The purpose of *Intuition* is to highlight undergraduate work and to give students exposure to academic publishing. And while our hope is to always publish high-quality work, the articles in this journal did not receive the rigorous peer review that would be required for publication in a peer-reviewed scholarly journal and should not be cited in peer-reviewed journals.

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Notes From The Editor

In the naming of our first-ever themed issue, we had a few titles in the running, most ranging from cheeky to flippant. Throughout the editorial process, we referred to the issue as *Sex on the Brain*, which we felt was descriptive but didn’t quite match the tone we were going for. Ultimately, we decided on *The Sex and Sexuality Issue*: precise, informative, and unsexy. But maybe that’s the point: to some, this project might seem like an excuse for a group of college students to talk about a taboo subject, but the topics that we tackle in this issue are palpable. We want meaningful, science-based answers and solutions. Sex and sexuality don’t take up the entirety of our lives, but they do take up a part and they have the capacity to affect us emotionally, mentally, physically, and socially. This issue honors that part: the good, the bad, the ugly, the complex, and the surprising, all through the lens of social science.

If you’ve been alive in the 21st century, then you’ve probably heard about how sex and technology intersect. Read Katharine Davidson’s “Love on the Telephone: Sexting and Intimacy in Committed Couple Relationships,” where she explores the potential benefits and harms of sexting. For a good read on the many components and layers of female sexuality, read Matysen Evensen’s “Sociocultural Factors of Female Sexual Desire and Sexual Satisfaction.” Sex is not always a joyful topic, as is the case in Rebekah Leavitt-Hatch’s “Unintentional Cost of a Free Public Sex-Offender Registry,” where she analyzes whether making sex-offender data available to the public does more harm than good. And for the future therapists out there, read Keith Burns’ “The Etiology of MDD is Sexual Minority Youth and Its Implications for Treatment,” where he calls on mental health
practitioners to use a more relationship-focused approach when working with LGBTQ+ individuals with depression.

I cannot say enough to thank all of those who poured their time into this issue. I am grateful to student authors and editors for their steadfastness; the journal’s faculty advisors for their support and expertise; and for the countless faculty reviewers who help us publish high-quality manuscripts every year. This issue required not only the expertise of a select group of psychology faculty, but also that of faculty from sociology, social work, and nursing. I thank the latter group for stretching beyond their own colleges and departments to aid our extracurricular endeavor. Finally, I’d like to thank current editor-in-chief Bryn Gale, whose leadership has been fierce and unwavering, and former editor-in-chief Bradley Talbot, who helped the idea for a sex-themed issue blossom.

Keep learning and always cite your sources,

Anessa Pennington
Senior Editor
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Sociocultural Factors of Female Sexual Desire and Sexual Satisfaction

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Abstract

Historically, research on the human sexual-response cycle has not accounted for individual differences in gender and context. As a circular female response cycle was introduced in the latter end of the 20th century, differentiation between male and female sexuality was embraced, and individual variation between women became commonly known for the first time. As part of this historical shift, sexual desire became an integral part of the sexual experience (Basson, 2000). Most research on female sexual desire focuses on low desire and diagnosable conditions, but, among researchers, there is a growing consensus for additional focus into the roots of female desire and optimal sexual experiences. Sociocultural influences, including body image and appearance, time and setting, gendered cultural scripts, and expectations for pleasure/orgasm, play an important role in helping determine sexual desire. As greater attention and understanding are given to sociocultural influence, women may experience greater desire and higher sexual satisfaction.
Historically, research on the human sexual-response cycle has been static, and studies have given little consideration to individual differences related to gender and context (Basson, 2000; Cherkasskava & Rosario, 2018; Leavitt et al., 2019b). Masters and Johnson first introduced the basic outline of the sexual-response system, characterized by arousal, orgasm, and resolution; Kaplan later introduced a desire phase (Basson, 2000; Cherkasskava & Rosario, 2018). The original notions for this system proved relatively useful in understanding men’s sexual functioning, however, further research showed men and women experiencing these phenomena differently, particularly in the area of sexual desire (Basson, 2000; Busby, Chiu, Leonhardt, & Iliff, 2018; Leavitt et al., 2019b).

Basson revolutionized the study of female sexuality through separation and distinction of individual sexual phenomena. In her (2000) seminal study of the female sexual response, she presented a model depicting a circular sexual-response cycle, as opposed to the linear models accepted in previous years. The circular model supports the theory that sexual responses in women are not cause-and-effect (Basson, 2000). Research suggests that sexual desire, orgasm, and satisfaction might happen simultaneously while building upon each other (Basson, 2000). This unprecedented phenomenon has contributed to ambiguity in differentiating between individual aspects of the female sexual experience. Within this model, there is also allowance for individual variation between women (Krasnow & Maglio, 2019; Leavitt, 2019b; Rosenkratz & Mark, 2018).

When asked directly, women describe sexual desire in abstract terms; many women struggle to describe how they understand desire, often reporting sexual desire and sexual arousal as similar constructs (Brotto et al., 2009). Historically misunderstood perceptions about the female sexual-response cycle may influence this ambiguity in differentiating between individual aspects of the female sexual experience. When sexual-response cycles were first outlined in research, traditional indicators of desire were mainly comprised of genital and physiological responses (Basson, 2000). In contrast, sexual desire today is commonly acknowledged as the emotional appeal to have sex, while arousal is more commonly defined by genital
and physiological responses. Furthermore, women sometimes report experiencing these physical responses without always feeling desire (Leavitt et al., 2019b). In other cases, evidence shows that sexual desire may not precede arousal, while other women still view arousal and desire as the same construct (Leavitt et al., 2019b). The multiple interpretations around the terms desire and arousal have resulted in a lack of understanding at a societal level. As a result, society has reverted to traditional theories in understanding sexuality, most of which appear to be tailored to men’s sexual response and desire (Cherkasskava & Rosario, 2018; Krasnow & Maglio, 2019; Leavitt et al., 2019b; Rosenkratz & Mark, 2018). Cultural assumptions and lack of awareness around individual differences may negatively impact sexual desire.

Additionally, research and culture have historically focused on low sexual desire in women, abandoning the notion of varied or high sexual desire in women (Basson, 2000; Cherkasskaya & Rosario, 2018; Graham et al., 2017). Earlier ideas pertaining to female sexual desire have been shown to be problematic, and yet little effort has been made to update them (Krasnow & Maglio, 2019; Rubin et al., 2019). Because of the way sexual desire has been integrated into society, and because of its universally complex nature, women’s desire and sexuality run the risk of being portrayed as inhibited (Basson, 2000; Cherkasskaya & Rosario, 2018; Rubin et al., 2019). Moreover, female sexual desire may not be discussed at all, when in fact, lack of understanding presents an even greater need to explore what drives female sexual desire and overall satisfaction.

While both men and women experience biological motives for sexual activity, women often report lower biological sex urge while noting higher levels of desire for meaningful connection, emotional vulnerability, and open communication (Basson, 2000; Leavitt et al., 2019b). For them, sexuality develops within sociocultural, political, economic, relational, and interpersonal contexts (Krasnow & Maglio, 2019; Leavitt et al., 2019b). A closer look at female sexual desire shows that it has previously been defined in a variety of ways including one’s wish to engage in sexual activity, necessity for arousal, longing for connection, and the wish to express ownership of one’s
body while submitting to another’s desire (Cherkasskaya & Rosario, 2018; Krasnow & Maglio, 2019). This begins to combine women’s interpersonal and physical needs and lends understanding to female sexual desire as being multi-faceted rather than defined by a single construct. Additionally, sexual desire can be initiated by intrinsic and/or extrinsic factors (Cherkasskaya & Rosario, 2018; Krasnow & Maglio, 2019, Leavitt et al., 2019b). Extrinsic factors are commonly rooted in context.

In recent years, emphasis on the sociocultural factors of sexual desire have intensified in the midst of the biological and physiological factors that have historically taken precedence (Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018; Rubin et al., 2019). Empirical evidence further dichotomizes sexual desire by labeling men’s as spontaneous, while noting women’s as more contextual (Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018; Rubin et al., 2019). Context appears to be heavily influenced by social and cultural influences (Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018). Although female sexuality and desire have been stereotyped and construed to match that of the male experience, female sexual desire is individual and influenced by sociocultural influence, including body image/appearance, timing and setting, gendered cultural scripts, and expectations for pleasure/ orgasm. Greater understanding of female sexuality, coupled with an emphasis on these misunderstood sociocultural aspects, may increase desire for women; as a result, sexual satisfaction may be heightened. This literature review will first establish a baseline knowledge of female sexual desire and then analyze related sociocultural influences, including the effort to normalize female sexual desire and increase overall satisfaction.

**Female Sexual Desire**

The original linear sexual-response theory did not differentiate between men and women and did not include sexual desire as part of the response system (Basson, 2000). As the differences between men and women’s sexual responses have become more widely examined, sexual desire has not only been incorporated into the circular female sexual-response cycle but also has been acknowledged as an integral
part of that cycle (Basson, 2000; Cherkasskaya & Rosario, 2018; McCarthy & Ross, 2018). While men’s sexual desire has historically been characterized as spontaneous, females’ sexual desire tends to be responsive to external stimuli (Cherkasskaya & Rosario, 2018; Krasnow & Maglio, 2019). Furthermore, research supports women reacting to men’s desire (Rubin et al., 2019).

Multiple meanings are associated with female sexual desire (Basson, 2000; Cherkasskaya & Rosario, 2018; Krasnow & Maglio, 2019). These include the wish to increase emotional intimacy with one’s partner, to feel attractive, to feel loved, to feel desired, and to experience arousal and pleasure (Cherkasskaya & Rosario, 2018). As part of sexual arousal, women claim that feeling desired, rather than a desire for sexual activity, is arousing (Leavitt, 2019b). These drivers for sexual activity support the role of context in female sexual desire and may be influenced by societal and cultural forces.

Sexual desire can manifest itself in different ways and at different times throughout the sexual experience (Basson, 2000; Cherkasskaya & Rosario, 2018; Krasnow & Maglio, 2019). Contrary to common belief, women do not need to experience high levels of desire at the beginning of a sexual experience to have positive sexual outcomes (Leavitt et al., 2019b). No matter when the desire is felt (i.e. before, after, or in conjunction with arousal), women report feeling desire as a satisfying sexual experience (Leavitt et al., 2019b). Desire (an emotional appeal) commonly feeds into arousal (genital and physiological responses) (Basson, 2000); when women do not take time to experience full arousal, sexual satisfaction is diminished (Leavitt et al., 2019b). Giving into sexual desire has also generally been associated with overall satisfaction (Leavitt et al., 2019b). While other factors of the sexual experience certainly impact satisfaction, the intrinsic connection between sexual desire and sexual satisfaction is clear.

Over time, society has seen women become more open to talking about sexuality and sexual response. This trend has been accompanied by an increase in diagnoses associated with problematic sexual desire, including female sexual interest/arousal disorder (FSIAD) and hypoactive sexual desire disorder (HSDD)/inhibited
sexual desire (ISD) (Cherkasskaya & Rosario, 2018; Kingsberg & Woodard, 2015; Krasnow & Maglio, 2019). In fact, low sexual desire is the most commonly reported problem for women seeking sex therapy (Kingsberg & Woodard, 2015; Krasnow & Maglio, 2019). One study found that 30% to 50% of women report low sexual desire (Krasnow & Maglio, 2019). It is possible then that sexual desire is being operationalized or construed poorly for the female population.

Significant attention has been given to studying the origins of sexual desire disorders; as a result, high sexual desire in women remains largely unexamined (Cherkasskaya & Rosario, 2018). Speculations concerning this phenomenon center around the concept that sexual desire takes place on a continuum (Cherkasskaya & Rosario, 2018); when both ends of said continuum are not recognized, women run the risk of having their lack of desire labeled as a clinical problem requiring a medical solution, when, in fact, sexual desire is varied and diverse (Graham et al., 2017; Krasnow & Maglio, 2019). Furthermore, female sexuality has been stereotyped as being inhibited and largely undisguised at both a personal and societal level (Basson, 2000; Rubin et al., 2019).

Many factors influence female sexual desire (Basson, 2000; Cherkasskaya & Rosario, 2018; Graham et al., 2017; Krasnow & Maglio, 2019; Leavitt et al., 2019b; Rosenkratz & Mark 2018; Rubin et al., 2019). These factors are rooted in biological (Basson, 2000; Leavitt et al., 2019b), physiological, relational (Busby et al., 2018), lifestyle, and sociocultural motivations (Kingsberg & Woodard, 2015; Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018). Biological and physiological factors of sexual desire include hormone levels, medical challenges, menopause, childbirth, stress, anxiety, depression, trauma, and other mental health-related occurrences (Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018). Sleep, eating, fitness, and substance-abuse habits pertain to lifestyle influences and likewise play a role in desire (Krasnow & Maglio, 2019). Relational factors can be comprised of relationship satisfaction, relationship stability, connectedness, and a willingness to put effort into a relationship while also striving for individual betterment (Krasnow & Maglio, 2019; Rosenkratz & Mark 2018).
These factors and influences are in no way exhaustive or all-inclusive, but they provide important insight into the sociocultural influence of female sexual desire. While not easy, lifestyle habits and relational components can be adjusted, and a vast number of resources exist for physiological concerns. Sociocultural factors, on the other hand, encompass long-held values, norms, and inequalities (Krasnow & Maglio, 2019). Because they take place on a large population scale, the role of sociocultural influences is often downplayed due to the reality that they are not quick or simple fixes (Krasnow & Maglio, 2019). The following society and culture-based motives in sexual desire have the capacity to enhance or hinder sexual outcomes and influence sexual satisfaction (Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018).

**Sociocultural Factors and Sexual Satisfaction**

For women, challenges with sexual desire are commonly interrelated with the context of everyday life in addition to the many other factors that play into the presence of sexual desire. (Cherkasskaya & Rosario, 2018; Krasnow & Maglio, 2019; Rubin et al., 2019). Cultural assumptions pertaining to women having lower sexual desire than men are contradicted by research showing that sexual desire for women is contextually based and situationally sensitive (Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018). These contextual factors are often rooted in sociocultural influences (Rosenkratz & Mark, 2018) and can be related to body image and appearance, timing and setting, gendered cultural scripts, and expectations for pleasure and orgasm (Cherkasskaya & Rosario, 2018; Graham et al., 2017; Krasnow & Maglio, 2019; Leavitt et al., 2019b; Rosenkratz & Mark, 2018; Rubin et al., 2019).

**Body Image**

Society has shaped many cultural beliefs around physical appearance (Cherkasskaya & Rosario, 2018; Krasnow & Maglio, 2019). Cultural attitudes toward the female body can encourage or discourage a sense of agency, integrity, and ownership over one’s sexuality from a young age (Cherkasskaya & Rosario, 2018).
Conflicting attitudes emerge and have the power to inhibit sexuality by subduing sexual body esteem and promoting body objectification (Cherkasskaya & Rosario, 2018). One study notes how this can take place from a young age within parent-child relationships; parents can foster self-consciousness and reduce sexual body esteem and agency in how they refer to their own body and talk about their child’s body (Cherkasskaya & Rosario, 2018). A qualitative study of personal interviews showed that positive body image, confidence, and being comfortable in one’s own body helped stimulate sexual desire, while negative body image, insecurity, weight gain, and lack of fitness impeded such (Krasnow & Maglio, 2019).

How the female body is approached at a societal level has a significant impact in either fostering positive or negative body-image conceptualization. In relationships, women have expressed increased sexual desire when they feel that their whole self is desired by their partner, rather than just their body (Krasnow & Maglio, 2019). While society has shaped body image and confidence to mean solely physical features, a woman’s image of herself includes many more facets, including a sense of autonomy and integrity of self. These additional factors of self-concept have been shown to foster sexual desire (Cherkasskaya & Rosario, 2018).

**Timing and Setting**

Timing, setting, and presence also play an important sociocultural role in female sexual desire (Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018). At a personal level, individuals are increasingly time oriented. Society sometimes presents the idea that life events should not interrupt a regular sex schedule (Graham et al., 2017), yet females report that a lack of time hinders their sexual desire and overall sexual experience (Krasnow & Maglio, 2019). Sexual desire is best fostered in relaxed and slowed-down settings, while lack of time is reported to hinder desire (Krasnow & Maglio, 2019). Timing refers to the full time allotted for the sexual experience and the timing of initiation. When these factors are timed right, desire increases, which can increase sexual satisfaction overall (Krasnow & Maglio, 2019). Relaxed and slowed-down settings within one’s home
can be intertwined with and influenced by the cultural scripts and norms that are reinforced outside of the private realm of one’s sexual relationships and life.

**Gendered Cultural Scripts**

An overarching cultural assumption is that sexual desire should be strong and spontaneous instead of being reactive and responsive (Graham et al., 2017; Leavitt et al., 2019b). Females often do not match the male-centric stereotypes assigned to them, yet gendered cultural scripts and rigid binary roles are socially reinforced (Krasnow & Maglio, 2019; Rosenkratz & Mark, 2018; Rubin et al., 2019). These scripts and roles include the expectations that males have an active desire for sex while females supposedly experience naturally weak desire, and that men initiate sexual advances while women restrict them (Rubin et al., 2019). Although stepping outside assigned roles is often frowned upon at a societal level, research shows that freedom to break the binary can increase desire (Rosenkratz & Mark, 2018). Likewise, gendered cultural scripts have the potential to create stress and pressure to meet societal expectations. Failure to meet these can contribute to feelings of guilt and shame and lower sexual desire as females are acting outside their stereotypical, scripted roles (Rosenkratz & Mark, 2018).

Cultural influences, such as religious views, may also lessen desire as religious beliefs often prohibit sexual exploration (Rosenkratz & Mark, 2018). Christian beliefs emphasize dangers of female sexuality without giving the same attention to men (Leonhardt et al., 2019). This double standard has been associated with feelings of guilt and shame for women and their sexuality (Leonhardt et al., 2019). Meanwhile, one’s personal relationship to sexuality, including, anxiety, self-consciousness, embarrassment, insecurity, and guilt, can hinder sexual desire. Alternatively, religious beliefs can promote sexual sanctification (the belief that sexuality has divine character and significance) (Leonhardt et al., 2019). This type of divine meaning-making of the sexual experience can invite peace and transcendence and has been linked to greater sexual satisfaction (Leonhardt et al., 2019). Overall, there are both negative and positive connections
between religiosity and the sexual experience for women, but religious influences, in the context of gendered cultural scripts, run the risk of suppressing female sexuality to the point of sexual guilt and anxiety. This can negatively impact the sexual experience (Leonhardt et al., 2019).

**Expectations for Pleasure**

Many cultural assumptions exist around female’s expectations for pleasure and/or orgasm (Graham et al., 2017; Krasnow & Maglio, 2019; Rubin et al., 2019). Not only are female orgasms complex at times, sometimes elusive, and less consistent than men’s orgasm (Graham et al., 2017), but gendered cultural scripts may prioritize male pleasure over female pleasure. Society and culture have shaped perception in creating false notions that women experience less orgasms and that their orgasms are less important (Rubin et al., 2019). Furthermore, female sexuality is too often focused on the act of being sexual rather than enjoying the sexual experience (McClelland, 2010). This can create scenarios where women neglect their own pleasure needs and instead focus on their partner’s pleasure due to women’s expectations often being so low that they do not advocate for themselves (McClelland, 2010). Routine and orgasm-focused sex can feel obligatory and lessen desire and overall satisfaction. Women are at risk for a pleasure disadvantage due to these cultural norms.

**Desire-Focused Intervention**

Sociocultural influences can either enhance or inhibit sexual desire, which can result in an increase or decrease in sexual satisfaction (Krasnow & Maglio, 2019; McCarthy & Ross, 2018; Rosenkratz & Mark, 2018). Low sexual desire and related diagnoses (i.e. hypoactive sexual desire disorder) have become increasingly prevalent among women. Because sexual desire has been socialized, researchers have suggested that this increase in diagnoses may not have a biological root but might be rooted situations where women’s personal preferences and pleasures are not being communicated or maximized (Kingsberg & Woodard, 2015). Consequently, desire becomes further inhibited. (Krasnow & Maglio, 2019).
In contrast, there is a growing need to focus on what enhances and increases female sexual desire. As these influences are understood in more depth and challenged, female sexual desire may be redefined to better align with the circular sexual-response system (Basson, 2000). This could eventually shift individual perception and attitude to a more comprehensive view of multi-faceted sexual desire, which may lend itself to a fundamental change in societal attitudes. A more sex-positive approach can be taken towards female sexual desire as a result. As desire increases and is recognized in its true context, the overall sexual experience for women will improve (Krasnow & Maglio, 2019).

