2 No	#3 Yes	#3 No	#4 Yes	#4 No
(1) This molestation involved threats or coercion.	___	___	___	___	___	___	___	___
(2) When this molestation was occurring, I was aware that it was (socially, morally) wrong.	___	___	___	___	___	___	___	___
(3) I willingly participated to some degree in my molestation.	___	___	___	___	___	___	___	___
(4) I believe the molestation was my fault.	___	___	___	___	___	___	___	___
(5) Other family members were aware of the molestation while it was occurring.	___	___	___	___	___	___	___	___
(6) Other family members believed the molestation was my fault.	___	___	___	___	___	___	___	___
(7) I disclosed the molestation immediately.	___	___	___	___	___	___	___	___
(8) I disclosed the molestation at a future time during childhood.	___	___	___	___	___	___	___	___
(9) I disclosed the molestation as an adult.	___	___	___	___	___	___	___	___

Appendix E (cont'd)

Check the correct answer for each molestation:

	Molestation #1 Yes	#1 No	#2 Yes	#2 No	#3 Yes	#3 No	#4 Yes	#4 No
(10) My father supported me after I disclosed the molestation.	___	___	___	___	___	___	___	___
(11) My mother supported me after I disclosed the molestation.	___	___	___	___	___	___	___	___
(12) I could count on my mother to be available and nurturant toward me.	___	___	___	___	___	___	___	___
(13) I could count on my father to be available and nurturant toward me.	___	___	___	___	___	___	___	___
(14) I felt the molester was remorseful upon my disclosure.	___	___	___	___	___	___	___	___
(15) The molester blamed me when I disclosed the molestation.	___	___	___	___	___	___	___	___
(16) The molester physically abused me.	___	___	___	___	___	___	___	___
(17) The molester physically abused my mother.	___	___	___	___	___	___	___	___
(18) The molester physically abused my siblings.	___	___	___	___	___	___	___	___
(19) An individual other than my parents was supportive to me.	___	___	___	___	___	___	___	___
(20) The molester denied the molestation when I disclosed.	___	___	___	___	___	___	___	___

MVII. Please select the number for each of the statements below according to the frequency from 1 (Never) to 5 (Always):

1 = Never 2 = Rarely 3 = Sometimes 4 = Frequently 5 = Always

(1) During masturbation or sexual relations, I experience flashbacks to my molestation. _____

(2) I become sexually aroused during masturbation or sexual relations when I think about my molestation experience. _____

(3) I become less sexually aroused when I think about my molestation experience during masturbation and sexual relations. _____

(4) I try not to think about my molestation experience. _____

(5) I relive my sexual molestation during sexual activities. _____

(6) I am orgasmic when I fantasize about being sexually molested. _____

(7) I am nonorgasmic when I fantasize about being molested. _____

(8) I think about my molestation during nonsexual activities. _____

(9) I am trying to understand why I was sexually abused. _____

(10) I frequently think about my molestation experience in an effort to find meaning in what has occurred. _____

(11) I experience anxiety whenever I think about my sexual molestation. _____

(12) I desire sex when I am stressed. _____

(13) My molestation experience/s intrudes into my thoughts against my my will. ____

Appendix E (cont'd)

MVIII. Any other information or observations about your experience of molestation and its effects on your sexual functioning (if any) you would like to share with us:

____

MIX. Any comments on the questionnaire you would like to make:

____

APPENDIX F

Sexual Fantasy Scales

Scale 1 - Romance

1. I imagine having sex (vaginal or anal) with my partner in a different location.
2. I relive a previous enjoyable sexual experience.
3. I make oral contact with my partner's genitalia and/or masturbate him/her and he/she does the same for me.
4. I imagine that my partner and I are experimenting with numerous coital positions/sex toys and that I am having multiple orgasms.
5. I imagine someone is kissing and sucking my breasts.

Scale 2 - Pain

1. I imagine I'm a slave who must obey my partner's every whim.
2. I imagine my partner strips me, lays me over his/her lap, and spanks me.
3. I imagine I am being whipped and beaten and/or violently raped.
4. I am sexually aroused when I observe someone being physically harmed while I engage in sexual activities.

Scale 3 - Dominating Someone or Someone Dominating You

1. I pretend to resist being overpowered and forced to undress and perform sexually, but I am actually aroused.
2. I imagine I have been tied up by several men/women who are sexually stimulating me.
3. I imagine my partner says crude or obscene words to me during sexual relations.

