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Dissociative Experiences during Sexual Behavior among a Sample of Adults Living with HIV Infection and a History of Childhood Sexual Abuse

Nathan B. Hansen, PhD¹, Lauren J. Brown, MA², Elizabeth Tsatkin, BS, BA¹, Brittany Zeligowski, MA¹, and Vienna Nightingale, PhD⁴

¹Department of Psychiatry, Yale University School of Medicine, New Haven, CT, USA

²Department of Psychology, University of Hartford, Hartford, CT, USA

⁴Yale School of Public Health, Yale University School of Medicine, New Haven, CT

Abstract

Little attention has been given to the occurrence of dissociative symptoms during sexual behavior in adults who have experienced childhood sexual abuse (CSA). For this study, 57 adults living with HIV infection who had experienced CSA and were entering a treatment study for traumatic stress completed study assessments and clinical interviews, including a 15-item scale of Dissociative Experiences during Sexual Behavior. Predictor variables included DSM-IV-TR diagnoses of PTSD and Dissociative Disorders, Rape by an Intimate Partner, Duration of CSA, Number of Perpetrators of CSA, and Current Sexual Satisfaction. A multiple regression analysis was conducted to identify significant associations between predictors and dissociation during sex. Mean differences by clinical diagnosis were also examined. Results indicated that PTSD, Dissociative Disorders, Rape by an Intimate Partner, Duration of CSA, and Number of Perpetrators of CSA were associated with increased dissociation during sexual behavior. Dissociation during sex likely increases vulnerability to sexual revictimization and risky sexual behavior. Standard behavioral prevention interventions may be ineffective for sexual situations when dissociation occurs, and prevention efforts should be integrated with mental health care for those who have experienced CSA.

Keywords

Childhood Sexual Abuse; Dissociation; sexual behavior; HIV infection

Introduction

Adults with histories of childhood sexual abuse (CSA) have relationships marked with greater discord and conflict, poorer communication, less satisfaction, and higher rates of

Address all correspondence to: Nathan B. Hansen, The Consultation Center, Department of Psychiatry, Yale University School of Medicine, 389 Whitney Avenue, New Haven, CT 06511. Phone: 203-789-7645. Fax: 203-562-6355. nathan.hansen@yale.edu.

For correspondence with co-authors:

Lauren J. Brown: The Consultation Center, Department of Psychiatry, Yale University School of Medicine, 389 Whitney Avenue, New Haven, CT 06511. Phone: 203-789-7645. Fax: 203-562-6355. lbrown@hartford.edu

Elizabeth Tsatkin: The Consultation Center, Department of Psychiatry, Yale University School of Medicine, 389 Whitney Avenue, New Haven, CT 06511. Phone: 203-789-7645. Fax: 203-562-6355. elizabeth.tsatkin@yale.edu

Brittany Zeligowski: The Consultation Center, Department of Psychiatry, Yale University School of Medicine, 389 Whitney Avenue, New Haven, CT 06511. Phone: 203-789-7645. Fax: 203-562-6355. brittany.zeligowski@yale.edu

Vienna Nightingale: The Consultation Center, Department of Psychiatry, Yale University School of Medicine, 389 Whitney Avenue, New Haven, CT 06511. Phone: 203-789-7645. Fax: 203-562-6355. vienna.nightingale@yale.edu

separation and divorce (DiLillo, 2001). Further, those who experienced CSA are at a higher risk for being revictimized either sexually or physically in adulthood (Classen, Palesh, & Aggarwal, 2005; Messman-Moore & Long, 2003) and are more likely to be in abusive relationships (Carlson, McNutt, & Choi, 2003; Daigneault, Hebert, & McDuff, 2009). Sex can also trigger memories of abuse and unpleasant emotions like sexual guilt, fear of sex, sexual problems, and reduced feelings of closeness with partners (Aspelmeier, Elliott, & Smith, 2007; Davis, Petretic-Jackson, & Ting, 2001; Randolph & Reddy, 2006; Rellini & Meston, 2007; Schloredt & Heiman, 2003). These factors all contribute to reduced sexual satisfaction among those who have experienced CSA (Mullen, Martin, Anderson, Romans, & Herbison, 1996).

