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**STRATEGIES OF SURVIVAL: COPING, CHARACTERISTICS OF
RESILIENCY, AND PERCEIVED IMPACT OF ABUSE IN RESILIENT
BLACK FEMALE SURVIVORS OF SEXUAL TRAUMA**

by

KAREN WALKER SINGLETON

**A dissertation submitted to the Graduate Faculty in Psychology in partial
fulfillment of the requirements for the degree of Doctor of Philosophy, The City
University of New York**

2004

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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In loving memory of my mother, Sadie Walker Singleton (1934-1982)

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CHAPTER I

INTRODUCTION

Sexual trauma¹ is not only a crime against one's body, but also against one's core sense of self. Each individual is therefore affected intrapsychically, intellectually, interpersonally and physically.² The experience of sexual trauma impacts each domain differently, depending on characteristics such as one's cognitive style (intrapsychic self), their belief systems (intellectual self), their access to resources and possibilities of physical threat (physical self) and their role in their family and ethnic and cultural communities (interpersonal self). Consequently, clinical work with sexual trauma survivors requires an appreciation and understanding of all of the above-mentioned areas, as they allow us to see the universality of the impact of trauma as well as the unique ways in which survivors make meaning of and cope with this experience (Davies & Frawley, 1994; Donovan & Williams, 2002; Grossman, Cook, Kepkep, & Koenen, 1999; Neville & Heppner, 1999; West, 2002).

In the past twenty years, fields such as psychology, social work, medicine, and law have come to realize this and have begun to conceptualize this crime in a way that documents and legitimizes the myriad ways women and men respond to such trauma. This shift is not just reflected in the content of the research and theory that has been produced, but also in the sheer quantity of articles that have surfaced. A review of the

¹The term sexual trauma encompasses childhood sexual abuse (CSA), incest, adult sexual assault and rape.

² This claim is based on my own model, The Self-in-Relation Model of the Impact of Sexual Abuse, which can be found in the appendix.

abstracts for many of these articles confirms that there is a strong interest in understanding the short and long-term intrapsychic and interpersonal effects of sexual trauma, as well as the most effective ways of taking care of survivors, their families, and more recently those that treat them.

A glaring omission in this body of literature is an analysis of the specific ways in which Black women have been impacted by and cope with sexual trauma (Priest, 1992; McNair & Neville, 1996; Neville & Heppner, 1999; Robinson, 2000; West, 1999). Consequently, one might gather from this omission that the experience of sexual trauma is the same for all women, regardless of their culture, race or ethnic identity (West, 2002; Collins, 2000). In fact, because the majority of large-scale and/or frequently cited studies of sexual assault (e.g., Herman, 1992, Finkelhor, 1979, Feinauer & Stewart, 1996, etc.) consist primarily of White women (Briere, 1992; Priest, 1992), the experiences of these women are often used to generalize to all women (Russell, Schurman, & Trocki, 1988; West, 1999; Henderson-Daniel, 1995)

An excellent example of this is Judith's research and theoretical work on incest survivors. Herman's (1992) extensively cited work is largely based on 60 research participants (incest survivors) who were all White women. Additionally, the work of Feinauer and Stuart (1996), Finkelhor (1979), and of Valentine and Feinauer (1993), which is also widely cited, was undertaken in areas where few people of color live.³ Thus, their samples are based solely on White women. Although other earlier studies have included people of color in their sample (e.g., DeFrancis, 1969; Meiselman, 1978), many fail to grasp the opportunity to examine the differences between the two groups

³ These studies took place in Utah.

(Russell et al., 1988). Moreover, Russell et al (1988) argue that the “assumption that data on Whites accurately reflect the experiences of members of all other groups denies the role of culture in people’s lives, denies the fact that racism has had an impact, and reflects the White bias of most researchers in this field” (p. 119-120). Such assumptions influence what various institutions (e.g., psychotherapy, law enforcement, the criminal justice system, etc.) regard as appropriate responses to sexual trauma, as well as what treatment is considered most effective, and the ways in which public policy should be altered. Moreover, the absence of the experiences of women of color limits us from exploring the specific ways in which being sexually victimized may be different for women who exist in a society that has historically devalued both their race and their gender (Russell et al., 1988).

For Black women⁴, who make up a disproportionate⁵ percent of reported trauma survivors, sexual violence occurs in exactly this type of a sociocultural context. Walker (1999) captures this experience well by conceptualizing it as a “dual trauma” in which sexual and racial violations are compounded and affect the way in which a survivor experiences and copes with such violence. Similarly, West (1999) argues that “despite the various elements that configure one’s personality or compose one’s individual biography, Black survivors struggle between resisting and absorbing the cultural meanings attached to their traumatic experience” (p. 122). This may include, but is not limited to, negative sexual stereotypes about Black women and men, ethnic identity and community affiliation, sexism within and outside of the African American community,

⁴ In this paper, African American and Black will be used interchangeably.

and institutionalized racism within law enforcement agencies and the criminal justice system. These elements create a silencing about sexual violence against black women not only in clinical research and academic literature (as referenced above) but within the African American community as well (Washington, 2001; West, 2002; Donovan & Williams, 2002).

Such silence is slowly being broken by several Black women who have created small research projects, books, documentaries and articles on Black women and sexual trauma over the past ten years (e.g., Wilson, 1993,1994; Wyatt, 1997; West, 1999; West, 1995, 2002; Simmons, 2002; Robinson, 2002). Like these projects, my research documents the experiences of Black female trauma survivors in their own words. I use their narratives, which have been collected through in-depth interviewing and supported by relevant literature, to generate theory about the impact of such violence, their coping strategies, and the ways in which Black female survivors demonstrate resilience. It is impossible, however, to speak of a collective Black women's experience of trauma, as there is much heterogeneity amongst Black women (Wyatt, 1997; West, 2002). Despite this, the inclusion of varied experiences of trauma that have been shaped by culture and racism would enhance the applicability of trauma theory for all women (Neville & Heppner, 1999).

⁵ Black women have higher rates of sexual assault per 1000 women than White women and 40% of Black women report having had a coercive sexual experience prior to age eighteen (Russo, Denions, et al, 1997; California Black Women's Health Project, 2002).

CHAPTER II

LITERATURE REVIEW

Child Sexual Abuse and Adult Sexual Assault: Definition of Terms

I have chosen to look at survivors of both childhood sexual abuse (CSA) and adult rape, although these traumas are generally defined very differently. For the purpose of this study, I am using the following definitions of child sexual abuse and adult rape, from experts in the field Lenore Walker (1996) and Diana Russell and Rebecca Bolen (2000) respectively:

Childhood Sexual Abuse: Sexual abuse is defined as any touching of a child's genital area or other body areas that has a sexual or seductive connotation or any coerced touching by the child of an adult's genital areas. Showing children pornographic movies and pictures, coercing a child to pose for such pictures, or telling sexual stories is also considered sexual abuse. (p. 87)

Rape: Rape is defined as nonconsensual sexual penetration of an adolescent or adult obtained by physical force, by threat of bodily harm, or when the victim is incapable of giving consent by virtue of mental illness, mental retardation, or intoxication. (p. 22)

While many researchers have chosen to study different forms of sexual trauma separately, a closer analysis of childhood sexual abuse and rape suggests that these experiences most often exist on a continuum (Dye & Roth, 1991). "The feelings of violation of power by a trusted other experienced by the incest survivor may be shared by many different sexual assault survivors," write Dye and Roth (1991, p. 105). "Even in cases of stranger rape," they (1991) write, "survivors frequently experience a loss of trust in the safety of the world they live in, and may feel an ongoing sense of betrayal and mistrust of others which generalizes throughout their lives"(p. 105). Moreover, the majority of themes

associated with sexual trauma (rage, helplessness, and alterations in self schema) were common across the different types of sexual trauma, irrespective of the nature of the trauma, the relationship with the perpetrator, and whether or not the abuse was repeated (Dye & Roth, 1991).

Experiences such as lack of trust in others, low self-esteem, anxiety, depression, difficulties with intimacy, self-destructive behavior, and tendency towards revictimization and substance abuse are cited as common responses to sexual trauma (Browne & Finkelhor, 1986; Stein, Golding, & Siegel, 1988; Herman, 1992; Walker, 1996). Further, many survivors of CSA are later victims of other forms of sexual assault.⁵ Overall, between 16% and 72% of women who experience CSA will be revictimized as adults (West, Williams, & Siegel, 2001). Finally, my decision to interview survivors of both CSA and rape emphasizes my interest in capturing the ways in which Black women cope with and display resiliency in response to sexual trauma, as a way of improving mental health outreach and treatment planning for survivors of African descent. An in-depth look at the severity and duration of abuse against such women and its relation to various long and short-term sequelae are beyond the scope of this study.

⁵ Wyatt (1992) reports that women with a history of CSA were 2.4 times more likely to be sexually re-victimized as adults. Urquiza & Goodlin-Jones (1994) found that 61.5% of the Black female CSA survivors they interviewed reported adult rape.

Prevalence of Sexual Trauma

Sound rape and sexual abuse theories, as well as effective social policies and activist strategies to combat these crimes, all require accurate knowledge of their prevalence (Russell & Bolen, 2000). The most commonly accepted prevalence rates for CSA and adult rape range between 18-33% and 22-25%, respectively (Walker, 1994). However, prevalence rates in the area of sexual trauma vary greatly depending on the study. For example, the percentage of women who have disclosed having been victimized by an attempted or completed rape has ranged from 2.6% to 44%, while the percentage of women who disclosed a history of CSA has ranged from 2%-62% (Russell & Bolen, 2000). The huge range is most likely explained by differences in methodological rigor and how narrowly (or widely) abuse is defined. The major studies that will be reviewed in this paper are considered the “soundest” by the trauma research community and are well regarded (Finkelhor, 1994; Russell & Bolen, 2000).

Rape Prevalence

Russell (1983) conducted the earliest substantial rape prevalence study. Her (1983) goal was to obtain an accurate estimate of the prevalence of a variety of forms of sexual trauma (including incest, rape, and sexual assault) among the general population of women. Russell’s (1983)⁶ research team interviewed 930 randomly selected women, age 18 and above, in the San Francisco area. They (1983) had a 64% participation rate. Of the 930 women, 24% disclosed at least one completed rape and 31% disclosed at least one attempted rape. Altogether,

44% of the participants disclosed at least one completed or attempted rape.

However, Russell's (1983) study did not include enough women of color to adequately analyze their data separately.

Kilpatrick, Edmunds, and Seymour (1992) conducted a survey referred to as The National Women's Study (NWS) between 1989-1991. Their (1992) sample consisted of 4008 English speaking American women ages 18 and older. Two thousand and eight of these women represented a cross section of all adult women and 2,000 were obtained by oversampling younger women between the ages of 18-24. They (1992) had a participation rate of 85%. Kilpatrick et al., (1992) found that 12.7 % of the women surveyed reported having been victims of at least one completed rape in their lifetime, and cite this as their prevalence rate. This rate is significantly lower than Russell's (1983) findings, and may reflect the duration of the interviews (only 35 minutes via telephone) or the narrow definition of rape (their definition did not include a women's inability to consent due to incapacitation).

Tjaden and Thoennes (1998) were the principal investigators in the National Violence Against Women (NVAW) Survey conducted in 1995 and 1996. They (1998) conducted a national sample of 8000 women and 8000 men and reported a 97% participation rate. Their (1998) methodology was very similar to that of Kilpatrick et al's (1992) National Women's Study. Tjaden and Thoennes (1998) found a prevalence rate of 18% for completed and attempted rape. The prevalence for completed rape alone was 15%. This finding is less

than half of the prevalence rate found by Russell (1983) and also lower than Wyatt's (1985;1999) 22% prevalence rate which will be discussed later.

Childhood Sexual Abuse Prevalence

Russell's 1983 San Francisco study also surveyed the prevalence of incestuous and extrafamilial child sexual abuse. She (1983) asked the same 930 randomly selected women about their experiences with childhood sexual abuse. Her (1983) participation rate was 64%. Russell (1983) found that 16% of her sample reported at least one experience of incestuous abuse prior to the age of 18. Further, she (1983) found that 31% of the sample reported at least one experience of sexual abuse by a non-relative. When the two categories are combined, her (1983) prevalence rate rose to 38%.

Finkelhor, Hotaling, and Smith (1990) wrote up the data from the first national survey of the prevalence of CSA, which was collected by Lewis in 1985. Lewis (1985; cited in Finkelhor et al., 1990) interviewed 2,625 adults over the age of eighteen. Fifty-six percent of the respondents were women. Their (1990) findings show that 27% of the women interviewed disclosed at least one experience of CSA. Although it is unclear how many people of color participated in the study, Finkelhor et al (1990) argued that the sample was representative of the demographics of the United States.

Kenny and McEachern (2000) surveyed 164 college women about their experiences of sexual abuse. Unlike most samples of college students which are predominantly White, theirs (2000) was multiethnic (although the percentage of Black women is very small). Fifty-one percent of the women identified as

Hispanic, 23% identified as Caucasian, 4% as African American, 8% as African Caribbean, 4% as Asian and 18% as biracial. Moreover, the women surveyed were from a variety of cultural and economic backgrounds as well. They (2000) found that 18% of the women recalled some experience of sexual abuse, most of which was perpetuated by non-family members. The most common form of abuse (67%) was fondling of the victim by the perpetrator. This study found a rate of sexual abuse that is much lower than past studies (Everill and Waller, 1995; Priest, 1992) but consistent with other studies such as Finkelhor's 1980 research.

Ethnic and Racial Differences in Prevalence Studies

In her groundbreaking studies of Black women and sexuality, Wyatt (1985) conducted a study in Los Angeles County that explored the childhood sexual abuse and rape experiences of African American and White women ages 18 to 36 years. Her (1985) goal was to recruit comparable samples of African American and White women regarding level of education, marital status, and number of children. Additionally, Wyatt (1985) matched the gender and ethnicity of participants and interviewers. Participants (126 African Americans and 122 White women) were given Wyatt's Sex History Questionnaire (which includes questions about CSA and adult sexual assault) and subsequently asked about experiences of nonconsensual sexual experiences that had occurred after the age of 18. She (1985) found that 25% of the Black women and 20% of the White women reported at least one incident of completed or attempted rape. Wyatt

(1985) explains that this difference is not statistically significant. However, this may be due to the small sample size of her study. Wyatt's (1985) study is groundbreaking because no prior study had matched the socioeconomic status of Whites and other ethnic groups, and had consequently confounded the respondents' ethnicity and social class.

Wyatt (1985) also concluded that there were no statistical differences in the short-term effects of sexual abuse between the two populations. However, she (1985) found differences in the long-term effects including "a greater percentage of Afro-American women than white women reporting being less trustful and more cautious." Wyatt (1985) also reported that a greater percentage of White women than Black women reported no lasting effects. She (1985) came to the following conclusion:

Afro-American women tended to seek more internal reasons, such as their physical development, as the cause for their victimization... This finding, along with Afro-American women's highly negative reaction to abuse, their tendency not to disclose incidents as often as to nuclear family members or to police and to disclose abuse to extended family members, some of whom have been found to abuse them, place Afro-American women at risk for more severe consequences of abuse. (p. 21-22)

Wyatt, Loeb, Solis and Carmona (1999) replicated Wyatt's 1985 study 10 years later and found that CSA continues to be widespread and underreported for both African American and White women. Wyatt and colleagues (1999) also found that there were no statistically significant changes in the prevalence rate of 34% since her previous 1984 study. They (1999) also found that there were no statistically significant inter-group differences (between Black and White women) in the prevalence rates. Most women did not disclose the abuse (53% of African

American and 60% of White women) and White women were less likely to disclose the abuse in 1994 than 1984, while Black women's disclosure rate remained the same. Wyatt et al. (1999) also found that Black women were more likely to be abused in a private location in 1994 than 1984 and that both African American and White women reported experiencing more severe abuse in 1994 than in 1984. Additionally, Wyatt et al. (1999) found that both African American and White women were significantly more likely to report no long term effects of the abuse (Black women were 14 times more likely to report no long term effects) in 1994 than in 1984. Wyatt et al. (1999) attribute this significant increase to the fact that women reported less chronic (although more severe) experiences of sexual abuse in 1994 than in 1984. They (1999) also suggests that, despite widespread public education efforts, women still may not be able to correctly identify long term effects associated with earlier incidences of abuse.

Additionally, Urquiza and Goodlin-Jones (1994) interviewed an ethnically diverse sample of 243 childhood sexual abuse survivors to better understand prevalence of sexual assault revictimization. They (1994) found that African American CSA survivors were more likely to be revictimized than White, Latina, and Asian American women (the rates were 61.5%, 44.2%, 40%, and 25% respectively). They (1994) argue that for all survivors, the self-blame and self-attribution process may increase the likelihood of a later assault. However, they (1994) write that other important factors should be considered when looking at revictimization among women of color, including violence perpetuated against people of color, religiosity, cultural values, acculturation, community definitions

of child sexual assault and adult rape, gender role socialization, and ethnicity specific historical contexts in which such experiences are framed. Urquiza and Goodlin-Jones (1994) also believe that cultural factors play a role in both the increase and decrease of risk factors associated with initial victimization and later revictimization.

Prevalence Studies in Samples of Black women:

Ford (1998) interviewed 55 African American female outpatient clients who met the diagnoses for a variety of psychiatric disorders, the majority of which were mood or anxiety disorders and Posttraumatic Stress Disorder. Almost half of the women (45.5%) in her (1998) sample reported that they had been victims of “sexual molestation during their childhood.” Ford (1998) defined sexual molestation as having had non-consensual sexual contact before the age of 18 with someone who was at least five years older than the survivor. Sixty-one percent of the participants reported having been sexually assaulted or raped during adulthood. Additionally, 74.5% reported having been the victim of a physical assault at some point during their life. Ford (1998) found that the Black women who had exposure to violence and trauma were more likely to report poorer mental health.

In 1992, Priest conducted a preliminary study to assess the prevalence of Childhood Sexual Abuse (CSA) among African-American college students. He (1992) used a modified version of Finkelhor’s (1979) self-report questionnaire which was originally used to measure the prevalence of childhood victimization.

The modified questionnaire was administered to 1,500 students from Historically Black Colleges and Universities (HBCU's) and 1,040 (66% female and 34% male) of them responded. Priest found that 168 (25%) of the female respondents and 44 (12%) of the male respondents reported that they had been sexually abused before the age of seventeen. Priest (1992) also found that of the 168 female respondents who reported sexual abuse, only 32 (19%) reported that they had participated in mental health counseling. Further, only 3 of those respondents reported that they had sought treatment in response to their sexual victimization. None of the male respondents that reported sexual abuse reported receiving counseling. Priest's (1992) finding of a 25% prevalence rate among women falls between Finkelhor's (1979) findings of a 19% prevalence rate among women and Wyatt et al.'s (1999) prevalence rate of 34%.

Impact of Sexual Trauma

Psychoanalytic Theories Regarding Sexual Trauma

Although both Charcot (1857, cited Davies & Frawley, 1994) and Janet (1909, cited Davies & Frawley, 1994) were the first to write about the psychological impact of trauma, Freud's ideas about sexual trauma, based on his work with female hysterical patients, have had the most noteworthy influence on psychoanalytic thinking and psychology in general. In fact, the short history of psychoanalytic writing on sexual trauma can be traced from Freud's recognition of the reality and impact of sexual trauma to his later renouncement of the veracity of such trauma and his belief that repressed memories were actually

wish-fulfilling fantasies (Herman, 1992; Davies & Frawley, 1994). With the exception of Fairbairn (1943) and Ferenczi's (1932) work⁷, analytic writing on sexual trauma discontinued after Freud's recant and did not resurface again until the 1980's.

Current psychoanalytic writing on sexual trauma most often focuses on father-daughter incest and can be divided among four schools of thought: classical, ego-psychological, object-relational, and self-psychological (Davies & Frawley, 1994). Although each school emphasizes different characteristics of the experience, there are commonalities among them. For example, all four schools appear to believe that the effects of trauma include impaired ego and superego functioning, impaired sense of self, disturbances in intimacy and interpersonal relationships, somatic disturbances, use of "lower level" defenses such as denial, disassociation, and repetition compulsion as well as use of "higher level" defenses such as repression.

Shengold (1989) is one of the few contemporary classical psychoanalysts writing about sexual trauma. He (1989) uses the term soul murder to refer to sexual trauma. "Soul, or psychic murder," he (1989) describes, "involves trauma imposed from the world outside of the mind that is so overwhelming that the mental apparatus is flooded with feeling" (p. 24). This terrifying experience of "too muchness" requires a "massive and mind distorting defensive operation" that is threatening to one's emotion sense of themselves (Shengold, 1989, p. 24).

⁷ Interestingly, Fairbairn (1943) and Ferenczi's (1932) groundbreaking ideas about the effects of trauma, including dissociating and internalization of bad objects (Fairbairn) and identification with the aggressor (Ferenczi), have currently re-emerged.

Shengold (1989) argues that a natural response to such an attack is an alienation from one's own feelings. This leads to the development of an "as-if" personality style that masks their isolation, mistrust of others, and fear of retreat into fantasy life (Shengold, 1989). He (1989) believes that survivors can heal from trauma through classical psychoanalysis, where (in the case of CSA) survivors would learn to give up and mourn the fantasied good parent.

Davies and Frawley (1994) have written more current theoretical papers on sexual trauma from a relational psychoanalytic perspective. They (1994) believe that trauma exerts its influence on all aspects (cognitive, emotional, behavioral, and relational) of an individual's internal organization. Thus, their (1994) perspective calls for a focus on the survivor's self organization and object representations. Davies and Frawley (1994) cite mood disorders and anxiety disorders, as well character disorders such as borderline, schizotypal, and histrionic personality disorders as reactions to such trauma. Additionally, they (1994) argue that many survivors experience somatic problems, sleep disturbances, sexual dysfunction, and eating disorders.

Given the enormity of the impact of sexual trauma, Davies and Frawley (1994) believe that the most effective treatment must be framed relationally and consequently involve all aspects of an individual's self. They propose the following stages of treatment: (1) containment of overwhelming emotions, (2) recovery and disclosure of traumatic memories and fantasied elaboration's; (3) symbolization and encoding of memory and experience; (4) integration of disparate self and object systems and of other reality-distorting defenses; and (5)

internalization of a new object relationship. These stages are not meant to be understood as discreet categories, and may not progress in this order. In fact, they (1994) remind readers that repeat visits to various stages are likely.

Mainstream Theories on Sexual Trauma

Van der Kolk (1996) suggests that trauma has an impact on every level of a survivors functioning, including biological, psychological, social and spiritual. Although Van der Kolk's (1996) research on the impact of trauma has mostly focused on survivors of war, the cluster of symptoms that he describes as Posttraumatic Stress Disorder (PTSD) have been applied extensively to survivors of sexual trauma. Further, research into the incidence and prevalence of Posttraumatic Stress Disorder (PTSD) suggests a high frequency of occurrence in sexual trauma survivors (Walker, 1996). For example, Kilpatrick et al. (1992) found that 57% of a large community sample of rape victims met the criteria for PTSD. Thus, we can infer from the characteristics that contribute to a DSM diagnosis of PTSD, that sexual trauma survivors may experience recurrent and intrusive recollections and/or dreams of the traumatic event(s), avoidance of stimuli associated with the trauma and a numbing of general responsiveness (e.g., feelings of detachment and limited range of affect), and symptoms of increased arousal such as hypervigilance, difficulty concentrating, irritability, and disturbance in sleep patterns.⁸

⁸ Description taken from the DSM IV

Valentine and Feinauer (1993), who have conducted extensive research on sexual trauma, believe that former victims of abuse are likely to experience depression, anxiety, feelings of isolation and stigma, problems in interpersonal relationships, negative self-image, and substance abuse. They note however, that such reactions can range from mild to life threatening and seriously debilitating. They cite studies from both Browne and Finkelhor (1986) and Gagnon (1965; cited in Valentine & Feinauer, 1993), which suggest that some women do in fact cope successfully with sexual trauma. In the Gagnon (1965; cited in Valentine & Feinauer, 1993) study that they cite, 75% of the 333 women reported no maladjustment as a result of sexual trauma. However, they failed to mention the effect of the year that this study was taken. Women may have experienced greater fear of reporting symptoms in 1965, as sexual trauma was rarely discussed.

Putnam and Trickett (1993) write that the effects of sexual trauma are likely to involve the areas of self-esteem, personal power and self-efficacy, development of cognitive and social competencies, emotional and behavioral regulation, and psychiatric symptomatology. Putnam and Trickett (1993) report that the majority of researchers report significant acute and chronic negative effects in both clinical and non-clinical samples. They cite a number of psychiatric outcomes that may be directly related to sexual trauma, such as Borderline Personality Organization, eating disorders, multiple personality disorders, somatization disorders, and substance abuse. They note that such disorders have an important characteristic, a disturbance in one's sense of self, in

common. They also frequently result in self-destructive behavior (e.g., self mutilation, suicide attempts, and risk taking).

Finkelhor, Hotaling and Smith (1990) have developed a theoretical model of the impact of sexual trauma⁹ based on his empirical work and published clinical reports. Although Finkelhor et al (1990) based their research on CSA survivors, the dynamics they outline are certainly relevant to other survivors of sexual trauma. They (1990) argue that there are four areas that are affected by this experience which he terms traumagenic dynamics. The areas are (a) traumatic sexualization; (b) stigmatization; (c) betrayal and trust; and (d) powerlessness. The process of traumatic sexualization includes the ways in which a survivor's sexuality is shaped in developmentally inappropriate and dysfunctional ways. Whereas, stigmatization refers to the negative connotations that are communicated to the survivor about the traumatic experience and the shame that such stigmatization elicits. Finally, feelings of betrayal, trust and powerlessness, which are a result of the traumatic experience, are often generalized to other relationships and skew the ways in which the survivor views the world.

Neville and Heppner (1999) argue that the impact of sexual trauma on survivors is both complex and multidetermined, thereby making it very difficult to understand why some women show little long-term effects and others have impaired functioning. In response to this, they (1999) have developed a conceptual model to better describe the differential outcomes of women's

⁹ Finkelhor (1990) refers to this as a model of *sexual traumatization*.

recovery, with a particular emphasis on cultural factors that are related to this process. Their (1999) model, the Culturally Inclusive Ecological Model of Sexual Assault Recovery (CIEMSAR), includes three out of the four major systems (first outlined by Bronfenbrenner, 1977) of human development: (1) microsystems or individual's relations in an immediate environment such as home, (2) mesosystems or interrelations among two or more of the microsystems the person is operating in, and (3) macrosystems or values, customs and practices within a culture or subculture.

Neville and Heppner (1999) describe the microsystem as including factors such as relationship to perpetrator, severity of injury, previous sexual assault, pre-rape psychological functioning, race and ethnicity, racial identity and cultural adherence, attributions, and coping behavior. Within the mesosystems, Neville and Heppner (1999) include social support systems and institutional support as other crucial systems. They (1999) describe the macrosystem as including important factors such as living in a rape-prone culture, societal rape myths, and ethnic-related cultural values and norms. They (1999) argue that sexual trauma impacts the survivor in all of the above-mentioned area and subsequently that effective treatment must consider all aspects of a survivor's experience.

Feminist Theories Regarding Sexual Trauma

Herman has written extensively on trauma from a feminist perspective. She (1992) argues that abuse is about power and control and stresses the fact that abuse occurs in an environment in which women are devalued based on gender.

With this in mind, she (1992) insists that we not pathologize survivors, but consider their responses reasonable given the context in which they occur. Along these lines, Herman (1992) argues that the core effects of trauma are disempowerment and disconnection from others. “The traumatic event,” she (1992) writes, “challenges an ordinary person to become a theologian, a philosopher, and a jurist. The survivor is called upon to articulate the values and beliefs that she once held and that the trauma destroyed” (p. 178).

Herman (1992) also argues that the sexual trauma survivor faces a double task—not only must she rebuild her own shattered assumptions about “meaning, order and justice in the world” but also find a way to resolve her differences with those whose beliefs she no longer shares. Such reconciliation may need to take place within her family, social network and community. Thus, the survivor of sexual trauma is left with fundamental problems in basic trust, autonomy and initiative. She approaches the tasks of adulthood –establishing independence and intimacy-burdened by major impairments in self-care, in cognition and memory, in identity and in the capacity to form stable relationships (Herman, 1992).

Additionally, Herman (1992) argues that, “survivors are often misdiagnosed and mistreated in the mental health system. Their treatment is often fragmented and incomplete and they may become engaged in ongoing, destructive interactions in which the medical and/or mental health system replicates the behavior of the abuse” (p. 123). Moreover, she (1992) also argues that such women are often diagnosed with pejorative diagnoses, such as Borderline

Personality Disorder, Multiple Personality Disorder (now referred to as Dissociative Identity Disorder) and Somatization Disorder.

Leonore Walker (1996) argues that a feminist analysis of sexual trauma must include an understanding of rape myths and myths about women and gender roles. She (1996) believes it must also consider the impact of gender oppression on female survivors, as women (like many other oppressed groups), are not culturally sanctioned to express anger against those they view as their oppressors. Female survivors are therefore likely to mask their rage and make accommodations to coexist with those that oppress and violate them (Walker, 1996). Walker (1996) suggests that working with survivors from a feminist perspective necessitates validating a women's anger and assisting women to focus that anger on the specific targets while mobilizing that anger to change the larger society.

With this in mind, Walker (1996) has developed a treatment approach that combines feminist theory and trauma theory. This treatment, which she (1996) named Survivor Therapy, takes into account the "gender based impact of trauma within the woman's sociopolitical, cultural and economic context...and attempts to integrate the current trauma response into the woman's historical, psychological, sociopolitical, cultural, physiological, biological, and situational context by dealing directly with changes in affect, cognition, and behavior" (p. 285). Further, survivor therapy focuses on survivor's strengths as well as their injuries and explores the coping strategies that the survivors themselves have adopted and assists in building on such strategies. Overall, she (1996) believes

that in order to understand the impact of trauma and treat survivors effectively, one must understand societal oppression and the psychological impact of race, culture, and ethnicity on a survivor.

Sheinberg and Fraenkel (2001) have drawn on feminist, social constructionist, and family systems theories to develop a treatment model for CSA survivors and their families. They (2001) conceptualize CSA as a relational trauma, thereby underscoring the many relational dilemmas a child survivor must face, in addition to the intrapsychic and behavioral sequelae. These dilemmas impact the survivor's sense of self, as one's self-concept, self-worth and sense of agency are influenced by the ways in which they are treated and viewed by those surrounding them (Sheinberg & Fraenkel, 2001). Moreover, such relational dilemmas are shaped by gendered power dynamics within and outside of the family system, as well as the ways in which individuals make meaning of their experiences (Sheinberg & Fraenkel, 2001). Thus, Sheinberg and Fraenkel (2001) argue that effective treatment of trauma survivors and their families requires an awareness of and sensitivity to these relational dilemmas.

