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Sexual Assault in Maryland: The African American Experience **Executive Summary**

In the fall of 2003, the University of Maryland School of Medicine, Center for School Mental Health Assistance in collaboration with the Maryland Coalition Against Sexual Assault undertook a research project that sought to examine and better understand the unique experiences of female African American sexual assault survivors in the State of Maryland. This project, funded by the National Institute of Justice, was titled, *Sexual Assault in Maryland: The African American Experience*, and will be referred to as 'the study' within this summary.

The three main goals of the study were to:

- Better understand the problem of sexual assault among African American women in Maryland;
- Assess their use of available resources in response to sexual assault; and
- Explore their use of alternative sources of care.

As a result of broadening our understanding with regard to African American survivors it was intended that information gained through the study would be used to improve services for this segment of the population as well as to help fill existing gaps in research. These research findings could then also be used to implement and/or improve policies that would more appropriately address the issue on both state and national levels.

Up to and including this study there has been limited research on the sexual victimization of African American women specific to post assault responses. Likewise, there is minimal research on the consequences and barriers to reporting or help seeking behaviors among different ethnic groups. Given the overwhelming historical context of rape as a method to control and oppress Black women throughout slavery in America, it can be easily anticipated that unique issues will occur when race, gender and sexual violence intersect. These anticipated issues became the key themes to be investigated by the study and ultimately helped frame the hypotheses.

The study began with a thorough literature review of previous studies on the topic, formulation of a multi-disciplinary, African American advisory panel, and hosting of a series of focus groups. Focus groups were conducted with staff from Maryland's rape recovery programs, domestic violence programs, sexual assault forensic exam programs and historically black colleges and universities in our State. The purpose of the focus groups was to gain greater insight into the experience that service providers have in responding to African American survivors including unique needs or barriers to healing.

Some of the key themes identified as part of the focus groups were as follows:

Barriers to Reporting

- Stereotyping and/or victim-blaming response to victims who had been using drugs and/or alcohol;
- Experience of racism by police officers; and
- Reluctance to report sexual crimes of African American males.

Barriers to Accessing Counseling Services

- Difficulty with acceptance of mental health services;
- Belief that mental health issues are a “way of life”;
- Belief that African American women can “take care of themselves”;
- Belief that “concrete” services (e.g., for housing, employment) are more of a concern than less concrete (e.g., counseling); and
- Belief that in challenging situations (e.g., in public housing) survivors may be too busy taking care basic needs to participate in counseling services.

Recommendations for Improvement in Response Systems

- Enhance access to services (e.g., through transportation, financial assistance);
- Remove stigma from therapy and medication services;
- Enhance relevant educational programs (e.g., on safety issues, acquaintance and statutory rape);
- Enhance resources for public awareness;
- Increase resources for alternative methods of healing (e.g., art, drama, meditation); and
- Better train police officers to competently work with victims.

The main source of data for the study came from face to face interviews with African American and Caucasian sexual assault survivors who were asked about details of the sexual assault, medical care, law enforcement response, prosecution/court process, sexual assault center services, other counseling services, and recommendations for improvement in Maryland’s sexual assault response systems. Survivors had to meet the following criterion to be eligible for participation in the study:

- African American or Caucasian female;
- Currently age 18 or over;
- Current resident of Maryland; and
- Experienced sexual assault/abuse at some point in life (including as child).

Participants were recruited through a variety of sources including rape recovery centers, domestic violence centers, sexual assault forensic exam programs, colleges and universities, community-based human service programs, and detention centers. Interviews were conducted with 139 African American survivors and 83 Caucasian survivors for a total of 222 interviews (an additional two women participated but did not

indicate their racial status). Participants received a stipend of \$10 for their voluntary participation.

Important to the interview process was ensuring the racial matching of the interviewer to the interviewee for all African American participants to better allow for a free exchange of information. In addition, interviews were conducted as often as possible at local rape recovery centers so that study participants would have immediate access to crisis counseling if needed and would also get the opportunity to learn more about local resources. There were no concerns or complaints expressed from survivors about the content or process of the interviews and in fact a few even found the interviews to be therapeutic. Interviews lasted anywhere from 45 minutes to 2 hours depending on how many response systems the survivor accessed.