Some individuals who have been exposed to CSA experience dissociation during and after the abuse. Dissociation, a disruption of consciousness and the experience of reality, can occur across a number of domains (American Psychiatric Association, 2000; Butler, Duran, Jasiukaitis, Koopman, & Spiegel, 1996), including: (a) perception (e.g., derealization); (b) behavior (e.g., automatized actions, withdrawal, avoidance); (c) affect (e.g., psychological numbing); (d) memory (e.g., amnesia); and (e) identity (e.g., depersonalization). These problems can cause individuals to misinterpret situations and act inappropriately or aggressively (Dell, 2009), and greatly impact interpersonal functioning and increase relationship difficulties and intimacy disturbances (Davis & Petretic-Jackson, 2000; DiLillo, 2001).

Characteristics of CSA impact the likelihood of dissociation. It has been demonstrated that children who experience CSA characterized by higher frequency and longer duration, younger age of onset, penetration, coercive or objectifying acts, familial perpetrators, and multiple perpetrators have increased chances of dissociation in adulthood (Draijer & Langeland, 1999; Gold, Hill, Swingle, & Elfant, 1999; Kirby, Chu, & Dill, 1993; Sacco & Farber, 1999; Zlotnick, Begin, Shea, Pearlstein, & Simpson, 1994). Further, children lack sophisticated coping resources, and traumatic events combined with a lack of caretaker support can make it more difficult for children to successfully process traumatic events, leading children to try to forget or avoid the event or to interpret the event as unreal (Dalenberg & Palesh, 2004; Freyd, 1996; Gold & Seibel, 2009). Indeed, CSA creates a cascade of losses, including the ability to trust, physical safety, healthy attachment, and appropriate social and emotional development (Cloitre, Cohen, & Koenen, 2006), all of which can impact intimate relationships.

Finally, CSA has been associated with multiple risky sexual behaviors, such as early sexual activity, more sexual partners, unprotected sex, HIV and other sexually transmitted infections (STIs), early and unwanted pregnancy, and involvement in sex trade (Arriola, Loudon, Moldren, & Fortenberry, 2005; Koenig, Doll, O'Leary, & Pequegnat, 2004). Dissociation related to CSA likely contributes to sexual risk as dissociation may limit the ability to provide consent for sex or to engage in safe sexual practice (Malow, Devieux, & Lucenko, 2006; Zurbriggen & Freyd, 2004). In fact, rates of CSA among people living with HIV infection are double those observed in the general population (Sikkema, Hansen, Meade, Kochman, & Fox, 2009). Given the combination of a history of CSA and a highly stigmatized, chronic and life-threatening disease that can be transmitted sexually, people living with HIV who have experienced CSA are at increased risk to experience sexual problems, including dissociative experiences during sex.

This study sought to understand the occurrence of *Dissociative Experiences during Sexual Behavior*. Specifically, we aimed to: (a) reliably measure the extent to which adults living with HIV infection who have experienced CSA have Dissociative Experiences during Sexual Behavior; (b) identify key predictors of Dissociative Experiences during Sexual

Behavior, including abuse-related variables, DSM-IV-TR diagnoses of PTSD or Dissociative Disorders, and sexual satisfaction; and (c) identify mean differences and preliminary normative values of Dissociative Experiences during Sexual Behavior consistent with clinical diagnoses of PTSD or Dissociative Disorders.

