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Traumatic symptoms, coping strategies and changes to physical appearance among Caucasian women and women of color survivors of adult sexual violence : a mixed-method analysis

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Running head: Female Survivors of Adult Sexual Violence

Traumatic Symptoms, Coping Strategies and Changes to Physical Appearance among Caucasian
Women and Women of Color Survivors of Adult Sexual Violence: A Mixed-Method Analysis

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DEDICATION

I dedicate this dissertation to my amazing mother, Alda Martin-Lowrie. Your face would always light up with joy each time you introduced us to others and I didn't understand why. I witnessed you working so hard, often sacrificing yourself, so that we could have a better life, while you received little acknowledgement for all that you had done. I always wished I could do more or give you more so that you would know that your hard work was not in vain. But you knew all along that it was not in vain because you had us to show for it. You were busy planting seeds that would grow into strong and fruitful trees. I am so proud to be your daughter, and yes, my beloved mother, your hard work and determination was not in vain. I love you more than you would ever know and more each day. You are always with me.

ABSTRACT

This exploratory study utilized a concurrent triangulation mixed-method approach to explore changes in physical appearance as a coping strategy in Caucasian women and Women of Color survivors of adulthood sexual assault. Recruited through posted advertisements and snowball effects, the sample consisted of 23 Caucasian women and 50 Women of Color, between the ages of 21 and 65, who had experience at least one incident of sexual assault or rape in adulthood. Standardized instruments included the Ways of Coping Questionnaire-Short Version, the Traumatic Symptom Checklist-40, and the Appearance Schema Inventory-Revised. Results from one-way ANOVA showed significant differences among traumatic symptoms and coping strategies between Caucasian women and Women of Color. Qualitative results revealed changes in physical appearance and dress among Caucasian women and Women of Color as coping strategies in the wake of sexual violence.

Chapter One

Sexual Violence

Violence against women is perhaps the most serious social problem facing women throughout the world. It affects females of all ages, social classes and educational backgrounds. The United Nations General Assembly (1993) defined violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual, and mental harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life” (World Health Organization, p. 1). This definition is purposely broad, wide-reaching in its encompassing of the many forms of violence against women, including acts of “physical, sexual and psychological violence occurring in the family and in the general community” (World Health Organization, p. 1). Acts of violence occurring in the family include battering, sexual abuse of female children in the household and marital rape. Acts of violence occurring in the general community include sexual assault, rape and prostitution. Sexual violence is a harsh reality facing women all over the world.

Background of the Problem

Sexual Violence in the United States

In the United States, women are confronted with daily acts of violence against their gender. These acts consist of domestic violence, rape and sexual assault. According to the U.S. Department of Justice’s 2007 National Crime Victimization (NCV) survey (2008), the largest randomly selected household survey conducted in the United States, every two and a half minutes, somewhere in America, someone is sexually assaulted. The U.S. Department of Justice’s Criminal Victimization 2006 Statistical Tables (2008) revealed that during 2006, there

were approximately 260,940 victims of rape and sexual assault. Based on this annual report of sexual violence, 232,960 of these victims were female. Further analysis of this number revealed that 110,080 women were victims of completed rape, 54,270 women were victims of attempted rape and 68,620 women were victims of sexual assault. Using this annual reported amount of female victimization, there were approximately 638 reported incidents of sexual violence daily.

Evidence from decades of research revealed that women are at risk for sexual violence throughout their life span. Various research studies on interpersonal violence against women estimated that 14% to 20% of women will experience rape at some point in their lives (Kilpatrick & Resnick, 1993; Koss, 1993; Tjaden & Thoennes, 2000); 25% to 28% will be physically abused in a sexual-romantic relationship (Elliott & Briere, 2003; Strauss & Gelles, 1990); and 8% to 24% will be stalked by someone known or unknown to them (Sheridan, Blaauw & Davies, 2003; Spitzberg, 2002; Tjaden & Thoennes, 2000). These amounts are added to the 25% to 35% likelihood that the average adult woman has been sexually abused as a child (Briere & Elliot, 2003; Finkelhor, Hotelling, Lewis & Smith, 1990). Endemic sexual violence in our society forces women to live in fear that their daughters, sisters, mothers, lovers, friends and even themselves will be among the next victims of sexual violence, inside and outside of their home.

Rape, Attempted Rape and Sexual Assault

While the terms “rape” and “sexual assault” are often used interchangeably, there is a clear distinction between the two terms. Rape, as defined by the U.S. Department of Justice’s Bureau of Justice Statistics (2008), is “forced sexual intercourse including both psychological coercion as well as physical force” (p. 142). Forced sexual intercourse means vaginal, anal or oral penetration by the offender(s).” Within this category, rape also “includes incidents where the penetration is from a foreign object, such as a bottle” (p. 142). Acts of attempted rape

include verbal or physical threats of rape. Sexual assaults, as defined by the U.S. Department of Justice's Bureau of Justice Statistics (2008), are "crimes including attacks or attempted attacks generally involving unwanted sexual contact between victim and offender" (p.143). While sexual assaults may involve force, these incidents stop short of attempted rape or rape. Sexual assault often "includes act such as grabbing or fondling and verbal threats" (p. 143). The main distinction between rape and sexual assault is that rape often involves some form of psychological or physical force leading to penetration, while sexual assault does not.

Sexual Violence and Sexual Trauma

Violence against women is often categorized under the heading of sexual violence. Sexual violence is a term used to encapsulate the various acts, some involving physical contact, of violence against women. The Center for Disease Control and Prevention (2007) defined sexual violence as completed or attempted penetration of the genital opening or anus by the penis, a hand, a finger or any other object; penetration of the mouth by the penis or other objects; abusive sexual contact without penetration, such as intentional touching of the groin; or noncontact sexual abuse, such as acts of voyeurism or sexual harassment (Basile & Saltzman, 2002). Critical to the definition of sexual violence is that the survivor does not consent to the sexual activity or is unable to consent (e.g., due to age or illness) or unable to refuse (e.g., due to physical violence or threats) (Basile & Saltzman, 2002). The term "sexual violence" also has international implications, as it includes acts such as systematic rape during times of war, sexual trafficking (the buying and selling of girls and women into prostitution and sexual slavery) and female genital mutilation.

The term “sexual trauma” is a term used to encapsulate the dramatic impact of violence against women. Nicole Yuan, Mary Koss and Mirto Stone (2006) noted that “sexual trauma refers to one or multiple sexual violations that invoke significant distress” (p. 2). The term “sexual trauma” serves two purposes. It is used by clinicians, advocates and researchers to describe the compounded “acts of violence with survivors’ responses,” and it is used “in response to observations that some survivors do not label their experience as rape or assault due to familiarity with the perpetrators or the absence of force” (p. 2). Secondly, the term facilitates healing among survivors. Yuan, Koss and Stone (2006) noted that the term “sexual trauma may be a less stigmatizing term for some survivors and may promote healing by acknowledging the impact of the violent acts on the individual’s well being” (p. 2). The terms “sexual violence” and “sexual trauma” will be used throughout this paper when describing the acts of violence and the impacts of those acts on women and on their lives.

Offenders of Sexual Violence

While our society clings to the belief that perpetrators of sexual violence are strangers to their victims, the Rape, Abuse and Incest National Network (RAINN), the nation’s largest anti-sexual assault network, noted that often the rapist isn’t a masked stranger. The U.S. Department of Justice’s Criminal Victimization in the United States 2006 Statistical Tables (2008) revealed that sixty-one percent, 155,720 of the 232,960, of incidents of sexual assault and rape reported by females in 2006 involved non-strangers. Based on this number, the offenders were well known by their victims in 71,510 incidents. These individuals were most likely the spouse or partner of the victim. The offenders in the remaining 69,320 incidents were reported to be friends or casual acquaintances of the victims.

The National Crime Victimization Survey of 2007 (2008) noted that, based on the 236,980 female victims of sexual violence, approximately 150,830, which accounts for 64% of the victims, were victimized by non-strangers. Further analysis of this amount revealed that 55,110, which accounts for 23% of the victims of sexual assault and rape, were assaulted by individuals who had or were involved in intimate relationships with their victims: 6,530 incidents, which account for 3% of the victims of sexual violence, were committed by relatives of the victims; and 89,190, approximately 38%, were committed by individuals who the victims considered friends or acquaintances.

Prevalence of Sexual Violence among Caucasian Women and Women of Color

The Prevention, Prevalence and Incidence and Consequences of Violence Against Women Survey (1998), conducted jointly by the National Institute of Justice and Center for Disease Control and Prevention, found that the lifetime rate of rape and attempted rape for all women is 17.6%. These rates differ for African-American women, European-American women and Women of Mixed Race. According to the survey, the lifetime rate of rape and attempted rape for African-American women was 18.8%; for European-American women it was 17.9%; and for women of mixed race it was 24.4%. The Extent, Nature and Consequences of Rape Victimization: Finding from the National Violence against Women Survey, a National Institute of Justice's Special Report (2006), found that there was not a significant difference in rape prevalence between non-Hispanic white women and Hispanic white women. Similar findings were discovered in the Bureau of Justice's National Crime Victimization (NCV) Survey (2008). According to the Bureau of Justice's 2007 Statistics of Criminal Victimization Report (2008), there were 19,070 rapes, 5,420 attempted rapes and 3,250 sexual assaults against Latino/Latina women in 2007. This number has increased significantly from 8,320 rapes and 2,250 sexual

assaults against Hispanics reported to law enforcement in 1998 (Sourcebook of Criminal Justice Statistics, 1999). Incidents of sexual violence against Native American women also reveal a harsh reality. The Bureau of Justice Statistics Statistical Profile, 1992-2002: American Indians and Crime (2004) found that Native Americans are victims of violent crime, including rape or sexual assault, at more than double the rate of other racial groups in the United States. The National Violence against Women Survey (2006) found that 37.5% of Native American women are victimized by intimate partner violence—defined by rape, physical assault, or stalking—in a lifetime.

According to the race and gender of victims on the Bureau of Justice's National Crime Victimization (NCV) Survey (2008), African Americans, as a racial group, and women were more likely to be victims of overall violence, including rape and sexual assaults. While women in general were more likely to report crimes to the police, African-American women (58.3%) reported more violent crime, including rape, than Caucasian women (53.9%) and women from other racial backgrounds (58.1%). The U.S. Department of Justice's Criminal Victimization in the United States 2006 Statistical Tables (2008) revealed that in 2006, African-American women reported higher rates (2.1%) of sexual victimization than European-American women (1.8%).

The National Crime Victimization Survey (2005) noted that 60% of all incidents of sexual assaults are unreported, making sexual assault one of the most unreported crimes nationwide. The Bureau of Justice's Special Report (2003) and the National Organization of Sisters of Color Ending Sexual Assault (2004) noted that for every European-American woman that reported an incident of rape, at least five European-American women do not report a rape. This number was noted to be significantly higher for African-American women. For every

African-American woman that reported an incident of rape, at least fifteen African-American women do not report a rape.

The Impact of Sexual Violence

Carolyn West (1999) noted that, “the way women feel about themselves and their environment is permanently altered by the incidence of intimate assaults in their lives” (p. 51). While women’s responses to adulthood sexual trauma are largely complex and unique to each individual, experiences of sexual assault and rape correlate with short and long-term distressing symptoms that severely impact the survivors’ psychological functioning. There are many documented mental health issues that correlate with violence against women. According to the World Health Organization (2002), victims of sexual assaults are three times more likely to suffer from depression, six times more likely to suffer from post-traumatic stress disorder, thirteen times more likely to abuse alcohol, twenty-six times more likely to abuse drugs and four times more likely to contemplate suicide.

John Briere and Carol Jordan (2004) noted that most non-organic forms of mental distress and disorder in women were found to be connected to at least one form of interpersonal victimization, such as sexual and/or physical assaults, within and/or outside of domestic relationships. Incidents of sexual and/or physical assaults have been associated with increased anxiety (Kemp, Green, Hovanitz & Rawlings, 1995); depression (Plichta & Weisman, 1995); cognitive disturbance such as hopelessness and low self-esteem (Janoff-Bullman, 1992); posttraumatic stress (Astin, Lawrence & Foy, 1993; Kilpatrick, Acierno, Resnick, Saunders & Best, 1997); dissociation (Briere, Woo, McRae, Foltz & Sitzman, 1997); somatization (Ullman & Brecklin, 2003); sexual problems (Briere, Elliott, Harris & Cotman, 1995); substance abuse

(Kilpatrick, Acierno, Saunders, Resnick & Best, 2000); and suicidality (Thompson, Kaslow & Kingree, 2002; Ullman & Brecklin, 2002).

Sexual dysfunction is a common reaction and often a chronic problem for sexual violence survivors. According to the Office of Victims of Crime, sexual violence survivors might experience loss of sexual desire, inability to become sexually aroused, slow arousal, pelvic pain associated with sexual activity, a lack of sexual enjoyment, inability to achieve orgasm, fear and avoidance of sex, intrusive thoughts of the assault during sex, vaginismus and abstinence.

One of the least mentioned impacts of rape is pregnancy. The Bureau of Justice's National Crime Victimization Survey (2005) revealed that during 2004-2005, 64,080 women reported being raped. According to the Office of Victims of Crime, incidence of pregnancy for one-time unprotected sexual intercourse is 2-4%. Using the 2004-2005 annual rape average and statistics from the Office of Victims of Crime, RAINN calculated approximately 3,204 pregnancies resulted during this period by incidents of rape.

Victims and Survivors of Sexual Violence

The terms "victims" and "survivors" are often used interchangeably by people who have experienced some form of sexual violence, including sexual assault in childhood and/or adulthood, dating violence and domestic violence. The terms are used to explain different stages of the trauma and recovery process and therefore convey different meanings to people and helping professionals who work with them. The California Coalition against Sexual Assault (2003) noted that the term "victim" is often associated with the early phase of trauma immediately following the victimization and is used to convey that a crime has been committed. In addition, the term "victim" is used when someone died as a result of their victimization. The

term “survivor” is used at a later phase of the recovery to convey the continual process of reclaiming one’s power in the wake of their victimization. “Survivor”, which is a descriptive of the act of survival, means "to continue to live or exist, to live or to exist longer than, to remain alive or in existence after" (Ehrlich, Flexner, Carruth & Hawkins, 1980, p. 927; Robinson, 2000). Both terms will be used throughout this paper to convey different stages of sexual victimization and the recovery process in women’s lives.

Coping with Sexual Trauma

All survivors of sexual violence utilize some form of coping strategies to deal with their sexual trauma. The forms of coping strategies utilized have a substantial impact on their journey toward recovery. Whereas some survivors avoid thinking about the rape and may even resort to maladaptive coping strategies such as using alcohol or drugs, others deal with their feelings directly by talking to other people and seeking help.

Richard Lazarus and Susan Folkman (1984) defined coping as the cognitive and behavioral efforts allocated to manage specific external and/or internal demands appraised as taxing or exceeding the resources of the individual. They postulated that coping strategies are influenced by the degree of perceived control one has and the degree of threat posed by the stressors. To this extent, Lazarus and Folkman (1984) outlined two distinct coping strategies: emotion-focused coping and problem-focused active coping. Emotion-focused coping strategies are often used when the stressors or events are viewed as outside of one’s control. These coping strategies include avoiding, distancing, self-blaming and controlling one’s feelings. Problem-focused active coping strategies are attempts utilized by individuals to manage the problem. These coping strategies are often used when the stressors or events are viewed as

within one's control. Problem-focused active coping strategies include confrontation, seeking social support and planning how to actively respond.

Based on the work of Lazarus and Folkman (1984), C.R. Synder and Kimberley Pulvers (2001) developed a coping model that outlined two common strategies commonly utilized by sexual assaults and rape survivors: approach coping and avoidance coping. Similar to emotion-focused coping, avoidance coping involves investing in cognitive and behavioral efforts to suppress thoughts and feelings associated to the stressor(s). Survivors used strategies such as isolating and keeping busy to avoid factors associated with the event(s). While the uses of any coping strategies are helpful initially, avoidance coping as a long-term coping strategy is detrimental to survivors' recovery (Arata, 1999; Frazier & Burnett, 1994; Frazier, Mortensen & Steward, 2005; Neville, Heppner, Oh, Spanierman & Clark, 2004; Valentiner, Foa, Riggs & Gershuny, 1996). This has been found to be particularly true when cognitive and behavioral avoidance strategies have prohibited survivors from integrating or making meaning of the assault (Boesch, Koss, Figueredo & Coan, 2001; Foa & Riggs, 1995).

Similar to Lazarus and Folkman's problem-focused coping strategies (1984), approach coping involves dealing directly with a stressor(s) or with one's emotional reaction to the stressor(s) (Roth & Cohen, 1986). In the case of sexual assaults and rape, the incident cannot be changed. Utilizing approach coping strategies involves dealing directly with the emotional responses to the incident and to the recovery process itself. Approach coping includes help-seeking strategies, cognitive reappraisal and letting one's emotions out (Burt & Katz, 1987; Meyer & Taylor, 1986). These strategies were found to support the survivors' recovery process (Arata, 1999; Arata & Burkhart, 1998; Frazier & Burnett, 1994; Valentiner et al., 1996).

Body Image and Physical Appearance

Survivors of sexual violence often have a disrupted view of their body image, specifically parts of their body, which may lead them to participate in self-mutilation behaviors, such as cutting and burning specific parts of their body violated in the assault. However, body image problems stemming from abusive experiences are not only specific to the abused body part but may also be generalized to the entire body, resulting in overall body dissatisfaction, intense feelings of shame about the event and the body and body distortion (e.g., perceiving the body as much larger than its actual size) (Fallon & Ackard, 2002). Patricia Fallon and Diann Ackard (2002) defined body image as the “mental representation of the body that includes perceptions of appearance, feelings and thoughts about the body” (p. 22). It is a fluid phenomenon that continuously incorporates information, based on new experiences and events, positively or negatively affects body image. Sexual trauma changes, and often shapes, the views that women have about their bodies.

Body Image, Physical Appearance and Sexual Violence

Women’s views of their physical appearance consist of evaluative beliefs about their appearance and investment beliefs of what they can do to change or maintain their appearance. These beliefs are based on the individual’s mental, personal and social experiences that shape, maintain and enforce said beliefs. In the acute stages of sexual trauma, which follow immediately after the sexual assault, needing to be covered might lead survivors to use extra layers of clothing to achieve a sense of mental and physical safety. It appears, however, that women made more changes to their physical appearance in the outward adjustment stages, during which steps are taken to return to pre-trauma personal and social normalcy. Changes to

physical appearance are used in the outward adjustment stage to either increase or decrease interactions with others. During this time, presenting with little or no availability for others or altering one's physical attractiveness can be used as defense mechanisms to create safety from physical/social and sexual advances, causing women to make changes to their clothing, mannerisms and appearances.

Limitation of Existing Trauma Literature

Despite extensive literature on traumatic symptoms, coping and body image, the literature exploring the relationships among incidents of sexual violence, coping strategies and changes to physical appearance are limited to obesity and eating disorders. It is common knowledge that women are forced to mask much of their internal and external reactions to sexual violence, even in situations where they have disclosed their experiences to others. While the literature documents that survivors are likely to experience depression after their assaults and may experience a period of weight gain or loss, there is limited research dedicated to the relationship between sexual violence and changes in physical appearance.

Mary Ellen Roach-Higgins and Joanne Eicher (1992) defined self as a “composite of an individual's identities communicated by dress, bodily aspects or appearance and discourse, as well as the materials and social objects (other people) that contribute meaning to situations for interactions” (p. 5). Sexual violence changes women's identity and concepts of her self, both of which are integral parts of her physical appearance. In its wake, many survivors struggle to retain a sense of personal and social power that often forces them to adapt lifelong patterns of behaviors to create a “comfortable fit” between their internal emotional world and the external physical appearance of their bodies. As many researchers continue to focus on supporting survivors to integrate the impact of sexual victimization, so that it is part, not all, of how she

defines and understands herself (Phillips and Daniluk, 2004), supporting survivors to integrate the impact that sexual violence has on their physical appearance and dress is essential to how women will see and present themselves. Addressing concerns about survivors' physical appearance and dress is an essential part of the healing process, which is often overlooked when supporting the "breadth and depth of women's evolving sense of self" (Phillips and Daniluk, p. 178) in the wake of sexual violence.

Theoretical Perspective

Feminist Ecological Model

Each survivor of sexual violence will have a unique response(s) to violence in her life. How, and if, she integrates the experience(s) depends on her responses to the event(s) and factors that shaped and influenced her life. An incident(s) of sexual violence is likely to affect her on many levels, as well as shape beliefs that she has about herself and her general community. Simone de Beauvoir (1949) wrote passionately that the female body is a situation placed in other situations. Through this description, she began to unravel the multiple identities of an individual who is situated within many situations (i.e., family, society) that influence and shape her world. Unfortunately, being a survivor of sexual violence is both a situation and an individual identity for many women. One theoretical perspective, the Feminist Ecological Model, conceptualizes the multiple identities of an individual interfacing with the multi-influencing systems and factors that shape one's life, and offers some explanations on the alarming rates of sexual violence facing women and their responses to sexual violence and coping approaches, including changes to their physical appearance, utilized in the face of their sexual trauma.

The Feminist Ecological Model, as developed by Mary Ballou, Atsushi Matsumoto and Michael Warner (2002), is a multi-dimensional, mutually-interacting, shifting historical view of reality that explores the multi-identities of individuals and the multi-influencing systems and factors that shape their lives. Drawing from the principles of an ecological model, feminist therapy theory, multicultural psychology, liberation psychology and critical psychology (Ballou, Matsumoto and Warner, 2002), the feminist ecological model seeks to identify and analyze how systems, such as families, school, work and personal identities (i.e., age, gender and race), collide to influence and shape the lived experiences of women in our society. For some women, their multiple identities within multi-influencing systems serve as buffers against attacks on their personhood, thereby enhancing their opportunities to focus on other aspects of personality and areas of their lives. However, for other women, their multiple identities within multi-influencing systems make them more susceptible to overt and subtle attacks on their personhood, thereby hindering opportunities in their lives. The feminist ecological model also strives to promote social changes by challenging society's values and norms in a way that increases awareness of inequalities and explores different ways that women can cope with events, such as sexual violence, in their lives.

Purpose of the Research

The purpose of this study is to explore the relationships between traumatic symptoms, coping strategies and changes to physical appearances among Caucasian women and Women of Color survivors of adulthood sexual assault. The essence of the paper is to determine the extent to which short-term and long-term changes in physical appearance are utilized as coping strategies among survivors of sexual assault and rape. In addition, this exploratory investigation

seeks to gain insight into the changes in physical appearance and mannerism made by sexual violence survivors in the wake of their victimization.

Potential Benefits of the Research

The goal of this investigation is to produce an empirically-based research study that will contribute to the research literature on adulthood sexual violence survivors and their responses (psychological, behavioral and social) to sexual victimization in their lives. The main objective of this study is to provide information that will broaden the current literature on sexual violence, sexual trauma and coping strategies utilized by survivors in the wake on their sexual victimization.

Major Research Questions

This study will examine the effects of traumatic symptoms, coping strategies and changes to physical appearance among Caucasian women and Women of Color survivors of adulthood sexual violence. The following research questions and hypotheses are posed.

Research Question # 1

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported traumatic symptom(s)?

Hypothesis: There is a significant difference in traumatic symptoms reported by Caucasian women and Women of Color in the wake of their sexual victimization.

Research Question #2

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported coping strategies?

Hypothesis: There is a significant difference in coping strategies reported by Caucasian women and Women of Color survivors of adulthood sexual violence.

Research Question #3

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their overall psychological investment in physical appearance in the wake of their sexual victimization?

Hypothesis: There is a significant difference in the overall psychological investment in physical appearance reported by Caucasian women and Women of Color survivors of adulthood sexual violence.

Research Question # 4

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported physical appearance self-schema (i.e., self-evaluative satisfaction/dissatisfaction about their physical appearance)?

Hypothesis: There is a significant difference in the physical appearance self-schema reported by Caucasian women and Women of Color survivors of adulthood sexual violence.

Research Question # 5

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported participation in behaviors aimed at managing their physical appearance (i.e., motivational salience of grooming behaviors)?

Hypothesis: There is a significant difference in attempts to manage physical appearance reported by Caucasian women and Women of Color survivors of adulthood sexual violence.

Operational Definitions

The following definitions are key words and concepts in this study:

Body Image: Thomas Cash and Thomas Pruzinsky (1990, 2002) defined this term as “a multi-dimensional construct that refers to subjective perceptual and attitudinal experiences about one’s body, particularly one’s physical appearance” (p. 22).

Coping: Richard Lazarus and Susan Folkman (1984) defined this term as the cognitive and behavioral efforts allocated to manage specific external and/or internal demands appraised as taxing or exceeding the resources of the individual.

Motivational Salience of Physical Appearance: Thomas Cash, Susan Melnyk and Joshua Hrabosky (2004) defined this term as “the extent to which individuals attend to their appearance and engage in appearance-management behaviors” (p. 312).

Physical Appearances/Dress: Mary Ellen Roach-Higgins and Joanne Eicher (1992) defined dress as all of the modifications made to the human body and supplements to the body. It includes a long list of changes to the body, which can be either permanent or temporary, such as tattoos, straightened teeth, exercise or permed hair, as well as additions to the body like clothing or weight.

Rape: The National Crime Victimization Survey (2008) defined rape as forced sexual intercourse including both psychological coercion as well as physical force. Forced sexual intercourse mean vaginal, anal or oral penetration by the offender(s). This category also includes incidents in which the penetration is from a foreign object such as a bottle.

Self-Evaluative Salience of Physical Appearance: Thomas Cash, Susan Melnyk and Joshua Hrabosky (2004) defined this term as “the extent to which individuals define or measure themselves by their physical appearance, which they deem influential in their social and emotional experiences” (p. 312).

Sexual Assault: The National Crime Victimization Survey (2008) noted that sexual assaults consist of a wide range of victimizations, separate from rape or attempted rape. These crimes include attacks or attempted attacks generally involving unwanted sexual contact between victim and offender over the age of 18. Sexual assault may or may not involve force and may include such things as grabbing and fondling. Sexual assault also includes verbal threats.

Sexual Trauma: Nicole Yuan, Mary Koss and Mirto Stone (2006) defined sexual trauma as one or multiple sexual violations that invoke significant distress. The term is recommended and used by many clinicians and advocates in response to observations that some survivors do not label their experiences as rape or assault due to familiarity with the perpetrators or the absence of force. In addition, the term may be less stigmatizing for some survivors and may promote healing by acknowledging the impact of a violent act on the individual’s well being. This term will be used interchangeably with sexual assault and rape.

Sexual Violence: The Center for Disease Control and Prevention (2002) defined sexual violence as completed or attempted penetration of the genital opening or anus by the penis, a hand, a finger or any other object; penetration of the mouth by the penis or other objects; abusive sexual contact without penetration, such as intentional touching of the groin; or noncontact sexual abuse, such as acts of voyeurism or sexual harassment.

Survivors of Sexual Violence: The California Coalition Against Sexual Assault (2003) noted that the terms “survivor” and “victim/survivor” emerged as part of the sexual assault victim’s rights movement to describe individuals who have experienced a violent incident, but no longer want any association with the perpetrator or the stigma of being viewed as remaining under the rapist’s influence and control.

Traumatic Symptoms: Cognitive, emotional, physical/medical and social symptoms experienced by survivors in the wake of sexual violence.

Victims of Sexual Violence: The California Coalition against Sexual Assault (2003) noted that the term “victim” is often associated with the early trauma following a rape or sexual assault and emphasizes the fact that a crime has been committed. In addition, the term is often used immediately after the occurrence of the assault or abuse and is always used when someone has died due to the assault or abuse.

Women of Color: Robinson-Wood (2005) noted that “the designation of people of color refers to individuals who are African American, Native American, Indian/Alaska Native (Indian/Native), Asian American, Latino, biracial and multiracial” (p. 5). The term “Women of Color” is an inclusive term used to acknowledge and describe lived experiences of non-white women, including but not limited to African-American, Biracial/Multicultural, Native American and Latino women in the United States.

Chapter Two

Review of Literature

This exploratory study postulates that Caucasian women and Women of Color survivors of adult sexual violence change aspects of their physical appearance and dress to alleviate psychological distress associated with their victimization. It hypothesizes that these changes in survivors' physical appearance and dress are coping strategies and it seeks to explore factors that mediate these changes, as well as to identify some of the changes survivors made to their physical appearance and dress. This chapter begins with a review of the feminist ecological model, the theoretical foundation of this study, which explores the multi-influencing systems in our society that attribute meanings to individual's personal identities (i.e., race/ethnicity, gender and age), thereby shaping their perceptions, and the importance, of self and their lived experiences. As victimization can occur at any time in a woman's life, sexual violence is explored from childhood, within and outside families, and in adulthood, within and outside of intimate relationships. Prevalence rates and psychological and physiological consequences of sexual violence are reviewed, and commonly utilized coping strategies are discussed. This chapter concludes with an exploration of the relationships among identity, body image, physical appearance and dress, and sexual violence.

Due to the extensive nature of this literature review, this chapter will be divided into five sections. The first section, theoretical foundation, focuses on outlining the feminist ecological model in explaining multi-systematic influences shaping individual's lives. The second section, sexual violence, focuses on the various types of sexual violence against women, including prevalence rates of sexual violence in childhood and adulthood, and offenders of sexual violence. The third section, vulnerabilities to sexual violence, focuses on social beliefs, attitudes and

factors that enhance women's vulnerability to sexual violence. The fourth section, coping with the impact of sexual violence, focuses on the impact of sexual violence on women's emotional and physical health and coping strategies commonly used by survivors to alleviate emotional and social distress. The fifth and final section, coping with sexual violence through changes in physical appearance and dress, focuses on changes survivors make to their physical appearance and dress to alleviate the psychological and physiological distress of sexual victimization.

Section I: Theoretical Orientation

Feminist philosopher Simone de Beauvoir wrote in *The Second Sex* (1949), "the body is not a thing, it is a situation; it is our grasp on the world and a sketch of our projects. It is an embodied intentional relationship that is engaged in a dialectical interaction with its surroundings, thereby influencing our projects and shaping our experiences of the body (p. 25). An analysis of this statement reveals that the body is an individual's subjectivity in the world, one's lived experiences. As such, de Beauvoir (1949) further argued that "the body is not a fixed reality. It is a historical sedimentation of our way of living in the world, and of the world's way of living with us" (p. 25). Jean-Paul Sartre defined "lived experiences" as the way an individual make senses of her (or his) situation and actions. A situation "is a structural relationship between our freedom (our projects) and the world" (Moi, p. 65). "As such the body is both a situation and is placed within other situations" (Moi, p. 65). An individual's class, race, gender and relationships to others are situations as well. Accordingly, de Beauvoir (1949) and Sartre (1965) would argue that an incident of sexual violence in a patriarchal society is a situation that is likely to change and shape a survivor's lived experiences, as well as her subjectivity, in the world.