The study explored eight specific hypotheses, and while it was expected that there would be substantial differences in victimization and in the manner in which systems responded to African American women compared to Caucasian women there were in fact minimal statistically significant differences found between the two races.

A summary of the research findings by hypothesis follows:

- *African American women will be more likely to experience sexual assault by a stranger*

Overall, study findings supported prior research data that indicates most victims of sexual assault know the perpetrator prior to their victimization. In this study, 69% of study participants knew the perpetrator and only 31% of respondents categorized the perpetrator as a stranger.

Specific to whether African American women were more likely to be assaulted by a stranger, findings were not supportive with 33% of African American women reporting a stranger assault compared to 28% of Caucasian reporting the same. Both groups of women were equally likely to experience a stranger assault.

- *Sexual assaults against African American women will be more intense*

Intensity of a sexual assault was measured in terms of sustained injuries to victims and whether weapons were involved in the assault. Data indicated that African American women were not more likely to have sustained physical injuries, nor to have had a weapon used against them. In fact, when looking at the specific injuries women sustained, there were no reports of differences, other than that Caucasian women were more likely to sustain internal injuries from their attack.

- *Fewer African American women will report their sexual assault to the police*

Overall, there was no difference based on race in the rate of reporting the assault to the police. The large majority of women did not plan to file criminal charges, regardless of race.

However, there was a statistically significant finding upon the inclusion of an income variable. When this variable was added and reviewed in terms of who reports to police and with what frequency, it was ascertained that African American women with a high level of income were less likely to tell police than Caucasian women with high incomes. With the variable of income added there was partial support for this hypothesis.

- *African American women will indicate a number of racial and cultural barriers to reporting sexual assault to the police*

While African American women did report a number of barriers to reporting sexual assault to police, there were no clear racial differences in data used to explore this hypothesis.

As discussed previously, only African American women with high income levels were less likely to report their assaults to the police. Their identified barriers to reporting centered on themes of being 'too young' to understand the criminality of their sexual assault and not knowing what to do or where to go for help. Additional barriers included desire to maintain confidentiality, perceived re-victimization, personal blame/guilt and simple fear of the police.

Another dimension of barriers to reporting was satisfaction with police encounters. Many women reported feeling dissatisfied with their interactions with the police, but there were no differences in satisfaction based on the victim's race. There were no significant differences in how African American and Caucasian women rated their satisfaction with the police, with how police handled their case, or with how satisfied they were with their overall interactions with police. Generally, both groups rated their encounters with police with dissatisfaction. For African American women approximately 35% indicated being 'dissatisfied or very dissatisfied' with their overall interactions with police and 46% of Caucasian women reported the same.

Study findings supported prior research data that indicate that victims of sexual assault are much more likely to be assaulted by someone of their own race.

- *Fewer African American women will report seeking medical and psychological services*

For this hypothesis, medical and psychological services were measured in terms of actual medical treatment sought and received, utilization of sexual assault crisis centers, and receipt of counseling services from other sources.

The findings indicated that there were no significant differences in the rates of medical treatment by African American women compared with Caucasian women. However, when the variable of education was examined, Caucasian women with low levels of education were significantly less likely than African American women with low education to seek medical care.

In terms of the other measures, African American women were significantly less likely to receive services from a sexual assault crisis center, less likely to receive counseling services from sources other than a sexual assault crisis center, and less likely to obtain services from a therapist or counselor. For African American women who did obtain counseling services outside of a sexual assault crisis center, they were nearly twice as likely as their Caucasian counterparts to have that source be something other than a therapist, hospital or pastor.

- *African American will report a number of racial and cultural barriers in seeking and receiving medical and psychological services after a sexual assault*

Barriers indicated in this study area largely echo those described in earlier sections. Recurrent themes were lack of knowledge about sexual assault crisis centers (SACC), issues of being 'too young' at the time of victimization, confidentiality issues and a preference for familial support. While barriers were reported to seeking and receiving medical and psychological services following an assault, there were no racial differences in perceptions of these barriers.