Methods

Participants and Procedure

Participants were part of a randomized controlled psychotherapy trial for adults living with HIV who have experienced CSA. Recruitment occurred from March 2009 to November 2010, through referral from care providers and flyers posted at two HIV/AIDS specialty clinics in New Haven, Connecticut. Interested individuals completed an initial phone screening, and those over 18 years of age, living with HIV infection, and reporting a history of CSA were invited to participate in a formal screening assessment at a local community agency. CSA was defined as any nonconsensual sexual experience (sexual exposure; sexual touch; or anal, oral, or vaginal sex), or consensual sexual experience occurring with someone five or more years older than the participant if occurring at age 12 or younger or ten or more years older than the participant if occurring at age 13 to 17. The current study includes data obtained from screening and baseline interviews.

Participants signed an informed consent form to participate in the two-part screening interview, consisting of demographic questions, a trauma history, and the Structured Clinical Interview for DSM-IV (SCID; First, Spitzer, Gibbon, & Williams, 2002). Interviews were verbally administered in English and simultaneously entered into a computer assisted personal interview program (CAPI) by research assistants who were doctoral level psychologists or fourth year Clinical Psychology practicum students. Exclusion criteria included acute psychosis or mania, or cognitive impairment. Of 78 individuals screened, two were excluded due to cognitive impairment, one was excluded as she had not experienced CSA, two did not return for the baseline assessment. The 73 eligible individuals signed a second consent form to participate in the intervention study and completed the baseline interview consisting of standardized psychological and health measures. Participants were compensated \$40 for each screening interview and \$50 for the baseline interview. Twelve participants did not complete part of the baseline assessment that was added after the study was initiated, and four participants had missing data and were excluded from the current study, leaving a final sample of 57 participants. The study was approved by the affiliated institutional IRB and a Certificate of Confidentiality was obtained from the National Institutes of Health.

Measures

Dissociative experiences during sexual behavior—Due to the lack of measures assessing sexual problems experienced by individuals with histories of sexual trauma, a 42-item scale is under development in the parent intervention trial. For the current study, 15 items indicative of dissociative experiences were selected from the larger scale. Participants responded to each item using a 5-point Likert scale indicating how often the participant experiences each symptom ranging from 0 (never) to 4 (very often). All 15 items are summed into a total score, with higher scores indicating more dissociation occurring during sex. Internal consistency for the scale was good, $\alpha = .85$.

Demographic and relevant medical information—During the first screening interview, participants provided information about their age, gender, race/ethnicity, sexual orientation, relationship status, current level of sexual activity, and education. For the

current study, two dichotomous variables representing gender (male/female) and sexual orientation (heterosexual/gay or bisexual) were created and used as covariates in analyses.

Psychiatric diagnosis—The *SCID* was used to assess for current PTSD diagnosis (First et al., 2002) and a structured clinical interview based on the *DSM-IV-TR* (American Psychiatric Association, 2000) was used to assess for Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder, Depersonalization Disorder, and Dissociative Disorders Not Otherwise Specified. Two dichotomous variables were created to indicate the presence or absence of Current PTSD Diagnosis or Current Dissociative Disorder Diagnosis.

Intimate partner violence (IPV)—A structured interview on IPV experienced in current or prior relationships was conducted, collecting data on the occurrence and extent of relationship violence, including: yelling, swearing, or insulting comments; control through threats or use of force; physical aggression; deliberate destruction of personal property; and forced sexual behavior. While many (36.8%) participants had been forced to engage in sexual behavior by a current or past partner, the frequency within participants was low. Thus, a dichotomous (yes/no) variable was created to indicate the occurrence of Rape by an Intimate Partner.

Childhood sexual abuse—Information from the trauma history interview was used to create two continuous variables for the current study, Duration of Childhood and Adolescent Sexual Abuse and Number of Perpetrators of Sexual Abuse.

Current sexual satisfaction—The item “I am satisfied with my sex life” from the revised *Functional Assessment of Human Immunodeficiency Virus Infection (FAHI*; Peterman, Cella, Mo, & McCain, 1997) was used to indicate sexual satisfaction. Participants rate how true the statement was over the past seven days on a Likert scale ranging from 0 (“not at all”) to 4 (“very much”). As this variable was categorical with a bi-modal distribution, a dichotomous variable was created with scores at or below the median value of 2 (“somewhat”) indicating lack of sexual satisfaction, and scores equal to or greater than 3 (“quite a bit”) indicating Current Sexual Satisfaction.