Scale 4 - Childhood or Being a Child

1. I imagine a man/woman is teaching me about sex.
2. I imagine I am a teenager who is babysitting and the man or couple I am babysitting for seduce me.
3. I pretend to be a sleeping child or to passively resist a woman/man who is trying to sexually arouse me.
4. I imagine I am engaged in a sexual activity with a female or male child.
5. I imagine I am a child being molested by an adult.
6. I imagine I am engaged in sexual activity with a family member.

Scale 5 - Performing Sexually in Front of Others

1. I imagine I observe myself or others having sex.
2. I imagine myself as a striptease dancer, harem girl, porno queen, or some other performer.
3. I imagine things I've read or seen in books/magazines or watched in a film.

Appendix F (cont'd)

4. I imagine a man/woman is watching me engage in sex with another man/woman.
5. I imagine another woman and I are having sex and being observed by or joined by a man/woman.
6. I engage in or observe other women engage in lesbian sexual activities.

Scale 6 - Identity of Partner Cannot Be Determined
1. I imagine I kidnap a man/woman and make him/her do as I order.
2. I imagine I am having sex with a man/woman whose face I cannot see.
3. I imagine I am a child and an unknown, scary creature is coming toward me.
4. I imagine a masked person who has an enormous penis is going to try to have sex with me.
5. I imagine I am being seduced by a man/woman whose face I cannot see.
6. I imagine I am a child and a faceless man/woman is engaged in sexual activity with me.

Scale 7 - You Being Other Or More Than You Are
1. I imagine I am a prostitute.
2. I pretend to be an irresistible woman who delights many men.
3. I imagine I am participating in an orgy.
4. I imagine I am being made love to by several partners at the same time.
5. I imagine I have larger breasts which cause men/women to stare at me when I wear tight clothing.
6. I imagine I am having sex with an older, experienced lover.
7. I imagine I have a blind date who is turned on by my body.
8. I imagine I am engaged in sexual activity with any of the following: screen actor/actress, millionaire, etc..

Scale 8 - Taking Risks
1. I imagine I am engaged in sexual activity with my partner who is driving the car.
2. I imagine my partner and I are engaged in sexual activity in a public place (i.e. elevator).

Appendix G

Scale of Sexual Activity Items

1. Self-masturbation
2. Vaginal intercourse
3. Oral female contact with male genitalia
4. Oral male contact with female genitalia
5. Anal intercourse
6. Masturbation by partner
7. Masturbation of partner
8. Affectionate fondling
9. Kissing
10. Hugging

APPENDIX H

Scale On Sexual Attitudes, Behaviors, and Functioning

Scale 1 - Sexual Attitudes
1. I have little interest in sex and could go on indefinitely without it.
2. I feel guilty when I experience sexual pleasure.
3. I have engaged in a pattern of sexual encounters where I sexually use men.
4. I am ashamed of my body.
5. I have engaged in same-sex sexual activities.
6. Sex is more enjoyable when I am in control.
7. As an adult (over 21 years of age), I have engaged in sexual activity with a minor (under 18 years of age).
8. When I masturbate, I worry about being caught.
9. I have sexual feelings toward children.
10. I experience intense anxiety during sexual activities.

Scale 2 - Sexuality and Partner
1. I am happy when my partner approaches me for sex.
2. After sexual relations with my partner I feel relaxed and contented.
3. I desire sexual relations and encourage my partner to have sex.
4. I have sex with my partner out of a sense of obligation, not desire.
5.I feel my partner is pressuring me sexually.
6. When my partner is being affectionate, I usually assume he/she is making a sexual overture when in fact he/she is just being affectionate.
7. I think I have sexual fantasies because I am tired of my partner.
8. When I have sexual fantasies, I feel detached from my partner.
9. I fantasized to overcome temporary feelings of boredom or anger toward my partner that might interfere with sexual pleasure.
10. I tell my partner about my sexual fantasies.

Scale 3 - Physical
1. Insufficient vaginal lubrication is a problem for me.
2. I sometimes become physically ill (nausea, vomiting, panicked, etc.) during sexual activity.
3. I experience genital pain during or after intercourse.