**Conclusion**

Research suggests that the lack of knowledge about the female sexual-response cycle and desire has influenced social norms (Krasnow & Maglio, 2019, Leavitt, 2019b), and that female sexual desire can be inhibited or enhanced through various sociocultural influences. While most research is centered on low sexual desire, there is a growing need for sex-positive approaches (especially directed towards women) and a societal paradigm shift. (Cherkasskava & Rosario, 2018; Krasnow & Maglio, 2019; Leavitt, 2019b; Rosenkratz & Mark, 2018). Specific measures can be taken to encourage and facilitate this cultural shift. Sexual mindfulness is one suggested evidence-based practice prescribed to help people be aware of and attentive to the pleasure of their partner, as well as their own pleasure (Leavitt et al., 2019a; Leavitt et al., 2019b). This practice is especially helpful for females. Women who can acknowledge their need for pleasure and insist on this need being met are more likely to experience sexual satisfaction. Research shows that engaging in sexual mindfulness boosts self-esteem, thus battling the guilt and shame that have long been associated with female sexual response and desire (Leavitt et al., 2019a; Rosenkratz & Mark, 2018). Changes in individual perception have the capacity to eventually influence society as a whole.

Other interventions that can take place on a large scale encompass components of sex education. Sex-positive curriculum that not only presents sex in a positive light but also acknowledges the pleasure
that women can experience and should expect in a relationship is needed. This approach could be incorporated into existing sex education in schools. Additionally, government resources could offer related curriculum that is widely accessible, including educational sex counseling and classes. Federally funded websites and organizations could also publish information on women’s sexual desire and response cycle that is not commonly known. As research evolves, education must accompany it. Similar to how changes in individual perception can influence society, interventions from a government level has the potential to influence individual homes and families. As wives and mothers become familiar with and empowered in their own sexuality, they will likely educate their daughters differently than how they were educated. Women can also educate boys and men to be aware of the sexual needs of women and encourage men to be partners that tend to women’s needs and encourage women to feel sexually empowered.

While these interventions and strategies carry potential, there is little empirical evidence to support them. Much of the existing research on female sexual desire focuses on low sexual desire and sexual dysfunction. The minimal research that does exist on female sexual desire enhancement and sex-positive approaches often takes place on a small scale with relatively little samples. While these studies are rich in qualitative data, larger studies are needed in order to generalize results and encourage widespread change and shifts in long-held stereotypes. Society might also benefit from longitudinal studies to see what ages women tend to experience the most negative effects related to their sexuality. Imprint periods could then be examined, and interventions could be strategically organized by age. As sex-positive approaches are taken in both research and education, the sociocultural aspects of female sexual desire may be better understood, and the barriers and stereotypes surrounding it may begin to dissolve. As a result, sexual desire may increase for women, thus increasing overall sexual satisfaction.

References


First Fictional Crush: Effects of Parasocial Attachments on Female Adolescent Relationships

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Abstract

Romantic movies, TV shows, and mature novels are endorsed and consumed by many individuals in society—particularly women. However, media may not always portray reality accurately, which might mislead adolescent females who are still developing socially, sexually, emotionally, and cognitively. Studies have indicated that young women may naturally turn to parasocial romantic relationships (PSRRs)—one-sided emotional attachments to fictional characters in media—to explore their developing romantic expectations and sexuality in a way that appears to be harmless and free of consequence (Erickson et al., 2018). However, several effects of PSRRs may have a detrimental impact on adolescent females whose emotions become extremely invested in fictional characters; they may become susceptible to adopting unrealistic expectations and acting on unhealthy sexual behaviors portrayed in the romantic media (Galloway et al., 2015; Gamble, 2018). Additionally, these expectations and behaviors that begin in adolescence may carry into adult life, having the potential to affect not only current relationships but also long-term future relationships (Aubrey et al., 2018). Thus, future research should focus on methods of avoiding excessive PSRRs and discovering other negative effects that this one-sided attachment can have on adolescents.

Keywords: parasocial, attachments, romantic relationships, media, adolescent females
Lindsey thoroughly enjoys watching the latest romantic “chick flicks” on Netflix. As she engages in her favorite pastime, she lets out a wistful sigh when the male figure, Antonio, sweeps his romantic love interest off her feet. Lindsey studies his bulging muscles with appreciation, and her heart flutters at how gently Antonio caresses the woman on screen. Lindsey jolts back into reality when her husband, Jon, walks into the room. “I wish you were more like that,” Lindsey says casually, gesturing to the television screen that portrays the couple having a romantic picnic on the beach. She again notices how attentive and passionate Antonio is to his lover. Jon rolls his eyes, but Lindsey doesn’t notice, because she is once again engrossed in the movie—or more specifically, in Antonio. Jon walks over to her with a half-hearted smile and asks, “Do you want to go on a walk with me outside?” Without taking her eyes off the rugged and ripped Antonio, Lindsey waves a dismissive hand at her husband. “No thanks, I would prefer to watch the ending of this movie.” Feeling wounded that a fictional figure has won over his wife’s affection, Jon walks out of the room, leaving Lindsey to her romantic fantasies. She is unaware that she is stepping down a path leading to heartache, disappointment, and displeasure. Lindsey is exhibiting signs of a developing parasocial romantic relationship (PSRR) with Antonio. Her emotional attachment to Antonio may be contributing to romantic expectations that are not being met in her life, decreasing her satisfaction with her husband, Jon. She may benefit from being made aware of the possible negative effects that romantic media has had on her adolescent self and may currently have within her marriage.

Lindsey is not alone in her love for romantic movies; the abundance of material readily available to meet viewer demand through television or the Internet is evidence that individuals in society commonly consume and endorse romantic media. Although research indicates that men can also be influenced by romantic media, females more often absorb romantic movies, novels, and TV shows and tend to place more value in relationships (Driesmans et al., 2016). Thirty-eight percent more women than men reported a favorable opinion towards romantic movies in a study done in 2018 (Morning Consult, 2018), illustrating romantic media is more popular among women.
than men. Perhaps this type of media is popular because it can serve as a way for women to escape from stress or disappointments they experience in reality (Anderton, 2009). Adolescent females are often susceptible to endorsing and learning from the media they encounter because they are still developing mentally and emotionally (Erickson et al., 2018). While studies have found that family, peers, and first-hand experience typically play a role in developing romantic beliefs and ideals (Erickson et al., 2018; Erickson & Dal Cin, 2018), romantic movies and other media may have a substantial influence on female adolescents’ developing perception of romance. These young girls are in the beginning stages of developing relationship expectations and may formulate opinions based on what they view.

During and after puberty, adolescent females tend to view romantic movies or TV shows as a natural process to discover and explore their arising sexuality and romantic feelings (Theran et al., 2010). As these feelings emerge, adolescent females often find that developing a one-sided crush on a fictional character is appealing, because there is no fear of rejection and it seems emotionally and physically safer than becoming involved in a real-life relationship (Erickson et al., 2018; Erickson & Dal Cin, 2018). As adolescent females form these attachments, they begin to formulate expectations for romantic relationships (Erickson & Dal Cin, 2018). These psychological attachments to fictional media characters are often the first romantic involvement that adolescents experience (Erickson et al., 2018). However, because media does not always accurately portray reality, adolescents may form relationships to media figures that would not otherwise be possible in real-life scenarios.

Many of the effects of PSRRs can be detrimental for adolescent females. For instance, Tukachinsky and Dorros (2018) stated that while PSRRs may be natural, they could have lasting negative effects on future relationships. For example, Lippman et al., (2014) described how many romantic movies directed at adolescents portray two individuals developing their first relationship, yet the traits exhibited were often found only in married couples. Thus, adolescents may not receive accurate information regarding what first relationships
look like, which can misdirect future development of healthy relationships. Unreal romantic ideals in media, which are accepted unconditionally by young girls who are emotionally affected and physically aroused by PSRRs, can be unhealthy in shaping romantic beliefs and behaviors (Driesmans et al., 2016). Although romantic movies, TV shows, and mature novels have historically been popular and are widely recognized as a natural part of cultivating romantic ideologies, adolescent females should be educated on the possible detrimental effects of developing a one-sided romantic relationship; otherwise, this parasocial attachment may create unrealistic expectations of romantic relationships, promote unhealthy sexual behaviors, and decrease satisfaction or commitment in current and future relationships.

**Unrealistic Expectations of Romantic Relationships**

Females who develop strong PSRRs with media figures may be not only emotionally connected to the character but also influenced by the ideals, beliefs, and opinions that are promoted by the author or producer. Patterns of unrealistic ideals contained in romantic media often include the notion of loving someone at first sight, having a soul mate, expecting one’s partner to know their needs without expressing them, overcoming every hardship through love, experiencing instant and never-ending chemistry, and having intense and perfect sexual intimacy every time (K. Brooks, personal communication, February 26, 2019; Galloway et al., 2015; Vaterlaus et al., 2018). In addition, Theran et al. (2010) discovered that greater emotional involvement may contribute to higher levels of PSRRs, and Driesmans et al. (2016) later found that adolescent females with a greater parasocial attachment to the media figure may become more accepting of the romantic ideals presented in the media. Thus, an adolescent female’s excessive emotional attachment to a fictional character within a romance novel, movie, or TV show may lead them to adopt the romanticized messages presented, many of which are unrealistic and harmful to an individual forming natural romantic expectations in relationships.
Influential Age

While the developing adolescent female is cognitively learning about relationships by observing others around her, the media she watches can strongly influence her perception of romantic expectations and feelings. Driesmans et al. (2016) discovered that age appeared to be an indication of the depth and intensity of romantic interaction and attachment. They found that pre-teen adolescent females expressed greater romantic involvement with the fictional characters in the romantic movie than older adolescent females (Driesmans et al., 2016). Thus, younger adolescents appear to be more emotionally involved in PSRRs than older females and seem more likely to endorse unrealistic expectations that they encounter in media.

Many adolescents have not had personal experiences with romantic relationships that would enable them to compare what they encounter in media with reality; however, even those who do have real-life experience may still be strongly influenced by PSRRs. Although many adolescents in Vaterlaus et al.’s (2018) study claimed that there was a noticeable difference between romantic relationships portrayed on television and real-life relationships, the adolescents still reported that romantic movies increased their current relationship expectations, which were often not met. Adolescents’ age may contribute to their susceptibility of PSRRs, which in turn may influence their romantic emotions and expectations. Furthermore, Osborn (2012) found that an individual’s acceptance of a romanticized ideal presented on TV tended to be more influential in affecting their beliefs about relationships than the time spent watching the media or their real-life experiences. Thus, instilled beliefs in adolescents caused by excessive parasocial romantic interactions may have a greater influence on formulating romantic expectations than other influential factors. Educating adolescent females about the role media figures have in influencing their emotions can help make them aware of their susceptibility to the unrealistic romantic ideals portrayed in movies or books.
**Cultivation Theory**

The cultivation theory proposes that repeated exposure to a message forms a belief of that message in the receiver (Coyne et al., 2019), which may explain how PSRRs are associated with unrealistic romantic ideals. Reizer and Hetsroni (2014) further described this theory as the long-lasting effect movies and TV shows can have on others; they found that messages portrayed on screen tended to be adopted by viewers as a representation of real life, though the message often did not match up with reality. Galloway et al. (2015) also found that people may copy behaviors and mindsets that are portrayed on screen, considering them to be the norm. An adolescent female experiencing an intense PSRR may dwell on the fictional world of her crush more frequently than others who are not parasocially attached, and as a result, she may interpret the presented ideologies to be representative of reality (Reizer & Hetsroni, 2014). Therefore, it appears that after adopting the unrealistic expectations into her belief system, an adolescent female may be disappointed when situations that occur in reality fall short of her assumptions due to her unrealistic ideals.

Moreover, PSRRs can have long-term detrimental effects on adolescent females because romantic novels, movies, and TV shows appear to create an alternate reality for the viewer. Osborn (2012) noted that people often surrounded themselves with specific types of media that were in accordance with their beliefs, creating a single viewpoint through which they interpret the actions of others. Adolescents whose ideologies are shaped by romantic movies or adult romance novels may continue to seek out entertainment in that genre (Osborn, 2012). Repeatedly consuming romantic genres may enable unrealistic ideals to develop in adolescents’ minds, shaping the way they view the world (Coyne et al., 2019). Hence, adolescents should recognize the harm in developing obsessive PSRRs to media figures, because this behavior may cultivate an unrealistic perception of romantic relationships.

**Promotion of Unhealthy Sexual Behaviors**

Sexual conduct is present in many platforms of media in America (Coyne et al., 2019), including movies, TV shows, and mature novels.
Coyne et al. (2019) reported that 81% of prominent movies and TV shows contain sexual content. In addition, several studies have found that adolescents who consume a large number of romantic movies, TV shows, or novels may be affected by the messages presented (Anderton, 2009; Erickson et al., 2018; Galloway et al., 2015). With a high probability of sexuality being a part of the romantic media teenagers consume, adolescent females may be influenced by the sexual viewpoints presented, many of which describe risky sexual behavior. Additionally, because sexual content can draw out powerful emotions, young women who connect to a fictional character or media message through PSRRs may be more prone to endorse the risky sexual conduct they encounter (Scull et al., 2018). As a result, the media adolescents consume may not only impact their ideals of romantic relationships but also encourage dangerous and unhealthy sexual behaviors.

**Imitating Sexual Practices**

By experiencing excessive PSRRs with media figures, adolescents may also endorse and copy the sexual practices and behaviors they are exposed to. Young women transitioning from adolescence to adulthood often have a hard time refusing unwanted sexual encounters because of the messages found in media (Gamble, 2018). Media frequently portrays sexual behaviors, so the females influenced by such messages may hesitate in refusing unwanted advances for sex because they believe they should have sex as often as media portrays. Not only may adolescents feel pressure to engage in sex, but they may also feel pressure to imitate new sexual acts they come across in media. Anderton (2009) surveyed a group of 53 adult women who read sexually explicit romantic novels and asked them about the effects it had on their sexual behaviors. She found that reading romance novels influenced the women to experiment with new sexual activities they read about. Thus, it appears that adolescent females who are beginning to explore their sexuality may desire to experiment with new information they come across in romantic media. Their PSRRs may enhance this desire to copy sexual behaviors they read about or watch, so they can experience the intense feelings described or portrayed in media.
Unhealthy Sexual Notions

Many of the sexual practices that adolescents endorse from romantic media should not be copied, because they can be hazardous and unhealthy. Multiple women in Anderton’s (2009) study said that many of the sex scenes they encountered were unsafe or incorrect. Other studies found that media promoted the expectations that women should (a) have sex frequently, because that is what men desire; (b) be reluctant in declining unwanted sexual encounters; and (c) engage in casual sex without commitment, because there are no consequences (Gamble, 2018; Gamble & Nelson, 2016; Scull et al., 2018). Additionally, information that could help make sexual intercourse safer is left out of most movies or books (Scull et al., 2018); this omission can be harmful for adolescent females to perceive when the sexual content they encounter is inaccurate or risky. Without understanding the full consequences of their actions, adolescents can contract sexually transmitted diseases, become pregnant, or experience emotional scarring (Scull et al., 2018). Therefore, guardians should teach healthy sexuality principles to their adolescent wards and discourage any unhealthy sexual behaviors that their loved ones observe in media.

Decreased Satisfaction or Commitment

Adolescents who are extremely involved in PSRRs may experience decreased satisfaction or commitment in their current and future romantic relationships. Lippman et al. (2014) observed that one’s overall happiness was affected by romantic relationships. When unrealistic relationship expectations are not met or harmful consequences arise from risky sex, people may experience major disappointment and dissatisfaction. Erickson et al. (2018) found that serious relationships, including one-sided PSRRs, could shape and project satisfaction and happiness in future relationships because adolescent girls are still developing cognitively, emotionally, and sexually. This finding indicates that the negative relationship experiences females have in adolescent years may be carried into adulthood, affecting their long-term relationships.
Researchers have found evidence that young females seem to endorse romantic notions and sexual behaviors portrayed in media when they are emotionally invested in a character (Galloway et al., 2015). Their strong emotional connection to a fictional character is associated with decreased satisfaction in current relationships (Tuckachinsky & Dorros, 2018). In a study comparing physical and emotional aspects of PSRRs, physical attraction did not appear to have a negative impact on the satisfaction of an adolescent females’ current relationship. Rather, the researchers found that as an adolescent female’s emotional investment in a fictional character increased, the satisfaction in her current romantic partner tended to decrease. This correlation may exist because adolescent-female relationships are framed by their previous experiences (Tuckachinsky & Dorros, 2018). Also, Reizer and Hetsroni (2014) found that the comparison of fiction to reality may have created a sense of loss and decreased satisfaction in their subjects when expectation did not match reality. Like adolescent females, adult women are just as capable of experiencing the effects of PSRRs. Aubrey et al. (2018) conducted a correlational study on moms who had a deep infatuation for the romantic Twilight saga and found that a deeper emotional connection to the characters correlated with decreased satisfaction in their partners. Thus, not only can an adolescent’s current relationship satisfaction decrease due to a PSRR, but if they continue their habit of developing emotional ties to fictional characters into adulthood, their satisfaction levels in these future relationships may also diminish.

Fiction does not always measure up to reality because movies and novels often perpetuate the idea of two people meeting by random chance, falling quickly and effortlessly in love, and living blissfully together (K. Brooks, personal communication, February 26, 2019). The sacrifice and hardships in a relationship or marriage are seldom portrayed in media, and this unrealistic depiction of romantic relationships may create false expectations, dissatisfaction, and cynical attitudes in the viewers (K. Brooks, personal communication, February 26, 2019). As a result, adolescent females can misunderstand the large amount of effort and commitment that is involved in building a lasting relationship. Additionally, media perpetuates the idea that
cheating and divorce is common and that individuals can move in and out of relationships frequently to find someone more attractive and convenient (K. Brooks, personal communication, February 26, 2019; Osborn, 2012). Adolescents may adopt this view, becoming more loyal to the message of infidelity in media than to their partner. For instance, married individuals who watched more romantic television and endorsed its portrayal of romantic relationships were more likely to have decreased commitment to their spouse and more benevolent opinions of alternative romantic partners (Osborn, 2012). Media often consists of exciting and extravagant stories meant to entertain, and adolescents experiencing PSRRs may feel dissatisfaction and decreased commitment in their current relationships, which can also negatively influence their later adult relationships. Consequently, adolescent females should be made aware of these outcomes so they can be mindful of the potential consequences of forming PSRRs.

Conclusion

The consumption of romantic movies, TV shows, and mature novels is fairly common among females. While some women report that they engage in romantic novels for pleasure or to escape from reality (Anderton, 2009), the romantic ideals in the book may influence their own romantic beliefs (K. Brooks, personal communication, February 26, 2019; Vaterlaus et al., 2018). A seemingly natural way that adolescent females explore their sexual feelings is by developing a one-sided romantic relationship with fictional characters in media (Erickson et al., 2018; Theran et al., 2010). Despite evidence that this one-sided emotional attachment is natural in maturing adolescents, PSRRs can have detrimental effects on adolescent females, because media does not always accurately portray reality (Lippman et al., 2014; Scull et al., 2018).

Adolescent females who experience strong PSRRs may form unrealistic expectations and conceptions about relationships. In a study, Driesmans et al. (2016) found that young females who claimed to have higher attachments to fictional media figures appeared to be more willing to endorse the romanticized ideologies presented in the movies they watched. Researchers have noted many of these romantic ideals to be unrealistic, such as physical intimacy always being perfect and individuals constantly feeling intense and all-consuming.
chemistry for their significant other (Galloway et al., 2015). When reality does not measure up to these ideals, the comparison of fiction to reality may create disappointment and discontentment in adolescents’ current romantic relationships (Reizer & Hetroni, 2014). Thus, emotional attachment in PSRRs can be harmful when unrealistic ideals are formed.

Moreover, adolescents who experience an intense emotional connection in a PSRR may want to experience those emotions in real life and may imitate the behaviors they read about or view. Coyne et al. (2019) revealed that sexual content is highly prevalent in the media adolescents view, and this may influence adolescent females to experiment with potentially unhealthy sexual behaviors. Females in one study reported that the sexual content they came across was often misleading or incorrect (Anderton, 2009). Adolescent females may be more likely to accept unrealistic and unhealthy sexual behaviors when experiencing strong emotional PSRRs, potentially leading to disappointment in current relationships and decreased satisfaction or commitment in later relationships.