Statistical Analysis

The statistical analysis consisted of three steps. *Step one* consisted of conducting an item and scale analysis on the items assessing Dissociative Experiences during Sexual Behavior. This included (a) evaluating the frequency of item endorsement, (b) computing the item mean and standard deviation among participants endorsing each item, (c) computing the item/scale correlation for each item, (d) conducting a preliminary exploratory factor analysis to assess the uni-dimensionality of the scale, and (e) computing the coefficient alpha for the items as a scale. *Step two* consisted of conducting a multiple regression analysis evaluating the relationships between key predictive variables and Dissociative Experiences during Sexual Behavior. *Step three* consisted of computing t-tests to evaluate the extent to which Dissociative Experiences during Sexual Behavior differentiated participants with and without DSM-IV-TR diagnoses of PTSD or a Dissociative Disorder and to identify preliminary normative ranges for means and standard deviations consistent with the presence and absence of clinical diagnoses.

Results

Sample Demographics

Participants had a mean age of 47.3 (SD=6.4), an education level of 11.9 years (SD=1.9), and were predominantly African American/Black (68.3%) and heterosexual (58.3%). About

half (46.6%) reported currently being in a relationship (mean duration of 1.4 years), and 43.1% reported currently being sexually active. Participants reported an average of 5.0 (SD=2.9) total years of sexual abuse and 2.4 (SD=1.2) perpetrators. Thirty-nine participants (68.5%) reported penetrative anal or vaginal sexual abuse. Notably, 93.0% of the sample reported past or current IPV, and 36.2% experienced rape by an intimate partner. Sample demographics by gender are presented in Table 1.

Item and Scale Analyses

As seen in Table 2, all items measuring Dissociative Experiences during Sexual Behavior were endorsed, with a frequency of endorsement ranging from six (10.5%) to 28 (49.1%) participants. Twelve items were endorsed by at least 25% of the sample, and two items were endorsed by over 40% of the sample. Mean responses among participants endorsing each item ranged from 1.47 (“Feel like you were outside of yourself”) to 2.29 (“Lose your memory for what happened”). Item/total correlations were generally good. The two items with the lowest item/total correlations were also the least frequently endorsed, and both relate to memory disturbance (“Forget where you are” and “Lose your memory for what happened”). Although the sample size is small, a preliminary exploratory factor analysis was conducted to evaluate the uni-dimensionality of the scale. A parallel analysis was conducted, comparing eigenvalues for factors extracted from study data with eigenvalues averaged across 100 randomly generated data sets created using Monte Carlo simulation. Only factors with eigenvalues greater than those resulting from random data are considered for retention. Both the scree plot and a parallel analysis suggested retaining one factor, and factor loadings for items are listed in Table 2. The scale mean for the study sample was 7.7 with a standard deviation of 7.9 and a reliability coefficient of .85.

Relationship between Dissociative Experiences during Sexual Behavior and predictive variables

Table 3 presents a correlation matrix of the bivariate associations between all study variables. Note that while gender and sexual orientation are related in this sample (men are more likely to be gay or bisexual), gender was not related to any other predictors or to Dissociative Experiences during Sexual Behavior. Heterosexual orientation was related to greater Current Sexual Satisfaction. The only other significant relationship among predictor variables was an association between Duration of Childhood and Adolescent Sexual Abuse and Number of Perpetrators of Sexual Abuse. With the exception of Current Dissociative Disorder and Current Sexual Satisfaction, all predictors were significantly associated with Dissociative Experiences during Sexual Behavior.

