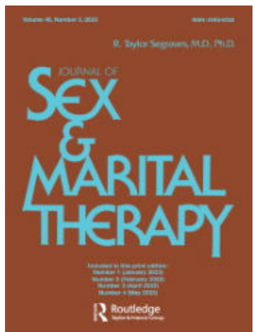

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Social Reactions to Disclosure of Sexual Violence in Adulthood and Women's Sexuality: The Mediating Role of Shame and Guilt

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ABSTRACT

This study examined the mediating role of emotions related to sexual violence in adulthood in the associations between social reactions to sexual violence disclosure and sexual outcomes. Self-reported data were collected from 324 women reporting sexual violence and path analyses were conducted among the 264 women (81.5%) who disclosed their most recent sexual violence experience. Results showed that emotional support was associated with higher sexual satisfaction. Victim blame was associated with greater guilt related to the sexual violence, which, in turn, was associated with higher sexual compulsivity. Stigmatization was associated with greater shame related to the sexual violence, which, in turn, was associated with higher sexual distress and avoidance, and lower sexual satisfaction and function. Our findings highlight the importance of social reactions to sexual violence disclosure in women's sexuality.

Introduction

Recent online movements have drawn public attention to the extent of sexual violence against women, and called for changes in social and legal responses to sexual violence disclosure. Based on nationally representative samples, sexual violence in adulthood (SVA) affects 39 to 44% of women (Breiding et al., 2014; Perreault, 2020). Sexual violence in adulthood (after the age of 16) includes any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion (World Health Organization, 2013). SVA is associated with both short- and long-term negative consequences on physical and mental wellbeing (Campbell, Dworkin, & Cabral, 2009), including sexuality (Van Berlo & Ensink, 2000).

Sexuality is a central part of a person's overall wellbeing and identity, and may be affected by SVA and the key experiences surrounding it, such as social reactions to disclosure and emotions following SVA (e.g., stigmatization, fear, shame; Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Coker et al., 2002). Although preliminary findings in a small sample suggest that women experiencing negative reactions to SVA disclosure report lower levels of sexual adjustment (i.e., lower sexual satisfaction and higher sexual difficulties; Therriault, Bigras, Hébert, & Godbout, 2020), the extent of the effects on multiple dimensions of sexuality and the mechanisms linking the social reactions to sexual outcomes were not examined. Studying a wide array of social

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reactions to SVA disclosure, multiple sexual outcomes, and potential underlying mechanisms in the associations between social reactions to SVA disclosure and sexual outcomes could contribute to a more comprehensive understanding of factors that may impede the sexuality of women victims of SVA. Therefore, the aims of the present study were to examine whether women who disclosed SVA—compared to women who did not—report different levels of SVA-related shame and guilt and sexual outcomes; and examine the mediating role of shame and guilt in the associations between social reactions to SVA disclosure and sexual outcomes.

Sexual violence and women's sexuality

Trauma theories contend that interpersonal trauma such as SVA can disrupt the victim's sense of security and comfort with intimacy, which are crucial to multiple aspects of a positive sexuality (Briere & Jordan, 2004; Briere & Scott, 2014). Sexuality is multidimensional and includes individuals' cognitive and affective evaluations of different sexual domains (Byers & Rehman, 2014). Multiple sexual outcomes (e.g., satisfaction, function, distress, avoidance, and compulsivity) are needed to grasp the complexity of this construct and to avoid drawing biased conclusions based on only one specific dimension of women's sexuality. Empirical studies showed that women reporting SVA may experience sexual difficulties, including decreased sexual satisfaction, higher sexual distress, and lower sexual function (e.g., inhibited arousal, desire problems and lubrication difficulties; Kelley & Gidycz, 2019; Turchik & Hassija, 2014; Ullman & Siegel, 1993; Van Berlo & Ensink, 2000). SVA can interfere with women's sexual satisfaction, function, and distress by shaping their physiological, cognitive, affective, and behavioral responses to sexual stimuli (Basson, 2001).

Some studies also suggested that SVA victims may report sexual compulsivity or sexual avoidance, although these indicators are rarely examined in relation to SVA (Nadelson, Notman, Zackson, & Gornick, 1982; Slavin et al., 2020). Sexual compulsivity after an interpersonal trauma could be understood as an attempt to cope with powerlessness and negative emotions by turning to external behaviors that distract or numb from the painful internal states, and give an impression of controlling one's body and sexual life (Briere, 1992; Fontanesi et al., 2021). On the other side, sexual avoidance might be used to protect oneself from reliving the trauma, as it is common to avoid trauma-related stimuli (American Psychiatric Association, 2013). Although most of past studies suggest that SVA may be related to negative sexual outcomes in women, they also show that a significant proportion of these women report a healthy and satisfying sexuality, underlying the need to understand risk factors of negative sexual outcomes.

One critical factor that may dampen the negative effects of SVA is its disclosure. Overall, 65 to 75% of women experiencing SVA disclose it to someone (Sabina & Ho, 2014 for a review), but whether disclosing is helpful to manage trauma-related outcomes remains an open debate. Indeed, findings on the associations between disclosure of SVA and psychological outcomes are mixed, with some studies reporting no associations (e.g., Carretta, Burgess, & DeMarco, 2015), some revealing that disclosure is related to positive psychological outcomes (e.g., Staples et al., 2016) and some reporting that disclosure is related to negative psychological outcomes (e.g., Ahrens, Stansell, & Jennings, 2010). These inconsistent results suggest that disclosing could be a reparative experience, although this may depend on the social reactions to the disclosure of SVA. Moreover, the associations between disclosure and SVA-related emotions and sexuality remain unexamined even if disclosure may represent a critical event in victims' sexual recovery, as it has the potential to bring back a sense of interpersonal security and comfort with intimacy.