Feminist Ecological Model

The Feminist Ecological Model is consistent with de Beauvoir's assertion that an individual is a situation embedded in other situations. As previously mentioned, the feminist ecological model is a multi-dimensional, mutually-interacting, shifting historical view of reality that explores the multi-identities of individuals and the multi-influencing systems and factors that shape their lives. It is "designed to represent the multiple spheres of influences in people's lives" (Ballou, Matsumoto and Warner, p. 116). The individual is the first sphere of the inner circle (Ballou, Matsumoto and Warner, 2002). Within this sphere, various aspects of the individual are identified, as well as how these aspects influence their interactions with others. Some of the identities within the inner phase may include the race, gender, age and classes of sexual violence survivors.

The second sphere, the micro-system, includes "elements in the person's environment offering immediate, face-to-face interactions and influences" (p. 123). This sphere reflects individuals' relationships with others, such as significant others, immediate family and members of their extended family. "This level of the model includes such factors as the neighborhood or community in which a person lives, the township or city, local government, the school system, including quality of educational resources and access, and resources for employment" (p. 123). Gender or cultural heritage plays an important role in how one interacts with family and immediate community, informs the belief system that one develops and impacts the expectations that one has for daily life in their community, school and work.

The third sphere, the exo-system, includes regional, state and national institutions at this level who are delegated the responsibility of identifying and responding to public interest

concerns. However, “while institutions hold potential to serve as a source for social change by responding to the needs of people, they are not currently structured to do so and remain at a marginal level in accommodating the diverse needs of individuals. Those who are located in positions of power within institutional settings too often make an assumption that they are capable of setting effective goals and determining the means to achieve them without listening to the daily experiences of individuals whose lives are affected by their decisions” (Ballou, et al., p. 125). These decisions often re-victimize those individuals whose lives may be dependent on receiving much-needed services.

The fourth sphere, the macro-system, “consists of a variety of structural and environmental forces, including values, worldviews, human rights, global distribution of resources, politics and the economy. Not only do these factors interact directly with the immediate circle of the exo-system, they further extend their influence in shaping the experiences of groups and communities, as well as the daily lives of individuals” (p. 127). Individuals’, families’, communities’ and societal worldviews about sexual violence are often represented in this sphere, which can greatly influence the resources (i.e., social support) available to survivors at different stages of their recovery process.

The Feminist Ecological Model includes two other factors in its framework: planetary/climatic conditions and time/history. Planetary/climatic conditions refer to constant changes in our environment that lead to severe effects in housing, food, water, clean air and health. Likewise, time and history factors are important as they interact to shape an individual's perception of themselves, of others and of their world. Ballou, Matsumoto and Wagner (2000) noted that “understanding historical events consisting of the exclusionary practices of ‘others’ requires multilevel analysis of power and privilege, while at the same time listening to how

individuals and groups make sense of historical events that shape their present conditions and their hopes for the future” (p. 131). This sphere examines the cumulative effects of developmental transitions, normative (i.e, going to college) and non-normative (i.e., incidents of sexual violence in childhood and adulthood) events that shape one’s interactions with one’s surroundings and affect how one’s surroundings respond to the individual.

While this model explains how different levels of internal and external factors shape the individual, Ballou, Matsumoto and Wagner (2002) also developed coordinates to further explain the connections between individual aspects and lived experiences within a society. Similar to the assertions made by Ferdinand de Saussure (1974) and Roland Barthes (2000) that signifiers are socially constructed signals that affect individuals’ lives, Ballou, Matsumoto and Wagner (2002) noted that sex-gender, race-ethnicity, age and class serve as coordinates (signifiers) that are in constant interaction with all levels of the feminist ecological model, “particularly in terms of their impact on the individuals' experiences with and interpretation of daily life” (p. 131). In addition, Ballou, Matsumoto and Wagner noted that “words, and the constructs they create, often mediate between our comprehension and our experiences” (p. 123). Hence, language is used to construct coordinates (signifiers) that are then used to “unequally distribute power, authority and credit to some while silencing and oppressing others” (Ballou, Matsumoto and Wagner, p. 135). Languages associated with socially accepted rape myths are used to further victimize survivors of sexual violence by prohibiting them from disclosing their victimization and forcing them to shoulder its effects of their own.

The feminist ecological model positions an individual within their family, within their communities and within the greater society. Similar to an input/output system, the model is activated by an individual’s experiences and shaped by their social positions, which are often

determined by personal identities such as age, gender and race/ethnicity, and the negative and positive responses (i.e., values, beliefs and attitudes) from others. These factors attribute meanings to the experiences and hence societal responses to them and to the individual. Sexual violence is one of those experiences that affects the lives of many females in our society daily and one in which women, rather than their offenders, are viewed negatively for the crime that was committed against them.

Section II: Sexual Violence

There are no sexual assault-free or rape-free societies. By the end of this day, more than 600 females will be sexual assaulted. Unfortunately, for many reasons, many of them will not report their sexual victimization to others. Violence against women is often categorized under the heading of sexual violence. As previously mentioned, sexual violence is a term used to encapsulate the various acts of violence against women. In addition to the Center for Disease Control and Prevention's definition of sexual violence, acts that involve the denial of the right to use contraception, or to utilize other measures to protect against pregnancy or sexually transmitted diseases, and forced abortion are also considered acts of sexual violence.

Acts of Sexual Violence within the Family

Childhood Sexual Assault

Sexual violence is rooted in childhood and is often referred to as a problem of youth. Childhood sexual abuse is an act of sexual violence against a child under the age of twelve. Acts of childhood sexual abuse are defined "as any activity with a child before the age of legal consent that is for sexual gratification of an adult or a substantially older child" (Johnson, p. 2).

These activities include oral-genital, genital-genital, genital-rectal, hand-genital, hand-rectal, or hand-breast contact. This definition of childhood sexual assault includes, but is not limited to, “exposure of sexual anatomy, forced viewing of sexual anatomy, showing pornography to a child or using a child in the production of pornography” (Johnson, p. 2). Acts that include viewing or touching the genitalia, buttocks or chest by preadolescent children, separated by no more than four years, and in which there has been no force or coercion, is termed sexual play (Johnson, 2001).

Incest

Childhood sexual abuse within the family is termed incest. The Rape, Abuse and Incest National Network defines incest as “sexual contact between persons who are so closely related that their marriage is illegal (e.g., parents and children, uncles/aunts and nieces/nephews, etc.). This usually takes the form of an older family member sexually abusing a child or adolescent” (RAINN, 2009). While these acts often occur within a family setting, these acts also occur within the general community setting by friends of family members and strangers. One researcher describes incest as: “the sexual abuse of a child by a relative or other person in a position of trust and authority over the child. It is a violation of the child where he or she lives—literally and metaphorically. A child molested by a stranger can run home for help and comfort; a victim of incest cannot” (Vanderbilt, 1992, p. 51). According to the National Center for Victims of Crime (1997), “incest also includes oral-genital contact, genital or anal penetration, genital touching of the victim by the perpetrator, any other touching of private body parts, sexual kissing and hugging.” An additional definition includes characteristics such as sexually staring at the victim by the perpetrator, accidental or disguised touching of the victim's body by the

perpetrator, verbal invitations to engage in sexual activity, verbal ridiculing of body parts, pornographic photography, reading of sexually explicit material to children and exposure to inappropriate sexual activity (Caruso, 1987).

Prevalence of Childhood Sexual Assault and Incest

Prevalence of incest in the United States continues to be difficult to measure, as attitudes, definitions and statistics continue to vary from state to state. Similar to other acts of sexual violence, incest is perhaps the most underreported and least discussed crime in the United States, according to the National Center for Victims of Crime (1997). In addition, incest survivors often conceal their victimization because of guilt, shame, fear and social and familial pressure, including coercion by the abuser(s). A synthesis of findings from sixteen studies on the prevalence of childhood sexual abuse estimated that 22% of U.S. women were sexually abused in childhood (Gorey & Leslie, 1997). Several U.S. surveys, including the National Women's Study (NWS), the National College Health Risk Behavior Survey (NCHRBS) and the National Violence against Women Survey (NVAWS), have found that numerous survivors of rape self-reported that their first sexual victimization occurred before the age of eighteen. The NCHRBS revealed that 71% of sexual violence survivors reported that their first rape occurred before the age of 18 (Brener et al., 1999). The NVAWS revealed that 54% of all first rapes of women occurred before the age of 18, and almost half of those occurred before the age of 12 (Tjaden & Thoennes, 2000). Likewise, the NWS found that 62% of all rapes occurred before the age of 18, and 29% occurred before age 12 (Kilpatrick et al., 1992).

According to *Child Maltreatment 2007* (2008), of the 794,000 victims of child maltreatment in the federal fiscal year 2007, 59.0% experienced neglect, 10.8% were physically

abused, 7.6% were sexually abused, 4.2% were psychologically maltreated and less than 1% of victims experienced other types of maltreatment such as abandonment, threats of harm and congenital drug addiction. Of the 794,000 victims of child maltreatment, 56,460 children were victims of sexual abuse in the United States. Based on the reporting of forty-eight states, Caucasian children accounted for 51.5% (29,086), African-American children accounted for 16.7% (9,450), Hispanics/Latino children accounted for 18.3% (10,344), Bi-racial/Multiple Race children accounted for 1.4% (792) and American Indian children accounted for 0.6% (317) of this amount. Overall, 51.5% of all victims, regardless of the types of maltreatment, were female.

The National Child Abuse and Neglect Data System (NCANDS), a voluntary national reporting system for the Department of Health and Human Services, collects and analyzes the reported data used in the Child Maltreatment 2007 Reports. NCANDS defines “perpetrator” as “the person who has been determined to have caused or knowingly allowed the maltreatment of the child” (Child Maltreatment 2007, p. 113). According to NCANDS, there were approximately 61,332 reported perpetrators for the 56,460 reported acts of sexual violence against children under the age of 17 in 2007. Based on this amount, 34,038 perpetrators accounted for 16,168 biological parents and 17,870 other relatives of the child. The remaining 27,294 perpetrators fell under the heading of non-parental and non-relative perpetrators, such as daycare providers, friends and neighbors, residential staff, foster parents and unmarried partners of parents.

In her article, “The Sexual Abuse of Afro-American and White-American Women in Childhood,” Gail Wyatt (1992) conducted a study to assess various aspects of childhood sexual violence, including prevalence, among a community sample of multi-ethnic women and found that African-American women were more frequently victims of sexual abuse than Caucasian

women. The study's sample consisted of 126 African-American and 122 White American women, between the ages of 18-36, in Los Angeles County. The women were matched accordingly by educational status, marital status and number of children and later divided into two age groups to explore changes in prevalence rates after World War II and before the sexual revolution in the 1960s. Although the women were not matched economically, Wyatt noted that 80% of Afro-American women and 20% of White women reported income less than \$5,000 annually. While this finding was significant, it was considered normative in comparison to statistics among African American and White American women residing in the Los Angeles County area.

Sexual experiences in the study were defined by four categories: types of behaviors; ages of subjects and the perpetrators; relationships of the offender(s) to the survivors; and willingness of survivors to give consent to participate in the sexual act(s). Sexual abuse comprised of contact of a sexual nature, ranging from non-body contacts (i.e., sexual gestures) to sexual intercourse. The act was considered sexual abuse when females were under the age of 18 and the offenders were five years or older than their victims. The role of perpetrators was broadly defined to include any offender of sexual violence inside and outside of the family. Survivors' willingness to participate was categorized as abusive or unwanted. Sexual experiences were considered abusive if it involved survivors who were 12 years old or younger or if the survivors were between the age of 13 and 17 and the offender was older. Unwanted sexual experiences included age-related peer perpetrators, regardless of the age of the survivors. The study's assessment instrument consists of the Wyatt's Sexual History Questionnaire, a 478-item structured interview that includes both open and closed-ended questions that assess participants'

sexual socialization, knowledge of sexual education, range of sexual behaviors and extent of sexual abuse.

There were several major findings of this study. One of the study's findings revealed that while there was not a significant difference in age, peer abuse, unwanted sexual experiences (i.e., solicitation and unwanted kissing) and incidents of sexual abuse in childhood and adolescence, African-American women reported more incidents of sexual abuse per person in comparison with Caucasian women. "The percentage of abused women who reported more than one abuse incident was 52% among Afro-American women as compared to 48% among White women, $\chi^2(2, n = 153) = 1.19, p > .05$ (Wyatt, p. 64). In terms of prevalence rate of childhood sexual abuse prior to the age of 18, Wyatt found that 1 in 2.5 Afro-American women experienced some form of abuse involving body contact, as did 1 in 2 white women. Additional findings provided information on contact and non-contact sexual abuse, location of sexual victimization and perpetrator of sexual victimization experienced by African-American and Caucasian American female survivors of childhood sexual violence. While White woman reported more body contact abuse before the age of 8, inside and outside of their home by white and non-white males, African-American women reported experiencing more body contact abuse during their pre-adolescent age mainly by Afro-American males in their home or homes of extended family members. Likewise, both African-American and White women reported non-contact abuse occurs within neighborhoods by members of various ethnic groups. This groundbreaking study provided a snapshot of a potential victim of childhood sexual assault as a pre-teen, unmarried, Black female of a lower socio-economic background at the hands of a family member. However, regardless of ethnic groups, the study clearly revealed the pervasiveness of childhood sexual abuse.

This study was instrumental in outlining the prevalence of sexual assaults in childhood among African-American and Caucasian women within their families and their communities. As a result, the study was crucial in tracing the prevalence of sexual violence in childhood to the prevalence of sexual violence in adulthood within families and within the greater communities (Wyatt, 1992). In exploring the prevalence rates among women of different ethnic and racial groups, this researcher revealed a noticeable difference in sexual violence perpetuated against African-American women. Unfortunately, sexual assault revealed in childhood leads to vulnerabilities to sexual violence in adulthood as well.

Domestic Violence and Marital Rape

There is an ongoing debate by domestic violence clinicians, advocates and researchers to define domestic violence. As a result of this debate, terms like domestic violence, family violence and spouse abuse have been used interchangeably to define domestic violence and are used to describe violence within family settings that is perpetrated by either a man or a woman (Straus & Gelles, 1986; Straus, 1999). However, using these terms has limited the messages about the intensity of domestic violence. For example, the terms “battered wife,” “batterer” and “assailant” convey images of repeated abuse of a woman by her possessive and violent husband, partner or lover, while terms like “battering” and “domestic violence” imply or are specifically limited to physical acts of aggression. Researchers argue that the impacts of psychological, sexual and emotional abuse are often missing from such definitions (Jones, Davidson, Bogat, Levendosky & von Eye, 2005; Chang, 1996; Tolman, 1992), leading survivors and others (i.e., clinicians, doctors and police) to minimize the effects of this crime.

Wife battering, one of the first recognized patterns of domestic violence, is constructed as a pattern of domination, intimidation and coercive control (Dutton & Goodman, 2005; Pence & Paymar, 1993). In this pattern, a husband or male partner is extremely physically and psychologically abusive toward his wife or female partner. Psychological abuse, such as belittling and constant criticism, often precedes physical violence (Frieze, 2005). As this pattern of abusive behaviors becomes more normalized, the female victim's self-esteem and self-image is decreased, which increases her belief that she must have done something to be treated poorly.

While the legal definition of marital rape varies within the United States, it is defined as any unwanted intercourse or penetration (vaginal, anal or oral) obtained by force, threat of force or when the wife is unable to consent (Bergen, 1996; Pagelow, 1992; Russell, 1990). As marital rape is most likely to occur in family relationships characterized by other forms of violence, Johnson and Sigler (1997) argue that marital rape is "just one extension of domestic violence" (p. 22). Finkelhor and Yllo (1985) found that the majority of women who are raped by their partners are also battered. Hence, they are likely to be victims of both physical and sexual violence. Women who are raped and battered by their partners experience the violence in various ways. For example, some women are battered during the sexual violence, or the rape may follow a physically violent episode when the husband wants to "make up" and thus coerces his wife or partner to have sex against her will (Bergen, 1996; Finkelhor & Yllo, 1985). Other women experience what has been labeled "sadistic" or "obsessive" rape; these assaults involve torture and/or "perverse" sexual acts and are often physically violent. Pornography is frequently involved with sadistic forms of rape (Bergen, 1996; Finkelhor & Yllo, 1985). "Although it may involve forced sexual relations, domestic violence, compared to adult sexual violence, is more likely to involve longer standing and more committed relationships, multiple co-occurring forms

of psychological and physical violence, repetitiveness and often escalation of the abuse over time, and the involvement of children directly or as witnesses” (Koss & Achilles, p. 1; Hopkins, Koss & Bachar, 2004). Domestic violence is really a family affair, as it impacts all members of the family.

Prevalence of Domestic Violence and Marital Rape

According to the Center for Disease Control and Prevention, intimate partner violence occurs in all kinds of intimate relationships, including between married couples and non-married couples whose partners are either living together or dating, or who share a child in common or who have been intimate in the past, regardless of marital status (Saltzman, Fanslow, McMahon & Shelley, 1999). Researchers have found that women are disproportionately affected by acts of domestic violence and marital rape. Rape by intimates may also be secondary to other types of ongoing physical abuse. In 1998, approximately 900,000 women in the United States were beaten or raped by their intimate partners (Rennison, 2000). The Council on Scientific Affairs (1992) revealed that women in the United States are more likely to be assaulted and injured, raped or killed by a current or ex-male partner than by all other types of assailants combined. Rennison (2000) found that between 1993 and 1998, intimate partner violence accounted for 22% of violent crime against women but only accounted for 3% of violent crime against men.

Every year in the United States, approximately 1,600 murders are committed by an intimate, and in three out of four cases, the victim is a woman (U.S. Department of Justice, 2005). More than three women a day are murdered by their husbands or boyfriends in the United States (U.S. Department of Justice, 2007). Women are 84% of spouse abuse victims and 86% of victims of abuse at the hands of a boyfriend or girlfriend (U.S. Department of Justice, 2005).

Most cases of domestic violence are never reported to the police (U.S. Department of Justice, Bureau of Justice Statistics, 2006).

The prevalence of domestic violence and marital rape differ for Caucasian women and Women of Color. While being mindful that differences between the various Latino/Hispanic subgroups exist, findings from the National Violence Against Women Survey (2000) noted that while there was little difference in Hispanic (21.2%) and non-Hispanic (22.1%) women's reports of intimate partner violence, Hispanic/Latino (7.9%) women were more likely than non-Hispanic (5.7%) women to report that they were raped by a current or former intimate partner at some time in their lifetime. Native Americans described the offender as an acquaintance in 34% of rapes/sexual assaults, and as an intimate partner or family member in 25% of sexual assaults. African-American females experience intimate partner violence at a rate 35% higher than that of white females and 2.5 times the rate of women of other races (Department of Justice, Bureau of Statistics, 2001).

Historical and present day racism against African-American women has contributed to their being less likely to report their abuser or seek help from social services, battered women's programs or medical caregivers. Research has also shown that, because of African-American men's vulnerability to negative stereotyping and police brutality, African-American women are less susceptible to report domestic violence (Nash, 2005). The number one killer of African-American women ages 15 to 34 is homicide at the hands of a current or former intimate partner (Africana Voices against Violence, Tufts University, Statistics, 2002).

Patricia Tjaden and Nancy Thoennes (2000) found that women were more likely to be physically or sexually assaulted by a current or former intimate partner than an acquaintance, family member, friend or stranger. Likewise, they found that approximately 25% to 35% of

women will experience intimate partner violence over the course of their lives. Some women are more vulnerable to intimate partner violence (Tjaden & Thoennes, 2000). Poor women and young women are particularly at risk for becoming victims of intimate partner violence. Women who are separated and divorced are also at increased risks for intimate partner violence. Tjaden and Thoennes (2000) also found that women from ethnic minority backgrounds, specifically Native American and African-American women, are at increased risk for intimate partner violence.

Acts of Violence in the General Community

Sexual Assaults and Rape

Sexual assaults and rape are among the most common crimes in our society. Date rape, also known as acquaintance rape, is a common form of sexual violence against women. While this type of rape is often linked to younger adults, mainly college students, date rape can occur at any age. This form of rape may include the use of physical– and mind–altering drugs. While the voluntary use of drugs and alcohol has been linked to increased sexual victimizations of women, date rape perpetrators use common drugs, such as gamma hydroxyl butyrate (GHB) and ketamine (Special K) to rape or commit other types of sexual violence. Often victims are unaware that they have been drugged before their victimization. “Perpetrators often choose these, and other drugs, to facilitate rape, because they work quickly to relax muscles and make the intended victim lose her memory for a period of time, usually several hours after taking the drug” (Schwartz, Milteer & LeBeau, 2000). Unfortunately, because these drugs are used recreationally by both men and women, it is difficult to determine if survivors use them intentionally or if they are used to perpetrate sexual violence.

Gang Rape

While discussed to a lesser degree than other acts of rape, gang rape is rape that involves at least two or more perpetrators. The U.S. Department of Justice's Criminal Victimization 2006 Statistical Tables (2008) revealed that during 2006 there were approximately 260,940 victims of rape and sexual assault. Of this amount, approximately 222,400 acts involved a single perpetrator and 38,520 acts involved multiple perpetrators. Using national statistics on rape and sexual assault, Greenfeld (1997) noted that one out of ten sexual assaults/rapes involve multiple perpetrators. Most of these acts of sexual violence are committed by people unknown to their victims. In comparison to individual rapes, Ullman (1999) found that gang rapes often involve more alcohol and drugs, night attacks, severe sexual assault outcomes, less victim resistance and fewer weapons. In addition, survivors of gang rape are more likely to seek out police services, contemplate suicide and seek therapy in comparison to survivors of a sexual violence involving one perpetrator.

Prevalence of Sexual Assaults and Rape

Sexual assaults and rapes continue to be some of the most underreported crimes in the United States, with more than 60% of incidents going unreported. As rape has one of the lowest reporting rates for any violent crime (Kilpatrick, Edmunds & Seymour, 1992; Bachar & Koss, 2001), it is often difficult to access the prevalence of sexual victimization. Researchers have found that women who are raped by their intimate partners and acquaintances are also less likely to report to the police (Lees and Gregory, 1993), are less likely to access medical and psychological care (Koss, Gidycz and Wisniewski, 1988) and may be seen as more culpable and

thereby less deserving of support from partners, family and friends (Baker, Sholnik, Davis and Brickman, 1991) than those who are raped by strangers.

Two federal government indicators, the FBI's Uniform Crime Report (URC), which included rapes reported to law enforcement, and the U.S. Department of Justice's National Crime Victimization Survey (NCVS), which surveys U.S households and tallies the responses of individuals over the age of 12, provide annual reports on violent crimes and property crimes in the United States. The American Medical Association (1997) has noted that the reported estimates of rape and sexual assault are consistently lower than actual occurrence of the incidents. While the results of the 2006 URC reported 92,455 incidents of sexual assaults that year (Crime in the United States, 2005), the NCVS (using new methodology) estimated 272,350 sexual assaults against victims over 12 years of age in 2006 (Rand and Catalano, 2007). 2006 Crime Clock calculations indicate that in the United States there is one forcible rape every 5.7 minutes.

In November 2000, the National Institute of Justice Centers for Disease Control and Prevention published its full report of violence against women study. The Prevalence, Incidence and Consequences of Violence against Women: Finding from the National Violence against Women Survey was conducted by Patricia Tjaden and Nancy Thoennes (2000) to further explore the prevalence and consequences of physical and sexual violence of male to female and female to male victimizations. Participants were recruited through random digit-dialing (RDD) from households with a telephone in the 50 states and District of Columbia. Eligible participants included residential households that included men and women age 18 years and older. Using a computer-assisted telephone interviewing (CATI) system, respondents were asked questions about incidents of sexual victimizations, physical assaults, stalking, victim-perpetrator relationships and characteristics and consequences of violence. While the study consisted of

8,005 adult men and 8,000 adult women from various racial/ethnic backgrounds, this study focused on the experiences of physical and sexual assaults of women.

The study's samples consisted of 6,452 Caucasian women, 780 African-American women, 133 Asian/Pacific Islander, 88 American Indian/Alaska Native and 397 women of Mixed Races. The participants' ages ranged between 18-80, with 62% falling between the ages of 30-59. Sixty-two percent of the women were currently married, with 15.4% never married and 13.2% divorced or separated. Thirty-five percent of the respondents over the age of 25 had earned a high school diploma or its equivalent and 45.7% had earned a college degree.

There were several major findings of this study. Tjaden and Thoennes (2000) found that 52% of the women surveyed reported incidents of physical assaults, which included behaviors from pulling hair or spanking to using a knife or gun, in childhood and in adulthood. Of the women surveyed, 1.9% reported being physically assaulted by someone within the past twelve months. Based on this amount, Tjaden and Thoennes (1998) alleged that approximately 1.9 million women are survivors of physical violence annually in the United States.

A second significant finding suggested that 18% of the women surveyed reported at least one incident of completed or attempted rape during their lifetime. Incidents of rape were defined as forced anal, oral or vaginal penetration. Of the women who reported an incident of completed rape in their lifetime, 22% noted that they were first victimized in childhood before the age of 12, and 32% of the rapes occurred between the ages of 12 and 17 (Tjaden and Thoennes, 1998, 2000). Based on their racial/ethnic backgrounds, while American Indian/Alaska Native women were more likely to report incidents of physical and sexual victimizations, Asian/Pacific Islander women were less likely to report incidents of physical and sexual victimizations. In addition, Hispanic women were less likely to report sexual victimization than non-Hispanic women.

The study also shed some light on the prevalence rate of domestic violence. Of the women surveyed 25%, in comparison to 8% of the men surveyed, reported incidents of physical and sexual assaults by a spouse, live-in partner or a date in their lifetime. In addition, 1.5% of women and 0.9 % of men reported being physically and sexually assaulted within 12 months of being surveyed. The study findings also suggested that violence against women often occurred in intimate relationships. Seventy-six percent of the women, in comparison to 18% of the men surveyed, who were physically or sexually assaulted at the age of 18 and beyond were assaulted by spouses, cohabitating partners or on dates. Although approximately 14% of the women surveyed identified as Women of Color, they accounted for 82% of women who reported rape and physical assault in their lifetime, in comparison to the 86% of women who identified as White and accounted for 18% of reported rape and physical assault in their lifetime.

In addition, Tjaden and Thoennes (2000) found that women were more likely to incur physical injuries during their assaults. Thirty-two percent of women and 16% of the men surveyed who were victims of sexual victimization after the age of 18 reported sustaining physical injuries in comparison to 39% of women and 25% of men in the most recent assaults. In the wake of their injuries, 35.6% of women raped and 30.2% of women physically assaulted reported receiving medical treatment in the wake of their victimizations. Finally, 8% of the women and 2% of men surveyed reported being stalked at some point in their life. Stalking was defined to include the victims reporting experiencing a high level of fear. One percent of the women and 0.4% of men surveyed reported being stalked within 12 months of being surveyed. Based on this study's results, Tjaden and Thoennes (1998) estimated that approximately 1 million women and 371,000 men are victims of stalking annually.

Tjaden and Thonnes's (2000) study expanded Wyatt's (1992) study on the prevalence rates of childhood and adulthood sexual violence among a group of multi-ethnic women, as well as offenders of sexual violence. The results expanded our knowledge about the impact of sexual violence on women's mental and physical health and revealed the continuum of sexual violence from childhood to adulthood that leaves women vulnerable to a lifetime of violence. While all women are vulnerable to sexual violence, the result of this study continues to provide evidence that suggests that Women of Color are most likely to be survivors of physical and sexual violence.

Offenders of Sexual Violence

The U.S. Department of Justice's Criminal Victimization 2006 Statistical Tables (2008) revealed 95.4% of perpetrators of sexual violence by a single offender and 89.6% of multiple perpetrators were male. Based on race/ethnicity, 48.8% of offenders were Caucasian, 18.1% were African American and 16.2% were identified as others. The race/ethnicity of 17.0% of offenders was noted as missing/unknown. Offenders between the ages of 18-20 accounted for 22.9% of all reported sexual incidents, those between the ages of 21-29 accounted for 22.8% of all reported sexual offenses and perpetrators over the age of 30 accounted for 28.9% of the reported sexual offenses. For all acts of sexual violence, regardless of the number of offenders, 21.4% of offenders were intimates of their victims, 44.3% were friends or acquaintances of their victims and 31.1% were strangers to their victims. In 71.6% of all reported incidents of sexual violence, no weapon was used, compared to 18.1% of incidents in which weapons were used.

The first and second sections of this literature review focused on the theoretical foundation of this study, various forms of sexual violence against women within their home and

their communities, prevalence rates of sexual violence in childhood and adulthood and offenders of sexual violence. The third section focuses on social beliefs, attitudes and factors that enhance women's vulnerability to sexual violence.

Section III: Vulnerabilities to Sexual Violence

Rape Myths and Stereotypes of Sexual Assault

There are many rape myths, misconceptions and stereotypes that impact how society views sexual violence against women. Originally defined by Burt (1980), rape myths were noted to be “prejudicial, stereotyped or false beliefs about rape, rape victims and rapists” (p. 217). Researchers have struggled for years over an operational and theoretical based definition for rape myths. They settled on three distinctive characteristics to define the term: “they are false or apocryphal beliefs that are widely held; they explain some important cultural phenomenon; and they serve to justify existing cultural arrangement” (Lonsway and Fitzgerald, p. 134). When these characteristics were later combined with a cultural theory of rape, a new definition of rape myths was proposed as “attitudes and beliefs that are generally false but are widely and persistently held, and that serve to deny and justify male sexual aggression against women” (p. 134).

Feminist researcher Susan Brownmiller (1975) identified four fundamental myths of rape: *all women want to be raped; no woman can be raped against her will; she was asking for it; and if you are going to be raped you might as well enjoy it.* Other gendered myths that support sexual assaults against women are: *husbands cannot rape their wives; women who are raped must have done something to cause it to happen; nice girls don't get raped; and most women secretly desire and enjoy being raped.* Brownmiller (1975) admitted that “virtually every

common stereotype existing about rape has been discredited by accumulated knowledge over the past 20 years” (p. 6). For example, one common myth is that *rape is a physically violent assault carried out by a psychotic stranger in a dark alleyway at night*. However, current sexual violence statistics (NCV, 2008) show that two-thirds of all sexual offenders are known to their victims.