A multiple regression analysis was conducted to examine the simultaneous associations of key predictive variables on Dissociative Experiences during Sexual Behavior. Because Duration of Childhood and Adolescent Sexual Abuse and Number of Perpetrators of Sexual Abuse had significant overlap, these variables were summed to form a Child Sex Abuse composite variable. No other predictive variables shared significant overlap. As shown in Table 4, all four trauma-exposure and trauma-related diagnostic variables were significantly related to Dissociative Experiences during Sexual Behavior in the final model ($F(1,5) = 6.982, p < .001$) and explained 35% of the variance in Dissociative Experiences during Sexual Behavior. Current sexual satisfaction did not contribute significantly to the model.

Mean Differences in Dissociative Experiences during Sexual Behavior by Clinical Diagnosis

Table 5 presents both the number and percent of participants who met *DSM-IV-TR* diagnostic criteria for PTSD or a Dissociative Disorder, as well as means, standard deviations, and mean comparisons. The mean level of Dissociative Experiences during

Sexual Behavior was significantly higher for participants who met DSM-IV-TR diagnostic criteria for PTSD ($t=2.70$, $p=.009$) and Dissociative Disorders ($t=2.53$, $p=.014$)

Discussion

The primary goals of this study were to measure the extent to which adults living with HIV infection who have experienced CSA have Dissociative Experiences during Sexual Behavior, identify key predictors of Dissociative Experiences during Sexual Behavior, and identify mean differences of dissociation during sex based on clinical diagnoses of PTSD or Dissociative Disorders. Findings from the current study merge the fields of dissociation and sex research. This is the only study we are aware of that has examined dissociative experiences that occur during sexual behavior. Results indicated: (a) most participants reported dissociative experiences during sex; (b) both trauma-exposure and trauma-related diagnoses predicted dissociative experiences during sex; and (c) participants with DSM-IV-TR diagnoses of PTSD or Dissociative Disorders reported significantly higher levels of dissociative symptoms during sex. Findings are discussed within their research and clinical significance.

Given that all participants had a history of sexual trauma, it was expected that many participants would experience at least transitory dissociation during sex. Only 7 of the 57 participants reported never experiencing a dissociative symptom in the course of sexual behavior. Further, our data provide preliminary support for the ability of our measure to reliably assess Dissociative Experiences during Sexual Behavior, for the uni-dimensionality of this construct, as well as preliminary evidence of criterion and construct validity. For example, the scale was significantly correlated with potential criterion variables DSM-IV-TR diagnoses of PTSD and Dissociative Disorders. Further, construct validity is supported through the prediction of Dissociative Experiences during Sexual Behavior by trauma exposure variables including Duration of Childhood and Adolescent Sexual Abuse, Number of Perpetrators of Sexual Abuse, and Rape by an Intimate Partner; and by significant differences in mean scores between participants with and without DSM-IV-TR diagnoses of PTSD and Dissociative Disorders.

Consistent with other studies, sexual abuse characteristics predicted dissociation (Draijer & Langeland, 1999; Sacco & Farber, 1999; Zlotnick et al., 1994). Sexual abuse occurring over a longer duration and an increasing number of perpetrators were related with higher levels of dissociation during sex. Additionally, 53 of 57 (93.0%) participants reported IPV, including 21 (36.8%) who had experienced rape by an intimate partner, which was related to dissociation during sex. Unfortunately, due to the cross-sectional and historical nature of the data, it is not clear whether rape by an intimate partner contributes to, or results from, dissociative experiences during sex. Given the high rates of sexual revictimization among those who have experienced CSA (Classen et al., 2005; Messman-Moore & Long, 2003), an important research question is to what degree do dissociative experiences occurring with sexual behavior contribute to revictimization. In fact, dissociation has been proposed as a mediating variable between CSA and adult sexual risk behavior (Malow et al., 2006; Zurbriggen & Freyd, 2004). We suspect that many individuals who have experienced CSA dissociate shortly before or during sex, which leaves them vulnerable to sexual revictimization and risky sexual behavior. Further, it has been noted that sexual risk reduction messages may not be effective for individuals who have experienced CSA, and mental health treatment may be required for these individuals to fully benefit from standard risk reduction efforts (Briere, 2004; Kalichman, Sikkema, DiFonzo, Luke, & Austin, 2002; Sikkema et al., 2010).