Social reactions to the disclosure of sexual violence

Trauma theories support that the disclosure of trauma should be made in a safe and supportive environment to promote recovery and to diminish the distressing emotional response that is associated with the trauma activation (Briere, 2002; Briere & Scott, 2014). However, social reactions

to the disclosure of SVA vary widely. Emotional support/validation and tangible aid (e.g., medical care, helpful information) are usually considered positive reactions. Taking control of the victim's decisions, blaming the victim, treating the victim differently or stigmatizing her responses, distracting the victim or discouraging her from talking (e.g., suggesting to stop thinking about it), and being egocentric (e.g., focusing on one's own needs, not the victim's; Ullman, 2000) are usually referred to as negative reactions. Some authors suggested that social reactions might have a greater impact on an individual's recovery than the disclosure itself (Scoglio, Lincoln, Kraus, & Molnar, 2020; Therriault et al., 2020). Positive social reactions may promote healing, as they are associated with more adaptive coping strategies (Ullman & Peter-Hagene, 2014) and lower psychological distress (Campbell et al., 2001; Coker et al., 2002). In contrast, negative social reactions are associated with higher levels of depression, anxiety, and post-traumatic stress symptoms (Orchowski, Untied, & Gidycz, 2013; Ullman, Filipas, Townsend, & Starzynski, 2007).

In the only study examining the associations between social reactions to disclosure of SVA and sexuality, victims who received negative social reactions ($n = 15$) reported more sexual difficulties than those who did not disclose ($n = 13$) and lower sexual satisfaction than those who disclosed and received positive social reactions ($n = 49$) (Therriault et al., 2020). Thus, receiving negative social reactions could sometimes be associated with worse outcomes than not disclosing. However, this study, as most previous studies examining the outcomes of social reactions (e.g., Ullman & Peter-Hagene, 2014), only differentiated between positive and negative reactions, limiting our understanding of whether different types of positive and negative reactions have the same effect. Yet, the scarce studies distinguishing between different types of positive and negative reactions indicated that they were associated differently with coping skills and psychological symptoms (Ullman, 2021), supporting the need to move beyond the positive and negative dichotomy. Also, little is known about the underlying mechanisms explaining why social reactions to SVA disclosure might be related to sexual outcomes.

Shame and guilt and their associations with disclosure

SVA victims often develop negative emotions like guilt and shame in relation to their SVA experiences (Aakvaag et al., 2016). Shame refers to a negative self-evaluation, including feelings of embarrassment, inferiority and fear of being judged negatively by others (Budden, 2009), whereas guilt refers to a negative appraisal regarding past behaviors (Beck et al., 2011). While shame focuses on one's entire being, guilt is directed toward specific aspects of one's self (Tangney, Miller, Flicker, & Barlow, 1996; Tangney & Dearing, 2003). These emotions are typically associated with different behaviors: guilt is known to motivate taking action, while shame is known to motivate hiding the self.

These negative emotions may especially be exacerbated in cases when SVA victims experience negative social reactions. SVA victims may feel a secondary victimization to the initial trauma if the social reactions from the environment are not adequate (Campbell & Raja, 1999). In a prospective study ($n = 36$) and a retrospective study ($n = 33$) among samples of rape victims, negative reactions from the romantic partner after disclosure of SVA were associated with higher levels of SVA-related shame (Ensink, van Berlo, & Winkel, 2000). In a sample of 207 female undergraduates, women who experienced more negative social reactions to SVA disclosure felt greater sexual violence-related shame which, in turn, was related to higher levels of psychological distress (DeCou, Cole, Lynch, Wong, & Matthews, 2017). However, although guilt is commonly felt in relation to a SVA experience, little is known about the association between social reactions and SVA-related guilt.

In return, both shame and guilt might be particularly important to understand negative sexual outcomes of SVA. Indeed, based on trauma theories, sexual activities might trigger traumatic memories including SVA-related emotions (i.e., guilt and shame) and broader negative self-perceptions that might interfere with sexuality (Briere, 2002; Briere & Scott, 2014). Shame and guilt experienced in relation to sexual violence are associated with subsequent fear of sex, lack of desire and sexual aversion, lower sexual satisfaction, and lower sexual function (Ensink

& Van Berlo, 1999; Glenn & Byers, 2009; Pulverman & Meston, 2020). Outside the context of sexual violence, other studies also reported associations between higher shame or guilt and higher sexual compulsivity, lower sexual desire, and lower sexual satisfaction (Gilliland, South, Carpenter, & Hardy, 2011; Woo, Brotto, & Gorzalka, 2012). Understanding their roles in the associations between social reactions to SVA and sexual outcomes could help point toward modifiable targets of therapeutic intervention to facilitate victims' sexual healing process.

Aims and hypotheses

The first aim of the present study was to compare women who disclosed their SVA experience and women who did not regarding their levels of SVA-related guilt and shame and sexual outcomes (i.e., sexual satisfaction, sexual function, sexual distress, sexual avoidance, and sexual compulsivity). Given mixed results reported in past studies (Ahrens et al., 2010; Carretta et al., 2015; Staples et al., 2016), we examined these associations in an exploratory manner. The second aim of this study was to examine the associations between social reactions to SVA disclosure and sexual outcomes and to test the mediating role of SVA-related shame and guilt in these associations. It was hypothesized that higher levels of social reactions of control, blame, stigmatization, distraction, or being egocentric would be associated with higher levels of SVA-related guilt and shame, which, in turn, would be associated with lower sexual satisfaction, lower sexual function, higher sexual distress, higher sexual avoidance, and higher sexual compulsivity. Moreover, we hypothesized that higher levels of emotional support and tangible aid would be associated with higher sexual satisfaction and sexual function, and lower sexual distress, sexual avoidance, and sexual compulsivity via lower levels of SVA-related guilt and shame.

