Key FINDINGS

From "Sexual Violence Victimization and Associations with Health in a Community Sample of African American Women"

NSVRC
national sexual violence resource center

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Research translation by NSVRC

Victims of sexual violence can experience a range of negative health outcomes over the course of their lives. A substantive body of research finds that individuals can experience physical, mental, and behavioral health impacts well beyond the duration of the event(s). Less is known, however, about particular consequences and life contexts of Black/African American[1] women who have been victimized.

Basile, Smith, Fowler, Walters, and Hamburger (2016) offer a window into the lived experiences of African American women in *Sexual violence victimization and associations with health in a community sample of African American women*. This study is part of a larger effort to better understand the context surrounding the findings that women of color experience sexual violence at a much higher rate than White women (Breiding et al., 2014; Tjaden & Thoennes, 2006). This research translation summarizes the article's key findings to help support sexual violence prevention and response strategies with Black and African American communities.

BACKGROUND

While there is substantial literature focused on the health-related consequences of sexual violence, existing research is often limited to findings that are generalized to all sexual violence victims. Sexual assault is associated with increased risk for behaviors or coping mechanisms such as excessive drinking, illicit drug use, and sexual practices that can cause negative health/mental health outcomes; however, many studies did not examine differences by race or ethnic groups (Wadsworth & Records, 2013).

[1]The terms Black and African American will be used interchangeably. Sexual violence in the lives of Caribbean and African immigrant women is beyond the scope of this paper.

In those studies that did focus on African American women, there were indications that mental and behavioral health problems may be especially impactful for African American women survivors, particularly for those that experience the additional and overlapping burdens of poverty and housing insecurity that frequently co-exist. For example, women earning low or no incomes often experience homelessness or live in housing where they may be at risk for multiple forms of violence.

There are additional research studies that find high correlations between low incomes, poverty, sexual violence, and/or adverse mental health outcomes (Bryant-Davis, Ullman, Tsong, Tillman, S., & Smith, 2010; Loya, 2014).

Methods

Researchers generated a random sample to identify addresses of potential participants from urban neighborhoods in a southeastern city predominantly comprised of African American residents. Interviewers then visited those households to recruit participants. Participants were told the study was about "women's health and well-being." Informed consent was obtained from interested participants in a safe, comfortable, and private location. During the informed consent process, participants were then given the specific information that the study was about sexual violence. A community sample of 168 African American women were interviewed in person and in private locations (most often in their homes) about their experiences with rape, sexual coercion, and a range of mental and physical health indicators as well as health-related behaviors.

The average age of the women in the sample was 48 years old. Total household incomes varied but tended to be low: 29% of participants reported an annual income of less than $5,000, and 12% reported incomes of $50,000 or greater. The remainder fell between those two ranges.

All participants were asked a wide ranging set of questions that included:

- each women's lifetime history of rape and sexual coercion (see below for definitions);
- experiences with negative health behaviors over the past 12 months, e.g. alcohol and drug use;
- experiences of food and housing insecurity;
- lifetime experiences with mental health conditions, including depression, suicidality, and PTSD.

Particular attention was paid to a group of 80 women who identified their first unwanted sexual experience as either rape or sexual coercion. This group was asked additional questions including:

- age at first having been raped;
- age of the person who perpetrated the assault;
- relationship to the person who perpetrated the assault;
- physical health conditions following the first nonconsensual experience.

Rape was defined as "completed or attempted sex after a perpetrator used physical force or threats of physical harm, gave the victim drugs or alcohol, or when the sex occurred when the victim was passed out, asleep, drunk, or high (and unable to provide consent to sex)" (Basile et al., 2016, p 7). Sexual coercion was defined as "completed sex after a perpetrator did any of the following: told lies, made false promises about the future, or threatened to end a relationship or spread rumors; wore down the victim by repeatedly asking for sex; or used his or her

influence or authority to make the victim engage in unwanted sex" (Basile et al., 2016, p 7). Note that these definitions do not include other forms of sexual violence such as unwanted sexual contact, non-penetrative child sexual abuse, voyeurism, or exhibitionism.

Findings

Over half (53%) of all study participants indicated rape victimization, and 44% reported sexual coercion within their lifetime, with approximately 42% reporting both. These are higher prevalence rates than other national survey estimates but in line with other community-based studies of high-risk populations when face-to-face interviews are used for data collection.

Participants with lifetime experiences of rape and/or sexual coercion:

• **Mental health:** Participants with experiences of rape and/or sexual coercion were more likely than those women who had not been victimized to report PTSD symptoms and/or depression. A significant majority (88%) of this group had a history of rape/sexual coercion. Additionally, 21% of all study participants indicated they had seriously considered suicide during their lifetime.

