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NEGATIVE SEXUAL EXPERIENCES AS PREDICTORS OF DEPRESSION AMONG WOMEN

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ABSTRACT
This study investigated negative sexual experiences as predictors of depression among women. A total of 107 participants comprising 62 female nurses and 45 female administrative staff of Federal Neuropsychiatric hospital Enugu using available sampling techniques were drawn for the study. Two sets of instruments were used namely; SES - Sexual Experiences Survey (Koss, Gidyez & Wisniewski, 1987); and CES-D - Center for Epidemiological Studies Depression scale (Rudloff, 1977). A cross-sectional design was adopted; while hierarchical multiple regression analysis was applied as a statistic to test the hypothesis which stated that negative sexual experiences would significantly predict depression among women. The result showed that a strong positive correlation was observed between negative sexual experiences and depression among women $r(107) = .47$at $p<.001$. Meaning the increase in negative sexual experiences would equally bring about an increase in depression among women. Further, negative sexual experiences accounted for an additional 25.5% ($\Delta R2 = 17.7\%$) variation in depression and this change in $R2$was significant, $F(10, 96) = 3.29$, $p<.001$/ and the relationship between variables were strong($R = .51$). However, only negative sexual experiences significantly and positively predicted depression $\beta = .45$, $t(96) = 4.77$, $p<.001$. It was concluded that the most important predictor of depression among women was negative sexual experiences which predicted strongly and remarkably depression among women. The findings were discussed in relation to pieces of literature reviewed and suggestions made.

Keywords: Negative Sexual experiences, Nurses, Administrative Staff, Depression and women

Background of the Study
How do memories of bad or negative sexual experiences affect our behaviours and decisions today? This question is considered more often now because so many people are choosing to come forward to disclose painful experiences they had when they were younger. Their experiences include sexual harassment, coerced sex, incest and rape. Even though we know it happens to adults and children in every segment of our society, it could still surprise us when we learn

who else has experienced it: well-known athletes, singers, comedians and actors; our neighbours' and friends; even religious, political and business leaders.

These disclosures reinforce what we know: people could be very resilient. Like many who have publicly talked about their lives, it's possible to have had negative sexual experiences. As a result, we could often overlook how these negative memories influence us daily. Reliving past painful experiences could have a wide range of impacts. They could include a fear of intimacy, difficulty trusting ourselves or others, avoiding sex or having risky sexual behaviour, negative body image, difficulty with sleep, diet, or concentration, unexplained body pain and anxious feelings. All of these effects could decrease our quality of life, sometimes preventing us from fully enjoying safe relationships, intimacies and other pleasant occasions. You could begin by considering what role the experience is playing in your present daily behaviours and decisions. You could also recognize memory patterns that may be leading to feelings that are hurting your life: shame, guilt, anger, resentment, fear, embarrassment, isolation, or depression.

Depressive symptoms are one consequence of adult/adolescent sexual victimization (ASV) and are linked to sexual health. Approximately 20% of women experience rape at some point in their lives with the majority occurring before age 24 (Black et al., 2011). Adult/adolescent sexual victimization (ASV) – defined as unwanted sexual experiences ranging from unwanted sexual contact to attempted or completed rape since the age of 14 (Abbey, Jacques-Tiura, & LeBreton, 2011) – has implications for both long- and short-term sexual health (Weaver, 2009). Sexual health is a multifaceted construct with physical (e.g., pelvic pain) and mental health (e.g., depression) components. Women with ASV histories often experience long-lasting decreases in the quality of their sexual experiences following an assault (e.g., lack of sexual desire and orgasm difficulties) and report higher rates of reproductive or other sexual health problems than non-victimized women (Weaver, 2009). Sexual assault is associated with genital burning, lubrication problems, and pain during sexual intercourse, and decreased sexual pleasure in cross-sectional and qualitative research (Letourneau, Resnick, Kilpatrick, Saunders, & Best, 1996; Perilloux, Duntley, & Buss, 2012; Postma, Bicanic, van der Vaart, & Laan, 2013; Turchik & Hassija, 2014; Weaver, 2009).