Method

Participants

A convenience sample of 324 women who had experienced sexual violence after the age of 16 was recruited through university email lists, social networking sites, posters, and flyers distributed in different community organizations (e.g., sexual assault centers). Women were aged from 19 to 69 years old (M_{age} = 30.27, $SD = 10.07$). A total of 53.1% ($n = 172$) of women reported being students, while 38.9% ($n = 126$) reported having a full-time or a part-time job, 5.6% ($n = 18$) being unemployed or on sick leave, 1.2% ($n = 4$) being at home, and 1.2% ($n = 4$) being retired. They had completed 7 to 30 years of education ($M = 16.72$, $SD = 3.27$). In terms of sexual orientation, 70.7% ($n = 229$) reported being heterosexual, 13.0% ($n = 42$) bisexual, 11.4% ($n = 37$) queer or pansexual, 3.7% ($n = 12$) uncertain or confused, 0.6% ($n = 2$) asexual, and 0.6% ($n = 2$) homosexual (lesbian). As for relationship status, 37.7% ($n = 122$) were single, 29.3% ($n = 95$) were in a romantic relationship and cohabiting with their partner, 24.4% ($n = 79$) were in a romantic relationship but did not live with their partner, and 8.6% ($n = 28$) were married. While the total sample was used for the group comparisons (aim 1), a total of 81.5% ($n = 264$) of the participants disclosed their most recent SVA experience and were included in the path analysis (aim 2).

Procedure

This study was part of a larger study advertised as a survey about unwanted sexual experiences. Interested women were invited to contact us via email to schedule a brief screening telephone interview with a research assistant. To be eligible, interested participants had to be a woman (sex assigned at birth), at least 18 years of age, and report having experienced an unwanted sexual experience after the age of 16. Participants were not eligible if they were unable to read French or if they did not want to answer questions about their unwanted sexual experience. Of the 415 women who contacted the research team about this study, 59 (14.2%) could not be

reached or were not interested to participate after learning more about the study by email, and six (1.4%) were not eligible. A link to the online survey hosted on the *Qualtrics* platform was sent to 350 women. Of these, 26 women (7.4%) did not complete any of the variables examined in the present study. Thus, the final sample for aim 1 included 324 women and for aim 2, only women that disclosed their most recent SVA experience were included ($n = 264$). All participants provided informed consent prior to completing the survey. This study was approved by universities' Institutional Review Boards.

Measures

Sexual violence victimization and disclosure

The Sexual Experiences Survey (Koss, 2006) was used to describe women's history of sexual victimization. Eleven items described possible behaviors that the offender could have committed, and women reported if they had experienced this behavior during their most recent unwanted sexual experience. Data about the most recent SVA experience was collected as this study was conducted in partnership with a local sexual assault center offering services to women who recently had a SVA experience. Moreover, as most women experienced sexual violence more than once, we were especially interested in women's immediate post-assault experience and the disclosure of their most recent SVA experience. An additional item allowed participants to mention any other behaviors. Other items created by Koss (2006) were used to assess the means used by the perpetrator(s) during the SVA (13 items), participants' relationship with the perpetrator (four items), where the SVA took place (four items), and how many SVA experiences the participants had after the age of 16. Sexual violence disclosure was assessed using a single item: "Have you ever told someone about your most recent unwanted sexual experience?" with two answer options: "No, I never talked about it" or "Yes, I have talked about it."

Social reactions to sexual violence disclosure

Women who reported having told someone about their most recent SVA experience completed the *Social Reactions Questionnaire* (Khouzam, Marchand, Billette, & Ouimet, 2000; Ullman, 2000). This 48-item self-report measure assesses seven possible social reactions to disclosure of SVA: (1) tangible aid and helpful information (five items, e.g., "Helped you get medical care"); (2) emotional support (15 items, e.g., "Told you that you were not to blame"); (3) taking control of the victim's decisions (seven items, e.g., "Told others about your experience without your permission"); (4) blaming the victim (three items, e.g., "Told you that you were irresponsible or not cautious enough"); (5) treating the victim differently or stigmatizing her responses (six items, e.g., "Avoided talking to you or spending time with you"); (6) distracting the victim (six items, e.g., "Told you to go on with your life"), and (7) being egocentric by taking actions that are geared more toward their own needs rather than the needs of the victim (four items, e.g., "Has been so upset that he/she needed reassurance from you"). Participants reported how often they had experienced each of the reactions when they disclosed their sexual violence on a five-point Likert scale (0 = *never* to 4 = *always*). Items were averaged for each subscale, with higher scores indicating they had experienced the given reaction more often regarding the disclosure of their most recent SVA experience. In this sample, the internal consistency's indices ranged from acceptable to good for all subscales (α = .68 to .89).

Sexual violence-related shame and guilt

The *Abuse-Related Beliefs Questionnaire* (Ginzburg et al., 2006) was adapted for sexual violence experiences in adulthood to assess emotions related to the SVA. We used the six-item subscale of shame (e.g., "When I think of the unwanted sexual experience I had, sometimes I feel dirty.") and the eight-item subscale of guilt (e.g., "When I think of the unwanted sexual experience I had, I sometimes feel guilty."). Participants indicated their agreement level with these items using

a five-point Likert-type scale (1 = *strongly agree* to 5 = *not agree at all*). Items were averaged for each subscale, with higher scores indicating higher levels of SVA-related shame and guilt. In this sample, the internal consistency' indices of both subscales were good (α_{guilt} = .83 and α_{shame} = .83).