• **Substance abuse:** Over half (65%) of the participants who indicated rape/coercion victimization engaged in binge drinking at some point in the last 12 months versus 35% of participants who were not victimized. Approximately 95% of participants who were victimized indicated drug use/misuse during the previous year versus 5% of those who were not victimized.

• **Financial and housing instability:** During the previous 12 months, 62% of those victimized worried about their ability to pay housing costs versus 38% of non-victims. Additionally, 68% of participants who were victimized were concerned about their ability to buy nutritious meals during the previous 12 months versus 32% of non-victims.

• **First unwanted experience:** Among women who indicated their first unwanted sexual experience was rape or sexual coercion:

• 73% were under the age of 18 years when they were victimized;

• 96% reported that the perpetrator was the same race;

• 90% knew their perpetrator (e.g., friend/acquaintance, family member, intimate partner);

• 40% were physically injured (ranging from minor cuts to being knocked unconscious);

• 8% contracted a sexually transmitted disease (STD);

• 18% became pregnant.

Within this group of women who experienced both physical injury and mental health problems resulting from their first experience with rape or sexual coercion, only half received the services they needed.

Study Limitations and Opportunities for Further Research:

• **Generalizability:** As with any race-level analysis, it is important to recognize the significant cultural diversity that exists; generalizations of the study results beyond the studied group must be made with care. For example, this study was conducted with women

in an urban setting in the southeast whose total household incomes varied but tended to be low. The findings may not generalize to higher income Black women or those who live in rural or suburban areas.

• **First-time victims of rape and sexual coercion:** Delving deeper into the reasons women identified for not getting multiple service needs met as first-time victims is important. Of the women who said they needed medical services, slightly over half were able to get them. Of those needing mental health services, about half indicated they were able to get them. It was not clear whether this group of women chose not to reach out, did reach out and services weren't accessible, or relied on informal help as an alternative.

• **Spectrum of violence:** This study's focus was specifically on rape and sexual coercion experiences throughout the lifetime of this group of women. Future research is needed to examine the full spectrum of sexual violence, including sexual harassment, non-contact child sexual abuse, and other types of sexual violence.

Discussion

While prevalence rates between national studies vary, they consistently show that African American women experience sexual violence at high rates. Additionally, help-seeking behaviors—the decision or ability to reach out for help—may be different for this group of survivors compared to white women survivors in their willingness to reach out to formal systems for help, e.g. law enforcement, medical services, or other organizations.

> Among participants reporting PTSD symptoms, 88% had a history of rape/ sexual coercion.

Offering responsive solutions to sexual violence requires looking at victimization within the lived experiences and larger contexts of survivors' lives. For this group of African American women, sexual violence victimization was associated with a broad range of compounding struggles including mental health needs, substance use, housing instability, and/or poverty.

The experiences of sexual violence are often reciprocal: women living in poverty are often at increased risk of victimization; victimization can then increase risk of unemployment and reduced income. African American women are disproportionately impacted, often living within complex intersections of violence, poverty, and mental and physical health struggles. The authors acknowledge that "...the added burden of traumatic sexual violence victimization for women living in poverty potentially exacerbates the need for multiple services and resources to address various intersecting problems" (Basile et al., 2016, p 18).

Prevention

Implications

Effective prevention strategies embrace socio-cultural relevance (Nation et al., 2003), meaning they are created for specific audiences with messages that resonate and reflect the cultural values and strengths within those communities. Additionally, sexual violence prevention is most effective when mobilized at all levels of the social ecology (individual, relationship, community, and societal) and throughout the lifespan (Tharp et al., 2012).

- **Child sexual abuse prevention:** Given that most women in the current study were sexually victimized before turning 18, prevention efforts that start early in life and continue through different developmental ages are crucial. There is a large body of existing research supporting the notion that child sexual abuse is a strong predictor of adult rape or revictimization (Black et al., 2011; Fargo, 2009; Rinehart, Yeater, Musci, Letourneau, & Lenberg, 2014).

Teachers, faith leaders, neighbors, parents, caregivers, and other community members can work together to protect children from sexual abuse; it is critical that they have the tools to identify and respond to child sexual abuse.

- **Supporting broad-based community norms change:** Investing in and supporting promising prevention practices with messages that combat racism and amplify the strengths, values, and aspirations of this community are critical. These can also be important countermeasures to generational or historical trauma that may be contributing to community and/or individual responses to sexual violence. Destructive, inaccurate images of African American women must be challenged and replaced.