In terms of medical treatment, there was one racial difference not related to barriers that the study found. African American women were more likely to be tested for sexually transmitted diseases than Caucasian women with 83% of African American women being tested for STDs versus 64% of Caucasian women.

When sexual assault crisis center services were received by African American women after an assault, survivors were generally pleased with those services. 93% of African American women rated their experiences at SACC's as 'good' or 'very good.' When reporting on counseling received (although less likely to seek these services) 96% of these same respondents were either 'satisfied' or 'very satisfied.' African American survivors did however report a lower satisfaction with SACC hotline services with slightly more than 15% stating that they were 'very dissatisfied' with hotline services.

It is important to note that both African American and Caucasian women took extended periods of time to access psychological services after an assault with over 55% of survivors taking more than a year to seek out sexual assault crisis centers and nearly 67% of survivors taking more than a year to begin counseling services. Regardless of race, the majority of survivors (84%) reported not knowing about SACCs prior to the assault.

- *African American women will receive less medical and psychological care compared with Caucasian women and report more problems receiving this care*

28% of African American women expressed that race was a factor in the response to their assault versus 13% of Caucasian women. Interestingly enough, Caucasian women with a higher level of education were much more likely to believe that the race of the perpetrator was a factor in how they were treated.

In terms of qualitative themes, African American respondents identified racism, stereotypes about poverty, issues of not being perceived as a victim, and involvement with drugs and prostitution as issues that impacted the response to their assault. However, there were no differences based on race in the perpetrator arrest status or the case prosecution status.

When asked to identify the “biggest problem” in their treatment experience, African American women were more likely to report unaddressed childhood abuse, whereas, Caucasian women were significantly more likely to report difficulty in finding mental health services.

- *African American women will be more likely to utilize family, friends, and faith communities to deal with the aftermath of their sexual victimization*

There was a different pattern of the first person told about the assault for African American women as compared to Caucasian women. African American women were more likely to first tell a relative, medical professional or no one at all, while Caucasian women were more likely to tell a friend first.

African American and Caucasian women were equally unlikely to receive counseling services from their church or pastor. However, African American women were more likely to use religion as a way to cope with the aftermath of sexual assault than Caucasian women who were more likely to use counseling.

Overall, both African American and Caucasian survivors reported counseling services as the most helpful service or experience (38%) as well as supportive family and friends (17%). However, Caucasian women were more likely to report that counseling was the most helpful service or experience for them, while African American women were more likely to report that medical personnel were the most helpful service or experience for them.

Conclusions and Next Steps

Surprisingly, the general overall findings of the study did not amplify any statistically significant differences in the experience of African American and Caucasian women who have experienced sexual assault. The failure to prove the hypotheses may be related to the small sample size of the women interviewed. However, there were important pieces of information documented in this study that both underscore prior research on the experience of sexual assault survivors and suggest further research or indicate future policy development. Salient learning points and suggested next steps are as follows:

- 69% of study participants knew the perpetrator.
- Survivors took an extended period of time to access psychological services after an assault with nearly 67% of survivors taking more than a year to begin counseling services.

- African American survivors were significantly less likely to receive services from a sexual assault crisis center, less likely to receive counseling services from sources other than a sexual assault crisis center, and less likely to obtain services from a therapist or counselor.
- For those African American survivors who did receive sexual assault counseling services, 96% were either 'satisfied' or 'very satisfied' suggesting that counseling works.
- The need for better marketing of sexual assault crisis center services was indicated. The public must be made aware of the existence of these centers, where they are and what they do. They must be marketed as part of the community a helpful and beneficial place for relief and recovery. Particular emphasis should be placed on dismantling the stigma of counseling or therapy.
- There is a need for emphasis on breaking the 'culture of silence' regarding rape in African American communities. Information about childhood abuse and how to access tools for recovery should be produced and distributed. Also suggested would be brochures on keeping kids safe and warning signs.
- Victim sensitivity trainings at sexual assault crisis centers and for law enforcement must include cultural competence as a key theme.
- Enhanced skill training should be provided to hotline providers so that African American survivors will be better served.
- There is a significant need to educate the community about 'how they can help' when sexual assaults occur, or when disclosures are made to private individuals. Especially important is their ability to refer an individual to a sexual assault crisis center.