The model that Sheinberg and Fraenkel (2001) propose has several goals, which are different for each member of the family. The treatment goals for the abused child include: 1) developing personal agency, 2) not blaming herself for the abuse, 3) reconnecting with a trusting family member, and 4) becoming asymptomatic in terms of emotional and behavioral sequelae. The treatment goals for the non-offending family member include: 1) being a trustworthy parent (making morally sound and protective decisions on behalf of her child), 2)

tolerating expressions of a range of feelings from the child, and 3) identifying, clarifying, and accepting her many feelings about the offending person. The goals for the offending parent include: 1) taking responsibility for the abuse, 2) showing empathy for the child, and 3) participation in generating a safety plan. Sheinberg and Fraenkel (2001) also outline treatment goals for the family as a whole, which include: 1) regaining and building upon stories of pride without diminishing the significance of the incest story, 2) resuming and/or strengthening relationships with supportive others in the extended family and community, and 3) becoming a place of nurturance safety, growth and protection from the possibility of future abuses (Sheinberg & Fraenkel, 2001, p. 8). Although, Sheinberg and Fraenkel (2001) have geared their treatment model towards children and families, their philosophy of treatment is easily applicable to adult CSA survivors and their families as well.

Impact of Sexual Trauma on Black Women

The reviewed literature suggests that there are similarities in the ways in which women are impacted by sexual trauma. This impact is, of course, mediated by circumstances such as the severity of the trauma, the age of onset, duration, and the relationship to the perpetrator. However, for Black women, racial and gender oppression also combine to shape how one is impacted by sexual trauma (Neville & Heppner, 1999; Robinson, 2000; West, 2002; Wyatt, 1997). Despite the fact that such repercussions do not occur in an additive fashion (e.g., first race, then gender, etc.) and do not apply in the same way to every incident of abuse,

common threads have been found in the experiences of African American female survivors. Black survivors of abuse may experience a wide variety of mental health problems, including depression, anxiety, dissociation, low self-esteem, and posttraumatic stress disorder (Banyard, Williams, and Seigel, 2002; West, 2002). Black survivors of CSA, domestic violence and sexual assault also reported higher rates of use and abuse of alcohol, marijuana, and cocaine, when compared to their peers (West, 2002).

Little research has been conducted that focuses specifically on the experiences of Black female survivors of sexual violence (McNair & Neville, 1996; Neville & Heppner, 1999; Urquiza & Jones, 1994; Wyatt, 1997). The large scale studies that do exist have focused more on the prevalence of sexual violence (as seen above) in lieu of the unique ways in which Black women have been impacted. The work that has focused on the impact of trauma has been largely theoretical and based on clinical work or a small number of qualitative interviews. Thus, in addition to reviewing the research that has been published, I will also outline the theoretical arguments that have been made regarding the ways in which Black women are impacted differently by sexual violence and the specific challenges they face.

Theory Regarding the Impact of Sexual Trauma on Black Women

“Dual trauma,” the previously mentioned term coined by Maureen Walker (1999), poignantly describes the ways in which race and gender interact to create the unique challenges that African American female survivors face. Regardless of

the age at which the abuse occurs, the experience of sexual trauma challenges an individual's belief system about the way the world operates (Herman, 1992). It confuses one's basic assumptions about which persons and situations can be trusted, and in many cases one's own judgment and ability to take care of themselves (Davies & Frawley, 1994; Herman, 1992). Thus, the situation is further complicated for Black women whose experience of the way the world works and who can be trusted, as well as how to take care of themselves, differs from the majority culture. Moreover, for Black women, the impact of sexual trauma may be mediated by the sociohistorical context of rape in the United States, as well as the various ways in which Black women are viewed in the world. The sociohistorical context of rape is qualitatively different from that of White women, as rape and sexual exploitation were used as a means of controlling Black women during slavery (McNair & Neville, 1996; West, 2002; Wyatt, 1997). Oppressive images of Black women, largely created to justify this violence, continue to exist in the American collective unconscious and consequently affect Black women's psychological functioning (McNair & Neville, 1996; West, 2002; Wyatt, 1997).

Cultural myths about black women and their impending effects require closer examination and are linked to the ways in which Black women cope with abuse (Greene, 1994; Walker, 1999; West, 1995; Wyatt, 1997). Wyatt (1997) argues that culturally constructed myths and images have enormous staying power and are at the heart of many longstanding, unresolved issues in the lives and relationships of Black women. She (1997) views these images as invisible chains

that bind Black women. A study by Wyatt (1997) attempted to demonstrate some of the ways in which Black women and society accept negative stereotypes. When Wyatt (1997) asked a sample of Black women to attribute various stereotypes statements (e.g., some women are more promiscuous than others) to a particular ethnic group, the majority believed that such statements applied to Black women. Wyatt (1997) suggests that, “these findings highlight the degree to which Black women have internalized and accepted stereotypes that depict them as stereotypical characters” (p. 38). It appeared that the findings were consistent, regardless of age, education and income. Additionally, Steele’s (1998) research on stereotypes and performance has shown us that African Americans (as well as other groups) do in fact internalize stereotypes, and that these stereotypes impact behavior. Along similar lines George and Martinez (2002) argue that, “stereotypes regarding Black sexuality generally, and Black victims and rapists specifically cause race to likely affect judgments regarding all rapes involving a Black person” (p. 110).

The stereotypes that are most likely to impact a Black women’s experience of sexual trauma are the Jezebel image and the Matriarch image. West (1995) explains that the Jezebel image originated during slavery when White slave owners exercised almost complete control over Black women’s sexuality and reproduction. Jezebel has been portrayed as seductive, hypersexual and an exploiter of men’s weaknesses (West, 1995). Wyatt (1997) describes Jezebel as a she-devil. “The assumption is,” Wyatt writes, “that these women don’t mind being sexual pets, exhibiting their bodies, or using provocative body language to

communicate their readiness for sex” (p. 33). Sexual stereotypes that are associated with the Jezebel image link promiscuity, engagement in early sexual activity, and a loose and morally deficient lifestyles with Black women. This type of woman contradicts our image of a victim of rape or child abuse. Many people continue to believe that loose and promiscuous women can't be abused, or that they must have somehow asked for the abuse. The image affirms that Black women cannot be victimized due to their wanton sexual nature. West (1995) argues that this image contributes to a sense of shame and reluctance to acknowledge sexual violence in one's life and in one's community. She (1995) emphasizes that awareness of the Jezebel image is crucial when conducting therapy with sexually victimized Black women.

The Matriarch image can also have an impact on African American sexual trauma survivors (Donovan & Williams, 2002; West, 1995; White, 1999; Wilson, 1993, 1994; Wyatt, 1997). This image combines the image of the Mammie (the self-sacrificing, breast to the world) and the Sapphire (iron willed, strong). What both of these images have in common (besides being one-dimensional, ever present television and screen characters) is their invulnerability. They depict Black women as being able to handle any and every conceivable situation. Such women can bear all burdens, their own and those of others, and acknowledge no personal pain (Greene, 1994; White, 1999). Black female sexual trauma survivors who have internalized the matriarch stereotype will be reluctant to see themselves as victims (Greene, 1994; White, 1999). They will have difficulty making sense of their suffering, given that they are supposed to be so strong. Such women will

have difficulty seeking help, as they will be concerned about appearing weak. Even when the facts of the abuse are believed, myths and stereotypes about Black women influence whether the insult and injury should be considered relevant or important (Henderson-Daniel, 1995; White, 1999).

Donovan and Williams (2002) argue that historical images of Black women, particularly the matriarch and jezebel images, are very present in the minds of contemporary Black women and contemporary American culture. These images affect Black women's decisions to disclose and report their rapes (Donovan & Williams, 2002). They (2002) argue that the jezebel image reinforces rape myths, promoting the idea that survivors have somehow contributed to their victimization. The Matriarch image reinforces the myth of the "strong black woman," which they (2002) argue contributes to Black women's reluctance to disclose, as well as the response they get from others when they do disclose (Donovan and Williams, 2002). Donovan and Williams (2002) offer therapeutic interventions, based on the above-mentioned factors, for clinicians that work with Black female survivors: 1) take a supportive therapeutic stance (which requires clinicians to assess their own internalized rape myths and stereotypic images, 2) address oppressive images of both Black women and Black men, and 3) encourage social support and activism.

Sexual trauma also impacts the way in which Black women feel about their community, as well as how they feel about the role they play within that community. Pierce-Baker (1998) argues that in the realm of sexual trauma, race has preceded issues of gender for Black women. "We are taught," she (1998)

explains, “that we are first black, then women. Our families have taught us this, and society with its harsh racial lessons has reinforced it.” Through the narratives she (1998) has compiled, Pierce-Baker allows the voices of women who are struggling with this conflict to come alive. One survivor plainly states that the possibility of her perpetrator going to prison and being another statistic is “almost as great an evil” as the rape that occurred. Another survivor confirms this, “for black women it’s taboo to tell – the brothers are hurting so bad that we don’t want to hurt them anymore.” Black women, aware of the systematic oppression of black men, often feel obligated to understand Black men (McNair & Neville, 1996; Wilson, 1993, 1994). Moreover, a woman may undergo a complex mixture of loss, fear and shame when sexually assaulted by someone they expect and desire to be a communal ally and “brother” to them.

The above-mentioned experiences impact a woman’s ability to name the violence that has occurred. Many women are unable to speak the truth about violence because they are burdened by the varying and specific definitions of appropriate behavior that have been given to them (West, 1999). Such behavioral expectations may be demanded from a women’s church and black community, gender role expectations in her family, and at times by the professional she seeks out for help (West, 1999). Thus, managing such expectations can further complicate a Black women’s recovery from sexual trauma.

Research Regarding the Impact of Sexual Trauma on Black Women

Russell (1983) conducted the largest quantitative study that looked at the impact of sexual trauma on samples of different ethnic groups. In her (1983) study of approximately 700 sexual trauma survivors, Black women incest victims (compared to White women and Latinas) reported greater trauma as a result of the abuse and greater long-term effects. The author's (1983) suggest that this may be due to the compounded traumas of incest and being born and raised in a racist and sexist society. Additionally, Russell et al. (1983) found that African American victims were more likely than White women to be abused at the severe level. They (1983) believe that this is likely due to the nature of the victim-perpetrator relationship. The majority of Black survivors reported abuse by non-blood relatives and non-blood relatives were more likely to abuse with force.

In a 1997 study, Bruce-Morrith interviewed 32 African American female childhood sexual abuse survivors. She found that the majority of the women (approximately half) in the study had been sexually abused by a family friend. This form of abuse was followed in frequency by a male relative other than their father, stepfather, or their brother. The other perpetrators, cited in order, were stranger, brother, father, stepfather, and sister. The most frequent type of sexual abuse cited was fondling, followed by exposure and vaginal sex. Interestingly, more than half of the subject pool also cited physical abuse from fathers. Bruce-Morrith (1997) found that half of the respondents found their caregivers to be "very supportive" after the disclosure of sexual abuse while 25% found their caregivers to be "very unsupportive." Contrary to other research findings, Bruce-

Morritt (1997) found only 25% of the participants to have experienced adult rape. She also found, against her stated hypothesis, that there was no connection between level of adult ethnic identity development and history of childhood sexual abuse.

Millet (1997) conducted interviews with 40 casemanagers who provided individual and group services to sexual trauma survivors that were primarily African American. When reporting their experiences of working with this population, the casemanagers cited the complex issue of experiencing oneself as an African American female “victim.” Such complexity was manifested in the naming and actual language that was used by the clients, who often rejected the traditional terms that are used in sexual assault assessment. It was also shown through the indifferent and controlled façade that the clients often portrayed in an effort not to appear weak. Moreover, the clients clung to their family and community care-taking roles, which were part of their self-worth as Black women, often at the expense of their own needs.

West (1999) conducted qualitative interviews with Black women survivors of rape and childhood sexual abuse. She (1999) found her interviewees to be impacted in the following ways: 1) questioning their belief in God, 2) experiencing great anger but not knowing how to express it, 3) feeling powerless and invisible, 4) losing their sense of themselves not only as women but as Black women, 5) experiencing fractured community ties and 6) experiencing self-erasure/suppression of selfhood. She (1999) describes the self-erasure as resulting from the range of methods a survivor uses to cope with the abuse which

may include dissociating from the immediate incident in the moment as well as from memories. Moreover, West (1999) found that sexual trauma existed on a continuum with racial trauma and degradation. One interviewee captured this through the following statement:

It feels the same. Being called nigger, being called nigger bitch in the street and having to deal with a racist white professor at my college. I feel powerless. It feels the same as having my father do what he did to me. I start to regress. I implode. I feel the same, as if it doesn't matter what I do or say, or what I think is wrong. There is nothing that I can do. (p. 67)

West (1999) refers to experiences such as this as the fused racial and gender consequences of sexual violence.

Wilson (1993, 1994) conducted interviews with Black female survivors of incest. She (1993, 1994) found that many of her interviewees "survived" this trauma at the expense of their emotional selves. Wilson's (1993, 1994) interviewee's displayed symptoms of depression, difficulties in interpersonal relationships (particularly with men), and road blocks in their careers despite their level of education. She (1993, 1994) draws from her research findings, as well as her own experience as an incest survivor, to suggest the following:

As Black women, we are all too painfully aware of the injustices that are perpetrated against our communities of colour. We know what it will mean for a brother if we report a crime of rape or incest. Everytime this occurs we are faced with having to weigh the consequences to us and to our communities of colour. You wonder, is it worth exposing our communities and our men to further harassment? Will we be believed by those within and without? Will it reinforce long entrenched prejudices about what we are like as black people sexually?

Wilson's (1993,1994) words poignantly capture the fears and concerns that have surfaced from the small body of research on Black female survivors, as well as the issues that have been raised in theoretical arguments on this topic.

More recently, West, Williams, and Siegel (2000) interviewed 113 Black women with documented histories of childhood sexual abuse. They (2000) sought to obtain information on the frequency of sexual abuse in childhood and adulthood, identify characteristics that may be used to predict revictimization, and clarify some differing findings in previous research. Although previous researchers have agreed that incest survivors were between 2 times as likely (Russell, 1983) and 2.4 times (Wyatt, 1985; 1999) as likely to be victims of rape or attempted rape, research findings based on ethnicity differed significantly. In 1994, Urquiza and Goodlin-Jones found that Black female college students with histories of CSA, when compared to their White, Latina, and Asian peers, were more likely to be raped as adults. However, Wyatt et al., (1992) did not find any ethnic differences in revictimization rates in her community sample. West, Williams, and Siegel (2000) found that 30% of Black female CSA survivors they interviewed reported later revictimization. They (2000) also found that survivors who experienced more severe forms of sexual abuse (most often involving physical force) were more likely to be revictimized. These findings are consistent with revictimization rates in the general population (Wyatt, 1992; Wyatt, 1999). West, Williams, and Siegel (2000) also found that in their sample of Black survivors, some women, particularly those that were later revictimized, were more at risk for involvement in prostitution and partner violence. Such

women also reported a greater increase in serious reproductive health problems (West et al., 2000).

Washington (2001) conducted qualitative interviews with 12 Black women who experienced various forms of sexual violence. She (2001) believed that the recovery process would likely be different for Black survivors and sought to understand the impact of such violence, particularly regarding their disclosure patterns. Washington (2000) also believed that there are “historical and contemporary differences in the resources available to Black survivors” (p. 1254) and used her study to better understand Black women’s willingness to access such resources and the services they receive when they do. Washington (2001) found that 7 of the 12 participants waited between 3-25 years to disclose the abuse. Of those seven, two maintained their silence until they participated in her study. Additionally, Washington’s (2001) found common themes amongst the barriers that most often kept her participants from disclosing, which included: 1) inadequate or inappropriate sexual socialization, 2) community of origin issues stemming from real or perceived White racism, 3) belief in the “strong” Black woman and “weak” White woman dichotomy, 4) historical and lived memory of racism in the criminal justice system, and 5) White dominated helping professions. Washington (2001) argues that such barriers negatively affected her participants’ recovery process and should be taken seriously by mental health providers.

In 1997, Banyard, Williams, Siegel and West (2002) re-interviewed 87 women from the original Women’s Study, a study which began following female

CSA survivors and a comparison sample in the early 1970's. Eighty-nine percent of the participants interviewed in 1997 were Black women. They (2002) found that when compared to the non-abused group, the survivors experienced higher levels of anxiety, depression, dissociation, sexual concerns, intrusive symptoms and an impaired sense of self. Survivors that reported being blamed for the abuse when they disclosed also reported higher levels of dissociation. Additionally, survivors who reported more force in their experience of CSA also reported increased symptoms of depression, anxiety, and sleep disturbances. Banyard et al. (2002) also found that women who were abused by a family member were more likely to report mental health symptoms. Increased levels of anxiety and heavy drinking in adulthood were also found amongst survivors who experienced multiple incidences of abuse, as well as amongst survivors who were older at the time of abuse. Banyard et al. (2002) make suggestions for intervention, based on their findings in this sample of mostly Black women. They (2002) recommend that clinicians establish cultural competency, conduct a thorough trauma assessment, encourage a strong support system for survivors, and develop a treatment plan that attends to the client's race, social class and sexual orientation.

Several Researchers have also looked at the ways in which sexual trauma and survivors of sexual trauma are viewed within African American Communities. As African Americans often rely on their community for emotional strength (Abney & Priest, 1995; Daly, Jennings, Beckett, & Leashore, 1995; California Black Women's Health Project, 2002; National Survey of Black Americans, 1996), this is a crucial factor in understanding how Black female

survivors may be impacted by trauma. Thompson and West (1992), in their community sample of 155 African Americans from the St. Luis area, found that participants were mostly (63%) able to identify short and long term sequelae of sexual trauma and did not generally view survivors as responsible for the rape. Yet, despite acknowledging the need for counseling following a rape, the majority of participants (51%) recommended treatment from a physician, in lieu of specific sexual assault treatment teams or victim's services programs. They also cited reasons that might deter them from seeking treatment, including fear of not being believed, distrust of possible police or judicial involvement, and perceptions of agencies as uncaring towards African Americans.

Sapp, Farrell, Johnson, and Hitchcock (1999) interviewed 230 students at a predominantly Black university. They (1999) found that compared to Black women, African American men held more gender role stereotypes about rape. Additionally, Sapp et al. (1999) found that sexist attitudes concerning rape exist more in African American male college students than their female peers. Carmody and Washington (2001), in their sample of 250 college women, found that ethnicity did not appear to affect the endorsement or rejection of rape myths. They (2001) did, however, find that Black women endorsed the following rape myth significantly more than White women:

If a woman gets drunk and has intercourse with a man there, she should be considered fair game to other men at the party who want to have sex with her.

Carmody and Washington (2001) suggest that Black women's endorsement of this myth may be linked to the historical persecution of Black

men falsely accused of rape and any subsequent questioning of the validity of rape situations. Interestingly, White (1999) found that Black women's level of racial identity development played an important role in their attitudes regarding rape. She (1999) found that preencounter racial attitudes, defined by Cross (1991, cited in White, 1999) as the stage in which individuals devalue their Blackness and attempt to assimilate into White culture, were associated with high rape myth acceptance. Whereas, internalization of racial attitudes, defined by Cross (1991, cited in White, 1999) as the stage in which individuals develop a secure African American identity and flexible worldview, were associated with rape myth rejection. She also (1999) found that Black women who identified as activists rejected rape myths and had more highly developed racial identities. Further, a victim's belief in her culture's rape myths is likely to influence her recovery (Walker, 1996).

Coping with Sexual Trauma

A thorough understanding of the ways in which survivors are impacted by sexual trauma leads us to question how survivors cope with such trauma. Coping behaviors have been consistently found to be linked to psychological health and also mediate the relationship between stress and psychological health (Neville & Heppner, 1999). Meyer and Taylor (1986; as cited in Neville & Heppner, 1999) defined coping as, "cognitive and motoric activities that a victim uses to master, redo, or recover from the characteristic symptoms of emotional distress that may develop after rape" (p. 1226). Because sexual trauma confronts individuals with

affects and meanings that are extremely difficult to manage, it presents a significant coping challenge (Wolf & Alpert, 1991). Traumatized people are often reluctant to seek help of any kind, especially psychotherapy (Herman, 1992). When survivors do seek treatment, they appear with a disguised presentation, such as severe relationship difficulties, problems with intimacy, excessive responsiveness to the needs of others and repeated victimization (Davies & Frawley, 1994; Herman, 1992).

Burgess and Holstrom (1979) were some of the earliest researchers to empirically investigate post-rape coping strategies. They (1979) conceptualized coping as adaptive strategies, most often defense mechanisms, that were created by the survivor to protect themselves from fear, depression, and other types of post-assault distress. Burgess and Holstrom (1979) found that adaptive strategies comprised of positive self assessments, minimization of the impact of the rape, and either suppression of the rape experience or ongoing discussion of the rape and their reaction to the trauma. Maladaptive strategies comprised of negative self-assessments, social withdrawal, attempting suicide and alcohol abuse.

Coping strategies can also be conceptualized as automatic actions that are experienced by a person as mechanisms over which they have no control (Miltenberg & Singer, 1997). Miltenberg and Singer (1997) write that survivors possess an inner logic that allows them to cope with day to day life. This logic, they (1997) argue, relates to their own survival and allows them to regulate their own emotions based on the outside world. Miltenberg and Singer (1997) suggest that one common way of coping is through splitting or dissociation. When

survivors dissociate they can observe what is going on around them without actually feeling anything. Interestingly, Miltenberg and Singer (1997) turn widely accepted beliefs about splitting and dissociation on their head. Splitting and dissociation, often viewed as negative coping strategies, are viewed as normal coping strategies used by all people and considered a form of active coping for survivors (Miltenberg and Singer, 1997).

Herman (1992) argues that with satisfactory coping, one recognizes a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory and from stigmatized isolation to restored social connection. She (1992) suggests that the management of and coping with trauma occurs in three stages: 1) the establishment of safety, 2) remembrance and mourning and, 3) reconnection with ordinary life. Similarly, Davies & Frawley (1994) believe that in order for successful coping to occur, recognition and mourning of the loss must also occur. They (1994) describe the mourning period as a long working through process, involving both intense rage and pain.

Burt and Katz (1987) studied 113 rape victims to determine their attributions, coping strategies and the effects on their recovery. They identified five major types of coping strategies (a) avoidance, in which women used strategies to make the rape go away in their minds; (b) expressive, in which feelings were encouraged; (c) nervous/anxious, in which high anxiety symptoms predominated the response; (d) cognitive, in which women tried to get back to business by intellectually processing the trauma and (e) self-destructive, in which high risk-taking, cutting, and substance abuse predominated. They (1987) found

that the survivors that used expressive and cognitive strategies tended to report the most successful recovery. Interestingly, researchers such as Janoff-Bulman (1979; 1988 cited in Walker, 2000) found that self-blame was positively associated with recovery. She (1979; 1988, cited in Walker, 2000) argues that assuming responsibility enables the victim to gain control over the event. Most researchers (Frazier, 1990; Meyer and Taylor, 1986), however, have found that self-blame is associated with poorer outcome.

Morrow and Smith (1995) investigated the personal constructs of survival and coping of 11 women who had survived sexual abuse. They used in-depth interviews and data from a 10-week focus group to generate more than 160 different coping strategies. Morrow and Smith (1995) coded and analyzed the coping strategies and used such strategies to create a theoretical model. They (1995) found that all of the survivors in the study (a) experienced feelings of helplessness, powerlessness, and lack of control and (b) were overwhelmed by feelings they experienced as threatening or dangerous. Moreover, the methods of coping were often mediated by the duration, frequency, and intensity of the above-mentioned feelings.

Morrow and Smith (1995) cited specific examples of coping which included: (1) taking care of others (e.g., to keep from feeling one's own feelings, (2) use of substances such as alcohol, cigarettes, food, or drugs to numb the feelings that arose, (3) intellectualizing and isolating themselves from emotion, (4) embracing prayer and spirituality and/or turning against organized religion and/or raging against God, (5) using self-induced physical pain to override

emotional pain, (6) using sex for validation, (7) use of humor, (8) artistic endeavors, (9) journal writing, (10) talking about feelings, (11) creating alternate personalities and fragmented parts of oneself, and (12) using “detective work” to search for outside evidence of the abuse. All 11 survivors in the Morrow and Smith (1995) project found the process of coping arduous and long. Several participants commented that they were barely surviving while others reported feeling empowered. Morrow and Smith (1995) argue that the common thread amongst these survivors is that they used methods that are not considered traditionally healthy coping styles (e.g., “spacing out”, intellectualization, etc.) to survive their trauma and eventually regain their lives.

Black Women's Coping Strategies

The various ways in which Black women cope with sexual trauma has received scant attention in the research (McNair & Neville, 1996; Russell et al., 1988; Robinson, 2002; West, 1999). This study uses the narratives of Black female survivors to add to the literature on coping. However, important contextual information can be gathered by examining the ways in which Black women cope with stress and trauma in general. For example, Neighbors (1986) as well as Babaur (cited in Jones, 1998) found prayer to be the most common coping response for African American adults. Neighbors (1986) found that African American's were much more likely to use prayer than Whites, and that this common method of coping was present across age and economic differences. Additionally, a 1985 study conducted by Harrison and colleagues (cited in Jones,

1998) found religious orientation and family closeness to be the top coping strategies among African Americans.

Black Women and Help-Seeking Behavior

To generate more comprehensive hypotheses about the ways in which African American trauma survivors cope, we can turn to the literature on help-seeking behavior. The patterns and expectations around help-seeking for African Americans are likely to influence how one copes with specific problems such as sexual trauma.

An early study by Sue (1977) found that African Americans utilize mental health services in ways that differ from other ethnic groups. African Americans tended to seek help for issues that were regarded as less personal (e.g., legal, school, social security, etc.) Therefore, he (1977) concluded that mental health service providers were viewed as referral sources and “ombudsmen.” Research from the National Survey of Black Americans (1996) indicates that the majority of Black women seek help from sources other than traditional mental health organizations (e.g., Black churches, beauty shops, sister circles and respected elders within the Black community). When Black women do seek help from traditional mental health agencies, it is generally not until a crisis occurs (Neal-Barnett & Crowther, 2000).

Abney and Priest (1995) also found that African Americans are more likely to seek help from family, friends, ministers, or family doctors rather than professional mental health services. Similarly, Daly et al. (1995) found that when

confronted with stressful situations, African Americans relied on “group derived ego strengths” such as family, community, and social support networks. They (1995) also found that African Americans often relied on metaphysical approaches to coping based on religious and or spiritual beliefs. Further, Lincoln and Masumiya (1990) argue that studies with African Americans have consistently revealed the importance of spirituality and the central role of the church in the social lives of African Americans. They specifically cite their own study of stress, adaptation and depression, which took place within a southern Black community. The study revealed that two of the four coping strategies that were used involved religion. The most commonly used strategy was religious or spiritual beliefs which were followed by religious participation.

An important study in the area of African American help-seeking behavior is Mathews and Hughes (2001) study of help seeking among African American lesbians. Such research is particularly important for many reasons, including the paucity of studies on Black lesbians and lesbians of color in general. However, this study is especially useful because of the contrast between research that shows high help-seeking behavior among lesbians (most studies have been done on White lesbians) and the research that shows low help seeking behavior among African Americans. In their (2001) study, 110 Black women were interviewed—70 lesbian women and 40 heterosexual women. The lesbian women in the study were far more likely than the heterosexual women to have received counseling or therapy in the past.

Interestingly, only lesbians in the Mathews and Hughes (2001) study reported seeking treatment for reasons related to sexual abuse (22% vs. 0%). Approximately one-fifth of the lesbian women reported seeking treatment for reasons related to sexual identity. The most commonly reported reasons for seeking treatment among participants, regardless of sexual identity, were feelings of sadness or depression, problems with family, issues related to self-esteem, and problems with romantic partners. Another interesting finding is that the majority of both lesbian and heterosexual participants indicated a preference for an African American therapist. The participants most often sought out therapists in private practice (Mathews and Hughes, 2001).

Black Female Trauma Survivors and Help-Seeking Behavior

As with overall help-seeking patterns, the research findings of Sanders, Thompson and West (1992), suggests that in cases of sexual abuse, treatment and crisis intervention services are underutilized by African Americans. They (1992) found that participants 1) feared not being believed, 2) distrusted police and the judicial system, and 3) perceived agencies as uncaring towards African Americans. This finding is not shocking, as women of color are less likely to see their rapist convicted (Crenshaw, 1993). The average sentence given to the rapists of White women was 10 years, while the average sentence for men convicted of raping Black women was 2 years (Crenshaw, 1993).

Taylor (2000), in her study of Black female survivors of interpersonal violence, found that survivors who sought group therapy found it helpful.

However, despite finding the benefits from such treatment, they often felt unwelcome in groups of mixed ethnicity. When choosing which group to attend, the majority of the women took race and social class into consideration, citing that they felt more comfortable with women who could deal with the complexity of their lives (Taylor, 2000). They explained:

I know that a lot of the groups are very White and I see my issues as very different from White women.

It [being in a Black women's group] is awesome. It really makes a difference to have a reflection of myself, whereas in the past I have had to sit across from White women and have to deal with how they are thinking about what I am saying, now what do they think, did I feed into any of the myths and stereotypes.

It's important for me to be around Black women because other races seem to stereotype and they don't really know, you know. And it's also, I feel like when I'm helping another Black woman I'm helping myself.

The thread that runs through these testimonies appears to be concern about seeing issues differently from White women, as well as sharing and receiving strength from other women of color.

When questioned about seeking treatment, the women in Taylor's (2000) study also expressed concern about the quality of the therapeutic process when cultural misunderstandings were present. The survivors also reported that they surrounded themselves with other women of color, particularly Black women to aid in the healing process.

Participants in the Taylor (2000) study also explained that being the one woman of color in a support group reinforced their feelings of shame and isolation—that they were indeed the “only abused women of color.”

Additionally, participants in women of color groups saw themselves as strong in a

positive way, rather than as the fulfillment of a stereotype. Taylor (2000) writes that they saw themselves as being in the group “not because they were weak, but because they wanted to remain strong. Interestingly, remaining in women of color groups became less important to many of the women as they received the initial foundation of support from the women of color group. Taylor’s (2000) study documents the experience of Black women disclosing sexual trauma in the presence of other Black women, as a crucial component of the recovery process.

Similarly, Millet (1997) found that when Black survivors did seek help, many found it useful to listen to the survival stories of other Black women. In some instances, the casemanagers Millet interviewed used this knowledge to incorporate narratives of African American female survivors (Maya Angelou, June Jordan, etc.) into their individual and group work. It was reported that in such cases, clients found it empowering to draw similarities between themselves and the writers. This appeared to facilitate a better emotional transition from victimization to recovery (Millet, 1997).