While it is common that individuals blame themselves for the outcomes of negative life events, perhaps what is more common is that many people often blame sexual assault victims for their victimizations. This stigmatization takes places at all levels of our society, unfortunately often starting with the individuals and exacerbated by their families and other external system. Victims are often bombarded with questions such as: Why were you out at that time of day? What were you wearing? Were you intoxicated? Did you scream for help? These questions all imply the same thing: the victims were responsible for their victimizations. These responses directly and indirectly confirm rape myths. Rape myths cause survivors to shoulder the blame for their victimizations, hindering their ability to report them and limiting their recovery process. Rape myths minimize the incident and impact of sexual violence and societal response to it, thereby increasing females’ vulnerabilities to sexual violence.

Perhaps a more appropriate question is when a woman gives up her power to consent to sex? Does she give it up if she is in her home or outside in her community too early in the morning or too late at night? Does she give sexual consent by what she is wearing, if she is intoxicated or whether or not she screamed in the face of sexual violence? Many would argue that woman has a responsibility to keep her power, particularly in a patriarchal society which deems her “weakness as a character trait indicative of her inferiority and her powerlessness as a political position, indicating her appropriate place in the hierarchical status system. While each

individual can hold on to her power by being aware of what beliefs, feelings and actions increase her vulnerabilities to violence, Smith (2004) noted the following:

“sexual intercourse without consent is always rape regardless of the circumstance and characteristics of the victim or offender. It is rape whether or not a weapon was used, excessive force was used, there are visible signs of violence, or a victim fought back. No one owes sex because they are dating, married, ‘sexually teasing,’ prostituting, or previously or currently engaging in other consensual sexual activity. No one deserves or does something to invite rape. Rape is always the responsibility of the offender” (Smith, p. 193).

Rape is never the responsibility of its victim(s).

Racial Myths of Sexual Assaults

Racist, classist and sexist stereotypes play a key role in the development and maintenance of rape and rape myths in the lives of African-American women. Living in the intersection of race, class and gender oppression often further complicates African-American women’s lives and their experiences of rape (Holzman, 1996; McNair & Neville, 1996). As the goal of a patriarchal society is to focus on the lives of men through maintaining male control, dominance, identification and centeredness, the lives of women are largely devalued by making both them and what they do invisible (Johnson, 2005). Women are to occupy a position of ‘less than’ or ‘one down’ in order to be truly feminine” (Stewart, p. 64). While gender constructs assign unearned privilege to men, particularly white men, race constructs assign privilege to some women and inequality to others. While disclosing incidents of sexual violence is challenging for all women, some women will experience patriarchy vastly differently depending on their race, class and other social markers of identity that are different from, and interact with, their gender identity (West, 1999). Historically, the roles of virtuous and moral women have often been set aside for white, not impoverished, married, heterosexual and law-abiding women, while the roles

of promiscuous and immoral women have often been set aside for nonwhite, working class or poor, rural, unmarried, homeless, sex worker, sexually active or queer women. Unfortunately, these role distinctions are still intact today. Donovan and Williams (2002) noted that African-American women, and other women of color, are likely to experience a double dosage of rape myths, those that target all women who are victims of sexual violence and those that claim that African-American women are especially deserving of being victims of sexual violence.

In *Crossing The Boundary: Black Women Survive Incest* (1993), author Melba Wilson noted that issues of racism, sexism and perceptions about Black women's sexuality, by those inside and outside of Black communities, has lead to the generation of myths and stereotypes that have contributed to and supported the invisibility of sexual violence, specifically incidents of incest in the lives of African-American women. She identified four fundamental misconceptions of incest, childhood sexual abuse and rape among African-American girls/women: *incest is normal in black communities; black women can handle it; incest is sexual education; and black girls/women are sexual animals*. She noted that "such myths are at best inexcusable and at worst detrimental to our well-being as women and as survivors" (p. 6). Wilson argued that the acceptance of these myths as realities sets the foundation for the belief that if incest is normal in Black communities, then it must only mean that Black women must be able to handle it throughout their lifespan.

The belief that Black women are un-rapeable continues to exist. In several studies, researchers asked college students to respond to hypothetical scenarios that involved sexual assault (Varelas & Foley, 1998; Willis, 1992). When the victim was a Black woman, students were less likely to define the incident as date rape, to believe the crime should be reported to the police and to hold the perpetrator accountable (Foley, Evanic, Karnik, King & Parks, 1995). In

addition, students rated a Black date rape victim, when compared to her White equivalent, as less truthful and more responsible for her sexual assault (Wills, 1992). It also appeared that Black rape survivors were held more responsible for their victimization, regardless of the perpetrator's race (Varelas & Foley, 1998). These data suggest that Black women's long history of sexual victimization, coupled with racial stereotypes, exacerbated their rape experiences. As a result, African-American survivors may receive less empathy, consideration and judicial support than their Caucasian counterparts.

Foley and colleagues (1995) have noted that "racial history and rape myths...make African-American women more vulnerable to forced sexual encounters while simultaneously making accusations of rape more difficult for them" (p. 15). Images of Black women as promiscuous, immoral Jezebels and as strong, dominant and aggressive Matriarchs is still alive today. Patricia Collin (2000) noted that "Jezebel was a powerful rationalization for the sexual atrocities perpetrated against enslaved African women and the use of this image was necessary to justify the rape and forced breeding of Black women." Matthew Christensen (1988) pointed out that it is paradoxical that "the only women to ever suffer socially sanctioned and induced sexual abuse were branded loose and immoral. Because Black women were portrayed as Jezebels, they become sexual temptresses who led men astray rather than victims of abuse (Collins, 2000; West, 2000). Contemporary Jezebels are referred to as *welfare queens*, *hoochies*, *freaks* and *hoodrats*. These myths about black women's sexuality continue to prevail, heightening their vulnerability to sexual violence in our society.

The Jezebel image influences perceptions of partner violence as well. While marital rape is very common and occurs throughout most cultures (Hall, 1985; Heise et al., 1994), a common rape myth is that *husbands cannot rape their wives*. Tameka Gillum (2002) investigated the link

between stereotypical images of Black women and intimate partner violence in the Black community. Although 94% of the African-American men in this sample endorsed positive beliefs about African-American women, 48% also endorsed the Jezebel stereotype, which was measured by items such as “African-American women are likely to sleep around.” The Jezebel stereotype was positively related to the justification of domestic violence against Black women, implying that sexual and physical assaults against Black women were taken less seriously.

Re-victimization of Sexual Violence

Recent studies have shown that women who have a previous history of sexual victimization, in childhood or adulthood, are at an increased risk for subsequent victimization. Survivors of childhood sexual abuse are 2.5 to 3 times more likely than non-victims to be sexually victimized in adulthood, a phenomenon referred to in the literature as sexual victimization (Arata, 2002; Cloitre, Tardiff, Marzuk, Leon & Potera, 1996; Roodman & Clum, 2001). Childhood sexual abuse survivors are three to five times more likely to be raped as adults than respondents who did not experience any type of child abuse (Maker, Kemmelmeier & Peterson, 2001; Merrill et al., 1999; West, Williams & Siegel, 2000).

Predictors of Sexual Re-victimization

Childhood Sexual Assaults

In an attempt to explain why sexual re-victimization occurs, several hypotheses that largely focus on mediating psychosocial factors have been proposed. Among the variables proposed to mediate the relationships between childhood sexual assault and re-victimization are personality variables, such as assertiveness, self-esteem and attributional style (Ellis, Atkeson &

Calhoun, 1982; Miller et al., 1978); psychological distress, particularly psychological adjustment, dissociation and posttraumatic stress disorder symptomatology (Arata, 1999; Ellis et al., 1982; Miller et al., 1978; Sandberg, Matorin & Lynn, 1999); interpersonal and family dysfunction (e.g., lack of maternal support or poor relationship with parents) (Mayall & Gold, 1995; Romans, Martin, Anderson, O'Shea & Mullen, 1995); risky sexual behavior (e.g., increased number of sexual partners) (Himelein, 1995; Mayall & Gold, 1995); and substance abuse (Gidycz et al., 1995; Greene & Navarro, 1998). Factors such as age, severity of victimization and mental health consequences may link women's early victimization experience to later vulnerability to new sexual assaults.

Poverty and Homelessness

Unfortunately, incident(s) of domestic and sexual violence often lead women into a cycle of poverty. A woman's experiences with domestic violence and sexual violence can lead to job loss, poor physical/mental health and homelessness. In 2004, the U.S. poverty rate was 12.7%. The Center for American Progress (2008) found that in 2007, the poverty rates were higher for women (13.8%) than for men (11.1%). The University of Michigan's National Poverty Center (2008) found that poverty rates for African-Americans and Hispanics were well above the national poverty level. The National Poverty Center noted that in 2008, "24.7% of Blacks and 23.2% of Hispanics were poor, compared to 8.6% of non-Hispanic whites and 11.8% of Asians" (National Poverty Center, p. 2). Poverty rates were also found to be highest for families headed by single women, specifically Black and Hispanic women. In addition, the National Poverty Center (2008) found that 28.7% of single women-headed households were poor. This number is

higher for households headed by single Black women, with one in three Black women living in poverty in the United States (DeNavas-Walt, Proctor & Smith, 2007).

Women living in poverty struggle daily with life stressors about how to meet their basic survival needs, such as housing, food and clothing. Scarcity of these resources makes basic safety an expensive commodity. According to the Center for Disease Control and Prevention (Tjaden & Thoennes, 2000), poverty can make women have less control over their own sexuality, their consenting to sex, their recognition of their own victimization and their ability to seek help when victimized. Poverty may also force women and girls to participate in high-risk survival activities such as sex work (e.g., prostitution), which has been associated with sexual victimization (Irwin et al., 1995).

Poverty coupled with homelessness significantly increases women's and children's vulnerability to rape and other forms of sexual violence. Goodman, Fels and Glenn (2006) found that the risk of adult sexual victimization is significantly increased for homeless women based on: a history of childhood abuse and substance dependence; the length of time they are homeless; coping strategies used for economic survival; their location while homeless; physical limitations; and a history of mental illness. In addition, they found that 13% of homeless women reported having been raped in the past twelve months, and half of these women reported being raped at least twice. In addition, 9% of the homeless women in this survey reported at least one experience of sexual violence in the last month (Goodman, Fels & Glenn, 2006). The National Center on Family Homelessness (2007) found that 41% of the homeless women studied were severely abused by their caretakers; 43% were sexually molested during childhood; 60% were abused before the age of 12; and 41% did not complete high school. Homelessness coupled with mental illness can increase a woman's risk of sexual victimization or re-victimization as well.

Goodman, Fels and Glenn (2006) found that the lifetime risk for violent victimization is extremely high for homeless women with severe mental illness (97%); many of these women might believe that sexual violence is a normal condition of their lives. As such, many homeless women suffer a higher rate of emotional distress, including major depression (47%), substance abuse (45%) and PTSD (39%), when compared to non-homeless women.

Section IV: Coping with the Impact of Sexual Violence

This section of the literature review focuses on the immediate and long-term impacts of sexual violence on women's bodies and coping strategies utilized by survivors to alleviate psychological and physiological distress associated with being victimized.

Sexual Trauma

The impact of sexual violence on women's lives can best be described as destructive. Laurie Ann Pearlman and Karen W. Saakvitne (1995) defined psychological trauma as "the unique individual experience of an event or enduring condition in which the individual's ability to integrate his/her emotional experience is overwhelmed or the individual experiences (subjectively) a threat to life, body integrity or sanity" (p. 60). This definition stands out from other trauma definitions by acknowledging that trauma is a unique individual experience that will generate unique individual responses to the event. Susan Brownmiller (1975) argued that rape is an expression of social power, a coercive power that attempts to put and keep women in their place within a patriarchal society. Mary Ann Stewart (2002) made the following argument:

“Rape is a particular type of power statement. It is a statement to a woman that she has no control, that she cannot protect her body, the entrance to herself. He forces himself on her not only to oppress but to humiliate, to speak to her and to those who love her about her worthlessness, her inability to protect or control herself, her life. It is a savagery against one's core, a purposeful violation of a woman's flesh, a vengeful assertion of male power over female, a reenactment of male oppression on an individual level, coupled with a culturally approved justification for that oppression” (p. 149).

In the wake of this physical, mental and emotional violation, it is normal for survivors to experience short and long-term symptomatic responses to their victimization.

Consequences of Sexual Trauma

Most survivors of adulthood sexual violence will experience post-assault emotional distress in response to their victimization(s). According to the Rape Treatment Center (2002) of the UCLA Medical Center in Santa Monica, California, rape symptoms may include shock, disbelief, preoccupation with thoughts and feelings about the assaults, intense sadness, anger, self-blame, shame, nightmares and fears for one's safety. These symptoms are inclusive of two diagnoses frequently associated with rape and sexual assault survivors: Rape-Related Post-traumatic Stress Disorder and Rape Trauma Syndrome.

The National Center for Victims of Crime (1992) noted that Rape-Related Post-traumatic Stress Disorder (RR-PTSD) is a form of Post-traumatic Stress Disorder experienced by survivors of sexual assault and rape. Rape-Related Post-traumatic stress consists of four major symptoms experienced by survivors: re-experiencing the trauma; social withdrawal; avoidance behaviors and actions; and increased physiological arousal characteristics. “Many survivors might have realistic nightmares and dreams about the actual rape...and may relive the event through flashbacks, during which victims experience the traumatic event as if it was happening now” (The National Center for Victims of Crime, 1992). Survivors tend to become socially withdrawn

from their feelings and others, and might be more likely to participate in actions and behaviors that would avoid thoughts and feelings that might remind them of sexual trauma. In addition, survivors might experience physiological reactions, such as sleep disorders, light sensitivity, noise sensitivity, hyper-arousal and hyper-vigilance.

While some of the emotional responses to sexual violence wane over times, “for some survivors, their experiences of sexual trauma fail to resolve and later develop into a chronic, thorough, heterogeneous symptom pattern that may persist for a variable length of time” (Koss & Burkhardt, 1989, p. 29; Ellis, 1983). Researchers found that the lifetime prevalence rates for PTSD range from 1% to 12.3% (Breslau, Davis, Andreski & Peterson, 1991; Davidsson, Hughes, Blazer & George, 1991; Kessler et al., 1995; Resnick et al., 1993), and current rates of PTSD range from .4% to .9% (Andrews et al., 2001; Perkonigg et al., 2000). Kessler et al. (1995) noted that PTSD tends to have a chronic course and postulated that as many as 40% of the individuals diagnosed with this condition continue to exhibit significant symptoms 10 years after its onset.

Studies on the prevalence of PTSD symptoms have provided mixed results. While Helzer, Robins & McEvoy (1987) found that low trauma and crime-related PTSD symptoms affected 1% of a large representative population sample, Breslau, Davis, Andreski & Peterson (1991) noted prevalence results varied on the instruments used to assess PTSD symptoms. Koss (1983) noted that, “data indicate that the use of global legal terms such as “rape” to identify sexual assault crimes leads to vast underestimation of true population rates that are observed when the same incidents are asked about using specific questions about occurrences of vaginal, oral and anal penetration that are unwanted by the victim and that happen as a result of force or the threat of force by any other person regardless of relationship to the victim (Resnick et al., p. 985). Kilpatrick, Saunders, Best and Von (1987) noted that events that presented a threat to life,

bodily injury and completed rape played a significant role in the development of lifetime PTSD. In a community sample of women, Kilpatrick (1987) found a 75% lifetime prevalence rate of exposure to various crimes. Although Helzer et al. (1987) found low trauma and crime-related PTSD symptoms, 27.8% of the women surveyed met the criteria for lifetime PTSD based on the DSM-III (APA, 1980). The highest prevalence rate of lifetime PTSD (57.1%) was found among incident(s) of sexual assault and rape in comparison to any other trauma event.

In their article, *Prevalence of Civilian Trauma and Posttraumatic Stress Disorder in a Representative National Sample of Women*, Resnick et al. (1993) sought to explore the prevalence of crime and non-crime civilian traumatic events and lifetime prevalence of posttraumatic stress disorder among a sample of U.S adult women. The sample consisted of 4,008 women, which comprised of 85.2% White women and 11.6% Women of Color, consisting mainly of African American women. The mean age of the respondents was 44.9 years, with a standard deviation of 18.4 years. Among the women surveyed, 17% had some high school education and 63.4 % had earned a high school diploma. Sixty-four of the women were married and more than 50% of the women were fully employed. The study consisted of six measures that were presented to the respondent as followed: introductory questions, a depressive disorder screening, a victimization screening, a drug and alcohol screening, post-traumatic stress disorder and demographic information. The victimization screening assessed women's exposure to major life events, homicide, rape, sexual molestation, attempted sexual assaults, and physical assault. Participants meet PTSD Criterion A if they reported one or more occurrences of a major life event, indirect victimization as a result of a homicide of a significant other, direct sexual assault and/or direct physical assault. Participants meet PTSD Criterion B, the positive lifetime PTSD diagnosis based on DSM-III-R, if they had one re-experiencing of trauma (Criterion B),

presented with three avoidance behaviors (Criterion C) and reported two increased arousal symptoms (Criterion D) were assigned a positive lifetime PTSD diagnosis. Respondents were assigned a positive current PTSD diagnosis if they reported the necessary Criterion B, C and D symptoms within six months prior to participating in the survey.

The study results found that a majority (68.9%) of the participants had experienced at least one type of traumatic event during their lifetime, with one-third of the women reporting incidents of sexual and/or physical assault. Respondents who experienced at least one lifetime traumatic event had a 12.3% base rate for lifetime PTSD and a 4.6% base rate for current PTSD. Resnick et al. (1993) stated that “these figures can be used to generate estimates that 11.8 million adult women in the United States experienced PTSD at some point during their lives and 4.4 million women currently have PTSD” (p. 988). In addition, “the highest rates of lifetime PTSD (38.5%) and current PTSD (17.8%) occurred among women with a physical assault history followed by those with history of rape” (Resnick et al, p. 988). The rate of completed rape in the current study was five times higher than the prevalence rate reported by Breslau et al. (12.7 vs. 2.6%) and three times higher than Norris’s (22.7% vs. 7.3%) findings for general sexual assault of any type (i.e., molestation, attempted rape, completed rape).

The overall prevalence rate for traumatic events in the current study ranged between 40% - 70%, and was consistent with other community surveys (Breslau, et al., 1991; Kilpatrick et al., 1987; and Norris, 1992). In addition, the overall population base rate of 12.3% for lifetime PTSD was similar to 9.2% found by Breslau et al. (1991). Variations in PTSD prevalence rates were contributed to a lack of consistency among assessment instruments. The highest rate of PTSD was associated with physical assault and rape. This finding was consistent with Norris’s (1992) findings that current PTSD was the most prevalent in association with physical and sexual

assault, and the findings by Breslau et al. (1991) that rape was most likely to lead to PTSD. Additional findings revealed that rape survivors who reported their victimization to the police had higher rates of physical injury and death threats in comparison to women who did not report their victimization to the police (Kilpatrick & Resnick, 1991). This study continued to reveal the psychological and physiological distress experienced by trauma survivors, specifically survivors of sexual violence.

Rape Trauma Syndrome

Rape Trauma Syndrome has also been used to describe some of the trauma symptoms experienced by survivors of sexual violence. The term, first coined in 1974 by researchers Ann Burgess and Lynda Homlstrom, is defined as “an acute phase and long-term reorganization process that occurs as a result of forcible or attempted forcible rape” (p. 982). When first introduced in the field, rape trauma syndrome consisted of a two phase-reaction: an acute phase that occurs almost immediately as a result of the rape and is marked by a period of emotional disorganization in the survivor’s lifestyles, and a reorganization phase, in which survivors begin to reorganize their lifestyles in the wake of their victimization. Currently, rape trauma syndrome consists of three phases: acute, outward adjustment and resolution.

According to the Rape, Abuse and Incest National Network (RAINN), the acute phase occurs immediately after the sexual victimization and usually lasts from a few days to several weeks. During this period, survivors present with a variety of emotional symptoms, including shock, fear, anger, loss of trust, shame, sadness and anxiety. “The Philadelphia Assault Victim Study reported that during the acute stage, common reactions to rape may include insomnia, fear of leaving home, guilt and self-blame, restlessness, hyper-alertness, crying, distrust of men and

generalized and specific fear” (Stewart, p. 264). Immediately after the rape, some survivors may present with a variety of expressive behaviors, including uncontrollable crying to smiling and joking with others. Other survivors will present calm, masking their inner feelings of their victimizations.

The second phase of the Rape Trauma Syndrome, the outward adjustment phase, begins approximately three to six months after the sexual victimization. In this phase, survivors make attempts to return to the life prior to the victimization despite being in considerable emotional turmoil. RAINN (2006) identified five primary coping techniques utilized by rape survivors during this phase. They are: minimization (i.e., pretends that “everything is fine” or that “it could have been worse”); dramatization (i.e., cannot stop talking about the assault as it is what dominates their life and identity); suppression (i.e., refuses to discuss, acts as if it did not happen); explanation (i.e., analyzes what happened—what the individual did, what the rapist was thinking/feeling); and flight (i.e., tries to escape the pain by moving, changing jobs, changing appearance, changing relationships, etc.). In this phase, which ranges from months to years, survivors might experience an array of difficulties, including difficulties concentrating, flashbacks, mood swings and difficulties in personal and sexual relationships. The third phase of the syndrome is called the resolution phase. While the assault may no longer serve as the focal point of the victim’s life in this phase of her recovery, the survivor may continue to struggle with some residual emotional symptoms of her victimization.

Some researchers have explored the importance of cognitive variables in the development and maintenance of symptoms related to post-traumatic stress disorder (Ehlers & Clark, 2000; Foa & Cahill, 2001; Foa & Jaycox, 1999; Foa & Riggs, 1993; Foa & Rothbaum, 1998) that might help explain why some survivors might experience more post-assault traumatic symptoms.

Based on the work of Foa & Korak's (1986) emotional processing theory and the information processing models of memory and psychopathology (Cahill & Foa, 2001; Foa & Cahill, 2006), Foa and colleagues postulated that post-traumatic stress disorder "develops when a traumatic experience interacts with an individual's pre-existing perceptions about their competence and the safety of the world" (Moser, Hajcak, Simons & Foa, p. 1040). When a traumatic event collides with an individual's perception about their overall competency to change the outcome and their beliefs about their general safety in the world, "the traumatic event can lead to PTSD if it either: 1) disconfirms rigid perceptions that the world is completely safe and that the self is completely competent or 2) confirms pre-existing perceptions that the world is completely dangerous and the self is completely incompetent" (Moser, Hajcak, Simons & Foa, p. 1040). While it is not uncommon for trauma survivors, specifically survivors of sexual violence, to develop a negative view about themselves, others and their world in the wake of their victimization, these perceptions usually wane in their daily positive interactions with, and absence of being re-traumatized by others (Foa & Cahill, 2001; Moser, Hajcak, Simons & Foa, 2007). However, survivors whose daily experiences are marked by avoidance and social isolative behaviors are likely to ward off or miss positive experiences that can "disconfirm the negative posttraumatic cognitions, thus fostering the development of chronic PTSD" (Moser, Hajcak, Simons & Foa, p. 1040). Hence, social support can play a significant role in the recovery process of survivors of sexual violence.

Long Term Outcome of Sexual Victimization and Re-victimization

Sexual re-victimization presents a host of emotional, medical and physical difficulties for survivors of sexual violence. Research has also provided evidence that sexual victimization is associated with higher rates of anxiety, depression, dissociation, posttraumatic stress disorder (PTSD) and interpersonal difficulties (Williams & Siegel, Long & Siegfried, 2000; Arata, 1999). Re-victimized women are more likely to report neglect or physical abuse by caretakers in childhood, witness parental violence in childhood and experience physical violence at the hands of a dating partner during adolescence than singly or never victimized women (Banyard et al., 2001; Collins, 1998; Stermac et al., 2002).

Numerous studies have found evidence that suggests that women who were victimized on numerous occasions by different perpetrators at different times have worse psychological outcomes than their non-victimized or singly victimized counterparts (Banyard et al., 2001; Gibson & Leitenberg, 2001; Gidycz et al., 1993). Previously victimized women take longer to recover from a subsequent assault, experience more post-assault PTSD symptomatology and use less effective coping methods to heal (Arata, 1999a; Gibson & Leitenberg, 2001). While there was a positive relationship between diminished psychological health and multiple interpersonal traumas (i.e., incidents of physical and sexual assault), non-interpersonal traumas (i.e., serious illness or accidents) did not generate the same level of psychological distress for many sexually revictimized women (Green et al., 2000). A recent meta-analysis by Roodman and Clum (2001), which included data from 19 empirical studies of sexual victimization in adult females, found an overall effect size of 0.59 for sexual victimization, which suggests that sexual victimization is a persistent and chronic phenomenon.

Increased likelihood of alcohol and other drug abuse has been consistently linked with childhood sexual assault (Briere & Runtz, 1993). When compared to their peers, Black survivors of childhood sexual abuse, domestic violence and sexual assault consistently reported high rates of use and abuse of various substances, including alcohol, marijuana and crack cocaine (Curtis-Boles & Jenkins-Monroe, 2000; Davis, R.E., 1997; Marcenko et al., 2000). Researchers speculate that binge drinking may be an effort to block memories of abuse, whereas heavy drinking may be an attempt to reduce generalized anxiety (Jasndinski, Williams & Siegel, 2000).

When compared to non-suicidal controls, suicide attempters were more likely to have had a childhood history of physical, emotional and sexual abuse (Thompson et al., 2002) and a history of physical and emotional partner abuse. Distress, hopelessness and drug use also accounted for the link between partner abuse and suicidal behavior (Kaslow et al., 1998). Black women in psychiatric facilities (Manetta, 1999) and substance abusing Black women (Hill, Boyd & Kortge, 2000) were more likely to attempt suicide if they had a history of childhood physical and sexual abuse. Researchers have found that childhood and adulthood survivors of sexual violence were more likely than non-survivors to smoke cigarettes, overeat, drink alcohol, not use vehicle seat belts, (Koss, Koss & Woodruff, 1991; Walker et al., 1999), smoke crack cocaine and be homeless (Irwin et al., 1995). Survivors have also reported self-mutilation or cutting one's own skin after rape (Greenspan & Samuel, 1989), as well as binge drinking, anorexia nervosa and pregnancy among date rape survivors.

In addition to psychological difficulties, survivors of sexual violence also experience physical and social consequences. In addition to immediate physical consequences such as bruises, scrapes, broken bones and genital trauma, long-term physical symptoms and illnesses associated with rape and child sexual abuse are gastrointestinal disorder, irritable bowel

syndrome (Heitkemper et al., 2001) and chronic back, neck and facial pain. Untreated STDs that result from rape can lead to pelvis inflammatory disease, which is a major cause of infertility (Koss, Heise & Russo, 1997). Other physical consequences of rape include chronic pelvic pain, irregular vaginal bleeding, painful menstrual periods, vaginal discharge, (Golding, 1996; Golding, Wilsnack & Learman, 1998) and premenstrual syndrome (Golding & Taylor, 1996). A social consequence of sexual violence is the negative effect it has on the survivor's relationships with friends, family and intimate partners. Although the quality of social support is helpful to survivors' recovery, positive social support does not appear to help survivors as much as negative social reactions hurt them (Davis, Brickman & Baker, 1991; Ullman, 1996b).

Numerous researchers have suggested that the sheer accumulation of traumatic experiences is responsible for the increased psychological distress found among revictimized women. Women who experience sexual assaults are at greater risk of experiencing non-sexual trauma both in childhood and adulthood (Banyard et al., 2001; Messman-Moore & Long, 2000; Stermac et al., 2002). Follette, Polusny, Bechtle and Naugle (1996) noted a stair step effect when assessing psychological outcomes of women with different levels of trauma histories. Increasing numbers of experiences of child sexual abuse, adult sexual assault and adult partner violence were accompanied by concomitant increases in anxiety, depression and posttraumatic symptoms. Similar effects were noted by Green et al. (2000), who argue that a "threshold effect" (p. 284) may exist, whereby an accrual of interpersonal traumas eventually overwhelms women's coping and healing resources, resulting in poorer psychological functioning. Along these lines, Banyard et al. (2001) found that non-sexual trauma experienced after an initial sexual victimization mediated the relationship between early child sexual abuse and psychological distress in adulthood.

Victims, Survivors and Victim/Survivors of Sexual Violence

In their article, *Restorative Justice Responses to Sexual Assault*, Mary Koss and Mary Achilles (2008) wrote that “the term *survivor/victim* is used...to retain the empowerment conveyed by the word "survivor" and the outrage implied by the word "victim" (p. 1). The California Coalition Against Sexual Assault (2003) further noted that, “the terms ‘survivor’ and ‘victim/survivor’ emerged as part of the sexual assault victim’s rights movement to describe individuals who have experienced a violent incident, but no longer want any association with the perpetrator or the stigma of being viewed as remaining under the rapist’s influence and control. In other words, the victim is now dealing with the trauma of the crime, which has been put into a perspective that allows her, as a survivor, to go on with life without the extensive, negative disruption created by the assault” (p. 1). In her article *Making the Hurt Go Away: Psychological and Spiritual Healing for African American Women Survivors of Childhood Incest*, Tracy Robinson (2000) noted that regardless of what women have done in past or current victimization(s) to survive sexual violence (i.e., promiscuity, food, drugs and alcohol abuse, self-injurious behaviors), they have survived. It is because they have survived that survivors can find different ways to survive in the face of future victimization.

Sexual Trauma and Coping

Sexual trauma limits a woman to the role of an object by robbing her of the right to define and to redefine herself (Stewart, 2002). Experiences of sexual violence often have severe negative effects on survivors’ quality of life, including persistent emotional distress, cognitive rigidity and psychopathology. Coping strategies utilized play an important role in their ability to not just survive the violence but to thrive in the wake of the incident(s). Two distinctive coping

strategies identified by individuals to cope with everyday stressors are problem-focused coping and emotion-focused coping. Problem-focused active coping is characterized by an individual's active engagement in behaviors in an attempt to manage the problem situations. It consists of strategies such as confrontation, seeking social support and planning how to respond actively to the stressors. Emotion-focused coping strategies are characterized by an individual's attempt to regulate their emotions when dealing with the stressors (Lazarus & Folkman, 1984), and consist of strategies such as avoidance, distancing, self-blame and controlling one's feelings. Lazarus and Folkman (1984) noted that events viewed as outside one's control, such as sexual assaults and rape, would more likely induce emotion-focused coping versus events that are viewed within one's control.