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Final Report

*Sexual Assault in Maryland: The African American Experience**

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PURPOSE, GOALS, AND OBJECTIVES

In response to the National Institute of Justice solicitation *Broadening Our Understanding of Violence Against Women From Diverse Communities*, the University of Maryland School of Medicine in collaboration with the Maryland Coalition Against Sexual Assault conducted a needs assessment of African American and Caucasian female residents of Maryland who have been sexually assaulted. This project, *Sexual Assault in Maryland: The African American Experience* broadens our understanding of the needs of African American women who are sexually assaulted, their use of traditional services and resources for sexual assault, and their use of alternative resources. We hope that the findings will assist in improving services for African American women who are sexually assaulted in the State of Maryland, will help to fill a critical research gap, and will help to improve policies to address this significant issue on state and national levels.

Health care professionals and researchers are increasingly viewing sexual assault as a public health crisis (Crime Victim Research and Treatment Center, 1992; Russell & Bolen, 2000;

Schafran, 1996; Von et al., 1991). Using a definition of rape that includes forced vaginal, oral, and anal sex, 17.7 million women and 2.8 million men have been raped as a child and/or adult (Tjaden & Thoennes, 2006). Sexual assault is associated with physical and psychological morbidity including pain, depression, Post-Traumatic Stress Disorder, and anxiety (Ackerman et al., 1998; Boney-McCoy & Finkelhor, 1995; Campbell & Raja, 2005; Ellis, 1983; Kaukinen & DeMaris, 2005; Koss, 2005; McFarlane et al., 2005; Roth & Lebowitz, 1988; Ullman & Filipas, 2001), and each episode of such an offense has the potential to produce multidimensional negative effects upon the well being of the victim. In addition, the suicide risk for victims of sexual assault far surpasses that of non-victims (Kilpatrick et al, 1985; Resick, 1987). The scope of the problem underscores the need for broad-based investigation of the strengths and weaknesses of our current service system for sexual assault victims.

Literature exploring post-assault responses, consequences, and barriers to reporting and help seeking behavior among different ethnic groups is limited (National Research Council, 1996). For example, Reid and Kelly (1994) identified 277 abstracts on psychological research on rape for the period 1987-1994. Only 7 of these included the keyword “African American” or “black” women (Reid & Kelly, 1994). Research paradigms directed at the study of the “universal woman” have focused on white middle class populations (Reid & Kelly, 1994). A number of issues have been noted in the literature on research on minority populations.

The most common use of race in published journals has been as a filter in sample selection and as a “control” variable in regression analysis (LaVeist, 2000). In addition, minority group status is often equated with lower socioeconomic status despite variation in social strata among minority population groups (Lillie-Blanton & LaVeist, 1996). Conclusions drawn from this literature strongly suggest a paradigm shift from research which merely describes racial

differences in health to research which attempts to elucidate differences in experiences in access to services and quality of services.

Related to the above themes, the goals and objectives of this research study were to:

Goal 1: To better understand the problem of sexual assault among African American women in Maryland.

Objective A: To assess the type and intensity of sexual assault among African American women.

Goal 2: To assess African American women's use of available resources in response to sexual assault.

Objective A: To assess reporting by African American women of sexual assault to police and potential barriers to reporting.

Objective B: To assess medical and psychological care received by African American women after sexual assault and to assess potential barriers to this care.

Objective C: To assess the possible influence of race/ethnicity on the receipt and quality of medical and psychological care following sexual assault.

Goal 3: To explore the use of alternative sources of care (e.g. from family/friends, faith communities, medical and mental health personnel) by African American women who have been sexually assaulted.