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Women exposed to gender-based violence, including ASV, have high rates of lifetime mood, depression and anxiety disorders relative to those without such exposure. Women with ASV histories are twice as likely to experience a major depressive episode following assault than women without ASV histories (Hedtke et al., 2008). Past-year depression was observed in 9.1% and 13.1% of female rape victims in national and college samples respectively (Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007). In the general population, one-third of rape victims met lifetime criteria for major depression and one in four met current criteria (Kilpatrick et al., 2007). Women with forceful sexual assault experiences have higher levels of depression than women with coercive sexual experiences and non-victims (Masters et al., 2015). Along with depressive symptoms, posttraumatic stress disorder (PTSD) or posttraumatic stress (PTS) symptoms are the most commonly observed mental health outcome of sexual assault. Posttraumatic stress symptoms are defined as symptoms consistent with the disorder, but the individual may not meet full PTSD criteria (McLaughlin et al., 2015; Stein, Walker, Hazen, & Forde, 1997). Such symptoms may be clinically significant and necessitate intervention (McLaughlin et al., 2015). Women with histories of ASV are found to have PTSD at three times the rate of women without such histories (Hedtke et al., 2008). PTSD and depression are frequently comorbid (Gros et al., 2012), although some research has found changes in PTS symptoms are associated with changes in depressive symptoms (Nickerson et al., 2013). This suggests that while PTS and depression have separate symptom constellations, PTS symptoms may include features that overlap with depressive symptoms. It is thus unclear to what extent depressive symptoms contribute unique variance to post-assault functioning.

Mental health symptoms are consistently negatively associated with sexual outcomes, including sexual enjoyment and arousal (Laurent & Simons, 2009). Depressive symptoms may contribute to post-victimization changes in sexual experiences. It is not clear whether depression is a contributor to sexual dysfunction or an outcome because depressive symptoms may both decrease the likelihood of having sexual partners and decrease quality of sex due to stress (Shindel et al., 2011). More research has investigated PTSD and PTS symptoms as negatively associated with sexual functioning (Letourneau et al., 1996; Schnurr et al., 2009). The learning model of sexual problems posits that women who experience a sexual assault are conditioned to respond to assault-related stimuli with negative feelings, including a fear response that decreases

sexual arousal and detracts from the quality of women's sexual experiences (Letourneau et al., 1996). PTSD symptoms of hyper vigilance, emotional numbing, interpersonal connection, and shames also affect sexual satisfaction, enjoyment, and functioning (Yehuda, Lehrner, & Rosenbaum, 2015).

However, negative sexual experience is an important contributor to the global burden disease called depression that affects people of communities all over the world. Psycho-biologically depression is a disorder of motivation that is usually associated with the insufficiency of biogenic amines. Depression is also referred to as a common mental disorder worldwide and a leading cause of disability with debilitating symptoms. According to Moussavi, Chatterji, & Verdes, (2007), as cited in Hamman et al (2004) around 350 million people suffer from depression globally with reports stating that almost 3.2% of individuals express having a depressive episode at least once in their lives (Costa, Santos, & Santos, 2012). Evidence has shown that the prevalence of depression is higher in negatively sexual experience individuals than in the general population.

Nevertheless, depression is a common mental disorder, characterized by persistent sadness and a loss of interest in activities that one usually enjoys, accompanied by an inability to carry out daily activities, for at least two weeks (World Health Organization, 2015). Also, people with depression often have the following manifestations: a loss of energy; a change in appetite; sleeping more or less; anxiety; reduced concentration; indecisiveness; restlessness; feelings of worthlessness; guilt, or hopelessness and thoughts of self-harm or suicide (World Health Organization, 2015). The symptoms of depression start at an early stage. They either remain persistent or increase at the alarming state, depending on the exposure to the environment and the potential capacity throughout the life of an individual, (Moussavi, Chatterji, & Verdes, 2007). Globally, the total number of people with depression was estimated to exceed 300 million in 2015 (World Health Organization, 2018). Depression occurs in every age and every country (Ibrahim, Kelly, & Adams, 2013). Depression is ranked by the World Health Organization (WHO) as the single most significant contributor to global disability (7.5% of all years lived with disability in 2015). Depression is also the major contributor to suicide deaths, which went up about 800,000 for each year (World Health Organization, 2017).

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Considering all these factors, it is assumed that women who have negative sexual experiences are at a higher risk for added marital stress, for instance, altered relationship with self, friends and families, major changes in physical and psychological wellbeing's, medical concerns, and specialized unhealthy happiness.

Behavioural Theory of Depression

This theory emphasizes the organisms' overt behaviours that could be directly observed, recorded, categorized and measured. Thus the theory postulates that both normal and abnormal behaviours can be learnt or unlearned. Specifically, in this study, the focus is on the depressive condition of the participants who are women working in the Federal Neuropsychiatric Hospital Enugu. As the woman struggles to work do they have a dysfunctional family and were they depressed? Studies have been conducted to explore how far a dysfunctional family influences the personality of these women. Watson (1967) asserts that depression results from faulty learning. Because women battle with conflicts emanating from the dual responsibilities of a dysfunctional family, could it be inferred that their personality could be affected? This could be how they may have learnt to handle realistically predicting depression. Wetzel (1999) opined that the activity of depressed persons and the feeling of sadness are partly due to the low rate of positive reinforcement and a high rate of unpleasant experiences.