However, the negative consequences associated with female adolescent PSRRs are not well-known. PSRRs may increase the likelihood of adolescents forming unrealistic expectations, engaging in unhealthy sexual behaviors, and experiencing decreased commitment and satisfaction in current and future relationships. Thus, guardians of adolescents should inform their wards of these possible negative outcomes in order for teens to understand and potentially avoid or overcome them. Further research should examine ways to decrease excessive PSRRs in adolescents so as to help them avoid these potential negative outcomes. Researchers might discover differing thresholds of PSRRs and test if the degree of emotional attachment correlates with the strength of negative relationship effects in an adolescent’s current and future relationships. They could also explore other detrimental effects of intense PSRRs, such as assessing whether attachments with media figures can contribute to moodiness in adolescents or unhealthy perceptions of abuse. Additional studies should explore how healthy romantic ideals can be fostered within adolescent females, such as by the promotion of sex education or documentaries on couples’ courtship and long-term relationships.
References


Girls Will Be Girls: Perceptions of Sexuality and Friendship Based on Gender

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Note from the Editor:

Most of the manuscripts that Intuition publishes are literature reviews and research papers. However, Intuition accepts a wide variety of manuscripts, including book reviews, essays, and psychology-themed creative works such as poetry. Thus, the following manuscript is an editorial article and will differ greatly in both content and tone from other pieces published in this issue.
When observing interactions between groups of all men or all women, it quickly becomes apparent that how women interact with women is different from how men interact with other men. Physical interactions especially are generally performed in very different ways between these groups. For example, when interacting with other men, men typically perform limited physical contact that has a degree of aggressiveness or playfulness to it. By contrast, women are typically much gentler and more liberal with their physical contact. An obvious observation is that women tend to interact physically with each other more frequently than men do.

What, then, is the reason for this discrepancy in behavior? Most human behavior, especially group behavior, is inextricable from social norms, and social norms come from current social attitudes. At present, I have observed through research that most Western attitudes toward gender are, in summary, as follows: men should be unemotional and hyper-masculine and only have romantic interest in women. They are sexual beings first and foremost. Women, on the other hand, are soft and gentle and affectionate. They should only have romantic interest in men, but not too much, as it is their job to be pursued. Unfortunately, these ideas have harmful effects.

One effect is the idea that men are sexual subjects (in full ownership and expression of their sexuality), while women are considered sexual objects (granted less access to their own sexuality, perhaps more acceptable when for the pleasure of a man). Another effect is the idea of compulsive heterosexuality: that women should only have romantic interest in men, and vice versa. Anything else is considered a threat to perceptions of not only sexuality at large, but gender itself. Paradoxically, another effect of these perceptions of gender is that certain types of non-heterosexual behavior are more socially acceptable than others. This paper will attempt to deconstruct some of these false perceptions.

With the help of research and a Sociology of Gender class, my eyes were opened to the idea that female sexuality is generally considered to be more fluid than that of males because of broader perceptions surrounding male vs. female homosexuality and how this contributes to “acceptable” gendered behavior. Essentially, the
behavior that is socially scripted (or expected) for females allows them to be physically close and affectionate with one another, while also allowing relatively more sexual freedom in terms of exploring their sexual identities. However, as a direct result of these imbalanced perceptions, women are simultaneously reduced to sexual objects who exist for the pleasure of others, as opposed to sexual subjects, who exist for themselves, and therefore have much of the ownership of their sexuality stripped from them.

In modern Western society, female sexuality is generally perceived as more fluid than male sexuality (Diamond, 2007). Whether as a cause or result of this perception, women are typically more willing to experiment sexually and use labels less frequently than do men. For example, if a woman were to have sexual contact with another woman, she is less likely to identify as bisexual or homosexual than a man would if he were to have sexual contact with another man (Diamond, 2007). Simply put, women may be more likely to experiment because they do not feel the same degree of pressure to conform to an identity label as men might feel. This could be in part because males may experience higher rates of discrimination for homosexuality than women do, so they fear labels more. The reason for this thinking, of the stigmatization of male homosexuality more than female homosexuality, could be due to the fact that women are seen as sexual objects to be acted upon and enjoyed by others to a much greater degree than their male counterparts. Essentially, the perception of female sexuality is a paradox: physical contact is seen as more acceptable because female homosexuality is perceived as more acceptable than male homosexuality. And because this contact is perceived as more acceptable if it did come with sexual meaning, physical contact between females is then less likely to be perceived as sexual because of the lack of stigmatization of female homosexuality relative to male homosexuality.

Physical affection is not typical scripted behavior for heterosexual males. If males display any more physical contact than a casual handshake or pat on the back, it could have been perceived as “gay,” which is then perceived as less desirable. Part of this skewed perception of female homosexuality being more acceptable than
male homosexuality is, unfortunately, a result of fetishization, i.e.,
the hypersexualization of females being intimate with each other,
particularly perpetrated by men (Puhl, 2010). Indeed, there is a large
market for lesbian pornography, generally consumed by heterosexual
men. This is an example of men being considered sexual subjects
(autonomous agents with power over their own sexualities) who
then enjoy the sexual objectification of women, thereby considering
women as objects rather than subjects (Ryle, 2012). As demonstrated,
a sexual object here refers to less-than-autonomous agents with no
power over their sexuality and who exist solely to satisfy others.

Perhaps another reason that physical contact/physical
affection between females is more acceptable is because it is the
gender composition least likely to have sexual meaning. This is
another example of (1) homophobia and how it negatively affects
more than just those to whom it is directed, and (2) where men are
seen as sexual subjects while women are sexual objects. Men are
perceived as the pursuers of sexual activity, while women are the
passive receivers. If there were two girls and one boy platonically
sharing a bed, it still would have been seen as more sexually charged
than three girls, equally so if the composition was two boys and one
girl, no matter how nonsexual the intentions. The idea that a bed of
three women is somehow less sexual than a bed of three men, or that
adding a man also adds sexual intent, takes away sexual power from
women. I am not suggesting whether there should be sexual meaning
here, merely pointing out that it is disproportionate to consider
men sharing a bed as automatically sexual, while simultaneously
considering three women sharing a bed as automatically platonic.
It also has an unfortunate effect on men: reducing them to sexual
beings who cannot be trusted not to engage in sexual behavior with a
woman, no matter the situation or intention.

Another reason that women expressing close physical contact
is considered an acceptable behavior is because of how female
friendship differs from male friendship. One theory of gendered
friendships proposed by Robin Ryle (Ryle, 2012, p. 214) is that female
friendship is characterized by “face-to-face” interaction, meaning
that there are emotional connections and feelings involved. When
female friends are emotionally close, they may enjoy the bonding experience of physical closeness.

Male friendship entails “side-by-side” interaction (Ryle, 2012, p. 214), characterized by objective-based interactions, such as playing a game or working on a project. If one puts stock into Ryle’s theory, they may find it strange to find boys bonding in the face-to-face—or female—way instead of side-by-side. Cuddling or being physically close would constitute face-to-face friendship, since the focus is on emotional bonding and not completing an activity.

To clarify, this theory does not posit that only females have face-to-face friendships or that males only have side-by-side friendships, but merely that the performance of these friendship scripts tend to line up with other qualities that we perceive as female and male, respectively. This theory becomes especially fascinating when observing female-to-male interactions and finding which types of friendship take precedence in different situations.

The influence of hegemonic masculinity (rigidly hypermasculine, narrowly defined by traditional gender norms) cannot be ignored here. This concept that there is one correct way for men to express friendship or closeness while maintaining the society-requisite masculinity is toxic. Worse is the idea that being gay is the worst thing a man can be and that by doing so he sacrifices ownership of his masculinity. This expected gender performance encourages boys—whether gay or straight or anything in between—to avoid anything that would make them “look” gay. This idea—that men touching other men is bad—is problematic in so many ways: it teaches boys that the worst thing they can be is gay, it teaches men that all touch is inherently sexual and therefore gay, and it discourages healthy bonding and physical connection.

This theory also clearly explains why females expressing physical affection to one another is the most acceptable instance of physical contact. Women are seen as sexual objects and are thus stripped of any sexual power, while also being allowed more fluidity in their sexual identities, though often at the cost of fetishization. And because women are seen as naturally more affectionate than men, they more often experience face-to-face friendship.
The idea that men and women have different natures that require them to perform in social situations differently is not based on any empirical data and is a manifestation of harmful gender performance norms. I believe that men and women should be held to the same sexual scripts: all genders viewed as sexual subjects with agency and able to evenly enjoy androgynous (both side-to-side and face-to-face) friendships that encompasses all types of companionship. No one deserves to be put in a labelled box or have unfair assumptions made about them. Let girls be girls and boys be boys and people be themselves, however they are.

References


Love on the Telephone: Sexting and Intimacy in Committed Couple Relationships

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Abstract

This literature review explores research on sexting—the sending of nude or partially nude photographs or sexual messages via technological mediums—within couple relationships. While sexting has often been touted as an unhealthy or deviant practice among adolescents and adults, recent attitudes and research suggest that sexting in committed couple relationships may be associated with some positive outcomes, such as higher sexual satisfaction. This paper focuses on the relationship contexts in which sexting is more likely to have positive or negative outcomes. Insecure attachment, lower emotional commitment, and negative motivations for sexting may lead to less intimacy in the relationship instead of more. For couples with these characteristics, sexting exacerbates previously existing distance in the relationship. Relationships with secure attachment and higher levels of couple commitment are more likely to experience increased intimacy from sexting and are less likely to experience negative outcomes associated with sexting.
In today’s culture, technology is intertwined with almost every aspect of daily living, including the development and maintenance of intimate relationships (Murray & Campbell, 2015). Smart phones, online dating services, text messaging apps, and social media all allow individuals and couples to communicate in ways that have previously been impossible, in terms of both medium and frequency. Computer-mediated communication (CMC) is becoming increasingly common in couple relationships, and romantic couples are more likely to use their cell phones to reach their partner than any other type of media communication (Coyne et al., 2011; Novak et al., 2016). Many couples use cell phones to send affectionate text messages to each other, and this behavior is associated with positive couple communication, positive attachment, and higher relationship satisfaction (Novak et al., 2016; Schade et al., 2013).

One controversial use of technology to express affection is sexting. The sending of explicit text messages, images, or videos has long been considered a risky behavior in adolescents and an avenue for infidelity in adults (Frankel et al., 2018; Wysocki & Childers, 2011). Adult sexting has even been viewed as a deviant behavior that should be considered for classification in the DSM (Wiederhold, 2011). While these negative outcomes have been examined extensively, there has been some shift in the literature to look at sexting behaviors in a different way. Recent findings have reflected that over half of both men and women aged 18 to 36 in committed relationships report having engaged in sexting (Drouin & Landgraff, 2012), and many couples view sexting as a way to bring greater intimacy into their sexual relationship (Galovan et al., 2018; Parker et al., 2013). The call for adult sexting to be considered a disorder has since been redacted by the same researcher that extended it, and other researchers have suggested prescribing sexting to couples in therapy who are struggling with intimacy (Parker et al., 2013; Wiederhold, 2015). Despite these changes in the scientific perspective surrounding sexting, the benefits of sexting for couples are still not entirely clear.

Couples who sext each other may experience greater overall satisfaction in their sexual relationship (Galovan et al., 2018), but the influence of sexting on other aspects of the relationship are less clear. Outcomes vary widely across demographic groups such
as males, females, heterosexual couples, non-heterosexual couples, cohabiting couples, and singles (Coyne et al., 2011; Currin et al., 2016; Parker et al., 2013). Attachment style is also an important mediator of outcomes of sexting; those with insecure attachments to their partner have more negative sexting experiences and fewer positive outcomes than those with secure attachments (Drouin et al., 2017; Galovan et al., 2018; McDaniel & Drouin, 2015). Overall commitment to the relationship is another influencing factor: in general, individuals in more committed relationships seem to be less affected by the potential negative consequences of sexting (Dir et al., 2013; Drouin et al., 2017).

Although the outcomes of consensual sexting between partners in committed relationships are varied, heterosexual couples with higher levels of security in their relationship are less likely to experience the potential negative outcomes associated with sexting than those in less secure relationships. This literature review will provide an overview of the research surrounding the topic of sexting in committed couple partnerships by addressing the relationships between sexting and attachment in romantic couples, commitment level between partners, and sexting motivations.

**Sexting and Attachment**

For many couples, sexting is not the passionate, intimacy-enhancing behavior they may imagine it to be; rather, it is a behavior related to greater ambivalence and lower commitment in their relationship (Galovan et al., 2018). This is likely due, at least in part, to the positive relationship between engaging in sexting and insecure or avoidant attachment (Drouin et al., 2017; Galovan et al., 2018; McDaniel & Drouin, 2015). Attachment has strong implications for sexual behavior, with insecurely attached individuals reporting higher levels of anxiety surrounding sex and greater avoidance of sex with their partners (Johnson & Zuccarini, 2010). These findings may translate into sexting, since people with less secure attachment styles have been found to sext more frequently, possibly with the intent of keeping their partner close and avoiding abandonment or creating emotional distance with their partner (Galovan et al., 2018; McDaniel & Drouin, 2015).
The differences between men’s and women’s sexting behaviors with regard to attachment, sexual desire, and emotional intimacy are important. Men are more likely than women to sext in a casual relationship in order to fulfill sexual desire while maintaining relational distance; women, conversely, are more likely to sext in a committed relationship in order to encourage relational closeness. However, given the gender differences in sexting, women’s sexting behavior may not produce the desired effect and, consequently, may lead to less intimacy in the relationship (Drouin et al., 2017). Indeed, women tend to have more negative expectations of sexting experiences overall (Dir et al., 2013). Thus, the implications of sexting and insecure attachment are different for women and men (Drouin et al., 2017; McDaniel & Drouin, 2015), perhaps because women tend to display more intimacy-seeking behaviors and men tend to display more distancing behaviors, both of which are associated with insecure attachments (Drouin et al., 2017).

In addition to the context of sexting, the type of sexting is also related to attachment. (Drouin et al., 2017; McDaniel & Drouin, 2015). Men and women who send nude or partially nude photographs are more likely to have anxious or avoidant attachment styles, respectively, but this correlation does not exist with “sexy messages,” or messages that contained words but no pictures (McDaniel & Drouin, 2015). The relationships between types of sexts and attachment styles are important because, although sexting does not have a significant relationship to depression or self-esteem on its own, those with greater attachment avoidance report more negative consequences, such as trauma and regret, as a result of sexting (Galovan et al., 2018; Drouin et al., 2017). Regardless of a person’s gender and subsequent motive for sending explicit messages, sexting negatively affects individuals and relationships when coupled with anxious or avoidant attachment (Drouin et al., 2017; Galovan et al., 2018; McDaniel & Drouin, 2015).

**Sexting and Couple Commitment**

The context of a couple’s relationship, sexual behavior, and consequent sexting behaviors influences sexting outcomes for individuals. This may be because those in less committed relationships or who have insecure attachment styles may use

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sexting as a replacement for, rather than as an augmentation of, true intimacy. Relationship type is the strongest predictor of positive or negative relationship outcomes of sexting. Individuals in committed relationships experience more positive outcomes, fewer negative outcomes, and more comfortable sexting experiences than do couples in casual relationships (Drouin et al., 2017; Galovan et al., 2018). Conversely, higher levels of sexting are also predictive of lower commitment within the relationship (Galovan et al., 2018). This finding points to the idea that a committed relationship may be one where partners are in a serious or married relationship but do not necessarily feel a deep emotional commitment to their relationship. This situation often occurs when couples engage in sexual behavior early in their relationship and remain in that relationship when they would not otherwise because they feel a sense of moral duty or convenience that discourages them from leaving (Busby et al., 2010; Stanley & Markman, 1992). Such couples may experience lower relationship satisfaction, communication, and sexual quality (Busby et al., 2010). Couples who sext earlier on in their relationships, perhaps when they are less committed to each other, could likely experience these same negative results, which could result in greater relationship ambivalence and lower commitment throughout their relationships (Galovan et al., 2018).

In addition to relationship length and commitment, demographics may also play a role in the relationship between sexting and commitment; much of the research on sexting between committed couples is conducted on heterosexual undergraduate populations (Currin et al., 2016; Dir et al., 2013; Drouin & Landgraff, 2012; Drouin & Tobin, 2014; Murray & Campbell 2015). The nature of undergraduate relationships, which are perhaps more transient than those of more mature adults, could contribute to the findings of negative sexting outcomes, particularly if undergraduate partners engage in sexual behavior, including sexting, early in their relationships. Furthermore, older adults are far less likely to engage in sexting with their partners (Galovan et al., 2018), perhaps due to cultural practices and values or lack of technological understanding. These nonrepresentative
samples could skew the general understanding of sexting influence because couples in the longest-lasting relationships are those that do not or have never sexted.

**Sexting Motivations**

Motivations for sexting may mediate the influence of sexting on relational outcomes (Parker et al., 2013; McDaniel & Drouin 2015; Drouin & Tobin, 2014; Drouin et al., 2017). As mentioned previously, those with different attachment styles have differing motives for sexting, from personal sexual fulfilment to bids for deeper relational intimacy (Drouin et al., 2017). Hedonism (Parker et al., 2013) and maintaining the relationship (Currin et al., 2016; Drouin & Tobin, 2014) are two significant sexting motivators that may be related to poor relational outcomes because of these variables’ relationships to emotional commitment and intimacy.

Hedonism, including pleasure and experience seeking, has been shown to be a greater motivator than intimacy for sending and receiving sext messages (Parker et al., 2013). The use of sexting for personal pleasure, rather than for couple pleasure or intimacy growth, could point to a lack of commitment to one’s partner. This is especially true if there is a discrepancy between male and female sexting motivations; women, who are more likely to use sexting to foster closeness in the relationship (Drouin et al., 2017), may feel ignored or unfulfilled if their male partners are using sexting instead for hedonic pleasure. Hedonism as a motivator may also lead to increased use of sexting for infidelity, particularly when considering the ease with which sexting can be used with individuals outside of one’s committed relationship (Murray & Campbell, 2015).

Another motivation for sexting is maintaining expectations in the relationship (Currin et al., 2016; Drouin & Tobin, 2014). Within a couple’s relationship, individuals may engage in consensual but unwanted sexting, which occurs when a partner agrees to exchange sexts even though he or she does not want to (Drouin & Tobin, 2014). Women may be more likely to engage in unwanted but consensual sexting than men (Currin et al., 2016), though men also engage in consensual but unwanted sexting (Currin et al., 2016; Drouin &
Tobin, 2014; Muehlenhard & Cook, 1988). This is particularly true if men feel pressure from peers to engage in unwanted sexual behavior (Muehlenhard & Cook, 1988). Women’s motivation for sexting, especially unwanted sexting, may stem from a cultural script that suggests women and their sexuality should submit to men and their sexuality (Currin et al., 2016). Women who refuse to return sexts to their male partners may feel as though they are inappropriately breaking from that script and not fulfilling their role in the relationship, resulting in greater relationship anxiety and feelings of being devalued in the relationship instead of increased intimacy (Currin et al., 2016).

Furthermore, young adults with anxious or avoidant attachment styles in committed relationships are likely to cite “avoiding an argument” as a motivator for sexting (Drouin & Tobin, 2014), suggesting that they are more willing to comply with their partner’s wishes than to risk losing their partner or discussing a relational problem. This behavior could create distance, perpetuate the partner’s avoidance and insecurity, and negatively influence the couple’s relationship satisfaction. Furthermore, sexting only to fulfill a romantic partner’s sexual expectations could create a false sense of intimacy within the couple. While the willing sexting individual might feel valued, sexually satisfied, and emotionally close to their partner, the reluctant individual might feel objectified, unheard, and lonely; partners may feel that their sexual relationship is being enhanced or undermined, respectively. When deciding whether to engage in sexting, partners should ensure that their motivations for sexting are aligned to ensure a positive sexting experience.

**Conclusion**

Although some researchers have recommended that therapists prescribe sexting to couples as a mechanism to create more intimacy in their sexual relationship (Galovan et al., 2018; Parker et al., 2013), the body of research reviewed here suggests that therapists should consider the couple’s attachment and relationship context before recommending sexting as a therapeutic intervention. Gaps and limitations also exist in the research that should direct future
Study of sexting and relationship outcomes. Much of the current literature review only examines sexting in heterosexual couples, and the relationship between sexting and couple commitment may be very different in non-heterosexual couples (Currin et al., 2016; Galovan et al., 2018). While some studies examine sexting in committed relationships, little data exists about sexting in married relationships. Studies of sexting behaviors between married partners could lend new insights into potential motivations for and outcomes of sexting if they consider unique characteristics and commitment patterns of individuals who choose to get married. Furthermore, these future studies could examine long-term implications of sexting on relationships as couples that are forming now have the ability to engage sexting throughout their entire relationship, a phenomenon that was not possible before the advent of mobile phones and other means of CMC.