LITERATURE REVIEW

Epidemiological Findings

According to the National Crime Victim Survey, African Americans are more likely than persons of other races to be victims of violent crimes (Catalano, 2004). Using Bureau of Justice statistics, Smith and colleagues (1999) reported that African American residents in urban areas have experienced a higher rate of violent crime than urban whites. Reported rates of sexual

assault for African American women have varied. Rennison (2001), using Bureau of Justice statistics found that between 1993-1998, the average annual victimization rate for rape and sexual assault was 3.7 per 1,000 persons aged 12 and over for African Americans, and 3.1 per 1,000 for whites.

The National Violence Against Women Survey found that the lifetime rate of rape and attempted rape for women was 18.8% for African Americans and 17.7% for whites (Tjaden & Thoennes, 1998). Wingood and DiClemente (1998) reported that rates of rape are higher among African American women than rates for women from other racial/ethnic groups. The National Crime Victim Research and Treatment Center (1992) reported that African-American women were sexually assaulted at rates almost three times higher than that of white women.

In addition, one study found that African American women reported slightly more incidents by strangers (Wyatt, 1992), and another study found that Black women had the highest incidence of forced intercourse through verbal threats (Kalof, 2000). However, using findings from the National Crime Victim Survey, Catalano (2004) reported that African Americans and Whites experienced similar rates of rape/sexual assault. Similarly, some researchers have found that race was not related to likelihood of sexual assault (George, Winfield, & Blazer, 1992; Priest, 1992). Thus, findings are mixed regarding the incidence of rape and sexual assault among African Americans versus other racial/ethnic groups.

Sociocultural Factors and the Reporting of and Response to Sexual Assault

Holtzman (1996) posits that to guide a rape survivor through the recovery process, it is necessary to know the meaning and consequences of rape in the specific sociocultural context of the survivor's community. Providing some historical and social context is necessary for understanding the sexual assault experience of African American women. Race has a profound

social meaning, rooted in history but with contemporary consequences (LaVeist, 2000). Specifically, a review of the literature by Fonow and colleagues (1992) offers a concise perspective on racism and rape. During slavery, the slave owner and his surrogates had *carte blanche* to the African enslaved woman's body. Rape was a form of terror and social control with no legal consequences. After slavery, most African American women worked as domestic servants in the homes of Caucasians, and were often repeatedly raped by the men in the families for which they worked, with no legal repercussions. In essence, the rape of African American women was an unpunished crime for centuries. As a consequence, today racial myths about rape persists; the most relevant being "African American women cannot be raped." Myths about rape as a whole persist contributing to low reporting rates.

In general, rape is an underreported crime; it is estimated that only 36% of rapes are reported to police (Rennison, 2002). Washington (2001) examined the disclosure patterns of African American women sexual assault survivors. The major barriers to disclosure and help-seeking were: 1) perceived racism and sexism in the legal system, 2) perceived racism of health care providers, and 3) an overall struggle with the structural inequalities. Results identified the following as factors influencing disclosure and/or help-seeking behaviors among African American women: 1) sexual orientation, 2) socioeconomic status, 3) nature of assault, availability of services, 4) prior negative experiences, 5) perceived need to protect African American males from legal prosecution, 6) perceived racism, and 7) religion/spirituality. Additional factors that influenced disclosure were noted such as internalization of the "Black Superwomen" myth, self blame, prior consensual sex with the perpetrator, and fear of sexual history being revealed.

Further, in a study of African American and Caucasian women sexual assault survivors, findings suggest that African American women were less likely to disclose the assault than Caucasian women (Neville, Heppner, & Clark, 2004). In addition, African American women were more likely to believe that overall, African American women were at a greater risk for being sexually assaulted than Caucasian women and that their living circumstances placed them at a greater risk for sexual victimization than Caucasian women (Neville, Heppner, & Clark, 2004). In another study, Wyatt (1992) found that African American women were significantly more likely than White women to offer explanations about their sexual assault victimization that involved risk factors in their living circumstances. Other possible cited reasons for the low reporting rates of sexual victimization by African American women include perceived insensitivity by police to African American women and reluctance to report African American men because of perceived racial bias (Karjane, Fisher, & Cullen, 2002; Neville & Pugh, 1997; Thompson & West, 1992; Wyatt, 1992).