DiLillo, Long and Russell (1994) found that emotion-focused strategies are more prevalent among sexual abuse and sexual assaults survivors. Spaccarelli (1994) noted that sexual abuse survivors who reported on their attempts to cope with their victimization noted an increased use of avoidance, denial and self-blame strategies with increased distress and symptomatology. Long and Jackson (1993) found that while college students with a history of childhood sexual assaults reported using both emotion-focused and problem-focused strategies to cope with their victimization, emotion-focused strategies were used predominantly and the uses of these strategies were more likely to be associated with adult distress. In addition, Gold et al. (1994) found that college students with a history of childhood sexual abuse were more anxious, dissociative and depressed when using non-expressive coping strategies (i.e., a combination of avoidance, internalization of feelings and self-destructive behaviors) to cope with their victimization. Problem solving coping strategies have proven to alleviate distress symptoms and promote recovery. Researchers have found that attempts to avoid the perpetrator(s) (Leitenberg,

Greenwald and Caldo, 1992), express emotions (Leitenberg et al., 1992; Runtz and Schallow, 1997) and restructure cognitions (Runtz and Schallow, 1997) have all been found to be associated with improved adjustment after sexual trauma.

Based on the works of Susan Folkman (1984), C.R. Synder and Kimberley Pulvers (2001) developed a coping model using two common strategies (approach coping and avoidance coping) used by rape survivors. Approach coping is chosen when the individual appraises the stressor as one for which she has sufficient coping resources and involves active strategies that are either focused on the problem at hand or the emotional reactions to the stressor. In contrast, when an individual appraises the stressor as one for which she does not have sufficient coping resources, she is likely to employ avoidance strategies, such as denying that the stressor exists, avoiding thinking about the stressor and fantasizing (Littleton & Bretkopf, 2006, p. 106). While all coping strategies are helpful, avoidance coping strategies, such as alcohol and drug usage, initially decrease post-assault emotional distress, which is the desired goals of all trauma survivors. Noh & Kasper (2003) found that Black women are likely to utilize passive coping strategies when faced with stressful events.

There are several negative aspects to avoidance coping. Individual attempts to suppress aspects of the event only lead them to be hypersensitive to aspects that they need to suppress and to their inability to suppress those aspects. This hyper-alertness causes disruptive thoughts and emotions, hindering their ability to cope effectively with the event (Synder & Pulvers, 2001; Littleton & Brietkopf; 2006). There is also a growing body of literature that suggests that many survivors may use drugs or alcohol to help them suppress thoughts and feelings associated with the assault (Sturza & Campbell, 2005; Miranda, Meyerson, Long, Marx & Simpson, 2002). Survivors may also actively avoid people, places and activities that remind them of the rape

(Feuer, Nishith & Resick, 2005). While many survivors may use avoidance coping strategies periodically, survivors with high levels of self-blame and survivors who receive negative social reactions tend to use avoidance coping more frequently (Littleton & Breitkopf, 2006; Ullman, 1996a).

In her article *Coping with Rape: The Roles of Prior Sexual Abuse and Attributions of Blame*, Catalina Arata (1999) explored variables that mediate survivors' reactions and coping strategies in the wake of sexual victimization. Specifically, Arata (1999) sought to explore the relationships between post-rape adjustment, coping strategies, attributions of blame and history of childhood sexual abuse, and hypothesized that prior history of childhood sexual abuse is associated with greater self-blame, higher frequency of avoidant coping strategies and greater trauma related symptoms. Ronnie Janoff-Bulman (1979) identified two blame attributions, characterological blame and behavioral self-blame, that impact survivors' post-rape coping strategies. She defined characterological self-blame "as blame that involves the idea that one's character or other enduring qualities are the reason one was rape; behavioral self-blame involves blame related to behaviors one had engaged in prior to the rape" (Arata, 2001, p. 63). Janoff-Bulman hypothesized that behavioral self-blame resulted in improved post-rape adjustment, while characterological blame lead to increased psychological distress. Studies on characterological self-blame and behavioral self-blame found that both blame attributions lead to increased levels of psychological distress post-rape and over time (Arata, 1994; Frazier, 1990; Frazier & Schauben, 1994). Likewise, engagement in self-blame was found to be associated with increased use of maladaptive coping strategies (Arata & Burkhart, 1998; Arata, 1994) and increased rates of post-traumatic stress disorder (Arata & Burkhart, 1996).

Participants for the current study consisted of 860 female college students recruited from an undergraduate introductory psychology class. From this larger number, 119 female college students who self-identified as having sexual experiences that involved forced penetration, forced sexual acts and/or forced intercourse were found eligible for study. This sample consisted of 95 (80%) White women, 21 (18%) African-Americans, 2 (2%) Latinas and 1 (1%) woman who self-identified as other. The study's participants' ages were between 17-47, with a mean age of 23. Based on relationship status, 83 (70%) participants identified as single, 23 (19%) identified as married, and 13 (11%) identified as divorced. Measures used in this study included the Koss & Oros' Sexual Experience Survey to assess adulthood victimization experiences. History of childhood victimization was assessed by behavioral questions based on Finkelhor's 1979 measure of childhood victimization. Attributions regarding sexual assaults were assessed using the Sexual Assault Rating Scale, which was devised particularly for this study based on Meyer and Taylor (1986) and Hill and Zautra (1989) to assess blame attributions. Coping was assessed using Burt and Katz's (1987) How I Deal With Things Scale. Survivors' adjustment/current functioning in the wake of sexual victimization was assessed with the Trauma Symptoms Checklist-33.

The results of the study found that survivors with a prior history of sexual victimization in childhood were more likely to participate in self-blaming and societal blame. In addition, they were most likely to report greater use of coping strategies, emotion-focused and problem-focused strategies, to alleviate trauma related symptoms. This finding did not support Arata's hypothesis that survivors of childhood sexual assault are likely to experience a higher frequency of avoidance coping strategies. She asserted that, "presumably, cognitive strategies are more adaptive. However, this finding is consistent with Burt and Katz's (1987) descriptions of rape

victims alternating between emotion-focused (nervous) coping and problem-focused (cognitive) coping, with use of all coping strategies decreasing as symptoms decrease” (p. 73). It is likely that the cognitive strategies utilized by survivors of childhood sexual assault are the same strategies utilized in the face of adulthood sexual assault or that increased trauma-related symptoms might be the result of adulthood victimizations.

Arata’s (1999) analysis of the impact of childhood sexual assault, self-blame and coping strategies revealed that coping strategies were the mediating factor of the intensity, frequency and severity of trauma-related symptoms. Arata (1999) noted that “specifically, self-destructive coping accounted for the largest portion of variance in current trauma symptoms, with nervous coping also being associated with higher symptom level. Expressive coping was also significantly associated with trauma symptoms, with expressive coping behaviors resulting in frequencies. Interestingly, situational blame, where the women blamed things such as being in the wrong place, not screaming for help, and making a poor decision, was also associated with increased symptoms” (p.74). A positive relationship was found between characterological blame and self-destructive coping, which suggested that if survivors blame themselves for the victimization, they are likely to experienced increased trauma-related symptoms. However, expressive coping and characterological blame lead to decreased trauma-related symptoms. This result lead Arata (2001) to suggest that blaming society by expressing feelings associated to the traumatic event might be an adaptive coping strategy, which is likely to decrease psychological distress and increase survivors’ current functioning. This finding supports Ullman’s (1996) finding that survivors benefit from positive social reactions from others, which help them to alleviate psychological and physical distress associated with post-rape adjustment.

Sexual violence often isolates a woman within herself, causing her to struggle with her perception of the act(s), her perception of herself, and with how she is viewed socially by others. While positive social support is often provided to victims in almost all other types of traumatic events, sexual violence is the only trauma in which the victims are often blamed for their victimization. Survivors are often forced to find different ways than social support to alleviate the psychological, physiological and social symptoms of sexual violence.

Coping with Social Support

The quality of social support can play an essential role in alleviating survivors' psychological and physical distress. Shumaker and Brownell (1984) defined social support as an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (p. 13). Cohen and Syme (1985) noted that this exchange of resources can have either a negative or positive effect on the recipient. Studies have found mixed reviews when determining whether social support alleviates the emotional distress experienced by survivors of sexual violence. While Orbuch, Harvey, Davis and Merbach (1994) and Kimerling and Calhoun (1994) found that good social support is a contributing factor to the recovery of survivors of sexual assault, Popiel and Susskind (1985) and Sales, Baum and Shore (1984) found that there was not a significant relationship between the two factors.

In relation to the inconsistent findings between social support and recovery, Ullman (1996b) postulated that "support" may be a misnomer for positive and negative reactions received from others and began to explore positive and negative social reactions. Ullman (1996a) later identified positive social reactions as "believing rape survivors, listening to them

and providing coping resources” (p. 288) and negative social reactions as blaming the survivors for some or all aspects of their victimization. In a series of studies on this topic, Ullman (1996a) found that “victims who have less physical injury, self-blame and post-assault distress were more likely to receive positive support” (p. 288). Negative social relations were strongly related to increased psychological symptomatology, delayed recovery and poorer perceived physical health (Ullman, 1996b; Ullman & Seigel, 1995). In addition, Ullman (1996c) found that “the identity of support provider also affects the probability of receiving positive support; friends were more supportive than helping professionals, and physicians and police were found to engage in more negative reactions than other sources” (p. 288). This suggests that helping professionals can play a major role in survivors’ recovery.

In their article *Social Reactions to Rape Victims: Healing and Hurtful Effects of Psychological and Physical Health Outcome*, Rebecca Campbell, Courtney Ahrens, Tracey Sefl, Sharon Wasco and Holly Barnes (2001) sought to expand Ullman’s (1996c) findings by conceptualizing survivors’ perceptions of positive and negative reactions and exploring the consequences of negative social reactions/negative support and no social support on survivors’ psychological and physical distress. The study sample consisted of 82 women who were 18 years or older, and were sexually assaulted by a spouse, co-habiting partner, acquaintance or stranger. The women were selected through an adaptive and snowball sampling in Chicago. Based on the 1990 Census, the metropolitan area of Chicago was divided into zip code regions and the request for study participants was solicited by flyers, posters and in-person presentations. The sample consisted of 51% African-American women, 37% White women, 6% Latina women, 5% multi-racial women and 1% Asian American women. Three measures were used in this study: the Social Reactions to Rape Victims–Shortened Version, Measures of Psychological

Well-Being and Measure of Physical Health to assess positive and negative social reactions, psychological distress and survivors' physical health, respectively. The average age of the women was 34.29 (SD = 10.05). Almost one-third of the sample (30%) was currently married; 53% had children; 82% had a high school education; 61% were employed; 66% were assaulted by someone they knew and 94% of the women were raped by a single assailant; 38% were not physically injured in the attack; 70% of the women did not have a weapon used against them; and 70% of the women were not under the influence of alcohol at the time of their victimization.

The study revealed several findings similar to Ullman's (1996) study. Similar to Ullman's study, Campbell, Ahrens, Sefl, Wasco and Barnes (2005) found that being believed and being allowed to talk helped alleviate survivors' psychological distress, while negative reactions had deleterious impacts on survivors' recovery. Their results revealed that women who had someone who believed their experience with sexual victimization, and defined this behavior as helpful, presented with fewer post-traumatic stress, depression and physical health symptoms in comparison to women who did not receive a similar reaction or who received a reaction that they perceived as hurtful (Campbell et al., p. 297). This finding was similar for survivors who were allowed to talk to others about their assault(s). Campbell et al. (2001) noted that "on the other hand, women who had someone tell them they were irresponsible, patronized them, wanted revenge, tell them to get on with their life, and tried to control their decisions defined these reactions as hurtful, and had higher emotional and physical health symptoms than women who did not receive these reactions or who received these behaviors but considered them helpful" (p. 297). In addition, Campbell et al. (2001) noted that while positive social reactions do not prevent survivors from experiencing psychological and physical symptoms in the wake of their

victimization(s), negative social reactions have shown to intensify these symptoms among survivors.

However, what are determined as positive and negative social reactions are influenced by survivors' perceptions of the reactions they receive from others. "When victims considered these reactions to be hurtful, they exhibited higher psychological and physical health symptoms. Conversely, when victims considered these reactions to be healing, they exhibited less psychological and physical distress" (Campbell et al., p. 300). An additional finding suggests that "victims may be better off receiving no support at all than receiving reactions that they think are negative" (Campbell et al., p. 300).

The results of this current study depart from Ullman's 1992 study that found that rape-related characteristics, such as race, significantly influenced negative and/or social reactions. Similar to McAustan's (1998) study on rape-related characteristics and social reactions, this current study found that race did not affect social reactions. In addition to assessing the impact of social reactions on psychological health and physical outcomes, Campbell et al. (2000) sought to assess survivors' perceptions of what were healing and hurting reactions of family, friends and others. Results revealed that of the 12 behaviors measured on the Social Reactions of Rape Victims, six were perceived as helpful (i.e., tell you it wasn't your fault), three were perceived as hurtful (i.e., encourage you to keep a secret) and three were perceived differently by the survivors. Campbell et al. (2000) stated that gaining a better understanding of survivors' perceptions to social reactions might serve as treatment intervention toward recovery.

Research on social support and people of color has been based largely on African Americans and their reliance on extended family (Tatum, 1999) and religious communities serving as support networks (Musgrave, Allen & Allen, 2002) to buffer the stress of trauma.

However, Brewer (1995) and George and Dickerson (1995) argued that these factors do not serve as buffers for all African-American women and noted that “the reality is that many Women of Color who are single mothers do not have supportive familial or other support networks and are subject to the stressor of racism by European-American women, as well as the stressor of other racisms” (Banks, Ackerman, Yee and West, p. 221). Jones and Shorter-Gooden (2003) found that without support, Women of Color are likely to experience various short and long-term health problems, including “depression, anxiety, substance abuse, hypertension and eating disorders” (Banks, Ackerman, Yee and West, p. 221). While many have found support in religious/spirituality-based support networks, participation in these networks often involves a monetary and/or physical cost, such as weekly financial contributions and involvement in institutional activities of the organizations (Banks, Ackerman, Yee and West, 2005). With limited roles for women in many religious organizations, these have not always been safe places for disclosure of trauma, such as incidents of sexual violence in childhood and adulthood. Thus, many women are forced to shoulder their experiences with, and the aftermath of, sexual violence alone.

Coping Through Food

Many survivors of sexual violence cope with this incident(s) of sexual violence with food. In her article *A Way Outa No Way: Eating Problems Among African-American, Latina and White Women*, Becky Thompson (1992) proposed that eating disorders, as issues of appearance, are the results of women’s attempts to cope with various personal and societal issues “including sexual abuse, racism, classism, sexism, heterosexism and poverty” (p. 52). Thompson outlined the three current theoretical models used for conceptualizing eating problems

in women: biomedical, psychological and feminist. While the biomedical model focuses mainly on physiological causes of eating problems and the devastating effects of purging, bingeing and starvation on the body (Copeland 1985; Spack, 1985), Thompson noted that this model fails to recognize and incorporate ecological factors that influence eating problems, thereby suggesting medical interventions that disempower women by pathologizing their symptoms and experiences. While the psychological model is more inclusive of the ecological factors creating and maintaining eating disorders in women's lives, it does this at the expense of women of color, lesbians and poor women. The feminist model coined the term *the culture of thinness model* to reorganize eating problems among women as gendered problems within a patriarchal society, with culturally and socially enforced norms about beauty and women's bodies. These norms often make women vulnerable to a host of eating disorders to conform to the concept of beauty. Thompson noted that "while feminists have rescued eating problems from the realm of individual psychopathology by showing how the difficulties are rooted in systematic and pervasive attempts to control women's body sizes and appetites" (p. 53), researchers continue to pay limited attention to how factors of race, class and sexuality affect women's relationships to their bodies. As a result, studies on eating disorders often misconstrue the relationships among eating disorders and issues of race, class and sexuality, leading eating disorders in women of color, lesbian women and poor women to be misdiagnosed or under-diagnosed.

In her 1992 study, Thompson sought to explore the variables that mediate eating disorders among African-American, Latina and White women. She postulated that eating is a way that women cope with trauma in their lives. Through a snowball recruitment process, 18 women (5 African-American women, 5 Latina women and 8 white women) were recruited for the study. The participants were administered lengthy questionnaires and participated in life

history interviews to explore eating disorders among a group of multi-ethnicity women. Some demographic information provided in the study revealed that of the 18 participants, five women identified as Jewish, 8 identified as Catholic and 5 identified as Protestants. Thompson noted that “the women represented a range of class backgrounds (both in terms of origin and current class status) and ranged in age from 19 to 46 years old (with a median age of 33.5). The majority of women reported having had a combination of eating problems (at least two of the following: bulimia, compulsive eating, anorexia nervosa, and/or extensive dieting)” (p. 55). 28% of the women reported being bulimic, 17% reported being bulimic and anorexic and 5% reported being anorexic. Two-thirds of the participants reported experiencing eating difficulties for most of their lives, with the onset age beginning at 11 years old. The participants’ weight changed from 16 to 160 pounds, with an average weight change of 74 pounds. Thompson (1992) noted that “this drastic weight change illustrated the degree to which the women adjusted to major changes in body size at least once during their lives as they lost, gained and loss weight again” (p. 56).

Thompson noted that “one of the most striking findings in this study was the range of traumas the women associated with the origins of their eating problems, including racism, sexual abuse, poverty, sexism, emotional or physical abuse, heterosexism, class injuries and acculturation (p. 56). Of the 18 participants, eleven women (61%) identified as survivors of sexual abuse who connected their eating disorder to their trauma. Binge eating was identified among the participants as the most common coping strategy, mainly because food was easily accessible to survivors and it helped to alleviate their psychological distress. Thompson noted that “binging helped women numb out or anesthetize their feelings” (p. 57). In her 1989 study, Demetria Iazzetto conducted extensive interviews and utilized an art therapy session to explore women’s relationships to changes in their bodies as a result of being sexual assaulted. Iazzetto

(1989) found that “the process of leaving the body (through a progressive phase of numbing, dissociating and denying) that occurs during sexual abuse parallels the process of leaving the body made possible through binging” (Thompson, p. 57). Many survivors of sexual violence believed that their weight caused or contributed to the victimization. As a result, they may participate in extensive dieting and bulimia to reduce or increase their weight and/or body size as a coping strategy and safety method.

Some of the African American and Latina participants identified their eating problems in association with poverty and the loneliness inherent in this social condition. Food can become a woman’s best friend in times of stress because it is affordable and comforting. Thompson noted that “one of the physiological consequences of binge eating is a numbed state similar to that experienced by drinking. Troubles and tensions are covered over as a consequence of the body’s defensive response to massive food intake. When food is eaten in that way, it effectively works like a drug with immediate and predictable effects” (p. 61). In this way, food is an effective drug of choice for many survivors of sexual violence.

Heterosexism was also directly linked to eating problems. Some of the women’s interviews revealed “compulsory heterosexuality as an institution” that influenced and shaped women according to its patriarchal views of men’s and women’s bodies. “In some homes, boys were given more food than girls, especially as teenagers, based on the rationale that girls need to be thin to attract boys. As the girls approached puberty, many were told to stop being athletic, begin wearing dresses, and watch their weight” (p. 62). Women who knew that they were lesbian from a young age linked their eating disorder to actively resisting the norms of compulsory heterosexuality. Binging provided the women with opportunities to resist

compulsory heterosexuality, fight for homosexuality and perhaps find freedom and acceptance through food.

The stress of racism and classism was also directly linked to eating problems among several of the African American and Latina participants. Several women of color participants noted that issues around lighter skin color as a beauty standard and body size created confusion about food, and the link between body expectations and class mobility left them vulnerable to eating problems. Thompson noted that “the fact that some of the African-American and Latina women associated the ambivalent message about food and eating to their family’s class mobility and/or the demands of assimilation while none of the eight white women expressed this (including those whose class was stable and changing) suggests that the added dimension of racism is connected to the imperative to be thin” (p. 65). Racist and class expectations of others exacerbated and reinforced beauty and weight standards that leave women more vulnerable to psychological distress and eating problems in a patriarchal society.

Body image is a fluid, evolving cycle that interfaces with the individual, her experiences and her cognitive, behavior and affective schemas about self and others on a daily basis. It is used to describe one’s perceptions, beliefs and experiences of one’s body. It is normal to assume that women with a history of physical, emotional, sexual and societal victimizations will have difficulty with their body image. However, Becky Thompson noted that “the term body image does not adequately capture the complexity and range of bodily responses to trauma experienced by the women.” She postulated that trauma not only distorts women’s visual image of themselves, it hinders their ability to even consider that they have bodies. Hence, trauma blurred, and in some cases erased, survivors’ boundaries of self.

Thompson (1992) coined the term “body consciousness” to encompass the survivors’ range of bodily responses to victimization. She noted,

“By body consciousness I mean the ability to reside comfortably in one’s body (to see oneself as embodied) and to consider one’s body as connected to oneself. The disruptions to their body consciousness that the women described included leaving their bodies, making a split between their body and mind, experiencing being ‘in’ their bodies as painful, feeling unable to control what went in and out of their bodies, hiding in one part of their bodies, or simply not seeing themselves as having bodies. Binging, dieting or purging were common ways women responded to disruptions to their body consciousness” (p. 63).

For survivors of sexual trauma, changes in physical appearance might be their response to disruptions to their body consciousness.

Coping with Spirituality

While Native American, Latino and African-American women in the United States have historically used religion and spirituality to cope with distressing life experiences, there is a significant distinction between the terms. Religion is a more collective activity that consists of beliefs and practices carried out by a group of people, whereas spirituality, which often consists of belief in a power/force greater than oneself, is a more personal, individualized set of beliefs and practices adhered to by an individual. Spirituality is often used to describe a consciousness of a divine presence within oneself. It is often descriptive of a force that gives meaning and direction (Few & Scott, 2002) and defines the search for purpose and meaning, within which ideas of transcendence and immanence form an integral part (Decker, 1993; King, Speck & Thomas, 1999). As culture and ethnicity influences an individual’s beliefs, as well as one’s acceptance and expressions of religion and spirituality, it is often difficult to separate the impact that they have on an individual’s daily life.

Native Americans have a rich tradition of spirituality that stresses connection to the earth and everything in it as a living and changing force. “Researchers have discussed how Native American spirituality, in its aggregate among the various tribal nations, incorporates four elements: Medicine (everything is alive), Harmony (everything has purpose), Relation (all things are connected) and Vision (embrace the medicine of every living being and your vision)” (National Abandoned Infants Assistance Resource Center, p. 3). These fundamental beliefs are a core part of Native Americans’ spirituality and way of life (Garrett & Wilbur, 1999). Similar to Native American, African-American and Latino cultures are heavily grounded in spirituality and religious beliefs and practices. For many African Americans, the church has been the safe haven from the ongoing hardship they experience, and continue to experience, in the face of racism and sexism. “Indeed, the black church’s historic role in providing blacks with education, social services and a safe gathering place prefigured its historic role in the civil rights movement” (Dilulio, p. 1). Smith (1999) noted that Black spirituality has its roots in Africa and was grounded in African slavery, and can be found in Black religious music and traditions, and in Black cultural responses to personal and communal suffering. To this extent, Black spirituality is found in the gathering of individuals in church, in reading the Bible and during prayer time, and “black women may express this spirituality in a variety of ways, including dance, art, music, cooking, personal adornment (e.g., clothing or hair care rituals), poetry, activism, journaling or reading the stories of Black women” (Smith, 1999).

Like much of African-American culture, many Latino cultures often describe themselves as Christian and tend to embrace Christian notions of spirituality. Willard (1990) describes “Christian spirituality as centered in the idea of a transcendent life characterized by the notions of accountability, judgment and the need for justice. This version of spirituality has been

equated with a relationship of the whole person to a personal God and to other people that is imbued with deep moral and ethical implications” (Musgrave, Easley and Allen, p. 557).

There is limited research that explores Caucasian women’s spirituality or that compares spirituality between Women of Color and Caucasian women. Bourjolly & Hirschman (2001) found that African-American women expressed a greater reliance on God as a source of support when coping with breast cancer when compared to Caucasian women. Silverman and colleagues (2002) found, while studying the effects of religion and spirituality on the health and self-care of elders suffering with osteoarthritis or heart disease, 83.4% of 292 Black Americans, as opposed to 58.1% of 345 Caucasians, stated that religion and spirituality were very important to them, and, for this group, were found to be associated with reduced pain.

Sexual violence survivors often have to come to terms with the fact that the world can be unsafe, unjust and unpredictable. Coping strategies such as cognitive reappraisals might be helpful to alleviate some post-assault distress. Drescher and Foy (1995) note that a spiritual approach can help survivors restore hope and acquire a more balanced view about justice and injustice, safety and danger, good and evil (Drescher & Foy, 1995). Likewise, Khouzan and Kissmeyer (1977) note that in posttraumatic stress disorder (PTSD), the acceptance of a spiritual power may lead to a spiritual awakening which, in turn, can assuage survivors’ guilt and lessen other symptoms of post-traumatic stress disorder.

Section V: Coping with Sexual Violence Through Changes in Physical Appearance and Dress

Thus far, we reviewed various forms of sexual violence, the impacts of sexual violence on women’s psychological and physiological health and coping strategies utilized by survivors to alleviate psychological, physiological and social symptoms as a result of sexual victimization.

Overwhelmed by the symptoms associated with their victimization, women may cope through the support of others, through food and through turning toward a force larger than themselves. For some women, these supports will be sufficient to help them move toward recovery. For others, these strategies will not be enough, forcing them to resort to other strategies, including changing aspects of their physical appearance and dress, to alleviate their distress.

Body Images and Physical Appearance

Mary White Stewart (2002) argued that, “rape is an attack on one's body, one's identity and one's soul” (p.146). Sexual violence impacts every aspect of a person's being and changes the way that women think and feel about themselves and their environment. By its very nature as an insidious interpersonal crime, sexual violence impacts one's relationship with one's self and one's sense of connection to one's self.

Research on body image, sexual violence and physical appearance has been mainly limited to eating disorders and obesity. In their chapter entitled *Sexual Abuse and Body Image*, Patricia Fallon and Diann Ackard (2002) defined body image as the “mental representation of the body that includes perceptions of appearance, feelings and thoughts about the body, how it feels to be inside the body and the body's functions and capabilities” (p. 117). They noted that new information and experiences are constantly being incorporated into our concept of body image, thereby changing it. Fallon and Ackard (2002) noted that “the development of body image is a fluid process, much like growth and aging over the lifespan; one is frequently adjusting to major or minor changes” (p. 117). They (2002) postulated that the concept of body image is a fluid phenomenon that continuously incorporates information, based on new experiences and events

that positively or negatively affect body image. As such, incidents of sexual violence can impair a person's body image and perception of their appearance.

Fallon and Ackard (2002) noted that "survivors of sexual violence often have a disrupted view of the specific body part(s) violated during the abuse. This disrupted view may range from hating the abused body parts to bodily mutilation, such as cutting or burning" (p. 119). However, body image problems stemming from abusive experiences are not only specific to the abused body part but may also be generalized to the entire body, resulting in overall body dissatisfaction, intense feelings of shame about the event and the body and body distortion (e.g., perceiving the body as much larger than its actual size) (Fallon & Ackard, 2002). For example, a sexual violence survivor of healthy weight might view her body as "fat and heavy." Burdened by persistent negative thoughts and feelings associated with her sexual victimization, she may view her body as "huge, disgusting, and ugly" and make changes, cognitively and physically, like restricting or increasing her dietary intake, to manage her discomfort with her body and her sexuality. "In her mind, altering her body to make it dramatically smaller or larger will make her unattractive to the sexual advances of others, and thereby decrease the risk of further abuse" (Fallon & Ackard, p.119). To regain control of their bodies, some sexual violence survivors will develop eating disorders such as anorexia nervosa and bulimia nervosa.

In *Body Image*, Thomas Cash & Thomas Pruzinsky (2002) defined body image as "a multi-dimensional construct that refers to subjective perceptual and attitudinal experiences about one's body, particularly one's physical appearance" (Cash, p. 201) and asserted that body image attitudes consist of two main factors: an evaluative component and an investment component. According to Cash (1994, 2000b), the evaluative component consists of self-ideal discrepancies and body satisfaction-dissatisfaction, and the investment component consists of cognitive-

behavioral salience of one's appearance. The motivational investment component of body image consists of investment placed on maintaining appearance through grooming behaviors.

Hazel Markus (1977) noted that appearance-related self-schemas are a core facet of body image investment. She described self-schemas as the cognitive structures used to process self-related information and noted that they are "cognitive generalizations that individuals develop about themselves to organize and guide the processing of self-related information. Self-schemas derive from one's history of personal and social experiences, and pertain to various domains within the individuals" (p. 27). Markus (1977) postulated that physical appearance is one of these domains. Cash, Melnyk and Hrabosky (2004) further asserted that, "cognitive-behavioral perspective and contextual events activate schema-based processing of self-evaluative, affect-laden information about one's appearance. The associated or resultant body image thoughts and emotions, in turn, prompt adjustive, self-regulatory activities (e.g., coping efforts)" (p. 306). Hence, they (2004) postulated that appearance-related self-schemas play a key role in understanding body image experiences, and positive or negative impacts, on everyday life (Cash, Melnyk & Hrabosky, 2004).

Various studies on self-evaluative measures of body image have found that African-American women have reported increased overall body satisfaction when compared to White women (Cash, Melnyk & Hrabosky, 2004). Celio, Zabinski and Wilfey (2002) had similar findings, even when African-American women had heavier body weights. In their current study, they "found that African-American women reported significantly less investment in their appearance on the original Appearance Schema Inventory, the overall Appearance Schema Inventory Revised and the Self-Evaluative factor than did White women, but there was no difference on the Motivational Salience factor" (p. 313). They noted that these findings

suggested that “African-American and White women are equally motivated to manage their appearance to look nice or be attractive, whereas White women are more invested in their appearance as a criterion of self-evaluation” (p. 313). Body image difference among Caucasian women and Women of Color may serve as a coping mechanism in the face of sexual violence.

Using Fallon and Ackard’s (2002) and Cash and Pruzinsky’s (1990, 2002) definitions of body image, one can conclude that the concept of body image is a fluid, evolving cycle that interfaces with the individual, their experiences and their cognitive, behavior and affective schemas about self and others on a daily basis. Incidents of sexual violence change, and often shape, the views that women have about their bodies. In response to these internal schemas in the wake of sexual violence, survivors may change aspects of their physical appearance to cope with the sexual trauma.