Concerning negative sexual experiences, studies have revealed that there is a significant negative relationship between negative sexual experiences and depression. Since in the extant literature, these was carried out in non-Igbo culture, revealed that negative sexual experiences impact negatively in the personality of women, the present study is in tandem or in support of this relationship between in Igbo cultural environment. The purpose of this study was to investigate whether negative sexual experience would significantly predict depression among women. It was hypothesized as follows:

1. That negative sexual experience would significantly predict depression among women.

METHOD

Participants

A total of 107 participants comprising 62 female nurses and 45 female administrative staff from Federal Neuropsychiatric hospital Enugu were

selected making use of available sampling technique. Their ages ranged between 25 and 60 years. They were all Christians. They possessed various educational qualifications, length of service and different job positions.

Instrument

Two sets of instrument were used for the study:
The Sexual Experiences Survey (SES) by Koss, Gidyez and Wisniewski (1987), adapted by the researcher and Center for Epidemiologic Studies Depression Scale (CES-D) by Radloff (1977) validated by Okafor (1997) and Ugwu (1998).

The Sexual Experiences Survey (SES).

The sexual experiences of the participants were assessed using revised version of Sexual Experiences Survey (5135) victimization version by Koss, Gidyez and Wisniewski (1987). This instrument is a 10- item, true-false measure that was developed to assess different degrees of unwanted sexual experiences: it was designed for use in nonclinical settings. The inventory examines whether a woman has ever experienced unwanted sexual encounters ranging from kissing to rape. Women were classified as: victims of penetrate sexual abuse if they answered 'yes' to items 6,7,8,9,10; Victims of sexual abuse without penetration if they answered yes to questions 1,2,3.4,5; and as having no experience of sexual abuse if they answered 'no' to all the questions. The SES has high levels of reliability and validity among samples of adult women, with obtained values of Chronbach alpha being consistently above .70. (Koss & Gidyez 1985) while Cecil and Matson (2007) obtained a Chrohbach alpha of .80. The researcher carried out a pilot study to establish the validity and reliability of the SES using Nigerian samples. The pilot study involved 72 female staff and students of the Enugu State University of Science and Technology (ESUT). They were asked to assess the instrument and point out areas that do not apply to women and also respond to the questions contained. The data obtained was analyzed using the SPSS— 17 package. The results showed an internal consistency estimate of Chronbach alpha .75. The results of maximum likelihood factorial analysis with variance rotation show that all items loaded on four factors (sexual contact, attempted rape, sexual coercion and rape).

Center for Epidemiological Studies-Depression Scale (CED-D)

This is a standardized psychological assessment instrument developed by Radloff (1977) and validated for use with Nigerian samples by Okafor (1997)

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with a reliability index of 0.85, Ugwu (1998) with concurrent validity index of 0.41 and Omeje (2000) with reliability and validity index of 0.85 and 0.92 respectively. The instrument contains 20-items designed to measure symptoms of depression in the general population. The Scale was developed at the American Institute of Marital Health. It is scored on a 4-point scale ranging from 1 (rarely) to 4 (always). But, items 4, 8, 12 and 16 reflect positive outcomes and are scored in the reverse order, for instance rarely (4) to always (1). The remaining 16-items reflect the negative outcome. The participants were instructed to report the frequency with which the 20-items were experienced within the previous 6 months. If any participants scored above 20, that indicated the participant had experienced depression.

Procedure

The permission and cooperation of the Head of Research and Training FNHE Enugu and the staff were solicited and obtained. After establishing a rapport with the participants, assuring them of the confidentiality of their responses, the researcher distributed 150 copies of the two sets of research materials to the participants. Out of these, only 107 were completed correctly, 33 were poorly completed and 10 copies were not recovered. 4 research assistants helped the researcher to collect the data. Participants were told that participating in the study was voluntary and they received no financial or monetary reward for their participation in the study.

Design/Statistics

A cross-sectional design and hierarchical multiple regression statistics were used for data collection and analysis.

Table 1: Summary table of Hierarchical Multiple Regression Model between the Negative Sexual Experience, Facets of Family Dysfunction and Depression among Women.(N = 107)

Variable	B	*SEB*	B	*t*	*R*	R^2	ΔR^2
Step 1					.18	.031	.031
Educational Level	-2.43	1.8	-.13	-1.34			
Marital Status	-.99	2.37	-.04	-.42			
Age	2.85	2.44	.11	1.17			
Negative Sexual Experience	3.49	.72	.45	4.77***			

* = $p < .05$, ** = $p < .01$, *** = $p < .001$

From table 1 above, the hierarchical multiple regression revealed that at step one, educational level, marital status and age had no significant contribution to the regression model, $F(3, 103) = 1.10$, $p>.05$. However, the relationship between variables were not that strong($R = .18$) and accounted for 3.1% ($\Delta R^2 = 3.1\%$) of the variance in depression scores.