Many African Americans mistrust police because of personal experiences of harassment or awareness of disproportionate arrests and incarcerations of Black men (National Institute of Justice, 2001; Robinson, 2002). Women of color must often contend with tension between their needs for justice and their felt obligations to buffer tension in the criminal justice system (Roze & Koss, 2001). Concomitantly, biases related to sexual assault perceived by African American women to operate in legal systems are supported by some research studies. For example, LaFree (1981) found that officials were more likely to file felony charges if a sexual assault involved an attack by a Black male against a White female, and also found that Black men accused of assaulting Black women were less likely to be arrested. Campbell (1998) found that legal cases of women of color who were raped by White men were more likely to “fall apart” during

processing. In a study of sexual assault victims that were 51% African American and 37% Caucasian, Campbell and colleagues (2001) found disproportional rates of case prosecution, with 70% of cases involving Caucasian women prosecuted, and only 30% of cases involving African American women prosecuted.

Further, in a mock trial study, participants with high scores for authoritarianism were more likely to agree with a White victim's rape claim against a Black defendant than a Black victim's claim against a white defendant (Landwehr et al., 2002). In another mock trial study, both Black and White defendants were rated as more guilty when the victim's race differed from their own (Hymes & Leinart, 1993).

Sociocultural Factors and Access to and Quality of Care

Our review yielded conflicting studies regarding access to care and quality of care. For example, Resnick and colleagues (2000) found that African Americans were more likely to obtain post-rape medical care than Caucasians. However, Campbell and Bybee (1997) found that African American women were *less likely* to receive follow up care, treatment for sexually transmitted diseases or pregnancy, emergency contraception, and information related to sexual assault. Dearwater and colleagues (1998) found that rates of acute trauma from abuse were significantly greater for African Americans than for Whites or Hispanics.

In another study, Campbell and colleagues (2001) found that women of color were four times less likely to have their injuries treated than were White women, and six times less likely to receive follow up care than White women. In addition, White women were more likely than ethnic minorities to receive HIV information. More recently, Campbell and Raja (2005) examined a sample of predominantly low-income African American women veterans and reservists who were sexually assaulted as adults (N = 104, 77% African American). Results

indicated that most of the survivors who sought help in military or civilian systems (medical or legal) felt guilty, depressed, anxious, distrusted others, and were hesitant to seek further assistance.

In a study of 155 African American adults, victims generally endorsed the need for counseling following a rape and expressed positive attitudes regarding treatment outcomes (Thompson & West, 1992). Additionally, Frazier, Rosenberger, and Moore (2000) found that only 9% of 522 sexual assault victims seen in emergency room settings returned for follow-up counseling and that young ethnic minority women who tended to be more distressed were least likely to seek follow-up counseling. However, in the study by Campbell and colleagues (2001) consisting of 51% African American and 37% white women, only 31% of those who contacted a mental health professional were of ethnic minority background. In addition, of those who contacted a rape crisis center, 91% were White and only 9% were ethnic minority. Furthermore, sexual assault survivors in general may prefer less formal sources of support following assault such as that provided by clergy (Cheston, 1993; Fouque & Glachan, 2000). African American women may desire to avoid further stigmatization of being treated for “mental illness” (Barbee, 1999) and may be more likely to turn to family, friends (Robinson, 2002; Wyatt, 1992) and clergy (Sims, 2002; Young, Griffith, & Williams, 2003) for assistance.

Priest (1992), in a study of 168 victimized African American women found that only 32 received more formal mental health counseling, and only three indicated that the counseling directly related to sexual victimization. However, in Ullman and Filipas’ (2001) examination of correlates of formal and informal help-seeking behaviors of sexual assault victims, results suggested that ethnic minority women received more emotional support from mental health professionals and physicians than from other sources of support. Similarly, Diala and colleagues

(2001), using data from the National Co-morbidity Survey, found that African Americans reported more positive attitudes than Whites toward seeking mental health services, but were less likely to actually use them. After utilization, their attitudes were found to be less positive than those of Whites. For Major Depressive episodes, African Americans had significantly lower odds of using mental health services than Whites.