Identity, Physical Appearance and Dress

Incident(s) of sexual violence changes a woman’s views of herself and therefore her self-identity. One of the consequences of sexual violence is the identity of being a survivor, which a woman must either deny, suppress or find ways to incorporate within her self and among her others identities. Mary Ellen Roach-Higgins and Joanne Eicher (1992) defined self as a “composite of an individual’s identities communicated by dress, bodily aspects or appearance and discourse, as well as the materials and social objects (other people) that contribute meaning to situations for interactions” (p.5). While some identities are assigned at birth, many are acquired through individual’s lived experiences, and since lived experiences are unique, no two will have the same lived experiences. Similarly, the ways in which individuals choose to communicate their identities are unique and personal.

Physical appearance is the most external and visual aspect of the human's body. It consists of both the dressed and undressed aspects of the human body as well as gestures and grimaces unique to the individual. An individual's color, body size and shape and gender all constitute aspects of one's physical appearance. While the term "dress" is often used interchangeably with physical appearance, Roach-Higgins and Eicher (1992) noted that "dress is more than appearance, for it includes aspects of body modifications and supplements recorded by all the senses – not just sight alone as the term appearance implies" (p. 3). They (1992) defined dress as "an assemblage of modifications of the body and/or supplements of the body" (Roach-Higgins and Eicher, p. 1). Likewise, although the word "clothing" is often used interchangeably with dress, the authors (1992) argued that "the word clothing is most frequently used to emphasize enclosure that covers the body and generally omits body modifications" (p. 3). Based on these definitions, an individual's dress can include a long list of permanent or temporary changes to the body, such as tattoos, straightened teeth, exercise or permed hair, as well as additions to the body like clothing or weight.

Aspects of individuals' identities are often conveyed through their dress. Roach-Higgins and Eicher (1992) postulated that dress has two main functions: to alter body processes and as a mode of communication. Altering of body processes through body modifications can serve many purposes and have positive and negative effects on the body. Likewise, while body supplements also alter body processes, "they serve simultaneously as microphysical environment and as interface between the body and the macrophysical environment" (Roach-Higgins and Eicher, p. 4). As a microenvironment, body supplements interact with the individual's body to provide many functions. It is not uncommon for survivors of sexual violence to modify their

body (i.e., weight gain or loss) or supplement their body (i.e., wearing a cross for protective purposes) in the wake of their victimization.

As such, dress is a mode of social communication that can convey messages about our lived experiences, as in the case of a veteran wearing his medals on his coats or a teenager wearing the button with a picture of a loved one he/she has lost on their hat. These gestures communicate something unique and personal about their individual identities, about their lived experiences and their use of dress to convey aspects of self to others in various social settings.

Sexual Violence and Physical Appearance

Body image, which represents the intersections of the physical body with cognitive and emotional activity, is significantly impacted by incident(s) of sexual violence. Sexual assault is likely to influence and shape women's sexual experiences, those that she consents to as well as those forced upon her. Among its many functions, the human body is a "social object." As such, "our appearance is our most apparent individual characteristic" (Johnson & Lennon, 1999, p. 1). Physical appearance distinctively identifies a person within his or her social world, conveying such basic information as gender, race/ethnicity, approximate age, social class and occupation. In addition, physical appearance influences social perceptions and behaviors, often in accordance with social stereotypes and myths. However, we are socialized not to judge others by their appearance, because to acknowledge that appearances play a significant role in everyday life is counter to the democratic notion that they are or should be superficial because they are not freely chosen" (Johnson & Lennon, 1999, pg. 1). Physical appearance can also be used to mask inner emotional and physiological responses to sexual violence. Counter to the belief that rape victims change aspects of their physical appearance to communicate their interest in sexual intercourse,

which blames women for their victimizations, the focus of this study is to explore how an incident(s) of sexual violence prompts women to change aspects of self and their physical appearance to cope with their sexual victimization.

Summary

Sexual violence, and the threat of sexual violence, is a pervasive social epidemic in the United States and throughout the world. It is a daily part of women's lives, making them vulnerable to violence within their home and communities and among families and friends. While all women are vulnerable to sexual violence, groundbreaking research by Wyatt (1992) and Tjaden and Thonnes (2000) revealed that Women of Color experience a higher rate of sexual victimization in comparison to White Women and provided a snapshot of a potential victim of childhood sexual assault as a pre-teen, unmarried, black female of a lower socio-economic background at the hands of a family member. The progression from childhood to adulthood does not decrease the impact or likelihood of further sexual victimization, but only intensifies it. Women of Color experience a greater rate of domestic violence, marital rape, sexual assault and completed rape in comparison to Caucasian women. Rape myths and sexism minimize the incident and impact of sexual violence and societal response for Caucasian women; racism and classism increase Women of Color's vulnerabilities to sexual violence. Societal factors, such as poverty and homelessness, will significantly increase women's likelihood of being victimized again.

In its wake, women are likely to experience various traumatic symptoms, such as depression, anxiety and social phobia, as they struggle to reclaim their lives. Survivors of sexual violence were found to have the highest rate of post-traumatic stress disorder. In fact, rape was

associated as the event with the highest post-traumatic stress disorder and lifetime post-traumatic stress. All survivors of sexual violence utilize coping strategies to alleviate their traumatic symptoms. While some will find comfort in seeking and receiving positive social reactions, food and religion/spirituality, others will find comfort in participating in high risk behaviors, such as drug abuse and prostitution. While it is clear that sexual violence changes a woman's view of herself and her identities, it is not clear if a survivor might change aspects of her physical appearance to cope with her victimization. The question that guides this inquiry is: "Do survivors of sexual violence change aspects of their physical appearance to cope with their victimization?"

Chapter Three

Methodology

This study explores the relationships among traumatic symptoms, coping strategies and changes in physical appearance between African-American and European-American female survivors of adulthood sexual violence.

Research Design

This exploratory mixed-method study utilizes a concurrent triangulation mixed method approach, which includes both quantitative survey data and qualitative open-ended interview data (Creswell, 2003). This design is often selected when two different methods are used to confirm, cross-validate or corroborate findings within a single study (Green et al., 1989; Morgan, 1998; Steckler et al., 1992). Through this design, both data sets are collected concurrently in two phases that later converge and integrate the results to provide a more comprehensive analysis of the research questions. The first phase of the study consists of the quantitative analysis, which includes a semi-structured demographic survey and three structured surveys. Concurrently, selected participants from the study's first phase participated in the second phase of the study, which consisted of qualitative analysis. In this phase, participants participated in small structured focus groups that consisted of open-ended questions.

Participants

Quantitative Measures

This exploratory study was comprised of seventy-six participants: forty-one African-American women, twenty-four Caucasian women, six Biracial/Multicultural women, four Latina

women and one Native American woman. Race and ethnicity of all participants was determined by self-identification and was later used to create two distinct groups: Caucasian women and Women of Color. The term Women of Color is an inclusive term used to acknowledge and describe the lived experiences of non-white women, including, but not limited to, the experiences of African American, Biracial/Multicultural, Native American and Latino women in the United States. Participants who self-identified as any of these races/ethnicities were included in the Women of Color group. This incorporation changed the study's sample to twenty-four Caucasian women and fifty-two Women of Color.

Participants were recruited through advertisements posted at local community colleges and private universities, a transitional housing facility, a women's center, community health centers, libraries, Laundromats and other public facilities in three Boston neighborhoods. The advertisement requested Black and White female participants between the ages of 21-45 who were sexually assaulted in adulthood before June 2005. This age criterion was selected to allow for a further exploration of traumatic symptoms and changes in coping styles and physical appearance through various stages of the women's life spans. Several of the women who participated in the study were sexually assaulted after June 2005.

Initially, a brief telephone screening determined eligibility for participation based on ethnicity criteria of black and white women with experiences of sexual trauma in adulthood who were within the age and date ranges of the study. However, several women asked to participate in the study, even though they did not meet the age and/or race/ethnicity criteria of the study. As one of the goals of the study was to assess women's experiences of sexual violence, traumatic symptoms and coping strategies through various stages of their life spans, the age criteria was expanded to 65 and race/ethnicity criteria was expanded to be more inclusive of

Biracial/Multiracial, Latina and Native American women's experiences of adulthood sexual violence.

Of the 76 participants, one woman was disqualified from the study, as her sexual assault did not take place in adulthood. Likewise, two women initially agreed to complete the surveys but later declined when they became emotionally overwhelmed by memories of their sexual victimizations while completing the surveys. Although the women returned the surveys, they were offered the handout of the contact numbers of several local mental health and sexual violence prevention and intervention services as potential resources. In the three cases, each of the women declined to take the handout and return the complete packet. The exclusion of these three women changed the study's sample to 73 participants.

As sexual violence often leaves a negative social stigma on survivors, some victims limit sharing their experiences with close friends and family. Two participants, one of whom participated in one of the focus group discussions, requested several packets of the surveys to distribute to family members, friends or acquaintances who are survivors of sexual violence and who met the study's criteria. One of these participants, who was co-facilitating a church-based women's support group at the time of the study, had shared her experiences in the study and later noted that several women in the group expressed interest in participating in the study. Both women were handed several packets of the survey, which they distributed to other women with the intent of participating in the study. When the packets were completed, the women returned them to the researcher. On several occasions, survey participants provided contact information (i.e., names and phone numbers) of potential participants for the researcher to contact at a later time. One participant who lived in a suburb of Boston requested that a survey packet be mailed to her. A packet was mailed to her, she completed it and mailed it back to the researcher.

Due the nature of the study, some of the women reported experiencing mild depressive and anxiety symptoms, such as feeling sad, overwhelmed and nervous, as a result of participating in the study and benefitted from a brief debriefing after completing the surveys. Providing the women with opportunities to share more about their experiences, supporting them to utilize positive coping strategies and tapping into personal and social resources, such as family and friends, religious/spiritual practices and professional providers, help to ground them and relay a general message that they are not alone. Some of the women who completed the surveys in a group or with other women present appeared to have less visible emotional reactions after completing the surveys than women who completed the surveys by themselves. When asked, many of the participants shared that they were either currently in counseling or had received counseling in the past pertaining to their victimization(s). However, some women did share that completing the surveys were the first time they had an opportunity to share the assault with others. All of the women who completed the survey received a handout of the contact numbers of several local mental health and sexual violence prevention and intervention services as potential resources in their recovery.

Qualitative Measures

Thirteen participants volunteered to participate in the study's four focus groups, which consisting of two to five participants. Criteria for participation in the focus group included an expressed desired to participate in a small, audio-taped focus group to share personal experiences of sexual violence, traumatic symptoms, coping strategies and changes to their physical appearance in the aftermath of their victimization.

Procedures

The quantitative and qualitative data for this exploratory study were collected concurrently in two phases. In the first phase, seventy-three participants were determined eligible to participate in the study and completed five short surveys. In the second phase, thirteen participants volunteered to participate in one of the study's focus groups, which involved a group discussion about their sexual victimizations, traumatic symptoms that they experienced in the wake of their victimization(s) and coping strategies utilized in the aftermath of sexual violence.

Phase I

In Phase I, the investigator conducted telephone screenings to determine participants' eligibility to participate in the study. Participants were given information about the goals of the study and their roles and expectations as study volunteers. An appointment for interested and eligible participants was later scheduled to complete the surveys. Informed consent was given by the participants through completing the surveys. Participants gave their permission orally to participate in the focus group. The participants received \$10.00 financial remuneration upon completion of the surveys.

Phase II

In Phase II, thirteen participants volunteered to participate in one of the study's four focus groups. With the exception of the first focus group, which took place immediately after a data collection session, focus groups were scheduled one week after the participants had completed the surveys. The groups focused on participants' experiences of sexual violence,

traumatic symptoms experienced, coping strategies utilized, changes in physical appearance and social supports helpful to participants and potential future sexual violence survivors. Permission to audiotape the focus groups was requested of and granted by each participant. The interviews were conducted by the author, who is a mental health clinician with ten years of experience. Refreshments were provided at the first two-focus group sessions. The third focus group occurred over lunch; the fourth focus group occurred after the women had breakfast. Focus group participants received an additional \$10.00 financial remuneration upon completion of the focus group interview.

Location

The city of Boston, with its connections to numerous suburban communities, was selected as the main location of the study because of the availability of participants who met the criteria of the study. There were three scheduled data collection sessions arranged for participants to complete the surveys at a local university and community college in the Boston area. However, due to limited participant turnout, individualized and small group appointments were made with participants to complete the surveys after the brief telephone screening to determine the participant's eligibility. Meetings were arranged at local libraries, community mental health centers, transitional homes and local universities. On several occasions, meetings were arranged at individuals' homes. In all instances, the surveys were explained to the participants, a contact number for questions was provided and a time was arranged to collect the packets and debrief the participant(s) if needed.

The study consisted of four focus groups. The first two focus groups were conducted at a local university. The third focus group was conducted at a local community mental health

center. The fourth focus group was conducted at a transitional shelter. All of the sites were located within the city of Boston.

Assessment Instruments

This study utilized data collected from two non-standardized and three standardized instruments. The two non-standardized instruments, the Traumatic Symptoms, Coping and Changes in Physical Appearance Demographic Survey, and the Martin's Coping, Traumatic Symptoms and Changes in Physical Appearances Sexual Assault Inventory, used in this study were developed by this researcher to collect relevant demographics and histories of sexual victimization(s) from the study's participants. The three standardized instruments utilized in this study are the *Trauma Symptom Checklist (TSC-40)* (Briere & Runtz, 1989), *The Ways of Coping Checklist-Short Version (WCCL)* (Folkman & Lazarus, 1985) and the *Appearance Schemas Inventory (ASI)* (Cash & LaBarge, 1996). All of the study's surveys were intentionally presented in their shortened versions to minimize re-experiencing anxiety and depressive symptoms as a result of participating in this study.

Non-Standardized Instruments

The Traumatic Symptoms, Coping and Changes in Physical Appearance Demographic Survey

The Traumatic Symptoms, Coping and Changes in Physical Appearance Demographic Survey was created to gather demographic information, such as age, ethnicity, educational level, employment level, marital status, parenthood status/child(ren), sexual orientation, housing and living area, religious affiliation and political affiliation about the study's participants.

Martin's Coping, Traumatic Symptoms and Changes in Physical Appearances Sexual Assault Inventory

The Martin's Traumatic Symptoms, Coping and Changes in Physical Appearances Sexual Assault Inventory was created to gather information about participants' sexual victimization(s) in childhood and adulthood.

Standardized Instruments

The Trauma Symptom Checklist-40

The *Trauma Symptom Checklist-40* is a 40-item self-report research instrument designed to measure various aspects of posttraumatic stress and other symptom clusters associated with childhood or adult traumatic experiences. This instrument consists of six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems and Sleep Disturbance. Each symptom item is rated according to its frequency of occurrence over the prior two months, using a 4-point scale ranging from 0 ("never") to 3 ("often").

The TSC-40 has very good internal consistency and reliably discriminates abused from non-abused individuals (Briere & Runtz, 1989; Elliot & Briere, 1992). Studies using the TSC-40 indicate that it is a relatively reliable measure (subscale alphas typically range from .66 to .77, with alphas for the full scale averaging between .89 and .91). The TSC-40 has a predictive validity with reference to a wide variety of traumatic experience, such as childhood and adulthood sexual traumatic experiences and perpetration of intimate violence (e.g., Dutton, 1995). Gold and Cardena (1998) conducted a research study to examine the convergent validity of the three posttraumatic symptoms inventories among adult sexual abuse survivors. The inventories were the civilian version of the Mississippi Scale of Combat-Related PTSD (CM-PTSD), the Trauma Symptom Checklist-40 and the Response to Childhood Incest Questionnaire

(RCIQ) in a sample of 52 adult sexual abuse survivors. “Significant and substantial correlations ($r = .6$ or higher) were found among the three inventories when the means of symptoms score for the RCIQ was used, supporting their convergent validity” (Gold & Cardena, p.178).

Whiffen, Benazon and Bradshaw (1996) conducted a study to assess the discriminant validity of the TSC-40 in an outpatient clinical setting of adult survivors of childhood adversity and trauma, including but not limited to childhood sexual assaults. The purpose of the study was to determine if childhood sexual assault survivors were more symptomatic within a clinical sample. When comparing childhood sexual assault survivors to non-survivors, they found that childhood sexual assault survivors were more symptomatic for the TSC-40, with $F(1, 139) = 16.69$, $p < .01$ and with effect sizes of .42 and .34 for males and females. A MANOVA executed on the TSC subscale was significant for the childhood sexual assault group, with $F(6, 137) = 4.34$, $p < .01$, and with females significantly higher than males, with $F(6, 137) = 3.83$, $p < .01$. Post hoc discriminant analysis produced a significant discriminant function for the childhood sexual assault group effect, $\chi^2(7) = 39.43$, $p < .01$, with an associated canonical correlation of .49.

Ways of Coping Checklist (Short Version)

The *Ways of Coping Checklist (Short Version)* is a 31-item questionnaire used to address a broad range of cognitive and behavioral strategies that people use to manage internal and/or external demands in a stressful situation (Folkman & Lazarus, 1985; Folkman, Lazarus, Dunkel-Schetter, DeLongis & Gruen, 1986). Stone et al. (1990) noted that the Ways of Coping Questionnaire reflects transactional theory in several ways. Holding a special stressful incident in mind, the instrument seeks to measure what a person actually does to cope with the situation and it reports all of their strategies, helpful and non-helpful, used to cope with the incident. The

individual's efforts are then categorized as either emotion-focused (avoidance) or problem-focused (active) ways of coping (Rexrode, Peterson & O'Toole, 2008).

While the Ways of Coping Manual asks participants to think and write a brief description about a stressful event that happened to them during the week, some aspects of this instrument's administration is flexible (Rexrode, Peterson & O'Toole, 2008) and gave researchers a clear advantage for using it. Although some researchers use elaborate interviewing techniques to assist the participant in focusing on an event, others use self-administration and open-ended referent events (Charlton & Thompson, 1996; Folkman & Lazarus, 1988b; Miller, Gordon, Daniele & Diller, 1992; Peterson & O'Toole, 2008).

The WCCL-Short Version measures consist of eight coping factors: Confrontative Coping (aggressive efforts to alter the situation, evidenced in statements such as "I expressed anger to the person[s] who caused the problem"); Distancing (cognitive efforts to detach oneself and to minimize the significance of the events, evidenced in statements such as "I went on as if nothing has happened"); Self-controlling (efforts to regulate one's feelings and actions, evidenced in statements such as "I tried to keep my feelings to myself"); Seeking Social Support (efforts to obtain informational, tangible and emotional support, evidenced in statements such as "I talked to so to find out more about the situation"); Accepting Responsibility (acknowledging one's roles in the problem and attempts to rectify the situation, evidenced in statements such as "Criticized or lectured myself"); Escape-Avoidance (wishful thinking or escapist behaviors, evidenced in statements such as "I went on as if nothing had happened"); Planning problem solving (deliberate, analytic, problem-focused efforts to remedy the situation, evidenced by statements such as "I made a plan of action and followed it"); and Positive Reappraisal (efforts to create positive meaning through personal growth, as evidenced in statements such as "I

rediscovered what is important in life”). Averaging the 4-point Likert scale responses for each of the subscale items provides a score for each subscale.

One of the original normative studies of the WCCL-Short Version involved 750 married couples using alpha and principal factoring with oblique rotation. Three separating factor analyses were completed using different strategies for combining person and occasions, or observation. First analyses were conducted on the entire 750 observations, five from each 150 subjects, with each of the five concerning a different stressful encounter. The second analyses were conducted on 150 stressful encounters (one per subject), randomly selected from the 750 couples, equally representing each of the five occasions. An additional sample of 150 stressful encounters was also randomly selected from the 750 total encounters without replacement of the prior 150 encounters, and again equally representing each of the five occasions (Folkman et. al, 1986). The three factor analyses yielded similar factor patterns, with thirty-seven items consistently loaded high on the same factor across all three analyses and twenty-two items loaded on the same factor fairly consistently. The Cronbach's coefficient alpha (α) for this measure is reported to range from 0.61 to 0.79, which is “higher than the alpha has reported for most other measures of coping processes” (*WAYSS Manual*, 1988, p. 16).

While the WCCL-Short Version has been used on various populations, including studies on sexual assault with samples of Caucasian women and Women of Color (African American, Latino, Native American and Mixed Ethnicity), one of the challenges of the WCQ-Short Version is that the scales were developed on a white, middle class population. Other challenges to the WCCL-Short Version rest in the fact that the number of extracted factors changed from sample to sample or from stressor to stressor (Parker & Endler, 1992). However, the inter-correlations among these scales were found to be rather low, confirming their desired distinctiveness.

However, the internal consistencies are not always satisfactory, and test-retest reliabilities are not reported. The flexibility of the WOCS might “compromise the reliability of scores, particularly in the absence of examining the impact of such deviations. The wide variability in WOCS reliability scores could be due to the leeway afforded the researcher. It is also possible that the variability in reliability estimates may be due to the instability of the factor structure across populations and settings” (Rexrode, Peterson & O’Toole, p. 264). This measurement will be used in this study to assess how survivors of adulthood sexual violence cope with their sexual victimization.

Appearance Schema Inventory-Revised

The *Appearance Schema Inventory-Revised* (ASI-R) is an assessment of an individual’s psychological investment in their physical appearance. The ASI-R measures core beliefs and assumptions about the importance, meaning and implications of appearance in one’s life (Cash, 2000; Cash & Labarge, 1996). This assessment focused on the salience of one’s appearance in six domains of one’s life: historical salience, attentional and cognitive salience, salience to one’s sense of self, behavioral salience, affective salience and interpersonal salience. Using a 5-point Likert scale (from 1 = *strongly disagree*, to 5 = *strongly agree*), the ASI-R asks participants to rate 14 statements with high scores reflecting higher appearance schematicity. The ASI-R has displayed a one-month test-retest reliability of .71 (Cash & Labarge, 1996).

Internal consistencies of the ASI-R from Cash et al.’s sample of 468 college women and 135 college men revealed that the Cronbach alphas were quite satisfactory. The ASI-R and the original 14-item scale correlated significantly, with $r = .76$ ($p < .001$) for both women and men. Among women, the original ASI correlated .79 ($p < .001$) with the Self-Evaluative Salience

factor and .45 ($p < .001$) with the Motivational Salience factor. Among men, these correlations were .77 and .53 respectively.

Pearson correlations were computed for the ASI-R and its two factors, with seven other measures, including the Body Image Ideals Questionnaires, Situational Inventory of Body-Image Dysphoria, Socio-cultural Attitudes toward Appearance Questionnaire-Internalization Subscale, Body Image Quality of Life Inventory, Perfectionistic Self-Presentation Scale V, Rosenberg Self-Esteem Scale and Eating Attitudes Test-26. The measures consist of various cognitive, affective and behavioral elements of body image or of personality and psychosocial functioning constructs known to be associated with body image. For women, the composite ASI-R and the two factors were positively correlated with three of the four body image measures, including self-ideal discrepancies on the BIQ, body image dysphoria on the SIBID-S, and internalization of media ideals on the SATAQ-3, although the BIQLI was negatively correlated with the Motivational Salience factor. In addition, bivariate correlations calculated between the ASI-R scales and three psychosocial functioning measures, including self-presentational perfectionism (PSP-V), self-esteem (RSES), and eating attitudes (EAT-26) revealed that for women, the ASI-R and both factors were both positively correlated with PSP and EAT-26 scores. Although the composite scale and Self-Evaluative Salience was negatively related to the RSES, Motivational Salience was unrelated to self-esteem. Correlations of the ASI-R with aspects of psychological functioning, such as social self-presentational, perfectionism, global self-esteem and eating disturbance reveal consistent results that suggest that there are stronger associations for women than men with the greater dysfunctionality of Self-Evaluative Salience than Motivational Salience.

A GLM ANOVA was performed on the original ASI scales and the revised ASI scale to evaluate racial differences between African-American women and European-American women. The results of this analysis revealed that African-American women reported significantly less schematic investment in their appearance on the original ASI, $F(1, 389) = 14.98, p < .001$, partial $\eta^2 = .04$ and on the composite score ASI-R, $F(1, 391) = 13.96, p < .001$, partial $\eta^2 = .03$. However, African-American women reported more comparable schematic investment on the Motivational Salience factor compared to White women, $F(1, 391) = .01, ns$. For women, BMI (Body Mass Index) was modestly and positively correlated with responses to items on the original ASI ($r = .13, p < .01$) and the Self-Evaluative Salience factor of the ASI ($r = .11, p < .02$), but was not related on the composite ASI-R or the Motivational Salience factor.

Worrell and Trevino (2007) used the ASI-R to examine its psychometric properties in Latino women. The composite scores of the ASI-R had an alpha coefficient of .89, an adequate estimate of internal consistency reliability for the subscales. In addition, they found that while the alpha coefficients for the ASI-R Composite and Self-Evaluation Salience subscale were similar to those reported by Cash, Melnyk and Hrabosky (2004), the Motivational Salience subscale revealed less internal consistency (alpha of .78 and .90, respectively) for the Hispanic sample than was previously reported by Cash and his colleagues.

Major Research Questions

This study will examine the effect of traumatic symptoms, coping strategies and changes to physical appearances among African-American and European-American women survivors of adulthood sexual assault. The following research questions and hypotheses are posed.

Research Question # 1

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported traumatic symptom(s)?

Hypothesis: There is a significant difference in traumatic symptoms reported by Caucasian women and Women of Color in the wake of their sexual victimization.

Research Question #2

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported coping strategies?

Hypothesis: There is a significant difference in coping strategies reported by Caucasian women and Women of Color survivors of adulthood sexual violence.

Research Question #3

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their overall psychological investment in physical appearance in the wake of their sexual victimization?

Hypothesis: There is a significant difference in the overall psychological investment in physical appearance among Caucasian women and Women of Color survivors of adulthood sexual violence.

Research Question # 4

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported physical appearance self-schema (i.e., self-evaluative satisfaction/dissatisfaction about their physical appearance)?

Hypothesis: There is a significant difference in the physical appearance self-schema reported by Caucasian women and Women of Color survivors of adulthood sexual violence.

Research Question # 5

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported participation in behaviors aimed at managing their physical appearance (i.e., motivational salience of grooming behaviors)?

Hypothesis: There is a significant difference in attempts to manage physical appearance reported by Caucasian women and Women of Color survivors of adulthood sexual violence.

Focus Group Questions

The focus group questions were part of an ethnographic interview process that seek to explore sexual violence survivors' opinions concerning the emotional symptoms experienced, coping strategies utilized, changes to physical appearance and helpful (personal and social) resources. Martyn Hammersley and Paul Atkinson (1995) wrote extensively about ethnography and noted, "We see the term as referring primarily to a particular method or sets of methods. In its most characteristic form it involves the ethnographer participating, overtly or covertly, in people's lives for an extended period of time, watching what happens, listening to what is said, asking questions—in fact, collecting whatever data are available to throw light on the issues that are the focus of the research" (p.1). Participants were asked the following questions:

1. What symptoms did you experience in the wake of being sexually assaulted?
2. What did you do to cope with the emotional symptoms of being sexually assaulted?
3. What did you do to cope with the medical symptoms of being sexually assaulted?
4. What did you do to cope with the physical symptoms of being sexually assaulted?
5. What did you do to cope with the social symptoms of being sexually assaulted?
6. Did you change any aspects of your physical appearance to cope with the various symptoms of being sexually assaulted?
7. What changes did you make to your physical appearance?
8. Did these changes alleviate any of your symptoms?
9. If yes, what symptoms were better?
10. In what ways were your symptoms better?
11. If no, what symptoms became worse?
12. In what ways did your symptoms worsen?

13. In what ways did you cope with the worsened symptoms?
14. What additional support would have been helpful to assist you to thrive in the face of being sexually assaulted?
15. What additional services might be helpful to assist survivors to thrive in the face of sexual assault?

Focus Group Themes

Focus group interviews were tape recorded, transcribed and analyzed. The final data set consisted of four focus groups consisting of thirteen participants. After transcriptions, the focus group interviews were read as a whole several times and were analyzed to identify the major themes and concepts that occurred in participants' responses. Because the questions were open-ended and participants were asked if they wanted to add anything, it was possible for them to make comments about a topic at a time other than when a specific question was asked. These responses were included in the transcript as part of the interview.

Major concepts and pertinent information were identified by a selective approach, in which they were underlined and noted as essential phrases (van Manen, 1990) in the transcribed text. Essential phrases were combined into relevant patterns and catalogued as sub-themes. Steven Taylor and Richard Bodgan (1989) defined the concept of themes as units derived from patterns such as "conversation topics, vocabulary, recurring activities, meaning, feelings, or folk sayings and proverbs (p. 131). Madeleine Leininger (1985) wrote about the importance of themes in research and noted that: "themes are identified by bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (p. 60). Narratives of the thirteen focus group participants were read carefully on several occasions to

identify common experiences. Themes were identified if six or more participants endorsed a specific experience. Through this process, six themes relating to the survivors' lived experience with sexual violence were identified: early trauma, psychological and physiological distress, adaptive and maladaptive coping strategies, retreat from over-representation of visible femininity, difficulties in creating and maintaining intimate relationships and social support.

Chapter Four

Results

The results of the research investigation are presented in this chapter. They are presented in two sections: quantitative and qualitative. The first section provides demographic information on the quantitative data collected through the study's surveys and inferential analysis on the participants' experiences of sexual assaults, traumatic symptoms, coping strategies, and changes to their physical appearance in the wake of their sexual assaults. The second section provides demographic information and inferential analysis on the qualitative data collected from participants of the study's focus groups about changes made to their physical appearance and the nature of these changes.

Quantitative Data Analysis

Demographic Information

The study's sample consists of 73 women with histories of sexual violence in adulthood, including incidents of sexual assault and rapes. The sample consisted of 39 African- American women, 23 Caucasian women, six Biracial/Multicultural women, four Latina women and one Native American woman. Race and ethnicity of all participants was determined by self-identification and was used to create two distinct groups: Caucasian women and Women of Color. The term Women of Color is an inclusive term used to acknowledge and describe the lived experiences of non-white women, including, but not limited to, the experiences of African- American, Biracial/Multicultural, Native American and Latino women in the United States. Participants who self-identified as any of these races/ethnicities were included in the Women of Color Group. This incorporation changed the study's sample from 39 African-American women,

23 Caucasian women, six Biracial/Multicultural women, four Latina women and one Native American woman to 23 Caucasian women and 50 Women of Color. The focus of this study is based on analyses among Caucasian women and Women of Color survivors of adulthood sexual violence. Demographic information on both groups is provided in Table 1.