Relationship contexts and characteristics play a significant role in determining whether is likely to lead to negative outcomes for individuals in a couple relationship. Although sexting has been shown to increase sexual satisfaction for some individuals in committed relationships, there is no evidence yet that sexting may lead to a global increase in relationship satisfaction or intimacy (Currin et al., 2016; Galovan et al., 2018; Parker et al., 2013). Individuals who have insecure attachments, are in less committed relationships, or have unhealthy sexting motivations are more likely to use sexting to replace instead of enhance intimacy, and are therefore more likely to experience anxiety and less intimacy in their relationships (Galovan et al., 2018; Johnson & Zuccarini, 2010). This relational anxiety and lack of intimacy could be due to a lack of emotional commitment in the relationship as a result of precocious sexual entanglement (Busby et al., 2010), characteristics of the sexting population’s demographics (Currin et al., 2017; Drouin & Landgraf 2012; Murray & Campbell 2015), or unhealthy motivations for sexual engagement (Currin et al., 2016; Drouin & Tobin, 2014; Parker et al., 2013). Although there is still much to learn about the effects of sexting on relationships, the current research supports this literature review’s claim that sexting to create intimacy is most successful and produces the fewest negative outcomes in securely attached, committed couple relationships.
References


Failure to Report: The Detrimental Effects Following Sexual Assault

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Abstract

Sexual assault is a prominent issue in society, yet many people remain unaware of the serious effects following sexual assault. Victims who report to legal authorities tend to experience disbelief and blame because of the prevalence of *rape myths*. Due to the severity of the trauma, hormones released by the brain hinder proper brain functioning and can cause a little-known evolutionary response termed tonic immobility (TI). The psychological outcome of sexual assault commonly results in or worsens several psychological conditions, including depression, anxiety, PTSD, and drug and alcohol abuse. Guilt, self-blame, and adverse emotions are accelerated with negative interactions while disclosing to the police, friends, family, or others. Avoiding these emotions is possible with support, affirmation, and helpful resources. By promoting education to the public on these topics, victims can receive support and proper clinical assessment on their way to recovery.
The word trauma can bring several thoughts to mind, including images of injuries in an emergency room, a fatal car crash, or first-hand experience in combat. Trauma typically involves being in shock and nearly in an altered state of mind. It often leaves an imprint that is seemingly impossible to erase. The linguistic derivatives of trauma—from Greek and Latin to be a “psychic wound, unpleasant state experience” with “abnormal stress”—make it the perfect word to describe the aftermath for a victim of sexual assault (Trauma, n.d., para. 1). Those who experience sexual assault have increased chances of developing post-traumatic stress disorder (PTSD), more so than those who experience a different kind of traumatic event (Walsh & Bruce, 2014), yet it is scarcely categorized with the descriptions listed above. When it comes to understanding the mental aftermath of sexual assault, the public is unaware of how detrimental it can be on the victim in the short and long term; it is much more significant than just pressing charges, as commonly believed. Thus, a change in understanding of the effects of sexual assault on victims is necessary to properly aid victims in their recovery.

Victims of sexual assault might need to seek professional help to learn to cope with the immediate effects—and later with the long-term effects—of the trauma they experience. Following a traumatic event, an individual may experience an emotional reaction, such as shock and panic, or an avoidance reaction in which repression and denial take place. If either of these reactions is not properly addressed, a chain of problems may arise and combine into symptoms of psychological disorders. The traumatic influence reaches into other aspects of life and may include the development of emotional instability and dysfunctional social relationships (Heaps, 2000). Difficulty coping with the reactions of traumatic or abusive events, namely sexual assault, may lead to mental issues following the event (Heaps, 2000; Thompson et al., 2003); therefore, positive intervention is necessary to counteract the possible detrimental outcomes.

Sexual assault often results in the development or worsening of psychopathology (in this case, mental illness or psychological impairment), which includes an extensive list of possible disorders: depression, anxiety, PTSD, drug and alcohol abuse, and so forth.
One study combined results to show that the severity of some disorders increases based upon the specificities of the incident such as full penetration and violence (Bak-Klimek et al., 2014). The foregoing studies demonstrate that psychopathology appears to be a result of experiencing some form of sexual assault, which underscores the psychological effects of sexual assault. As the symptoms form due to unhealthy coping, they progress into complex mental disorders.

Notwithstanding the known psychological effects following sexual assault of any kind, many victims do not report the sexual assault and therefore fail to receive treatment or fail to recover. An altered state of mind from symptoms of PTSD, fear, emotional distress, or the desire for privacy can all result in a victim not reporting the sexual assault (Walsh & Bruce, 2014). The National Crime Victimization Survey (NCVS)’s 2018 statistics show only about 24.9% of crimes dealing with sexual assault were reported to legal authorities, leaving 75.1% of rapes unreported (Morgan & Oudekerk, 2019). The rate of reported sexual assault crimes was 2.7 per 1,000 persons aged 12 and older (Morgan & Oudekerk, 2019). Applying the rate of reporting and per 1,200, an estimated total rate of 10.8 for rape crimes were committed in the US during 2018. Alarmingly low statistics show that few victims of sexual assault report their cases. Few reported cases continue in the process of prosecution (Campbell, 2012). Symptoms following the event, even besides those discussed of trauma, can lead to not reporting (Walsh & Bruce, 2014).

Despite the onset of shock symptoms, unhealthy coping, and the subsequent development of psychological disorders, many sexual assault victims do not receive clinical assessment and therapy. Referring explicitly to female victims, Greeson et al. (2016) addressed the phenomenon of rape culture, or the increasing “victimization of women and girls” combined with a decreasing liability of the men who sexually assault (p. 91). With the increased stigma of victimized women, female assault victims may not take action to receive clinical assessment. Although some survivors of sexual assault do communicate the event to another person or take legal action, the public needs to be made aware of the detrimental effects of sexual
assault and assist survivors, because failure to properly recover from the trauma of sexual assault can lead to chronic, harmful, and long-term mental effects. In this paper, issues with the legal system, immediate neurobiological and psychological effects, and the psychopathological outcome will be addressed, with special focus on adolescent and adult women, to illustrate the necessary changes the public must adopt to avoid these outcomes for such victims.

**Issues with the Legal System**

The few cases reported to the legal system show little success in prosecution. Case attrition, or the failure to bring the accused to trial or conviction after an arrest, produces a problem in sexual assault. Campbell and colleagues (2012) assessed case attrition in rural to urban areas and found an average of 86% of cases are never referred by the police officer involved in the original reporting, which means a vast majority of reported cases were not charged or referred. In that same research, only 1–5% of cases reached trial and conviction (Campbell, 2012). As previously mentioned, less than 24% of cases are even reported to the police (Morgan & Oudekerk, 2019). These statistics raise the question: What is obstructing the criminal justice system from continuing investigations and prosecutions?

The first answer is that cases of sexual assault do not reach the criminal justice system because sexual assault is not easily defined or understood, especially by the public. *Rape myths*—a term described by Bohner (1998) as “descriptive or perspective beliefs about rape . . . that serve to deny, downplay, or justify sexual violence that men commit against women” (as quoted in Hine & Murphy, 2017, p. 1)—interfere with one’s concept of what defines sexual assault. Perceiving what may be a true rape has become a stereotype typically involving a horror scene of a stranger, a weapon, and a dark setting, where the female victim blatantly resists (Hine & Murphy, 2017). The prominent cases that advance in the criminal justice system tend to “[involve] a weapon, full penetration, victim injuries, and crime co-occurrence” (Shaw et al., 2016, p. 447). However, this narrow scope excludes most cases. For example, one study with data collected from approximately 100 hospital emergency departments showed 24.2% of female victims
were raped by a friend or acquaintance (Loder & Robinson, 2020). Additionally, 45.6% of cases occurred within the victim’s home, while only 4.0% occurred in the street (Loder & Robinson, 2020). Moreover, blame is focused back to the victim of sexual assault for their actions or behaviors (Greeson et al., 2016; Hine & Murphy, 2017; Shaw et al., 2016). When those in the public misunderstand what sexual assault consists of and consequentially blame the victim, survivors are deterred from pursuing criminal justice and the path to recovery.

As public misunderstanding continues, so does that of those involved in the criminal justice system. Rape myths impede police officers and prosecutors from believing the victims, which ultimately influences the product of reported cases (Hine & Murphy, 2017). The more a situation does not entail typical scenarios upheld in rape myths, the less likely it is that the investigation will continue (Hine & Murphy, 2017; Shaw et al., 2016). Believing that the rape myths extend to those experiencing sexual assault also leads the victimized women to not identify the event as a serious sexual assault (Hine & Murphy, 2017). Thus, rape myths and sexual assault misperceptions interfere both with victims reporting their cases and with the criminal justice system pursuing reported cases. By reckoning the event as not serious enough or not worthy of investigation, the victim forsakes the ordeal with self-blame and without support.

Unfortunately, both reporting and not reporting can be unfavorable for the victim. Primary relating is typically to a close relative or friend before additional disclosure occurs (Greeson et al., 2016). Again, due to misperception, initial contact can be less than supportive, as the victim can consequentially feel doubt, blame, lack of assistance, and so forth (Greeson et al., 2016). Contact with police officers or other officials can result in the same discouraging lack of support (Greeson et al., 2016). While some disclosures are positive and helpful to the victim, the negative experience marked by doubt and blame may result in what is called secondary victimization, or “the attitudes, beliefs, and behaviors of social system personnel that victims experience as victim blaming and insensitive” (Campbell, 2012, slide 12). It receives its name from the additional aggravation of the trauma, similar to undergoing yet another sexual assault.
The rape myths and the discouragement from both close relations and police officers cause further damage, self-blaming of the victim, and worse conditions overall. Neither the police officers nor the public are to blame; the lack of understanding regarding the detrimental effects on the victim is to blame for the negative experience. The existence of such harmful experiences post-assault is worthy of attention and alteration.

**Immediate Neurobiological and Psychological Effects of Sexual Assault**

Perhaps the most misunderstood part of sexual assault is the immediate psychological and neurobiological effects from the severe trauma. This trauma begins during the event, not just following the event. The misunderstanding is evident during police interviews; the words and testimonies of victims are incomprehensible, the stories do not coincide, lying seems evident, and behavior is strange (Campbell, 2012). The ultimate solution is to combine the expertise of the criminal justice system with a psychological perspective so that a full explanation may be given (Campbell, 2012). This combination will assist the police and the legal system to understand the victims and promote a relationship between the victims and prosecution.

Adding a psychological perspective would incorporate the understanding of what happens to the brain and the mind during sexual assault. The brain and body are changed during the trauma of sexual assault—changes in both chemicals and functions (see Figure 1 in Appendix)—which can hinder proper memory coding. The amygdala and the hippocampus, brain structures that work to encode memories, are activated at the onset of stress or trauma. The hypothalamus, the pituitary gland, and the adrenal glands (HPA axis) are affected at the onset of stress detected by the hippocampus and amygdala, which trigger a release of several hormones in reaction to the trauma (Campbell, 2012). Catecholamine neurotransmitters are released and send messages to the limbic system in preparation for fighting or fleeing and change the serotonin and neuroendocrine levels in the brain (Bovin et al., 2008; Campbell, 2012). Catecholamine temporarily deactivates rational thinking by the prefrontal cortex.
due to circuit damage. Cortisol is also increased to mediate energy given to the adrenaline responses, along with opiates and oxytocin to prevent pain and negative feelings. The activated opiates that block pain are responsible for impeding emotional reactions as well. With the chemical changes in the brain, memory encoding does not proceed with proper function, but rather is fragmented, disorderly, or missing; however, the fragments can be gradually pieced together to rebuild proper recall of the event (Campbell, 2012).

These changes in overall function lead to more reactions of the brain and body. Without proper encoding, the memory of the traumatic event, in this case sexual assault, is incomprehensible. Recalling events, namely to police officers, is then more difficult than with a brain that is functioning normally. Incomprehensible and unstructured stories about the traumatic event can explain the disbelief of police officers or other individuals as it resembles dishonest and false reporting.

**Tonic Immobility**

The brain and body can react in more severe ways to the trauma than fragmented memory encoding. The fight-or-flight response is well understood, but adrenaline causes a third response, termed freeze (Abrams et al., 2009; Bovin et al., 2008; Campbell, 2012; Niermann et al., 2017; Roelofs, 2017). The freeze response is rigid stillness of the body, which increases awareness and senses in preparation for an attack (Bovin et al., 2008). Cortisol, the previously mentioned hormone, can decrease overall energy in the body, and, according to the research of Campbell (2012), it results in freezing to an extreme state called tonic immobility (TI). Other researchers, however, state that freezing is a preparatory response and not the same as TI, because TI occurs once fighting, fleeing, and freezing are not enough to safely escape a possibly fatal situation (Bovin et al., 2008; Roelofs, 2017). As a response controlled in the autonomic nervous system (Niermann et al., 2017), TI is an “evolutionary adaptive strategy” to escape and/or play dead in the presence of prey (Bovin et al., 2008, p. 402) but is effective at the onset of intense, excessive fear (Abrams et al., 2009; Campbell, 2012). The likeliness of experiencing TI increases
with interpersonal violence and trauma (Abrams et al., 2009). TI is marked by a state of complete paralysis and immobility (Abrams et al., 2009; Bovin et al., 2008; Campbell, 2012), and it has been defined as a “temporary state of motor inhibition” (Abrams et al., 2009, p. 550). The body is literally unable to respond during the attack, which refers not only to moving but also to calling out for help, thinking of how to escape, or producing logical responses (Bovin et al., 2008). The brain also typically transfers into trauma-mode and further blocks rational responses. This completely eliminates the possibility of executing actions of retrospectively desired changes (Campbell, 2012), meaning that even if the victims had wanted to take action, they would not have been able to do so. The brain responds to sexual assault with the reaction of TI because of the high level of trauma involved.

Some victims of sexual assault may experience TI, and such an experience can lead to worsening psychological conditions. Primarily, victims whose bodies respond with TI regain their logical thinking and rationalize multiple options of what could have occurred differently during the assault, leading to the eventual development of guilt (Abrams et al., 2009). Guilt converts to self-blame that triggers psychological disorders (Bovin et al., 2008) and is heightened with negative experiences related to disclosure to authorities (Greeson et al., 2016). Furthermore, TI and the accompanying neurobiological effects can enable PTSD symptoms, especially anxiety (Abrams et al., 2009; Bovin et al., 2008; Niermann et al., 2017; Roelofs, 2017). The explained neurobiological disruption behind TI may worsen the guilt, self-blame, and symptoms of PTSD. Therefore, psychopathological damage can increase during the trauma of sexual assault and exacerbate the need for seeking clinical help or therapy.

Reactions to Trauma and Acute Stress Disorder

While the body is reacting to the traumatic event, the brain causes other immediate reactions that are also detrimental to the mental health of victims (see Figure 1). Abrupt emotional reactions may include shock, panic, fear, sadness, grief, and/or anger. On the other hand, the avoidance reaction suppresses or denies the emotions in an
attempt to numb the mental pain. Typically, the victim experiences one or the other or starts emotional and turns to numbing the emotions. Both reactions lead to intrusion of horrific memories, images, or distress. Due to the intensity of trauma resulting from sexual assault, the emotional reaction can progress into terror, frantic behavior, confusion, and exhaustion; avoidance reactions can progress into maladaptation, emotional numbing, and withdrawal; and intrusion can progress to guilt, shame, despair, memory issues, obsessive thoughts, and compulsive repetitions. These progressions impair victims emotionally. Due to greater impairment, it is difficult to confide the details of the event to an individual, which then further delays healthy coping. If the immediate psychological reactions are not interrupted or if healthy coping remains blocked, victims are more susceptible to severe psychopathology (Heaps, 2000).

**Long-Term Psychopathological Outcome**

Psychopathology can develop from unhealthy coping from the neurobiological and psychological responses. For those who experience these responses following sexual assault, immediate assistance may not be easily attainable and the psychological effects from the trauma often lead to foregoing proper treatment. This causes a chain reaction, leading to developing psychological disorders (Heaps, 2000), all of which appear to be more prominent among those who have experienced sexual assault (Thompson et al., 2003). PTSD, borderline personality disorder, somatoform disorders, and dissociative and conversion disorder are considered to be connected regulation of trauma and emotions (del Río-Casanova et al., 2016). Emotional regulation, a byproduct of trauma previously discussed, connects the trauma to psychopathology (del Río-Casanova et al., 2016). If the assault involves more violence, the victim is subsequently more sensitive to developing psychopathology, as are those who are abused by a person with a familiar relationship (Gokten & Duman, 2016). The effects of sexual assault are not allotted to the timeframe of the event, nor even to a period of a few weeks; these disorders are complex and may require long-term clinical assessment for improvement.
Serious mental disorders are not the ultimate fate of all survivors of sexual assault, however. Personality factors and previous experience of extreme stress may support healthy coping skills, which can then continue as one copes with the distress and trauma of sexual assault (Regher & Marziali, 1999). Positive attachments and other advantages of a functional family life aid in developing healthy coping skills under stress, whereas familial dysfunction is typically detrimental to coping skills and personality factors (Regher & Marziali, 1999). Nevertheless, experiencing sexual assault appears to increase the possibility of mental disorders.

In order to avoid the development of mental disorders, coping skills are vital to recovery after sexual assault, but the stress can be excessive and can transcend the scope of self-help. Healthy coping skills start with approaching the intruding distress, followed by reflection and a coherent resolution (Heaps, 2000). The victim’s first cry for help is not always successful, as established previously, and the healthy coping skills may be unattainable (Heaps, 2000). Suppressing the emotional and avoidance reactions may lead to unhealthy coping (Heaps, 2000); therefore, urgent assistance should be available to the victim to promote recovery and repress psychopathology.

**Post-Traumatic Stress Disorder**

Trauma is commonly followed by the onset of PTSD given the neurobiology of sexual assault, but the likelihood of developing it is higher for victims of sexual assault—more so than other forms of traumatic events (Walsh & Bruce, 2014). Elements of sexual assault promote PTSD, especially the following: severity, physical injury, number of occurrences, self-blame, and avoidance coping (Ullman et al., 2007). Related to TI, symptoms of PTSD such as anxiety and flashbacks are heightened from the trauma of sexual assault (Abrams et al., 2009; Bovin et al., 2008); in fact, symptoms of TI resemble those of PTSD (Bovin et al., 2008). The reoccurrence of symptoms increases chances of a diagnosis of PTSD, while avoidance decreases chances (Walsh & Bruce, 2014). The symptoms of PTSD occur nearly instantaneously and persist until clinical assistance can reverse the progression of the disorder.
Although PTSD is not unavoidable in cases of sexual assault and is a serious issue, it can be effectively treated. Along with studies indicating PTSD is an inevitable outcome are contrary studies that show how quickly symptoms of PTSD can subside (Regher & Marziali, 1999). The issue following the event is still prominent, because the symptomatology of PTSD remains chronic for women who do not see results of quick improvement (Regher & Marziali, 1999). Even so, PTSD symptoms are 6–7 times more common for those who have experienced trauma of sexual assault, whether in childhood, adulthood, or both (Thompson et al., 2003). The symptoms of arousal and avoidance were respectively 2–3 times higher for victims of sexual trauma that those with other forms of trauma (Thompson et al., 2003). Recovery from PTSD is possible for victims of sexual assault, yet for some, the symptoms may still be present and require clinical assessment for proper coping.

**Other Disorders**

Psychological disorders tend to occur simultaneously, which is referred to as comorbidity; disorders following sexual assault are no exception. The psychological impact of sexual assault brings many problems, including the possibility of depression, alcohol abuse or dependence, and more (Walsh & Bruce, 2014). Heaps (2000) outlines the possible outcome of disorders from sexual assault once aspects of healthy coping are blocked: sleep problems, anxiety, depression, psychosomatic disorders, and personality difficulties. This list is not all-inclusive but rather includes some of the singular and comorbid possibilities (Heaps, 2000). The neurobiology and psychology of sexual assault is complex and so is the psychopathological effect on the victims, so the resulting disorders commonly intertwine a web of comorbidity.

**“I Believe You”**

For those who choose to report or disclose a sexual assault, victims can experience difficulties with both loved ones and the legal system, which may lead to self-blame. A university campus study showed that individuals who tend to accept rape myths are less likely to offer support or aid in obtaining resources than their counterparts with...
feminist ideals (Holland et al., 2020). Frequently, upon hearing that
the victim didn’t try to fight back, that they did not think through
the situation, or that the story is incomprehensible, one tends to not
believe the victim (Campbell, 2012; Shaw et al., 2016). The self-blame
worsens into more detrimental psychopathology if left unattended
(Bovin et al., 2008). Negative responses from any person can cause
further detriment to the victim.