Scale 4 - Orgasm
1. My orgasms are very intense.
2. I have multiple orgasms.
3. During sexual relations, I am orgasmic.

Appendix H (cont'd)

<u>Scale 5 - Fantasy</u>

1. I fantasize as part of my regular sex routine like kissing, petting, hugging, etc..
2. I fantasize to put me in the mood for sex when I'm not ready.
3. I have a favorite recurring fantasy that arouses me during sex.
4. During masturbation, I fantasize.
5. During sexual relations, I fantasize.
6. The content of my sexual fantasies remains the same over time.

APPENDIX I

Eight Sexual Fantasies Which Were Not Reported By The Non-Traumatized Subjects

I relive a previous unpleasant or disturbing sexual experience which has left me marked or branded.

I am sexually aroused when I observe someone being physically harmed while I engage in sexual activities.

I imagine I humiliate or torture my partner.

I imagine I am engaged in a sexual activity with a female or male child.

I imagine I am engaged in sexual activity with a family member.

I imagine I am a child and an unknown, scary creature is coming toward me.

I imagine I am a child and a faceless man/woman is engaged in sexual activity with me.

I imagine I am engaged in sexual activity with a partner who I know may have been exposed to AIDS.

REFERENCES

Arndt, W., Jr., Foehl, J. C., & Good, F. E. (1985). Specific sexual fantasy themes: A multidimensional study. Journal of Personality and Social Psychology, 48, 472-480.

Baisden, M. J., & Baisden, J. R. (1979). A profile of women who seek counseling for sexual dysfunction. American Journal of Family Therapy, 7, 68-76.

Becker, J. V., Skinner, L. J., Abel, G. G., Axelrod, R., & Cichon, J. (1984). Sexual problems of sexual assault survivors. Women and Health, 9, 5-20.

Becker, J. V., Skinner, L. J., Abel, G. G., & Cichon, J. (1986). Level of postassault sexual functioning in rape and incest victims. Archives of Sexual Behavior, 15, 37-49.

Becker, J.V., Skinner, L.J., Abel, G.G., & Treacy, E.C. (1982). Incidence and types of sexual dysfunctions in rape and incest victims. Journal of Sex and Marital Therapy, 8, 65-74.

Bender, L., & Blau, A. (1937). The reaction of children to sexual relations with adults. American Journal of Orthopsychiatry, 7, 500-518.

Bender, L., & Grugett, A., Jr. (1952). A follow-up report on children who had atypical sexual experiences. American Journal of Orthopsychiatry, 22, 825-837.

Benward, J., & Densen-Gerber, J. D. (1975). Incest as a causative factor in antisocial behavior: An exploratory study. Contemporary Drug Problems, 4, 323-346.

Bibring, E. (1943). The conception of the repetition compulsion. Psychoanalytic Quarterly, 12, 486-519.

Brown, J. J., & Hart, D. H. (1977). Correlates of females' sexual fantasies. Perceptual and Motor Skills, 45, 819-825.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99, 66-77.

Campagna, A. F. (1985). Fantasy and sexual arousal in college men: Normative and functional aspects. Imagination, Cognition and Personality, 5, 3-19.

Carmen, E., Rieker, P. R., & Mills, T. (1984). Victims of violence and psychiatric illness. American Journal of Psychiatry, 141, 378-383.

Cole, C. L. (1985). A group design for adult female survivors of childhood incest. Women and Therapy, 4, 71-82.

Coons, P. M., & Milstein, V. (1986). Psychosexual disturbances in multiple personality: Characteristics, etiology, and treatment. Journal of Clinical Psychiatry, 47, 106-110.

Courtois, C. A. (1979). The incest experience and its aftermath. Victimology, 4, 337-347.

Courtois, C. A. (1988). Healing the incest wound. New York: W. W. Norton & Company.

Courtois, C. A., & Watts, D. L. (1982). Counseling adult women who experienced incest in childhood or adolescence. The Personnel and Guidance Journal, 60, 275-279.

Crepault, C., Abraham, G., Porto, R., & Couture, M. (1977). Erotic imagery in women. In R. Gemme, & C. C. Wheeler (Eds.), Progress in Sexology (pp. 267-283). New York: Plenum Press.

Crepault, C., & Couture, M. (1980). Men's erotic fantasies. Archives of Sexual Behavior, 9, 565-581.