In Wyatt’s (1992) study, less than five percent of the women received any kind of counseling for their sexual trauma. The participants specifically reported not seeking help due to fears that their experiences would not be considered “real rape,” and/or that they would not be viewed as victims by society. When the survivors in Wyatt’s (1992) study did receive counseling, they often terminated prematurely because they believed that the therapeutic plan focused mainly on aspects of their lives that they could not change.

Resiliency

Resilience Factors Observed in Sexual Trauma Survivors

Many sexual trauma survivors, despite the traumatic impact mentioned above, are able to work through the trauma and lead lives that do not include repeated victimization, severe psychopathology, and abuse of others (Banyard et al., 2002; Grossman et al., 1999; Valentine & Feinauer, 1993). Such women, who are often able to establish secure and consistent personal relationships and careers, can be considered resilient. It is important to study what contributes to such resilience, as that information can be used to encourage survivors who are in the process of healing, and also to develop more successful treatment plans.

Resilience is generally understood as the ability to do well despite a history of serious stress or trauma. Luther and Zigler (1991) describe resilience as the ability to defy expectations and develop into a well-adapted individual in spite of serious stressors in one's life. In other words, a resilient individual has demonstrated the ability to "bounce back" from adversity. Moreover, they possess a flexibility that allows them to successfully meet the various challenges of their life situation (Grossman et al., 1999). Consequently, characterizing a trauma survivor as resilient does not suggest an absence of experiences such as depression, anxiety or other PTSD symptoms (Grossman et al., 1999; Valentine and Feinauer, 1993). What the label suggests is an ability to manage and navigate such experiences in a way that demonstrates self-determination and strength. Along the same lines, a trauma survivor may demonstrate resilience in one area and a lack of resilience in another, as success in coping with one task does not

necessarily guarantee anyone's (survivor or not) ability to cope well with other tasks at the same time or the same task at a later time. This underscores the way in which resilience must be understood as an overarching strategy, style, or process that survivors use to make sense of what has happened to them and to cope with traumatic feelings when they arise.

Valentine and Feinauer (1993) specifically looked at resilience in CSA survivors. They used a sample of 22 adult White female CSA survivors. Of the 22 women, all were currently employed and none were or had been institutionalized in hospitals, prisons, shelters for homeless or battered persons. The themes of resilience that surfaced were: the ability to find emotional support outside of the family; high self-regard; religion or spirituality (note that the sample was predominantly Mormon); external attribution of blame and an internal locus of control. The majority of the women indicated that they were able to find at least one caretaker (parent, grandparent, or other adult) with whom they could establish a close bond. Those participants cited that having someone believe in them helped them to believe in themselves. They cite that such support helped them to move away from home, attend school, start a career and get into healthy relationships and out of bad ones.

Valentine and Feinauer (1993) explain that the participants in their study had attributional styles that were quite noteworthy. Despite having difficulty with or simply being unable to make sense of the abuse as a child, they were eventually able to place the blame outside of themselves. They were eventually able to figure out that the perpetrators were "crazy," "sick," or "users." They also

seemed to recognize that the abuse would end. Valentine and Feinauer (1993) also noted that their participants possessed a positive “philosophy of life.” The researchers (1993) suggest that such points of view enabled them to view the abuse as a challenge instead of an insurmountable stumbling block. Although all participants reported struggling with guilt, depression, difficulty trusting others and establishing intimate relationships, low self-worth, patterns of people pleasing and feeling overly responsible for others at various points in their lives, they stressed that such experiences did not rule their lives.

Spacarelli and Kim (1995) examined resilience in a sample of 43 sexually abused girls (ages 10-17) presenting for psychotherapy intake in the Phoenix area. They (1995) defined resilience as the maintenance of social functioning at a rate comparable to their peers and the absence of symptomatology, specifically anxiety, depression and self-destructive behavior. Spacarelli and Kim (1995) found that resilient girls reported greater warmth and support from the non-offending parent and were less likely to cope by seeking to aggressively control others. They (1995) also found that lower levels of abuse related stress (e.g., disclosure-related stress, adjudication related stress, etc), and fewer negative cognitive appraisals of the abusive relationship were significant predictors of resilience. Interestingly, they (1995) found that parents of abused girls rated their daughters as significantly more resilient than their daughter’s self-report measures demonstrated.

Liem, James, O’Toole, and Boudewyn (1997) analyzed data from a sample of 687 undergraduate students and found that severity of sexual abuse did

not correspond to the level of resilience demonstrated by their participants. They (1997) did, however, find that the non-resilient sexually abused participants were more likely to report the use of overt physical force. The experience of CSA was also more distant (19.4 vs. 15.9 years) for those in the resilient group. Liem et al. (1997) also found that the resilient group had more internal vs. external attribution styles, were more likely to have had less stressful environments (divorce, death, family illnesses, etc.), and were less likely to blame themselves for the CSA. Interestingly, they (1997) also found that resilient survivors in their sample were no more likely than the non-resilient to disclose the abuse. The resilient survivors, however, were less likely to have sought psychotherapy as adults. They (1997) believe this suggests that resilient individuals experienced healthy adjustment without the need for psychotherapy.

Grossman et al. (1999) conducted a study of 10 adult female CSA survivors who considered themselves resilient. Their (1999) sample was diverse in terms of age, ethnicity (two of the participants were African American), type of sexual abuse, social class, and religion. Grossman et al. (1999) measured their current life adaptation (Subjective Life Adaptation Questionnaire), their history of abuse using Diane Russell's (1986) abuse interview, and the resiliency interview they (1999) developed specifically for this study. Grossman et al. (1999) found that each woman, despite having struggled with the difficulties Valentine and Feinaeur (1993) described above, showed tremendous signs of resilience.

Grossman et al. (1999) were most interested in identifying the ways in which their participants possessed resiliency related processes. These processes

included 1) having authority over one's memory, 2) tolerance of strong feelings, 3) integration of memory and emotions, 4) mastery over symptoms, 5) ability to make safe attachment relationships, and 6) the capacity to find meaning in the trauma. They (1999) found that their participants did indeed possess such processes, as well as a profound ability to reframe experiences. Like Valentine and Feinaeur's (1993) participants, Grossman et al.'s (1999) participants cited support from a caring adult during their upbringing as a buffer against the traumatic feelings. Of the 10 participants, eight of them felt that an adult had noticed their pain and tried to intervene or protect them. Additionally, the women cited familial support for their academic achievement, as well as their work success, as particularly helpful.

Interestingly, Grossman et al. (1999) compared the strategies that were used to cope with trauma as children to the ones that the participants currently used. They (1993) found that as children, participants used distancing, avoidance, somatization, hiding feelings and vivid fantasy lives to cope with CSA. Grossman et al. (1999) view these coping strategies as resilient within the context of sexual trauma because they kept the survivor alive. They (1999) argue that as participants grew older they realized that these strategies were no longer protecting them but inhibiting their growth. As adults, the participants in Grossman et al.'s (1999) study demonstrated resilience through 1) use of individual psychotherapy to make meaning of the abuse, assist with tolerating strong emotions and to reframe the experience, 2) group work with other

survivors, 3) self-care (meditating, exercising, yoga, etc.), 4) practicing religion or spirituality, and 5) using humor.

Resilience and Black Female Sexual Trauma Survivors

Many Black female survivors are very resilient and do not exhibit long-term negative consequences as a result of their trauma (Banyard, Williams, Siegel, & West, 2002; Hyman & Williams, 2001). However, there have only been two studies to date that have looked at resilience in African American survivors of sexual violence. This gap in literature can be attributed to the lack of research conducted on the strengths of Black women, as well as the lack of research on African American survivors of sexual trauma.

Both Hyman and Williams (2001) and Banyard et al. (2002) used participants from The Women's Study (which began following CSA survivors in the early 1970's) to examine resilience in African American CSA survivors. The Women's Study sample comprised mostly of African American girls (84%) who were between 10 months and 12 years old at the time of the abuse. Hyman and Williams (2001) defined resilience as, "physical health, mental health, interpersonal relationships, adherence to community standards, and economic well being" (p.203) and Banyard, Williams, Siegel and West (2002) used this definition as well. In total, 136 women were interviewed and it was found that 52% of the participants (71 women) demonstrated poor or fair resilience. Twenty-nine percent of the participants (40 women) exhibited good resilience and 18% of the participants (25 women) demonstrated excellent resilience. It was also demonstrated that neither age at the time of the abuse or the experience of

genital penetration was associated with level of resilience. Additionally, it was discovered that the experience of abuse-specific therapy was not significantly associated with high resilience. However, high resilience was associated with the absence of severe physical abuse, parents with no substance abuse problems, graduation from high school and a relatively stable family life. It also appeared that in the group of more resilient women, social support from someone they deemed special and significant was an important protective factor.

Summary of Literature Review and Research Questions:

To facilitate a close analysis of Black women's narratives of trauma and survival, I have chosen the above mentioned theoretical domains, which includes the general literature on the prevalence and impact of sexual trauma, specific literature on the prevalence and impact of sexual trauma on Black women, and the research and theoretical arguments concerning the unique challenges that Black female survivors of trauma face. To build upon the research on prevalence and impact, I have also reviewed the various coping styles of trauma survivors (both White and African American) and the characteristics of resilience that have been detected in survivors thus far.

The overall findings suggest that both CSA and adult rape are serious societal problems that effect approximately 34% of women (Wyatt et al, 1999) and 27-34% (Finkelhor, 1994; Russell, 1983) of women respectively. The findings also suggest that there are common psychological sequelae associated with both CSA and adult rape which include anxiety, depression, low self esteem,

difficulties with intimacy, self destructive behavior, and tendency towards revictimization and substance abuse (Browne & Finkelhor, 1986; Herman, 1992; Walker, 2000). Moreover, the findings suggest that both CSA and adult rape are significantly underreported (Wyatt et al., 1999).

The reviewed literature also suggests that Black women report greater long term effects of abuse and are more likely to be abused at the severe level (Russell, Schurman, & Trocki, 1988). The literature also suggests that Black women are more likely to be victimized in a private location (Wyatt et al., 1999). Additionally, Black women and their families are less likely to report incidences of CSA and/or rape to the police and social service agencies than White women (Abney & Priest, 1995; Wyatt et al., 1990). Further, Black women with histories of CSA are more likely to be raped than their White counterparts (Urquiza and Goodlin-Jones, 1994). Much of the literature also calls for additional research on the unique ways in which sexual trauma is experienced by Black women and the ways in which such differences may vary from the majority of research findings on trauma survivors thus far (Priest, 1992; Robinson, 2000; Russell et al., 1988; West, 2002; Wilson, 1993; 1994). This study has sought to answer this call by using data gathered from the narratives of Black female sexual trauma survivors to generate theory about the experiences of such women, thereby enhancing trauma theory and making its application more appropriate for Black women.

The literature review above has led this researcher to the following research questions:

1. What are the strategies that resilient Black female sexual trauma survivors use to cope with the experience of trauma?
2. What characteristics contribute to their resiliency?
3. In what ways are these women impacted (intrapsychically, interpersonally, physically, spiritually and intellectually) by sexual trauma?

I have used these questions to guide the development of an in-depth qualitative interview (see appendix C) which will be discussed in detail in the methods section.

CHAPTER III

Methodology

Sampling

All of the participants in this study were screened over the telephone prior to being accepted for the study. I asked each prospective participant the following six questions: 1) have you ever participated in psychotherapy, 2) are you currently employed or a full-time student, 3) are you currently in or have you ever been in a committed romantic relationship, 4) do you have a support system (e.g., close friends, family), 5) are you currently suffering from depression, anxiety or any other severe psychological disorder, and 6) do you consider yourself resilient.

The first question (regarding participation in psychotherapy) was a requirement of the City College Institutional Review Board (IRB). The IRB stipulated that all participants in this study were required to have participated in psychotherapy. Thus, participants that had not been in psychotherapy were immediately disqualified from the study. If the prospective participant answered affirmatively to the first question, they were asked the subsequent five questions, given more information about the study and, if interested, an interview was scheduled. Five prospective participants were not included in the study because they had not participated in psychotherapy. One participant that originally met the criteria was not used for the study because she developed a serious medical illness. Ultimately, all of the participants in the final pool were currently employed, college educated, and reported a consistent history of and/or current

intimate relationships and close friendships. They also reported an absence of severe psychopathology. Additionally, all of the participants in this study considered themselves resilient.

This study utilized purposeful sampling as a method of obtaining participants. The sampling was purposeful sampling (Patton, 2002; Strauss and Corbin, 1998) because of the specificity of the research question. With this type of sampling, the researcher chooses persons that will maximize opportunities for comparative analysis, as well as “information-rich” cases that enable to one to learn about issues of central importance to the purpose of the research (Patton, 1990; 2002). Thus, this sample consisted of women who define themselves as Black women, who have a history of childhood sexual abuse or adult rape, who are at least eighteen years of age, and who have demonstrated signs of resilience.¹⁰ Snowball/chain referral sampling was used to identify participants who were relevant to this study. Individuals who knew survivors (either colleagues or, in the case of therapists, patients) that might be willing to participate were asked to refer prospective participants to the study. I also utilized the strategy of convenience sampling, by advertising the study in publications, on websites and at conferences focused on violence against women of color.

¹⁰ This was measured by factors such as stable and consistent interpersonal relationships, career success,

Description of Participants

Table 1 presents the characteristics of the participants and their sexual traumata. The participants ranged in age from 22-48. All participants self-identified as Black women, although two were bi-racial (White mother, Black father, in both cases). Three of the participants identified more specifically as Caribbean American (one was born in Honduras and raised in the U.S., another was born in Haiti and raised in the U.S., another was born in Jamaica and came to the U.S. as a young adolescent). One participant had a Caribbean father and an African American mother, she was raised mostly in the United States, but spent some of her growing up in Trinidad. The remaining participants had both parents that were African American. Ten of the twelve participants had completed college, and two participants had attended, but not completed, college. And three of the ten participants that completed college were currently attending graduate school (2 doctoral candidates, 1 MBA student). One of the ten participants that completed college also completed medical school. The participants represented a variety of professions, including: filmmaking, photography, journalism, medicine, business, and social services/mental health.

Five of the participants identified as lesbian and seven identified as heterosexual. The majority of the participants were raised in working-class and middle-class homes, although the majority of the participants (with the exception of 2 graduate students) described themselves as currently living comfortably, exceeding the socio-economic status of their upbringing. Although the majority

Table 1

Participant Characteristics

| Subject | Age | Ethnicity | Sexual Orientation | Level of Education | Profession | Type of trauma | Perpetrator |
|---------|-----|--------------------------------------|--------------------|--------------------|-------------------|--|---|
| 1 | 26 | African American/ Caribbean American | Heterosexual | Ph.D. Candidate | Graduate Student | 1. Molestation 2. Acquaintance rape 3. Acquaintance rape | 1. Female Babysitter 2. Boyfriend 3. Acquaintance |
| 2 | 29 | African American | Lesbian | BA | Business | Molestation | Older Male Neighbor |
| 3 | 30 | African American | Lesbian | MD | Medicine | Acquaintance rape | High School Boyfriend |
| 4 | 37 | African American | Heterosexual | BA | Journalism | Molestation | Uncle |
| 5 | 22 | African American | Heterosexual | BA | Education | 1. Incest 2. Rape | 1. Step-father 2. Cousins |
| 6 | 34 | African American | Heterosexual | BA | Journalism | Rape | Two Strangers |
| 7 | 30 | Caribbean American | Heterosexual | Ph.D. Candidate | Dance | Incest | Father |
| 8 | 31 | African American | Lesbian | AA | Filmmaker | 1. Incest 2. Acquaintance rape | 1. Grandfather 2. Date |
| 9 | 30 | Biracial (African & White American) | Lesbian | BA | Education | Molestation | Uncle |
| 10 | 34 | Caribbean American | Lesbian | BA | Photography | Molestation | Uncle |
| 11 | 48 | Biracial (African & White American) | Heterosexual | BA | Author/ Professor | 1. Molestation 2. Molestation 3. Acquaintance rape 4. Stranger rape | 1. Neighbor 2. Neighbor 3. Date 4. Stranger |
| 12 | 25 | Caribbean American | Heterosexual | AA | Student | 1. Childhood Sexual Abuse 2. Molestation | 1. Neighbor 2. Neighbor |

of the women identified as spiritual rather than religious (mixing a variety of spiritual & religious rituals), two identified as practicing Muslims and four identified as practicing Christians.

All participants were provided with a list of referrals for psychotherapy, rape crisis counseling, and 24-hour hotlines, which was a requirement of the City College IRB. Of the twelve participants, seven reported solely experiencing incidences of childhood sexual abuse/molestation by members of their nuclear families, extended families, neighbors, and boyfriends of their mothers. One reported solely experiencing adult sexual assault (stranger rape). Four participants reported experiencing both CSA and adult sexual assault (see Table 1).

Recruitment of Participants

Participants were recruited through advertisement in college mental health centers, rape crisis and anti-violence centers, and journals and newsletters that are geared towards survivors of sexual trauma and/or Black women. Six African American psychologists that practice in New York City and New Jersey were also contacted, as well as one White New York City psychologist that specializes in treating trauma survivors. They were also recruited via flyers displayed at conferences and events focused on sexual violence within the African American Community. The flyer had the following heading: “Women are needed for a Research Study at City College.” It then stated the following, “We are conducting a study to understand the coping strategies of Black women who have been sexually abused in childhood and/or adulthood. All interviews will be: 1)

individual, 2) 2 hours (approximately), 3) conducted at City University of New York (CUNY), and 4) conducted by a female Ph.D. candidate in Psychology, who has experience working in the area of sexual abuse.” The flyer also stated that participants must have had counseling or currently be in counseling for the abuse and that confidentiality and respect for the participants was assured. Prospective participants were asked to contact me if interested.

When I was contacted by prospective participants, the project was explained and the prospective participants were screened by phone. Each prospective participant was asked the six screening questions outlined above. They were also informed that there would be no financial compensation for participation in the study. If the participant agreed to participate, a time for the interview would be arranged at the convenience of the prospective participant. All of the participants but two requested to be interviewed in their own home. This request was granted. One participant preferred to be interviewed in her private office and another requested to be interviewed in a café-- these requests were granted as well. This was the only area in which the interview process deviated from what was advertised. This decision was made to respect the wishes and convenience of the participants, as there was no financial incentive for participating in the interview.

Materials

Three instruments were used in this study, the initial screening form, the interview guide, and the demographic questionnaire (see Appendix A, Appendix C, Appendix D, and Appendix E). An audiotape recorder and tapes were also

used. Additionally a phone adapter for phone audiotaping was used for several follow-up interviews.

Screening form.

The first instrument (see Appendix A) was the initial screening questionnaire that was used to determine whether prospective participants could participate in the study. This six item questionnaire was designed in part based on guidelines from the institutional review board of the City College of New York (e.g., had the participants been in psychotherapy) and in part based on questions to determine resilience. The creation of a short screening questionnaire was suggested by Peter Fraenkel, Ph.D., a member of the dissertation committee.

Interview guide.

The second instrument (see Appendix C) was the semi-structured interview that I designed specifically for this study. The interview is referred to as semi-structured because the interviewer can prompt for elaboration of important thematic material, as well as restate the question in different ways (Patton, 1990). The initial interview guide consisted of three major sections: 1) initial concepts of self, family and community (8 questions), 2) Disclosure of abuse and coping (13 questions), and 3) reflections on experience of trauma (15 questions). Each section was preceded by a short introduction (e.g., okay, now I'd like to ask you several specific questions about your experience of sexual trauma) to set the tone for the questions and/or serve as transitional statements. The questions were designed based on ideas gathered from an extensive literature

review and my clinical familiarity with the population of sexual trauma survivors. An addendum to the interview (see Appendix E) was added following the researcher's proposal defense, based on suggestions from the dissertation committee members.

Demographic questionnaire.

The third instrument used in this study (see Appendix D) was the demographic questionnaire. The 20 questions in the demographic questionnaire were adapted from Perry, Herman and van der Kolk's (1992) Traumatic Antecedents Interview, as it has been used on samples of sexual assault survivors. For the purpose of this study, the questionnaire was only used to gather data such as age, employment, socioeconomic status, and religious affiliation to provide descriptive information about the participants as a group.

Procedure

Ten of the first twelve participants were individually interviewed on two separate occasions. Participants were interviewed on two separate occasions in order to incorporate feedback from the first round of interviews and additional findings from the literature review into a second round of interviews. Along similar lines, Patton (2002) argues that "on occasion, gaps or ambiguities found during analysis cry out for more data collection, so, where possible, interviewees may be recontacted to clarify or deepen responses" p. 437. The last two participants were recruited following the first and second interview of the other participants, when all of the new questions had already been incorporated into the interview.

Each interview was tape recorded. To ensure confidentiality, each participant was assigned a number and that number was placed on the audiotape and on the written copy of the transcript. I then transcribed each interview verbatim. I also hired a transcriber to transcribe four of the interviews. Patton (2002) recommends that the researcher transcribe all or some of her interviews in order to immerse herself in the data and consequently generate emergent insights.

Prior to the first meeting I made arrangements with the prospective participant via telephone or internet about when and where to meet. As stated previously, the majority of participants preferred to meet in their own homes. One participant requested to meet in her private office and another requested to meet in a café. After these requests were granted, the prospective participant and I negotiated a time, and the prospective participant was informed that the interview would be audiotaped and given the approximate duration of the interview.

The first meeting was approximately 90-120 minutes in duration. At the start of the interview, the participant's confidentiality was emphasized and the subject was asked to review the informed consent (see Appendix B) with the investigator. During the review, the purpose of the study was reiterated and the subject was reminded that the interview would be audiotaped (with the tape stored securely and later destroyed) and that she could choose to no longer participate at any point in the interview. If the subject agreed she signed the consent and was given her own copy. Following that, the subject completed a 20-item demographic form (see Appendix D). The final four participants completed the

demographic questionnaire following the interview, a suggestion that was made at the researcher's proposal defense.

Following several minutes of "small talk" to develop rapport, I then commenced with questions from the semi-structured interview. (see Appendix C). At the close of the interview, all participants were asked to debrief by providing feedback and thoughts regarding the interview process. The debriefing process was also recorded on audiotape.

The second meeting took place approximately 13-15 months after each interview and was approximately 30-45 minutes in duration. In this interview, participants were asked a second series of questions in areas that had surfaced as themes from the previous wave of interviews (see Appendix E). Again, the participants were informed that the interview would be taped (safely secured and later destroyed) and that they could choose to no longer participate at any point during the interview. This set of questions focused on four different areas: (1) the impact of sexual trauma on the survivor's sense of self, (2) specific coping strategies used to survive sexual trauma, (3) whether or not the survivors viewed themselves as resilient, and if so, what factors contributed to their resiliency, and (4) what impact, if any, did the race of the perpetrator have on the survivor. After answering the questions, the participants were again invited to give feedback on the interview process and were reminded that they could receive a copy of the research when completed. Each subject expressed interest in receiving a copy of the completed document.

Qualitative Research

“People live by stories,” writes qualitative researcher and sociologist Davidman (2000): “They attempt to give shape to their lives by placing them within the available narrative frameworks of their culture and society” (p. 25). Further, individual women’s stories provide an excellent opportunity to understand the interactions of ethnicity, culture and victimization (Walker, 2000). Because my study sought to capture such interactions in an in-depth way, I chose to analyze the data qualitatively. Wainwright (1997) explains that, “generally, qualitative research can be characterized as the attempt to obtain an in-depth understanding of the meanings and ‘definitions of the situation’ presented by informants, rather than the production of a qualitative ‘measurement’ of their characteristics or behavior” (p. 20). Additionally, paying very close attention to the stories of each participant allows us to preserve the context of their lives (Grossman et al., 1999). Qualitative methods are particularly appropriate in research that aims to preserve the context of individual lives as well as generate theoretical questions about such experiences (Strauss and Corbin, 1998). Moreover, the ability of qualitative analysis to accommodate differences among participants is a particular advantage in studying this group, as I want to explore the similarities as well as the differences among African American female survivors. Black women are often studied as if they are one monolithic group which leads to generalizations and assumptions within the psychological literature.

Qualitative research, with its open-ended style of inquiry and attention to the experiences and voice of the participants, offers the perfect paradigm for investigating the traumatic experiences of Black women. The epistemological principles of this method of study emphasize the dynamic process of inquiry whereby the investigator, who functions as a participant observer, and her informants engage in a cross-cultural exchange, requiring the researcher to carefully and continually monitor her own assumptions in the process of gathering and interpreting data (Fetterman, 1989; Kidder & Fine, 1997). This approach allows the investigator to explore how each individual participant constructs meanings out of her own experience. Grossman et al. (1999) also argue that through qualitative research, investigators are able to “give voice to survivors, who have too often been silenced” (p.23).

Data Analysis

In qualitative research, data analysis requires the researcher to capture the complexity of the phenomena and make convincing sense of it (Strauss, 1989). In the case of this qualitative study, grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1998) was the guiding principle used to interpret the interview data. Grounded theory is a discovery-oriented methodology developed by the sociologists Glaser and Strauss (1967) during their research on terminal illness. Grounded theory allows for the development of theory that is not only “grounded” in the interviews and field memos of the researcher, but also guides the researcher’s focus on the ways in which people makes sense of and locate themselves in their own experiences (Henwood & Pidgeon, 2003). Strauss and

Corbin (1998) define the process of conducting grounded theory based research in the following way:

In doing our analyses, we conceptualize and classify events, acts and outcomes. The categories that emerge, along with their relationships, are the foundations for our developing theory. This abstracting, reducing and relating is what makes the difference between theoretical and descriptive coding (or theory building and doing description). (p. 66)

Charmaz (1995) writes that grounded theory methods:

Consist of a set of inductive strategies for analyzing data...you start with individual cases, incidents or experiences and develop progressively more abstract conceptual categories to synthesize, to explain, and to understand your data and to identify patterned relationships within it. (p. 28)

Moreover, the grounded theory method is unique among qualitative approaches, as it permits themes and concepts to emerge from the narrative material without the imposition of a pre-constructed framework (Patton, 2002).

The qualitative research software package Atlas-ti (Muhr, 1997), which is guided by the conceptual framework of grounded theory (Glaser & Strauss, 1967), was used to organize, manage and analyze the interview transcripts. Each transcript was uploaded separately into the software package and given numerical designation (e.g., primary document 1, primary document 2, and coded within the software system. The software system stores the primary documents, the codes given to data within the various primary documents (the most basic open codes as well as more complex codes), the frequency and groupings of such codes, and the theoretical memos in one storage unit (referred to as a "hermeneutic unit" by the designer of the program). The software system keeps a running list of the codes generated by the researcher, thereby allowing the researcher to select codes from her list as recurrent themes present themselves.

In the coding process, this researcher read each transcript in full (making meaningful notations in the margins of the transcript) and then proceeded with the following data analysis once the transcripts were uploaded into Atlas-ti (Muhr, 1997).

The analysis of data first involved dividing the transcripts into meaningful units. A meaningful unit is a “segment of the data which represents a separate idea, thought, theme, issue, observation, or process identified by the participant in the interview” (Bolger, 1999, p. 346). The units were then examined closely by the open coding method. Strauss and Corbin (1998) describe open coding as a process in which the data are broken down into discrete parts and concepts are identified. The concepts are either given a label generated by the researcher, such as ‘shame’ or ‘denial/minimization’, or given a label generated from the actual words and expressions of the participants, which is known as an “in vivo” code (Patton, 2002; Strauss, 1987). Strauss and Corbin (1998) refer to in vivo codes as “catchy terms that immediately draw our attention to them” (p. 113-114). In the present research, statements regarding the experience of sexual trauma, such as “for a long time I tried to write it off and not think about it” and “I think my coping was, like, suppression...not dealing with it or naming it as something else” were given the open code minimization/denial. Whereas, when participants recurrently discussed the ideas of “keeping busy,” and the desire to “keep going” and “keep moving,” the in vivo code “keep moving” was designated.

After coding the raw data, these data were compared and contrasted through the use of “constant comparison”(Glaser and Strauss, 1967), and placed

in higher order categories. In “constant comparison”, the data are sifted through carefully and compared and contrasted based on conceptual similarities or differences (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Lincoln and Guba (1985) describe this process as extracting units of information from each interview and comparing them with units of information in other interviews. In the present research, codes such as “heavy drinking” and “marijuana use” were noted as conceptually similar and given the higher order code “substance abuse”. In the same way, the conceptually similar codes “binge eating” and “restricting one’s diet” were given the higher order code “disordered eating”. Thus, the “constant comparison” method allows the researcher to become more familiar with the complexity of the data, and consequently yields categories which can be further sorted and grouped in a more abstract way. This process, which is highly interactive, is “central to promoting dense conceptual development” (Henwood & Pidgeon, 2003, p. 141).

I used the “constant comparison” process to not only group conceptually similar codes (e.g. “binge eating” and “restriction of one’s diet”), but to assist in the development of axial codes. Unlike open codes, which identify and break part the data, axial codes bring the data back together in a more conceptually sophisticated way (Strauss & Corbin, 1998). Conceptually, axial coding involves asking questions about the ways in which the identified open codes are related and systematically sorting out these relationships. The categories that arise from axial coding represent phenomena, which Strauss and Corbin (1998) define as “repeated patterns or happenings, events or actions/interactions that represent

what people do or say, alone or together, in response to the problems and situations in which they find themselves” (p. 130). For example, the previously mentioned open code “minimization/denial” was coupled with other open codes such as “promiscuity” and “disordered eating” to form the axial code of “negative coping strategies.” Therefore, in this sample, “negative coping strategies” is a phenomena associated with the process of surviving sexual trauma.

The next step in the data analysis was selective coding. With selective coding, all of the categories and subcategories become linked to one or several core categories of the research project (Strauss, 1987). This is the process of generating or “grounding” theory. Strauss and Corbin (1998) describe selective coding as the process of “integrating and refining the theory” (p. 161). By grouping the axial categories and referring to the theoretical memos that were written throughout the data collection and analysis processes, this researcher was able to generate four selective categories. These selective categories were used to organize the presentation of the results in Chapter IV and to serve as building blocks for the theory presented in Chapter V.

Methodological Soundness

The methodological soundness of a qualitative study is judged differently than that of a quantitative study. The concept of reliability, which in quantitative studies most often refers to whether or not the study is generalizable, is measured differently in qualitative studies. Hammersley (1992; cited in Altheide & Johnson, 1998) argues that in qualitative research “an account is valid or true if it represents accurately those features of the phenomena that it is intended to

describe, explain or theorize” (p. 288). He (1992; cited in Altheide & Johnson, 1998) explains that in order to demonstrate such soundness, researchers must carefully and clearly delineate all of the research activities, including “accounts of the interactions among the context, researcher, methods, settings, and actors” (p. 292).