Table 1.

Demographic Characteristics of Respondents (N = 73)

<u>Characteristics</u>	<u>n</u>	<u>%</u>
Age Groups		
21-29	15	20.5
30-45	28	38.3
46-55	25	34.3
56-65	5	6.9
Race/Ethnicity		
Caucasian Women	23	31.5
Women of Color	50	68.5
Education		
No High School Diploma	10	13.7
High School	23	31.5
Some College Credit	18	24.6
2 year college/Associate Degree	3	4.1
Bachelors	7	9.6
Masters	6	8.2
Technical/Vocational Degree	3	4.1
Professional Degrees	3	4.1

Employment

Full Time	15	20.5
Part Time	12	16.5
Unemployed	46	63.0

Social Class

Low Income	52	71.2
Middle Class	16	21.9
Upper Class	5	6.8

Living Area

Urban	53	72.6
Suburban	12	16.4
Rural	1	1.4
Missing	7	9.6

Relationship Status

Single/Never Married	28	38.4
Single/In a Relationship	18	24.7
Married	5	6.8
Divorced	11	15.1
Separated	10	13.7
Widowed	1	1.4

Parental Status

Children	50	68.5
No Children	21	28.8

Sexual Orientation

Heterosexual	50	68.5
Gay/Lesbian	6	8.2
Bisexual	10	13.7
Transgender	1	1.4
Questioning	1	1.4
Non-Sexual	5	6.8

Religious Affiliation

Christian	58	79.5
Jewish	1	1.4
Buddhist	1	1.4
Atheist	3	4.1
No Preferences	3	4.1
Others	5	6.8

Sexual Violence in Childhood

In this section, additional demographic information is provided on participants' histories of sexual violence in childhood because of the direct connection between sexual violence, the frequency and intensity of traumatic symptoms and coping strategies utilized in adulthood survivors of sexual violence. A common vulnerability to sexual victimization in adulthood rape

has been a previous history of sexual abuse in childhood. Several women reported more than one occurrence of sexual violence by different perpetrators in childhood and adolescence.

The rates of recurrence of sexual assault and rape reported by participants during childhood are presented in Table 2.

Table 2.

Frequencies and Percentage of Caucasian Women and Women of Color who Reported Incidents of Sexual Victimization in Childhood by Different Perpetrators

	One Incident of Inappropriate Touching	One Incident of Childhood Rape	Two Incidents of Childhood Rape	Three Incidents of Childhood Rape
	n (%)	n (%)	n (%)	n (%)
Caucasian Women	16 (69.6)	10 (43.5)	5 (21.7)	3 (13.0)
Women of Color	43 (86.0)	31 (62.0)	9 (18.0)	2 (4.0)

Sexual Assaults in Adulthood

As a requirement of the study, all participants experienced an incident of sexual violence in adulthood. Several women reported more than one incident of rape in adulthood. Incidents of sexual violence reported by participants in adulthood are presented in Table 3. Participants reported various types of sexual violence in their sexual victimization narratives. Many of the women were raped, but not all shared the nature of the penetration (i.e., anal, oral or vaginal). These incidents were coded and referred to as unidentified penetration. In addition, some of the participants shared that they initially consented to some physical contact with their offender(s), but declined as the contact became more sexual and were later raped. These incidents were

coded and referred to as rape. Some respondents identified one or more incidents of sexual violence by different perpetrators in adulthood.

Table 3.

Frequencies and Percentage of Caucasian Women and Women of Color Who Reported Incidents of Sexual Victimization in Adulthood by Different Perpetrators

	At Least One Incident of Sexual Assault	One Incident of Adulthood Rape	Two Incidents of Adulthood Rape	Three Incidents of Adulthood Rape
	n (%)	n (%)	n (%)	n (%)
Caucasian Women	9 (39.1)	21 (91.3)	4 (17.4)	1 (4.3)
Women of Color	21 (42.0)	38 (76.0)	14 (28.0)	5 (10.0)

The types of sexual violence reported by participants who reported one incident are presented in Table 4.

Table 4.

Sexual Victimization Reported by Caucasian Women and Women of Color Who Reported One Incident of Sexual Violence

	Caucasian Women (N = 21)	Women of Color (N = 38)
	n (%)	n (%)
Forced Anal Sex	1 (4.3)	5 (10.0)
Forced Oral Sex	5 (21.7)	7 (14.0)
Forced Vaginal Sex	6 (26.0)	10 (20.0)
Unidentified Penetration	14 (60.9)	22 (44.0)
Penetration W/Objects	0	2 (4.0)
Rape	0	2 (4.0)
Date Rape	2 (8.7)	2 (4.0)
Gang Rape	3 (13.0)	2 (4.0)
Partner Rape	3 (13.0)	11 (22.0)

Analysis of Research Questions**Traumatic Symptoms**

Research Question # 1

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported traumatic symptom(s)?

Methods

Data analysis was executed through the use of two tests. A Levene's test of equality of variances was conducted within a one-way analysis of variance (ANOVA) to assess the differences between Caucasian women and Women of Color on the Traumatic Symptom Checklist-40's six subscales. The subscales are Dissociation, Anxiety, Depression, Sexual Abuse Trauma Index (SATI), Sleep Disturbance and Sexual Problems. Each subscale assesses the relationship between ethnicity and traumatic symptoms reported by the study's participants. Significance level was set at $\alpha = .05$ (2 tailed). All analyses were conducted using SPSS 16.0 for Windows. Analysis of the Traumatic Symptoms Checklist-40 (TSC-40) Composite Score and subscales are presented in Table 5.

Table 5.

One-Way Analysis of Variance for Traumatic Symptoms Checklist-40 Composite Score and Subscales by Ethnicity

TSC-40 Subscales	Caucasian Women		Women of Color		F	df	p	η ²
	M	SD	M	SD				
TSC-40 Comp. Score	72.82	21.36	62.84	28.50	2.237	72	.139	.031
Dissociation	10.04	4.15	8.56	4.79	1.637	72	.205	.023
Anxiety	14.74	5.34	11.64	6.93	3.603	72	.062	.048
Depression	18.43	5.61	15.14	6.47	4.419	72	.039	.059
Sexual Abuse Trauma	13.65	4.81	11.36	5.65	2.827	72	.097	.038
Sleep Disturbance	13.73	4.42	12.72	5.22	.657	72	.420	.009
Sexual Problems	13.00	6.52	11.94	7.19	.362	72	.549	.005

Note: M = mean, SD = Standard Deviation, F = Observed F value, df = Degrees of freedom, p = significance level, η² = eta squared (measurement of effect size)

Results

A one-way analysis of variance (ANOVA) was calculated to assess the difference in traumatic symptoms among Caucasian women and Women of Color. While Caucasian women reported higher level of traumatic symptoms on all of the Traumatic Symptoms Checklist-40 Composite score and on all of the TSC-40 subscales when compared to Women of Color, a significant difference ($F = 1,73 = 4.41, p < .039$), $\eta^2 = .059$ in reported depressive symptoms among Caucasian women and Women of Color. Caucasian women ($M = 18.43, SD = 5.61$) reported more depressive symptoms in conjunction to their sexual victimization than Women of

Color ($M = 15.14$, $SD = 6.47$). Noteworthy, Caucasian women and Women of Color's mean scores on the Anxiety subscale, which suggests a trend toward statistical significance for Caucasian women ($M = 14.74$, $SD = 5.34$) when compared to Women of Color ($M = 11.64$, $SD = 6.93$). The hypothesis that there is a significant difference in traumatic symptoms experienced by Caucasian women and Women of Color was supported.

Coping Strategies

Research Question #2

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported coping strategies?

Methods

Data analysis was executed through the use of two tests. A Levene's test of equality of variances was conducted within a one-way analysis of variance (ANOVA) to assess the differences among coping strategies between Caucasian women and Women of Color on the Ways of Coping Checklist-Short Version. This instrument consists of eight subscales: Confrontive Coping, Distancing, Self-Controlling, Seeking Social Support, Accepting Responsibility, Escape-Avoidance, Planful Problem-Solving and Positive Reappraisal. Each subscale assesses various coping strategies utilized to alleviate life stressors. All analyses were conducted using SPSS 16.0 for Windows. The results of the one-way analysis of variance on the Ways of Coping Checklist (WCCL) Composite Score and subscales are presented in Table 6.

Table 6.

One-Way Analysis of Variance on the Way of Coping Checklist's Subscales by Ethnicity

	Caucasian Women (N = 23)		Women of Color (N = 50)		F	df	p	η^2
	M	(SD)	M	(SD)				
WOCC Composite Score and Subscales								
WOCC Composite Score	1.48	.458	1.48	.483	2.99	72	.088	.040
Confrontive Coping	1.15	.824	1.58	.888	3.90	72	.052	.052
Distancing	1.82	.773	1.84	.829	.009	72	.927	.000
Self-Controlling	1.71	.743	1.79	.626	.215	72	.645	.003
Seeking Social Support	.94	.827	1.38	.940	3.72	72	.058	.050
Accepting Responsibility	1.73	1.01	1.51	.716	1.19	72	.278	.017
Escape-Avoidance	1.97	.602	1.88	.698	.34	72	.562	.005
Planful Problem Solving	1.21	.732	1.63	.971	3.27	72	.074	.044
Positive Reappraisal	1.52	1.17	1.98	.957	3.22	72	.077	.043

Note: M = mean, SD = Standard Deviation, F = Observed F value, df = Degrees of freedom, p = significance level, η^2 = eta squared (measurement of effect size)

Results

A one-way analysis of variance (ANOVA) was calculated on the Ways of Coping Checklist-Short Form to assess coping strategies utilized by Caucasian women and Women of Color in the wake of sexual violence. A significant difference ($F = 1, 73 = 3.90, p < .05, \eta^2 = .052$) was revealed among Confrontive Coping strategy among Caucasian women and Women of Color. Women of Color ($M = 1.58, SD = .888$) reported utilizing confrontive coping strategies at a higher frequency in comparison to Caucasian women ($M = 1.15, SD = .824$). Noteworthy, Caucasian women and Women of Color's mean scores on the Social Support subscale suggests a trend toward statistical significance for Women of Color ($M = 1.38, SD = .940$) in comparison to Caucasian women ($M = .939, SD = .827$). The hypothesis that there is a significant difference in coping strategies utilized by Caucasian women and Women of Color was supported.

Physical Appearance

Research Question # 3

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their overall psychological investment in physical appearance?

Methods

Data analysis was executed through the use of two tests. A Levene's test of equality of variances was conducted within a one-way analysis of variance (ANOVA) to assess overall differences in Caucasian women and Women of Color's overall psychological investment in their physical appearance on the Appearance Schema Inventory-Revised Composite Score. Significance level was set at $\alpha = .05$ (2 tailed). All analyses were conducted using SPSS

16.0 for Windows. The results of the one-way analysis of variance on the Appearance Schema Inventory–Revised Composite Score are presented in Table 7.

Table 7.

One-Way Analysis of Variance on the Appearance Schema Inventory–Revised Composite Score by Ethnicity

Appearance Schema Inventory	Caucasian Women		Women of Color		F	df	p	η ²
	M	(SD)	M	(SD)				
ASI-Composite Score	3.00	.581	3.03	.521	.054	72	.818	.001

Note: M = mean, SD = Standard Deviation, F = Observed F value, df = Degrees of freedom, p = significance level, η² = eta squared (measurement of effect size)

Results

A one-way analysis of variance (ANOVA) was executed on the Appearance Schema Inventory (ASI) to assess the overall psychological investment in physical appearance of Caucasian women and Women of Color survivors of adulthood sexual violence. The result revealed that there was no significant difference ($F = 1, 73 = .054, p < .818, \eta^2 = .001$) noted among Caucasian women ($M = 3.00, SD = .581$) and Women of Color ($M = 3.03, SD = .521$) on the ASI’s Composite Score. This finding suggests the Caucasian women and Women of Color do not differ in the mental and emotional investment in their physical appearance. The hypothesis that there is a significant difference in Caucasian women and Women of Color’s overall psychological investment in their physical appearance was not supported.

Research Question # 4

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported physical appearance self-schema (i.e., self-evaluative satisfaction/dissatisfaction about their physical appearance)?

Methods

Data analysis was executed through the use of two tests. A Levene's test of equality of variances was conducted within a one-way analysis of variance (ANOVA) to assess differences in the extent to which survivors of adulthood sexual violence define or measure themselves by their physical appearance on the Self-Evaluative Salience of Physical Appearance Subscale on the Appearance Schema Inventory–Revised (Cash, Melnyk & Hrabosky, 2004). Significance level was set at $\alpha = .05$ (2 tailed). All analyses were conducted using SPSS 16.0 for Windows. The results of the one-way analysis of variance on the Appearance Schema Inventory–Revised Self-Evaluative Salience of Physical Appearance subscale are presented in Table 8.

Table 8.

One-Way Analysis of Variance on the Self-Evaluative Salience of Physical Appearance Subscale of the Appearance Schema Inventory by Ethnicity

Appearance Schema Inventory	Caucasian Women		Women of Color		F	df	p	η^2
	M	(SD)	M	(SD)				
Self-Evaluative Salience Subscale	2.97	.677	3.06	.643	.299	72	.586	.004

Note: M = mean, SD = Standard Deviation, F = Observed F value, df = Degrees of freedom, p = Significance level, η^2 = eta squared (measurement of effect size).

Results

A one-way analysis of variance (ANOVA) was executed on the Self-Evaluative Salience of Physical Appearance Subscale of the Appearance Schema Inventory (ASI) to assess Caucasian women and Women of Color's self-evaluative salience of their physical appearance. The result revealed that there was no significant differences ($F = 1, 73) = .299, p < .586, \eta^2 = .004$) noted among Caucasian Women ($M = 2.97, SD = .677$) and Women of Color ($M = 3.06, SD = .643$) on the Self-Evaluative Salience of Physical Appearance Subscale. This finding suggests that Caucasian women and Women of Color adulthood survivors of sexual violence do not differ in self-evaluative beliefs about their physical appearance. The hypothesis that there is a significant difference in self-evaluative salience in physical appearance between Caucasian women and Women of Color was not supported.

Research Question # 5

Do Caucasian women and Women of Color survivors of adulthood sexual violence differ in their reported participation in behaviors aimed at managing their physical appearance (i.e., motivational salience of grooming behaviors)?

Methods

Data analysis was executed through the use of two tests. A Levene's test of equality of variances was conducted within a one-way analysis of variance (ANOVA) to assess overall differences in the extent to which adulthood survivors of sexual violence attend to their appearance and engage in appearance-management behaviors (Cash, Melnyk & Hrabosky, 2004), as measured by the Motivational Salience Subscale on the Appearance Schema Inventory.

Significance level was set at $\alpha = .05$ (2 tailed). All analyses were conducted using SPSS 16.0 for Windows. The results of the one-way analysis of variance on the Appearance Schema Inventory–Revised Motivational Salience of Physical Appearance subscale are presented in Table 9.

Table 9.

One-Way Analysis of Variance on the Motivational Salience of Physical Appearance Subscale of the Appearance Schema Inventory by Ethnicity

Appearance Schema Inventory	Caucasian Women (N = 23)		Women of Color (N = 50)		F	df	p	η^2
	M	(SD)	M	(SD)				
Motivational Salience Subscale	2.90	.590	3.12	.500	2.65	72	.108	.036

Note: M = mean, SD = Standard Deviation, F = Observed F value, df = Degrees of freedom, p = Significance level, η^2 = eta squared (measurement of effect size)

Results

A one-way analysis of variance (ANOVA) was executed on the Motivational Salience of Physical Appearance Subscale to assess attendance to appearance and engagement in appearance-management behaviors among Caucasian women and Women of Color adulthood survivors of sexual violence. The result revealed that there was significant difference ($F = 1, 73$) = 2.65, $p < .108$, $\eta^2 = .036$) was noted among Caucasian women ($M = 2.90$, $SD = .590$) and Women of Color ($M = 3.12$, $SD = .500$) on the Motivational Salience of Physical Appearance Subscale. This finding suggests the Caucasian women and Women of Color do not differ in how their appearance management behaviors in the wake of sexual victimization. The hypothesis that

there is a significant difference in attendance to appearance and engagement in appearance management behaviors among Caucasian women and Women of Color survivors of adulthood sexual violence was not supported.

Qualitative Data Analysis

Demographic Information

Thirteen respondents participated in one of the study's four focus groups. Each participant self-identified her race/ethnicity as either Caucasian woman or Woman of Color. The focus group sample consisted of six African-American women and seven Caucasian women. Demographic information on the focus group participants is provided in Table 10.

Table 10.

Characteristics of Focus Group participants (N=13)

Name	Focus Group	Race	Age	Sexual Orientation	Employment Status	Living Status	Marital Status
Allison	1	Black	40	Asexual	Unemployed	Others	Single ³
Amy	1	White	43	Heterosexual	Part-time	Partner	Single ²
Andrea	1	Black	43	Bisexual	Full-time	Alone	Divorced
Ann	1	White	45	Asexual	Unemployed	Shelter	Separated
Abigail	1	Black	50	Heterosexual	Unemployed ¹	Others	Single ³
Barbara	2	White	22	Bisexual	Unemployed	Others	Single ²
Beverly	2	White	27	Bisexual	Unemployed	Others	Single ²
Donna	3	Black	47	Asexual	Unemployed ¹	Alone	Single ³
Dawn	3	Black	49	Asexual	Unemployed	Alone	Single ³
Kelly	4	White	38	Heterosexual	Employed	Shelter	Divorced
Kim	4	White	42	Bisexual	Unemployed	Shelter	Single ³
Kate	4	White	43	Heterosexual	Unemployed	Shelter	Single ²
Kathy	4	Black	45	Heterosexual	Unemployed	Shelter	Separated

Note: None = Unemployed, Part = Part-time employment, Full = Full-time employment¹, Student² = Single/In a relationship³ = Single/Never Married.

Sexual Violence in Childhood and Adulthood

Additional demographic information is provided in this section on participants' history of sexual violence in childhood and adulthood because of the direct connection between sexual violence, the intensity and frequency of traumatic symptoms and coping strategies utilized by adulthood survivors of sexual violence in the wake of the incident. A common vulnerability to

sexual victimization in adulthood rape has been a previous history of sexual abuse in childhood. Several women reported more than one incident of sexual violence in childhood and adolescence. Incidents of sexual violence reported by participants in childhood and adulthood are presented in Table 11.

Table 11.

Sexual Incidents in Childhood and Adulthood Reported by Focus Group Participants by Ethnicity

	Caucasian Women (N = 7)	Women of Color (N = 6)
Sexual Incidents		
Inappropriate Touching in Childhood	6 (85.7)	6 (100.00)
Incident of Childhood Rape	4 (57.1)	4 (66.7)
Inappropriate Touching in Adulthood	2 (28.6)	4 (66.7)
Incidents of Adulthood Rape	7 (100.0)	5 (83.3)

Participants reported various types of sexual violence in their sexual victimization narratives. The sexual victimization of focus group participants is presented in Table 14.

Table 14.

Types of Sexual Victimization Reported by Focus Group Participants based on Race/Ethnicity

Sexual Victimization	Caucasian Women (N = 7)	Women of Color (N = 6)
Forced Anal Sex	1 (14.3)	0
Forced Oral Sex	1 (14.3)	2 (33.3%)
Forced Vaginal Sex	3 (42.9)	2 (33.3%)
Unidentified Penetration	5 (71.4)	2 (33.3%)
Date Rape	1 (14.3)	0
Gang Rape	1 (14.3)	0
Partner Rape	1 (14.3)	3 (50%)

Descriptions of Focus Groups

Each of this study's four focus groups consisted of two to five participants. Each group was a unique representation of survivors forging relationships with others in an expressed desire to share their lived experiences with sexual violence. A brief description of each group is presented below in the order of the interview date.

Focus Group Number One

The first focus group consisted of five participants — two Caucasian women and three Women of Color. Four of the women completed the surveys prior to participating in the group interview; the fifth woman completed the surveys about two weeks prior to the focus group and came back to participate in the group discussion. While there were some prior relationships in this group (two of the women were cousins and planned to participate in the study together), the women quickly formed a bond that provided opportunities to ask and answer questions as well as to cry, affirm and laugh with each other. At the end of the focus group, the women expressed the benefit of being among others with similar backgrounds, expressed a desire to keep in contact and hugged each other before exchanging phone numbers with promises to keep in touch.

Focus Group Number Two

The second focus group consisted of two Caucasian women who had been dating for approximately three months. They met while attending an outpatient treatment program at a local hospital and were currently making plans to move in together. Both participants struggled openly with their disconnection from their family, persistent symptoms associated to the history of sexual victimization (i.e., insomnia, traumatic amnesia) in childhood and adulthood, everyday coping with their victimization and making sense of their love and dependency on each other.

Focus Group Number Three

The third focus group consisted of two African-American women whose friendship helped them to survive sexual violence in childhood and adulthood. They had been friends for over thirty years. The women shared openly about how their long-time friendship saved their

lives and how songs (i.e., “Wildflower”) affirmed their childhood experiences and propelled them forward despite facing many obstacles. One of the participants relayed a story of going to a local hospital at the age of 10 and sharing that she was being sexually assaulted, only to be disbelieved and later released back to her family.

They also talked openly about being raped in adulthood. One of the women talked openly about having a nervous breakdown after being raped, which led to severe drug usage, psychiatric hospitalization, losing her job and later becoming homeless. They talked about coping strategies that helped them to move forward in their lives and their struggle to trust others and create, and maintain, loving intimate relationships.

Focus Group Number Four

The fourth focus group consisted of three Caucasian women and one Woman of Color who all lived in a transitional home for women who carried an HIV diagnosis. The participants in this group talked about the role that sex played in their lives from a young age, as they were often taken care of by men who were also their perpetrators. They noted that these experiences created many opportunities for sexual violence to thrive, and over time, they learned to use sex to get what they wanted (i.e., food, money, housing and what they believed they needed to be loved). Three of the four women in the group were once prostitutes and were sexually victimized while working the streets. One of the women shared a horrific story about being raped by a man who threatened to cut her up with a chain saw, which he turned on during the assault to let her know that he was serious. The women talked about coping by leveling the playing field by having unprotected sex with men, some who were potential perpetrators, without

disclosing their HIV status. Each of the women talked about experiencing intense difficulties in their interpersonal relationships, particularly intimate relationships.

Focus Group Themes

A close analysis of the four focus groups generated six major themes relating to the survivors' lived experience with sexual violence: (1) early trauma; (2) psychological and physiological distress; (3) adaptive and maladaptive coping strategies; (4) retreat from overrepresentation of visible femininity; (5) difficulties in creating and maintaining intimate relationships; and (6) social support. Quotations that embodied survivors' responses for six primary themes are presented below.

Theme One: Early Trauma

Nearly half of the focus group participants noted that early trauma enhanced their vulnerabilities to later victimization. While each of the women had a prior history of childhood sexual assault, some identified vulnerabilities prior to their childhood victimization, stemming from neglectful and absent caregivers. Their vulnerabilities stemmed from feeling alone, being unprotected, not being taught to protect or take care of themselves, being invisible and being misunderstood. For some of these women, these vulnerabilities occurred prior to their incident(s) of childhood victimization and continued in adulthood.

Kelly: “I put myself in that position because I didn’t have any self-care. Self care, like daily things, you know, like I came totally last on the totem pole. As a kid, I wasn’t even taught that. My mother...we were left to the wolves so to speak. We just grew. My sister took care of me and she was six years older. My mother told me, well she displayed to me, that the man always come first, even though she had many different men in the house, you know whichever one was there at the time, he took precedence over us and her.”

Andrea: “My mom was going to school and everything and I was the oldest and only female child, so I wanted to make sure that I protected my brothers because I did not want my father to do what he did to me to my brothers. So that’s why sometimes I have guilt, because I found myself in situations thinking that I’m going to protect him. I tried to find comfort through my mom and I didn’t actually tell her what my father was doing, but I tried to sleep next to her in her bed or go into her room and at times... she would kick me out saying I was too big.”

Kelly: “When I got raped, I was 14, he was 25 and I thought he was a boyfriend and I remember running out of the house and the first house I ran into was cop’s son and I ran in throwing up because I got chased by...he chased me with a knife through the neighborhood, so it was on television. Oh. It was just too much, it was too much, you know what I mean...they blew it up into an embarrassment for me. My name was all out there and my mother got mad at me. And my mother, it was on New Year’s Eve and my mother got mad at me and came to the hospital, screamed at me and said that I was to

blame. Yeah, my mother got pissed off at me because she had to leave for a New Year's Eve Party."

Beverly: "She (her mother) did not know anything that had happened but I feel like she should have known by my behavior that something was wrong, but she just kinda ignored it and there was just a lot of yelling and screaming going on in the house and a lot of physical abuse. I think that if I had had a parent who could instill, like, confidence in me, I think that it would have been a lot easier for me to not have to deal with it alone."

Donna: "Something that is real important for me...my mother gave me a letter. She gave me a letter that was dated September 29th of 1978. In this letter, it said that I was a failure. She is an excellent mom as a result of two children with successes and one was a failure. The one that is a failure is a lost soul unable to function as a being and it is due to circumstances beyond her and my control. Well I was 18 when she wrote that (talking to Dawn) you know me at eighteen ...that is the last thing that I was a lost soul. I was hurt because of child rape and being raped from...I didn't know when it started but I know that it ended at 16 and that it was me that stopped it. So, put all of that together. I know for a fact that everything my mother thought that I was, I didn't feel that way and if I had felt the way that she felt, I would have killed myself because I attempted suicide twice and if I had felt that way either time in my life, I would have made it happen for real and I let her know that and she is mad at me now because I told her I will not accept her abuse any anymore. I could not have done that...I did not do that after the childhood rape. I did not do it...she wasn't around when the guy broke in. She personally did not

help me through it and I only believe that matches what she could do in child rape but I know that I am not anything that she saw in me. If I had gotten that same letter about the time that I had gotten raped, I believe that I would have taken that second suicide attempt out. I believe that if I had felt any of that I would have. So, before and after rape there are definite transactions that I have to make but I know for a fact that people make them harder for you than you do yourself.”

In these narratives, survivors outlined early traumatic experiences of psychological abuse and physical abandonment by their caregivers enhanced their vulnerabilities for future physical and sexual victimization in their lives. These experiences left a sense of inferiority, of feeling less than and unimportant, that perhaps placed them in other environments where psychological and physical abuse could flourish.

Theme Two: Psychological Distress

All of the women reported psychological and physiological distress after being sexually assaulted. Psychological and physiological distress refers to the emotional and physical symptoms experienced by survivors as a direct result of being victimized. Some of these symptoms included shock, confusion, irritability, difficulties eating and sleeping, constant fear, self-loathing, guilt and shame. Twelve of the thirteen women reported sustaining physical injuries. When the women began talking about the emotional, medical and physical symptoms they had experienced, they had difficulties stopping.

Kelly: “As an adult when it happened, I felt shame. It almost felt like it was my fault because I put myself in that situation and that goes along with the lifestyle I was living so I felt like, you know, I shouldn’t feel sad about it because you know, don’t do the crime if you can’t do the time type of mentality. And I just felt like a, you know a piece of shit, but I felt like a piece of shit anyway so...yeah plus the lifestyle I was living when I was older, it just was like, fake, you can’t even protect yourself. You know what I mean?”

Ann: “First of all, it was being in shock and secondly, it was lack of...I seemed to have a disintegration of my emotional and physical self and I felt loathing so that I couldn’t protect myself, loathing for myself...that I couldn’t stop it from happening. Then I felt anger inside that when I reached out for help I wasn’t able to...it was the same response that it wasn’t right having then. I actually had my first blackout (drinking alcohol). I believe I may have even had a seizure from trying to stop myself from thinking about it.”

Barbara: “If felt like I didn’t exist. I always describe it like feeling like a ghost.”

Abigail: “When I got assaulted as an adult, by the time I was assaulted, I had enough information to know how to not put myself in that situation, in that position. But due to my relapse, it brought me back to a place like that...it just took that one time, that was it for me. And what happened, I was embarrassed, I was ashamed, you know because how you are going to let that happen with all the information you know. Because I used and my disease got me using and it took me back to another place where, you know, it takes you. I was bruised; you didn’t even recognize me. And I got stitches on the side of my

head, so I got a scar right here for the rest of my life and it showed me everyday what would happen if you used, you know, take you back there and emotionally I beat myself up.”

Amy: “I got a disease from the situation. I never had a disease in my life until this sexual assault. The pain got so bad I didn’t even know what was wrong with me. It was pretty bad. It caused scarring on my inside, so bad I can’t have children.”

Donna: “I blamed myself...I actually hated him for not killing me.”

Allison: “Being swollen, not only that I would put that in the category of physical as well as emotional. To this day, it’s like I can really still, like I think about it, I can smell the whole situation, the semen, the everything, right here, right now, just thinking about it, just so if it just happened minutes ago. I can smell it and gets to the point where it gets me sick to my stomach.”

Abigail: “I didn’t like myself. I didn’t love myself. I thought I was ugly. I didn’t like my short hair; I didn’t like my skin, I didn’t like my big breasts, I didn’t like my crooked toe, I didn’t like any of that.”

Kathy: “Couldn’t sleep, couldn’t eat, just in shock really. It’s just basically fear also, that it might happen again, you know.”

Beverly: “I didn’t care what I looked like...so just...like it affected my perception of myself like in the way that...like...I felt more shame and more guilt because I couldn’t get into the shower. I was afraid to get into the shower...I couldn’t like...bring myself...like to get dressed.”

Allison: “I would never walk around with my head up. I always walked around like ashamed. You know, I’d be on the street but I was walking with my head down. I found a lot of money like that, but I (laughter) don’t know what to say, I was ashamed. You know the shame wasn’t even mine but it was affecting me and I was affected by that for years.”

Kelly: “I had physical abuse from the rape. I mean I had my nose broke, took a beating, ribs broke, bludgeoned my face.”

Allison: “I found a lot of irritability, trying to take care of myself as well as the process within. It made a lot of confusion and lack of ability to concentrate in doing anything.”

Kim: “My face was like a balloon. I got threatened with a saw, an electric saw. Threatened to cut me in little pieces and nobody would find me and that person wasn’t playing, it was the truth.”

Some of the women indicated social symptoms they experienced as a result of sexual violence. They ranged from a fear of being alone to isolation to losing social status.