In a study of victim assistance workers, African American victims were perceived as less credible and as more responsible for the assault than White victims (Winkel & deWinter, 1995). For African American victims, the consequences of the event were considered to be less serious, while the available evidence was seen as less convincing for them. The occurrence of the event was significantly more often attributed to the African American person's behavior.

Further, Nagel, Matsuo, McIntyre, and Morrison (2005) examined a community sample of African American and White adults concerning their attitudes toward victims of rape. Results suggest the existence of a complex interaction of demographic variables such as age, race, gender, income, education, and religion. More specifically, results suggested that: 1) Females held more sympathetic attitudes toward rape victims than males; 2) African Americans held less sympathetic attitudes toward rape victims than Whites; 3) African American men held the least sympathetic attitudes towards rape victims than did other groups; 4) younger respondents held more sympathetic views of rape victims than did older respondents; and 5) respondents with higher levels of education and income held more sympathetic attitudes towards rape victims than those with lower levels of education and income.

These studies provide a review of key variables explored so far in research on experiences of sexual assault victims of varying racial/ethnic backgrounds. They helped to

inform the goals, objective and measurement approach of the study, which is presented in the following.

METHODOLOGY

Advisory Panel

All aspects of the project were coordinated by the principal investigator (PI; M. Weist), and the MCASA Director (J. Pollitt-Hill). The PI and the MCASA Director worked very closely with an Advisory Panel developed for the project, including six state and community leaders with respective backgrounds in clinical psychology, domestic violence, treatment and support to sexual assault victims, law enforcement, community organizing, and advocacy. All panel members were African American with two males and four females. The Panel held meetings in person five times, in December, 2003; June, 2004; October, 2004; October, 2005; and March, 2006 to plan for various aspects of study development, implementation and interpretation of findings. Panel members were also in communication with the PI and MCASA director through email and by phone as indicated.

Data were gathered by two methods: (1) **focus groups** with MCASA member program staff and other community service providers, and (2) face-to-face **interviews** with African American and Caucasian female residents of Maryland who were sexually assaulted.

Focus Groups

Focus groups and training sessions were held with the four professional groups originally identified to assist with study recruitment efforts – rape recovery programs (including both SA only and dual SA/DV programs), domestic violence only programs, sexual assault forensic exam programs and historically black colleges and universities in Maryland. On several occasions, as in the case of historically African American college and university (HBCUs) counseling center

personnel, it was challenging attempting to schedule a focus group for all personnel in a particular group, so individual interviews were conducted over the phone and in person with several representatives of HBCUs, hospitals, and rape crisis centers. These four groups were part of the original proposal and study design approved by NIJ. Training sessions were held with each of these four recruitment partners to explain the context, history, and purpose of the study as well as discuss ethical issues relating to human research studies, referral/recruitment protocol and marketing materials. The purpose of the focus groups was to gain information from our recruitment partners regarding perceived barriers to services for African American survivors, not to formulate hypotheses.

The list of five focus group questions was constructed by project researchers with consultation from sexual assault victims and advocates. Topics covered included unique issues and needs of African American women who have been assaulted, and issues of the agency (e.g., strengths, problems) in assisting African American sexual assault victims. Each focus group participant received a nametag. Instead of the participant's name, the nametag had a number so that participant's answer was not recorded by name. Notes were taken by a research assistant and project coordinator and sessions were audio-taped. All information gathered during focus groups was kept confidential and once transcribed, all audiotapes were destroyed.

Focus Group Recruitment and Informed Consent

Rape crisis center representatives and the other community service provider representatives received a letter informing them that a focus group was going to be conducted at the end of their study training session and asking them for their participation. They were informed about the purpose of the focus group, the topics to be covered, and the length of the session.

Informed consent forms were given to the participants before the focus group was conducted. Research staff emphasized to participants that they were under no obligation to participate in the focus group, and that choosing not to participate would have no adverse effects to them in their employment or with the study. Research staff then went over the informed consent form and responded to questions from participants, which were limited.