Sexual compulsivity

The *Sexual Compulsivity Scale* (Kalichman et al., 1994; Vaillancourt-Morel et al., 2015) was used to assess compulsive sexual behaviors, including difficulties managing sexual thoughts, intrusive preoccupations or behaviors, and the effects of these on daily functioning (e.g., “I think about sex more than I would like to.”). This 10-item measure is answered on a Likert-type scale (1 = *not at all like me* to 4 = *very much like me*). Items were averaged, with higher mean scores indicating higher levels of sexual compulsivity. This measure demonstrated good internal consistency in the present sample (α = .88).

Sexual avoidance

The sexual avoidance subscale of the *Sexual Aversion Scale* (Katz, Gipson, Kearl, & Kriskovich, 1989; Vaillancourt-Morel et al., 2015) was used to measure the tendency to avoid sexual activity with a partner (e.g., “The way things are now, I would never engage in sexual intercourse.”). Participants answered the 10 items on a four-point Likert-type scale (1 = *not at all like me* to 4 = *very much like me*). Items were averaged, with higher scores indicating a greater tendency to avoid sexual contacts. The sexual avoidance subscale showed good internal consistency in the present sample (α = .92).

Sexual satisfaction

Satisfaction with one's sexual life was measured using the *Global Measure of Sexual Satisfaction* (Lawrance & Byers, 1995). This five-item measure was rated on five different seven-point bipolar scales (good-bad, pleasant-unpleasant, positive-negative, satisfying-unsatisfying, valuable-worthless) and mean scores ranged from one to seven, with higher scores indicating higher sexual satisfaction. This measure showed good internal consistency in the present sample (α = .92).

Sexual distress

Sex-related personal distress was assessed using the 13-item *Female Sexual Distress Scale-Revised* (DeRogatis, Clayton, Lewis-D'Agostino, Wunderlich, & Fu, 2008). Participants indicated how often a sexual problem has bothered them or caused distress during the past 30 days, using a five-point Likert-type scale (0 = *never* to 4 = *always*). Items were averaged, with higher scores referring to more sexual distress. The scale demonstrated good internal consistency in the present sample (α = .94).

Sexual function

Sexual function was measured using the short version of the *Female Sexual Function Index* (Isidori et al., 2010; Rosen et al., 2000). This six-item questionnaire assesses six domains of sexual function, each with one item: subjective desire (“How would you rate your level (degree) of sexual desire or interest?”), arousal (“How would you rate your level of sexual arousal (“turn on”) during sexual activity or intercourse?”), lubrication (“How often did you become lubricated (“wet”) during sexual activity or intercourse?”), orgasm (“When you had sexual stimulation or intercourse, how often did you reach orgasm?”), pain/discomfort (“How often did you experience discomfort or pain during vaginal penetration?”), and satisfaction (“How satisfied have you been with your overall sexual life?”). Items 1 and 5 are answered on a five-point Likert-type scale (1 = very low or absent to 5 = very high; 1 = very unsatisfied to 5 = very satisfied), whereas the

other items include an additional point: 0 = No sexual activity. In line with Meyer-Bahlburg and Dolezal (2007) recommendations, this answer was recoded into a missing value in the total score to avoid biasing the score toward dysfunction. Items were averaged, ranging from one to five, with higher scores indicating better sexual function. This measure demonstrated good internal consistency in the present sample (α = .81).

Data analysis

For statistical analyses, *SPSS* 25 and M*plus* 8 (Muthén & Muthén, 2017) were used. Women who disclosed SVA and women who did not disclose SVA were compared with respect to SVA-related guilt and shame, and sexual outcomes, using independent samples *t*-tests, and Mann-Whitney *U* tests if the assumptions of independent samples *t*-tests were not met.

Path analysis was used to examine the associations between social reactions to SVA disclosure and sexual outcomes (i.e., sexual satisfaction, function, distress, compulsivity, and avoidance) via the mediating role of SVA-related shame and guilt (see S1 in the supplemental material for the full hypothesized model). First, a fully saturated model was tested and then non-significant paths were removed from the model. The models were tested with the robust maximum-likelihood (MLR) estimator that provides robust standard errors and fit statistics.

Commonly used goodness-of-fit indices were examined (Brown, 2015) to assess the acceptability of the model: Comparative Fit Index (CFI ≥ .95 for good, ≥ .90 for acceptable); Tucker–Lewis Index (TLI; ≥ .95 for good, ≥ .90 for acceptable), and Root-Mean-Square Error of Approximation (RMSEA; ≤ .06 for good, ≤. 08 for adequate). In addition, following Schellenberg and Bailis (2016) suggestions to examine the significance of indirect effect, 95% bias-corrected bootstrapped confidence intervals (CIs) with 10,000 resamples were computed. Missing values (ranging from 5.6 to 6.0%) were missing completely at random, based on Little's (1988) MCAR test (χ^2 = 1.98, *df* = 5, *p* = .853), and were treated using the full information maximum likelihood (FIML) method.

Results

Characteristics of the sexual violence experiences

Characteristics of SVA experiences reported by women in the sample are presented in Table 1. Most women experienced penetration (73.8%, *n* = 239), and the most frequent means used by the perpetrator were threats and verbal pressure (45.4%, *n* = 147). Most perpetrators were close to the victim as 39.2% (*n* = 127) of women reported it was a friend or an acquaintance, and 34.0% (*n* = 110) of women reported it was a romantic partner. Almost all perpetrators were men (99.1%, *n* = 321). The SVA mostly took place at the perpetrator's place (39.2%, *n* = 127) or at the woman's place (34.6%, *n* = 112). On average, women reported having had 8.84 (*SD* = 32.79) SVA experiences since they were 16 years old. Most women (81.5%; *n* = 264) disclosed their most recent SVA to someone.