Dally, P. (1975). The fantasy game. New York: Stein & Day.

Davidson, J., Sr. (1985). The utilization of sexual fantasies by sexually experienced university students. Journal of American College Health, 34, 24-32.

Eisnitz, A. (1984-85). Father-daughter incest. International Journal of Psychoanalytic Psychotherapy, 10, 495-503.

Faria, G., & Belohlavek, N. (1984). Treating female adult survivors of childhood incest. Social Casework, 65, 465-470.

Finkelhor, D. (1979). Sexually victimized children. New York: The Free Press.

Finkelhor, D. (1980). Sex among siblings: A survey on prevalence, variety, and effects. Archives of Sexual Behavior, 9, 171-194.

Finkelhor, D. (1986). A sourcebook on child sexual abuse. Beverly Hills, CA: Sage Publications.

Fisher, S. (1973). Understanding the female orgasm. New York: Basic Books.

Freud, S. (1920). Beyond the pleasure principle. In J. Strachey, & A. Freud (Eds.), The Standard Edition of the Complete Psychological Works of Sigmund Freud (pp. 7-64). London, England: Hogarth Press.

Freud, S. (1954). The origins of psychoanalysis. London, England: Imago Publishing Company.

Friday, N. (1973). My secret garden. New York: Trident Press.

Fritz, G. S., Stoll, K., & Wagner, N. N. (1981). A comparison of males and females who were sexually molested as children. Journal of Sex and Marital Therapy, 7, 54-59.

Fromuth, M. E. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. Child Abuse and Neglect, 10, 5-15.

Gagnon, J. H. (1965). Female victims of sex offenses. Social Problems, 13, 176-192.

Gelinas, D. J. (1983). The persisting negative effects of incest. Psychiatry, 46, 312-332.

Gordy, P. L. (1983). Group work that supports adult victims of childhood incest. Social Casework, 65, 300-307.

Grosskopf, D. (1983). Sex and the married woman. New York: Simon & Schuster.

Groth, A. N. (1978). Guidelines for the assessment and management of the offender. In A. W. Burgess, A. N. Groth, L. L. Holmstrom, & S. M. Sgroi (Eds.), Sexual Assault of Children and Adolescents (pp. 25-42). Lexington, MA: Lexington Books.

Gundlach, R. H. (1977). Sexual molestation and rape reported by homosexual and heterosexual women. Journal of Homosexuality, 2, 367-384.

Hariton, E. B., & Singer, J. L. (1974). Women's fantasies during sexual intercourse: Normative and theoretical implications. Journal of Consulting and Clinical Psychology, 43, 323-329.

Henderson, D. J. (1972). Incest: A synthesis of data. Canadian Psychiatric Journal, 17, 299-313.

Henderson, J. (1983). Is incest harmful? Canadian Journal of Psychiatry, 28, 34-40.

Herman, J. L. (1981). Father-daughter incest. Cambridge, MA: Harvard University Press.

Herman, J. L., & Hirschman, L. (1977). Father-daughter incest. Signs, 2, 735-756.

Hessellund, H. (1976). Masturbation and sexual fantasies in married couples. Archives of Sexual Behavior, 5, 133-147.

Hollender, M. C. (1970). Women's coital fantasies. Medical Aspects of Human Sexuality, 4, 63-70.

Horowitz, M. J. (1973). Phase oriented treatment of stress response syndromes. American Journal of Psychotherapy, 27, 506-515.

Horowitz, M. J. (1975). Intrusive and repetitive thoughts after experimental stress. Archives of General Psychiatry, 32, 1457-1463.

Horowitz, M. J. (1979). Psychological response to serious life event. In V. Hamilton, & D. Warburton (Eds.), Human Stress and Cognition (pp. 235-263). New York: John Wiley & Sons.

Horowitz, M. J. (1986). Stress response syndromes. Northvale, NJ: Jason Aronson.

James, J., & Meyerding, J. (1977). Early sexual experience as a factor in prostitution. Archives of Sexual Behavior, 7, 31-42.

Jehu, D. (1979). Sexual dysfunction. New York: John Wiley & Sons.

Jehu, D., & Gazan, M. (1983). Psychosocial adjustment of women who were sexually victimized in childhood or adolescence. Canadian Journal of Community Mental Health, 2, 71-82.