Barbara: “I couldn’t be alone ever. And as long as I was with other people I was fine, but when I was alone I felt like I didn’t matter, that I was worthless, I didn’t exist or that I was hated by the world. As long as I was with someone I was fine. So I always had to be with someone. It hurts a lot less.”

Andrea: “This speaks for social. I was really isolated. Isolation...I didn’t really want to be around anyone, people, places and things...I felt like nobody could really understand what I went through, like I was the only one who went through it. You know, like I couldn’t really like sit down and talk to anybody. I was too ashamed because I felt like it was my fault because of the time I was out there in the street, that hour, you know, didn’t want to get high, wanted to be with someone, met with someone and it just went crazy after that.”

Donna: “I struggled to figure out where I was going cause I lost everything after the second rape, I lost my job as a police officer so I lost my apartment so the foundation of what was there was gone as a result of being raped. So, I had to put everything back together again so my analogy was I was standing straight on my feet, shoulder back, chin up and someone pulled the rug from underneath me. Being raped felt like someone pulled the rug from underneath my feet from behind not like I seen it coming, so I couldn’t brace myself and possibly jumped and shifted. This was snatched from

underneath me and all I did was fall flat on my face. My face hit the ground before my body and I hit concrete. That what being raped was like to me.”

In Theme Two, the survivors experienced numerous symptoms, ranging from intense shame that often lead to self-hatred, confusion and fear, to intense blame that appeared to lead survivors to fall apart. Some of the women experienced external and internal scars that served as constant reminders of their victimizations. These symptoms indicated a sense of initially being consumed by the impact of their victimization(s) and the distress they experienced in its wake.

Theme Three: Difficulties in Creating and Maintaining Intimate Relationships

One of the long-lasting symptoms of sexual violence identified by participants was difficulties creating and maintaining intimate relationships. While some of the women talked lovingly, others in relationships talked about having nightmares and flashbacks about their victimization that hinder their current relationships and cause difficulties in remaining present during sexual intercourse. Other talked about their fears about being in relationships.

Barbara and Beverly talked lovingly about their relationship. They both agreed that their relationship is a lot easier because they are both survivors of sexual violence.

Barbara: “I know from my perspective, she makes me feel a lot better about myself, a lot better than my parents, like because I feel more secure because I know someone who is beautiful thinks that I am beautiful, which is the most shocking thing to me because she is the most beautiful person I ever met. I feel a lot more confident knowing that she is

there and that she believes in me and that there is someone who does not think that I am vile.”

Beverly: “I am very comfortable like I don’t um... our communication is very open so we would say what is bothering us. Specifically, like sexually or anything. She is the only one that I feel comfortable with in many ways, so I am protective of the relationship...like it (victimization) tried to affect our relationship, it does affect our relationship but we are able to talk about it. So, it isn’t not so much...so much like an impact.”

Amy, Allison and Kate talked about intimate difficulties they experienced currently in their relationships.

Amy: “...Any then my partner, he brings me back to reality. When I wake up, I’m shaking and so scared and I’m looking around the room and sometimes I can’t even recognize him. I’ll be like ‘don’t touch me, don’t touch me’ and I start freaking out and he has to learn to deal with that.”

Allison: “He knows not to touch me when I’m sleeping and he’ll wake me when, you know, if he wants to be in relationship, he has to make sure I’m awake and willing.”

Kate: “I think prostituting myself make things worse for me. Like my sex life, like trying to separate what I did and then go have a relationship. Just keeping on the prostitution tunnel, when I did that, I’m having a hard time focusing on my sex life at times because I saw myself trying to separate the two... and then I am trying to have sex with my boyfriend. Sometimes it takes work to focus, because my mind is like, you know, on my needs, what can I get, like I’m thinking about the drugs and it’s just not – it’s a mess, a mess.”

Kathy talked about an intense anger toward men that prevents her from entering into relationships with them. Excerpts from her interview with this researcher are presented below. In these excerpts, she explains why she struggles to create relationships with men in the wake of her sexual victimization.

Kathy: “I’m mad at all males. Like this guy I know I mentally abused him with my mouth, verbally. I mentally abused him too you know what I’m saying, by sitting there just telling him, “leave me alone” or “I don’t want to talk to you” or this or that you know. You know, I’ve been in kind of, you say it’s a relationship, but it’s not a relationship, you know, because we haven’t had sexual intercourse or whatever and I won’t let him touch me you know. If he kiss me, I let him kiss me on my cheek, I won’t let him kiss me on my mouth, you can’t kiss me on my mouth.”

AM: “Because that symbolizes more of a relationship?”

Kathy: “Yes. I feel as though it’s a disease, you know, what had happened. If you’re a man you can’t touch me because I’m going to defend myself. I like... I put the shield up – I put the whole wall. If you’re a man you can’t touch me.”

AM: “So you cope, correct me if I’m wrong, mainly by having males stay away from you, and particularly don’t touch you?”

Kathy: “Yeah.”

AM: “So you get more angry?”

Kathy: “Right. Oh I got a lot of anger. I really do and I don’t believe myself that I have that much anger, you know from being such, in the past, a loving person you know. And wanting to be up on my boyfriend and hugging him and all that. But now you can’t touch me. If you’re a man, you can’t touch me. I’ll kick you. I’ll do anything I can to get away from you, you know.”

Several of the women in the first focus group talked openly about finding love and the difficulties that prevent them from being close to others. Excerpts of their interviews highlight the desire for, as well as the fear associated with, being in an intimate relationship at this point in their recovery process.

Amy: “I have this friend and he saw what this other man was doing to me, like shaking me and smacking me, even burned me with a cigarette and that was the last straw. He came out and he said, “What are you hitting this girl—why are you doing what you’re doing to her?” He punched him and knocked him out, told me to come to dinner with him and from there it was just pure, nothing but love. I never had that, never. And this man, he knows I get really jumpy when people yell at me or make a sudden move, I get very, very defensive. I’ll pick up a knife, I’ll pick up anything. I’m not liable, I am liable but I’m not liable (lots of laughter), I’m legal. I feel very, very frightened, but I find him to be the most supportive, understanding and not hurting me in any way shape or form, nothing but pure love and kissing me good night, how was my day at work – I never had that.”

Andrea: “I still don’t have it.”

Ann: “I have difficulty with that kind (intimate) of relationship – when I get too much attention. I can’t tolerate that closeness. It’s been awhile, I have not really gotten into...understand why that is, but when someone starts being too nice like that (everyone talking at once), if he does it again my boundaries will close up.”

Allison: “I’m always thinking somebody’s looking for something for something.”

Donna talked about lowering her standards after being raped in order to find someone to love and support her.

Donna: “What I found is that...I was less particular in choosing...not particular...less demanding. My requirements were not the same for a man. At that point, I basically just accepted who loved me because I wanted that love I guess.”

She also talked about her fears of dating.

Donna: “Because of the day and age we live in and with technology, I don’t trust going over to somebody’s house. I can’t meet somebody and go over to anybody’s house and even think about getting comfortable because I am worried about being taped, worried about where I will end up as a result of some kind of perverted tape. I am also worried about anybody raping me for sure. I don’t want to bring anybody to my house. I don’t want to open up my world to let anybody in like that.”

Andrea talked about difficulties creating relationships with others.

Andrea: It (the assault) affects my relationship with people now. Whether it’s an intimate relationship with a partner or it’s a relationship with your friends and with people I don’t know, I don’t trust. You know, because I did before and look what happened to me, so, I just try to, you know, I have family members that I talk to and everything to try to keep me together. And even as far as to help me build healthy

relationships, cause this sexual assault as young and as an adult has affected me in working with people and dealing with people in general.

Theme Four: Adaptive and Maladaptive Coping Strategies

All of the women mentioned adaptive and maladaptive coping strategies that helped them to cope with the psychological and physiological distress in the wake of the victimization. It appeared that after their victimization, the women initially participated in maladaptive coping skills with the intent of alleviating their distress and regaining a sense of power and control. As they continued to recover from their victimization, the women turned toward more adaptive coping strategies.

Andrea: “I self-medicated myself with drugs, including alcohol and cocaine, just to numb the pain. I just didn’t want to talk about it.”

Kelly: “I know for me, I vacillate between wanting too much sex, can’t get enough, and then being as frigid as the green one (Iceland).”

Donna: A doctor who had got my case (after she was hospitalized) told me that I had (laughing)...he said, “How much cocaine did you do?” I said, “What?” He said do you know how much cocaine you had in your system, I said I smoked for a day or two (laughing). He said, Donna, you had cocaine in your system. I don’t believe what I said. I said I do, it was pain. I blocked it, every hit keep pain from happening.

Kim: “I used. The first thing I did was use. Give me a beer, give me something to move the pain on.”

Over time, Donna talked about using more adaptive coping strategies in the acceptance and recovery phase of trauma.

Donna: “My coping strategies were finding a life again and finding a purpose. I use school as a child and I use school as an adult because after the adult rape, needing a place to go in life and a job foundation and community ties yourself to the community, good things follow that.”

Kelly talked about utilizing prostitution to regain a sense of power and control in her life.

Kelly: “Sometimes I use it (prostitution) as power and control like who’s doing who...I got your...pay money, guess what, your wife doesn’t have it. I look at it as now I’m getting even – I am the perpetrator. I’m getting even and I’m getting over. Because not only am I getting you, I’m getting your money too – thank you. And now I’m getting your wallet.”

Kim talked about a similar sense of gaining power. This is an excerpt of her interview.

Kim: “As an adult, my fear also was that I would take the law into my own life and seek my own justice. You know, there’s been time when I’ve been violated as an adult, knew that I was infected with HIV and didn’t say anything.”

Kathy: “Payback there?”

Kim: “For the perpetrator – “here come get this – you know what I mean. Never revealed the fact that I had AIDs, you know, when in fact, all well and good. I should have, but I didn’t.”

AM: “So payback?”

Kim: “Sure. Do I feel guilty about it now – I really don’t. Was it the right thing to do – no, but I’ll deal with that when judgment day comes you know. As an adult it creates a tremendous amount of anger.”

Creating and maintaining intimate relationships with others continues to be extremely challenging to survivors in the wake of sexual victimizations. Shame and blame from their present victimizations and fear of future victimizations prevents many survivors from entering into intimate relationships with others. Those survivors who are able to create and maintain intimate relationships also struggle with flashbacks and physiological triggers that impact their relationships as well.

Theme Five: Retreat from Over-Representation of Visible femininity

Ten (76.9%) of the thirteen focus group participants made direct comments that they made some changes to their physical appearance to cope with their sexual victimization. Most of these changes reflected a desire to be less visible and less feminine, while increasing a sense of safety. Some of the participants' answers included changing their physical appearance and dress, as well as changing their physical mannerisms, gestures and demeanors as safety precautions.

Donna: "I don't let my braids get too old. I have to comb them every few days or else it takes me back to the past."

Andrea: "When I was sexually assaulted, after that, I tried to look like a straight up dude. For me it's like I don't want my appearance to be...you know, to look good like that and the only way that I kind of like got out if it was my job because I have to look a certain way, look presentable and dress, but I feel like if I do the opposite you know, I won't be attracting anybody. And then someone would say to me when I have on sweaters and stuff like that "Oh, you look attractive" and I'll be like "What?" You know, I'm not trying to look attractive. You know what I mean, I try to stay looking really tomboyish to people."

Allison: "I was wearing lip gloss that night. I won't wear makeup again, you know, because of that party. I will not put the makeup on. I try, I try, it makes me feel nasty."

Beverly: “I don’t look like everybody else because of my hair and piercing and stuff like that and I often wondered if I did that on purpose because people tend to look down on them a lot...like tattoos and piercing and stuff.”

Ann: “Well I noticed that when my boundaries felt like they were smaller, I started to lose weight. That’s how I dealt with it. I seemed to get smaller and smaller. I had lost about 15 pounds. I weighed about 135 and I went down to 120. But my boundaries just got smaller. I feel much more protected (when I get smaller). I feel my boundaries are being chipped away at—smaller, you know, that’s less of them that they can get at me. It’s a sick feeling but it’s the way I deal with it.”

Beverly: “My whole body has to be covered all the time. Even in the summer I wear a long sleeve shirt. See. I have passed the point where it doesn’t even bother me like I don’t even feel hot. I like turtlenecks because it covers my neck and wrists. I just like to be covered up.”

Ann: “One of the best things, which is, I don’t get...I’m not as attractive as I was. Put it that way, I was younger, sometimes like the idea that getting older, people won’t look you as much. I know it sounds silly, but it’s a survival thing for me too. To notice not too many people look at you. You know, so when you’re not as attractive, people don’t look at you as much, bother with you basically.”

Beverly openly questions whether her tattoos and facial piercings were attempts to change her physical appearance to keep others away from her. Below is an excerpt from her interview with this researcher as we explored the nature of her tattoos and facial piercings.

Beverly: “I know that I don’t look like everybody else does but...I mean it is OK I guess. I have a lot of feeling I guess. I don’t look like everybody else because of my hair and piercing and stuff and I often wondered if I did that on purpose because people tend to look down on them a lot...like tattoos and piercing and stuff.”

AM: “So they look down on you because of that?”

Beverly: “Yes, so I often wondered if I did that because of the way that I felt.”

AM: “Did you come up with an answer?”

Beverly: “No...because I kinda like it. I don’t know if that was it...but I did have some piercings and tattoos but not as much as before...just a little bit, I tried to distance them.”

Donna talked about participating in a safety gesture in the wake of her sexual victimization.

Donna: “I walked in a circle to check myself. So if I am walking from my door to my house then I do it, I walk in a circle. And I...I make it look like a dance that I am just enjoying life but in actuality, I am checking my security. I am checking my surroundings without walking around going uh...uh and apparently see me looking underneath the cars and around the corners and my eyes are bugging big so I tried...tried to make it something

that someone would look at and say wow, isn't she having a good time but in reality yea...I am making sure that I am safe."

Barbara talked passionately about the importance of her appearance in her life in the wake of sexual violence. An excerpt of her interview with this researcher is presented below as she explained what would happen if she did not invest efforts in her physical appearance.

Barbara: "I can't really remember what happened immediately after but I know that I became...it was just before I started woman studies...so I became more politically aware of body image and rape...and actually became less concerned about my appearance until that summer when I got raped again twice in two months. And my appearance became a huge focus for me and continues to be a huge focus for me. Mostly because I want attention and I want people to see me positively...and I feel like everyone who looks at me can see what happened to me...but if I hide it well enough then they won't notice. And so my appearance is a huge...I mean I care more about my appearance than my health. Like I went to get glasses today and there were no good frames and so I said to myself there is no fucking way that I can get glasses. I mean I check myself in the mirror everyday and I don't think that I am thin enough. I don't think that I will ever be thin enough."

AM: "What would happen if you didn't take care of yourself and let it be exposed through your appearance what happened to you? What would happen to you?"

Barbara: “Everyone would be able to see everything that happened to me and they would be disgusted and they would want to stay as far away from me as they could and I would be totally isolated. They would see...They would see how disgusting I am because it wasn't like I've been raped when I stand before them and I have been sexually abused by my mother my whole life. They will see a vile...creature and stay the fuck away from me.”

Changes in physical appearance and dress appeared to help survivors alleviate some of the psychological and physiological distress associated with being sexually victimized. According to the survivors, these changes served several purposes, including hiding the level of psychological distress they were experiencing, increasing their physical safety by keeping people away from them and suppressing aspects of their femininity. All of these purposes helped to alleviate their distress.

Theme Six: Social Support

Some of the participants talked about various social support systems that helped them alleviate some of their traumatic symptoms.

Barbara: “So I think that one of the biggest things that helps is having a positive female role model and I think that part of the reason why I am able to be a little bit more comfortable with myself now is because I have Beverly as a role model.”

Andrea: “I have family members that I talk to and everything to try to keep me together. And even as far as to help me be able to build healthy relationships, because this sexual assault as a young child and as an adult has affected me in working with people and dealing with people in general.”

Amy talked about being supported by her partner, who grounds her when she becomes overwhelmed by her memories associated with being ganged rape.

Amy: “You know what I find helps a lot, is when I’m having a flashback, he sits beside me, doesn’t touch me, he says “baby” and I’ll look at him and I’ll go right back to... and then he’ll talk to me “go to that special place – come on let’s go on a cruise – let’s start to feel each other” – that helps. Or he’ll like say “c’mon let’s put on your coat”. We live right across from Franklin Field Park – you know “let’s go for a walk in that cold air” and he’ll literally put my coat on, put my shoes on, lift me up and take me out.”

Allison, Ann and Abigail talked about the benefits of social support in their healing process.

Allison: “To appreciate that you’re not alone. Even walking on the sidewalk can be very, very isolating.”

Ann: “If I hear myself talking, then that’s healing.”

Abigail: “I got me a therapist and I just started dealing with my feelings. You know, what I did for the dope, why I did it, you know and who I’m going to be. And I gain a lot of wisdom for that. Now it’s an education that we got from that. So my thing is like back to those who are in this situation who don’t have a way and I can teach them how to get a way. I don’t think God put me in a situation for a lot of it to happen, but I gained so much for having faith in God.”

Donna and Ann talked about the negative social support they received and the impact it had on them.

Donna: “I went out with this guy at this time. He didn’t know what happened. I called him up the next two days later to tell him what happened. I said come meet me over at my brother’s house, I don’t want to tell you over the phone. He said, ‘No tell me, tell me, tell me.’ No, I’m not. I finally tell him. He hangs up the handle of the phone. I have always since to this day do not hang up a freaking phone but I hold the phone for a few seconds and I don’t say goodbye. So I usually let people say what they have to say because I hang up when I am done and they will say that I hanged up on them so I developed that habit and I heard him say, ‘Oh shit!’ and the guy he was with said, ‘What, she alright?’ He said ‘she got raped’ and then the guy said, ‘She got raped, is she okay?’ ‘I don’t know, I just know I don’t want that pussy no more.’ Fuck my head up, worst than the rape actually. The guy who worked with him had more compassion for me than the guy I was going out with.”

Ann talked about refusing to identify her offender because the detective investigating her rape case at the hospital treated her like a street worker.

Ann: “He (the detective investigating the case) made a mockery of me. He actually went to the nursing station when I was taken care of and tried to ask them if I was street girl, which horrified me. You know, here I was in a domestic violence shelter and he was asking was I a street girl. I didn’t even have a record you know. This is what killed me, that he would ask my friend that right after he left the hospital. And so I didn’t want anything to do with him”.

Allison talked about getting social support to help her to eat more regularly.

Allison: “I’ve been trying to gain weight, can’t gain weight because I’ve got the stress on me... I’m still trying. My physical appearance is I need to like... I eat one meal a day. What I just ate, that’ll be the last meal I eat. And I had it bad. You look at me and you say, damn, she had six kids, where. You know because I eat one meal a day. But when I’m with a lot of people that helps me because I’ll eat. I’m with a group that’s just like me I’ll eat and I will eat once I can throw it down, but I have to be comfortable. And this is a zone for me, this is my zone, you know, people just like me. They’re not criticizing me or analyzing me.

All of the participants mentioned additional services that they thought would have been helpful to them and to other women who are survivors of sexual violence.

Donna: “A whole after-rape care center with hospital, police and other human services agencies attached. You get cancer they don’t send you out of the fucking door and tell you have a nice life. You get raped; they send you out of the door. You can’t put stitches on this and then it heals up.”

Barbara: “I think that rape and body image both have to be a part of a dialogue at a much younger age than they currently are...especially body image. I think that’s something that should be a part of a curriculum in education for children, both male and female, starting as soon as they are in school because body image and...um...media literacy. Media literacy in order to understand body image issues as well as a lot of other...um...um...what is the word conditioned...a lot of other conditioned um...issues. And somebody like kids really needs to learn when they are at that age because that is when they are being the most manipulated by the media. And so I would like to see a lot more discussion about that, which I think would help to affirm and empower women...um...and also enable men to understand more themselves and where they are coming from and the fact that they are conditioned to feel that they need to take the power using rape to reestablish control.”

Andrea: When I started abusing drugs more, I went into treatment and that was when they have the peers, I call them. I was in treatment for two years, in a residential program for two years, and I found support through my peers around the table, I was able to deal with my pain. And then I went to therapy one on one and everything so that's how I deal with things.

Beverly: "I think definitely programs like the Women's Partial Hospitalization Program (at a local hospital) for someone dealing with something like this from the past or from the present..."

Ann: "What would be nice if there were focus group with more women like this because I found that I felt so alone that I didn't know how to handle it, but I find that it makes me feel, in a part, true to form, smaller. So that's how I was able to deal with it – just felt smaller. A lot of times I just walk. A lot of times like today I could have taken the bus, but sometimes I try to make myself just to feel like, you know, I can do something...smaller little steps that can heal."

Social support played an essential role in the survivors' recovery. Positive support from family, friends and members of the helping professionals appeared to empower survivors and fuel their recovery process. A lack of positive support negatively impacts survivors' recovery process. This highlights the need for more program resources, specifically educational and treatment, to educate others about sexual violence and its impact, as well as to aid survivors throughout the various stages of recovery.

Summary

The results of this mixed-method exploratory study revealed several major findings. The quantitative portion of this study revealed significant and statistical differences in traumatic symptoms and coping strategies among Caucasian women and Women of Color survivors of adulthood sexual violence. However, the quantitative study revealed no significant and statistical differences in overall psychological investment in physical appearance, appearance-related schemas and appearance management behaviors among Caucasian women and Women of Color adulthood survivors of sexual violence. Nevertheless, focus group participants acknowledged changing aspects of their physical appearance and dress to alleviate some of their psychological and physiological distress associated with being sexually victimized.

Six focus group themes - early trauma, psychological and physiological distress, adaptive and maladaptive coping strategies, retreat from over-representation of visible femininity, difficulties in creating and maintaining intimate relationships and social support - were identified by the participants. Through these themes, some survivors were able to identify early traumatic experiences of psychological abuse and physical abandonment that enhanced their vulnerabilities to future victimizations. All of the participants noted common and unique short-term psychological and physiological symptoms. One of the long-term symptoms of their sexual victimizations continues to be a difficulty creating and maintaining intimate relationships. Adaptive coping strategies, such as seeking professional help, and maladaptive coping strategies, such as using drugs and alcohol, were helpful in alleviating distress. Changes to their physical appearance and dress had similar effects in alleviating their distress symptoms. Survivors identified that positive social support enhanced their recovery process while negative social support stunted their recovery process. Likewise, all of the participants recommended

educational resources to inform individuals and communities about the acts, prevalence and impact of sexual violence, and treatment programs to support survivors' recovery process.

CHAPTER FIVE

Discussion

This chapter presents the quantitative and qualitative results of this exploratory study, which explored the relationships between traumatic symptoms, coping strategies and changes to physical appearance among multi-ethnic female survivors of adulthood sexual violence. The goals of the study were two-fold: to determine whether survivors made changes to their physical appearance and dress, and whether these changes were used to alleviate psychological distress in the wake of their victimization. The study presumed that all major findings were the direct results of incident(s) of sexual violence in the respondents' lives. The chapter begins with the major results of the study and is followed by a discussion of the findings in relation to the current literature on traumatic symptoms, coping strategies and changes in physical appearance and dress among survivors of adulthood sexual violence. Implications for future systemic reform, research, theory and mental health practitioners are explored to maintain and advance the current literature on sexual violence. The chapter will conclude with the limitations of the study.

Study Findings

There were six major results of this mixed method study. The first major finding revealed a significant and statistical difference in traumatic symptoms among Caucasian women and Women of Color survivors of adulthood sexual violence. The second major results revealed a significant and statistical difference in coping strategies utilized by Caucasian women and Women of Color survivors of adulthood sexual violence. The third, fourth and fifth major findings revealed no significant and statistical differences in overall psychological investment in physical appearance, appearance-related schemas and appearance management behaviors among

Caucasian women and Women of Color adulthood survivors of sexual violence. Finally, through the qualitative portion of the study, Caucasian women and Women of Color survivors of adulthood sexual violence acknowledged and identified changes to their physical appearance and dress as a result of their sexual victimizations, made with the intent of protecting them from future victimization(s).

Discussion of Findings

Caucasian women survivors of adulthood sexual violence reported a significant and statistical difference in traumatic symptoms, specifically feeling guilty and feeling inferior (inferiority feeling) in comparison to Women of Color survivors in the wake of their sexual victimization. Current research revealed that the highest rates of PTSD symptoms and lifetime PTSD are among survivors who received threat to life, bodily injuries and a completed rape. Ongoing research on mental health outcomes of sexual violence noted that while each survivor's response to this traumatic crime is unique, several factors can elevate post-assault distress. Although their research did not account for differences in traumatic symptoms among women from different racial and ethnic backgrounds, Resnick et al. (1993) and Breslau et al. (1991) found that survivors of physical and sexual violence reported higher PTSD and lifetime PTSD symptoms than any other groups of trauma survivors (i.e., those who lose a significant loved one to homicide or who survive a natural disaster). As a result, many survivors of sexual violence will report PTSD symptoms post-rape and for some time after. It is likely that the higher rates of post-assault symptoms are due to the intimate nature of sexual assault, where threats to harm and completed harms are, unfortunately, an essential component of the victimization by offenders who are often familiar to their victims.

As an eligibility requirement for participation in the current study, each of the 73 women experienced at least one incident of sexual assault and/or rape in adulthood. Of the 73 respondents, 91% (21) of Caucasian women and 72% (36) of Women of Color reported receiving verbal threats, which consisted mainly of derogatory comments and threats to hurt/kill them, during their sexual assaults. Weapons were often utilized in their victimization as well. Based on the narratives of their sexual victimizations, 70% (16) of Caucasian women and 68% (34) of Women of Color reported that weapons were used during their victimizations. Sixty-five percent (15) of Caucasian women and 40% (20) of Women of Color reported that the weapons more frequently used in their victimizations were their offenders' fists/hands. All of the focus group participants reported incurring physical injuries as a result of their assaults. The injuries included broken body parts, such as noses and ribs, external scars that required stitches and internal scars to one of the respondent's uterus, preventing her from ever being able to have a child. In comparison, the nature of physical injuries sustained by Caucasian women survivors of sexual violence appears extensive, which may suggest that many of the offenders were strangers to these women. Indeed, a closer analysis of offenders revealed that 43% (13) of the offenders among Caucasian women survivors of sexual violence were strangers, in comparison to 61% (15) of the offenders among Women of Color survivors of sexual violence who were not strangers. This analysis revealed that Women of Color survivors of sexual violence are more likely to be victimized by offenders that are familiar to them. It is likely that the survivors' relationships to the offender impacted the nature of her sexual victimization, the severity of physical assaults incurred during the incident(s) and the intensity of psychological distress post-assault.

A second factor that contributes to increased psychological distress among adult survivors of sexual violence is prior victimization in childhood and adulthood. Research has consistently found that incidents of childhood sexual abuse (CSA) are associated with greater risk for sexual assault in adulthood (Arata, 1999; Cloitre et al., 1996; Messman & Long, 1996; Messman-Moore & Long, 2000, 2002; Noll et al., 2003; Roodman & Clum, 2001) and increased traumatic symptoms, such as depression, anxiety, post-traumatic stress disorder, self-injurious behaviors, substance abuse, sexual problems, eating disorders and interpersonal problems. In the current study, 16 (70%) Caucasian women and 43 (86%) Women of Color survivors of sexual violence reported at least one incident of inappropriate touching in childhood, and 10 (44%) Caucasian women and 31 (62%) Women of Color survivors of sexual violence reported at least one incident of childhood rape. Some of the women reported more than one incident(s) of sexual victimization in childhood and adulthood, which is likely to increase and intensify the level of psychological distress experienced in their most current victimization.

Other co-morbid factors that are commonly associated with the increased post-assault distress include the characteristics of the sexual violence in childhood and adulthood, environmental conditions (i.e., environments that enhance or limit opportunities for sexual violence), attributes of survivors (i.e., psychiatric disorder, physical and mental disabilities), availability to positive social support and social conditions (i.e., poverty and homelessness). Social conditions play a key role in woman's right to control her sexuality, her ability to consent to sex, to recognize her own victimization and to seek help when she has been victimized (Center for Disease Control and Prevention, 2007). Seventy-one percent (52) of the respondents self-identified their social class as low income and approximately 16% (12) reported living in a transitional shelter at the time of the study.

Blame attributions negatively influenced post-assault distress. Janoff-Bulman (1979) identified two types of blame attributions, characterological self-blame and behavioral self-blame, which influence survivors' post-rape distress and coping strategies to alleviate such distress. While she (1979) found that characterological self-blame increased psychological distress, Arata (1994) and Frazier (1994) later found both types of blame attributions lead to increased psychological distress. Feelings of guilt and inferiority, which can represent both characterological and behavioral self-blame, might also explain the difference in traumatic symptoms among Caucasian women and Women of Color survivors of sexual violence.

Societal blame increases post-assault distress among survivors as well. Numerous research studies have revealed that one of the leading predictors of future sexual violence is past incidents of sexual violence, including childhood sexual abuse. Women who experienced single or multiple acts of victimizations are often viewed as "damaged goods" by family, friends, peers and, in some cases, by helping professionals. The term "damaged goods" is a commerce term that refers to an object or commodity that has lost its original value. Women who have been sexually victimized are referred to as "damaged goods", similar to spoiled, ruined and irregular goods sold at second hand stores. In our society, women's bodies are viewed as objects to be judged by others who place high values on their sexuality, in general, and their virginity in particular. Donna, one of the focus group participants, talked painfully about her boyfriend's response to her being raped. He stated, "I don't want that pussy no more." While incidents of sexual victimizations do not change the values and strengths of a survivor, the act(s) are viewed as reducing, distorting or blurring her humanity, leading others to blame her, and her to blame herself, for the terrible things that have happened to her.

Significant differences in traumatic symptoms among the multi-ethnic groups of women may also be the result of cognitive variables (making meaning of the traumatic experiences within the pre-trauma knowledge structure of self, others and the world) and coping strategies (i.e., avoidance behaviors) utilized, which can lead to the development and maintenance of chronic post-traumatic symptoms (Cahill & Foa, 2006; Foa & Cahill, 2001). It is also questionable whether culture plays a role in the intensity of psychological distress experienced by survivors of sexual violence. Most cultures of color, regardless to where they reside, often identified themselves as collectivist cultures. With a collectivist culture, individuals tend to view themselves as members of a larger group (i.e. families, ethnic/racial groups, tribes), and the needs of the group are considered more important than the needs of the individuals. The overarching culture of the United States is identified as a Western culture. While the greater need of the group is emphasized in a collectivist culture, the importance of independency and the needs of the individual are emphasized within a Western culture. These cultural approaches present with their own set of strengths and weaknesses for survivors of sexual trauma. While a collective culture, by its very nature, may provide more avenues for individuals to get support in times of personal and community hardships, survivors may experience greater feelings of shame and blame for their victimizations. Survivors in an individualist culture might feel more isolated in the wake of their sexual victimization and left to shoulder the burden of their victimization alone.