Finally, this study failed to find an association between sexual satisfaction and dissociation during sexual behavior. Prior research indicates that trauma symptoms related to child abuse negatively impact relationship functioning, and this relationship was mediated by decreased sexual activity (DiLillo et al., 2009). CSA has also been linked with sexual problems and dysfunction in both men and women, contributing to relationship dissatisfaction (Davis et al., 2001; DiLillo et al., 2009). Future research should explore the role of dissociation in relationship functioning in general, and in sexual problems specifically.

It is of note that we found no differences in variables associated with childhood sexual abuse, adult intimate partner violence, and dissociation during sex by gender or sexual orientation. While our sample size is small, and thus findings should be viewed with caution due to limited power to detect underlying difference, a strength of this study is our inclusion of almost equal numbers of women and men, including equivalent proportions of gay, bisexual, and heterosexual men. To date, much CSA research has focused on women, and heterosexual men have been largely excluded. Our findings suggest that there may not be important differences by gender or sexual orientation in the occurrence or predictors of Dissociative Experiences during Sexual Behavior.

A second point of note is that our sample was comprised of individuals who are living with HIV infection. We believe that the occurrence of dissociative experiences associated with sexual behavior are probably common among people who have experienced CSA, and may well have predated and contributed to infection with HIV among participants in our sample. However, there are important factors associated with HIV infection that may limit the generalizability of these findings. For example, fear of sexually transmitting HIV or the reminder of one's own sexual exposure to HIV may heighten anxiety around sexual behavior among people living with HIV, resulting in increased dissociative experiences. Despite this, people living with HIV are an important population to consider in trauma-focused research. First, there is a high prevalence of CSA and other trauma-exposure among people living with HIV. Second, given the chronic, life-threatening nature of HIV infection, there is an ongoing need for medical care in this population, and traumatic stress can pose important complications for care. Third, HIV is transmissible through sex and injection drug use, both of which are affected by traumatic stress. Fourth, the majority of people in the U.S. living with HIV are relatively convenient to locate and recruit through HIV care settings, providing researchers' access to a population with high levels of trauma exposure and clinical need.

We note additional limitations to this study: First, this study was underpowered to examine multivariable models and potential mediating and moderating effects. Further, the infrequency of occurrence of some variables (e.g., Dissociative Disorders) limited our ability to model them effectively. Second, cross-sectional data limits our ability to make causal inferences. Third, all data was collected via self-report, and thus are subject to reporting and recall bias. Also, data was collected with an interviewer, which may further affect reporting bias. Finally, there are no existing norms for the Dissociative Experiences during Sexual Behavior scale for normative comparisons. However, our sample was diverse in gender, race/ethnicity, and sexual orientation. Diagnoses were based on structured clinical interviews, including the *SCID*, and were conducted by trained and experienced interviewers. The Dissociative Experiences during Sexual Behavior scale demonstrated good reliability and appears to have validity for measuring dissociation during sex.

Our findings emphasize the long-term negative impact of CSA on psychological and relational functioning in general (Briere, 1992), and specifically, on sexual functioning and dissociation occurring before or during sex. In fact, dissociation in relation to sex may have contributed to study participants' engagement in high risk behavior (Arriola et al., 2005) and

sexual revictimization (Classen et al., 2005), thus increasing their risk for infection with HIV. Additionally, ongoing dissociation in relation to sex could contribute to high levels of engagement in HIV transmission risk behavior observed among people living with HIV who have also experienced CSA (O'Leary, Purcell, Remien, & Gomez, 2003; Sikkema et al., 2009).