If the initial response at disclosure were positive, many harmful
mental disorders could be avoided or properly treated. This is the
hope and the purpose of the “Start by Believing” campaign. In
essence, the campaign educates the public on how to respond to
victims in the moment of disclosure (“What to Say,” n.d.). “Start by
Believing” gives four simple tips to the public for avoiding worsening
the situation and ultimately avoiding second victimization (“What to
Say,” n.d.). The first tip is implied from the name of the campaign:
start by believing, which means not reacting with doubt or blame
but rather replying with “I believe you” (“What to Say,” n.d.). The
following tips instruct on giving supportive responses, avoid asking
why, and assist in seeking help (“What to Say,” n.d.). By applying the
principles of this initiative, the public can help a victim of sexual
assault if the detrimental effects are generally known. Greeson et
al. (2016) examined adolescent and adult female survivors to show
that the majority disclosed the sexual assault to a family member or
friend. The disclosure is where recovery may begin, and it depends
upon the individual being informed and aware. Understanding the
immediate reactions of the brain and mind and knowing the possible
outcomes of mental disorders can prevent the development of long-
term issues and aid in facilitating recovery following sexual assault.

Conclusion

Unbeknownst to most of society, a victim of sexual assault
experiences many negative outcomes from their trauma. At the
detection of danger, the body releases hormones and activates the
autonomic nervous system, while causing increased anxiety, loss of
rational thinking, and inability to form coherent memories (Campbell,
2012; Niermann et al., 2017). Immediately following the event and its
neurobiological effects are emotional or avoidance reactions from the extreme trauma (Heaps, 2000). These outcomes may escalate into long-term mental disorders (Heaps, 2000). Neurobiological and psychological reactions of sexual assault are not commonly known but are a prominent factor of the long-term mental health of victims.

The combination of neurobiological, emotional, and social pressures often leads victims to fail to report. While each individual may have their own reasons for not reporting, research has shown that reasons can stem from the psychological damage of the trauma (Walsh & Bruce, 2014). Roughly one fourth of sexual assault victims report the crime to the police, and an even smaller fraction of those reports continue in the legal system (Campbell, 2012; Morgan & Oudekerk, 2019). Rape myths remain an impediment to reporting because an act of sexual assault that does not match the myths are not considered seriously (Greeson et al., 2016; Hine & Murphy, 2017; Shaw et al., 2016). Additionally, the neurobiology that inhibit coherent memories and the ability to react leaves room for blaming the victim for lying about it and not escaping. Many factors can play a role in failure to report, but properly understanding the effects of sexual assault may help victims report and at least receive treatment.

Along with being unaware of the effects of sexual assault on victim, one may not know how to help a victim and effectively facilitate recovery. Responding with belief and support, seeking professional help, and avoiding blaming questions can aid in victims' recovery (“What to Say,” n.d.). Extreme mental disorders may not be the fate for each victim. Nevertheless, not all victims receive the help they need or the support from those around them. Exacerbation of the trauma can be replaced with healing by understanding the possible effects and believing the victims of sexual assault.

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Figure 1. Flow chart of trauma leading to psychopathology. This figure maps out the psychological and neurobiological effects as they advance to psychopathology. Adapted from Abrams et al. (2009); Campbell (2012); del Río-Casanova et al. (2016); Heaps (2000); and Walsh & Bruce (2014).
The Events of Child Sexual Abuse Disclosure

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Abstract

Child sexual abuse (CSA) is a worldwide issue leading to problems shortly following abuse and well into the victims’ lives. Specific barriers have been found to delay one’s disclosure of CSA. Common reasons for delayed CSA disclosure among recently abused children and adult survivors of CSA are the fear of not being believed and not having a trusted adult with whom they can disclose their CSA experience. Feelings of shame brought on by comments from the perpetrator were also common among those who delayed CSA disclosure. Action is needed to transition CSA disclosure from being an event into more of a lifelong process, and researchers are looking for new ways to better address the needs of CSA survivors. These findings have implications for policy changes in educating children and adults on how to better respond to cases of CSA and shows the importance of further future research on this subject.
Sexual abuse is an ongoing problem that occurs worldwide among individuals of all ages and ethnicities (van Duin et al., 2018). Among the abused are children whose cases are classified as child sexual abuse (CSA). CSA is defined as the act of an adult or older child using a child under the age of 12 for any form of sexual gratification (McTavish et al., 2019). Foster (2014) categorized kinds of perpetrators of CSA into one of four categories: (a) sexual abuse done by a family member for a period of time, without a parent or parents having knowledge of the abuse; (b) abuse by either one parent or both along with other forms of neglect; (c) sexual abuse by an individual outside of the immediate family who comes into contact frequently with the child; (d) abuse performed by a stranger on the child. The definition of CSA varies from study to study, but these forms of abuse include unwanted touching, rape, or threatened sexual violence (McTavish et al., 2019). Based on recent statistics, one in four girls and one in six boys will experience some form of sexual abuse before the age of 18, with only 10% to 20% of children ages 7–12 disclosing that they suffered from CSA (Foster, 2014; Hébert & Daignault, 2015). A child should have a trusting adult in their life to be able to disclose such information to, but years may pass as the child continues to hide their experience of CSA, leaving them to have to process their feelings alone.

A child may experience many barriers following an incident of CSA that may delay the CSA disclosure to an informal or formal recipient. Informal recipients include parents, friends, or peers, while formal recipients are categorized as professionals such as teachers, therapists, social workers, or law-enforcement officers (Münzer et al., 2016). Many of the barriers a CSA survivor will face are psychological, making it difficult for adults to ascertain whether or not a child is being sexually abused. This literature review will evaluate these psychological barriers, including a fear of not being believed, among studies performed on children and adults and how the lack of a trusting adult recipient can influence a child’s decision to disclose an experience of CSA. This literature review will further address the barrier of shame and guilt felt by a child as a result of perpetrator influence on the child following CSA, and the review will discuss further action to address CSA disclosure as a process rather than an event.
Methods

The present study aims to review all empirical research concerning barriers created by a child’s fear of not being believed, lack of a trusting adult in the child’s life, and shame that accounted for delayed disclosure of CSA. Studies were also examined to determine the importance of making CSA disclosure a process rather than an event. A search was undertaken using three databases: PsycINFO, Scopus, and Google Scholar, along with direct searches from the journal *Child Abuse and Neglect*. To identify relevant studies to incorporate in this review, terms searched include “disclosure and nondisclosure” AND “CSA, PTSD disclosure,” “CSA” AND “Disclosure patterns,” “Disclosure and nondisclosure” AND “Child sexual abuse or child sexual assault or childhood sexual abuse or childhood sexual trauma,” “CSA” AND “disclosure or nondisclosure,” AND “pediatrics or children” AND “sexual abuse or sexual trauma” AND “trauma-focused CBT.” Boolean options including peer-reviewed, academic journal, and between the years of 2009 and 2019 were used to specify the findings. A search was also performed on Google Scholar to identify studies that were not found in the databases using the searched terms above.

A total of 26 articles were found as a result of these search techniques. However, based on search criteria, a total of 16 papers were excluded. Those excluded were found to be literature reviews, student theses, or were not focused on the topics found in this literature review. This exclusion left 10 to be reviewed for this paper. Each article was carefully evaluated to identify the main points, findings, and limitations.

Results

Modern barriers that prevent children from coming forward about their experience with CSA leave many children feeling alone and confused. This literature review will evaluate barriers like the fear of not being believed and what impact the absence of a trusting adult has on a child who has experienced CSA. Further review explored how shame and guilt affect a child’s decision on whether to disclose their experience of CSA. Lastly, literature was reviewed to measure the impact of disclosure as a process rather than a sole event in the child’s life.
When deciding whether to disclose a CSA experience, fear of not being believed is a common barrier found among children and adolescents. Studies using children and adolescents to observe CSA disclosure patterns received short-term responses from participants as to why the fear of not being believed is such a common barrier. McElvaney et al. (2014) interviewed 22 adolescents ranging from ages 13 to 18 to investigate factors that led to the delay of CSA disclosure. Results showed five distinct barriers that prevented a child from having an earlier disclosure of CSA: fear of not being believed, not being asked, feelings of shame and self-blame, fear and concern for self and others, and lack of trusting individuals. McElvaney et al. (2014) discovered that the fear of not being believed was the most common response to why those in the sample delayed CSA disclosure.

Similarly, Münzer et al. (2016) sampled 42 individuals ranging from 6 years and 0 months to 17 years and 11 months (mean age of 12.6 years); Münzer et al. (2016) recorded autobiographical accounts given by the CSA survivors to what was impeding disclosure of CSA. Münzer et al. (2016) found that participants delayed disclosure due to the fear of not being believed by those with whom they disclosed their CSA experience. It should be noted that unlike McElvaney et al. (2014), Münzer et al. (2016) determined that feelings of shame and guilt were the most common barriers among their participants and that the fear of not being believed was a reason for delayed disclosure among children and adolescents.

Findings by Magnusson et al. (2017) support those of Münzer et al. (2016) by concluding that the fear of not being believed was not the leading reason of delayed CSA disclosure. Among the 57 sexually abused preschool aged children in their sample, 6 of the children were disbelieved by the informal recipient when they disclosed their experience with CSA. They too found that the fear of not being believed was not the most common barrier. One reason why the barrier of fear of not being believed was not as common in the studies performed by Münzer et al. (2016) and Magnusson et al. (2017) could be due to the age of the participants participating in their study. With both studies included children under the age of 12 in their research, unlike
McElvaney et al. (2014), who observed adolescents. The age of these children may affect the results of which barriers were most common. The cognitive processes and fear development within a child is very different compared to an adolescent; this difference must be noted as to why results between these studies were different. Although the studies did not come to the same conclusion on whether the fear of not being believed was the most common barrier resulting in delayed disclosure of CSA among children and adolescents, they all support the idea that it is a barrier worth being acknowledged.

Limitations pertaining to this portion of the research mainly involve the idea that younger children are often difficult to study since they do not fully understand what had occurred or how to process their feelings about what happened. This idea influenced the studies of McElvaney et al. (2014), Münzer et al. (2016), and Magnusson et al. (2017) with McElvaney et al. (2014) focusing only on adolescents rather than children, Münzer et al. (2016) researching a combination of groups including both children and adolescents, and Magnusson et al. (2017) observing only preschool-aged children. Furthermore, Magnusson et al. (2017) focused only on preschool-aged children, whose cognitive capabilities differ from an adolescent, with an adolescent being able to recall specific details about their abuse more accurately. In the study done by McElvaney et al. (2014), it must also be noted that with only 22 participants instead of the preferred 30, generalization to other populations must be accounted for due to a limited sample size.

Similar research with adult populations produced the same result that fear of being believed was one reason adults recall being responsible for their delayed CSA disclosure. Consistent with this notion, Swingle et al. (2016) performed a study where 301 adult survivors of CSA were categorized into three groups (non-disclosure, disclosure/abuse continued, and disclosure/abuse stopped) to evaluate what triggered CSA disclosure and the psychological impacts disclosure had on the participant prior to the study. Swingle et al. (2016) noted that when adults were asked to recall whether they thought their parents would believe them at the time of disclosure, those who thought their parents “seemed to believe” reported that the abuse continued. These participants confirmed their belief that
they should not have disclosed because most found that no action was done to end the abuse, despite pushing through the barrier of not being believed. In addition, Brattfjell and Flam (2019) evaluated 27 adults who voluntarily completed a questionnaire, which addressed topics such as the circumstances of their CSA experience, the time between CSA and disclosure, and the reasons for finally disclosing their experience with CSA. Participants reported that they delayed CSA disclosure due to many factors, including a fear of not being believed. Together with other studies, this research shows how, even over time, adults can still recall the fear of not being believed as one of the main reasons for the delay of CSA disclosure.

The research involving adult CSA survivors shows that the fear of not being believed is a barrier for delayed CSA disclosure; however, limitations must be acknowledged, such as the amount of time between the CSA experience, when the individual disclosed the experience, and when they participated in these studies. Over time, aging can be attributed to memories being forgotten or changed (Brattfjell & Flam, 2019). Views on the CSA experience can also change over time. For example, decades-old, altered views can limit studies to adult survivors rather than children or adolescents who have more recently experienced this abuse. Also, the study conducted by Brattfjell and Flam (2019) only had a sample size of 27 adult survivors rather than the preferred 30, requiring caution when wanting to generalize these findings to other populations.

In short, the evidence shows that the fear of not being believed is common across all age groups, including adults, adolescents, and children, as a reason for not disclosing CSA earlier. Many associated this fear of not being believed with the responses they would receive from the recipient. This fear of not being believed, coupled with the lack of an adult with whom they can reveal their experience of CSA, can lead to feelings of isolation that may cause a child to continue to hide their CSA experience from an adult.

**Absence of a Trusted Adult**

Emerging research has established that along with the fear of not being believed, the absence of a trusted individual in a child’s life will delay the process of disclosure following CSA. Brattfjell et
al. (2019) found that among the 23 individuals who participated in their questionnaire, 11 reported that having a trustworthy person was critical to ever having disclosed their CSA experience. Similarly, Münzer et al. (2016) found that 19 of their participants recalled not having felt comfortable to disclose their CSA experience with any known adult at the time, resulting in delayed CSA disclosure. From these studies, one can infer that not having a trusted adult present in the life of a child experiencing CSA can delay disclosure. The absence of a trusted adult may also delay professional help, which may be needed to help a child recover.

Due to the informal nature of most CSA disclosures, many forms of abuse are left invisible to professionals. Majeed et al. (2019) performed a study on all individuals 17 years of age and younger living in a sexual-assault referral center. Case files were evaluated to review several aspects of CSA. From the review, they found that 60.8% of the patients had disclosed their CSA experience to a parent or caretaker with only 19.8% ever disclosing to a healthcare professional and 10% reporting to a teacher. Similar results were found in a study done by Lahtinen et al. (2018), using a population-based research project performed on 1,364 children, which resulted in 256 children reporting some form of CSA. Those who reported having experienced some form of CSA completed a series of questions related to the CSA experience. Those who had delayed CSA disclosure were asked to give reasons as to why they had delayed disclosure. Results showed that 80% of the children were able to disclose their CSA experience to a trusted friend or parent, with only 12% ever reporting to a formal recipient. These findings support the work done by Münzer et al. (2016), who found that even after disclosure of CSA to an informal recipient, the likelihood of eventually reporting CSA to a professional or formal recipient was low. In addition, Malloy et al. (2019) found similar results from studying 94 women in a juvenile facility. They reported that none of their participants first disclosed to a formal recipient, but rather, disclosed their CSA experience to an informal recipient who was unlikely to later report to a formal recipient. Since participants were from a juvenile facility, results may differ when compared to the majority of women—those within the facility may
have had trouble with the law around time of disclosure (resulting in nondisclosure to formal recipients). Together, these findings support the idea that many cases of CSA go undetected by professionals and formal recipients.

Most studies done on this topic were performed through clinics or with participants who had been recruited from reported CSA accounts to formal recipients. Many cases of CSA disclosure then go undetected and unstudied due to the lack of them being reported to formal recipients. Lanhetin et al. (2018) acknowledged the disadvantages of not conducting more population-based surveys on the topic of CSA due to legal reasons; however, through their population-based research, unreported accounts of CSA were able to be identified. The experiment performed by Majeed et al. (2019) also showed limitations by only collecting cases from CSA survivors residing at the Saint Mary facility who had or were expected to have suffered CSA. These findings, although compatible with other results, should be looked at carefully before generalizing into other areas of research.

**Shame**

Among CSA survivors, shame is another common barrier tied to delayed disclosure. Comments made by the perpetrator can lead the child to feel ashamed of themselves and even leave them convinced that the act was their own fault, ultimately resulting in the child feeling shame and guilt. McElvaney et al. (2014) supported this claim after reports from a sample of 22 adolescents ranging from ages 13 to 18 stated that shame was prompted by the perpetrator, whose remarks claimed that the victim was, in fact, the one to blame for the incident. Specific instances include young female victims believing the perpetrator was punishing them because they were “bad” (McElvaney et al., 2014). It is likely for someone who is told these remarks at such a young age to believe them. These feelings of shame and self-blame became stronger as the perpetrator’s comments continue, resulting in delayed disclosure of CSA. Consistent with these findings, Malloy et al. (2019) found that comments from the perpetrator would induce the idea that the victim was the one responsible for the abuse. This
led to feelings of shame and guilt, ultimately delaying CSA disclosure among the majority of the 44 women who participated in this study. Additionally, Münzer et al. (2016) reported that the perpetrator’s tactics to convince the child not to disclose the CSA led to feelings of shame. These results came from their sample of 42 children ranging from ages 6 years and 0 months to 17 years and 11 months. These children reported feeling guilty or responsible for the victimization even after disclosure. These studies suggest that shame continued to develop with the perpetrator’s continuous comments to convince the child that the abuse occurred because it was their fault. Together, these studies show how the perpetrator’s verbal threats can induce feelings of shame and guilt, further delaying CSA disclosure.

Although there is compelling evidence that perpetrator influence can instill feelings of shame, a limitation that must be acknowledged is that most studies, including the ones analyzed, have high or full sample sizes of female CSA survivors. This results in a lack of male CSA survivors participating in these studies. Until the issue of more gender-representative data is resolved, caution is advised in generalizing these findings to male survivors of CSA due to uncertainties of whether women are more or less prone to feelings of shame than males.

The definitions of terms used to ask children if they had suffered an experience of CSA are another factor that led to varied findings on whether feelings of shame were, in fact, a common barrier among children for not disclosing. Feelings of shame that delay CSA disclosure was not supported as the number one cause of delayed CSA disclosure by Lahtinen et al. (2018), who worked with 256 children through a population-based research project. Lahtinen et al. (2018) used a broad definition of CSA, which included actual contact but also invitations and propositions to do something sexual. With this definition, Lahtinen et al. (2018) found that the most common reason for delayed CSA disclosure among the 256 children observed (41%) was that the child did not think that the act was serious enough to tell someone. Findings by Münzer et al. (2016) found shame to be the leading cause to delay CSA disclosure. Munzer et al. (2016) used a different definition of CSA with it either being (a) sexual assault
by a known adult, (b) sexual assault by an unknown adult, (c) sexual assault by a peer, (d) attempted or completed rape, (e) flashing/sexual exposure, (f) verbal sexual harassment, (g) statutory rape/sexual misconduct, and (h) being exposed to pornography or being involved in the production. Due to the differences in definitions of CSA, children and adolescents who participated in these studies may have reported differently to why disclosure was delayed. For example, in the study conducted by Lahtinen et al. (2018), their definition suggested that if a child was asked to participate in some form of sexual act and if a child refused, they still qualify to have experienced CSA. This was not the case with Münzer et al. (2016). Disclosure may have been delayed in accordance with the definition provided by Lahtinen et al. (2018) because the participants may not have felt they fit the definition of CSA. A limitation present in the study done by Münzer et al. (2016) is that the wording in the definition of CSA may have been difficult to understand, lending different results on the barrier of shame than in the study performed by Lahtinen et al. (2018).

Emerging research shows how these feelings of shame are prevalent among many CSA survivors. Considering comments from perpetrators and different definitions of CSA, individuals were still able to identify shame as being a reason for delayed CSA disclosure. These feelings of shame and guilt lead to other problems in the child’s life. Other barriers can form, preventing the child from disclosing their experience of CSA. These barriers are a continuous circle with one influencing the other, and this process should be given more attention in research.

**Disclosure as a Process Rather than an Event**

Recent studies have proposed the idea of CSA disclosure being a process rather than popular perception of disclosure being a one-time event. Many children struggle with disclosing their CSA experience, and with many barriers having to be crossed to eventually disclose CSA, it is important to acknowledge the needs of the child at the time of the first disclosure and into the future. Ullman and Filipas (2005) distributed a voluntary questionnaire among college students that discussed different CSA experiences. Seven hundred and thirty-six students participated in the study, and they were asked to reflect on their experiences and to answer questions regarding their disclosure. The results indicated that disclosure is a complex process that involves various factors.
three college students participated in this study, and responses to the questionnaires were evaluated to see gender differences in such areas as disclosure rate and PTSD symptoms following CSA disclosure. Their findings conclude that in the majority (74.5%) of disclosure cases, the individual was brief in disclosing to a recipient and that 25.5% did not share detailed accounts of the CSA. Findings like this show the importance of doing follow-up discussions with CSA survivors, knowing that such little information is revealed during a first-time disclosure. Findings by Easton (2019) through an anonymous online survey with a sample of 487 male CSA survivors aimed to find results linking early disclosure to adulthood mental illness. They also evaluated whether the timing of having an in-depth conversation following the disclosure was related to adulthood mental illness. Results from this study should be analyzed deeper in order to be generalized across genders, since this study only consisted of male CSA survivors. Easton (2019) found that having an in-depth conversation following CSA disclosure was negatively correlated to adulthood mental illness, meaning that the more often an in-depth conversation occurred, the more fully the CSA survivor could process and understand the situation. Their chances of adulthood mental illness were also significantly lower than those who had not had an in-depth conversation following their CSA disclosure. These findings suggest that disclosure should be a process including telling, reporting, and discussing later on what had occurred in different stages throughout a CSA survivor’s life; this process allows closure but also avoids mental illness. In addition, discussed similar findings among 301 adult survivors of CSA while evaluating CSA disclosure patterns and psychological impacts of disclosure following the process as a child into adult years. Current intervention programs were assessed and found to exclude long term follow-ups after CSA disclosure., Swingle et al. (2016) claimed that rather than leaving CSA disclosure as a one-time event, disclosure should be an in-depth process with therapeutic help. In short, research shows the growing need for in-depth conversations and narratives to occur following CSA disclosure rather than one disclosing and talking about their experience with CSA one time.
Limitations should be addressed in the reliability of these findings. In the case of Swingle et al. (2016), participants were already being treated at clinical facilities; in the study done by Ullman and Filipas (2005), researchers distributed questionnaires to college students who voluntarily participated whether they were receiving treatment or not. Even with similar conclusions on the importance of CSA disclosure being a process rather than an event, those participating in the Swingle et al. (2016) case were engaged in the in-depth conversations they needed following CSA disclosure due to the participants currently seeking treatment at the time of the study. However, it is unknown whether students who participated in the Ullman and Filipas (2005) study were receiving such treatment. These limitations can bias the results and should be considered when wanting to generalize.