Jehu, D., Gazan, M., & Klassen, C. (1984-85). Common therapeutic targets among women who were sexually abused in childhood. Journal of Social Work and Human Sexuality, 3, 25-45.

Jortner, S. (1985). To what degree was Freud wrong-and how much difference does it make in psychotherapy. Journal of Contemporary Psychotherapy, 15, 114-122.

Justice, B., & Justice, R. (1979). The broken taboo. New York: Human Sciences Press.

Kanin, E. J. (1982). Female rape fantasies: A victimization study. Victimology, 7, 114-121.

Kaplan, H. S. (1985). Disorders of sexual desire. Washington, DC: American Psychiatric Press.

Katan, A. (1973). Children who were raped. Psychoanalytic Study of the Child, 28, 208-224.

Kaufman, I., Peck, A. L., & Tagiuri, C. K. (1954). The family constellation and overt incestuous relations between father and daughter. American Journal of Orthopsychiatry, 24, 266-277.

Landis, J. (1956). Experience of 500 children with adult sexual deviance. Psychiatric Quarterly Supplement, 30, 91-109.

Larson, N. R., & Maddock, J. W. (1983). Incest and other sexual contacts between adults and children. In C. Nadelson, & D. Marcotte (Eds.), Treatment Interventions in Human Sexuality (pp. 162-173). New York: Plenum Press.

Lentz, S. L., & Zeiss, A. M. (1984). Fantasy and sexual arousal in college women: An empirical investigation. Imagination, Cognition and Personality, 3, 185-202.

Lewis, M., & Sarrell, P. M. (1969). Some psychological aspects of seduction, incest, and rape in childhood. American Academy of Child Psychiatry, 8, 606-619.

Lukianowicz, N. (1972). Incest I: Paternal Incest. British Journal of Psychiatry, 120, 301-313.

MacFarlane, K. (1978). Sexual abuse of children. In J. Chapman, & M. Gates (Eds.), The Victimization of Women (pp. 81-109). Beverly Hills, CA: Sage Publications.

Maltz, W., & Holman, B. (1987). Incest and sexuality. Lexington, MA: Lexington Books.

Marmor, J. (1976). Frigidity, dyspareunia, and vaginismus. In B. Sadock, H. Kaplan, & A. Freedman (Eds.), The Sexual Experience (pp. 398-403). Baltimore, MD: Williams & Wilkins.

Maslow, A. H. (1942). Self-esteem and sexuality in women. Journal of Social Psychology, 16, 259-294.

Masson, J. M. (1984). Freud and the seduction theory. The Atlantic Monthly, 2, 33-60.

Masters, W. H., Johnson, V. E., & Kolodny, R. C. (1982). Masters and Johnson on sex and human loving. Boston, MA: Little Brown.

McGuire, L. S., & Wagner, N. N. (1978). Sexual dysfunction in women who were molested as children: One response pattern and suggestions for treatment. Journal of Sex and Marital Therapy, 4, 11-15.

Meiselman, K. C. (1978). Incest: A psychological study of causes and effects with treatment recommendations. San Francisco, CA: Jossey-Bass Publishers.

Meiselman, K. C. (1980). Personality characteristics of incest history psychotherapy patients: A research note. Archives of Sexual Behavior, 9, 195-197.

Moreault, D., & Follingstad, D. R. (1978). Sexual fantasies of females as a function of sex guilt and experimental response cues. Journal of Consulting and Clinical Psychology, 46, 1385-1393.

Morokoff, P. J. (1985). Effects of sex guilt, repression, sexual "arousability", and sexual experience on female sexual arousal during erotica and fantasy. Journal of Personality and Social Psychology, 49, 177-187.

Nutter, D. E., & Condron, M. K. (1983). Sexual fantasy and activity patterns of females with inhibited sexual desire versus normal controls. Journal of Sex and Marital Therapy, 9, 276-282.

O'Connor, J. F., & Stern, L. O. (1972). Developmental factors in functional sexual disorders. New York State Journal of Medicine, 72, 1838-1843.

Parkes, C. M. (1972). Bereavement. New York: International Universities Press.

Peters, J. J. (1976). Children who are victims of sexual assault and the psychology of offenders. American Journal of Psychotherapy, 30, 398-412.

Price, J. H., & Miller, P. A. (1984). Sexual fantasies of black and of white college students. Psychological Reports, 54, 1007-1014.