Similarly, Patton (2002) puts forth criteria to determine the soundness of a qualitative study. He (2002) argues that soundness should be judged by “substantive significance,” which includes asking the following questions: 1) how solid, coherent, and consistent is the evidence in support of the findings, 2) to what extent and in what ways do the findings increase and deepen understanding of the phenomena studied, 3) to what extent are the findings consistent with other knowledge, and 4) to what extent are the findings useful for some intended purpose (e.g., contributing to theory, informing policy, etc.).

This study used both Hammersley’s (1992; cited in Altheide & Johnson, 1998) and Patton’s (2002) criteria as guidelines for judging methodological soundness and credibility. First, soundness and credibility were ensured through a thorough documentation of all research activities. I provided detailed accounts of the ways in which I gained access to this population, the gathering of information (data collection and recording), and the ways in which I conceptualized the data (data coding, analysis and theory building). Additionally, I provided detailed accounts of the actual population. Such detailed accounts allow the reader to critically ask what was done, how it was done, and also provide an understanding of how the researcher made certain decisions about the

handling of the data (Altheide & Johnson, 1998). These detailed accounts also contribute to what Patton (2002) refers to as “thick description”. “Thick, rich description,” according to Patton (2002), “provides the foundation for qualitative analysis and recording...in such a way that we can understand the phenomena studied and draw our own interpretations about meaning and significance” (p. 437-438).

Methodological soundness was also achieved through the keeping a journal throughout the research process which detailed the various stages and choice points of the process. This journal was separate from the theoretical memos and often included strategies for sampling and the diagramming of various themes and ideas. Lincoln and Guba (1985) argue that doing this ensures confirmability by making the research process and findings available to be confirmed by others.

Further, “substantive significance” (Patton, 2002) was achieved through a thorough discussion of the coherence and consistency of the findings, as well as a discussion of the ways in which the findings are consistent with other knowledge in this area. The ways in which the findings are useful and deepen the understanding of these phenomena is also discussed. Additionally, I presented the research findings to an ongoing research group of my peers and our faculty advisor. This allowed me to receive feedback from my peers and advisor regarding the ways in which I conceptualized the material, as well as debrief after the interviews. Presenting the findings to the research group also helped me to

monitor my own biases. Being a Black woman myself, this forum also allowed me to particularly explore my own cultural assumptions.

Methodological Limitations:

Because rape is the most underreported violent crime in the United States, it poses many challenges to those who choose to research it (Russell & Bolen, 2000). Russell and Bolen (2000) consider survivors' abilities to recall rape and child sexual abuse experiences, particularly those that occurred long ago, one of the most challenging methodological issues in this type of research. They (2000) argue that sexual assault experiences, which are cloaked in secrecy, are more difficult to remember than other traumatic experiences that people feel more comfortable talking about (e.g., surviving a natural disaster). Secrecy, denial, and difficulty with recall likely contribute to underestimates of the prevalence of such crimes. Additionally, research on memory processes has suggested that memories are not always stored intact and may be difficult to accurately access (Russell & Bolen, 2000). However, the purpose of this study was not to ascertain exact memories from the participants' experiences, but the meaning that the participants have given to such experiences. Further, my sample was voluntary and was not obtained through a random selection. As with any self-selected group, it is likely that this sample would differ from women who were sexually assaulted but who would choose *not* to be part of a study focusing on sexual trauma.

CHAPTER IV

RESULTS

The 12 interview transcripts were analyzed according to the methods outlined in Chapter III. This in-depth analysis yielded 43 open categories, eleven axial categories, four selective categories, and two minor open categories (see Table 2) which were based on themes that were raised by the majority of the research participants. This chapter will focus on presenting the four selective categories, along with the axial categories that fall underneath the umbrella of each selective category, and the open categories that are subsumed under the axial categories. These categories have served as the foundation for generating theory about the healing processes of resilient African American female survivors of sexual trauma, which will be discussed in Chapter V.

The participants that were interviewed for this study spoke openly about the ways in which they negotiated their healing processes and made sense of their experiences of sexual violence. Four selective categories were determined based on the research questions that were outlined in Chapter III. These research questions were derived from an extensive review of the relevant literature and served as the catalyst for the interview questions. They included 1) How do resilient Black female sexual trauma survivor's conceptualize and make meaning of the healing process, 2) what are the strategies that they use to cope with the trauma, 3) what are the characteristics that contribute to their resiliency, and 4) what are their perceptions of the impact of the trauma.

Table 2

Selective, Axial, and Open Categories

| Selective | Axial | Open |
|----------------------------------|---|--|
| 1. Perception of Healing Process | 1. Healing as an Ongoing Process | 1. Healing as Non-linear Experience 2. Healing as Working Through 3. Finding Language for Abuse 4. Living a Balanced Life 5. Desire for a Balanced Life |
| 2. Coping with Sexual Trauma | 2. Positive Coping Strategies 3. Negative Coping Strategies | 6. Spiritual Practices 7. Psychotherapy 8. Artistic Creation 9. Connecting w/ Other Survivors 10. Political Activism 11. Reading Black Women's Literature 12. "Keep Moving" 13. Minimization/Denial 14. Unhealthy Romantic Relationships 15. Disordered Eating (minor) * |
| 3. Characteristics of Resiliency | 4. Resiliency as Longstanding | 16. Internal Locus of Control 17. Belief in Divine Order 18. Strong Female Relationships/Role Models 19. Education 20. Placing Blame Outside of Self 21. Cultural Resiliency |
| 4. Impact of Abuse | 5. Intrapsychic Impact 6. Spiritual/ Intellectual Impact 7. Physical Impact Interpersonal Impact: Overarching Themes 8. Familial Impact 9. Impact on Friendships 10. Impact on Romantic Relationships | 22. Shame 23. Feeling Singled Out 24. Strong Like Foremothers 25. Deepening of Faith 26. Suspicion of Organized Religion 27. Hating One's Body 28. Disconnection from Body 29. Medical Problems (minor) * 30. Becoming a Caretaker 31. People Pleasing/Good Girl 32. Difficulty w/ Trust 33. Lack of Discussion in Family re: Abuse 34. Lack of Protection/Vulnerability 35. Family Denial 36. Keeping Ties to Family 37. Setting Boundaries w/ Friends 38. Negotiating Romantic Relationships 39. Negotiating Relationships w/ Black Men 40. Negotiating Sex 41. Silence in Black Community 42. Reluctance to Disclose in Black Community 43. Coming Out |

Categories

Selective Category: Participants' Perceptions of the Healing Process

Although the semi-structured interview asked participants specific questions about different aspects of their healing process, each participant in the study commented, throughout each interview, on the overall experience of the healing process. It was clear that presently each participant conceptualized the experience of healing from trauma as an overarching process that co-existed with most aspects of their lives (e.g., spiritual development, interpersonal development, body image), although many admitted that they may not have always recognized this as so.

Healing as an Ongoing Process (Axial):

A common perspective that was stressed in every interview was the belief that the healing process was an ongoing process. Despite seeing themselves as resilient, the majority of participants stated that they continue to struggle with issues that they believe are attributed to the trauma. They explained that there are times when they feel far removed from the traumatic experience, and times when they feel as if it happened yesterday. It does not appear that the amount of time that has passed plays an actual role in how close the experience seems. In fact, many of the women reported that relatively benign experiences (e.g., arguing w/ an acquaintance, having someone accidentally bump into them on the street) have triggered memories of feeling victimized when they least expected it. One participant captured this when she explained, "I still bear the scars, you know, a

lot...in just the flashbacks and stuff like that at times. So it's very easy to have good days but yet you also see the other side."

One participant noted that the most difficult part of the healing process is simply that it exists. She explained, "the hardest part is the fact that it's there. The fact that it [the trauma] happened...that it happened no matter how much work I do and how much I try to rebuild myself." Along similar lines, another subject simply stated, "I'm going to tell you now that this [healing from trauma] is a process and I am not there."

Healing as a Non-linear Experience (Open)

The process the participants described, although clearly moving towards successful healing, is ongoing. Each participant was able to conceptualize their healing process as a movement through various stages, with each stage having its own particular challenges. The shift from one stage to another was not, however, always linear. For example, several participants described the shift from being a more closed, walled-off to a more open one. Yet, a variety of incidences (ranging from relationship breakups to everyday misunderstandings) would lead the participant to become more closed again. One participant explained how she copes with this:

Sometimes it's more intense than other days. But, you know, I've just...I've just tried not to focus and dwell on the past but really think about the future and my goals...every now and then I'll have one of those emotional times when I'll start thinking about it. I'll get really down, but I'm learning not to focus on it in that way.

Another participant explained how she understands the non-linearity of her healing process, as well as revisiting stages that she felt she had previously mastered.

I've begun to understand...to understand that it's okay to stop [at a point in the process]...it's okay to go backwards...to backtrack...to do-over. It's okay to take a break...it's okay to say enough for now, you know. It's okay to just be wherever you are. Wherever part of the process you are at it's okay.

Healing as a Working Through Process (Open)

The process of healing was described by the participants as not only ongoing, but arduous. Nearly every participant commented on how much work was involved in healing from sexual trauma. One participant described this in the following way:

I'm feeling like someone who is constantly working on myself and constantly challenging herself, whether it be spiritually, or intellectually, or physically.

Similarly, another participant explained:

We got to get it off our shoulders, pick it apart, do whatever you got to do with it, go through it, learn what you got to learn, and you got to keep going.

Another participant explained that although she continues to work hard at healing, the nature of the work has shifted as her healing process has progressed.

It's a process...it's in progress. In a way I feel like I have work to do but it's a different kind of work. You know, it's not so urgent.

Another participant stressed the magnitude of the process:

It [the process] is huge. I don't want to minimize it at all. It's really huge. And at the same time, I think my surviving it in the way that I have survived it, you know, helps me see how huge I am.

Finding Language for the Experience (Open)

Many of participants reported that finding a way to communicate about the experience was a crucial part of the healing process. The majority of participants stated that the threat of sexual trauma was never discussed in their family of origin. Consequently, there was no language for them to describe what was happening to them. The one participant that reported discussion of childhood sexual abuse in her home was molested as a young girl by her female babysitter. This participant was warned about male perpetrators, but had no terminology to describe the violence that was being perpetrated against her by a woman.

Another participant described her process of finding the words to describe the abuse her step-father was inflicting upon her, but not the abuse that her cousins were perpetrating, because they were boys. Another participant, the eldest in the sample, stressed the importance of naming and finding a language to talk about sexual trauma. She explained:

Up until a few years ago there wasn't even language for this [sexual trauma]....so, growing up, you know, people of my generation...you can't really think about something or process something if you can't name it. So, as a child, there was no word...no pedophilia, no childhood sexual abuse, no assault, molestation, fondling, none of these words were there-- which makes it hard for a person to process things, let alone heal.

Most often, the participants attributed their ability to find language for their experiences to psychotherapy, connecting with other survivors, and reading Black women's literature.

Living a Balanced Life (Open)

Nearly all of the participants conceptualized successful healing as living a balanced life. They described a balanced life as one that includes work satisfaction, relationship satisfaction, spiritual fulfillment, and adequate time for oneself.

My life is just so much more balanced. I think that's a sign of resilience...just that you're in balance...that different parts of your life have the appropriate amount of weight.

Another participant explained:

I'm feeling very balanced. I think that obviously the goal in life is to be balanced. You want to balance out your personal life, your professional life...all these different things should be in balance with one another.

Desire for a Balanced Life (Open)

Although some participants expressed satisfaction and relief that their lives finally felt in balance, others discussed balance as something they were striving towards. One participant, for example, commented on her desire for her life to be more in balance, as well as her search to become more spiritually connected:

I'm trying to be a well balanced individual...I do think I'm trying to become more and more spiritually developed.

Similarly, another participant described the ways in which she has positioned herself to be more in balance:

I'm more open to analyzing and communicating and talking and that whole thing. I'm very positioned to be more in balance.

Selective Category: Participants' Ways of Coping with Sexual Trauma

One of the primary areas explored in the interviews were the ways in which participants' coped with the experience of sexual trauma. All participants provided both positive and negative ways with which they coped with the trauma. Participants that only mentioned positive ways were asked about negative ways and vice versa.

Positive Coping Strategies (Axial)

Each participant reported far greater positive coping strategies than negative ones. The category of positive coping strategies has been broken down into seven separate techniques that will be listed in order of mentioned frequency: 1) spiritual practices (both traditional & non-traditional), 2) psychotherapy, 3) artistic creation, 4) connecting w/ other survivors, 5) activism, 6) reading Black women's literature, and 7) a final "in vivo" category of "keep moving." In vivo codes, which are codes that are labeled using a participant's phrase or wording, are particularly useful when one participant's phrasing captures the thoughts of many other participants. Some of the categories encompass several different coping techniques (e.g., artistic creation/expression includes journal writing, writing poetry, photography; psychotherapy includes group, individual, crisis counseling) and others are very narrow (e.g., reading Black women's literature).

Spiritual Practices (Open)

The use of spiritual practices and reliance on spiritual belief systems were the most commonly cited positive coping strategies. The participants that cited spirituality as a coping strategy were quick to differentiate between spirituality and religion. The majority of participants considered themselves spiritual, but not

religious. Thus, despite citing specific religious practices (e.g. prayer, listening to gospel music) they stressed that such practices need not take place in a church or in an organized public context. Many participants described a reluctance to embrace and/or a turning away from traditional organized religion, which will be discussed later in greater depth. Additionally, many of the participants mentioned finding comfort in integrating practices from different religions, such as Christian prayer and Buddhist meditation, in order to feel spiritually comforted.

The majority of participants described spirituality as an overarching philosophy that was used to frame all of their experiences, both positive and negative. Others spoke about specifically drawing on spirituality and incorporating spiritual practice into their healing process. The spiritual practices that were cited ranged from daily reflections on the sense of comfort experienced through a connection with God to daily ritualistic reading of the Bible, and prayer. One participant described the ways in which her belief in God allowed her to believe that there would be an end to her suffering. She explained, “I just accepted that God can work miracles. I’m going to feel better. I’m going to be one of those miracles.” Another participant echoed this when she noted, “having spirituality has helped me to accept what’s happened [the experience of trauma] and to some degree resolve it within myself.” The idea of using spirituality to frame the experience is further elucidated by another participant:

I would say that I do use spirituality to cope with things, but not necessarily in a sense that perhaps others would use spirituality to cope with things, you know, which is basically, ‘I pray for rain, it doesn’t rain, so my prayer wasn’t answered.’ It’s not that kind of thing. It’s more fluid. It’s more of an acceptance that things are going to happen, but you still have to make your effort and set the goal and try to reach it. And then just

take your lesson, take your sign and try to figure out if you're moving in the right direction, wrong direction, try harder, try differently.

The majority of participants also noted that, in addition to an overall belief system, they also used spiritual practices in their healing process. "It was really a spiritually based healing process," one participant explained, "I found music that was relevant and did dance...a lot of writing and affirmations." Another participant explained how she used spiritual practice to maintain closeness with God:

Spirituality is huge. Because when I was with my dad (he's Muslim) I practiced Islam with him and it was a way for me to get closer to good and God. Just, you know, purism...purity...being pure. And I mean it's played a huge role in my life now and during the whole time that I was dealing with all this stuff...just trusting that God wouldn't hurt me.

Additionally, several participants incorporated the practice of listening to spiritual music into their healing process. One participant explained that she found gospel music to be a great source of comfort, as well as a crucial part of her healing process:

I listened to gospel music that I found uplifting like every night when I went to bed. I would go to sleep with it...I just felt like I was sucking up the energy. It was like a meditation I guess, but there was like a song called, Let the Healing Begin. My image of that is like a thirsty person who has, you know, had nothing to drink for however long, and they get a slurpy and they just slurp it all up, and they're still, they're as thirsty as they were...that's how I feel when I hear that music.

Several participants also spoke about the ways in which their families used spirituality and religion to cope with the aftermath of the survivor's assault. One participant described her family's use of prayer:

I remember [after disclosing about the rape] she [her mother] called her sister, her older sister to say, you know, this happened. 'Should I tell her

[the participant's] father because I don't think he can handle it?' So she said, 'let me pray on it and I'll call you right back.' She prayed, she called back, and she said, 'yes, you need to tell him.'

In addition to statements reflecting the use of spirituality as a way of framing and consequently coping with the experience, many participants also expressed a reticence towards traditional organized religion. In many cases, *traditional organized religion* was either associated specifically with the perpetrator (in several cases a respected member of the church) or a general sense of sexism and patriarchy. The majority of the women described their search for a spiritual belief system that they could find validating and approach on their own terms. One participant explained:

I've had to come to know God as I believe God to be.
She...he...whatever...on my own terms and without the help of a
guide...a religious institution.

Another participant expressed similar feelings:

I read the Bible either in the morning or at night, but I don't go to church. I would definitely say that from that standpoint, I'm more spiritual. For me, my relationship is directly with God, and I'm not saying that it's not helpful to go to an institution to help you out, but for whatever reason I'm not doing that and I feel comfortable.

Additionally, several women described using non-traditional spiritual practices or religious beliefs that differed from those of their upbringing, to cope with the aftermath of sexual trauma. One participant described the ways in which Buddhist practice has helped her:

I'm getting more and more into Buddhism. I'm learning the power of silence and how critical that is. You know, I used to always have to have sound. I had to have music going or something, you know, just afraid of the silence because of what can emerge.

Furthermore, two other participants spoke of the ways in which they became involved with Yoruba religious practices. They also described the connection they felt with particular Yoruba Goddesses who represent positive expressions of sexuality and African womanhood:

At one point I was seeing a priestess. I was going to those sessions with the priestess and what she would do is we would have rituals and those rituals would ...she would like cleanse me and that...that was very cathartic and I think that helped me to some degree deal with what happened. Like in particular there's a particular Goddess and her name is Yemiyah and we would do different rituals around my sexuality and that was very physically cathartic and very helpful.

The other participant described a similar experience:

There's this festival in Philadelphia that's called the Doomsday and it's dedicated to the Yoruba Goddess Oshun. They [people at the festival] were like we think you're ruled by Oshun. And I was like, 'who is Oshun?' Then I went home and there was this painting that I realized I had and it was Oshun. And she was the Goddess of love and sexuality and I think that was really helpful to me at the time because it just embraced...it wasn't about the Virgin Mary. It was about being sensual and being sexual and being o.k. with that.

Further, another participant explained how reading about Goddess worship and non-Judeo-Christian religions allowed her to embrace a spiritual belief system that was more matriarchal:

I was doing a lot of reading about Goddess worship and non-Judeo Christian religions. That helped...although not in the direct sense of I prayed and I felt better sort of way but in a sense of things being connected in myself to things outside of my family. The understanding of life outside patriarchy and a spirituality that was matriarchal and not patriarchal, where men were not in charge and certainly not in charge of little girls. I think this was very comforting and strengthening.

Another participant spoke of her use of traditional Haitian spirituality as a way of coping with her history of trauma, as well as, her realization that she may be practicing Voodoo:

I definitely feel like I've embraced spirituality in a sense...and that's kind of where practicing, like sometimes I think I might be practicing voodoo, like some variation of it, like without initiation or anything like that, but just because...it's not like a faith based practice, it's like a practice. It's like what you do.

In some cases, spiritual beliefs helped the participant reconcile with the perpetrator. One participant gave an example of this when she explained:

Since my grandmother's passing I really didn't want to deal with my grandfather [the perpetrator], but lately I've been calling my grandfather and I'm going to go over and spend time with him and it's like it's gone, it's lifted. I used to see myself as a solely political person but now I see my self as more of a spiritual person in terms of wanting to do that work. So I really feel like that was a gift that I feel like I received from her [the grandmother].

Use of Psychotherapy (Open)

In order to participate in this research project, all participants were required to have been in therapy at some point in their lives. This was included as a stipulation in order to prevent any re-traumatization of survivors who had not previously discussed these issues in detail. Most participants stated that they had found therapy extremely helpful, however, they also expressed their initial reservations about therapy. Only two of the survivors interviewed sought psychotherapy following the incident (s) to particularly address the trauma. One participant explained how she learned about and became involved in trauma specific treatment:

A friend of mine was working at a PTSD clinic and they were doing treatment for women that were rape survivors so luckily my first treatment was there. So for four months. So that was helpful in a sense that I had to retell my story over and over...tape record it...listen to it at night...tell it over and over. And it treated the initial symptoms. Like, I started having sex with my boyfriend, I was doing little things like walking by myself at night, things like that. But I don't think it was set up to work on the long term symptoms of sexual assault. I don't think I even knew what they were. I mean, I knew I wasn't cured, but I thought I'd finished.

The same participant also sought out trauma-specific treatment several years later when she was suffering with depression. She explained:

I started going to Women Organized Against Rape in Philadelphia when I was like in crisis. I was going twice a week, started individual therapy and group therapy and I was like in my mind suicidal.

This participant was one of two participants that discussed feeling suicidal in the past. The majority of participants reported that, despite being depressed and hopeless at times, they never considered suicide as an option.

The other participant who sought treatment following the sexual assault returned to a therapist she had previously seen. The participant, a survivor of stranger rape, describes her experience of going for treatment the day following the rape. She also described her therapist's use of non-traditional therapeutic practices (other participants described similar experiences) and the ways in which she found such practices helpful:

My therapist is an ordained minister, but not like an ordinary Black church ordained minister. Like, she knows about all kinds of spiritual systems and incorporates them into her work. And she's a Reiki master. She had me using aroma therapy and crystals in addition to talking. And I think it was just what I needed. I mean, the first day I went [following the rape] she asked if I'd been hurt physically, like did it hurt, like physical pain, and I said, 'yes.' And so she did Reiki on me, and I remember literally feeling like the pain was...she healed me...so like I got up and when I walked out I felt extraordinary.

The majority of participants did not consider seeking therapy immediately following the abuse. Some of the participants saw therapy as something that simply would not be helpful to them. Those participants generally viewed therapy in an “all talk no action” sort of way or described feeling that they could handle things on their own. One participant recalls feeling as if she should handle things on her own:

My mother was suggesting that we go to therapy and I was...I kind of told her, ‘no, I don’t want to go to therapy.’ I don’t know, maybe that was my way of trying to deal with the emotional aspects of it. That’s what my mother believes...maybe that’s true. But at the time therapy was not the thing that I was thinking would help me. Um...I don’t know what I thought would help me, but I didn’t think that it would be therapy though. I just felt like, well, it happened, I should just accept it and let it go...move on...that was my attitude.

Another participant remembered feeling as if talking about what happened would not be helpful to her:

I’m gonna talk [in therapy]. I’m gonna talk it out and that’s really not going to make me feel better.

Another participant recalled having many friends who were in intense therapeutic relationships and remembered experiencing of those relationships as being more of a commitment than she was prepared to make at that time:

I think I perceived it at the time that it would be more of a commitment than I was prepared to make. And um...I certainly knew from other friends who were in therapeutic relationships...I had friends who were in really wonderful therapeutic relationships and other people who were in relationships that seemed inappropriate or seemed like they took a huge portion of their lives and that it was just something that I wasn’t as interested in.

Other participants associated therapy with a stigma, especially in the Black community. One participant aptly described the sentiments expressed by many of the participants when she simply stated, “going to therapy was definitely a stigma. I didn’t want any of my Black friends to know I was going there.

Most frequently, participants sought psychotherapy many years following the trauma to assist with interpersonal difficulties and/or self-esteem issues that they were experiencing in their current lives. Although everyone in this group of participants eventually disclosed the trauma to their therapist, some only disclosed when asked directly about trauma by the therapist. Some participants described their process of understanding the ways in which the trauma was linked to the other difficulties they were struggling with:

I don’t think I went to therapy necessarily for it [dealing with sexual trauma], but I did discuss it with the therapist. I had issues, I had serious issues...it wasn’t easy...it wasn’t easy to talk, but um I had to tell. I was uncomfortable and I was asked why. Because it was still in my head. I was still suffering. And what do you know, I was suffering from trauma. I just realized that now.

Similarly, another participant explained:

So we started to deal with why it was that every time I start something new, a new challenge, that I’m just full of self-doubt. And that’s where we started, started off therapy, and in the process I started talking about the abuse...and she helped me to see how all these things are inextricable.

One participant, who sought therapy many years following her assault, eventually disclosed her history of trauma to her therapist. The therapist referred the participant to a psychotherapy group specifically for sexual trauma survivors. Although the participant was reluctant at first, she eventually decided to try the group. She explained the impact the group had on her healing process:

Going to the support group was tremendous. Thank God she [the therapist] pushed me to go to that because I didn't want to go. She [the therapist] could see how it would be so helpful.

When asked about what made the group so helpful, the participant responded:

It's like for so long it's been a secret and for so long it's just you. And so seeing...knowing that the other person's been through that and seeing them as a woman and as capable of all these things...you see a reflection of yourself...but a good self...a self that you like.

Another participant described a similar reaction to attending a support group:

There were three of us [in the support group], there was one woman, she was Filipino, and myself and a Pakistani woman. And we all experienced childhood sexual abuse. So we had a lot of similarities. That was really helpful. It was helpful to talk to the group and it was helpful that they were all women of color and all immigrants. We had a lot in common.

Overall, the participant's feelings about therapy were quite complex. The majority of the participants talked about the importance of having a Black female or woman of color therapist. One participant reported that her primary concern, when searching for a therapist, was the therapist's level of experience with trauma. However, this participant also described feeling ambivalent, at times, about her decision making process:

It has been more important for me to have a sexual assault [therapist]. Like you're rare...it doesn't seem like a lot of Black women go in that area. It seems like sisters...yeah it bothers me because all of...a lot of my friends have Black women therapists and they have this wonderful time...it's great. I don't know...I don't know...because she's not Black, I'm always explaining...explaining my relationship as a Black woman...my relationship to Boston...I don't talk about that much. Sometimes I do, but I just think there are other things inside of me that I think are not necessarily racially specific or gender specific.

Another participant, who specifically sought out an African American female therapist, spoke about why this connection was so important:

I have a therapist I've been seeing since 1992 and it's been, I think that it's an extremely important relationship that I have with her. She's a Black feminist and I feel like we've done so much work...spiritual work...definitely psychological emotional work. So I feel like there isn't anywhere I can't go with her. I really value that relationship.

Other participants discussed the feelings that emerged when faced with White female counselors, which ranged from neutrality to discomfort:

I remember them [the campus rape crisis center] having counselors, but I think I kind of had the reaction...I remember seeing, you know, the White [counselors] ...it felt very...I had had so many negative experiences with people who weren't of color who I trusted and thought they were an ally and then found out later...just a lot of broken trust.

Another participant shared the experience she had at her local rape crisis center:

I actually did go to the Rape Crisis Center just to see about therapy there as well...and I had this young White woman who, you know, just a totally neutral experience. And if I can remember correctly, I couldn't start therapy for some time. So, I never went back there.

Another participant spoke about her concern about whether all aspects of herself would be accepted and validated at rape crisis centers and whether or not she would have to "check some [of her] identities at the door." She explained:

I did largely have the perception of [rape crisis] programs being largely White and that was something that I kind of alternatively felt...I felt comfortable with the whole White feminist piece, But as my identity as a woman of color and my identity as a woman who was very much in progress towards her racial identity...I wasn't sure that that would be a place where that journey would be supported as much as the other.

Artistic Creation (Open)

The majority of the participants used artistic expression as part of their healing process. The ways in which they expressed themselves artistically ranged from writing in journals, to the use of dance and photography chronicling

experiences of abuse, to creating independent films and the writing of books about sexual trauma. Similar to the reasons they cited for becoming activists, the participants who created public works of art cited the desire to help and connect with other survivors as motivation for their work. Moreover, the idea of creating art was viewed as a crucial component of the healing process, and not (as several participants described), as a luxury. One participant explained this:

I do think of myself in an artist community and like art meaning something that's necessary for survival but not the traditional western kind ...or the luxury or privilege that you get to experience.

Another participant, a professional dancer, spoke about the ways in which she used dance to communicate her story of survival:

Through the dance I initially started to feel like I had to tell this story. I had to put it in my body, through my body, get it out of me. That was the major...I feel like that was the most positive and the most sustaining coping mechanism. That's the one I'm committed to...that's the thing that's keeping me going, you know, with joy now rather than strictly as a...as the shelter that it was in the beginning. 'Cause with dance...dance helps me to be so present. And it helps me absolutely bring a moment—even if it's a past moment—but I need to bring it to the present. I need to be present in that rendering of the past.

Another participant, a filmmaker, spoke about how making a film on sexual violence in the Black community played a crucial role in her healing process:

Working on [the participant's independent film] has played a major role [in her healing]. I mean, therapy and working on [the film] has been the most important thing. Turning the trauma into this gift to use it as a way to hopefully prevent other women from going through what I went through. But given that I had been raped, and was just in a complete state of depression, that I was able to turn that into being a filmmaker, being a writer, being an activist, for me that's really wonderful.

Similarly, another participant shared how working on a multi-media performance piece about her acquaintance rape survival (along with her sister) helped with her healing process:

The show [the survivor co-created] has different things. It has pictures, but then it has my testimony. Then it has other interviews with me, one about my body image, one about rape, one about coping. And then we end with this West African dance piece...it's pretty much to Oshun [the Yoruba Goddess], like embracing your sexuality. So it's like the healing process. It's like rebirth...uplifting. So that's been pretty helpful to me.

Other participants wrote about how they used writing as a method of coping with their traumatic experiences. Some participants did this by writing their private thoughts in a journal while others wrote articles for college newspapers, national publications, and in two cases, books. One participant described her personal writing process:

I wrote a lot in my journal. Well. I wrote about it in two ways. One was sort of like a narrative about dealing [with trauma] and I also wrote about it in poetry.

Another participant had the opposite experience with journaling and spoke of how difficult it was to use journaling as a way of coping with her feelings about being raped:

It was so hard to write about. I used to journal all the time. When I got raped, I stopped writing in the journal completely. For some reason it was too painful.

Several years later, however, when asked by a friend, this participant wrote an article for the friend's newsletter. Following that she wrote an article for a national magazine and subsequently decided to write a book. Despite having

previously written articles, she experienced great difficulty when beginning to write her book, and initially felt re-traumatized:

So... I'm reliving the trauma, and it was excruciating, and I cried through the first few paragraphs. So, yeah, something about, I think, you know, the retelling and the re-writing [of the experience] has been helpful I think, but I don't know how that's worked.

Later in the interview the same participant explained:

I just feel, like, with the process of writing this book, that, spiritually I'm being guided...just learning so much about gender violence and working with this issue so much for six years, or whatever, after researching or writing or editing the book, I think that's been part of my healing process, which was not like an expectation I had when I started writing the book.

Similarly, another participant felt the need to write a book on sexual trauma, focusing specifically on Childhood Sexual Abuse (CSA) in the African American community. She described how her search for books in this area to assist in her own healing process compelled her to write such a book:

I started looking for books [on trauma] and came across a couple that focused on Black women experiencing rape. But there was nothing that, I mean, nothing that talked about healing, talked about the things that we talked about in therapy, like what it is that we inherited from our ancestors and our parents that shape us and that help or hinder how we deal with these issues. I thought, 'I need to write that book,' and that's what led me to write the book...just the process of writing the book was therapeutic.