Unfortunately, there are many factors, individually or collectively, that can account for the significant difference in traumatic symptoms reported by Caucasian women survivors of adulthood sexual violence in comparison to Women of Color survivors of adulthood sexual violence. Self-blame, doubt, guilt and feeling inferior are normal post-sexual assault feelings.

Some of the traumatic symptoms reported by focus group participants included feeling: worthless, shame, “like a piece of shit,” shock, like a ghost, embarrassed, confusion, irritability and the lack of ability to concentrate on anything. These feelings influence whether a woman discloses her victimization(s) to others and/or seeks medical and psychological support. If she chooses to disclose her victimization(s) to significant others (i.e., family and friends) and helping professionals (i.e., police, doctors, psychologists), but does not perceive their reactions as sources of social support (Ullman, 1996), it is likely that the intensity, duration and frequency of her traumatic symptoms will increase as well.

Coping can best be described as an individual’s attempt to manage their emotions in the present moment. A significant and statistical difference in coping strategies, specifically Confrontative Coping strategies, were found among Women of Color survivors of adulthood sexual violence in comparison to Caucasian women survivors. A trend toward statistical significance was found in the Seeking Social Support coping strategy for Women of Color in comparison to Caucasian women survivors of sexual violence. Women of Color survivors reported utilizing seven of the eight coping styles (Confrontative Coping, Distancing, Self-Controlling, Seeking Social Support, Escape-Avoidance, Planning Problem Solving and Positive Appraisal) assessed in this study more frequently in comparison to Caucasian women survivors of sexual violence. Caucasian women survivors of sexual violence reported a higher mean score in the Accepting Responsibility coping strategy in comparison to Women of Color survivors.

Consistent with DiLillo, Long and Russell (1994) that emotion-focused (avoidance) coping strategies are more prevalent among survivors of sexual abuse and assault. In this work, Caucasian women and Women of Color survivors reported utilizing emotion-focused coping strategies post-assault. Alleviation of psychological and physiological distress was the goal.

Respondents reported participating in avoidance behaviors (i.e., internalizing their feelings, skipping school, stopping dating and avoiding men) and emotional dysregulation behaviors (i.e., experienced uncontrollable anger and rage, participated in self-injurious behaviors, shoplifted, sexual promiscuity, etc.). In addition, respondents reported substance abuse behaviors (i.e., increased and/or multiple drug usage) to cope with post-assault distress. Analysis on coping strategies based on race/ethnicity revealed that five (21.7%) Caucasian women survivors reported participating in avoidance behaviors, three (13%) reported using emotional dysregulation behaviors and 14 (60.9%) reported turning to substance abuse to cope with post-assault distress; 16 (32%) Women of Color survivors reported participating in avoidance behaviors, seven (14%) reported using emotional dysregulation behaviors and 15 (30%) reported turning to substance abuse to cope with post-assault distress. Participants also noted that they coped with their sexual victimization by either increasing or decreasing their eating and sexual behaviors. Based on their reporting, three (13%) Caucasian women and 10 (20%) Women of Color survivors reported increased or decreased eating behaviors and 19 (82.6%) Caucasian women and 35 (70 %) Women of Color survivors reported increased or decreased sexual behaviors after their victimizations. While some participants shared common adaptive and maladaptive strategies, such as writing in their journals or turning to alcohol or drug usage and abuse, others were quite unique to the individuals. Dawn, one of the focus group participants, was able to cope with her victimization by indirectly working with young adult and adult males incarcerated in correctional facilities on how to better manage their feelings and actions toward women in their lives.

As mentioned in the review of literature, the Burgess and Homlstrom's (1974) Rape Trauma Syndrome has been used to describe many of the symptoms experienced by sexual

violence survivors. The syndrome is helpful in organizing trauma symptoms in three phrases: acute, outward adjustment and resolution. While the acute phase, which occurs immediately after the sexual victimization, is marked with a variety of emotional symptoms, including shock, fear, anger, loss of trust, shame, sadness and anxiety, in the outward adjustment phase, which begins approximately three to six months after the sexual victimization, survivors make attempts to return to the life prior to the victimization despite being in considerable emotional turmoil. Within this outward adjustment phase, survivors utilize various coping strategies. They are: minimization (i.e., pretends that “everything is fine” or that “it could have been worse”); dramatization (i.e., cannot stop talking about the assault as it is what dominates her life and identity); suppression (i.e., refuses to discuss, acts as if it did not happen); explanation (i.e., analyzes what happened—what the individual did, what the rapist was thinking/feeling); and flight (i.e., tries to escape the pain by moving, changing jobs, changing appearance, changing relationships, etc.). It is likely that survivors utilize a combination of coping strategies to alleviate psychological distress. The third phase of the rape trauma syndrome is the resolution phase. In this phase, while the assault may no longer serve as the focal point of the victim’s life in this phase of her recovery, the survivor may continue to struggle with some residual emotional symptoms of her victimization.

The current study assessed respondents’ traumatic symptom association with being sexually victimized through the Traumatic Symptoms Checklist (TSC)-40. While it did not assess the Rape Trauma Syndrome, many of the symptoms outlined in the syndrome are identical to those assessed through the TSC-40. The significance of the Rape Trauma Syndrome in this study was to utilize the organizational structures of the three phases to identify when a survivor

might utilize certain coping strategies, including changes in physical appearance, to alleviate psychological and physiological distress.

It appeared that as survivors transitioned from the acute stage toward the reorganization stages (i.e. outward adjustment and resolution stages) in the recovery process, they were able to integrate more adaptive coping strategies in their coping repertoires. Caucasian women and Women of Color survivors of adulthood sexual violence also mentioned utilizing problem-focused (active coping) strategies, such as seeking social support, problem-solving and positive appraisal. This trend toward more adaptive coping strategies was noticeable in the focus group interviews in which participants mentioned numerous coping strategies utilized immediately following their sexual victimizations. Interestingly, after they talked openly about mainly maladaptive coping strategies utilized to alleviate psychological and physiological distress, the women made a clear shift in their discussion and began to share more adaptive coping strategies not only to minimize post-assault distress but to assist in returning to pre-trauma states of being.

A significant and statistical difference was found in Confrontative Coping strategies among Women of Color survivors of adulthood sexual violence in comparison to Caucasian women survivors of sexual violence. Confronting coping strategies often include some sort of aggressive or risk-taking behaviors to alter the situation, as evidenced in the items assessed, such as “I expressed anger to the person(s) who caused the problem.” Anger and aggression are a common post-assault reaction to sexual violence (RAINN, 2006) and may be the result of a survivor’s inability to prevent the incident, or feeling like one’s behaviors led to the victimization. Some survivors may also feel like they lost control over their lives as a result of their victimization, leading them to direct their anger toward their offenders and others. This anger might also be directed inward toward themselves.

The challenge with managing one's anger, which is described as an emotion-focused coping strategy, is that when left unresolved, it can be misdirected, destroying relationships with others. Many Women of Color survivors have been victims of historical oppression and discrimination that have enhanced their vulnerabilities to neglect and victimizations in all areas of our society. With limited avenues for recourse, anger toward oneself and others may be the most effective way for survivors to cope with political, educational, medical, social and personal injustices. It is also likely that increased confrontative coping might help survivors to take actions to report their victimizations and seek help in their recovery process. Overall, while confrontative coping strategies are helpful if anger is directed to the appropriate party (or parties) or when used to fuel the recovery process, if survivors' anger is misdirected, they are likely to alienate themselves from others, become more isolative, and experience more prolonged and chronic PTSD symptoms.

In this study, a trend toward statistical significance was revealed for seeking social support. This coping strategy was utilized more frequently by Women of Color survivors. Analysis of social support behaviors revealed that 20 (40%) Women of Color and 12 (52%) Caucasian women survivors reported some forms of social support (i.e., entering psychotherapy, joining support groups) in the wake of their victimizations. The most commonly form of social support sought by participants, regardless of race/ethnicity, was treatment support. Other findings suggest that Women of Color survivors, particularly African-American women, depend heavily on their kinships and church family as social support resources in times of stress and crisis (Bernhard, 1994; Manns, 1988; White, 1984).

However, seeking social support does not always translate to disclosing their victimizations to helping professionals, such as the police and doctors. Although 29 (58.0%)

Women of Color revealed that they reported their sexual victimization to others, only four (8%) women reported disclosing their victimization to the police and three (6%) women reported their victimization to medical or mental health professionals. Similarly, 14 (61%) Caucasian women survivors of adulthood sexual violence reported disclosing their victimization to others. Two women reported disclosing their victimization to the police and two women reported their victimization to medical or mental health professionals. This finding is consistent with other findings that suggest that sexual violence is an underreported crime. In addition, these findings are consistent with Ullman's (1996c) research on social support reactions, which found that family and friends were more supportive than helping professionals (i.e., doctors and police), who tend to engage in more negative reactions. Donna and Ann, two of the focus group participants, talked openly about reactions they received from others after their victimizations and the devastating impact it had on them. In Ann's case, while she reported her victimization to the police, she refused to identify her offender as a result of the negative interactions she had with the detective investigating her case.

Two interrelated factors that account for social support as a coping strategy frequently utilized by Women of Color survivors of sexual violence are the collectivist culture common among people of color and the increased vulnerabilities for sexual violence inherent in some close-knit communities. By its very nature, a collectivist culture consists of various members of the immediate and extended family, as well as members of the larger communities. These members often serve various roles within the family as well as the communities. Hence, supporting an individual often leads to supporting, and sometimes strengthening, the group as a larger family unit. While being a member of a collectivist culture has many financial, physical and psychological benefits, one of its greatest benefits rests in its members' ability to access

support and guidance from others in times of distress. However, a collective culture may also be a source of constant threat of attempted and completed sexual violence for its females. A close analysis of relationships among perpetrators and survivors revealed that while eight (35%) Caucasian women survivors reported that their offenders were their partners/spouses or an acquaintance, 22 (44%) Women of Color survivors reported that their offenders were their partners/spouses, family members and friends. This finding is similar to Wyatt's (1992) finding that childhood sexual violence among Caucasian survivors often occurred outside of the family, whereas childhood sexual violence among African-American survivors often occurs inside of the family. Hence, while Women of Color depend on the social support inherent in a collective culture, this environment appears to enhance their vulnerability to becoming victims of sexual violence. This finding might also be helpful to explain how Women of Color survivors of adulthood sexual violence might resort to using anger as a coping strategy as well as a protective strategy against future victimizations.

Each of the focus group participants mentioned a critical need for social support resources that supported or could have supported their recovery process in the wake of sexual violence. Supportive resources included access to community-based mental health services for culturally sensitive mental health and medical care. Unavailable resources that respondents reported would have helped their recovery process included after-care centers that could provide access to treatment options, (i.e. supportive treatment groups, day programs and residential programs), and supportive interactions with police and court officers to enhance the arrest and prosecution rates of their offender(s). In addition to emotional and physical consequences, survivors also mentioned facing social consequences, such as unemployment, loss of health insurance and homelessness as a result of their victimizations. Respondents reported needing

easier access to human services sources to help them get back on their feet. In addition, participants identified a need to educate family, friends, peers and communities about the impact and consequences of sexual violence, the impact of the media on the development of female and male' body image, and the socialization of males to use rape as a tool to gain and maintain power and control.

Further analysis of coping strategies utilized by adulthood survivors of sexual violence reveal that Caucasian women survivors of adulthood sexual violence reported higher frequencies of Accepting Responsibility coping strategies. This coping factor focuses on recognizing one's role in solving the problem. It is a combination of both emotion-focused and problem-focused coping strategies, and can lead to both positive and negative responses in survivors. Initially, accepting responsibility for their victimizations might empower survivors to feel more in control of the feelings, thoughts and actions related to the sexual assault. This might be true particularly in situations in which the survivors believed they did something to cause their victimizations or if they became physiologically aroused and/or experienced an orgasm during the incident(s). However, over time, accepting responsibility for one's victimization might lead survivors to blame themselves for the assault and force them to address post-assault distress on their own, causing them to experience a higher frequency and intensity of traumatic symptoms (i.e., depression, guilt, hopelessness, helplessness).

The third, fourth and fifth major results of this study suggests that there were no significant and statistical differences in overall psychological investment in physical appearance, appearance-related schemas and appearance management behaviors between Caucasian women and Women of Color survivors of adulthood sexual violence. The study's findings were mixed, as they followed and diverged from Cash, Melnyk and Hrabosky's (2004) findings on Caucasian

women and African-American women's overall investment in their physical appearance. It is important to note that limited demographic information was provided on female participants in Cash et al.'s study, and it is likely that the women assessed did not match the demographic and trauma history of this current study. While Women of Color survivors of adulthood sexual violence demonstrated larger ASI-R Composite and Self-Evaluative Salience Score in comparison to Caucasian women survivors, both groups invested equal effort in managing their physical appearance. The latter finding was similar to that reported by Cash, Melnyk and Hrabosky (2004).

The finding of no significant statistical differences in the overall psychological investment in physical appearance, appearance-related schemas and appearance management behaviors between Caucasian women and Women of Color survivors of adulthood sexual violence may be the result of several factors. While incidents of sexual violence impact survivors' body image, body image assessments, such as the Appearance Schema Inventory, may not adequately capture the complexity and range of bodily responses experienced by survivors. This finding supports the work of Becky Thompson (1992), who postulated that trauma distorts the visual image and body boundaries of survivors, thereby hindering their ability to even consider that they have bodies. If survivors view themselves as disembodied, bodily responses to sexual violence are neither acknowledged, identified nor endorsed on assessment of body image. In 1992, Thompson coined the term "body consciousness" to encompass a survivor's range of bodily responses to victimization. She explained that "by body consciousness I mean the ability to reside comfortably in one's body (to see oneself as embodied) and to consider one's body as connected to oneself" (p. 63). Similar to Thompson's (1992) examples of body

consciousness, several focus group participants endorsed disliking all or parts of their bodies and reducing the boundaries of their bodies to cope with their victimization(s).

Societal factors such as sexual re-victimization, homelessness and poverty are likely to impact survivors' body schema and their ability to participate in appearance grooming behaviors. Surviving and thriving in the face of these interrelated factors are likely to take priority over body image concerns. A survivors' placement in the recovery process is likely to affect her body image. Changes in physical appearance made in the acute or outward phase may become permanent, instead of temporary, changes as a survivor seeks to redefine herself through the recovery process. This might be particularly true for survivors who have been re-victimized.

The sixth major results revealed, through the qualitative portion of this study, Caucasian women and Women of Color survivors did change aspects of their physical appearance and dress as a result of their sexual victimizations. Ten (76.9%) of the thirteen focus group participants made direct comments about changes they made to their physical appearance and dress in direct response to their sexual victimizations. Based on race/ethnicity of the survivors, five (71.4%) Caucasian women and five (83.3%) Women of Color reported altering some aspects of their physical appearance and dress to cope with their sexual victimizations. It appears that changes to physical appearance and dress occurred in the outward adjustment stage of the phase of the Rape Trauma Syndrome.

Initially, several of the women shared being emotionally overwhelmed by the intensity of their psychological symptoms and were unable to contemplate investing any psychological effort in how they appeared to themselves and others. It appeared that these changes took place over time as survivors moved further along their recovery process, during which they would most likely have interacted or were ready to interact with others. This will support the study's

hypothesis that changes in physical appearance and dress are likely to occur in the reorganization stage rather than in the acute stages immediately after the assault. However, it is unclear whether these changes are permanent or temporary. It is likely for some women they are permanent and for others they are temporary. Several focus group participants acknowledged that their changes in physical appearance and dress are ongoing, as they continue to struggle with accepting who they are and who they have become internally and externally post assault. Fortunately, some survivors had secured full-time employment and developed long-term friendships and/or intimate relationships, which have provided them with opportunities to assess and reassess changes they made to their physical appearance and dress. It is likely that other survivors will be provided with similar opportunities in the future as well.

Implications for Systemic Reform

The Feminist Ecological Model is the theoretical perspective utilized in this study to conceptualize the multiple identities of sexual violence survivors interfacing with multi-influencing systems and factors that shape their lives. This model offers some explanations on the alarming rates of sexual violence against women, their responses to sexual violence and coping approaches, including changes to their physical appearance, in the face of sexual violence. The utility of an ecological framework can also be helpful in providing multiple interventions, at various systemic levels, to prevent sexual violence and alleviate the psychological, physical and medical harm caused in its wake. In response to the feminist ecological model framework, Campbell, Dworkin and Cabral (2009) outlined the need for a rape recovery ecological model that explores how external systemic interactions support or hinder

survivors' recovery process, particularly for women who have been re-victimized sexually at various stages in their lifespan.

Similar to the feminist ecological model, the rape recovery ecological model would represent various systemic spheres that contribute, positively or negatively, to survivors' recovery process. This recovery model will include various domains, such as mental health centers, law enforcement, public health, human service agencies, rape crisis centers and hospital-based rape programs actively working together to prevent violence against women. On an individual level, public education can emphasize that any woman can be a victim of sexual assault, that most rapes are not "stranger rape," and survivors' responses to sexual violence are individualized and diverse. Some of the work in this area consists of ongoing sexual violence prevention presentations to middle school, high school and college students, teachers and parents to enhance community awareness and ability to prevent this traumatic crime. On the micro-level, community and hospital-based rape awareness programs can provide treatment support to survivors. In addition, these resources can be used to inform their family, friends, significant others and peers about the multiple reactions that their loved ones might present with. It would be important to emphasize that emotional support and resources are likely to enhance a survivor's recovery, while negative reactions will hinder her recovery process.

At the meso/exosystem level, sexual assault nurse examiner (SANE) and sexual assault response teams (SARTs) are two community-based interventions that are currently used to improve consistent, victim-centered medical and crisis intervention services that support survivors and increase the arrest and prosecution rate of offenders. Some of the current work in this area includes educating veteran and new police officers on how to better support sexual violence victims and protecting female passengers from sexual assaults on the various modes of

public transportations. These services can be helpful in reducing incidents of sexual violence and re-victimization and promoting positive help-seeking behaviors among survivors. In addition, restorative justice programs for sexual assault, such as those utilized in Native American communities, provide an alternative option, to the criminal justice system to address victims' needs and hold offender(s) accountable, while educating, stabilizing and strengthening their community.

While changes on the macro-level are still challenging, national agencies such as the Centers for Disease Control and Prevention, Violence Prevention Alliance, Global Violence Prevention Advocacy and World Health Organization are working in collaboration to outline various intervention strategies that promote systemic and global changes that can enhance communities' responses to preventing sexual violence, supporting survivors through advocacy and access to resources and holding offenders accountable for their behaviors. Some of these strategies include policy changes in organizations and systems, media campaigns and rape awareness and prevention centers. By working together, meaningful changes are possible at all levels to prevent sexual violence.

Implications for Future Research

This study revealed the importance of qualitative research on the sensitive topic of sexual violence on underrepresented populations, as well as various implications for future research. The importance of qualitative research on sexual violence is crucial in assessing prevalence, revealing consequences and identifying recovery resources for survivors. Qualitative research provides a space for participants to give voice to their personal and often distressing experiences, alleviate social isolation and seek peer supports. For researchers, qualitative

research provides an intimate setting to capture, explore and understand aspects of sexual violence as a social phenomenon, thereby allowing them to identify themes among participants. While there are many benefits to qualitative research, there are, also many difficulties which may prevent researchers from conducting this form of research.

Qualitative research on sensitive topics can be very emotionally draining for researchers, leading to exhaustion and burnout. While institutions provide safeguards to buffer participants from psychological or physical harm as a result of participating in a study, qualitative researchers are often left to manage difficult emotions and interactions on their own while trying to identify ways in which participants can be helped or advocate for themselves. Due to the nature of qualitative research, researchers face the risk of physical threat or abuse and risks of psychological trauma as a result of the participants' disclosures. Qualitative researchers are at risk of being in compromising situations that might lead to accusations of improper behaviors.

While these risks are real, the benefits of qualitative research, particularly on sensitive topics and under-represented populations, are paramount to the future of public health research and access to life-changing resources. Common risk-management prevention strategies utilized by researchers to prevent burn-out and stress include joining a mentoring professional support group that can provide various opportunities for self-development and self-care, included leaving enough space between the interviews to process difficult information and interactions, and specific trainings and preparation to undertake research on sensitive topics. Additional research on the benefits of undertaking qualitative research in pairs or groups and other risk-management prevention strategies may be helpful in meeting the growing need for qualitative research.

While the current literature on sexual violence is more inclusive of the experiences of African-American women, the experiences of other Women of Color (i.e. Latina, Native

American, Asian American and Mixed Races), women with cognitive, mental and physical disabilities, middle age and elderly women, immigrants, lesbians, transgender and bisexual survivors continue to be missing. These diverse populations of women continue to be largely invisible in the current literature, which is likely to falsely suggest that they are less vulnerable to incidents of sexual victimization and re-victimization in their lives. In fact, the absence of qualitative research that explores the prevalence of and responses to sexual violence among these women only serves to exacerbate their victimization and alienation from post-assault recovery resources. Survivors of sexual violence are not a homogenous population. Acknowledging that culture, class, sexual orientations, age, disabilities and acculturation impacts women's experiences and responses to violence are necessary to provide culturally sensitive and appropriate medical and mental health resources. There is a great need for researchers to give voice to all women who struggle with violence in their lives.

While there have been numerous studies that explore personal and socio-demographic factors that build resiliency in trauma survivors, all of the co-morbid factors that contribute to the development and maintenance of post-traumatic stress disorder in some women and not in others remain unclear. Research has shown that social support that empowers, informs and educates survivors helps to alleviate post-assault distress and enhances are social support that empower, inform and educate survivors help to alleviate post-assault distress and enhances survivors' recovery process. Participants in the study overwhelming endorsed the importance that social support played or could have played in their recovery process. Continued research on the benefits of accessible, culturally sensitive and survivor-friendly mental health and medical care, as well as employment, housing and legal advocacy, remains missing from current literature on sexual violence.

While there is limited research on body image of sexual violence survivors, it is reasonable to assume that incidents of sexual violence may lead survivors to change aspects of their physical appearance and dress in the wake of their victimization. However, past research on sexual violence survivors and physical appearance is limited to the development of eating disorders, such as anorexia, bulimia and obesity. One of the goals of this study was to explore other changes in physical appearance and dress in the wake of sexual victimization.

Altering aspects of physical appearance and dress has played a crucial role in the recovery process of burn and breast cancer survivors. Hence, various modifications or supplements to the body are made to prevent future damage as well as to return the survivors, as much as possible, to their psychological, physiological and social state post trauma. Although these goals should be similar for survivors of sexual violence, changes in physical appearance and dress are often overlooked as an essential component of their recovery process. Future research on a larger, multi-racial sample of survivors of sexual violence might reveal more factors that influence changes to physical appearance. Research may also be helpful in determining what factors impact whether these changes are temporary or permanent, as well as shedding light on developing or revising assessment tools that could adequately assess survivors' bodily responses to sexual violence.

Implications for Theory and Clinical Practice

Implications for theory suggest the inclusion of coping strategies as an individual's characteristics in the Feminist Ecological Model Theory. Coping is the cord that binds all aspects of an individual's well being (i.e., physical, cognitive, emotional and spiritual states) in moments of psychological calm and crisis. In light of personality characteristics, medical and

mental conditions pre-assault and those that a survivor might experience post-assault, and coping strategies, adaptive or maladaptive, play a key role in the recovery process of survivors of adulthood sexual violence. If an adult survivor has also experienced sexual victimization(s) in childhood, the coping strategies utilized will be essential to how she will cope with the present victimization, whether she discloses her victimization, to whom she discloses to (micro-system level) and how issues of culture, ethnicity and class might influence the negative and positive reactions that she might receive from others. In addition, coping strategies will determine whether or not she might complete a rape kit by a SANE (Sexual Assault Nurse Examiner) who might later refer her to a rape crisis clinic that might be able to provide her with some legal and medical advocacy and case management services to support her in the recovery process (exo-system). As all levels work closely with each other, together they can begin to dispel rape myths, prosecute offenders and educate communities about the impact of sexual violence on the individuals' mind and body. Without considering the coping strategies utilized by survivors in conjunction with others personal factors and characteristics, there is no cushion to buffer the collision that often occurs between individuals and the systems that surround them in times of crisis. This cushion is necessary for the healing process to begin for many survivors of sexual violence.

The study's results have several implications for mental health professionals working with survivors of sexual violence. While survivors of multiple sexual victimizations, particularly those who were victimized in childhood, present with similar issues as survivors of single victimizations, many struggle with more complicated problems. These problems include physical and mental health problems, substance abuse, difficulties with maintaining employment, accessing education, and finding stable housing, and fear of future victimization. These long-

term issues are not easily resolved by a one-size-fits-all therapeutic approach. Service providers that ignore the importance of differences among survivors may offer services that are ineffective, inaccessible and harmful to women. It is imperative that survivors of single or multiple victimizations not be treated as damaged goods but as individuals in need of therapeutic approaches that would best meet their needs.

Mental health professionals can be helpful by tailoring their approaches to meet survivors' needs by providing active, long-term interventions that are based on the specific needs, perspectives and cultures of the survivors. Each survivor will present with a unique perspective of her victimization(s), how she was affected by the violence, support she sought and services utilized. Hence, each advocacy approach should be survivor-defined and survivor-friendly. Culturally competent providers can nurture a respectful working relationship that includes being observant of survivors' reactions and being knowledgeable about interpreting those reactions. As survivors' issues are likely to cut across various systems and disciplines, providers can be helpful in facilitating and coordinating care among various community agencies to address a range of needs, including crisis intervention, mental health responses, alcohol and drug services, health care responses, economic support and legal advocacy. Finally, as many survivors are likely to be victimized on multiple occasions, a universal service and intervention approach that improves the understanding of issues facing survivors and removes barriers to accessing services will be beneficial to all survivors of sexual violence.

Limitations of Study

There are several methodological limitations of this exploratory study. The first limitation is recall bias. It is likely that some of the participants' responses on the surveys were affected by the time lapse between their actual victimization(s) and completion of the study's surveys. Hence, this recall bias might have affected their thoughts, feelings and actions surrounding the initial event(s), which might have influenced their responses on the surveys. However, it is likely that the traumatic nature of sexual violence might have caused many survivors to retain and recall many aspects of their victimizations. The second limitation involves the potential overwhelming nature of the study. Although all of the measures were presented in their shortened versions to minimize participants' likelihood of experiencing anxiety and depressive symptoms as a result of their participation in this study, it is likely that some of the participants may have become overwhelmed by the study's measures, which could have affected their responses on the surveys. Although all of the measures used presented with good internal consistencies, some of the measures provided limited demographic information on their respondents, and their psychometric properties were not normed on African-American, Biracial/Multiracial, Latina and Native American women. In addition, a factor analysis conducted on the Ways of Coping Questionnaire for African-American women found that 35 items out of 65 items loaded on three of the eight factor models, which suggested possible elimination of some items on these measures when used for assessing African-American women's coping strategies (Smyth and Yarandi, 1996). It is likely that a factor analysis on the shortened version of the Ways of Coping Questionnaire used in this study might produce similar findings. It is also likely that some of the coping strategies assessed by this measure did not fully capture the coping strategies utilized and appearance concerns expressed by survivors of sexual

violence. This finding may be similar for aspects of physical appearance assessed through the Appearance Schema Inventory on this study.

A fourth limitation of the study lies in distributing several packets of surveys to two study participants who had access to other participants who expressed interested in participating in the study. Through this process, the researcher did not have complete control of the questionnaires and access to each participant who participated in the study. Likewise, some participants presented with several limitations that hindered their ability to complete the surveys without additional support from the researcher or others. These limitations include comprehension difficulties, language difficulties (English as a Second Language) and mobility limitation that impacted manually completing the surveys. These limitations continue to highlight the many difficulties facing survivors of sexual violence. Finally, the sample size of the quantitative and qualitative study was small, with smaller samples among the various age groups in the study; for example, 72.6% of the sample population fell between the ages of 30-55. Further studies should increase the sample population to enhance generalizations of the findings to a larger population of adulthood survivors of sexual violence.

Conclusion

Sexual violence is a harsh reality in the lives of women. By the end of the day, approximately 638 women will become a victim of sexual violence in the United States. Based on the current prevalence rates and research on sexual violence, this number is a small fraction of the actual incidents of sexual violence committed against women daily. This traumatic and devastating crime, which is frequently perpetrated by offenders who have a close or intimate relationship with their victims, often causes severe and long-term chronic symptoms among its

survivors. Issues of race/ethnicity and class further intersect to heighten the experiences of violence in women's lives. Some women, particularly those with access to positive social support and structured and supportive home and work environment(s), are psychologically resilient in the wake of their victimization and will recover from incident(s) of sexual violence in their lives. However, other women, especially those who are poor and have prior histories of physical and sexual violence, are likely to experience severe short-term and long-term emotional distress. As sexual violence and the threat of sexual violence is commonplace in women's lives, some may struggle to fully acknowledge the impact of violence on their bodies and minds.

As survivors struggle to make sense of their victimizations, they often implement a combination of adaptive and maladaptive coping strategies to manage their thoughts and feelings associated with the assault. Some survivors have, and will, change aspects of their physical appearance and dress to soothe and manage their emotions and to heighten their sense of safety in relationships with themselves and with others. Unfortunately, society often places the responsibility on survivors to prevent repeated victimizations, while directly or indirectly blaming them for past or present victimizations.

Interestingly, all of the focus group participants mentioned creating pre-assault prevention services and accessible post-assault services to help survivors take the next steps toward integrating the event(s) as a part of their lives, as a necessary phase of the recovery process. However, prevention of sexual violence as well as available treatment resources for victims of sexual violence should not be another burden that they must shoulder alone. It is the responsibility of our families, friends and communities to keep all of our residents safe from violence. It is the responsibility of our organizational and institutional systems to educate individuals about the prevalence and consequences of sexual violence, to create policies that

prosecute offenders and allocate resources to fund prevention projects and support survivors' recovery. Finally, it is the responsibility of our society's value and worldview systems to treat victims of sexual violence with dignity and respect, as integral members of these societal systems. Sexual violence against women is a complex social phenomenon perpetuated and supported throughout society. As a society, we need to work tirelessly in collaboration with individuals, organizations, policy makers and communities to end sexual violence, and end it now.

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