Differences between women who disclosed sexual violence and women who did not

Using Mann Whitney *U*-tests and independent samples *t*-tests in the total sample (*n* = 324), potential differences in women who disclosed and women who did not disclose their unwanted sexual experience on SVA-related guilt and shame and sexual outcomes (i.e., sexual satisfaction, sexual function, sexual distress, sexual compulsivity, and sexual avoidance) were examined. As shown in Table 2, the two groups did not show significant differences on any of the examined variables.

Table 1. Characteristics of women's sexual violence ($N = 324$).

Type of sexual violence	*n*	%
Penetration	239	73.8
Touching	208	64.2
Attempt of penetration or the possibility of penetration	156	48.1
Oral sex or the attempt to have oral sex	146	45.1
Other (e.g., non-contact or non-consensual sexual behaviors during a consensual sexual activity)	4	1.2
Means taken by the perpetrator		
Threats or verbal pressure	147	45.4
Taking advantage of their unconsciousness or of their inability to consent due to drug or alcohol use	96	29.6
Using force	91	28.1
Unwittingly giving them drugs or highly concentrated cocktails	27	8.3
Encouraging them to consume drugs or alcohol	22	6.8
Acting with other people	8	2.5
Relationship with the perpetrator(s)		
Friend, acquaintance, colleague, or friend of a friend	127	39.2
Romantic partner	110	34.0
Someone they very recently met or met the same day	59	18.1
Stranger	24	7.4
Authority figure (teacher, boss, superior, trainer, etc.)	17	5.2
Cousin	4	1.2
Sibling	3	0.9
Paternal figure	2	0.6
Grandparent	1	0.3
Maternal figure	1	0.3
Uncle or aunt	0	0
Sex of the perpetrator(s)		
Man/men	321	99.1
Man/men and woman/women	3	0.9
Woman/women	0	0
The place where the sexual violence happened		
At the other person's place	127	39.2
At their own place	112	34.6
In a public place (for example, at a bar, at a restaurant, at the mall, etc.)	30	9.3
At a friend's or acquaintance's place	21	6.5
At the other person's friend's place	14	4.3
In a car	12	3.7
Outside (for example, in a park, in the woods, etc.).	11	3.4
At a stranger's place	8	2.5
Disclosure of sexual violence		
Disclosed	264	81.5
Did not disclose	60	18.5

Note. Multiple answers options were possible; therefore, the percentages may be higher than 100%.

Table 2. Differences between women who disclosed sexual violence and women who did not disclose sexual violence on sexual outcomes, and sexual violence-related guilt and shame.

	Women who disclosed sexual violence ($n = 264$)	Women who did not disclose sexual violence ($n = 60$)		
Variables	Mean (*SD*)/Median	Mean (*SD*)/Median	Independent samples *t* tests/ Mann Whitney *U*-test [a]	Cohen's *d*
Sexual compulsivity	1.40	1.45	$U = 7429.00$, $p = .692$	0.09
Sexual avoidance	1.50	1.60	$U = 7279.00$, $p = .527$	0.12
Sexual function	3.50	3.08	$U = 6648.50$, $p = .114$	0.23
Sexual distress	1.15	1.23	$U = 6772.50$, $p = .167$	0.20
Sexual satisfaction	4.70 (1.58)	4.53 (1.64)	t (314) = −0.71, $p = .460$	0.10
Guilt	2.43 (0.87)	2.56 (0.93)	t (314) = 1.04, $p = .301$	0.15
Shame	2.84 (0.98)	2.89 (1.13)	t (314) = 0.40, $p = .687$	0.06

Note. SD = standard deviation. [a] = Mann Whitney *U*-tests were used for variables that were not distributed normally and did not meet the assumptions of *t* tests. [b] = Medians are presented for variables that were not distributed normally and means with standard deviations are presented for variables that met the assumptions of *t* tests.

Associations between reactions to disclosure, shame and guilt, and sexual outcomes

Descriptive statistics and correlations between social reactions to SVA disclosure, SVA-related guilt and shame, and sexual outcomes in the sample of women who disclosed their most recent SVA ($n = 264$) are shown in Table 3. Preliminary analyses were conducted between potential confounding variables and shame, guilt and sexual outcomes. Women's age, education, sexual orientation, and occupation were either not significantly related to shame, guilt and sexual outcomes, or the correlation had a small effect size ($r < .20$). Women's relationship status (single vs. in a relationship) was related to all sexual outcomes and was therefore controlled for in the model.

Using path analysis, the hypothesized associations between social reactions to SVA disclosure (i.e., tangible aid, emotional support, control, blame, stigmatization, distraction, and being egocentric), SVA-related guilt and shame, and sexual outcomes were examined in the sample of women who disclosed their most recent SVA ($n = 264$). First, a fully saturated model was examined. In the next step, all non-significant ($p > .05$) paths were trimmed and only the significant ones were estimated, providing model fit indices. Results of this model including the bootstrap indirect effects are reported in Table 4 and depicted in Figure 1.

The final model demonstrated excellent fit to the data, $\chi^2(28, N = 264) = 32.05$, $p = .272$; CFI = .99; TLI = .99; RMSEA = .02; 90% CI = .00 to .06). Higher levels of victim blame were associated with higher levels of SVA-related guilt with a small effect size, which in turn, were associated with higher levels of sexual compulsivity with a small effect size. Higher levels of stigmatization were associated with higher levels of SVA-related shame with a moderate effect size, which in turn, were associated with lower levels of sexual function and sexual satisfaction, and higher levels of sexual distress and sexual avoidance with small-to-moderate effect sizes. Higher levels of emotional support were directly associated with higher levels of sexual satisfaction with a small effect size. Overall, the model explained 6.9% of the variance in women's sexual compulsivity, 21.3% in sexual avoidance, 19.4% in sexual satisfaction, 19.0% in sexual distress, and 5.4% in sexual function.