The same participant went on to share how the combination of therapy and writing helped her to find her own voice:

Through therapy, I've learned to trust my voice. I never had a voice, but I was competent [with writing]. And so I was comfortable and made a very good career of editing other people's words. And I'm learning to trust my own voice. And so this process, the process of writing helped me to understand I do have this voice, and it's a good one.

Connecting with Other Survivors (Open)

Each participant spoke about the importance of connecting with other survivors. Some of them connected with other survivors in ways that, at the time, seemed unintentional to them (e.g. volunteer work, activist work), while others specifically sought out other survivors. What was common throughout all of the narratives, however, was validation they received from talking to others who had experienced sexual trauma. One participant explained how she found other survivors unintentionally:

I almost didn't realize it but I actually sought out other survivors. And I didn't really know that's what I was doing. But somehow, you know, when I was in college and I first disclosed and to...to my friend B. Somehow, I don't know if this is intuitive, but somehow I just kept meeting survivors...it would help to talk about coping with it and knowing that you aren't by yourself.

Another participant discussed the strength she gained from connecting with other survivors, as well as her desire to only talk to other survivors following her disclosure:

I think [meeting other survivors] has helped me from not going crazy and later just being able to connect with others who've also experienced the same thing as me...cause at that time, you know after Take Back the Night, I was just feeling isolated. The only people I wanted to talk to were people who had actually gone through what I'd gone...you know, because sometimes it's hard to speak when you want to be heard or valued in speaking. You know, having that visceral connection...that seemed to help me.

Another participant described finding comfort in a community of survivors that defined sexual trauma in a variety of different ways:

I think what happened really was finding a supportive community where it wasn't abhorrent to have experienced sexual abuse and for me that was very much the community of women in college. So I think that was what really made a difference. Being a part of a community that was

identifying sexual abuse in ways that I could connect my own experiences to...because it wasn't...it wasn't rape. And so I never...I don't think I realized that it could be abusive although there hadn't been physical sex....so I just started talking about it and writing about it and talking to other survivors—a community of men and women who were also survivors really helped.

Political Activism (Open):

Many of the participants have become politically active, particularly organizing around issues relating to sexual assault, and in half of the cases organizing specifically around violence against Black women. Political activism appears to be viewed by many of the participants as a way of helping other survivors, connecting with other survivors, and, in many ways, as a means of helping themselves heal. One participant explained that, despite viewing political activism as one of her ways of coping with trauma, she did not initially make this connection:

I think that being politically active was also a resource and a coping strategy that I kind of in a way...I think that when I became politically active I didn't identify as a survivor, so I wouldn't have consciously said, 'I want to do rape crisis work because I need rape crisis counseling.' But retrospectively, I think that was very much part of the connection.

Another participant described being motivated to become politically active by her own experience of sexual trauma:

Definitely activism and my involvement in the sexual assault movement has very much been fueled by my own experience as a survivor. You know, I think the kind of anger and confusion and all of that really did become kind of fuel for energy for activism and that so...so...absolutely I think activism was a way of challenging that and a way of connecting with other women um...individually and collectively. A way of addressing the feelings of isolation and feeling freakish or strange or singled out.

Another participant noted how becoming an activist assisted her in her healing process:

I started becoming more of an activist and very public about it [the sexual assault]. I guess each time I shared my story with someone I became more and more comfortable with it. I feel like at this point I've integrated a lot of it into my life...into who I am and who I'm becoming.

One participant commented on how becoming an activist in the area of sexual trauma, despite assisting in her healing process, has been very challenging:

Becoming an activist, I really think that helped. It's hard though. It's really hard because it's not simply me doing work around rape...it's sharing myself.

Reading Black Women's Literature (Open)

The majority of the participants spoke about the ways in which literature by Black women was incorporated into their healing process. Such writing (both fiction and non-fiction) by authors such as Maya Angelou, Alice Walker, and Toni Morrison, were at times sought out for comfort and strength, but most often unwittingly stumbled upon. The participants seemed to see images of themselves in the fictional characters, and this mirroring appears to have lessened their own feelings of loneliness and isolation. One participant explained this connection:

I guess I just feel a connectedness to them [Oprah Winfrey and Maya Angelou], like, you know, I guess it was either when I was reading novels or reading an interview...but I do feel some kind of connectivity to them. I feel connected to what happened to them. When they talk about their experiences and how trusted those people [the perpetrators] were.

Another participant explained how reading such stories helped to normalize her experience:

I'm drawn to the Alice Walkers and the, like, The Women of Brewster Place. Like, you know, that's where I found like...I wasn't admitting it...I wasn't saying this is my experience also, but it was just...I guess I was...I guess it was a way to normalize it...like connect to them.

Only two participants mentioned the utilization of mainstream trauma self-help books such as Bass' The Courage to Heal. One participant stated:

I didn't read what I perceived as self-help books. More in terms of fiction and poetry...that was probably the stuff I was drawn to.

The use of culture specific and relevant literature appears to be a common experience.

"Keep Moving" (Open)

"Keep Moving" is an in-vivo code that was developed by this researcher after hearing many participants make reference to this concept as a way of coping with trauma. The phrases "just keep moving", and "just keep going," appeared throughout the interviews. One participant referred to this as an ability to move beyond the trauma:

I think it's my personality also to move beyond things...I think it's really my general attitude towards life. There are certain things that you can control, and there are certain things that you can't control.

Similarly, another participant noted:

I've always just known that I was going to get through...I've always just known that I got to keep going...just keep going for something bigger.

It seems, however, that when thinking retrospectively, the participants were unsure of whether this was a positive coping strategy or a negative one. One survivor described what she referred to as "keeping busy" as a way of not dealing with her issues. She explained:

I stayed really busy...I kind of stayed really busy. I didn't spend a lot of time with myself.

Most participants ultimately decided to place it in the positive domain because it was a strategy they felt they must have needed to move forward. One participant described this dilemma:

My mom told me I couldn't get less than a B in that whole traumatic time and so I think of, like, I don't know. It's bordering on not being healthy in some ways. But kind of like keep moving, keep moving, keep moving.

Another explained how "moving on" may not have been the best strategy, but a way of not facing what she felt she needed to do:

My whole attitude wasn't like I need to get my rights...I have to defend myself [legally]. It was more like I need to just...this person is a jerk but I need to drop it and move on and not belabor this.

Negative Coping Strategies (Axial)

In retrospect, many participants noted that the coping strategies they once viewed as positive or neutral (e.g. minimization/denial, promiscuity), were actually negative and damaging. Several participants explained, however, that they believe they did what they had to do to survive at that time.

Minimization/Denial (Open)

Each participant reported that, to some degree, they used minimization and denial to cope with their experiences of sexual trauma. These strategies ranged from telling themselves (and others) that the traumatic experiences were "not such a big deal," to actively trying to put the experiences out of their minds. One participant explained:

I think in the long term my coping mechanism was denial, well not denial, but just not thinking about it. Putting it in a drawer and shutting that drawer.

Similarly, another participant explained how she coped by either suppressing the experience or calling it something other than sexual violence:

I think my coping was, like, suppression. Not dealing with it, or naming it something else like, 'I didn't want to do it but...'

Another participant illustrated how beginning a new school reinforced her ability to deny and separate herself from her past experiences of trauma:

I didn't talk about...didn't deal with...didn't acknowledge any of that stuff. It was like a split...it was a very dramatic split. And it was so easy for me to do because I was like in a totally new world [the new school]. So, of course, I mean I could become this new person, I was that new person. So, I mean, that was definitely not a positive way that I coped.

Furthermore, the participants stated that despite their efforts to store the experiences in the back of their minds, the memories continued to surface. One participant described the breakdown of her denial coping mechanism, and how it eventually led her to seek treatment:

For a long time I tried to write it off and not think about it, which was not the best thing to do because it will come up. And whenever it did come up it wouldn't be a good time. So, then, I decided to seek help.

Another participant described how difficult it was to admit that the traumatic experience had had an effect on her:

I think the biggest struggle has been recognizing that it has had an impact. I think for a long time I wanted to believe that this thing happened, and I'm fine I'm okay. It's very difficult to turn around and say, you know, these things this guy did to you have had a lasting impact on who you are today.

Engaging in Unhealthy Sexual Relationships (Open)

All but two of the participants discussed engaging in unhealthy romantic relationships. They spoke about this in terms of engaging in risky sexual behavior (e.g., unprotected sex, sex with persons they didn't want to have sex with, sex with persons they didn't really know) with both male and female partners. Many of the participants understood their promiscuity as an effort to re-do the experience of trauma and reassert control of one's body and one's sexuality. One participant explained this:

I think I was really needy of male attention...male affirmation. Even though I was in a relationship at the time, I went out of my way to seek sort of non-platonic male friendships, I guess, and so I did that. I eventually broke up with my boyfriend and continued to do that for awhile. And then started finding myself in situations where I was actually fooling around with people and engaging in sexual activity, but not fully, like not having intercourse. So, I think that was my way of re-enacting it [the trauma] and being able to say, "no," and have this person listen or trust me.

Similarly, another participant explained:

I found comfort in men, in boys I mean. I was sexually active at 13, with not my mother's blessing, her acknowledgement. And that was a constant. I always felt I had to have a man in my life to some extent, to the point that I was cheating on my boyfriend...this sense of conquest.

In retrospect, however, the participants that reported using sex as a way of reclaiming their bodies and their sexuality, now view this behavior differently. They understand that they were doing what they believed was right at the time, but also recognize that they were placing themselves in dangerous situations. One survivor explained this dilemma:

I think one negative coping strategy that I only can only recognize as a coping strategy retrospectively is about sexual promiscuity and sexual risk-taking. You know, I think sort of about...I don't know...sort of about reclaiming my sexuality and sort of being in charge but, at the same time it definitely had an element of...risk taking and putting myself in situations that were dangerous and possibly re-traumatizing... the standards that I used to decide who I was wanted to be intimate with were kind of looser.

Another participant described this similarly:

And I look back and I think, well, you know, this [sexual assault] was done to my body, now I can do whatever I want with my body. Because...this was how I thought, when in actuality I was sort of giving away something very precious. But I thought of it as a sense of control...I have control.

Additionally, several of the participants spoke about feeling as if, after being violated, they stopped holding themselves accountable for what happened to their body. One participant explained:

I did a lot of work on...working out the issues around my sexuality and having some moments of basically not taking accountability for what happens to my body—you know with partners—just letting things happen to me.

Similarly, another participant described the struggle to make sense of such behavior:

I can like someone and love people in so many different ways, but it doesn't mean I need to be your partner. It doesn't mean I need to have sex with you. And it's just, I think as a child who had been sexualized and is, you know, had become sexually active without any choice. You get...you get confused about making the choice to be sexual and why you become sexual and it can be so confusing. It can be really difficult.

Another participant described the severity of her inability to feel that she could make choices about sex, likening it to an addiction:

I saw myself as very sexual. So I would have sex without necessarily considering that there was even an option for a deeper connection or giving myself the option to think about whether I wanted a deeper more profound...it wasn't necessarily sexual. It was this addiction that I had. It wasn't for sex. It wasn't for romance. It was for that attention. It was like a drug.

Disordered Eating (Minor Open)

Although only three of the participants made references to disordered eating, the severity of this issue, and the lack of research on this issue in populations of Black women, merits its inclusion as a category (Streigel-More, Dohm, Kraemer, Taylor, Daniel, Crawford & Shreiber, 2003; Perez & Joiner, 2003; Talleyrand, 2002). One participant disclosed that she once had an eating disorder, when asked about her relationship with her body. She explained:

Right before I fell into the depression [following a sexual assault] I had an eating disorder. I was taking laxatives. And I mean all of that was about thinning away and trying to lose weight and I was pretty thin at the time. So, just really a very negative relationship with my body.

Another participant disclosed when asked if there were any negative ways that she coped with the abuse. She responded:

I think [coping with] compulsive overeating and just kind of bingeing and stuff like that...overeating and bingeing.

Another participant understood her desire to be thin and poor eating habits as a desire to be in control of a body that she had little control over as a child. She explained:

There was a time when I decided I was going to be thin. I didn't eat properly, and I was teaching aerobics three times a day. So there was an issue of control, but it was for all the wrong reasons. It got to the point where I would do...I tried the purge thing once and I was really disgusted. I would just not eat properly. I would like not eat all day and then I would eat some junk.

She later explained further:

I've always thought that I was fat. I mean I wear a size six. And I think, "oh God, you're putting on weight." And it's never going to go away, but I used to be obsessed with it.

Characteristics of Resiliency (Selective)

All of the participants in this study considered themselves resilient. Resilient women were selected because the researcher's goal was to better understand the factors that contribute to optimal healing from sexual trauma. Therefore, exploring and discovering the ways in which the participants conceptualized resiliency, as well as what they believed contributed to and allowed them to maintain such resiliency, is a major focus of this study. For the purpose of this study, resilience was broadly defined as the ability to recover or "bounce back" from a traumatic situation. Interestingly, despite considering themselves resilient, many participants stated that they were not sure if survivors ever completely recover or "bounce back." They appeared to view resiliency as a quality that is not static, but something that changes form and shape throughout one's life. An eloquent example of this is one survivor's comparison of resilience to a traditional Haitian dance that she was studying. She described the position of the body, during this dance, as being trancelike where, "a lot of times people are fighting the possession...fighting their egos being supplanted. So there is a physical struggle with the spirit and so the body...the body has a kind of fall and recover motif that goes on. It's just very, very resilient."

A careful analysis of the data yielded six open codes that characterize what enabled the participants to maintain their resiliency, or in the words of the previously cited participant, “fall and recover.” The six open codes are 1) internal locus of control, 2) belief in a divine order, 3) strong female relationships/role models, 4) education, 5) placing the blame outside of themselves, and 6) cultural resiliency. Cultural resiliency is a term the writer is using to describe the way in which many of the participants located themselves within a history of Black female survivors and a history of Blacks as survivors in general.

Internal Locus of Control (Open)

Each of the participants attributed their resiliency to something deep within themselves, something in their core that sustained them throughout traumatic experiences. The characteristics they described, although unique to this population, are most closely related to the psychological concept of internal locus of control, which is most often described as a sense of personal efficacy (Feinauer & Stuart, 1996). The participants made reference to qualities that dated back to childhood, including a strong sense of will, an inner conviction, an intrinsic sense that they would be okay, and a belief in a better life. One participant, when trying to describe this experience, compared it to the process of a Phoenix rising:

I do feel that I kind of get these tremendous blows, but there’s something in me that rises like a phoenix, that just won’t completely let me fall out forever.

Other participants made reference to an inner sense of strong will and self-preservation:

There is something within me. That self-preservation that deep, deep core that I'm trying to bring up to the surface, that's all about self-preservation and helping me to lift myself up.

Another explained:

I've definitely had to overcome a lot of anxiety and things, but I think deep down, deep down I must have a strong will.

While other participants' spoke of this internal strength as an inner knowledge that there was a bigger purpose for their lives:

I guess...feeling like there's a bigger purpose for my life. So it was...I didn't give in or just crumble. It was...I always felt like there was something more in there.

Another noted:

I never really thought that being really sad or being blue meant it's the end of it...of all things. It's just an emotion.

Furthermore, most participants' believed that this was a quality that they always possessed. One participant explained that she has always felt self directed:

I'm spiritually driven...by a strong sense of purpose...a strong sense of purpose. I think I always have been. I'm internally driven. I'm self-motivated. What do they call it? Self directed.

Additionally, many participants recalled examples of having a strong internal sense of determination as children:

I've always...ever since I was a little girl like I was...I was 5 or 6...I was in kindergarten and I remember...I remember feeling a weight of everything around me and just knowing that there was something...like feeling a connection like...understanding God at that age, you know, and so I've always known that I was going to get through. I've always known that I got to keep going...just keep going for something bigger.

Similarly, another participant explained:

I guess a large part of my mind [following the rape] was saying that I've always been, like nothing gets in my way when I decide I want to do something. I'm very persistent and determined.

One participant put it very simply when she stated, "you know, I think I was resilient in my core."

Belief in Divine Order (Open)

The reference to a divine order, as well as the statement "everything happens for a reason," was a recurring theme throughout the interviews. Many of the participants used this belief system to frame their understanding of their own abuse, and traumatic experiences, in general. Although this philosophy was often presented as part of a spiritual belief system, it was also presented as an independent life philosophy that many of the participants maintained throughout their lives. One participant explained how this belief system has allowed her to turn a traumatic experience into a more positive one:

I have faith that everything that happens is supposed to happen and that everything was in divine order and I'm at the right place at the right time. And definitely I have those moments when I doubt that or curse all of that. But there is this place in me that kind of knows that. Like looking at the trauma I experienced and figuring out how to make lemonade out of that. I was able to turn that trauma into a blessing.

Along similar lines, another participant discussed how she has used what she has learned from her own traumatic experiences to support and educate other survivors:

I think it's divine order that I'm doing what I'm doing. I think things kind of just lined up for me to do this. And so in terms of being resilient, it's not just that it's me, it's just kind of divine order for me to do what I'm doing and get the support that I get.

For some participants, spirituality has framed their belief that everything happens for a reason:

I try to use spirituality just as a general backdrop in understanding that things have their own time and place, that you meet certain people, you're in certain places, you do certain things at certain times, certain things happen to you or don't happen, and a lot of these things are beyond your control.

Another participant explained:

I have a strong faith in God and I have a strong belief that everything that's happened in my life, good and bad, has happened for a reason.

For other participants, divine order seems to be an overall sense that things simply happen for a reason. They appeared to find comfort in believing that what happened to them was not a random occurrence. It seemed to help participants' recovery to turn such negative experiences into something meaningful. One survivor explained how framing the experience in this way has helped her:

What helped me a lot was, you know, I think that everything that happens happens for a reason. So when I began to look at things like when I reflected back on that experience [sexual trauma] I didn't simply feel like this...this terrible thing happened to me and there was no reason for it. I began to think that there was something in my experience that needed to happen. For whatever reason it was more empowering than to look at it as something that was just random that just happened to me with, you know, no logic or reason.

Another participant explained this strategy as well:

I've come up with my kind of set conclusion, you know, it happened to me so that I could explore ways to help other people deal with it.

Some participants were also able to hold onto the belief in a divine order, even if they were still unsure of what purpose the event served in their lives:

I'm having all these different experiences for a reason, and it's going to be revealed to me at one point, at some point.

Almost identically, another participant explained:

I see it [sexual trauma] as an experience I had to have for a reason. I'm still in the process of discovering what that reason is.

Strong Female Relationships/Female Role Models (Open)

The majority of participants spoke of close relationships with their mothers, female siblings and/or grandmothers. They spoke of such relationships as sources of ongoing support in their lives, but they also spoke of such women as role models. In fact, many participants stated that they would not be the women they are today, if it was not for their mother or grandmother. One participant described the value she has placed on her relationship with her grandmother:

My grandmother, very confident, very, very confident and strong. Where I'm at today is because of her. That is the bottom line. She was the only adult there, really, growing up...such a strong woman. And having her as a role model. You know, I know she went through a lot. But at the same time she kept her head up. She did what she had to survive.

Another participant described her relationship with her grandmother similarly:

She [my grandmother] was my lifeline. I would spend hours on the phone with this woman...I mean about everything. I mean she shared about abortion, about choice, there wasn't anything I felt I couldn't talk to my grandmother about.

Another participant spoke of benefiting from the relationship that she has with her mother, despite not seeing her often:

I have a close relationship with my mom, she's like my...whenever I cry. I don't talk to her a lot, but when I do need her she's there. She's been through the same kind of experience as me [sexual trauma], so we talk a lot.

One participant spoke of deriving strength from the relationship with her deceased grandmother whom she had never actually met:

My grandmother, who I never met, like she did come to me in a vision...And since then I've always felt like she's kind of like my spirit guide and that she helps me to make sense of everything that's happened.

Placing Blame Outside of Self (Open)

It was clear from the interviews that all of the participants placed the blame for the abuse outside of themselves. They repeatedly referred to the abusers as perpetrators and discussed their disappointment regarding judicial, community, family and religious systems that failed to hold the perpetrator accountable for their behavior. Interestingly, one emotion that was rarely mentioned was anger towards the perpetrator. When asked about this one participant responded, "I guess I've never been able to express anger...I guess a lot of Black women have this...like when I'm mistreated or disrespected or whatever, it gets turned inward."

Another participant shared a different perspective on the role that anger plays in the healing process:

I almost feel like I have to be, but I'm not angry at him, I don't hate him, I don't carry around, I'm not attached to him anymore. When I hated him, you know, like he was attached to me. But I don't feel that way. He's just like not there. And if he dies, he dies, that's it. I wouldn't feel one way or the other. I wouldn't feel good, I wouldn't feel bad. Because that's my way of letting go.

Other participants, while discussing the blame they placed on the perpetrators, also expressed empathy for them and wondered what would cause them to behave in such a way:

I think their lives must be so pathetic that it makes sense for them to do that. You know, 'do you [the perpetrators] have a soul?' 'Like what happened in your life that brought you to the point where you think this [raping someone] is a good idea?'

Another explained:

My first defense, I guess, of the whole situation was to think, 'this person is in such a terrible state of mind, to do such a thing.' So, I was trying in my heart to try and forgive this person and saying, 'well, he's such a whatever...this low type of person who can't control himself.' So, that made me feel better. I guess that made me feel superior at the time and that kind of helped me get through it.

Education (Open)

All of the participants in the study attended college and nearly half attended graduate school. A recurrent theme in the interviews, which was not dependent on level of education, was how much value they placed on education. Most participants described a history of being in a supportive nurturing school environment where they were allowed to feel smart, independent, and competent. Several of the participants also spoke of education as something that they could count on, as something that could be trusted, and served as a comfort in lives that were often chaotic and unsafe. One participant explained how education was the one thing she could count on:

Education [helped to maintain resiliency]. Because that was the one thing that I was able to latch onto...having that to focus on.

Similarly, another participant commented:

Academically I feel like I've been supported. Even from first grade to now, I feel like I've had a pretty nurturing environment which was good.

Many of these participants also described the presence of teachers who believed in them and served as role models in such environments:

My teacher in junior high, a Black woman, got her PhD. She was the first Black woman doctor that I've ever seen...she always pushed me and just her...just her presence was enough to make me strive.

Cultural Resilience (Open)

Cultural resiliency was coined as a term to describe the ways in which the majority of participants located themselves within a cultural history/legacy of Black women as survivors in general (e.g. racism, sexism), as survivors, more specifically, of sexual trauma, and African Americans and Caribbean Americans as survivors. The themes of surviving racism, sexism and poverty for both Black women and men were mentioned throughout the interviews. Additionally, many participants also referred to the legacy of their Black foremothers and the struggles they faced. Interestingly, although most of the women were referring to Black women as survivors of rape historically, several of the participants shared that their mothers and grandmothers had also been victims of sexual assault. One participant shared how the history of Black women and rape related to her own experience:

I'm very aware of the tradition of Black women being raped...justified by the state or by various institutions and by the people doing it. And understanding that allows me to understand what's happened to me and how unfortunately I'm part of this long history.

Other participants spoke about the ways in which they've drawn on the historical strength of others to maintain their own resiliency:

When you think of the fact that we are here because we're survivors, you know, people who survived slavery. And their children did survive, you know, 400 years, the just horrific experiences of being enslaved.

Another explained:

When I hear the word resilient, I immediately think of Haiti and Haitian people. Knowing that, you know, my parents came from a place [Haiti] where, you know things seemed to be as bad as they could possibly be. But you know people still live and make a life, so I guess that's a part of it [maintaining resiliency].

Impact of Abuse (Selective)

One of the primary areas explored in this study were the ways in which participants were impacted by the experience of sexual trauma. Like the other primary areas of interest in this study (negative and positive coping, resiliency), the results presented in the impact category were based on the participants perceived impact. In other words, the ways in which they believed the trauma influenced them retrospectively. This study did not seek to quantitatively measure how participants are affected by sexual trauma following such an experience. The aim of this study was to gain knowledge from how the participants conceptualize their process of healing from sexual trauma.

A careful analysis of the narratives led the author to divide the ways in which the participants were impacted into four major categories: 1) intrapsychic impact, 2) spiritual/intellectual impact, 3) physical impact and, 4) interpersonal impact. The first subcategory, intrapsychic, encompasses effects such as shame,

embarrassment, and guilt. The second subcategory, spiritual/intellectual, includes the ways in which the trauma impacted the survivors belief systems (e.g., the world is no longer a safe place, the church is no longer a safe place, etc.). The third subcategory, physical impact, focuses on the ways in which participants believe the trauma impacted their physical health, as well as their feelings about their bodies. The fourth subcategory, interpersonal, includes the ways in which the trauma impacted the participant's relationships with their friends, family, and community. Themes in this area were mentioned so frequently throughout the interviews that the subcategory was further divided into familial impact and community impact.

It became clear early in the study that such categories are not mutually exclusive, and that the boundaries that divide them should be thought of, not as rigid, but as porous and fluid. They are presented as distinct categories to underscore the myriad ways that participants were impacted by sexual trauma.

Intrapsychic Impact (Axial)

Several recurrent themes surfaced about the ways in which the participant's believed they were intrapsychically impacted by the trauma. These themes were 1) shame, 2) feeling singled out, and 3) feeling as if they needed to be strong like their foremothers.

Shame (Open)

A recurrent theme in the participants' narratives was shame. The participants described an enormous amount of shame and embarrassment about

having been sexually assaulted. Such feelings impacted the ways in which they viewed and placed value on themselves, and subsequently (in many cases) led to their silence about the assault. One participant explained this process:

I think the abuse has a layer of embarrassment, and I think that somehow I had something to do with what happened. That's what I carried with me, and so I didn't want anybody to know.

Another explained how feelings of shame and embarrassment have impacted her sense of self:

It [sexual trauma] has impacted my sense of self worth. That there are feelings that I struggle with ...have struggled with...continue to struggle with...shame...sense of shame about myself, about my body, about my sexuality, about my sort of right to exist in...you know the world.

Another participant, who was raped and robbed, described feeling embarrassed about disclosing that she had been raped. She noted that her first instinct was to tell others that she had been robbed before disclosing that she was raped:

I remember saying that I was robbed and raped, like I wanted to say the robbed first.

Another participant compared her feelings of shame and embarrassment to a feeling of complicity. She commented:

I think that there's also this thing about complicity. You know feeling at the time of the abuse and especially as I was coming out to my family about this, this real feeling of complicity. Why hadn't I said something earlier? Had I enjoyed it? Had I gone along? Why didn't I resist? You know all of those feelings.

Feeling Singled Out/ "He Picked Me for a Reason" (Open)

Another recurrent theme in the narratives was the belief, on the part of the participants, that they were singled out or picked for a reason. Although this was

sometimes coupled with self blame (e.g., “why didn’t I do anything about this?”), it was more about feeling that the perpetrator (who they viewed as clearly responsible) saw something in them that motivated him to seek them out intentionally. They believed such qualities ranged from their appearance to having compliant personalities. One participant explained how her feelings about “being chosen” led her to try to not draw attention to herself:

I also thought, well, you know, he picked me for some reason. If I don’t stand out, then I won’t get picked. So I became very withdrawn. My family read it as snobbish, and kind of serious and odd. So that’s the way I survived and avoided him for years. [My philosophy was to] stay out of the limelight. Because then I might be chosen again. Something might happen to be again. So if I didn’t draw attention to myself then I couldn’t be picked on.

The same participant described this feeling of being “picked” as something that remained with for a long time, only subsiding recently. She explained how this feeling manifested itself:

On the subway somebody’s bumping me and I’m thinking, “o.k. they picked me for some reason to fuck with. Everyday.

Another participant, who was sexually abused by her father following his attempt to abuse her sister, described her feelings about being “singled out”:

It [the incest] started with her [my sister] but then it stopped...then I thought, wow, my personality could be the problem, like because kind of what attracted my dad to me was because my personality wouldn’t speak up. So, in terms of how I saw myself was not positive around my keeping quiet and stuff and not having a voice and so forth.

Similarly, another participant described feeling singled out in her family, but for different reasons. This participant, whose mother was White and father

was Black, grew up as the only person of color in her nuclear and extended families. She explained this dilemma:

In a way I think I feel I was singled out. I mean I don't think...my uncle didn't abuse my other cousins and I think part of the reason that happened was a perception of me being more vulnerable because of being a person of color and coming from a single parent. So, it's hard to separate abuse from my experience of being a person of color because I think they're kind of connected. And at the source it has to do with this feeling of being really different in my family.

Strong Like Foremothers (Open)

Half of the participants referred to feeling as if they needed to be strong like the Black women whom have gone before them. Some participants, when mentioning this legacy of strength, referred to actual women who had preceded them (e.g., their grandmothers and great-grandmothers) while others implied a non-specific community of women that had come before them. One participant explained this using her grandmother as an example:

You know she [her grandmother] did what she needed to to survive. So you know I can't just spend my time and energy blaming someone...I've got to go beyond that.

Another participant spoke of the legacy of Black women that came before her and the fact that many women had survived traumatic experiences:

I guess there's this thing where, you know, you just need to kind of get over it...you need to...we all go through these things.

One participant described the danger in placing too much emphasis on the notion of "getting over it and moving on:"

You're not necessarily given the space to crumble. You know and you see the people before you and their lives and you know they've gone through

some mess too. And so you move on and sometimes it's not a healthy way to move on.

Spiritual/Intellectual Impact (Axial)

A recurrent theme in the interviews was the way in which the participants' felt that their spiritual and religious beliefs, as well as the ways that they make sense of the world, were challenged by their experiences of sexual trauma. One participant, when asked if the abuse changed the way she made sense of the world, captured the feelings of many participants when she responded, "it [the sexual trauma] challenged my understanding of what I think is fair and just."

Suspicion of /Turning Away from Organized Religion (Open)

Many participants spoke about the negative impact the abuse had on their feelings about church and organized religion. More than half of the women interviewed associated organized religion with the perpetrator, who was often a respected member of a Christian congregation. In each case, this association resulted in the participant feeling suspect of organized religion, but also resulted in the desire to find a religious or spiritual belief system that she could comfortably embrace. One participant shared this struggle:

I was molested by an uncle who was a prominent member of the church, who walked around with the bible everyday, who wasn't seen without a bible. It was part of him. And it just kind of...because of that experience I know...I mean I know that everybody who goes to church doesn't behave that way. But I just...just stay away.

Similarly, another participant explained:

I also think that there was a connection because my perpetrator was a deacon in the church. So, he was someone who was very religious. So, I think that my turning away from what I perceived as traditional Judeo-

Christianity had a great deal to do with...seeing how that was corrupted by that individual.