Grass-roots education and media campaigns can provide a unifying voice to these messages. They can be a natural tie-in to messages promoting respect, consent, and the right that all bodies are worthy of respect and dignity.

• **Community organizing:** Sexual assault advocates can initiate, join, and support existing community organizing efforts. They play a key role in helping to educate on the relationship between sexual violence and the larger field of violence and forms of oppression including misogyny and racism. Connecting these dots in partnership with communities can allow for a powerful response to take shape for survivors and non-survivors both.

Community leaders are not just those with identified roles. Leaders exist in many pockets in all communities and have significant impact in influencing attitudes and opinions of those around them. The fragile relationship between many communities of color and law enforcement makes informal networks even more important. Beyond prevention, informal support networks may also be first responders for survivors. Understanding sexual violence can preclude inappropriate responses and victim blaming attitudes which can have serious impacts on survivors.

Intervention

Greater community investment

Bridge building and cross-training between service providers: A broad community-based approach to services for people impacted by sexual violence may be more responsive to the needs of some African American women. For many, sexual violence is often experienced as one of many burdens present in their lives. They may not even identify victimization as being the primary issue in their lives demanding attention. Women in lower socioeconomic classes are likely to live farther from service providers and/or lack insurance, transportation, child care, and/or stable housing. Multiple and other pressing basic needs may take priority over reporting and accessing services for sexual violence.

The consequences stemming from sexual violence victimization may or may not be at the root of other challenges this group of women face, given the systemic barriers that racism, classism, and other forms of oppression have on their lives. Do unstable housing situations, for example, create conditions where women face a higher risk for sexual violence? Does untreated victimization create instability in women's lives that can lead to unhealthy coping mechanisms such as substance abuse and others?

If African American women are reluctant to seek help from formal systems such as law enforcement, medical providers, or the formal social service network, then allied or community organizations where women are receiving help for other needs can be cross-trained in sexual violence issues and trauma-informed responses, even if women choose not to disclose their victimization. For example, engaging faith-based leaders in understanding the dynamics of sexual violence and the importance of expressing unconditional support for all victims may encourage survivors to access help.

Training can be made accessible to community groups or allied organizations in a manner that doesn't require advanced education levels or laborious training requirements. Providing education and training to other service providers including social

workers, child care workers, educators, health care providers, attorneys, faith/traditional leaders as well as the community at large is important in ensuring that survivors are surrounded by knowledgeable providers and community members.

Culturally relevant organizations: Services currently offered by more mainstream organizations do not always reflect the cultural diversity of the community, which can affect survivors' willingness to seek help from them. It is important that survivors can see themselves and their realities in the organizations designed to be of service to them. When organizations are staffed by diverse counselors and service providers, and they work to establish rapport and collaborations within the community, they may begin to be seen as trustworthy, safe, and culturally relevant places for traditionally marginalized populations to access help. While informal systems of support are crucial, it is also important that sexual violence programs and other agencies are relevant and responsive to the people they serve and that they partner with both formal and informal sources of help to ensure African American communities have access to quality services.

Culturally relevant approaches to trauma: PTSD symptoms, depression, anxiety, and suicide were found to be significantly connected to sexual trauma. It is important to understand that mental health struggles such as PTSD and depression are not necessarily experienced or described in the same way across cultures.

Victim service providers can adopt a trauma-informed approach—one that understands the role trauma plays at individual, organizational, and larger systemic levels. Central to this approach is an understanding of the similarities and differences across cultures and individuals' experiences with violence and trauma.

Also central to a trauma-informed approach is a focus on strengths. Services that are strengths-based acknowledge the healing strategies that have been successfully used by African American women, including spiritual practices, music, storytelling, activism, artistic expressions, and others.

Conclusion

This study contributes to the growing research base expanding our understanding of sexual violence victimization. It acknowledges and identifies ways that sexual violence is experienced for some African American/Black women within a host of overlapping and compounding situations. Responding effectively as well as working preventively has to occur within the larger realities of victims/survivors and their communities that are often impacted by racism, classism, and other forms of oppression.

This study identifies a large number of women who experienced both physical injury and mental health problems resulting from their first experience with rape or sexual coercion, yet only half received the services they needed. This speaks to the need for both early and sustained culturally relevant prevention strategies as well as the need to strengthen the safety net of services that women may require after victimization. This will be accomplished by developing stronger and more meaningful community partnerships as well as developing culturally relevant prevention messaging and programs.

While no event in any person's life is experienced in isolation, the oft-accompanying life situations and burdens within this group of African American women are significant. They demand focused and intentional efforts that are instituted across the individual lifespan as well as the breadth of the entire community.

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