Discussion

Review of this literature brings new understanding to the barriers and difficulties a child endures in eventually disclosing an experience of CSA as well as the need to make the CSA disclosure a lifelong process rather than just a one-time event. Independent of the age of the CSA survivor, one of the main barriers across all studies was the issue that once the victim disclosed the abuse, they felt they would not be believed. The barrier of not being believed was evaluated among children, adolescents, and later reported by CSA adult survivors to be a hindrance not only to acknowledging that this crime persists but also to obtaining proper treatment for the victim. The more information and education that is available to children, the more confident they will likely feel in revealing these experiencing not only to informal recipients but to formal recipients.

Along with these findings, attention was drawn to the importance of a trusted adult being present in the child's life for the child to disclose their CSA experience. One possible solution is that public schools could train teachers to recognize certain behavior often found in victims of CSA through in-service sessions. Training sessions could also provide support agencies available within the community to facilitate rapid referral process so the perpetrator could be
prosecuted. Without this enhanced network of disclosure and referral, the cycle of not having a trusted formal recipient in the child’s life will continue to be a greater reason for delayed disclosure. Furthermore, feelings of shame led by the influence of the perpetrator was another common barrier that delayed disclosure.

Along with discussing the barriers found to delay CSA disclosure, this review highlighted the importance of regarding CSA disclosure as a process rather than an event as a crucial factor to be implemented more in clinical practices. As clinicians work with individuals who have suffered CSA, these professionals need to see the importance of turning this disclosure into a process by implementing lifelong disclosure and therapy treatment. A number of therapy centers acknowledge the importance of longitudinal CSA disclosure, but in-depth conversations and narratives associated with CSA experiences and disclosures need to be implemented as these disclosures become processes rather than events. These discussions will allow CSA survivors to continue the healing processes that may have not occurred for years following their CSA disclosure. These applications will allow CSA survivors to receive needed support throughout their life rather than in just one moment following the CSA disclosure.

In the context of future research, it is essential to note that one of the main limitations in the present studies is the lack of male participants. With females being more prone to experience some form of CSA in their lifetime than males, many of the studies contained majority participation or full participation of female CSA survivors. It would be useful to have more studies that involved the experiences of CSA disclosure among male CSA survivors to be able to compare results and see if findings indeed can be generalized across genders. Another limitation that future researchers will need to address is how, in many of the articles reviewed, participants were selected from clinicians or facilities where formal cases of CSA were reported. This implies that formal recipients had been informed about participants’ CSA and that these reports were kept on file. This implies that these individuals had already received, and were receiving, treatment when these studies were performed; furthermore, those who had not yet disclosed their CSA experience to a formal recipient were omitted.
Many individuals go a lifetime without ever receiving treatment for their CSA, and their disclosure experiences or barriers may be different than compared to those that have been reported to formal recipients. Future research and an informed network need to be further established on this subject due to the increasing number of CSA accounts worldwide. Much can be done to stop CSA in the world. However, for this study, further research must be conducted to better address the needs of those disclosing accounts of CSA, to discuss the need to better educate potential formal recipients of a CSA case, and to strengthen family members to be able to support CSA victims within their homes.

References

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The Unintentional Cost of a Free Public Sex Offender Registry

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Abstract

This literature review analyzes the efficacy of modern legislation guiding public access to sex offender registries and draws on research utilizing surveys, interviews, and statistical observations of convicted sex offenders to determine sources of ineffective practices at the legislative level. By utilizing Braithwaite’s reintegrative shaming theory (1989), in which stigmatizing shame is significantly less efficient in criminal contexts, current legislation and its impact on common issues experienced by sex offenders (including sexually addictive behaviors and childhood sexual abuse) are examined. The discerned prevalence of stigmatizing shame in modern legislation, which focuses on the individual rather than the undesirable behavior, indicates that contemporary legislation allowing public access to sex offender registries is ineffective at facilitating the rehabilitation of sex offenders, creating an unintentional cost for both the sex offender and the general public. Because of the limits imposed by the relatively few studies performed since sex offender registries were made public, further research should be conducted to evaluate more effective and reintegrative policies, which should then advise expedient legislative changes that will better benefit both the general population and those listed on the sex offender registry.
It was John’s twenty-first birthday, and some of his college friends took him out for drinks at a bar to celebrate the milestone. Several hours later, after succumbing to peer pressure, John became intoxicated and could barely walk a straight line home. While being thus impaired, he decided to relieve himself next to a wall, only to realize that a child and the child’s mother were nearby. Because of a subsequent conviction of indecent exposure in the presence of a child, John is now listed on the public sex offender registry; along with Paul, a 23-year-old band member who was convicted for relations with a minor after she lied about her age; and Henry, who was accused and convicted of inappropriate relations by his high school girlfriend’s wealthy parents as soon as he turned eighteen. All three people, from adapted true stories, are now required to live determinable distances from child-prominent areas. According to state laws, one or two of them may be required to report in at night at decided curfews, but none of them will be able to avoid the complexity of obtaining employment as registered sex offenders. While the actions of John, Paul, and Henry are not condonable, it is often surprising to the general population that instances of relatively minor sexual crimes are included in the results of a local sex offender search. This is due to an upheld belief that local search results will be primarily saturated with serial rapists and pedophiles; thus, it tends to be inconceivable that such a search could contain results of family or friends who made unintentional mistakes.

Several factors guide the presence and legislation of a sex offender registry (SOR). The foundational idea of an SOR is a requirement of the sex offender to notify local law enforcement of any changes to address or other identifying information (Thomas, 2013). This has been believed to help reduce recidivism as it should allow the local police to better protect citizens by being more aware of the sexual criminal’s location in the community, though this has not empirically been verified (Thomas, 2013). Despite a lack of evidence supporting the supposed benefits of SORs, countries around the world are progressively adopting legislation that requires documentation of sex offenders and, in some places, requires public disclosure of this documentation. The United States currently allows the most public
access to sex offender information, with the United Kingdom trailing in second place (Thomas, 2013). Public access to SORs in the United States began with two prominent acts of federal legislation: (a) the Wetterling Act and (b) Megan’s Law. The Wetterling Act, named after an 11-year-old boy kidnapped in 1994, is the first federal legislation requiring every state to maintain an SOR. Two years following, in 1996, this legislation was intensified by the adoption of a law known as Megan’s Law, requiring public access to SORs nationwide (Thomas, 2013; Vandiver et al., 2008). Beyond this rigorous federal legislation, many states and local communities opt for additional legislation, including community notification systems, which further impacts rehabilitation efforts of sex offenders (Swensen et al., 2014; Thomas, 2013). This expanding amount of legislation demanded by the general population indicates a misplaced trust and expectation that public knowledge of local sex offenders serves a protective function. However, relatively few studies in the twenty years since SORs were made public have analyzed the actual impact of a SOR, and even fewer have supported any believed benefit.

Increasingly, some argue that when viewing SORs through well-established criminology theories (primarily Braithwaite’s reintegrative shaming theory), the legislation and publicity of SORs could be potentially detrimental to the rehabilitation of sex offenders. When reviewing ineffective stigmatizing shaming of the individual in comparison to effective reintegrative shaming of the behavior, as well as their application in legal settings with other crimes, there is significant evidence that stigmatizing shame plays a role in higher recidivism rates in the majority of criminal behaviors, including common crimes and white-collar crimes (Murphy & Harris, 2007; Ray et al., 2011). The personally identifying information of individuals listed on public SORs and other consequences of current legislation often facilitates stigmatizing shame through an exclusive focus on the individual. This indicates a likely relationship between public SORs and the rehabilitation (and consequent recidivism rates) of sex offenders—but perhaps not the positive relationship that the legislation intends. While published SORs are ideally intended to serve a protective function in the communities
where convicted individuals reside, public access to unfavorable, personally identifying information of those convicted of various degrees of sexual misconduct should be re-evaluated to avoid potentially harmful effects, because such registries (a) typically facilitate stigmatizing shame, which may negatively impact effective reintegration, and (b) often worsen progress overcoming persistent issues (including addictive sexual behaviors and effects of childhood sexual abuse), which can potentially increase recidivism rates and put neighborhoods at even greater risk.

**Stigmatizing Shame and Its Impact on Reintegration**

To understand stigmatizing and reintegrative shame and their relationship to public SORs, it is imperative to understand their origins. In his book *Crime, Shame, and Reintegration*, Braithwaite first observed these contrasting patterns of shame and recognized shame as independent of punishment despite the societal norm to interchange the two ideas (Braithwaite, 1989; Hay, 2001). Punishment, then, is defined as either the loss of desirable conditions or gain of undesirable conditions; whereas, shame is primarily a social-communication device that communicates what is wrong and to what degree (Braithwaite, 1989; Hay, 2001; Steinberg, 2000). Braithwaite (1989) argued that shame requires consideration separate of punishment because shame is nonuniform in its application and implication. With two modes of possible shaming within the same punishment, it is necessary to understand and recognize stigmatizing shame and reintegrative shame especially within criminal contexts.

**A Comparison of Stigmatizing and Reintegrative Shaming**

By observing stigmatizing and reintegrative shame in normal communication, the pattern of functionality for both can begin to be analyzed. Ray et al. (2011) disclosed recorded conversations from mental health courts (MHC) that illustrate the difference of the two forms of shame as observed by Braithwaite (1989). In these detailed conversations, reintegrative shaming compares to the way a mother punishes a child, a boss encourages a coworker, or a spouse voices concern. In stark contrast, stigmatizing shaming compares to
polarized political confrontations, bad management, and emotional abuse. The differences between stigmatizing and reintegrative shame extend into their effectivity (Braithwaite, 1989). Although both are equally possible within the same punishment, it is essential to clearly recognize stigmatizing and reintegrative shame as distinctly different in how they communicate to comprehend the difference in yield of both patterns of shaming.

Stigmatizing shame, with an exclusive focus on the individual, communicates that the individual is bad but does not allow room for the individual to remediate. This type of shame works against reintegration by creating a situation where the individual is labeled and ostracized (Ray et al., 2011). Such shame in criminal contexts is observed more in traditional criminal courts and can be measured by factors including respect, forgiveness, or disapproval towards the offender (Ray et al., 2011). With lower respect and forgiveness, but higher disapproval for the offender, this mode of communication often leads to feelings of hopelessness and helplessness (Vandiver et al., 2008). Studies analyzing the impact of hopelessness and helplessness created by stigmatizing shame have consistently found a positive correlation between stigmatization and rates of reoffending (Makkai & Braithwaite, 1994; Murphy & Harris, 2007; Ray et al., 2011). With this correlation, stigmatizing shame is shown to be a potential primary contributor to increased rates of recidivism. This correlation, therefore, emphasizes the low effectivity of stigmatizing shame as a social communication device in the criminal sector.

In contrast, the observable success of reintegrative shame in social communication affirms the trend observed with stigmatizing shame as a less effective social communication device. Reintegrative shame, which focuses on the undesired behavior, is a shaming pattern identified by the amount of support, approval, and respect offered to the offender (Murphy & Harris, 2007; Ray et al., 2011). Currently, these traits associated with reintegrative shaming are primarily observed in MHCs dealing with criminal activity of mentally disabled persons (Ray et al., 2011). As reintegrative shame communicates feelings of hope of overcoming negative behaviors, the socio-judicial effort in MHCs to encourage and recognize success of the individual
results in significantly lower rates of recidivism when compared to traditional criminal courts (Ray et al., 2011). This pattern is echoed by observations of reintegrative shaming in other contexts, including white-collar crime (Murphy & Harris, 2007). The relationship between reintegrative shaming and recidivism supports this mode of communication as a more effective communication device in criminal court. This further supports the more positive shaming pattern of reintegration as a preferable and beneficial mode of communication when compared to stigmatizing shame.

**Application of Stigmatizing and Reintegrative Shame in Public SORs**

Due to the difference of success and impact on recidivism with both patterns of shame in criminal contexts, it is imperative to analyze public SORs to determine the current mode of shaming predominately practiced within contemporary legislation. Despite the increased understanding of the success of reintegrative shame, it is found through analysis that sex offenders experience stigmatization more than reintegrative shaming in three different facets of current public SOR legislation (Thomas, 2013). These attributes include risk assessments, legislation, and public knowledge, as these are the leading facilitators of stigmatizing shame in contemporary legislation and its negative impact on effective reintegration of sex offenders.

**Risk assessment on reintegration.**

Stigmatizing shame is first noticed in SOR legislation through the utilized risk assessments that evaluate the likelihood of sex offenders to reoffend. Risk assessments are used to judge the duration of time that a convicted sex offender should be required to register on a public SOR. Lanterman et al. (2014) found, in states using risk assessments, that the measures were often manipulated to suit the discretion, personal beliefs, and priorities of juries, judges, and law enforcement. Because the measures of risk assessments are utilized to determine length of conviction, the biased manipulation of these measures was found to allow stigmatizing shame to be amplified in the application of current SOR legislation as the length of sentencing was longer than when risk assessments were used appropriately to
inform SOR legislation application (Lanterman et al., 2014). The result of this is that those evaluating the level of risk for recidivism of sex offenders allowed personal discretions and biases to influence judgments that foster long-term, negative ramifications for the sex offender. Consequently, these judgments communicate to sex offenders—even if incidentally—that they are defined by who they are perceived as because of what they did, rather than focusing solely on correcting the negative behavior. By this it can be concluded that the primary communication device in the context of risk assessments is the less effective pattern of stigmatizing shame.

Legislation on reintegration.

Stigmatizing shame is also found in current legislation itself. Swensen et al. (2014) studied effective methods to help those with criminal records assimilate back into society and find effective employment. They noted that cases of sexual offenses warrant special consideration due to strict legislation that includes additional public notification systems and strict residence and workplace laws (Swensen et al., 2014; Thomas, 2013). While many of these regulations make sexual offenses a difficult case of consideration in employment, compared to other criminal records, these regulations are generally deemed necessary for public protection at the expense of the sex offender. However, the regulation is not behavior dependent. For example, an abstinence from deviant sexual behavior does not grant the offender the right to be expunged from public SOR results. Rather, the duration of registration is determined at the time of conviction regardless of future improvement (Swensen et al., 2014). Because the focus of shame is on the individual, it inherently shows a pattern of stigmatizing shame, where sex offenders face punishment regardless of future actions towards rehabilitation. This severely inhibits and discourages necessary motivation to overcome previous negative patterns of behavior.

Public knowledge on reintegration.

In addition to stigmatization from legislation, the public access to SORs allows for stigmatization to be expressed by the general population, potentially leading to increased harassment. When
community members in Florida were interviewed on the effectiveness of the public SOR, many replied that they believed sex offenders would invariably reoffend, necessitating public access to these records to identify local sex offenders (Levenson et al., 2007). But the results of the existing empirical studies contradict this common belief when the statistical variance in recidivism of offenders before and after the publicity of SORs is compared, as no statistically significant reduction in rates of recidivism has been measured since public access was permitted (Levenson et al., 2007). As increases in recidivism in other criminal contexts have been attributed to stigmatizing shame, it is possible that the stigmatizing shame inherent in public access to SORs is either counteracting improved rehabilitation efforts of sex offenders or it is potentially preventing reduction in overall rates of recidivism. Either way, this firm, incorrectly-based belief in public access has instead led to possibilities for harassment of those listed on the SOR. Vandiver et al. (2008) found that in a survey of 183 male sex offenders, one in ten reported being harassed, threatened, assaulted, or had suffered property damage while nearly twenty-eight percent had lost a close friend due to the public nature of the SOR. The ability of the public to harass individuals because of public access to past offenses and critically identifying information is another example of stigmatizing shame in current SOR legislation. This harassment does not allow individuals to rehabilitate or improve behavior by stripping away necessary motivation because of the negative communication between the public and listed sex offenders. The effect of this harassment consequently impacts sex offenders’ ability to reintegrate and rehabilitate and essentially not only harms the sex offender but also the general population.

**Overcoming Persistent Issues and Increased Risk**

With consideration of the stigmatizing shame resulting from public SORs, it may not be enough to simply recognize the correlation between stigmatizing shame and higher rates of recidivism. It may be equally essential to consider the impact of expressed stigmatizing shame on common issues that face sex offenders as they seek rehabilitation. These common issues include sexually addictive behaviors (also identified as hypersexuality) and childhood sexual
abuse. Studies consistently find that both are disproportionally represented in sex offender populations (Jespersen et al., 2009; Kingston & Bradford, 2013). The correlation between sexual offenses and these issues requires an examination on the impact of stigmatizing shame expressed by public SOR on both sexual addictions and childhood sexual abuse.

Sex Addiction and Stigmatization

Sex addictions, also known as hypersexuality, are a common issue for registered sex offenders. Hypersexuality is identified by excessive urges, fantasies, or other related sexual behaviors and is typically defined as a common issue experienced by sex offenders (Kingston & Bradford, 2013). Hypersexuality is often manifested in impersonal behaviors, including masturbation and usage of pornography, and in relational behaviors, including multiple partners in a short amount of time (Kingston & Bradford, 2013). It is difficult to determine at what point hypersexuality becomes an addiction by traditional measures, including compulsivity and a disregard of negative consequences. Because of this difficulty, neither sexual addictions nor hypersexuality are recognized as diagnosable disorders by the DSM-V, despite being associated with a list of psychiatric conditions (Kingston & Bradford, 2013). Accordingly, the prevalence of hypersexuality is difficult to determine with the shifting definitions and diagnostic parameters of sexual addictions and hypersexuality; however, many studies still choose to study hypersexuality in view of the addiction model (Kingston & Bradford, 2013). With an understanding of the difficulty to accurately measure hypersexuality as an addiction, studies have generally found the prevalence of sex addictions among sex offenders to be as high as fifty percent with implicit variance (Carnes, 1989; Kingston & Bradford, 2013; Marshall & Marshall, 2006). Therefore, hypersexuality, as understood by sexual addiction models, is considered a serious issue facing a large portion of sex offenders. As a significant issue, it is necessary to consider the impact of stigmatizing shame on hypersexuality.

Addictions have an extensive relationship with shame, as shame both influences and defines addiction experiences. Flanagan (2013) noted that addiction has two points of failure: (a) failure to use...
agency rationally and with self-control, and (b) shame because of this failure. Flanagan emphasized that while shame is important in addiction recovery, “there can be shame without blame” (Flanagan, 2013, p. 1). By promoting shame but not blame, Flanagan supported reintegrative shaming as an effective way to shame addictive behaviors without painting the individual as a failure through blame. Matthews et al. (2017) expounded on the importance of public shame and beliefs in addictions by defining self-stigmatization as the result of an internalization of societal constructs of addiction, where societal constructs are primarily communicated through patterns of public shaming. If self-stigmatization is primarily inherited from public-stigmatization patterns, it is possible that stigmatizing shame from the public and from current legislation may play a central role in the self-stigmatization created internally by sex offenders. As the current shaming pattern by legislation communicates a message that the individual is bad, rather than that the behavior is bad, a negative self-stigmatization can be internalized by the sex offender, which would destroy hope and motivation for recovery.

The negative connotation of sexual addictions internalized by sex offenders who experience these issues has a strong relationship to a higher risk of recidivism. Clarke et al. (2017) found that feelings of isolation and loneliness are linked to higher rates of both recidivism and addictive behaviors as explained by addiction models. With more stigmatizing shame expressed, there is a higher amount of loneliness, isolation, and perceived risk, and as addiction models link higher perceived risk to more frequent addictive behaviors, it can be concluded that stigmatizing shame is linked to increased addictive behaviors along with higher recidivism (Alamani, 2007; Bilevicius et al., 2018). The assimilation of this information indicates that higher amounts of stigmatizing shame may lead not only to feelings of isolation, loneliness, and depression, but also that these negative moods may lead to more perceived risk, which further encourages addictive behaviors; each factor creates a strong correlation of increased rates of reoffending due to stigmatizing shame and its negative impact on overcoming sexually addictive behaviors (Alamani, 2007; Bilevicius et al., 2018; Clarke et al., 2017). By this, the stigmatizing nature of
public SORs appears to play a role in recidivism of sex offenders struggling with sexual addictions by stigmatizing shame’s impact on negative emotional states and perceived risk. Because of this effect of stigmatizing shame on hypersexuality, and with the prevalence of hypersexuality in sex offender populations, it inherently disqualifies stigmatizing aspects of public SOR legislation, and instead identifies these aspects as increasingly ineffective and unnecessary for both sex offenders and the public.