Another participant recalled a similar experience:

In my church I remember seeing my uncle warmly embraced by the pastor and I was like, "what?" That was the last time I went to that church. I said, "I can't."

Other participants described a general suspicion of organized religion, not necessarily based on their perpetrator's connection with the church. One participant explained how the guilt and shame she experienced in the Catholic church reinforced her feelings of guilt and shame as a trauma survivor:

We kind of grew up more in the Catholic church. So, I didn't go to church that much initially, but it was hard for me because the initial thing is based on sin and guilt. As a rape survivor, like you feel so much guilt. So I felt like I couldn't...it wasn't helping me. And also like you go and, you know, it's not very...it's very sexist these Catholic churches.

Another participant explained similar ideas about perfectionism:

The Christian model I grew up in, it was like about appearing perfect all the time, like whether or not it was that way. But even if it wasn't, like you had to believe that eventually it would get perfect or like you're holding out for some perfection that's just so unreal. So, there's no room to deal with imperfection and the crimes and the things that actually do happen, you know.

Another participant described her struggle to separate her faith from the institution of religion, which she believes is sexist and oppressive to women. She explained:

I've had to separate faith from...faith and spirituality from the institution of religion and the church because there's a disconnect to me between um, you know, having faith and having faith in God and hearing someone in the pulpit interpret the bible in a way that, um, is oppressive to women and children.

Physical Impact (Axial)

All but one participant believed that the abuse had an impact on their physical selves. Some participants cited specific medical problems (e.g. fibroids) that they believed were linked to the abuse. Others cited ways in which the abuse impacted how they feel about their bodies. Several participants also mentioned a split between their intellectual selves and their physical selves, as well as a long history of feeling disconnected from their bodies.

Hating One's Body (Open)

A recurrent theme throughout the interviews was the extreme dislike of one's body at some point in their lives. One participant simply captured what many of the participants described when she stated, "When I feel bad, my body typically becomes the target of that." Moreover, many of the participants became teary when reflecting on how much they had disliked their bodies in the past.

One described how the hatred of her body began during the sexual assault:

Seeing myself as a third person [during the rape], just waiting for it to end. And because of that experience I've had a lot of body image issues. And I just remember at that moment...just hating my body.

Later in the interview, the same participant explained how she has struggled to address this problem:

I hated my body. I work on it and I've gone to a body image group...different things but it's ongoing. I think it's better at times than others, but still very much there.

Another participant described the ways in which she tried to hide her body. She recalled:

I don't know how old I was, but I remember there was a summer in which I wore a red windbreaker everyday zipped up. My mother would say, 'why do you have that one, it's so hot?' And it was when I was developing and I was just horrified that, 'oh, I'm drawing attention to myself.' It [sexual trauma] definitely affected my sense of my body.

Moreover, another participant commented on not only disliking her body, but staying involved with partners who disliked it as well:

I vacillate between not really liking my body and not living in my body and having been involved with women who didn't like my body.

Additionally, participants shared that, at times, such dislike for their bodies manifested itself in a lack of desire to take care of one's body. One participant explained this:

That [disliking her body] can play out in terms of not taking care of myself or making really informed choices that diminish my health...smoking as an asthmatic...around alcohol...and other drug use particularly as a younger person. Where it wasn't a question of not having information but really being disconnected from my physical self.

Disconnection from Body (Open)

Many of the participants spoke about the disconnection that they have felt from their bodies. One participant referred to this as a mind-body split that occurs:

There's definitely a way that I live in the head rather than live in the body, which I think could be about this experience [sexual trauma]. That, you

know, I can really easily just not pay attention to what happens to my body.

Similarly, another participant noted:

It's getting better, but for awhile I didn't even recognize that part of my body. So now I'm making more of a connection, like its not bad and it's o.k. to feel all of those [sexual] feelings.

Medical Problems (Minor Open)

Although only three of the participants commented on the connection between their sexual trauma and later medical problems, the fact that it was mentioned three times in a small sample made it worthy of inclusion. One participant spoke of how she believed her development of asthma might be connected to her experiences of sexual trauma. She explained:

Asthma is one of those psychosomatic...or can be triggered by psychosomatic situations. So it's definitely possible that the asthma is also related to that [the sexual trauma] because there's a way that when you are asthmatic you create a health crisis. Where you're then...your body gets paid attention to and gets recognized that you need help in a way that, as a young kid and even as a young woman, you can't articulate—absent a physical crisis.

The two other participants who made the connection between sexual trauma and physical health discussed gynecological problems. One mentioned that she has developed fibroid tumors. "I think the fibroid tumors that are in my uterus are strongly connected to it," she explained. The other participant connected the experience to the development of ovarian cysts. She described the diagnosis of the cysts as a "wake up call to start an intensive healing process [from sexual trauma]."

Interpersonal Impact (Axial)

Examples of the ways in which the participants were impacted interpersonally by the experience of sexual trauma are plentiful and consistent throughout the interviews. The participants described how experiencing sexual trauma affected their relationships with their family, their close friends, their romantic partners, and members of their community (most often defined as the Black community). The participants also cited several overarching themes that cut across all of their relationships. The overarching themes will be presented first, and will then be followed by the particular themes that surfaced within familial relationships, friendships, romantic relationships, and in relationships within one's community.

Overarching Relational Themes

Three overarching relational themes were recurrent throughout the interviews: 1) becoming a caretaker, 2) becoming a people pleaser/good girl, and 3) difficulty with trust. These themes appeared to be present in all types of relationships (familial, professional, romantic, etc.).

Becoming a Caretaker (Open)

Many of the participants described taking on the role of caretaker for others following the assault. Several of the participants understood this as a way giving others what they really wanted to receive for themselves. Other participants conceptualized this as stemming from protecting one's family by remaining silent about the trauma. All of the participants who mentioned this theme, however, agreed that it was something they wanted to change. One participant described her struggle to relieve herself of the caretaking role:

I think that over all those years I created an image of myself as a caretaker. Like I had to hold onto this secret and take care of the family being together somehow. Because if I told, the family would break apart and so forth...I thought I was taking care of the family with my silence. And that wasn't...certainly not helpful to me either. I have slowly been shedding the whole idea because I did find that it manifested a little bit with friends—where it was hard for me to talk to friends who weren't in crisis.

Another participant described her caretaking as an unconscious way of learning about how to heal herself from sexual trauma:

I think I was also caretaking other people. I think that it wasn't a coincidence that I was drawn to [a volunteer organization] where other people were survivors. And I very much positioned myself as a kind of caretaker for others. I think it was a real way of gleaning information for me.

Another participant described her attempts to redefine the caretaker role:

I'm trying to reinvent what a caretaker looks like. You know what I mean? In other words, like rather than...it's o.k. to take care of folks, but, you know, my mom thought she was taking care of her family also [by remaining silent about her suspicions of abuse]. So I just think that that didn't help me.

People Pleasing/Good Girl (Open)

Similar to the theme of caretaker, the themes of “people pleasing” and “being a good girl” were recurrent throughout the interviews. As one survivor explained, “I always try to please people and make them happy...I'm less like that now which I think works to my benefit.” Like the caretaker role, participants shared the ways in which they struggled to shed this role as well. One participant explained how this role is connected to her experience as a sexual trauma survivor:

I was a good girl and I was the kid who got all A's and everybody said I was smart. I had this sense that I'm going to do everything perfect, cause

you know that little girl that allowed this to happen must have been stupid. So, I'm going to prove to everybody that I'm not stupid. So I'm going to be smart...I'm going to get A's...I'm going to be at the top of my class. I'm going to go as far and as fast as I can go.

Similarly, another participant explained:

I was very much like the obedient, you know, listen to what your parents say. And one of the reasons I remember is because my dad was always saying that, 'if you listen to me and do what it is that I tell you to do, if anything goes wrong, I will take care of it. I'll take the responsibility.' And that had huge ramifications on me to be able to be responsible for things I do. Because I would in the past, sometimes still now, get involved in things but thinking somehow...like waiting for permission or waiting for someone else to do it...and then, okay, if anything doesn't go right then I have someone to blame.

One participant equated the need to please people with her ongoing fear of abandonment. She explained:

The notion of fear of abandonment and wanting to be liked by any means necessary, right, almost to my detriment. Therefore even when people were awful to me, not wanting them to abandon me, wanting them to still like me.

Difficulty with Trust (Open)

The majority of participants mentioned how difficult it has been for them to trust others. Participants reported difficulty trusting romantic partners, co-workers, therapists, friends, and members of their own family. Several participants stated that they believed their difficulties with trust had led them to be "closed" and "shut down" with certain people and in certain areas of their lives.

One participant described this:

I think it [sexual trauma] had a very general way of shutting me down and making me a very closed person and less trusting...because here's someone who everybody trusted [the perpetrator]. You were over there [at his house]. He had everyone's trust, including mine, and he violated it.

Another participant described the ways in which she struggles with trusting others:

Trust is one of the big things. And for me, you know, it's definitely one of the things that I struggle with all of the time. Trusting people, even though I know that they will...they love me and okay, they're probably not always there when I need them...it doesn't mean that they don't love me. For me, it's like when you're there all the time that really shows that you love me...that you care.

Another participant described how her difficulties with trust impact her ability to love someone fully and commit to that person:

It [trust] would definitely come into one-on-one interactions with intimate...with people I'm dating. That I...I haven't been able...I haven't been able to give myself to someone...to love someone fully.

Similarly, another participant explained:

Even in my long-term relationship, I had this outlet of going out and getting into these different scenarios with people and not completely committing myself, which to me, commitment has a lot to do with trust.

One participant also explained that her difficulties with trust led her to keep romantic relationships rather superficial:

I don't know, it's a whole trust issue. You know, I don't want to get too close. Keeping it just a sexual relationship, it's a matter of not getting too close

Additionally, several participants spoke about being suspicious of the intentions of others in general. One participant noted, "I think it made me suspicious. I think there's a kind of suspicion in which I approach situations...concern about [people's] motivations." Similarly, another participant stated:

Because I don't tell [talking about the abuse], you know, other than to my therapist, to my husband, you know, to my mother and my sister. I just

feel like people can use things like that against you, and so that may be paranoia or whatever.

Impact on Familial Relationships (Axial)

The overall impact of sexual trauma on the participants' family, as well as, the impact the trauma had on her relationships with various family members were recurrent themes throughout the participants' narratives.

Lack of Discussion about Sexual Trauma in Families (Open)

One theme that surfaced in each of the narratives was the lack of discussion about sexual trauma in the participants' families of origin. On the rare occasions that sexual trauma was mentioned, the participants were warned to be wary of strangers. One participant explained, "no one ever talked about incest or, you know, somebody's child being touched by the father or cousin. Never was this mentioned." Another participant, who was sexually assaulted by a girl, explained how she was never told that perpetrators could be women:

As a kid I was assaulted by a girl, I just thought that assailants were all men. So I really didn't have a language to say, 'this person touched me.' So that was like the primary message—men are the only ones who can violate.

Lack of Protection/Vulnerability (Open)

Another theme regarding the impact of trauma on the family was recurrent among participants that were Childhood Sexual Abuse (CSA) survivors. These participants consistently spoke of a lack of safety and protection from their

families, as well as an ongoing sense of being vulnerable. One participant described this as not feeling valuable within her family. She explained:

When I was younger I think it had an impact on how much value I placed on myself. I didn't think I had a lot of value. I didn't feel valued a lot.

Another participant explained:

The lack of protection...like you protect something that's valuable. And so if you're not protected then you don't feel valuable. Like things...people let things happen to you, and things happen to you as if it doesn't matter at all.

Similarly, another participant recalled, "no one ever told me I was valuable. No one ever made me feel valuable." She then spoke about the ways in which not feeling valued has now motivated her to serve as a mentor for other young girls in crisis.

Additionally, several participants specifically described ways in which their families could have protected them, but failed to do so. One described her frustration towards her mother for not protecting her:

I have to believe that she [her mother] wouldn't intentionally leave me out there to the wolves, so to speak. Because she was so self-absorbed and so concerned about her own sense of is everything okay, and do things look on the surface like things are okay. She refused to ask questions that would jeopardize what she was putting in her mind.

Another described frustration and anger towards her family because they were aware that there was a perpetrator among them:

My aunt, for example, acknowledged that she had also been abused by the same person who abused me as a child. So, then I had a great deal of anger towards her and towards my mother for putting me in the situation where I would be made vulnerable if they already knew this person was a pedophile.

Further along in the interview, this participant also discussed the amount of pressure disclosing to such a family placed on her:

It was sort of this known quantity [the fact that there was a perpetrator in the family] in a sense, but no one kind of called it. So I kind of felt like I was opening this Pandora's box and after I, you know, kind of told there were these other revelations that continued to come out about, you know, his role in other family situations. So there was definitely this family feeling that I had opened this box and there's a pride in that, but also a discomfort...a shame...an exhaustion about why do I always get to be the one. Could someone else say anything ever?

Family Denial (Open)

Family denial was another theme that surfaced consistently throughout the interviews. Even in families where CSA did not occur (e.g., stranger rape, acquaintance rape), participants reported that family members, particularly fathers, often behaved as if the abuse didn't occur. The level of family denial that was reported by the participants who were CSA survivors was astounding. In the cases where families did not blatantly deny what had happened, the perpetrator was still not held accountable for his actions. Nearly all of the participants framed this denial culturally and situated the denial within the larger context of the African American experience. One participant explained this problem in the following way:

I know we trace those family connections um, you know, back to our African roots and you know the tribe...we stick together. And so I think those are the factors that have influenced my family to just remain silent on this issue...this person is still allowed access to children, which just makes me crazed because no one wants to address the problem.

One participant, who like many others continued to feel the need to protect her family, explained how the problem failed to be addressed in her family:

During that time when I was molested by my grandfather, both my parents...I still feel like I need to protect the family. I did go to both of my parents and they didn't do anything. My mother's response was, 'are you sure you weren't dreaming?' My father had said that he talked to my grandfather and said, 'I talked to [the grandfather] and he said he didn't do it,'...so it silenced me.

Another participant explained how her family reacted to her disclosure and the perpetrator's denial that the abuse happened:

He denied it. And there was just this eerie silence. Like I didn't know what happened, but whenever I came home from school [college] or whatever and came to a family gathering, he was not there. But it was odd because nobody talked about it. Nobody ever said anything.

Another participant described her disappointment in her mother's denial and the lack of protection she provided. She shared the following interaction that she had with her mother, soon after her disclosure of the abuse:

I asked her directly, I said, 'well, mom, did you ever suspect anything was going on at all?' and she said to me, she said, 'well,' she said, 'I thought,' she said, 'sometimes when we were watching television with your father and he would have his arm around you...and you didn't look really comfortable...I felt something was wrong, but I didn't say anything.' I was like, 'mommy, why didn't you, you know, follow your gut or why didn't you say something?' And she said, 'well, I didn't want him to think I was jealous of you.'

Several participants commented on the ways in which the family denial contributes to the silence of other survivors in their families. One survivor explained that one of her cousins, also assaulted by the same perpetrator, had chosen to remain silent. She explained:

She [her cousin] does not want to disrupt the family and I'm kind of seen out there [in her hometown] as the odd bird. Oh, she's out there writing and talking and Lord only knows what else she's going to do.

Keeping Ties to Family (Open)

The participants that survived CSA described an important dilemma pertaining to familial relationships. Despite being assaulted by a member of their immediate or extended family, these participants felt it was important to maintain ties with their families. Several participants described their struggle to negotiate relationships with mothers, aunts, and grandmothers who continued to have relationships with the perpetrators. One participant explained:

For many years I felt that she shouldn't have a relationship with him. And then I oscillated back and forth feeling like I had made too big of a...to much of a deal of it and that I was causing this family crisis and making everyone uncomfortable and feeling like everyone else was minimizing it too much and why weren't they making a bigger deal of it.

Two participants described their struggle to maintain some type of relationship with the perpetrator. The participants who reported such struggles framed them within a need to stay connected to their families. One participant explained:

I still talk to my father [the perpetrator]. The fact is I'm not someone...you know there are people who have experiences and, you know, they just...they just cut people who have been toxic in their lives off. They just cut them out and for whatever reason I don't feel like that's an option for me...I've consciously...I accept the fact that I am choosing to stay in touch with my family and stay in touch with my parents.

This survivor later continued:

My parents did shape my life, but it was always this kind of fight, like making what they created, like making what happened [incest] in the family, what they participated in, making it work for me has been like my

constant struggle, as opposed to having it be something that hinders me from growing.

Impact on Friendships (Axial)

Although most of the ways that the participants spoke about negotiating relationships referred to familial and romantic relationships, five of the participants spoke of difficulties they experienced negotiating friendships as well. One participant, when discussing this issue, stated, “I have kind of built a wall around myself. While I was friendly with people, it was difficult to let them in, you know, just because I felt vulnerable and didn’t want them to have access.”

Difficulty Setting Boundaries with Friends (Open)

Other participants discussed difficulties setting boundaries with friends and acquaintances. One participant noted:

It’s about boundaries, it’s very much about that. And that’s something, because of the incest, that’s something that I really needed to work on. Because I’m either totally open, like you can get all up in my business and let me get all up in your business and this sort of enmeshment thing happens or, you know, let me just be cold. So, I’m trying to find a happy medium and just trying to be as real as I can be...as real as I can be in the moment.

Similarly, another participant explained:

I’ve had certain male friends and female friends who have crossed boundaries. And I don’t see the signs at first, but something happens...something bad happens. It’s like co-dependent relationships or people crossing boundaries. It was hard, but better now...I’m better now.

Difficulty Negotiating Romantic Relationships (Open)

The majority of the participants cited difficulties negotiating romantic relationships. These difficulties ranged from dealing with intimacy, to feeling respected and valued, to negotiating sex. One participant described how difficult it had been for her to leave unhealthy romantic situations:

As a result of that [the abuse], as a result of not being taken out of the [abusive] situation, um I think that it has impacted...I think that I think I have to stay in situations. Kind of like somehow figure out how not to be abused, but not extricate myself from the situation. So...this notion of not understanding that I deserve more.

Similarly, another participant explained:

In my relationships...I never asked or expected anything for me. I didn't know how to assert myself in the...just in the most basic kind of way.

Another participant described what she believes has been a lasting impact of the abuse:

I think having these negative reactions towards men, I think I really began to feel like I hadn't gotten over it and I had internalized a lot of the hurt and anger that I felt. And I felt like I internalized it on a more physical or subconscious level.

Difficulty Negotiating Relationships with Black Men (Open)

Several of the heterosexual participants spoke of how the race of the perpetrator has had an impact on their romantic relationships:

The hardest part is my relationship with men. That's the hardest part. It definitely is ah...complicated...it's harder to trust Black men.

Similarly, another explained:

The guy who I'm seeing now, he's Black and, you know, I still constantly...just I mean...let him know if you're going to be with me you

have to love me the way I deserve to be loved. I'll let you know from the get go what you're getting into and I make it very clear with him.

Another participant, a survivor of abuse from a Black perpetrator, explained that she had to accept the fact that White men do not trigger flashbacks for her in the same way that Black men do. She stated:

I think the race factor and the fact that now I'm with someone who is White...I just surrendered to the fact that I like the fact that he does not trigger me.

Difficulty Negotiating Sex (Open)

Difficulty negotiating sexual relationships was a recurrent theme throughout the interviews. One participant noted:

I mean, I didn't have anyone touch me for like years. I couldn't even deal with that.

Both the lesbian and heterosexual participants in the study shared that, at times, they continue to have difficulty engaging in sex. They also expressed difficulty asking for sex. One participant explained this dilemma:

At times it's hard for me to ask for sex. And, you know, wanting and understanding that it's o.k. to want sex. That it's healthy to want sex, that sex is good. So, really grappling with all of that.

Another participant explained that she continues to experience guilt about having difficulties with sex:

Definitely guilt about when I'm having sort of sexually intimate interaction with my partner...it still comes up. It's not not going to come up. It's wonderful, but if something happens, more likely than not I'm the one who doesn't want to have sex. So if there's something that happens, if we have to stop in the middle or something like that...I just feel bad...I feel bad.

Impact on Community (Axial)

When asked about their community affiliation, the majority of participants reported that they considered their community to be the African American or Caribbean American communities. Several, but not all, of the lesbian participants mentioned the lesbian community. And half of the participants spoke about their academic communities. The one theme that was consistent throughout their discussions on community was captured by one of the participants when she stated, “as an Black woman you’re always balancing your multiple identities.”

Along similar lines, another participant explained:

It [race] is always there...you think you can’t choose which box to be in. As a Black woman you’re really concerned about that. About how people are going to perceive you.

Silence about Sexual Trauma in Black Communities (Open)

The majority of the participants discussed the silence around sexual violence that they believe exists in Black communities. Statements such as, “I know that we tend not to want folks in our business” and the idea of “let’s not air our dirty laundry” were mentioned throughout the interviews. Many participants believed that such silence contributes to Black women not coming forward about sexual trauma. One participant explained this:

But if we go to the police or go to the, you know, the county or the authorities, then it’s going to affect the way we live. We [African Americans] just don’t put our business out on the street. Number two, he’s a Black man and we’re not reporting him and having him taken to jail, ‘cause we don’t do that to our men we stick together.

Another participant explained how she feels Black communities stick together at the expense of the victims:

Like to have a Black man accused of sexual violence is like, the automatic assumption is it's White people trying to bring down Black men. Like it's really disturbing, but also confusing because obviously there are a whole lot of people who have been victimized. So I just think the Black community has a lot of growing up to do.

Another participant explained her belief that continuing the silence not only negatively impacts Black female survivors, but reflects negatively on Black men as well. She explained:

The sad thing is that when people don't want to talk about Black men being rapists, the assumption is that both Black and White people ...I don't know, they must believe that all Black men are rapists and therefore let's not break the silence. Instead of believing that some are and some aren't.

Reluctance to Disclose in Black Communities (Open)

Other participants spoke about their own reluctance to disclose their experiences of sexual trauma in Black communities. One participant recalled listening to her family discuss Black female rape and sexual harassment survivors such as Desiree Washington and Anita Hill. "They were always supportive of the men," she explained, "...they were always supportive. Saying, 'trying to bring a Black man down,' and that sort of stuff."

Another participant discussed her discomfort around coming out as a sexual trauma survivor within her African American community. She explained:

Because they were both men of African descent...yeah...I mean a whole bunch of things come up. Like when it comes to pressing charges...you feel guilt...you don't think people are going to believe you. And the one thing that I was always aware of is the hostility that women are met with

within the Black community. I mean in terms of like talking about it or breaking silences...being political about it...you're always negotiating all those things.

Another participant discussed her reluctance to disclose at events primarily comprised of members of the Haitian community:

It's difficult sometimes...in terms of [concern about] how the whole [Haitian] community is going to be judged based on this experience and the fact that you acknowledge that there are perpetrators in your community...most of the time I say I'm a survivor, I don't mention the perpetrator, like the relationship the person has to my life. So that's something still that I'm just not comfortable doing.

One participant described her decision not to share the fact that she had been sexually assaulted with her Black friends. She explained:

There's this group of friends that I didn't disclose to and it's like...those were like my Black friends. Um...and we would like hang out...like party and maybe in a roundabout way they knew but I've never told them face to face...I felt like I was sharing different pieces of myself.

She continued:

There are other things that they didn't understand [about her] but I know that you just don't talk about it. And those are the ways that I felt kind of isolated and ostracized.

Lesbian Communities

The lesbian women in the study frequently spoke about the ways in which coming out as survivor coincided with coming out as a lesbian or bisexual woman. They described how coming out as either a gay woman or a survivor increased their level of comfort with themselves and subsequently led them to face other issues. One participant described this process:

The 90's is when I came out as a lesbian and at that point I hadn't dealt with my trauma at all. But at that point it was the beginning of my road to healing.

Similarly, another participant described how the process of coming out created space for her to begin her healing as a trauma survivor:

About eight years ago I came out. I felt better about myself. Becoming a better person and taking care of myself.

One participant shared the ways in which finding a community of lesbians assisted her in the process of disclosing that she was a survivor. She explained the ways in which she found comfort in this community:

A community where working in anti-violence work at a rape crisis center. So people were talking a lot about being survivors. A lot of very confident, and what felt like very comfortable, self-disclosures as survivors.

Summary of Findings

The findings presented in this chapter indicate that there are many recurrent themes amongst this sample of resilient Black female survivors of sexual trauma. Four Selective categories including 1) participants' perception of the healing process, 2) ways of coping with trauma, 3) characteristics of resiliency, and 4) impact of abuse have been presented. Additionally, 11 axial categories have been presented, along with 43 open categories. Two of the 43 open categories, disordered eating and medical problems, are minor categories that were presented because of the clinical significance they may have with this population.

Chapter V will be used to discuss the categories that have been presented in this chapter in greater depth. The themes will be compared and contrasted with prior research and theoretical arguments about this population. New theory that has been generated by this researcher, based on the findings presented in this study, will be introduced as well.

CHAPTER V

Discussion

Framing the Research Findings

We have suffered. We have been in pain. So what we have to ask ourselves is what nourishes us. What do we need for nutrition? What makes us healthy? What keeps us balanced?

-Alice Walker, 2003

These words, spoken by Alice Walker at a keynote address at Barnard College, capture the aim of the present study. The purpose of the research was to understand the ways in which resilient Black women heal from sexual trauma. The study set out to learn from Black survivors who perceive themselves as living healthy lives (i.e., successful in their careers, educational pursuits, satisfied with their relationships), in order to add to theory regarding clinical work with sexual trauma survivors. These were all women who believed that their lives could have taken a very different (and more negative) turn, if not for their belief in themselves, their belief in God, if not for their families, if not for their art, if not for their education. Consequently, this study explored the nuances of the strategies and factors that kept them, as one participant explained, “safe, successful and sane.”

The women that shared their life stories to contribute to research in this area can best be described as phenomenal. They were equally open about their

triumphs and struggles, and very frank about their fears. The strategies that they used to further their healing processes and maintain their resiliency can (most definitely) be used to help other survivors—whether the survivor is in the beginning or the latter stages of her healing process. What was most striking about these women was their determination to break the silence around sexual trauma in Black communities, as well as, their desire to help other survivors learn from their own experiences. They wanted to communicate to other survivors that being “a strong Black woman” also meant dealing with sexual abuse, not just being the stalwart of the family, as many Black women were raised to believe. This is one of the qualities that may set this group apart from the majority of Black women who remain silent about sexual abuse. In some way, these women decided that it was courageous to confront and process the abuse—they developed the courage to face the trauma.

A consistent theme in the trauma literature is that the act of processing the traumatic experience is a crucial component of healing (Davies & Frawley, 1994; Herman, 1992). Although trauma theorists disagree about the most appropriate ways to go about such processing, the importance of processing has been agreed upon. For survivors, processing such experiences requires sharing them, being vulnerable, asking for help (often from a professional), and placing oneself in a position where negative feelings such as rage, sadness, and feeling betrayed can be tolerated and explored. This is antithetical to the ways in which Black women have been raised. The concept of asking for help, being vulnerable and sharing one’s secrets, particularly with someone outside of Black communities, defies

gender role expectations within Black communities. Moreover, the idea of expressing feelings of betrayal by Black men, or others in Black communities, and the notion of speaking out about violence against Black women and one's own story in particular, is akin to treason. What makes this sample extraordinary is that they were able to speak out and up for themselves, airing this "dirty laundry", to varying degrees. This researcher found that we can learn equally as much from Black female survivors who have written books and made films about sexual trauma, as we can from those who have only confided in their therapist and several of their closest friends. What we learn about is the shift from a position in which one places the needs of her family and community over her own, to a place where she puts her own needs first. This is an act of both resistance and resilience.

Understanding the ways in which Black women have historically put the needs of others before their own is crucial in understanding how Black women cope with sexual trauma. Black women have traditionally been the caretakers of the world (i.e., caring for their own families while caring for the families of White women) (West, 1995; Wyatt, 1997). Black women have also historically been asked to prioritize race over gender, and consequently the problem of racism over the problem of sexism (Walker, 1999; West, 1995; Wilson, 1993, 1994; Wyatt, 1997). Further, Black women have also been socialized to believe they should, and can, carry any burden. These three issues in particular converge to create very powerful dilemmas for Black women. If they are supposed to be taking care of everyone else, where is the time to take care of themselves? If they are

supposed to prioritize race over gender, where is the space to speak out about the gender oppression of Black women? If they are supposed to be strong and bear any burden, how could they have been raped, and moreover, how could they go to anyone and ask for help. Thus, the feelings that many trauma survivors experience such as shame, guilt, isolation, embarrassment, and stigmatization are even more complicated for Black women. Feelings of shame and embarrassment, for example, may arise when having to ask for help (especially outside of Black communities), or having to report an intraracial sexual assault within or outside of Black communities (e.g., one could be viewed as a traitor and/or “airing dirty laundry”). This is something that clinicians, as well as, trauma researchers and theoreticians, should be mindful of.

Although speaking out about sexual trauma would be difficult in any community, understanding the silence about sexual trauma in Black communities and the factors that contribute to such silence is crucial for understanding Black women’s survival processes. Many of the women in the study reported an important double-bind—they did not feel comfortable disclosing about sexual trauma in their community of Black friends for fear of not being believed or being viewed as a traitor. They also did not feel comfortable seeking support at organizations that they perceived as predominantly White, such as rape crisis centers, college counseling services, etc.. This double-bind can leave Black female survivors feeling alone and isolated, as if they are the only Black female survivor in the world. Clearly this can lead to depression, anxiety, addiction, and a host of other clinical conditions. But it can also contribute to the common

survivor experience (expressed often in this study) of feeling as if something is wrong with them. Many survivors that feel as if something is inherently wrong with them, hold onto their secrets and continue to struggle alone. Several of the participants mentioned how this feeling was reinforced by seeing other Black survivors publicly come forward, only to be questioned and maligned by their Black communities. Such examples further the notion that the women in this study demonstrated great resilience and courage by coming forward and not surviving in isolation and silence.

What further sets this sample apart from other sexual trauma survivors is their remarkable ability to make meaning of their experiences. Mattis (2002), in her study of Black women and their coping strategies, suggests that meaning-making:

...encompasses the ways that events, objects, and experiences are symbolically represented, as well as individuals' efforts to grapple with existential concerns (i.e. with questions of purpose, loss, good, and evil) and to understand the causes and effects of life events (p. 311).

The participants in this study found numerous ways to do what Mattis (2002) describes. They incorporated various cognitive strategies (e.g., telling themselves that the trauma happened for a reason, telling themselves that God has a purpose for them, telling themselves that they can create something good out of something bad) into their survival process.