Discussion

Disclosing SVA to someone is a complex social interaction that is fraught with vulnerability. The goals of this study were to examine the differences between women who disclosed and women who did not on SVA-related emotions and sexual outcomes and to examine the mediator role of SVA-relation emotions in the associations between social reactions to disclosure and sexual outcomes. Our findings showed no significant differences between women who disclosed their SVA experiences and those who did not regarding their SVA-related emotions and sexual outcomes. Tangible aid, distracting the victim, taking control of the victim's decisions and being egocentric were not significantly associated with SVA-related emotions and sexual outcomes, whereas blaming the victim, stigmatization, and emotional support were all related directly or indirectly via SVA-related shame or guilt to at least one sexual outcome. Overall, our results suggest that it is not the disclosure itself that plays a role in women's SVA-related emotions and sexuality, but rather, the social reactions following victims' disclosure.

Disclosure of sexual violence in adulthood

Our findings showed that women who disclosed their SVA were not significantly different from those who did not in terms of SVA-related emotions and sexuality. Feelings of shame and guilt appear to be common in most women who experienced SVA–regardless of SVA disclosure–which is in line with the results of prior studies reporting that trauma victims often present trauma-related feelings of shame and guilt (Aakvaag et al., 2016; Feiring & Taska, 2005). Also, disclosing a history of SVA might be insufficient to help women experience more positive sexual outcomes–which is consistent with results revealing no differences between people who

Table 3. Correlations between social reactions to sexual violence disclosure, sexual violence-related guilt and shame, and sexual outcomes in women who disclosed sexual violence ($n = 264$).

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.
1. Tangible aid	–													
2. Emotional support	**.47*****	–												
3. Control	.14*	**-.31*****	–											
4. Blame	.03	**-.29*****	**.61*****	–										
5. Stigmatization	.06	**-.32*****	**.75*****	**.54*****	–									
6. Distraction	.07	**-.32*****	**.69*****	**.47*****	**.60*****	–								
7. Being egocentric	**.26*****	.08	**.42*****	**.28*****	**.36*****	**.28*****	–							
8. Guilt	.15*	-.00	.09	.18**	.05	.06	.14*	–						
9. Shame	.13*	-.10	**.37*****	.19**	**.38*****	**.31*****	**.26*****	**.44*****	–					
10. Sexual compulsivity	.05	.01	.11	.10	.05	.07	.02	**.28*****	**.20****	–				
11. Sexual avoidance	-.01	-.16*	.13*	.08	**.20****	.13*	-.07	.03	.31***	-.06	–			
12. Sexual satisfaction	.06	**.25*****	-.13*	-.13*	-.16*	-.16*	.08	-.03	**-.22*****	.02	**-.65*****	–		
13. Sexual function	-.06	.13*	-.11	-.06	-.12	-.10	.01	.01	-.14*	**.25*****	**-.49*****	**.60*****	–	
14. Sexual distress	.09	-.17**	**.27*****	.11	**.27*****	.16**	.02	.18**	**.39*****	.14*	**.59*****	**-.63*****	**-.48*****	–
Range	0-4	0-4	0-4	0-4	0-4	0-4	0-4	1-5	1-5	1-4	1-4	1-7	1-5	0-4
Mean	0.90	2.32	0.77	0.72	0.66	0.95	0.88	2.43	2.84	1.63	1.75	4.69	3.37	1.33
Standard Deviation	0.81	0.76	0.71	0.86	0.73	0.79	0.77	0.87	1.00	0.65	0.78	1.58	0.99	0.81

Note.
***$p < .001$;
**$p < .01$;
*$p < .05$
Correlations above .20 are in bold.

Table 4. Indirect effects when examining the associations between reactions to disclosure of sexual violence, sexual violence-related shame and guilt, and sexual outcomes in women who disclosed sexual violence ($n = 264$).

	Direct effects				
Variables	β	95% CI	b	95% CI	p
Victim blame → Guilt	.19	0.08, 0.30	0.19	0.08, 0.30	.001
Stigmatization → Shame	.40	0.30, 0.50	0.54	0.40, 0.69	< .001
Shame → Sexual function	-.16	−0.28, −0.04	−0.16	−0.28, −0.04	.007
Shame → Sexual satisfaction	-.21	−0.32, −0.09	−0.32	−0.50, −0.14	< .001
Shame → Sexual distress	.38	0.27, 0.49	0.36	0.25, 0.46	< .001
Shame → Sexual avoidance	.31	0.19, 0.42	0.24	0.24, 0.59	< .001
Guilt → Sexual compulsivity	.23	0.10, 0.36	0.17	0.10, 0.34	< .001
Emotional support → Sexual satisfaction	.12	0.03, 0.20	0.24	0.07, 0.46	.008
	Indirect effects				
	β	95% CI	b	95% CI	
Victim blame → Guilt → Sexual compulsivity	.04	0.01, 0.08	0.03	0.01, 0.06	
Stigmatization → Shame → Sexual function	-.06	−0.12, −0.01	−0.09	−0.16, −0.02	
Stigmatization → Shame → Sexual satisfaction	-.08	−0.13, −0.03	−0.17	−0.28, −0.06	
Stigmatization → Shame → Sexual distress	.15	0.09, 0.21	0.19	0.11, 0.28	
Stigmatization → Shame → Sexual avoidance	.12	0.07, 0.18	0.13	0.07, 0.19	

Note. Bootstrapped confidence intervals were based on 10,000 replications and were estimated; β = standardized regression coefficients, 95% CI = bias-corrected bootstrapped confidence intervals. Indirect effects are significant if the 95% CI excludes 0.