CSA also has a long-term negative impact on physical functioning and health (Irish, Kobayashi, & Delahanty, 2010). This is particularly critical for immune-suppressed populations such as people living with HIV, as they are at increased risk for the negative effects of stress (Leserman et al., 1999). Furthermore, psychological and relational functioning may also negatively impact health related behaviors such as treatment and medication adherence (Malta, Strathdee, Magnanini, & Bastos, 2008; Whetten, Reif, Whetten, & Murphy-McMillan, 2008). Therefore, it is imperative that care for individuals living with HIV include assessments for CSA, its ongoing impact on current physical, emotional, and sexual functioning, and its effect on intimate relationships. Further, evidence-based mental health interventions are needed to address CSA within the context of HIV, particularly for neglected subgroups such as people of color, men who have sex with men, and transgendered individuals.

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Table 1

Descriptive Statistics of Study Variables by Gender

Variable	Female (N=26)		Male (N=31)		χ^2
<i>Categorical Variables</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	
<i>Race/Ethnicity</i>					0.48
African American/Black	19	73.1%	20	64.5%	
White	4	15.4%	4	12.9%	
Hispanic	0	0.0%	6	19.4%	
Other	3	11.5%	1	3.2%	
<i>Sexual Orientation</i>					17.15**
Straight/Heterosexual	21	80.8%	12	38.7%	
Bi-sexual	3	11.5%	9	29.0%	
Gay/Homosexual	2	7.7%	10	32.3%	
In a Relationship, Current	14	53.8%	13	41.9%	0.81
Sexual Activity, Current	12	46.2%	13	41.9%	0.10
Current Sexual Satisfaction	15	57.7%	13	41.9%	1.41
Past or Present Intimate Partner Violence	25	96.2%	28	90.3%	0.74
Rape by an Intimate Partner	11	42.3%	10	32.3%	0.61
<i>Current Psychiatric Diagnosis</i>					
Posttraumatic Stress Disorder	16	61.5%	15	48.4%	0.75
Dissociative Disorders	3	11.5%	5	16.1%	0.25
<i>Continuous Variables:</i>	<i>mean</i>	<i>s.d.</i>	<i>mean</i>	<i>s.d.</i>	<i>t-test</i>
Age (years)	47.9	6.8	46.6	5.7	-0.75
Education (years)	11.2	1.8	12.4	1.9	2.53*
Length of Current Relationship (years)	1.5	2.4	1.3	2.3	-0.36
Duration of Child and Adolescent Sexual Abuse	5.3	3.5	4.7	2.4	-0.81
Number of Perpetrators of Child and Adolescent Sexual Abuse	2.5	1.1	2.2	1.2	-0.99
Dissociation During Sex	7.3	6.4	8.1	9.1	0.34

* Value significant, $p < .05$;** Value significant, $p < .01$.

Table 2

Frequency of Dissociative Experiences during Sexual Behavior Item Endorsement, Means and Standard Deviations among Participants Endorsing Each Item, and Item/Total Correlations

<i>^aDuring sex, how often do you:</i>	Frequency (%)	Item Mean	Item SD	Item/Total Correlation	^a Factor Loading
1. Feel spaced out?	28 (49.1%)	2.11	0.88	.48	.56
2. Forget where you are?	6 (10.5%)	1.67	0.52	.25	.29
3. Feel as if you were somewhere else?	18 (31.6%)	2.11	0.90	.34	.38
4. Forget all or part of what happened?	14 (24.6%)	2.00	0.68	.39	.44
5. Feel like you were outside of yourself?	17 (29.8%)	1.47	0.62	.63	.72
6. Become numb?	17 (29.8%)	2.18	1.07	.43	.49
7. Seem like you are watching sex happening to someone else?	6 (10.5%)	2.17	1.17	.60	.73
8. Feel like you had no control?	21 (36.8%)	1.95	0.97	.61	.69
9. Lose the ability to make decisions and just go along with whatever happened?	24 (42.1%)	1.79	0.78	.66	.75
10. Feel like someone else was controlling you from inside?	6 (10.5%)	1.83	0.75	.39	.53
11. Feel like you were in a fog and unable to think?	17 (29.8%)	2.00	0.71	.66	.76
12. Feel like you were someone else?	9 (15.8%)	2.11	0.93	.69	.78
13. Feel like your partner was someone else?	21 (36.8%)	2.00	0.89	.42	.48
14. Lose your memory for what happened?	7 (12.3%)	2.29	0.49	.21	.28
15. Become limp, like you have lost control of your muscles?	16 (28.1%)	1.56	0.51	.50	.61
<i>^bInternal Consistency</i>	.85				