However, the majority of participants in the sample took the meaning that they made from the abuse and turned it into a specific project or mission, which

they directly linked to the experience. Such actions included writing books and articles about healing from sexual trauma (at least five of the participants did this), creating art about the experience (three participants), making a film about sexual trauma (one participant), and becoming activists in the area of sexual trauma, particularly in communities of color (more than half of the participants). Other participants did this in less public ways (e.g., mentoring at-risk girls, becoming a campus health educator). The majority of women also considered participation in this study as another part of their healing process and yet another way to make meaning and sense out of the abuse. Interestingly, the participants spoke of these actions (making public and private meaning of the experience, participating in the study) as ways of connecting to a larger community of Black female survivors. This capacity to make meaning out of the experience, especially meaning that is directly related to addressing these issues in one's own community, and the ways in which it allowed participants to feel connected to a larger community of Black women, was extremely helpful to them and is something that can be suggested and cultivated by clinicians.

Clearly, the experience of sexual trauma can shatter one's belief system about what is just or right in the world and leave one feeling as if the world is not a safe place (Davies & Frawley, 1994; Herman, 1992). We can learn from the ways in which the participants in this sample view the world, as they understood it in a way that was not antagonistic and not pessimistic, but realistic. An important part of the healing process is the ability to conceptualize the world as a place where suffering is not the overarching experience and where violence does

not lurk around every corner (Grossman et al., 1999). The participants in this study were able to transition from the position of viewing the world as an unsafe place (often immediately following the trauma) to a place of greater security. The participants attributed the ability to make this shift mostly to their spiritual beliefs, their hard work in psychotherapy, support from select family members and close friends (overwhelmingly female siblings, mothers and grandmothers), and their ability to make meaning out of their experiences and to create something significant (e.g., writing, film, dance) out of such experiences.

Discussion of Research Questions and Core Themes

Three main research questions were asked in this study: 1) What are the strategies that resilient Black female survivors use to cope with the experience of sexual trauma, 2) What characteristics contribute to their resiliency, and 3) In what ways are resilient Black female trauma survivors impacted by sexual trauma (i.e., intrapsychically, interpersonally, spiritually, and intellectually)? One recurrent theme which surfaced was not one of the original research questions, “Participant’s Perceptions of the Overall Healing Process”, and this will be presented first.

Participant's Perceptions of the Overall Healing Process (Selective Category)

The participants conceptualized the experience of healing from trauma as a long and arduous process that co-existed with most aspects of their lives. They described the process as, at times, taking center stage in their lives. At other times, however, healing from sexual trauma was not the predominant feature in their lives. How and why the healing became central at particular times varied considerably. Most participants reported that new challenges that were faced when negotiating interpersonal relationships (e.g., dating someone new, negotiating sex, setting boundaries with friends and at work) brought the survival issues to the forefront. However, most participants also recalled incidents where flashbacks surfaced without particular triggers, which forced the healing process to become central again. Such occurrences are most likely the reason why the majority of participants characterized the healing process as something that is ongoing, non-linear, and with varying intensities. This point of view was stressed many times and is similar to the ways in which the participants in Grossman et al.,'s (1999) qualitative study of resilient sexual assault survivors conceptualized the healing process. These participants understood the memories and consequences of their trauma as burdens they would always carry (Grossman et al., 1999).

The desire for a balanced life appears to be a response to the acceptance that the survival process is difficult and ongoing. Each participant in the study discussed the importance of feeling that their lives were in balance. The majority of participants felt their lives were in balance and cited satisfaction with their

relationships, their work, and their families as examples of such balance. The minority of participants that desired more balance in their lives spoke of striving towards balance. They were also passionate and specific about the ways in which such balance could be achieved (e.g., pursuing their educational goals, finding healthy and rewarding romantic relationships).

Research Question # 1: What are the strategies that resilient Black female survivors use to cope with the experience of sexual trauma?

Spiritual Practices

Overwhelmingly, the participants in this study use spirituality as a way of coping with sexual trauma. This is consistent with Higgins (1994) finding that spirituality was central to the experience of resilient survivors. The findings from this study are also consistent with Mattis's (2002) study of Black women's methods of coping with adverse experiences. As indicated in the results of the present study, the majority of participants made the distinction between spirituality and religion. Most stated that they considered themselves spiritual but not religious, and integrated a variety of spiritual beliefs (e.g., Christian, Muslim, Buddhist) into their healing process. This finding is consistent with Grossman et al.'s (1999) study of resilient CSA survivors, where the majority of participants spoke of the importance of their spiritual beliefs, despite only a few being involved in organized religion.

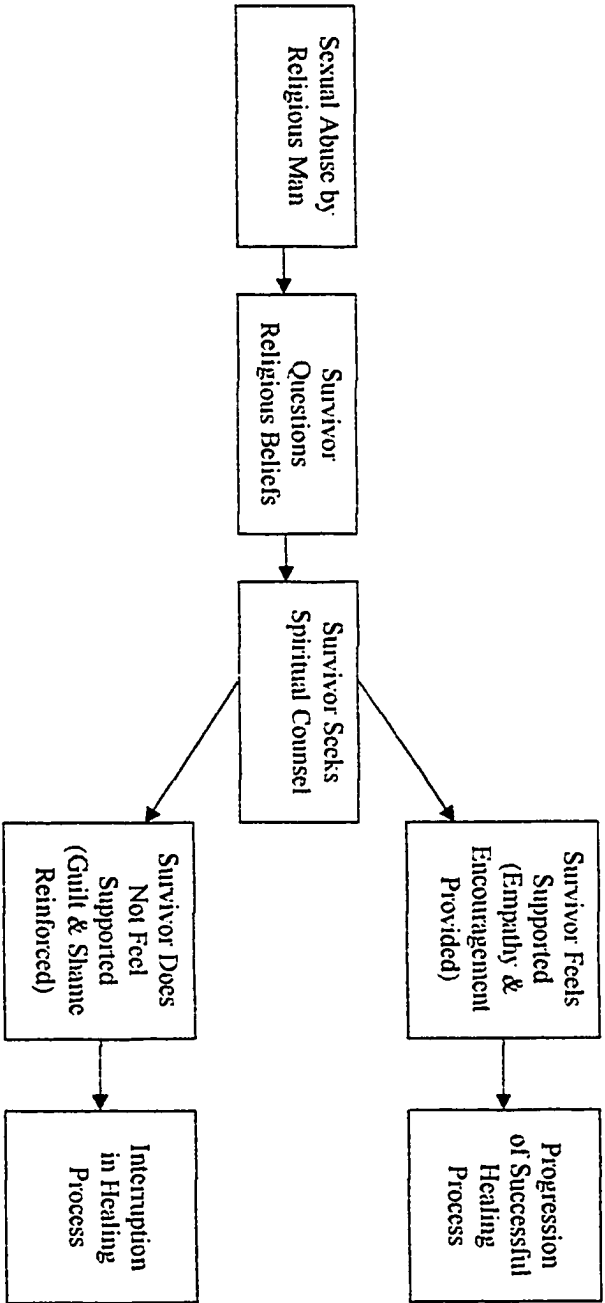
Additionally, at least half of the participants in this study explained that they were suspicious of organized religion, as they either associated "the church"

with their perpetrator (in several cases a religious man and/ or member of a local church) or with concepts such as patriarchy, oppression of women, and emphasis on guilt (See figure 1). These findings are also similar to those of Morrow & Smith (1995) who, in their qualitative study on coping processes of sexual trauma survivors, found that embracing prayer or spirituality, and/or turning against organized religion were common coping responses.

An overarching ideological belief system, such as religion or spirituality, has been positively associated with resiliency in African Americans (Howard, 1996). Lincoln and Masumiya (1990) found, in their studies of stress, adaptation, and depression in African Americans, that two out of the four most common coping strategies for African Americans involved spirituality (religious and/or spiritual beliefs and religious/spiritual participation). Similarly, several researchers have found that African Americans most often relied on religious or spiritual behaviors to cope with stress (Babaur, 1992; cited in Jones, 1998); Daly et al., (1995); and Neighbors et al. (1983). Prayer was cited as a particularly common method of coping by Babaur (1992; cited in Jones, 1998); McAdoo (1995); and Neighbors et al (1983), which is consistent with the participants in the present study. One participant, in particular, spoke about her search to find prayers and bible verses that particularly addressed healing from sexual trauma. This participant compiled a collection of such prayers and published them in her book.

Figure 1

Impact of Religious Perpetrator on Trauma Survivors with Strong Spiritual Beliefs



Use of Psychotherapy

Participation in psychotherapy was a prerequisite for inclusion in this study. Although all of the women had participated in psychotherapy, their experiences with psychotherapy varied considerably. The only recurrent themes were that the majority of participants sought therapy for reasons other than coping with sexual trauma, and that all but one participant recommended therapy for coping with sexual abuse. Seeking therapy for reasons other than sexual trauma is consistent with the findings of Davies and Frawley (1994) and Herman (1992). In both studies (1994; 1992), women presented in therapy complaining of relationship difficulties, problems with intimacy, and excessive response to the needs of others. Similarly, Mathews & Hughes (2001) who specifically researched Black female survivors of sexual trauma, found that the women that sought treatment did so because of sadness or depression, problems with self esteem, problems with partners, and problems with family. These presenting problems, along with the problems cited in Davies and Frawley (1994) and Herman (1992), are consistent with those that were found in this study.

Finding participants for this study that had participated in psychotherapy was quite difficult. Approximately ten women who approached the researcher about participation in the study had not attended therapy. These women explained that their “sister circles” – healing friendship circles of Black women, their families, and/or their spiritual communities had been their therapies. Several stated that they had simply coped with the trauma on their own. This is consistent with several studies (Abney & Priest, 1995; Daly et al., 1995; Neal-Barrett &

Crowther, 2000) that suggest that African Americans primarily seek help from informal support systems such as family, friends, and ministers. This occurrence is also consistent with Sanders, Thompson, and West's (1992) assertion that mental health services are underutilized by Black trauma survivors. Although Sanders et al. (1992) argue that the primary reason for not seeking treatment was fear of not being believed, this fear was not a recurrent theme in this sample (although it may be a reason why the women who were not included the sample chose not to seek treatment). The other fears mentioned by Sanders et al. (1992), include distrust of criminal justice system and perception of mental health agencies as uncaring towards Black survivors, were found in this sample—however, the participants in this study overcame their fears and sought treatment.

The majority of participants sought out therapists that were women of color and stressed the importance of doing so. Half of the participants shared their worry that White therapists would objectify them and misunderstand the ways in which race played a role in their lives. The two participants that attended group therapy for survivors found it extremely helpful. This is consistent with Taylor's (2000) finding that Black survivors found therapy (group and individual) very useful. One participant spoke about how helpful it was for her to be in a group that consisted solely of women of color. The other participant explained that she became particularly close to the other woman of color in her group and felt a special bond with her. This participant explained that this particular group member is the only one she continues to keep in touch with. Participating in a trauma recovery group with other women of color can reduce intra-community

feelings of isolation by providing an opportunity for Black female survivors to speak out about sexual violence and not be seen as traitors. Like traditional trauma recovery groups, women of color trauma groups can be used to validate the reality and frequency of sexual victimization as well. Women of color groups also allow for the disclosure of secrets in a supportive environment where the survivor may have to worry less about fulfilling sexual stereotypes about Black women or perpetuating sexual stereotypes about Black men.

Artistic Creation

The creation of visual art (e.g., photography, film), writing (e.g., private journaling, as well as writing poetry, essays, magazine articles, books) and dance were common strategies that were used to cope with sexual trauma. Eight out of the twelve participants cited creating art as a crucial component of their healing process. This is consistent with the findings of Morrow & Smith (1995), who found that their participants often cited artistic endeavors and journaling as strategies used to cope with sexual trauma. It is also consistent with the long history of Black women using writing to document their experiences of abuse (Adisa, 1997; Bell-Scott, 1994; Henderson-Daniel, 2000; Wilson, 1993, 1994) and as both a safe place to disclose such abuse, and to become empowered (Few & Bell-Scott, 2002; Wilson, 1993, 1994).

Connecting with Other Survivors

The participants in this study cited the development of connection with other survivors as a central component of their healing process. Some participants actively sought out other survivors through groups, special programming or via the internet, but most often connected with other survivors through political organizing and volunteer work. Many of the participants felt that, in retrospect, they most likely sought out such activities to connect with and gain strength from other survivors, despite not being consciously aware of this at the time. This is consistent with Grossman et al.'s (1999) finding that their participants were often drawn to work in the areas of sexual assault counseling and activism, without consciously linking such behavior with their own histories of abuse.

Connecting with other survivors is a coping strategy that is not frequently mentioned in the sexual abuse literature. The concept of talking about the abuse and reaching out to others is mentioned throughout the literature, but not with regards to specifically connecting with other survivors. In 1979, Burgess & Holstrom found that the ongoing discussion of rape was a common adaptive strategy of trauma survivors. More recently, Burt & Katz (1987) and Morrow and Smith (1995) found that talking about feelings and expressing feelings are common and useful coping strategies. More specifically, Goldstein (1998; cited in Grossman et al., 1999), found that "adult abuse survivors who described themselves as reaching out to others for emotional support were doing significantly better than those who tended not to turn to others" (p. 148).

Political Activism

Six of the twelve participants spoke specifically about the ways in which becoming politically active around violence against Black women and girls had helped their healing process. Several of the participants that did not speak directly about being politically active spoke of their desire to become more involved with political activism and their anger over the ways in which violence against women is not being adequately addressed in Black communities. This is consistent with White's (2001) research on Black anti-rape activists. White (2001) concludes that political activism can be an important part of a survivor's healing process. White (2001) argues that "activism should be encouraged as a healing modality just as individual and group therapy are encouraged" (p. 20). Similarly, West (2002) urges clinicians working with Black female trauma survivors to encourage activism. West (2002) argues that activism can take many forms including developing violence prevention programs, or participating in media campaigns. Participation in activism can help Black female survivors to connect with other Black survivors and allies, develop a sense of purpose by creating social change, and feel good about giving back to their communities.

Reading Black Women's Literature

Seven of the twelve participants described the reading of fiction and narratives by Black women as helpful in their healing process. Several of the women that did not refer to Black women's fiction and narratives specifically,

referred to reading self help books by the African American spiritual leader Iyanla Vanzant or reading interviews with Oprah, where she talked about being sexually abused. This is consistent with the findings from Millet's (1997) study of Black female survivors. The participants in Millet's (1997) study found it helpful to read survival stories by other Black women and benefited from incorporating such narratives (e.g., Maya Angelou, June Jordan) into their individual and group work. Similarly, Few and Bell-Scott (2002) found that Black female survivors of emotional abuse considered self-help books by Black women, such as Iyanla Vanzant, to be very helpful. Interestingly, several of the participants in this study stated that they found reading survival stories by other Black women depressing and not helpful. They called for more books, articles, and narratives that focused on the healing process, and reported that they were pleased that that was the focus of this research study. This discrepancy may be explained by the stage survivors were at in their healing processes. Women that are further along in their healing may be more interested in reading about strategies for and ways to further cultivate healing, and may find that personal accounts of trauma, in the words of one participant, "dampen their spirit and bring them down."

"Keep Moving"

"Keep Moving" is a phrase that one of the participants used to define the way she coped with the experience of sexual trauma. One participant explained, "it's borderlining on not being healthy in some ways. It's kind of like, keep moving, keep moving...it was just like keep pushing, keep pushing." Many of the

participants spoke about this concept. At first glance, the strategy of “keep moving” seems like an attempt at avoidance or suppression. However, although that may be true, avoidance and suppression do not fully capture this experience. The participants’ described this experience as an active attempt to stave off negative feelings with the awareness that they would deal with them later. Statements such as, “I just kept focusing on finishing school,” and “I just had to finish the semester,” were given as examples of “keep moving.” Although the participants struggled with whether this was a positive or negative coping mechanism, they viewed it as very different from minimization and denial, which they saw as negative. The participants considered “keep moving” to be more of a method of holding off on dealing with the trauma until they were ready, as well as a method that they were aware of using when they used it. This finding may be similar to the PTSD literature that warns that asking trauma survivors to recount traumatic experiences too early on can lead to re-traumatization (Raphael, Wilson, Meldrum, & McFarlane, 1996).

Minimization/Denial

The most commonly cited negative coping strategy cited by the participants was the use of minimization/denial. Participants referred to this as “putting it in a drawer and shutting that drawer”, “naming it something else” and making it “not such a big deal.” The use of minimization and denial is consistent with Burt and Katz (1987; 1988) study of 113 rape survivors. The strategy of “trying to make the rape go away in their minds” was one of the five major coping

strategies. Black women may be particularly prone to minimizing and denying the effects of a traumatic experience, as they are conditioned to not show weakness when facing any situation.

Additionally, several of the participants stated that although they considered minimization and denial a negative coping strategy, this strategy may have been what they needed to do to cope at the time. Burgess and Holstrom (1979), who found that minimization and suppression were common coping strategies for sexual trauma survivors, actually saw this as a necessary process for survivors and placed it in the adaptive realm. Other researchers have also noted the potentially adaptive purposes of minimization and denial (Raphael et al., 1996). Thus, it is crucial that clinicians carefully assess whether encouraging the patient to let down her guard and disclose will be useful to the patient or re-traumatizing. We can do this by initiating honest and respectful discussions with survivors about their internal and external resources for coping with the disclosure of trauma, as well as inquiring about the level of safety they experience within the therapeutic relationship. Additionally, it is crucial that clinicians be mindful of their own assumptions about when and in what way a survivor should disclose, as well as their own countertransferential responses to the traumatic experience.

Unhealthy Sexual Relationships:

The finding in this study of participants engaging in unhealthy sexual practices is consistent with findings in the mainstream literature on sexual trauma survivors (Briere & Runtz, 1987; Browne & Finkelhor, 1986). Like the use of

minimization and denial, participants placed their risky sexual behavior within the negative realm, but felt that the behavior was what they needed to do at the time. They were not justifying the behavior, but framing it in a way that respected their belief (at the time) that they were trying to reclaim their sexuality. The research of Burt and Katz (1987) and Morrow & Smith (1995) both found that adult survivors engaged in risk-taking as a coping strategy and used sex as a way of feeling validated. The few studies that have focused on Black female survivors (West et al., 2000; Wingood et al., 1997) found that victimized Black women engaged in unhealthy sexual behavior and perceived themselves as having less control over their sexuality respectively.

The experience of engaging in unhealthy sexual relationships may be further complicated for Black women, who may be influenced by the historical legacy of racism and sexism against Black women. This long history of Black women's bodies being controlled by men (e.g., slavery) can be transmitted intergenerationally (Wilson, 1993, 1994; Wyatt, 1997). Risky sexual behavior may also be influenced by the internalized negative Jezebel stereotype of the sexually promiscuous Black women (West, 1995; Wilson, 1993, 1994; Wyatt, 1997). This stereotype contributes to the exoticism of Black women and suggests that they are ready, willing, and able for sexual encounters at all times.

Disordered Eating

As stated in the results section, this category, although minor, was presented because there is little research in the area of Black women and eating

disorders. Until recently, it was commonly believed that few women of color suffer from eating disorders. This is particularly interesting in this study, because, despite conflicting research findings, a history of sexual trauma is often associated with eating disorders (Neville & Heppner, 1999). One racially and ethnically diverse large scale study of this connection found that a history of sexual assault was related to one or more symptoms of anorexia and the self-perception of being too fat for White women and Latinas, but not for Black women (Laws & Golding, 1996)

The participants in this study who talked about disordered eating referred to it as a way to maintain control over a body that they felt they had little, if any, control over. The majority of participants in this study spoke of having a negative relationship with their body at some point in their healing process. The participants who disclosed disordered eating also spoke about it as a way of managing difficult feelings. Overeating was described as a way to “stuff feelings down,” as a way to manage anxiety, and as a way to self soothe. This particular finding should be further explored because of its implications for Black women’s health. The finding of disordered eating, although relatively small in this sample, is most consistent with Morrow and Smith’s (1995) finding that sexual trauma survivors used food, cigarettes, and alcohol to manage feelings.

Research Question # 2: What characteristics contribute to the participants’ resiliency?

Labeling survivors resilient does not suggest an absence of depression, anxiety, and other PTSD symptoms, but the ability to negotiate such experiences

in a way that demonstrates self-determination and strength (Valentine & Feinauer, 1993). All of the participants were very open about periods of depression, sadness, despair, and in one case, feeling suicidal. However, all of the participants also shared they had either found the tools to deal with such feelings (e.g., psychotherapy, prayer, confiding in/leaning on friends) or were actively trying to find and utilize such tools.

Additionally, being labeled resilient does not suggest that an individual is resilient in every aspect of their lives. In fact, the majority of survivors in this study volunteered examples of areas in which they were not particularly resilient (e.g., managing their money, overworking). This understanding of resiliency as something that exists on a continuum, as something that exists to greater or lesser degrees depending on the area of one's life or the time in one's life that is being studied, is very applicable to this sample.

The participants in this study demonstrated many characteristics of resiliency. The characteristics that appeared most frequently, as noted in the results were 1) internal locus of control, 2) belief in a divine order/everything happens for a reason, 3) strong female relationships/role models, 4) education, 5) placing blame outside of oneself, and 6) cultural resiliency.

The themes that surfaced in this study were most consistent with the findings of Valentine and Feinauer's (1993) study of resilient CSA survivors. That was a predominantly White sample. Valentine and Feinauer (1993) found religion and spirituality, external attribution of blame, and internal locus of control to be common characteristics of resiliency in their sample. Interestingly,

their sample was also largely Mormon, which suggests that spirituality and religiosity were likely to be robust factors.

Additionally, Valentine and Feinauer (1993) found that the ability to find emotional support outside of one's family and regard oneself highly were associated with resiliency. In this sample, the majority of participants did find emotional support outside of the family, but it is striking that most were able to rely on at least one person within their families as well (most often a grandmother or a sister). The participants in this sample also regarded themselves highly. However, for many of them, high self-esteem is something they have achieved gradually and work towards.

Another similar finding is that Valentine and Feinauer's (1993) resilient survivors also possessed what they (1993) referred to as a positive philosophy of life. Like the participants in this study, despite suffering from depression, difficulty trusting others, and periods of low self-worth, these experiences did not rule their lives. The participants in this study continued to have positive and uplifting philosophies about life and continued to make positive meaning out of their experiences. All of the participants believed that life was very meaningful and that they were making meaningful contributions to the world through their work and relationships. Each participant also reported looking forward to their future.

Internal Locus of Control

Liem et al.'s (1999) study of 687 undergraduate women found that more resilient sexual trauma survivors possessed a strong internal locus of control and

were less likely to blame themselves for the abuse. This is consistent with the themes that surfaced in this study. Grossman et al., (1999) found that resilient survivors possessed the capacity to make meaning of their experiences, make meaningful attachments, have authority over their memories and tolerate powerful feelings. Like the participants in the Grossman et al., (1999) study, the participants in this study used spiritual practice, meditation, yoga, and exercise as ways of taking care of themselves and managing powerful feelings. The participants in this study also made incredible meaning from their experiences. One participant eloquently stated, “ I started to realize that the ones that were wounded later become the healers...Maya Angelou, Iyanla Vanzant, Oprah,” she continued, “I realized this and that’s when I came up with the phrase, ‘the wounded become the healers’”. Another participant, a Haitian American woman, used the Haitian proverb “piti piti, zwazo fe nech li” to movingly describe her healing process. When translated from creole, the proverb states: little by little, the bird builds her nest.

Belief in Divine Order/ Everything Happens for a Reason

The recurring theme of believing in a divine order or believing that everything happens for a reason was the theme that was most surprising to this researcher, as I expected to hear phrases such as, “why did this have to happen to me?” or “what happened wasn’t fair.” Interestingly, not one of the participants used such phrases and nearly every participant volunteered the phrase “everything happens for a reason” during their interview. They believed that there was a

reason why the traumatic experience (s) happened to them and that they were destined to make use of it in some way. This finding differs from Mattis' (2002) study of Black women's coping strategies. Mattis (2002) found that only 48% of her participants believed that there was a greater purpose for both the negative and positive experiences that they had had.

Furthermore, several participants in this study stated that they would not be the women that they are today (e.g., empathic towards the suffering of others, informed about and committed to ending sexual violence, more spiritually connected to God) without such experiences. Although the participants were quick to report that such a belief system did not mean that they were glad the experiences happened, they were generally satisfied with the women they had become. This is not consistent with the findings of Mattis (2002) –the majority of the Black women in her study did not believe that adverse events presented an opportunity for growth. However, the results in this study are consistent with the findings of Burt and Katz (1987) whose participants also cited positive aspects of surviving abuse. This ability to consider a broader perspective in the face of abusive experiences suggests resiliency (Cohler, 1991; Grossman et al., 1999)

Strong Female Relationships/Role Models

Strong female relationships were a consistent theme throughout this study. Participants spoke at length about grandmothers, aunts, sisters, and female teachers who shaped who they are today. They also spoke, but to a lesser degree, about their relationships with their mothers. Interestingly, the majority of women

in this study did not cite their own mothers as their major sources of positive influence. Several participants described negative and difficult relationships with their mothers, but most simply explained that they were closer to grandmothers, sisters, and aunts. It is possible that this finding may be a result of feeling that their mothers did not protect them adequately from trauma. However, it is also important to note the prevalence of extended family systems in African American and Caribbean American communities. Several of the participants were raised primarily by their grandmothers and others were co-parented by aunts and other female relatives. Immigration also impact this, as several of the participants remained with their grandmothers while their mothers came to the United States to work. Many grandmothers and aunts filled in for mothers who worked long hours. This may better explain the centrality of these relationships to Black women.

The presence of close relationships as a characteristic of resilience in this sample is consistent with findings in the resilience research. Valentine and Feinauer (1993) found that the majority of resilient women from their sample were able to establish a close relationship with at least one caretaker with whom they could trust. Hyman and Williams (2001) and Banyard, Williams, Siegel and West (2002) found that the Black female survivors in their sample who were resilient had been able to find social support from someone they considered special and significant. Mattis (2002) also found that the Black women in her study of coping reported deriving great strength from their female friendships. Mattis' (2002) participants stated that it was these relationships which provided

the context for the ways in which they made sense of the positive and negative events that took place in their lives. Of particular interest in this study was the fact that, despite such closeness, most participants took years to disclose the abuse to the women they were closest to. Grandmothers, sisters and aunts provided general support, but not always specific support regarding sexual trauma. In several cases, the participants never disclosed the abuse to such women at all. All of the participants who prolonged (or avoided altogether) disclosing to the women they were closest to, explained that they feared upsetting or hurting such women. The need to protect others at the expense of oneself, a common cultural practice among women of color, may contribute to keeping Black female survivors silent.

Education

In this study, education seemed to serve as a protective factor. The participants interviewed either found comfort in their academic studies and the control they had over that realm of their life, and/or they found female teachers at school who often served as role models and encouraged them to persevere. In the two previous studies that were conducted on resilience in Black female CSA survivors (Banyard, Williams, Siegel & West, 2002; Hyman & Williams, 2001) high resilience was associated with graduation from high school, as well as, social support from someone the survivor deemed special and significant. With this in mind, elementary, high school, and college counselors should be trained to meet the needs of Black female survivors. Providing the appropriate resources for such

women to remain supported and connected to school, even if a leave of absence is needed, appears to be an important aspect of the healing process.

Placing Blame Outside of Oneself

The participants in this sample were very clear that they did not blame themselves for the abuse, clearly a characteristic of resiliency. This finding is consistent with Liem et al.'s (1997) study where they found external attribution of blame to be a characteristic of resilience. Similarly, Valentine and Feinauer (1993) found resilient survivors less likely to blame themselves. One difference between the participants in this study and Valentine and Feinauer's (1993) participants was the way in which they viewed the perpetrator. The participants in their (1993) study saw the perpetrators as being "sick" and "crazy." The participants in this study rarely referred to the perpetrator unless asked. When asked, they most often discussed their struggle to not hate the perpetrator, to no longer feel emotionally tied to him or her, and they generally regarded them with pity.

Despite placing the blame outside of themselves, many of the participants were able to recall a time when they did wonder what they might have done that may have contributed to the abuse. They spoke openly about the process of shifting the blame from themselves to the perpetrator. This process seemed most difficult for the survivors who were related to or lived with the perpetrator. These survivors had great difficulty blaming a perpetrator who also served as their caretaker, and also reported extensive emotional abuse and manipulation that

further complicated their experiences. It was hard for them to fully place the blame on the perpetrator until they (or the perpetrators) left the home permanently. Factors that contributed to shifting the blame in this study were primarily psychotherapy and connecting with other survivors and hearing their stories. The process of shifting the blame, and the factors that contribute to such a shift, are consistent with the findings of Grossman et al. (1999).

Cultural Resiliency

“Cultural Resiliency” is a term this researcher is using to describe the ways in which the majority of participants in this study located themselves within a larger cultural history of African Americans and Caribbean Americans. The women referred to their ancestors as having survived slavery, colonialism, and other forms of racial oppression. They were not just referring to their own particular ancestors, but African Americans and Caribbean Americans who had come before them. This ability to locate oneself within a cultural legacy of survivors clearly demonstrates resilience. It appeared to contribute to the participants making sense of what happened to them, as well as, decrease their feelings of isolation. The participants in this study also spoke of drawing strength from such individuals in order to maintain their resiliency. One participant, a Haitian American survivor, reported that she drew strength from her knowledge of the long history of Haitian people resisting oppression.

The idea of cultural resiliency is something that should be further investigated in populations of color. A strong cultural identification appeared to

play an important role in the successful healing processes of the research participants. This is consistent with much of the resilience literature that considers a strong ethnic identification a protective factor (Jenkins, 1993; Kambon, 1998; Taylor, 1994). This is also consistent with the findings from Bruce-Morrith's (1997) study of African American CSA survivors. Bruce-Morrith (1997) found ethnic identity level to be a mediating variable between a history of CSA and one's psychological functioning. Although Bruce-Morrith (1997) hypothesized that Black women with histories of abuse would present lower levels of ethnic identity development, this was not supported. The findings from this study suggest that resilient Black women would more likely present with stronger ethnic identification. A quantitative study measuring such factors would significantly add to the research on Black women and sexual trauma.

Research Question # 3: In what ways are these women impacted (intrapsychically, interpersonally, physically, spiritually, and intellectually) by sexual trauma?

The participants in this study reported the most common ways that they were impacted by the abuse (intrapsychically, spiritually/intellectually, physically, and interpersonally). These areas of impact will be discussed, along with research that supports and contradicts these areas. The researcher's own theory of the impact of sexual trauma on Black female survivors will then be presented.