**Childhood Sexual Abuse and Stigmatization**

Childhood sexual abuse (CSA) is equally essential to consider with the impact of stigmatization expressed by public SORs, as CSA often stands as an obstacle in the recovery of abusers. CSA is a prevalent issue faced by sex offenders due to the tendency of the abused to become the abuser (Jespersen et al., 2009). CSA results in a distortion on the view of the self as well as feeling a general lack of control over situations or the victim’s own actions (Karr et al., 2012). Likewise, there are common feelings of fear, shame, guilt, and mistrust experienced by victims (Thomas et al., 1994). Jespersen et al. (2009) found that SORs had disproportionate amounts of individuals coping with CSA when compared to general populations, recommending that negative, distorted views of the self and a feeling of a lack of control, along with shame and fear, are consequently experienced more often by sex offenders than the average population. Additionally, these victims of CSA listed on public SORs are overwhelmingly male (Jespersen et al., 2009). When comparing male to female recovery patterns, it is important to note that males tend to be less disclosive on CSA and are less likely to seek help (Thomas et al., 1994). Due to the prevalence of these feelings and issues that arise from coping with CSA, it is important to evaluate the relationship of stigmatizing shame to the process of healing CSA demands, especially in the male context.

The common forms of long-term healing from CSA are often reliant on supportive relationships. The most popular form of therapy is group therapy, especially as this form of therapy promotes supportive relationships, education on CSA symptoms for both the victim and loved ones of the victim, and compassionate and positive internal dialogue (Arias & Johnson, 2013). In a study specifically
focused on males experiencing effects of CSA, the effectiveness of group therapy was highlighted as it addressed specific healing issues more commonly experienced by males. These issues included a fear of diminished self-reliance, culturally biased reactions, and assumptions of males to become abusers themselves (Thomas et al., 1994). Group therapy is often effective in dealing with these issues as it provides an opportunity to test new beliefs of one’s self, reduce isolation, and access support from individuals with similar struggles (Arias & Johnson, 2013; Thomas et al., 1994). Consequently, group therapy (and the necessary support and compassion associated) is especially effective in cases of males who have experienced CSA. In the context of the public SOR being primarily male, with many of its members coping with the consequences of CSA, it becomes apparent that both legislated and unlegislated treatment need to incorporate principles found in group therapy. As group therapy focuses on the behavior while embracing the individual into the social system, principles of group therapy are more closely mimicked by reintegrative shame. Because public SORs are currently stigmatizing in their shaming pattern, this creates a lack of these positive interactions that are necessary for sex offenders struggling with CSA, potentially acting as an obstacle in their recovery from both CSA and previous sexual offenses while also potentially acting as a primary contributor to increased rates of recidivism.

Conclusion

Braithwaite’s (1989) reintegrative shaming theory explained stigmatizing shame as being a less beneficial social communication device than reintegrative shame. SORs primarily exhibit stigmatizing shame through manipulation of risk assessment, individual-focused legislation, and potentially harassing public access (Lanterman et al., 2014; Levenson et al., 2007; Swensen et al., 2014; Vandiver et al., 2008). The result of primarily utilizing stigmatizing shame is that current legislation is employing a less effective social communication device and points to the possibility of improvement if focus was instead shifted onto behaviors rather than individuals. This would allow sex offenders to experience the more effective reintegrative
shaming while still receiving the same necessary punishments and consequences. Moreover, in other criminal contexts where reintegrative shame is compared against stigmatizing shame, practices of reintegrative shaming appear to directly influence rates of recidivism (Ray et al., 2011). This means that a shift to reintegrative shaming, while positively impacting recidivism rates of sex offenders, would also positively impact society.

Additionally, a shift to reintegrative shaming would better address common issues faced by sex offenders, including sexual addictions and CSA. Sex offenders struggling with sexually addictive behaviors would likely be more successful with positive social constructs of addiction that are behavior-centered and communicative of hope for recovery (Matthews et al., 2017). Likewise, sex offenders coping with CSA could also improve faster through reintegrative shaming, as this shaming pattern closely follows the success markers of group therapy and other related healing tools (Arias & Johnson, 2013; Thomas et al., 1994). Addressing both issues through a reintegrative approach could potentially lower recidivism rates further, as both issues are likely strongly correlated with rates of future sexual offenses. As reintegrative shaming could lower rates of sexual reoffending, changes to legislation are not only in the interest of sex offenders but also in the interest of the general population for increased safety and health for all.

Returning to the adapted true stories of John, Paul, and Henry, if reintegrative shaming became their experience, John would be encouraged to strive towards more responsible drinking, Paul would be motivated to be more thorough before future sexual relations, and Henry would be able to overcome his past and return as a functioning and contributing member of society for the rest of his life. However, these are not their stories because of the stigmatizing shame they currently experience and because the encouragement, motivation, and ability to move above and beyond previous sexual offenses are not offered to them in contemporary legislation. Instead, they face the negative effects of stigmatizing shame, isolating them and possibly encouraging them to be more careless with avoiding future sexual offenses.
For the sake of those like John, Paul, and Henry, as well as for the good of the general population, it is in the best interest of both groups to change the pattern of shame communicated by current legislation. To effectively change the current pattern of shame, further research should be performed to analyze the degree of stigmatizing shame expressed by all aspects of current sex offender legislation. After identifying all areas where stigmatizing shame is predominantly communicated, research should then be directed to identify the most effective ways of communicating reintegrative shame in the context of sexual crimes. Once best practices are identified, along with the legislative areas needing the most improvement, the research should inform a policy change, with an intent to continuously evaluate proposed changes to ensure maximum benefit for both sex offenders and the general population. The extensive nature of this research and policy process suggest a more reintegrative society is some time away, so for now, the first step to an effective change is to recognize that all of society is paying the unintentional cost for what is supposed to be a free public SOR.

References


The Unintentional Cost of a Free Public Sex Offender Registry
Experiences of Nonbinary and Gender Nonconforming Individuals Within the Healthcare System

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Abstract

Though nonbinary and gender nonconforming people are becoming increasingly recognized in North America, specialized healthcare—specifically gender-affirming procedures—are not becoming available to them. Researchers have examined the subjective experiences of these individuals as they have navigated the healthcare system in order to further understand possible limitations for nonbinary and gender nonconforming populations. Methods include assessing the procedures available to participants and their interpersonal experiences with healthcare professionals and family members. Scientific resources on this topic are limited, and the results are overwhelmingly represented by self-report. Furthermore, the content of the results is majorly negative toward the participants' experiences. Participants report verbal abuse and physical attacks in healthcare settings, medical procedures being unavailable or difficult to access, and a lack of support from family and various healthcare professionals. Continuing research in more objective formats and with greater specificity toward the subject is prompted.

Keywords: Nonbinary, gender nonconforming, gender-affirming care, healthcare
Transgender individuals are people who identify as a gender that is not usually associated with their sex at birth (American Psychological Association, 2018). They are becoming increasingly familiar in pop culture, with celebrities such as Caitlyn Jenner and Jazz Jennings—both transgender women—being well-known throughout North America. Both Jenner and Jennings are binary transgender individuals, meaning that they identify within the two discrete, normative gender categories—male and female (American Psychological Association, 2018). In contrast, there is a less well-known but increasingly prevalent group of people with nonbinary and gender non-conforming identities. Nonbinary and gender nonconforming (NGNC) people do not identify as the gender typically associated with their sex at birth, but they also do not identify with the other normative binary gender—male or female (National Center for Transgender Equality, 2018). Despite being less well-known, there are still several celebrities who identify as NGNC—such as Sam Smith or Bex Taylor-Klaus, both of whom identify as nonbinary and use they/them pronouns rather than the binary he/him or she/her pronouns. Even though experiences vary greatly between transgender and gender nonconforming (TGNC) people who may identify inside or outside the gender binary, they are often addressed and discussed together in popular literature with little emphasis placed on their differences.

The current population of NGNC people is unknown, but in recent years more people seem to be identifying overall as TGNC, with some reports up to 1,600 individuals per 100,000 people (Deutsch, 2016a). With this growing population, the demand for specialized healthcare is also growing, but clinics and health centers are not changing to meet this demand. In a survey performed by the National Center for Transgender Equality and the National Gay and Lesbian Task Force, of 6,436 TGNC people 19% of respondents reported being outright denied healthcare from doctors or other healthcare providers due to their identity as TGNC (Grant et al., 2011). In this same survey, 28% of respondents reported being verbally harassed at a medical facility, and 2% reported being physically assaulted in a doctor’s office (Grant et al., 2011). One participant described an experience in which they
were forced to undergo a pelvic exam despite only going to the doctor for a sore throat. Furthermore, the doctor invited others into the room during the exam and let them look at the participant while talking about their genitals (Grant et al., 2011). These experiences can make a place as vital as the hospital feel like a hostile environment to TGNC individuals who are looking for care, especially gender-affirming care.

Gender-affirming care is made up of practices and procedures that are meant to respect and assist TGNC people as they transition physically or socially to their affirmed gender, or their gender identity. One of the most common first steps in TGNC individuals’ transition is receiving hormone replacement therapy (HRT), which is often the supplementation of cross-sex hormones. For example, a transgender man who was assigned female at birth (AFAB) may receive testosterone shots in order to masculinize his body (Deutsch, M. B., 2016c) and a transgender woman who was assigned male at birth (AMAB) may receive estrogen in order to feminize her body (Deutsch, M. B., 2016d). Other procedures are more extreme and more permanent, including top surgery, in which the breast tissue is removed or augmented; bottom surgery, which can include vaginoplasty, phalloplasty, and metoidioplasty, in order to alter the sex organs to a physical presentation that is more validating of their identity; and aesthetic procedures like facial feminization/masculinization, which changes the facial structure to look more like their desired gender (Deutsch, 2016b; Chen et al., 2019). With all of these options, the most commonly accepted path to transitioning is receiving HRT, then top surgery, and then bottom surgery—but this norm becomes an issue for NGNC people who do not wish to transition to the “other” binary gender (Clark et al., 2018, p. 159). Many NGNC people do not want to undergo procedures to achieve the idealized “total” transition and would rather pick and choose among the different procedures to affirm their gender.

Decisions regarding transition opportunities differ for adolescents versus adults, particularly in the ability to give informed consent to receive procedures. Many TGNC adolescents are not old enough to give consent to receive transitional care, so they must rely on their
guardians who may have different opinions on their transition (Kimberly et al., 2018). On the other hand, TGNC adults are able to give informed consent without consulting their guardians and generally have more control over the professionals they see and the procedures they choose to undergo. The other difference between opportunities for adults and adolescents is related to preventative measures. Much of the current transition procedural norm comes from “reversing” the effects of puberty: removing the development of breasts, undergoing facial feminization, and going through other similar procedures. However, pre-pubertal TGNC youth have the option to start puberty blockers, which are gonadotropin-releasing hormone agonists (GnRH agonists), to prevent the development of these secondary sex characteristics (Kimberly et al., 2018). This is an option that is not available to most adult and older adolescent TGNC people because they have already gone through puberty (Puckett et al., 2017). This has created a conversation about whether puberty blockers should be made widely available for TGNC adolescents, or if underage people should be forced to develop as typical and then have the option of procedures to alter or reverse the effects of puberty.

Despite the growing NGNC population and the types of issues mentioned prior, information about the actual needs and experiences of these individuals is not widely available. I will analyze and discuss the current research on gender-affirming healthcare practices available to adolescent and adult NGNC individuals, and the subjective experiences of NGNC people navigating the healthcare system as seen through their interactions with family members and healthcare professionals. This includes differences in experience between minors and adults, family and friend support systems, further discussion of puberty blockers, violence and perceived ignorance in a clinical setting, and self-treatment. I will also discuss the limitations in the current research and implications for future research and policy.

**Methods**

I accessed the material from three databases—PsycInfo (EBSCO), Medline (EBSCO), and Scopus (Elsevier)—using the following keywords: nonbinary or non-binary or “non binary” or
genderqueer or “gender queer” or “gender fluid” or genderfluid or “gender nonconforming” or “gender nonconformity” or gender-nonconforming, and healthcare or “health care” or hospital or “health services,” and gender-affirming or “gender affirming.” Many of the articles included information on binary transgender people, but where possible, I attempted to only use results from nonbinary or gender nonconforming participants. In cases where the source included information on both binary and NGNC people, only the information about NGNC participants will be included. I restricted inclusion to articles written in the English language between 2009 and 2019 and focusing on North American NGNC youth. This left 11 articles, which were then further narrowed to five based on content relevant to NGNC individuals.

Results

**Adolescent and Adult Comparisons**

The experiences of adult and adolescent NGNC people can be very different. Adults have autonomy to seek out healthcare on their own but may not be able to receive care for many reasons. Clark et al. (2018) conducted a study that included a group of older youth between the ages of 19 and 25. Interestingly, this group—all of whom were legal adults—reported forgoing medical care at nearly twice the rate of the younger (aged 14–18) individuals. One reason for this was because of poor familial relationships. In another study by Goldberg et al. (2019), a nonbinary participant responded that they could not obtain healthcare because they did not have a support network to care for them during recovery. Lack of support is an often-cited barrier, with one youth stating that “[their] dad would never allow it” (Clark et al., 2018, p. 164). Though family support is more often a barrier for NGNC adolescents, for reasons mentioned later in this literature review, it can also greatly impact NGNC adults who are not financially secure or would be unable to care for themselves after a procedure. Another major reason for inability to receive care, or choosing not to, is that many NGNC people report being disregarded by healthcare professionals when they speak about pursuing transitional procedures.
Though NGNC adults have the legal right to request and consent to certain methods of care, they are likely to be outright denied the care that they request or be belittled and distrusted (Goldberg et al. 2019). In contrast, adolescents have to seek out healthcare with their guardians, unless they turn to self-treatment, such as buying hormones off the Internet or attempting silicone injections on their own (Kimberly et al., 2018). Self-treatment can be very dangerous but is popular in TGNC people who are younger or of a lower socio-economic class. The topic of self-treatment will be further discussed later.

In the U.S., guidelines on whether a minor can access healthcare without parental consent varies from state to state (State Laws on Minor Consent for Medical Care, 2019). Due to this, many TGNC youths lose autonomy or control in their own health care, which can be problematic for youth with unsupportive parents as they will remain unable to receive any transitional care until they are of a legal age. The lack of a supportive and stable family environment greatly affects access for youth. Situations such as homelessness, being in government custody, or a lack of familial support for gender transition goals can all prevent NGNC youth from accessing the different transitional procedures that they need (Clark et al., 2018). Circumstances such as these often prevent NGNC youth from accessing most treatments because they are unable to receive parental consent. For some procedures, many places throughout Canada and the United States have lower ages of informed consent for healthcare, but the regulations are inconsistent. In Canada, most provinces and territories allow youth to consent to healthcare from age 14 (Clark et al., 2018), though many people have gone through puberty by the time they are 14—negating the option for preventative measures—while in the United States each state has their own policy surrounding informed consent, resulting in an inconsistency in treatment access (State Laws on Minor Consent for Medical Care, 2019). Due to this, finding treatment as an NGNC youth can be challenging.

NGNC youth have the opportunity to access a transitional method that is not available to older NGNC persons. Puberty suppression is a transition method that is only effective in very young NGNC people.
because once puberty has taken place, it cannot be reversed through hormones. Puberty blockers can be useful for transition, but the long-term effects are not well known, and there are few studies available on the topic (Kimberly et al., 2018). On the other hand, suppressing puberty can allow people who are questioning their gender more time to explore their gender identity before any permanent changes to their bodies occur. This also means that if someone decides to further transition to a gender other than their assigned gender at birth, there are often less procedures needed to remove or alter secondary sex characteristics (Kimberly et al., 2018). A major obstacle to the use of puberty blockers is that there is little information about the long-term mental and physical effects of stalling the development of the body. Because of this, informed consent comes into play when deciding at what point an adolescent can be allowed to go through puberty suppression. Currently, there is a discussion about the ethics in deciding whether a youth is making an informed choice, or if they are acting on a whim when making a life-altering decision (Kimberly et al., 2018).

Further issues come with a lack of access. Even in cases where, theoretically, a youth could gain use of puberty blockers, many people cite issues of limited access (Kimberly et al., 2018; Clark et al., 2018). This forces many NGNC people to go through the pubertal changes of their assigned sex, making transitioning in the future more complicated (Clark et al., 2018). In the case of adults, puberty blockers were often something that many participants saw as a missed opportunity—either because they understood their gender identity after puberty took place, or because they did not know it was an option for them (Puckett et al., 2017). Research indicates that puberty suppression is an opportunity that many wished they could have taken advantage of but were unable to (Puckett et al., 2017; Clark et al., 2018). There is a popular aphorism that states that an ounce of prevention is worth a pound of cure, and in the case of NGNC people, that belief holds true. For many NGNC adults, access to puberty suppressants in their youth could have prevented the much more invasive transitional methods they used later in life.
Qualitative Experiences

Positive Experiences

Throughout the literature, there were very few mentions of positive experiences within gender-affirming care. The good experiences were typically minor, such as others’ use of the correct pronouns and education on different gender identities that made NGNC patients feel welcomed and understood. Goldberg et al. (2019) conducted a study in which one participant said their provider understood the idea that gender can be fluid and would check with the participant every once in a while to know whether their name or pronouns had changed. Experiences as simple as this were enough to make healthcare experiences positive for many NGNC people. Unfortunately, only 16.66% of the respondents in this study endorsed any positive experiences with mental health professionals.

Negative Experiences

The experiences within healthcare relayed by NGNC respondents were overwhelmingly negative. Many of the experiences overlapped with the major issue being disrespect for important parts of NGNC identities, such as pronouns. This disregard can be intentional or due to ignorance about the topic. In a study by Puckett et al. (2017), one genderqueer participant described their experience with a trans-specialized provider who did not understand the patient’s desire to receive testosterone HRT without identifying as male or taking it in a dosage or regimen that is not standard to the practice. In this case, the patient felt as though they had to educate their healthcare provider on things that they, as a trans-specialized healthcare professional, should have known. Many TGNC people have reported feeling especially alienated by providers who should have been the best resource for them (Lykens et al., 2018). Misunderstanding NGNC identities, even with good intent, can be just as damaging. Often, healthcare providers will endorse or offer procedures that the patients neither asked for nor wanted, usually because the procedure was seen as the next obvious step in a binary transition (Lykens et al., 2018). According to Clark et al. (2018), NGNC participants were
Experiences of Nonbinary and Gender Nonconforming Individuals

less likely to have a family doctor, and if they did, the doctor was less likely to understand their trans experience (p. 164). In research by Puckett et al. (2017), a genderqueer participant reported that there was very little information available to those who wanted treatment that was not standard in a transition to the other binary sex. All of these experiences express a lack of knowledge about and resources for NGNC people, including how their needs may differ from binary trans peoples’ needs.

Willful ignorance on the part of the medical provider can be even more alienating. Goldberg et al. (2019) discuss experiences with therapists who emphasize the gender binary or have narrow definitions of what it means to be transgender. This behavior can be invalidating and harmful for NGNC people as some have reported that they have been abused or belittled because of their identity. One genderfluid participant said that a mental healthcare provider suggested that they discontinue hormone therapy and live life as a woman, rather than their affirmed identity (Goldberg et al., 2019). Another agender individual said they met with a therapist who kept on using the phrase “inner little girl” when talking about them, rather than a gender-neutral phrase like “inner child” (Goldberg et al., 2019, p. 20). This participant also referenced other therapists who refused to use they/them pronouns and insisted on referring to the participant with the incorrect she/her pronouns (Goldberg et al., 2019). These negative experiences were reflected across the literature. In the study by Puckett et al. (2017), a nonbinary participant said that they were unable to find a healthcare provider that would discuss their body and chest in the context of their nonbinary identity, and a genderqueer person said that many mental healthcare providers they encountered would only allow binary trans people start HRT because the requirements for approval were heavily based in binary ideals.