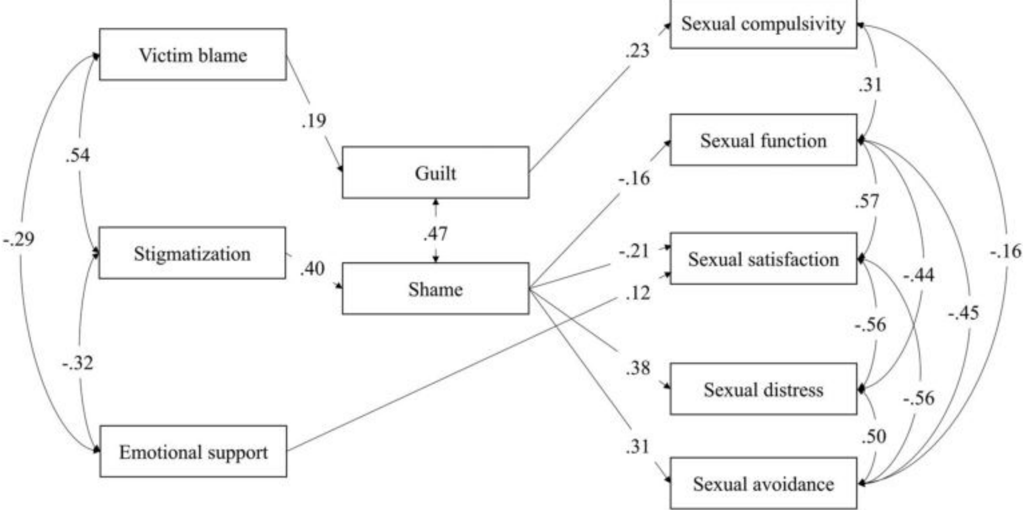

Figure 1. Examination of the associations between reactions to disclosure of sexual violence, sexual violence-related shame and guilt, and sexual outcomes in women who disclosed sexual violence ($n = 264$).

Note. The final trimmed model after removing all the non-significant paths. All paths were significant at $p < .05$. Two-headed arrows represent correlations, one-headed arrows represent standardized regression coefficients. Relationship status (0 = single, 1 = in a relationship) was included as a control variable but was not displayed in the figure for the sake of clarity.

disclosed SVA and people who did not regarding their psychological symptoms (Carretta et al., 2015). However, some past studies reported that disclosure is related to positive outcomes including higher orgasm functioning and lower pain during sex (Staples et al., 2016). The absence of differences between the two groups in our study might be explained by the different samples (e.g., Staples et al. included only single women), the diversity of coping skills used by women to deal with SVA, or by the broad range of social reactions that victims may receive after disclosing. Indeed, disclosing SVA potentially exposes the victims to both helpful and less optimal social reactions. In sum, our results support the need to examine the social reactions following SVA disclosure, as the disclosure in itself is not related to SVA-related shame and guilt, and sexuality.

The mediating role of shame and guilt in the associations between social reactions to SVA and sexuality

In line with our hypothesis that SVA-related emotions would mediate the associations between social reactions to disclosure and sexuality, *blaming the victim* was associated with higher levels of SVA-related guilt, which, in turn, were associated with higher levels of sexual compulsivity. These results are in line with those of previous studies indicating that blaming the victim is associated with higher post-traumatic stress symptoms and drinking problems (e.g., Sigurvinsdottir & Ullman, 2015). Victim blaming may be specifically related to guilt, and not shame, as this social reaction puts the responsibility on the victim, who would then feel that she is guilty of the SVA because of her actions. Guilt motivates action taking to repair the perceived failure (Tangney & Dearing, 2003) and compulsive sexual behaviors are sometimes used to cope with negative emotions (Fong, 2006). Thus, women who experienced SVA may engage in compulsive sexual behaviors in response to SVA-related guilt in an attempt to overcome powerlessness and regain power on their sexual feelings.

Stigmatizing the victim and treating them differently was associated with higher levels of shame, which, in turn, were associated with higher levels of sexual distress and sexual avoidance, and lower levels of sexual satisfaction and sexual function. This positive association between stigmatization and SVA-related shame is consistent with previous findings suggesting that stigmatization largely explains the mental health impact of SVA (Verelst, De Schryver, De Haene, Broekaert, & Derluyn, 2014). Theories within the sexual assault literature have suggested that stigmatization imposed by others may be internalized by victims in the form of shame and self-blame (Kennedy & Prock, 2018). As shame is characterized by negative feelings toward the self in its whole (Tangney & Dearing, 2003), women who present higher levels of SVA-related shame may have a vision of themselves as not being worthy of loving, of being loved, or feeling sexual pleasure (Derogatis & Melisaratos, 1979). This negative vision of themselves may incapacitate them sexually by preventing them to exhibit sexual behaviors that would ensure their sexual wellbeing, like communicating their sexual preferences and desires with their partner. Moreover, as opposed to guilt, shame motivates inaction and hiding the self, which may lead women to avoid sexual contact (Tangney & Dearing, 2003) and result in passive coping strategies that are associated with the inhibition of sexual pleasure and avoidance of sexual activity (Aaron, 2012). Shame is focused on the whole self and motivates inaction and silencing the self (Jack & Ali, 2010; Tangney & Dearing, 2003), which might explain why shame was unrelated to sexual compulsivity (which is an active engagement in sexual activities) but related to all other sexual outcomes that do not imply action but are closely related to the self.