Each focus group utilized two facilitators and two note takers. The number of participants in the focus groups ranged from 4 to 10 with an average of 7 participants per group. The focus group sessions were taped and notes were taken. The tapes were transcribed, and transcriptions were augmented by written meeting notes. These augmented transcriptions were then used by research staff to identify key themes in focus groups. For these qualitative analyses thematic conceptual matrices were developed. Data were analyzed following the process suggested by Marshall and Rossman (1999): An iterative process was undertaken, wherein (1) themes were sorted by a priori categories, (2) a priori and emergent hypotheses were tested against augmented focus group transcripts; and (3) alternative explanations were considered and tested against the transcripts.

Focus Group Findings

As mentioned, focus group questions and key themes are presented in Appendix A. For Question 1, regarding needs of African American sexual assault victims, key themes included enhancing access to services (e.g., through transportation, financial assistance), removing stigma from therapy and medication services, and enhancing relevant educational programs (e.g., on safety issues, acquaintance and statutory rape). For Question 2, regarding experiences with the legal system, key themes included problems with response to victims who had been using drugs and/or alcohol, experiencing racism by police officers, and reluctance to report sexual crimes of

African American males. For Question 3, on unique issues to the use of available resources by African American women, themes included problems with acceptance of mental health services by these women, and that mental health issues are a “way of life,” that they can take care of themselves. For Question 4, on experiences in outreach to African American victims, themes included perceptions that outreach is generally limited, that “concrete” services (e.g., for housing, employment) are more of a concern than less concrete (e.g., counseling), and that in challenging situations (e.g., in public housing) survivors may be too busy taking care of their own circumstances to participate in outreach services. For Question 5, on recommendations for the State of Maryland to improve services, themes included enhanced resources for public awareness, increased resources for alternative methods of healing (e.g., art, drama, meditation), and better training for police officers to competently work with victims.

Interviews

Recruitment of Study Participants

Criteria for inclusion in the interview component of the study included: (1) African American or Caucasian female, (2) age 18 and over, (3) resident of Maryland, and (4) victim of sexual assault. There were four streams of recruitment for the interview portion of the study: (1) victims receiving services at one of 18 rape crisis centers located throughout the state of Maryland, (2) community outreach sessions conducted by rape crisis center community educators, (3) through community service providers, including those working in domestic violence centers, forensic nurse examiners (SAFE programs), probation and parole offices, reproductive health centers, county health departments, community services agencies, HBCUs and local colleges, and (4) through three detention centers housing female inmates. Please note that we did not originally plan to recruit participants from detention centers. However, in a

meeting held in October, 2004, the Advisory Panel made a strong recommendation to recruit and conduct the study with incarcerated women. This recommendation was based on findings that these women have elevated rates of sexual assault. For example, in Brown, Miller, and Maguin's (1999) review of the literature of sexual assault and incarcerated women they found that the rates of physical abuse or sexual assault among these women ranged from 43% to 75%, rates significantly higher than those for other populations (see Rennison, 2001, 2002).

(1) Rape crisis centers. Each of the rape crisis centers (referred to in Maryland as *Sexual Assault Recovery Centers*) were asked to identify and refer female victims for an interview. A designated representative from each rape crisis center attended a training session to receive information about the study. Each clinician at the rape crisis centers attempted to recruit both African American and Caucasian clients of non Hispanic backgrounds. Clinicians gave prospective participants a flier and described the study by covering the following topics: purpose of the study, areas covered in the interview, length of the interview, compensation for participants, and assurances of confidentiality and the right not to participate in the study. If the client agreed to participate, she called the MCASA site coordinator to schedule an interview. If possible, the interview was scheduled to coincide with the client's next visit to the crisis center.

(2) Community educators. Rape crisis center community educators made an announcement about the study when they spoke to adult groups about sexual assault. They also had fliers and question and answer sheets available. For community members who expressed an interest, the study was described and recruitment proceeded as above.

(3) Community service providers. Fliers and posters about the study were displayed in reception areas and offices of various community service providers. A designated representative from each provider organization was identified and trained about the study by the MCASA site