One of the most common barriers for NGNC youth is finding a doctor that will prescribe hormones (Clark et al., 2018). NGNC youth have reported twice the odds of experiencing barriers to hormone therapy than binary youth (Clark et al., 2018, p. 164). In one study, a genderqueer participant said that they were told that they were too young to know what they wanted, despite being of legal age (Puckett et al., 2017). All of these instances indicate a pattern of healthcare
professionals’ outright dismissal of the healthcare needs and wants of NGNC people, simply because they identify outside of the gender binary.

Healthcare providers have also, in some cases, insisted that NGNC youth’s mental health issues stem from their gender identity (Goldberg et al., 2019) rather than understanding that one’s mental state can be attributed to several different aspects of life. Participants in the study by Goldberg et al. (2019) indicated that professionals, and especially psychiatrists, were “skirting around” (p. 21) the topic of gender, avoiding speaking about it even when the participants addressed it directly. Other college-age participants reported having supportive and understanding therapists, but less knowledgeable on-campus healthcare professionals who repeatedly misgendered them or made inaccurate assumptions about their gender and identity. NGNC students in this study reported more misgendering by counseling and health professionals compared to binary students. These experiences suggest a discipline-wide pattern of disregard and lack of respect for people who identify outside the binary.

Self-Treatment

Those NGNC individuals who have had negative experiences with healthcare providers have reported resorting to alternative methods of treatment. In the interviews performed by Lykens et al. (2018), many participants reported modifying their treatment without discussing it with their care providers because they believed that the regimen given by the care provider would not achieve the transition they desired. The adult respondents reported their ability to modify their treatment without their physician knowing (Lykens et al., 2018), using methods such as administering smaller or larger doses than recommended and changing the schedule of administrations. Similarly, many trans people turn to illicit hormones and self-administration (Lykens et al., 2018). This is dangerous for several reasons, including the possibility that the hormones are poor quality or toxic, the inappropriate administering of doses, and a lack of professional guidance. This can also lead to contracting hepatitis C and HIV from needle sharing. Despite all of the risks of HRT self-treatment, it is a widely reported practice (Kimberly et al., 2018).
These results illustrate that best practices in the medical sphere are supported by education, access, and acceptance. Each negative experience was due to a lack in one or more of these categories. Poor access to HRT and puberty suppressant, medical professionals misunderstanding and disregarding NGNC patients, and parents refusing their NGNC children support throughout transition were the most commonly reported categories. Additionally, NGNC persons are frequently put in harmful positions, ranging from self-administration of controlled medication to physical abuse from medical professionals. Positive experiences included simple things such as respecting one's chosen name and pronouns. Such experiences were also provided at a fraction of negative experiences, suggesting that these experiences are also much rarer in the greater population.

Discussion

Limitations

The two most common ways that information was gained came from face-to-face interviews with NGNC individuals and online surveys distributed throughout different LGBTQ resource centers and pages online. Due to this, the types of data gathered are limited to personal accounts, and thus, are almost entirely subjective—making the conclusions drawn from each study ungeneralizable to most other populations or contexts.

The greatest limitation to this literature review was the lack of information about NGNC people specifically. After inclusion criteria, as noted prior, only five articles actually focused on the treatment and experiences of NGNC people. Many of the other articles were broadly about TGNC healthcare, but they showed greater emphasis on treatment for those with binary identities—often just mentioning NGNC people under the TGNC umbrella and never discussing their unique challenges. Further limitation came from the samples in the studies included, which were overwhelmingly white and AFAB. Of the 10 people interviewed by Lykens et al. (2018), eight were AFAB, two were AMAB, and half were white. Similarly, in Puckett et al. (2017), 78.9% of participants were white and 70.3% were AFAB. Furthermore, only 35.2% of the participants were NGNC; even within
an article that addresses NGNC challenges specifically, they are still a minority. These limitations should prompt further research into NGNC identities and how NGNC people experience something as vital as healthcare.

**Conclusion**

Healthcare is a vital resource for many people, and it is important that the system be effectively utilized by all types of people in order for them to maintain a healthy and happy lifestyle. Nonbinary and gender nonconforming people especially need the healthcare system to be a viable resource for them due to their life experiences outside the gender binary. In this literature review I intended to examine the ways that NGNC people experience the healthcare system, and how that may intersect with their age. Despite the limited amount of information available about NGNC people, the studies included in this literature review described overwhelmingly negative stories and experiences from many different NGNC people across North America, with only a small number of research participants relaying positive experiences. There is further understanding gained when looking at the intersection of age and gender identity, which highlights the restrictions placed on NGNC adolescents specifically, and how NGNC adults are affected in unexpected ways. Despite all of the information laid out in this document, there is still a need for further research into NGNC people, especially in regard to developing a system of best practices when providing care for gender minorities.

**References**


Experiences of Nonbinary and Gender Nonconforming Individuals


The Etiology of MDD in Sexual Minority Youth and Its Implications for Treatment

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Abstract

Greater tolerance and understanding of homosexuality, transgenderism, and other forms of gender nonconformity have sparked an increased effort to reach out to and help sexual minorities (i.e., groups whose sexual identity, orientation, or practices differ from cisgender heterosexuality), especially those who experience mental health challenges. Despite immense progress in society, deeply rooted social stigma, prejudice, and discrimination have often left sexual minorities feeling bullied, ostracized, and isolated, which tends to reinforce a host of negative mental health outcomes, such as increased risk of major depressive disorder (MDD) and suicidality (Hatchel et al., 2018). While mental health clinicians have become increasingly aware of hardships faced by lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals (particularly youth), they have yet to implement customized therapeutic approaches that cater to the unique circumstances and experiences of LGBTQ individuals (Painter et al., 2018). Treating depression in sexual minorities the same as depression in cisgender heterosexuals tends to be less effective and should be replaced by a more social, relationship-focused approach (Willging, Salvador, & Kano; Painter et al., 2018). Future research should focus on identifying and testing novel therapeutic orientations in an effort to help LGBTQ individuals with MDD to develop and strengthen meaningful relationships in their lives.
According to a large-scale census survey of over 2,500 lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, 31% reported having current symptoms of major depressive disorder (MDD); four times greater than the prevalence in the general population (National Institute of Mental Health, 2017; Yarns, Abrams, Meeks, & Sewell, 2016) (see Figure 1). According to the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-V), MDD is characterized by a depressed mood or a loss of interest/pleasure, along with at least four of the seven following symptoms: significant weight fluctuation, sleep disturbances, feelings of worthlessness, psychomotor agitation, loss of energy, concentration disturbances, and recurrent thoughts of death or suicide (American Psychiatric Association, 2013). Because MDD is such a prevalent disorder, researchers and mental health clinicians are currently seeking to better understand its etiology in hopes of alleviating the pain and suffering it causes in so many.

Research to better understand MDD among sexual minorities, (i.e., any group whose sexual identity, orientation, or practices differ from cisgender heterosexuality), along with societal efforts to reduce discrimination and stigmatization, have significantly grown in recent decades. As a result, a large body of research demonstrates that the LGBTQ community reports significantly higher levels of peer-victimization, discrimination, and thoughts of suicide, along with lower levels of self-acceptance than heterosexuals (Drescher, 2015; Hatchel et al., 2018; Roi et al., 2016). However, less research examines the effectiveness and quality of therapeutic treatments specific to LGBTQ individuals. In order to provide the most effective treatment methods for LGBTQ youth with MDD, mental health clinicians must consider and understand important factors that make this community unique.

In the general population, MDD occurs more commonly among members of the same family, with a prevalence about three times greater among first-degree relatives (Lyons & Martin, 2014). However, the etiology of MDD among the LGBTQ community does not appear to be as genetically rooted. According to Hatchel et al. (2018), peer-victimization, bullying, and feelings of loneliness among LGBTQ
youth generally precede symptoms of depression. Diamond et al. (2011) also found that a loving, nurturing, and accepting relationship between LGBTQ youth and their parents strongly predicted decreased depressive symptoms and suicidal behavior. Findings like these suggest that negative factors around one’s relationships and social environment significantly contribute to MDD among the LGBTQ community, especially during adolescence.

Understanding that social and relational influences have a greater influence on MDD in the LGBTQ community than in the general population, mental health clinicians must avoid the tendency to view all patients with a universal sameness or blanket approach. Willging et al. (2006) reported that mental health clinicians’ attempts to treat sexual minority patients with the same therapeutic approach as heterosexual cisgender patients had negative effects on LGBTQ patients. Although mental health clinicians have historically treated mood disorders equally across varying sexual orientations and gender identities, LGBTQ youth would benefit from more customized, relationship-focused therapy, because key biological, psychological, and social differences in the etiology and course of MDD may necessitate a unique therapeutic approach in the LGBTQ community.

Biological Differences

Within the last half century, mental health professionals and scientists have developed a significant body of evidence demonstrating the neurobiological etiology of MDD. Although researchers have yet to identify significantly associated genes with depression, it has become increasingly clear that MDD is heritable, or genetically predisposed, with estimates of heritability ranging from 32% to 41% (Kaufman, 2018). This means that the origin of MDD in an individual’s life may be explained, on average, by 32% to 41% of that person’s genetic makeup. MDD is also largely influenced by hormonal and neurotransmitter levels in the nervous system. The influential monoamine hypothesis suggests that depression may be caused by a deficiency in monoamine neurotransmitters in the brain (Lyons & Martin, 2014). Many researchers have also underscored the
important role of the hypothalamic-pituitary-adrenal axis (HPA axis) in MDD (Lyons & Martin, 2014). For example, Cushing’s Syndrome, a disorder resulting from abnormally high levels of HPA-related hormones, especially cortisol, is associated with an increased risk for depression (Lyons & Martin, 2014). Also, many studies suggest that blood-cortisol levels are significantly elevated in depressed patients (Benca & Peterson, 2008). While it is difficult to identify whether neurobiological, genetic, and hormonal factors precede or co-occur with MDD, all appear to play key roles in the formation and maintenance of the disorder.

**Genetic Factors**

With decades of evidence confirming the significant heritability of MDD, some may assume that LGBTQ individuals who experience MDD have similar genetic vulnerabilities. However, there is little to no evidence suggesting that genetic risks associated with MDD predict identifying as a sexual minority any more than such risk would predict depression in non-LGBTQ individuals (King et al., 2008; Diamond et al., 2011). In other words, people who experience significant genetic predispositions toward MDD are not more likely to identify as a sexual minority. Conversely, nothing about the genetics commonly associated with sexual minorities necessarily predicts a predisposition for MDD, which may explain (in part) why homosexuality was removed from the DSM-II as a psychiatric disorder in 1973 (Drescher, 2015). In support of this evidence, King et al. (2008) suggested that lesbian, gay, and bisexual (LGB) people may be at a higher risk for MDD because of institutionalized prejudices, social exclusion and victimization, and internalized feelings of shame and guilt about their sexual identity, not because of genetic vulnerabilities. The National Alliance on Mental Illness (2009) further confirmed that the increased risk of MDD among the LGBTQ community is strongly associated with social rejection, isolation, and internal lack of acceptance. Thus, while it is true that an individual could simultaneously identify as LGBTQ and have an increased genetic predisposition for MDD, it is unwise to causally link genetic risks of depression with disproportionately high rates of MDD among sexual minorities.
Hormonal Factors

Benca and Peterson (2008) explained that hormonal dysregulation often plays a role in MDD. They estimated that approximately half of those with MDD show some kind of abnormality in the HPA system, usually by having elevated levels of cortisol in the blood (Benca & Peterson, 2008). Because LGBTQ youth often experience inordinate amounts of stress compared to their heterosexual peers (Lewis et al., 2003), their HPA activity may be higher than normal, which could contribute to hormonal dysregulation commonly associated with MDD. In addition to cortisol, various sex hormones have been implicated in increased risk for MDD, especially estrogen (Lyons & Martin, 2014). Because mood disorders are more common in females, researchers have speculated that estrogen could play a key role in regulating mood by affecting neurotransmitter function (Steiner et al., 2003). And because hormonal imbalance seems to play a role in the formation of gender identity and sexual orientation among the LGBTQ community (Cousino et al., 2014), abnormal levels of estrogen and testosterone could be linked with a greater risk of developing MDD. However, because hormonal levels fluctuate in both men and women, evidence linking hormonal dysregulation in sexual minorities with increased risk of depression is inconclusive and minimal (Cousino et al., 2014). In fact, many researchers believe that gender or sexual nonconformity, in and of itself, does not increase risk of depression (Drescher, 2015), continuing to affirm that social rejection and discrimination are the main predictors of MDD among sexual minorities.

Psychological Differences

Because members of the LGBTQ community identify as gender or sex variant and are nonconforming with culturally defined identities and expectations (Cousino et al., 2014), psychological issues such as feelings of loneliness, poor self-esteem, and internalized homonegativity (i.e., homophobic feelings about the self), are very common (Lewis et al., 2003). These challenges often stem from and are exacerbated by peer-victimization, lack of family acceptance, and social rejection (Painter et al., 2018). As members of the LGBTQ
community, particularly youth, continue to experience mistreatment from others and societal marginalization, heightened risk of suicidality and depression become serious mental and physical health concerns that demand increased clinical attention (Kelleher, 2009).

**Suicidality**

According to Painter et al. (2018), youth who experience high levels of LGBTQ-specific victimization are around 5.6 times more likely to attempt suicide. Similarly, another study indicated that sexual minority youth were 6.2 times as likely to have ever attempted suicide, and 5.4 times more likely to report suicidal ideation than their heterosexual counterparts (Painter et al., 2018). However, youth simply identifying as LGBTQ does not cause suicidality in and of itself (Ryan et al., 2009). Many researchers have found that peer victimization and lack of familial acceptance increase the risk of suicidality dramatically (Ryan et al., 2009). For example, Diamond et al. (2011) reported that LGB young adults who reported high levels of family rejection were over eight times more likely to have attempted suicide in the past six months than LGB youth who reported low levels of family rejection. In support of this finding, Burton et al. (2013) found that peer-victimization and bullying were almost always present with suicidality in a longitudinal study of LGBTQ youth. Mental health clinicians must constantly keep in mind not only the high prevalence of suicidal ideation and attempts among LGBTQ adolescents but the specific social, and relational reasons that underlie this phenomenon.

**Internalized Homonegativity**

Along with disproportionately high rates of suicidality, LGBTQ youth also experience high levels of homonegativity. This often manifests itself in a lack of self-acceptance along with feelings of intense shame, guilt, and self-hatred (Lewis et al., 2003). Similarly, Hatchel et al. (2018) emphasized the reciprocal and overlapping interaction between the individual and their environment, explaining that external messages conveying a lack of acceptance from peers and/or loved ones may lead to the internalization of automatic negative thoughts by the individual (see Figure 2). According to Lyons
and Pepping (2017), these automatic negative thoughts primarily consisted of internalizing and accepting others’ stigmas as being true, which often led to a concealment of sexual identity and greater fear about coming out. In a longitudinal study of gay-identifying individuals, researchers found that low levels of psychological and emotional support in adolescence predicted increased internalized homonegativity and sexual identity concealment (Lyons & Pepping, 2017). In line with this, Lewis et al. (2003) also showed that LGB-related stress and discrimination independently predicted depressive symptoms among LGB individuals, making them 2.5 times more likely to have clinical depression than the general population (Painter et al., 2018). Consistent ostracism, bullying, and lack of acceptance, therefore, may generate and reinforce chronic feelings of self-hatred, guilt, and shame, exacerbating symptoms of MDD among LGBTQ youth.

**Self-esteem**

Closely related to internalized homonegativity, LGBTQ youth who experience homophobic stigma and victimization also demonstrate decreased levels of self-esteem and confidence (Hatchel et al., 2018) (see Figure 2). In a sample of 300 self-identifying LGBTQ youth, Kelleher (2009) found that homophobic bullying and harassment predicted an increase in symptoms of MDD and a decrease in levels of self-esteem. According to the minority stress theory, as self-esteem decreases because of social stigma, prejudice, and discrimination, general performance on academic and extracurricular tasks suffers (Hatchel et al., 2018). During adolescence, a stage in life where positive self-image is particularly important, sexual minority youth are vulnerable to experiencing lower levels of self-esteem, which likely intensifies symptoms of MDD (Kelleher, 2009).

**Social Differences**

LGBTQ youth report significantly higher rates of sexual harassment peer victimization, and lack of family acceptance than heterosexual youth (Hatchel et al., 2018). These trends may contribute to negative mental health outcomes, especially a high prevalence of MDD and suicidal thoughts/behaviors (Boza & Perry, 2014).
Throughout decades of studying MDD among sexual minorities, researchers have shown that gender nonconformity of any kind does not, in and of itself, produce depressive symptoms and suicidality (Painter et al., 2018; Ryan et al., 2009). Instead, LGBTQ-specific victimization and mistreatment from friends, family, or both, seem to be the greatest predictor of MDD among LGBTQ youth.

**Peer Victimization**

School environments have often been places where bullying, ridiculing, and teasing are common. As a socially stigmatized minority, most LGBTQ youth have been victims of such behaviors and have suffered serious mental health challenges as a result. Hatchel et al. (2018) reported that 64.4% of LGBTQ youth experienced sexual harassment at least once, significantly higher than the prevalence of the general population. About half of these LGBTQ youth reported being victims of unwelcomed sexual comments, jokes, or gestures, with a third of them reporting homophobic slurs as the most distressing event they had ever experienced at school (Hatchel et al., 2018). Such treatment may lead to feelings of isolation, lack of belongingness, decreased self-esteem, increased levels of depression, and higher risks of suicide (Kelleher, 2009). Thus, many researchers believe that peer victimization precedes and contributes to the onset of MDD in many LGBTQ youth (Hatchel et al., 2018; Painter et al., 2018). To support this notion, Hatchel et al. (2018) and Painter et al. (2018) have shown that sexual minorities who report increased feelings of school belongingness and peer acceptance do not experience depressive symptoms and suicidality nearly to the degree that bullied and victimized sexual minorities do. These findings suggest that social and relational factors, especially at school, have profound implications on the etiology and course of MDD among LGBTQ youth.

**Familial Acceptance**

Although most parents become increasingly accepting of their child’s sexual orientation over time, Diamond et al. (2011) found that approximately thirty-five to forty percent of one parental sample either outwardly rejected or were inwardly intolerant of their child.
Some maintained their rejecting stance for years, particularly those who saw gender nonconformity and untraditional sexual orientation as immoral or conflicting with religious beliefs (Diamond et al., 2011). A lack of tolerance and acceptance in a relationship as proximate and intimate as parent-child can have severely negative effects on the mental well-being of LGBTQ youth (Ryan et al., 2009). In a study of gay male adolescents, researchers found that half of the participants attributed their past suicide attempts to problems with family members (Remafedi et al., 1991). More recently, another team of researchers found that sexual minority young adults who reported high levels of family rejection were over eight times more likely to have been suicidal in the past six months and four times more likely to suffer from MDD, compared to sexual minorities who reported low levels of family rejection (Ryan et al., 2009). The importance of accepting, nurturing, and loving familial relationships with sexual minorities cannot be overstated. Contrary messages of disapproval, disappointment, and rejection often leave LGBTQ youth feeling alone, hopeless, and isolated, increasing risks of depression and suicidality.

**Conclusion**

While genetic and hormonal factors have important implications on risk for depression, there is little to no evidence suggesting that gender nonconformity and nontraditional sexual orientation alone increase the risk of depressive symptoms and suicidality. Instead, a vast and replicated body of research suggests that peer victimization and family rejection induce and exacerbate feelings of homonegativity and low self-esteem, which drastically increases risk of suicidality and depression (Hatchel et al., 2018). Therefore, traditional antidepressants coupled with conventional forms of psychotherapy may not sufficiently address the social and relational factors of MDD among sexual minorities.

Researchers are beginning to suggest that mental health clinicians should focus primarily on peer and family relationships when treating LGBTQ youth with mood disorders. For example, Diamond et al. (2011) found that family-focused therapy, which seeks to target and strengthen family relationships, significantly decreased...
levels of depression and suicidality in LGBTQ youth. Similarly, Painter et al. (2018) found that increasing the focus on social support in therapy acts as a safeguard for both depression and suicidality. Thus, a therapeutic focus on important peer and family relationships of sexual minority youth appears to have promising implications for future mental health outcomes among the LGBTQ community.

Mental health clinicians must focus on the specific needs and circumstances of their LGBTQ patients by focusing their prevention and treatment efforts on bolstering and strengthening the quality of important relationships (Painter et al., 2018). Recognizing that MDD among LGBTQ individuals is often exacerbated by social and relational wounds, therapists should seek to help bind these wounds through social and relational healing. There is an urgent need for future research evaluating and developing specific treatment methods that can accomplish this goal. Despite remaining uncertainties about the most optimal treatment methods for LGBTQ youth with MDD, making large-scale societal changes about how marginalized groups like the LGBTQ community are treated, accepted, and loved will perhaps have more immediate power than anything else.

References


The Etiology of MDD in Sexual Minority Youth