However, the negative sexual experience of the regression model accounted for an additional 25.5% ($\Delta R^2 = 17.7\%$) variation in depression and this change in $R^2$was significant, $F(10, 96) = 3.29$, $p<.001$ and the relationship between variables were strong($R = .51$). Meaning that, increases in negative sexual experiences would equally bring about increases in depression among women. This hereby confirmed the first hypothesis that negative sexual experiences would significantly predict depression among women.

DISCUSSION

The outcome of this study showed that negative sexual experiences significantly predict the depressive symptoms of women. This indicates that women who were sexually abused reported more symptoms of depression than those who did not experience sexual abuse. This study accepts the first hypothesis of this study which stated that negative sexual experiences would significantly predict depression among women.. This finding seems to suggest that negative sexual experiences could be risky factor for depression in adult women given the significantly higher scores on CES-D by those who reported sexual abuse than those who did not. The result of this present study is in harmony with the findings of Ferguson et al.(1995) and Ross Crowder et al.(1998) which found that although there are immediate reactions by the abused child, the scars of these incidents lingered to adulthood manifesting in symptoms of clinical depression.

Childhood sexual abuse unlike other forms of child maltreatment which may be connected to child rearing, discipline or attention to developmental needs constitutes a breach of trust, deception, intrusion and exploitation of a child's innocence status. This in part explains the reason for this long term effect. Studies have shown that the risk of this long term Psychopathology can be reduced if the abused child receives compassion and support from family members, friends and professional mental health care (Hoekesema, 2004). Besides the treatment that is offered, the victim is also imbued with skills for self-defense against further abuse. The psychological problems are more likely

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when the abused person tries to hide or deny the abuse (Hoekesema, 2004). Umeora et al (2008) found that in Nigeria, it is uncommon for people to report negative sexual experiences. The reason for this as they identified includes but not limited to threats of harm by the perpetrators, feelings of shame and guilt, and fear of being stigmatized. The result is that in most cases, rather than open up to receive the needed medical, social and psychological attention, the victim suffers in silence. Such victims are also at risk of further abuse, (Hoekesema 2004; Garland, 2006). This further intensifies the detrimental impact of the abuse on the victim. The higher scores on the CES-D by women who reported negative sexual experiences could be explained within this context.

The result of this study found that negative sexual experiences given the findings, tend to pose a threat to depression based on their remarkable effects, hence the occurrence of depression are highly implicated by the early negative sexual experience in childhood. This implies that women who experienced sexual abuse would require both medical and psychological treatments to develop and actualize their potentials. Such needs must match the needs of wide range of children who may have all kinds of symptoms or no symptom at all (Beliner & Elliot 2002). The victims treatment should also involve education and support to help her understand why she had such experiences and how she can learn to feel safe and protect herself against further abuse.

Victims of sexual abuse should seek help from appropriate authority when parents fail to take the appropriate measure at the time. For women who face depression due to negative sexual experiences, they should engage in group psychotherapy and obtain comfort that comes from feelings of stigma and isolation. In addition to the above suggestions, counseling services should be provided in both primary and secondary schools to guide the students in realizing the dangers of sexual abuse. They will learn that sexual abuse could come in different forms like touching, hugging, padding, kissing, necking, texting, gifts and touching of sensitive places that can arouse sexual feelings. These are minor forms of abuse that may lead to sexual abuse. To teach them that sexual abuse could come from even same sex, like homosexuals and lesbians.

However, this present study adds to the existing literature examining associations between sexual victimization and depressive symptomatology on

women's sexual functioning. Sexual victimization is associated with increased probability of reporting sexual problems (Lemieux & Byers, 2008; Lutfey, Link Rosen, Wiegel, & McKinlay, 2009), including pelvic pain (Postma et al., 2013). PTS symptoms in women with a history of sexual victimization have been associated with negative sexual outcomes (Letourneau et al., 1996; Schnurr et al., 2009), whereas less research has focused on the impact of depressive symptoms. These results indicate that depressive symptoms are a potential contributor to sexual outcomes for women with low severity histories of sexual victimization. The interaction of depressive symptoms with adults' sexual victimization may exacerbate the unique negative outcomes following sexual assault. Sexual assault is associated with shame and disgust that affect women's sexual experiences (Vidal & Petrak, 2007; Weaver, 2009). Women with high levels of ASV may possess levels of shame and disgust that affect their sexual experiences to the extent that depressive symptoms do not provide any additional unique contribution.

CONCLUSION

It can be stated based on the findings of this study that negative sexual experiences increases the risk for depression among women; this finding fits well with previous studies which suggested that childhood adversities may lead to psychological and biological changes which increase vulnerability to depressive symptomatology. This implication buttresses the need to create awareness on the dangers of these negative experiences which may pose for girls and women as well as the need to provide a protective and healthy environment for the upbringing of female girl child.

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