Participants respond using a five-point Likert Scale with the following anchors: 0="never"; 1="once or twice"; 2="Sometimes"; 3="Often"; and 4="Very Often".

^aFactor loadings based on Varimax Rotation;

^bCronbach's Alpha.

Table 3
Bivariate Correlations between Predictor Variables and Dissociative Experiences during Sexual Behavior

Variable	1	2	3	4	5	6	7	8
1. Gender ^a								
2. Sexual Orientation ^b	<i>c</i> .424 **							
3. Current Sexual Satisfaction	<i>c</i> .157	<i>c</i> .269 *						
4. Current PTSD Diagnosis	<i>c</i> .132	<i>c</i> -.139	<i>c</i> -.087					
5. Current Dissociative Disorders Diagnosis	<i>c</i> -.066	<i>c</i> .140	<i>c</i> .108	<i>c</i> -.036				
6. Rape by an Intimate Partner	<i>c</i> .104	<i>c</i> -.012	<i>c</i> -.241	<i>c</i> .188	<i>c</i> -.099			
7. Duration of Child and Adolescent Sexual Abuse	<i>d</i> .028	<i>d</i> .017	<i>d</i> -.186	<i>d</i> .008	<i>d</i> .180	.147		
8. Number of Perpetrators of Child and Adolescent Sexual Abuse	<i>d</i> .190	<i>d</i> .252	<i>d</i> .094	<i>d</i> .055	<i>d</i> .119	.039	.629 **	
9. Dissociative Experiences during Sexual Behavior	<i>d</i> .050	<i>d</i> -.079	<i>d</i> -.208	<i>d</i> .306 *	<i>d</i> .163	.328 *	.382 **	.338 *

^aMale is coded as 0 and female as 1;

^bGay/bisexual is coded as 0 and heterosexual is coded as 1;

^cPhi coefficient or Kendall's tau;

^dSpearman's rho, all others Pearson's r.

* Value significant, $p < .05$;

** Value significant, $p < .01$.

Multiple Regression Analyses Examining the Relationship between Key Predictive Variables and Dissociative Experiences during Sexual Behavior

Table 4

Predictor Variables	B	Std. Error	Std. Beta	t-value	p
Child Sex Abuse Composite Variable	0.532	0.213	.279	2.496	.016
Rape by an Intimate Partner	3.428	1.688	.231	2.031	.048
Current PTSD Diagnosis	3.926	1.584	.273	2.478	.017
Current Dissociative Disorders Diagnosis	5.991	2.283	.291	2.624	.011
Current Sexual Satisfaction	-2.370	1.619	-.165	-1.464	.149
Model Adjusted R ² = .348					

Table 5
Comparisons of Dissociative Experiences during Sexual Behavior on Key Predictive Variables

Predictor Variables	N (%)	Mean (SD)	t-value	p
Current PTSD Diagnosis	Yes 31 (54.4%)	10.19 (9.35)	2.70	.009
	No 26 (45.6%)	4.81 (4.35)		
Current Dissociative Disorders Diagnosis	Yes 8 (14.0%)	14.00 (13.49)	2.53	.014
	No 49 (86.0%)	6.71 (6.24)		