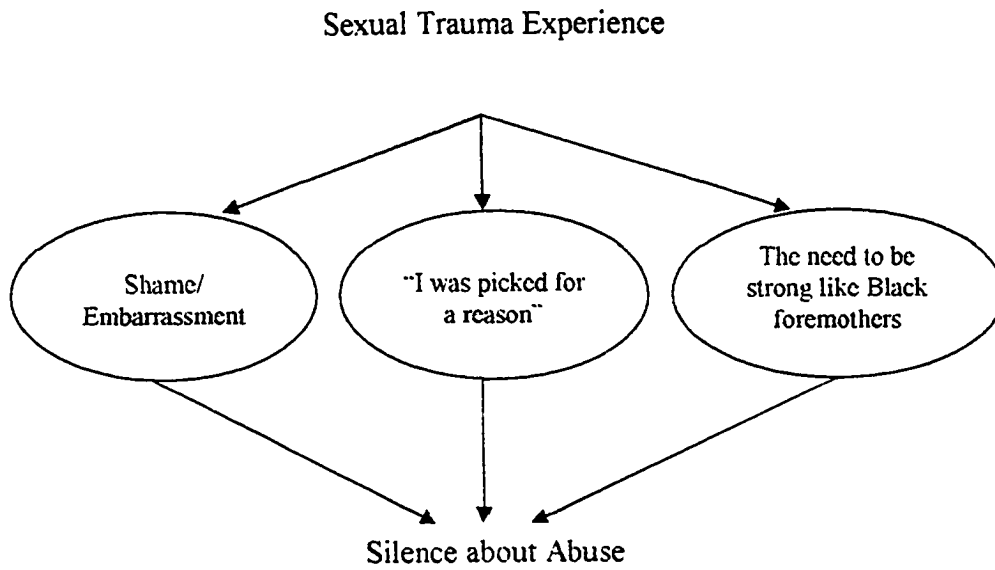
Intrapsychic Impact

The participants described past feelings of shame and embarrassment about being sexually assaulted, as well as, feeling as if they had been chosen for

some reason (either related to their personality or appearance), as results of the abuse (see figure 2). These findings, which are regarded as common sequelae of sexual trauma, are consistent with the seminal research findings of Browne and Finkelhor (1986) and Herman (1992). The feelings of shame and embarrassment and the stigma of feeling picked may be further complicated for Black women who have to manage racism, as well as, sexism. West (1999) explains that “because shame has a psychic identity, it can readily merge with the social stigmas based on race and gender that are usually already at work on Black women’s psyches” (p. 67).

The additional theme of needing to be strong like one’s foremothers, like other Black women that preceded them, is the other side of cultural resiliency. Specifically, an awareness of the history of Black women having to survive under incredibly difficult circumstances contributes to a survivor’s feelings that she should be able to weather through any storm and not complain. Black women often feel as if a particular adverse experience is their cross to bear (Mattis, 2002; Wilson, 1993, 1994). The sentiments expressed most often among the participants in this study were “she (usually their grandmother) went through a lot, so I guess I just figured that I should too.” This feeling, along with feelings of shame, embarrassment, and stigmatization, can cause a survivor to remain silent about the abuse (see figure 2). This may explain why, despite feeling very connected to their grandmothers and aunts, the survivors’ delay in disclosing (or never disclosing to them) about the abuse. A better understanding of the barriers

Figure 2

Intrapsychic Impact of Sexual Trauma on Black Women

that prevent disclosure, especially to people survivors trust, would greatly enhance our clinical work with survivors.

Spiritual/Intellectual Impact

The participants in this study frequently shared the ways in which their spiritual beliefs and the ways in which they view the world were impacted. Overall, the participants felt that the experience of trauma strengthened their spiritual beliefs and their connection with God. They were clear that it was their spiritual beliefs that allowed them to cope successfully with and make sense of the trauma.

Physical Impact

The majority of participants in this study believed that the abuse had an impact on their physical bodies. They either felt that the abuse caused them to hate their bodies at some point in the past, or to not care for their bodies adequately. Several survivors described the onset of hating their bodies as taking place during the abuse. Such hating took the form of negative body image, hiding one's body in baggy clothes, not treating their bodies well (not exercising, eating poorly, smoking), remaining in relationships with partners who devalued their bodies, and feeling disconnected from their bodies. Interestingly, two participants shared that becoming pregnant and giving birth improved their relationships with their bodies. The process of carrying a child and giving birth made them feel powerful and proud of their bodies, it also allowed them to surrender control of

their bodies (to a growing child, during childbirth) in a way that did not feel traumatic. This is an important discovery that should be explored in future research.

Several of the participants connected current medical problems such as fibroid tumors, ovarian cysts, and asthma to their histories of trauma. These connections are consistent with previous research that has linked a history of sexual trauma to physical complaints such as headaches, gastrointestinal problems, ulcers, and gynecological difficulties (Davies & Frawley, 1994; Koss et al., 1991; Walker, 1996). Van der Kolk (1996) argues that the impact of trauma on physical health should be further researched. The connection between sexual trauma and physical health should be further explored in this population.

Interpersonal Impact

The overarching themes that surfaced in this sample regarding the interpersonal impact of abuse, becoming a caretaker, people pleasing, and difficulty with trust, are supported in the trauma literature (Davis, 1991). The more specific themes of negotiating relationships with family, friends, romantic partners, and one's community are common amongst survivors regardless of ethnicity. However, some of the particular ways that Black women are interpersonally impacted by abuse are evidenced in this sample.

Impact on Familial Relationships

The majority of participants stated that they were never told about sexual abuse in their families of origin. When sexual trauma was discussed, it was only

in reference to famous cases in which the perpetrator and/or victim were African American. In such cases, survivors recalled hearing their families blame victims such as Anita Hill or Desiree Washington (the Miss Black America contestant Mike Tyson was convicted of raping), referring to such women as “race traitors” and as “trying to keep the Black man down.” Several of the participants noted that witnessing such victim blaming further contributed to their silence.

Participants also spoke of the lack of protection and vulnerability they felt within their families, which is also a common experience of most survivors. However, many of the participants in this study spoke about their belief that not enough value is placed on the lives of Black girls and women, by Black communities, as well as the larger society. The participants also spoke at length about the level of denial that existed in their families. Although this characteristic is common in families where abuse is present (Vangelisti, 1994), the participants placed family denial within the larger context of Black familial norms. They described the common familial codes of “sticking together”, “not airing dirty laundry” and “protecting Black men” as factors that may have contributed to their own silence in particular, as well as, the silencing of other Black women.

Interestingly, many of the participants described the centrality of family in the lives of Black Americans. They discussed the dilemma of wanting to take care of oneself, while at the same time not relinquishing family ties. The majority of the participants that experienced abuse within their families felt that cutting themselves off from their families was simply not an option. These participants struggled with finding ways to remain connected to sisters and wives of the

perpetrator, and in several cases the perpetrator. The negotiating of such relationships by Black female survivors is an area that needs further exploration, as several of the participants stated that this contributed to successful healing.

Impact on Friendships and Romantic Relationships

Several of the participants spoke about the difficulty they experienced when setting boundaries with friends. This is consistent with findings from the Grossman et al. (1999) study. Nearly all of the participants spoke about difficulty negotiating romantic relationships, which is also consistent with the trauma literature. However, this is further complicated the participants' feelings about the Black men and Black women that abused them. This led to struggles in negotiating romantic relationships with members of their own ethnic communities. Several of the participants stated that they were able to keep the positive experiences that they had with Black men (family members, friends and siblings) in mind to counter any negative images that surfaced. Other participants spoke of widening their dating pool in an effort to not feel triggered by Black men. Overall, the participants shared that the ways in which an abuse history with Black men (and in several cases Black women) complicated their romantic relationships saddened them. This is a struggle that clinicians working with Black female survivors should be aware of.

Impact on Community Relationships

Several of the lesbian participants explained that the process of coming out as a lesbian, allowed them to come out as a survivor of sexual trauma. The

participants attributed this connection to an increased comfort with themselves. Several participants also noted that sexual violence was being discussed in lesbian communities in a way that was not taboo. This led the participants to feel less isolated and less stigmatized, which contributed to their own disclosure. An important dilemma that was mentioned, however, was the discomfort Black lesbian participants felt in White lesbian environments. Although the participants felt that these environments valued their sexual orientation and experiences as a survivor, they often felt as if their ethnic identity was not valued—or that they were asked, as one participant aptly noted, to “check [their] ethnicity at the door.” This is a common dilemma faced by Black lesbians and supported by the literature (Greene, 1994). However, the participants in this sample dealt with this by finding Black lesbian activists communities or activist communities led by Black women or women of color that were able to validate all of their identities. The ability to find a community where one can feel supported and empowered is also a demonstration of resilience.

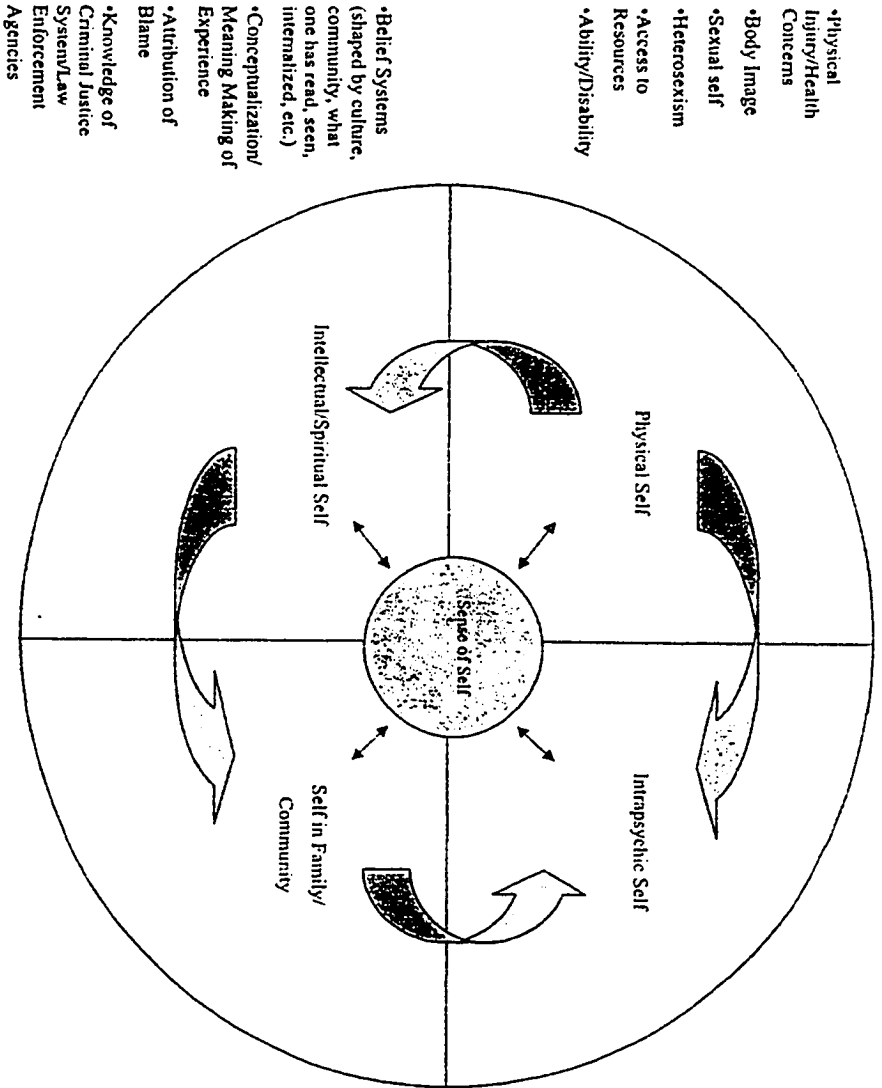
The ways that participants described the trauma as impacting their relationship with their Black communities is similar to the familial impact that was described earlier. The community codes of “not airing our dirty laundry” “not wanting folks in our business” and “protecting Black men” are similar to the codes that exist in many Black families. The participants repeatedly spoke of feeling silenced and feeling as if they needed to remain silent about sexual abuse by Black men at the expense of themselves. They also expressed concern about embarrassing their families and/or reinforcing negative sexual stereotypes about

Black men and women. Despite this, many of the women came forward anyway, which again points to their resiliency and adept negotiation skills.

The participants in this study coped with feeling silenced in their Black communities in a variety of interesting ways. Some participants kept ties with their Black communities (without disclosing the trauma) and found other communities, often non-Black church communities, feminist communities, lesbian communities, where they could disclose the trauma. Most participants found ways to connect with other Black survivors (either through volunteer work or activist work), and used the strength and courage they derived from such communities to speak out about their own violent histories and about violence against women in general. It is this amazing transformation—the shift from feeling isolated and silenced to speaking out publicly—that led the researcher to want to interview such women. Understanding the ways in which survivors make this shift, or as one participant so eloquently stated, how “the wounded become the healers,” will greatly benefit the field of trauma.

The Self-in-Relation Model of the Impact of Trauma for Black Female Survivors.

Childhood Sexual Abuse (CSA) and sexual assault are relational traumas that attack one’s sense of self. The fact that an egregious act is committed against one person by another places sexual trauma in a different realm than natural disasters or debilitating physical illnesses. Consequently, the trauma effects all aspects of a person’s sense of self, their intrapsychic self, their spiritual self, their physical self, and their interpersonal self, which are all embedded within the person’s cultural experience (See figure 3). How one feels about oneself and



- Physical Injury/Health Concerns
- Body Image
- Sexual self
- Heterosexism
- Access to Resources
- Ability/Disability

- Belief Systems (shaped by culture, community, what one has read, seen, internalized, etc.)
- Conceptualization/ Meaning Making of Experience
- Attribution of Blame
- Knowledge of Criminal Justice System/Law Enforcement Agencies

- Guilt
- Isolation
- Shame
- Cultural Identity identification w/Aggressor
- Anger
- Helplessness
- Distrust

- Family Role
- Community Role
- Gender role
- +& Stereotypes
- Racism & Sexism, Heterosexism
- Community Help-Seeking Norms

Self-in-Relation Model of Impact of Sexual Trauma

Karen Singleton, 2002

one's body, their spiritual belief systems, and the role that they take up or disavow in their families, and the meaning they make from the experience is shaped by the cultural communities they inhabit and their location in larger society (e.g., does the larger society make them feel valued or devalued?). This experience is further complicated for Black female trauma survivors, who may feel marginalized within their own communities for disclosing trauma, in addition to the marginalization that occur as a result of racism and sexism within society at large. The Self-in-Relation Model of the impact of trauma (Singleton, 2002) represents the myriad ways that women are impacted by abuse, as well as the ways in which the different areas that are impacted influence one another.

Clinicians working with Black female trauma survivors, as well as researchers studying this area are advised to consider the ways in which messages and expectations from a survivor's ethnic community, as well as larger society, impact the experience of sexual trauma and the process of surviving such trauma. A comprehensive understanding of the complexity of traumatic experiences of Black women, along with an understanding of the collective history that Black women carry, is essential for assisting in their survival process. The researcher is not suggesting that this model be used as a checklist or prototype of how all Black women experience sexual trauma, but as a way of understanding and valuing the commonalities that exist between Black female survivors, as well as the variety within this population. We have learned from the participants in this study that, although there is no right or wrong way of healing from sexual trauma, there are clusters of coping strategies and characteristics that resilient survivors may share.

Knowledge of this unique information can help survivors, their families, their friends and their clinicians better manage the survival process.

Study Limitations

Qualitative research aims to investigate particular phenomena in an in-depth way with a relatively small sample size (Patton, 1990). Qualitative research studies are not designed to generalize to the general population. The results of this study are unique and highlight the particular experiences of a sample of twelve Black female survivors of sexual trauma. These twelve women were highly educated, successful in their careers and educational pursuits, and had all attended therapy. Thus, the Black women in this study fall within a certain socioeconomic status and have experienced talking about their abusive experiences in psychotherapy. Given this, the findings of this study are only representative of this group and have only been used to broaden our understanding of sexual trauma and build theory in this area, not to generalize. This researcher is not suggesting that all Black female survivors of sexual trauma will respond similarly, as Black women are an extremely heterogeneous population. The researcher is suggesting that an awareness of the research findings would benefit clinicians and researchers working with Black female trauma survivors.

A small sample size allows a researcher to examine participant's thoughts, feelings, and behavior in an in-depth manner. Unfortunately, a small sample size also reduces the variety of perspectives that can be presented. The participants in this study were also chosen purposefully. This researcher's intention was to

identify resilient Black women with histories of sexual trauma. Thus, the researcher advertised and solicited participation in places where resilient Black women might be found (e.g. community organizations, activist groups, listserves for Black women, anti-violence conferences). Women who are not involved in such organizations or activities would most likely present different findings. A number of the participants were also recruited through the technique of “snowballing”, meaning that several participants that were interviewed suggested friends that might also want to be interviewed.

Furthermore, the participants in this sample chose to become involved in this research. Their responses are likely to differ greatly from those of women who would never consider participating in such a project. Additionally, the participants in this study were asked to provide information retrospectively. Retrospective designs rely on the participant’s ability to access memories regarding particular experiences in their lives. However, qualitative research does not seek to present the objective truth, but focuses on the ways in which participant’s make meaning of their experiences.

Implications for Clinical Practice

The most important recommendation that the researcher can give to clinicians that are working with Black trauma survivors is to develop cultural competency in this area. Walker (2000) defines cultural competency as “a measurable professional standard that evaluates the incorporation of the differential historical, political, socioeconomic, psychophysical, spiritual, and ecological realities, their interaction, and its impact on groups.” Just as one would

try to better understand eating disorders if they were working with a college population, clinicians should improve their knowledge base in this area.

Therefore, the researcher challenges clinicians to keep the following issues in mind:

1) Clinicians must understand the centrality of religion and spirituality in this population. They must understand it not as a form of escapism, which is common throughout psychological literature, but as something that many survivors derive strength from. Clinicians need to recognize that spirituality may not just take the form of attending worship services or participation in organized religious activities, but may be defined in a variety of ways, including listening to music, dance, creating art, yoga, eating habits, and/or use of traditional African Spiritualities (Yoruba, Voodoo, etc.).

2) Clinicians must understand the complexity of Black women coming out as survivors to White clinicians and mental health care centers that are largely White. Clinicians should understand that there are legitimate historical reasons within psychology and research (e.g., the pathologizing of Black family structures, Moynihan's research on Black families, the Tuskegee Experiment) which cause Black women to fear "airing dirty laundry" from within Black communities to people outside of those communities.

3) Clinicians need to understand the historical usefulness of strength for Black women, and the necessity of such strength for survival. However, this strength needs to be reconceptualized for Black survivors as a way of taking care of

oneself and asking for help, instead of remaining silent and “sweeping things under the rug”. Black survivors can be assisted in understanding that sexual trauma does not have to be their “cross to bear”.

4) Clinicians need to understand the importance of negotiating family relationships in this population. Some survivors may not want to terminate relationships with their family or even with their perpetrator. This should not be taken as resistance or weakness—there are many roads to healing.

5) Clinicians need to investigate the survivor’s relationship with her ethnic community. Does the survivor feel connected, supported, or silenced by this community? If she does not feel connected to her community, how does she negotiate this? Many of the participants in this study noted that this conflict contributed to remaining silent about sexual trauma.

6) Artistic expression should be further explored by clinicians and their clients as a possible method of healing. The participants in this study greatly benefited from journaling and using other forms of art work to represent their experiences. Several of the participants who did not create art specifically about their experiences found photography and participation in dance classes very helpful.

7) Clinicians should keep in mind the importance of sister circles and close Black female or women of color friendship bonds. Nearly every participant in this sample cited the importance of such relationships as a source of ongoing strength and support.

Suggestions for Future Research

This study provided information about the ways in which resilient Black women are impacted by and heal from sexual trauma. As with most research, areas that would benefit from additional exploration surfaced throughout the study. Thus, possibilities for future research include, 1) exploring the healing processes of Black female survivors who do not identify themselves as resilient, 2) studying the healing processes of Black female survivors who have not participated in psychotherapy, 3) examining the stages of healing in a sample of Black female survivors (e.g., does the use of spiritual practice as a coping strategy precede psychotherapy, 4) systematically investigating the belief systems that exist about sexual assault survivors among Black men and Black women of varying generations (this could be done qualitatively, quantitatively, and through focus groups), and 5) interviewing family members of Black female survivors to discuss the ways in which families are impacted by trauma. Additionally, more research on the ways in which other women of color (e.g., Latinas, South Asian women) heal from sexual trauma is needed as well.

APPENDIX

Appendix A

Resiliency Screening Form (RSF)
 (to be administered via telephone)

Initial Screening for Prospective Study Participants:

Participant Initials: _____

Date of Screening: _____

- | | | |
|--|-----|----|
| 1) Have you ever participated in psychotherapy? | Yes | No |
| 2) Are you currently employed or a full-time student? (this includes full-time homemaker) | Yes | No |
| 3) Are you currently in or have you ever been in a committed romantic relationship? | Yes | No |
| 4) Do you have a support system (e.g., close friends, family)? | Yes | No |
| 5) Are you currently suffering from depression, anxiety or any other severe psychological disorder? | Yes | No |
| 6) Do you consider yourself resilient? | Yes | No |

.....

| | | |
|--|-----|----|
| Was the participant accepted for the study? (affirmative answers for all six questions) | Yes | No |
|--|-----|----|

| | | |
|--|-----|----|
| Did the participant agree to be interviewed for the study? | Yes | No |
|--|-----|----|

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Appendix B

Patterns of Adaptation in Sexual Trauma Survivors of Color

Participant Consent Form

Name: _____

Date: _____

I understand that to participate in this study I must be over 18 years of age.

I understand that the purpose of this study is to explore the ways in which I have coped with the experience of sexual trauma. Further, I understand that this study will also look at how I conceptualize this experience as a woman of color.

I understand that the interview will include questions covering many aspects of my life, including my family life.

In agreeing to take part in this study, I agree to meet with the interviewer for approximately 2 hours to discuss my experience as a sexual trauma survivor of color.

I understand that all of my responses to the interview questions will be tape recorded and will remain confidential. On the tapes I will only be identified by a participant identification number. I will not be asked my name, address, or phone number during the taping, but I will be asked to provide identification on a separate sheet of paper. I understand that this information will be kept separate from the interview tapes in order to assure confidentiality. By signing this form I agree that I am willing to be contacted in the future for possible interviews, although I am under no obligation to participate.

Although I may learn something about myself from the interview, I understand that the purpose of the research is not for my immediate benefit. I also understand that I may experience some distress from discussing issues relating to sexual trauma. With this in mind, I understand that the interviewer, in acknowledging the sensitivity of the topic, will conduct the interview in a sensitive and professional manner. In response to the sensitive nature of the interview, the interviewer will also provide a list of professional referral sources for each participant. Consequently, I understand that this interview is not intended as a therapeutic exercise. The content of the interview will remain confidential, only the principal investigator and the faculty advisor will have access to the interview material.

I have been given the opportunity to ask any questions that I have about participation in this study. I understand that my participation will not subject me to any possible physical risk. My participation is voluntary. I understand that I may refuse to answer any questions I wish to and I may end the interview at any time without penalty.

I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction. If I have any questions or complaints about my rights as a subject, I may call Ethel Breheny, Institutional Review Board Administrator, at 212-650-7903 during office hours. If I have further questions about this study, I may call Karen Singleton at 212-650-6602 or Dr. Jeffrey Rosen, Professor of Psychology at the City College of the City University of New York at 212-650-5694. I have been given a copy of this form to keep.

I agree to participate in this study.

Signature

Print Name

Witness

Signature

Print Name

Appendix C

Interview Guide:

Interviewer: *As you know, I am interviewing African American women who are survivors of sexual trauma. I'd like to begin by first asking you some general questions about your life and your background before moving on to specific questions about sexual trauma. Does that sound o.k. to you?*

Initial Concepts of Self and Family and Community:

1. Why don't we start with you telling me when and where you were born and describing your family background?
2. What's your current family make-up like?
3. What relationships have been really important to you? Why? How would you describe those relationships?
4. Have you had a relationship with someone who helped shape you? In what ways have they helped you become the person you are?
5. How would you describe yourself? Is the way you see yourself now different from the way you saw yourself, say five or ten years ago? What has led to the changes? What were the turning points, do you think?
6. When you think of the word "community", what kind of things come to mind?
-Probe for various community ties and affiliations, etc. Do you feel that your community gives you the support that you need? Where do you have the strongest support? Where is it lacking?
Please give an example of a time when you felt most supported and least supported.
7. Lastly, could you tell me what being a woman means to you? (If necessary probe for whether they think there are significant differences between men and women.)
8. In what ways is this different or similar to what being an African American woman means to you? How different or similar is this to what being an "African American" means to you?

Disclosure of Abuse and Coping:

Interviewer: *Okay, now I'd like to ask you several specific questions about your experience of sexual trauma.*

1. First, could you describe the situation or the situations in which the abuse occurred?
2. When did you first disclose about the abuse? What concerns, if any, did you have about disclosing?
3. Please think back to the time that you decided to tell that person about the abuse. What kinds of things went through your mind? What made you decide to tell that particular person?
4. In what ways did that person meet and not meet your expectations?
5. Did you seek professional counseling from a counseling center, rape crisis program and/or spiritual leader/advisor? Why or why not? If not, what did you imagine would happen if you did?
6. Did you have an image of what professional counseling centers would be like? If so, could you describe that image?
7. Did you have any thoughts about how such a center might perceive you?
8. Can you describe the other ways that you coped with the abuse?
9. Can you describe some of the resources that you used to cope? How helpful did you find these resources to be?
10. Did you ever attempt to read about sexual abuse (articles, works of fiction, poetry, etc.). If so, how did you feel about what you read? Was there anything that you read where you said, "that's how I feel about what happened to me."
11. Do you consider yourself a spiritual or religious person? In what ways, if any, do you feel your religious or spiritual beliefs impacted how you coped with the abuse?
12. What has been your greatest struggle in coping with the aftermath of sexual abuse?
13. When did you feel strongest during your period of recovery and where do you feel such strength came from

Reflections on Experience of Trauma:

Interviewer: Now, I'd like to return to some questions about your family and your community—but this time in reference to your experience of sexual trauma.

1. Was sexual abuse ever talked about in your family growing up? What was said?
2. What kinds of messages were given about people who were victims of abuse?
3. What kinds of messages were given about people who were perpetrators of abuse?
4. Think back to when you first thought of telling a family member about the abuse. What kinds of things went through your mind? Did you have any fears, concerns, and/or expectations?
5. What concerns, if any, did you have about the impact your disclosure would have on your family? What impact did it have?
6. Did the ethnicity of the perpetrator have any influence on your decision to disclose?
7. Is sexual abuse something that's talked about in your community (however they defined community previously). What was said?
8. What kinds of messages were given about people who were victims of abuse?
9. What kinds of messages were given about people who were perpetrators of abuse?
10. Think back to when you first thought of telling someone in your community about the abuse? What kinds of things went through your mind? Did you have any fears, concerns or expectations?
11. What concerns, if any, did you have about the impact your disclosure would have on your community (if Af. Am. Community hasn't been mentioned yet, probe for this, e.g. "I noticed that you didn't mention _____, did you ever have any thoughts on how your disclosure would affect _____)?
12. Do you have any thoughts on the ways in which sexual abuse has been characterized in the African American community? For instance (give age appropriate cultural references, e.g. Clarence Thomas/Anita Hill; Mike Tyson/Desiree Washington).
13. How do you think, if at all, that being an African American woman has had an impact on your experience of sexual abuse?
14. As we come to the close of the interview, what kind of advice would you give to other Black women coping with sexual abuse? [sort of corny, but may be useful to re-organize them and allow them to feel as if they're giving something back]
15. And lastly, are there aspects of this experience that you would have liked to have talked about that I didn't ask you about?

Appendix D

Demographic Questionnaire

Questions adapted from Traumatic Antecedents Interview (Perry, Herman & van Der Kolk, 1992)

1. Age at last birthday _____
2. Relationship Status _____
 1. Single, never married
 2. Married/Partnered
 3. Single, living with Partner
 4. Separated
 5. Divorced
 6. Widowed
3. Gender of Partner _____
 1. Male
 2. Female
 3. Transgendered
4. Sexual Orientation _____
 1. Lesbian
 2. Heterosexual
 3. Bisexual
 4. Other
5. Present Religious Affiliation _____
 1. Catholic
 2. Protestant
 3. Jewish
 4. Muslim
 5. Other
 6. None
6. Role of Religion in Current Life _____
 1. Minor
 2. Major, positive
 3. Major, negative
7. Role of Religion in Upbringing _____
 1. Minor
 2. Major, positive
 3. Major, negative

8. Role of Spirituality in Current Life _____
1. Minor
2. Major, positive
3. Major, negative
9. Role of Spirituality in Upbringing _____
1. Minor
2. Major, positive
3. Major, negative
10. Ethnic Background _____
1. Black American
2. Caribbean American
3. Latino American
4. Bi/multiracial
5. Other
11. Level of Education _____
1. <12th grade (years completed _____)
2. Completed High School/GED
3. H.S. + other training
4. Some college
5. Completed College
6. Some postgraduate education
7. Masters
8. Ph.D.
12. Occupation _____
13. Current Employment _____
1. Full-time student
2. Employed full-time
3. Employed part-time
4. Employed within home
5. Unemployed
6. Retired
7. Other _____
14. Current Socioeconomic status _____
1. < Working Class
2. Working Class
3. Lower middle
4. Middle class
5. Upper Middle
6. Upper Class

15. Estimate of current household income per year _____
1. under \$10, 000
 2. \$10, 000-15, 000
 3. \$16,000-25,000
 4. \$26, 000-35,000
 5. \$36,000-50,000
 6. \$51,000-75,000
 7. more than \$75,000

16. Socioeconomic status (family of origin) _____
1. <Working class
 2. Working class
 3. Lower middle class
 4. Middle class
 5. Upper middle class
 6. Upper class

17. Number of people in Household. For each member of household record:

| First Initial You | Age | Gender | Relationship to |
|----------------------|-------|--------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

18. Number of children _____

19. People you rely on for practical help:

| First Initial You | Age | Gender | Relationship to |
|----------------------|-------|--------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

20. People you rely on for emotional support:

| First Initial You | Age | Gender | Relationship to |
|----------------------|-------|--------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Appendix E

Interview Guide: Follow-up Questions

Introductory Statement [to be read to the participant]: Thank you again for participating in this study. As you know, this study is looking at the healing processes of Black female survivors of sexual trauma. I would now like to ask you several more questions about your healing process. You should feel free to stop me at any point if you have questions or need further clarification. Do you have any questions before we proceed?

1. Can you tell me more about some of the specific ways that you coped with your experience(s) of sexual trauma? [If they only give positive ways ask about negative ways and vice versa]
2. Do you continue to see yourself as resilient? And, if so, what has helped you to maintain that resiliency?
- 3a. Are there ways that you feel you may have been impacted by the abuse interpersonally, for example how your relationships have been impacted?
- 3b. Are there ways that you feel like you were impacted spiritually or ways that your belief systems or the ways in which you make sense of the world were impacted?
- 3c. Are there ways that you feel you may have been impacted intrapsychically, meaning the way you felt about yourself with regards to these experiences?
- 3d. Are there ways that you feel your physical self may have been impacted, for example your feelings about your body, your health?
4. And lastly, what impact, if any, did the race of the perpetrator have on you?

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