In line with past studies suggesting that shame and guilt are associated with negative sexual outcomes (e.g., sexual aversion, lower sexual satisfaction, lower sexual function, higher sexual compulsivity; Ensink & Van Berlo, 1999; Gilliland et al., 2011; Glenn & Byers, 2009; Pulverman & Meston, 2020; Woo et al., 2012), our results showed that shame and guilt play a mediating role in the associations between social reactions to disclosure and sexuality. Even if other emotions may be related to social reactions and sexuality after SVA (e.g., fear, anger; Van Berlo & Ensink, 2000), past findings showed that victims of SVA internalize victim-blame associated with sexual violence (Kennedy & Prock, 2018), making them especially susceptible to feel emotions like shame and guilt. Our results suggest that receiving social reactions of blame or stigmatization may exacerbate this tendency. In turn, given the relational nature of SVA, these SVA-related emotions may interfere with sexuality if they are triggered by sexual activities (Briere, 2002; Briere & Scott, 2014).

Our results also show an important direct association between *emotional support* as a reaction to SVA and higher levels of sexual satisfaction, with a small effect size. This finding corroborates the results of prior studies reporting that social support from the entourage may help trauma victims' recovery (Campbell et al., 2001; Coker et al., 2002) and promote favorable outcomes, such as greater sexual satisfaction (de Montigny Gauthier et al., 2019). Providing emotional support might be empowering to the victims since it involves letting them express themselves

and therefore giving them a feeling of control over their situation–which they could not have during their SVA experience. Although emotional support might not be sufficient to alleviate guilt and shame, it was directly related to higher sexual satisfaction.

In comparison to emotional support, *tangible aid*, which is also theorized as a positive social reaction to SVA (Ullman, 2000), was unrelated to SVA-related emotions and sexuality in the integrative model. The support offered by tangible aid may not always be well adjusted to women's needs, especially if it is not accompanied by emotional support. Indeed, in a qualitative study among 103 female sexual assault survivors, most women who reported receiving tangible aid felt that it was at least somewhat hurtful, with some women being upset with the lengthy questioning involved with this aid (Ahrens, Cabral, & Abeling, 2009). These notions warrant future research.

Implications

The current study has several implications for social policies and clinical practice. Our results showed that the reactions received by victims who choose to disclose a history of SVA may be diverse and may be associated with both negative or positive sexual outcomes. While it may appear surprising that disclosure is not significantly associated with its presumed benefits (i.e., being an intrinsically liberating and healing experience), these results should be interpreted carefully, since past studies have shown that, in some contexts (e.g., Staples et al., 2016), or when the reactions include emotional support, disclosing may be associated with positive outcomes. Our results should not be used to discourage women to disclose, but rather to stress the importance of accompanying women in this complex and continuous process (e.g., by guiding them in choosing who they feel safe to disclose to, how they want to disclose). Furthermore, efforts should be put on education regarding how to respond when receiving a disclosure of SVA. Furthermore, since emotional support appears to be the only social reaction to be associated with positive sexual outcomes over and above the others, these programs aimed at educating the population on the best ways to receive a disclosure of SVA should emphasize the need to offer emotional support to promote recovery (Scoglio et al., 2020). Practitioners should also dedicate time to explore how social reactions received by the SVA victims might affect them, and how it may be related to their experience of shame and guilt. Our findings support the role of shame and guilt as a possible barrier to sexual wellbeing after a SVA experience and discussing SVA-related emotions is a central part of many treatment modalities (e.g., compassion focused therapy, dialectic behavior therapy; Au et al., 2017; Harned, Korslund, & Linehan, 2014). Thus, SVA-related shame and guilt may represent a modifiable target of therapeutic intervention to minimize negative sexual outcomes.

Strengths, limitations, and future research

This study used a large sample of women reporting SVA to examine the associations between seven social reactions to disclosure of SVA and multiple sexual outcomes, and tested the mediating role of SVA-related guilt and shame. Findings suggest that social reactions to SVA disclosure and SVA-related emotions are key elements of the sexuality of women victims of SVA. However, results must be interpreted in the context of this study's limitations. Generalizability of our findings is limited to women from a convenience sample. The use of self-report measures may have introduced social desirability or recall bias. Moreover, participants were asked about the social reactions and emotions related to their most recent SVA experience. We assumed that the most recent experience would be affecting current sexuality the most. However, future studies could also investigate the most prominent or traumatic experience. This study also focused only on social reactions to disclosure and SVA-related shame and guilt, thus explaining only a modest amount of variance in sexual outcomes. Other factors that were not considered here may have

an important contribution to sexual outcomes after SVA (e.g., coping skills, other SVA-related emotions including anger, hostility, and fear). Finally, given the cross-sectional design, no causal inferences can be made from our results. Future longitudinal studies are needed to examine the directionality of the associations between social reactions to SVA, SVA-related guilt and shame, and sexuality.

Conclusion

Our findings highlight the importance of social reactions to the disclosure of SVA in women's sexuality. More than the disclosure itself, the way people react to the disclosure can be crucial in women's sexual healing process. Women reporting higher levels of emotional support when disclosing reported higher levels of sexual satisfaction, whereas women reporting victim blame or stigmatization reported higher levels of SVA-related guilt or shame, which were related to negative sexual outcomes. Thus, efforts should be put on educating and encouraging the general population as well as professionals who are likely to receive such disclosures (e.g., police officers, doctors) to respond to SVA disclosure with more emotional support and avoid responding with social reactions of blaming or stigmatizing the victim, to help women recover a satisfying and healthy sexuality.

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Conflict of interest

The authors declare that they have no conflict of interest.

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