Rascovsky, M. W., & Rascovsky, A. (1950). On consummated incest. International Journal of Psychoanalysis, 31, 42-47.

Rosenfeld, A. A. (1979). Incidence of a history of incest among 18 female psychiatric patients. American Jooournal of Psychiatry, 136, 791-795.

Ruch, L. O., & Chandler, S. M. (1982). The crisis impact of sexual assault on three victim groups: adult rape victims, child rape victims, and incest victims. Journal of Social Service Research, 5, 83-100.

Rush, F. (1977). The Freudian cover-up. Chrysalis, 1, 31-45.

Rush, F. (1980). The best kept secret: Sexual abuse of children. Englewood Cliffs, NJ: Prentice-Hall.

Russell, D. E. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. Child Abuse and Neglect, 7, 133-146.

Russell, D. E. (1986). The secret trauma: Incest in the lives of girls and women. New York: Basic Books.

Scharff, D. E. (1978). Childhood origins of sexual difficulty. Medical Aspects of Human Sexuality, 12, 61-70.

Sedney, M. A., & Brooks, B. (1984). Factors associated with a history of childhood sexual experience in a nonclinical female population. Journal of the American Academy of Child Psychiatry, 23, 215-218.

Shainess, N. (1984). Sweet suffering woman as victim. New York: Bobbs-Merrill.

Shainess, N., & Greenwald, H. (1971). Are fantasies during sexual relations a sign of difficulty? Sexual Behavior, 1, 38-54.

Shanor, K. (1978). The Shanor study. New York: Dial Press.

Shapiro, D. (1981). Autonomy and rigid character. New York: Basic Books.

Silbert, M. H. (1982). Prostitution and sexual assault. International Journal for Biosocial Research, 3, 69-71.

Silbert, M. H., & Pines, A. M. (1981). Sexual abuse as an antecedent to prostitution. Child Abuse and Neglect, 5, 407-411.

Silbert, M. H., & Pines, A. M. (1983). Early sexual exploitation as an influence in prostitution. Social Work, 28, 285-289.

Silver, R. L., Boon, C., & Stones, M. H. (1983). Searching for meaning in misfortune: Making sense of incest. Journal of Social Issues, 39, 81-102.

Simari, C. G., & Baskin, D. (1982). Incestuous experiences within homosexual populations: A preliminary study. Archives of Sexual Behavior, 11, 329-344.

Stanko, E. A. (1985). Intimate intrusions-women's experience of male violence. London, England: Routledge & Kegan Paul.

Stoller, R. J. (1979). Sexual excitement. New York: Pantheon Books.

Sue, D. (1979). Erotic fantasies of college students during coitus. The Journal of Sex Research, 15, 299-305.

Sullivan, P. R. (1969). What is the role of fantasy? Medical Aspects of Human Sexuality, 3, 79-89.

Summit, R. (1982). Beyond belief. In M. Kirkpatrick (Ed.), Women's Sexual Experience (pp. 127-150). New York: Plenum Press.

Summit, R., & Kryso, J. (1978). Sexual abuse of children: A clinical spectrum. American Journal of Orthopsychiatry, 48, 237-251.

Tsai, M., & Wagner, N. N. (1978). Therapy groups for women sexually molested as children. Archives of Sexual Behavior, 7, 417-427.

Tsai, M., Feldman-Summers, S., & Edgar, M. (1979). Childhood molestation: Variables related to differential impacts on psychosexual functioning in adult women. Journal of Abnormal Psychology, 88, 407-417.

Van Buskirk, S. S., & Cole, C. F. (1983). Characteristics of eight women seeking therapy for the effects of incest. Psychotherapy: Theory, Research and Practice, 20, 503-511.

Weiner, I. B. (1962). Father-daughterr incest: A clinical repoort. Psychiatric Quarterly, 36, 607-632.

Weiss, J., Rogers, E., Darwin, M. R., & Dutton, C. E. (1955). A study of girl sex victims. Psychiatric Quarterly, 29, 1-27.

Werman, D. S. (1977). On the occurrence of incest fantasies. Psychoanalytic Quarterly, 46, 245-255.

Yorukoglu, A., & Kemph, J. P. (1966). Children not severely damaged by incest with a parent. Journal of the Academy of Child and Adolescent Psychiatry, 5, 111-124.