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SEXUAL VIOLENCE IN THE LIVES OF WOMEN: AN EXPLORATION OF HELP-SEEKING, EMOTIONAL SOCIAL SUPPORT, RACE, AND CULTURE

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SEXUAL VIOLENCE IN THE LIVES OF WOMEN: AN EXPLORATION OF HELP-SEEKING, EMOTIONAL SOCIAL SUPPORT, RACE, AND CULTURE

By

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ABSTRACT

SEXUAL VIOLENCE IN THE LIVES OF WOMEN: AN EXPLORATION OF HELP-SEEKING, EMOTIONAL SOCIAL SUPPORT, RACE, AND CULTURE

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Incident rates of sexual violence among women vary with estimates ranging from 1 out of 6 to as many as 1 in 3 women experiencing some form of SV in their lifetime (Koss & Harvey, 1992; Tjaden & Thoennes, 2000, 1998; Ullman & Knight, 1992). The following studies extend the help-seeking literature exploring survivors of SV. The first study used grounded theory and phenomenological qualitative methodology to analyze open-ended interviews with eight ethnically-diverse female SV survivors in order to assess their attitudes toward help-seeking and their perceptions of the social support they received. Emerging themes promoting help-seeking included: willing to listen, believing, and shared connection. Themes inhibiting help-seeking included: shame and blame, not believing/ignoring, protecting others, and cultural themes. The second study examined the survey responses of 108 female African American survivors of SV in attempt to explore the interrelationships among emotional social support, racial identity development, and psychological help-seeking attitudes. The findings reveal that racial identity is significantly linked with help-seeking attitudes among African American survivors of SV. Greater identification with Caucasian ideals and racial stereotypes was associated with greater perceived need of psychological help, and greater tolerance of stigma associated with receiving such help. Additionally, the findings suggest that as women endorse less "Pro-Black" attitudes, and endure more severe or more frequent

instances of SV; they are more likely to disclose personal problems. Implications for clinicians, community outreach, training, research are discussed

This dissertation is dedicated to my family who provided unending love and support during my graduate years, and always.

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Introduction

Alarming statistics concerning the prevalence of sexual violence (SV) among women underscores the need for continued research in this area. Sexual violence is defined as any unwanted sexual activity forced by one person on another, including, but not limited to: stranger rape, forced sodomy, acquaintance rape, date rape, marital rape, gang rape, child sexual abuse, and incest. Incident rates of SV against women vary with estimates ranging from 1 out of 6 to as many as 1 in 3 women will experience some form of SV in their lifetime (Koss & Harvey, 1992; Tjaden & Thoennes, 2000, 1998; Ullman & Knight, 1992). It is estimated that as many as 1 in 4 college women will experience SV during their college years (Fisher, Cullen, & Turner, 2000). More alarming is the fact that many sexually violent incidents go unreported, suggesting that the available statistics underestimate the actual number of women who have experienced SV (Mahoney, 1999). Researchers estimate that as much as 60% to 84% of SV goes unreported to police (NCVS, 2003; Kilpatrick, Edmunds, & Seymour, 1992.)

An examination of the short-term and long-term aftereffects experienced by survivors provides initial insight in to the psychotherapy needs of this population. Common aftereffects include: shame, isolation, sexual inhibition, sleep disturbances, substance abuse, sexual dysfunction, mistrust, intrusive thoughts, denial, dissociation, helplessness, feeling overwhelmed, feeling loss of power and autonomy, fear, guilt, depression, anxiety, impairment of concentration, exaggerated startle responses, and post-traumatic stress disorder (PTSD), (Delahunta & Baram, 1997; Foa, Rothbaum, & Steketee, 1993; Resick, 1993). It is estimated that only 30% of survivors enter

psychotherapy, a fraction of the women directly impacted by SV (George, Winfield & Blazer, 1992; Miller & Cohen, 1995).

Help-seeking is generally conceptualized as a sharing of problems with others in an attempt to receive aid, guidance, or assistance for problems causing distress (Gourash, 1978). When these behaviors are psychological in nature (i.e. anxiety, depression, and PTSD) it is termed mental health help-seeking (Neal-Barnett & Crowther, 2000). Terminology related to mental health help-seeking is confusing; psychotherapy and counseling have been used in describing such behaviors. Some researchers view counseling, also termed professional counseling, as a more brief intervention (up to 12-15 sessions), and infer that psychotherapy is more long-term (more than 12 sessions), with the term therapy often used interchangeable with psychotherapy (Gelso & Fretz, 2001). Wolf (1977) has defined psychotherapy as the treatment of problems of an emotional nature where a relationship is established between the professional and client with the intent of eliminating/changing/decreasing problems, reconciling disturbed patterns of behavior, and encouraging healthy development. Psychotherapy has also been described as work with more distressed individuals that attempts to restructure personality, features in-depth examination, and focuses on analytic processes (Gelso & Fretz, 2001). An emphasis on situational events and conscious process that is supportive defines the process of counseling (Brammer, Abrego, & Shostrom, 1993). A combination of these events, which is more common, suggests that the terms counseling and psychotherapy can be used interchangeable (Gelso & Fretz, 2001).

Although research suggests that psychotherapy (counseling) contributes to positive post-SV adjustment among survivors (Neville & Pugh, 1997), there is limited

empirical research on this topic. Neville and Pugh (1997) reported that counseling was associated with increased long-term self-esteem among rape survivors. Moreover, Cohen and Roth (1987, cited in Neville & Pugh, 1997) observed that survivors who sought counseling reported a decrease in intrusive thoughts regarding SV as compared to survivors that did not seek counseling. Furthermore, the timeframe within which services are received influences outcomes; survivors who sought counseling immediately following SV experienced less anxiety and depression as compared to those survivors who delayed seeking treatment (Stewart, Hughes, Anderson, Kendall, & West, 1987). These studies demonstrate that psychotherapy interventions may reduce symptomology related to sexual violence among women survivors. Possible psychotherapy inventions include group counseling and/or individual counseling which are either trauma-based and specific to SV or more general. As such, these findings encourage the need for continued research on help-seeking practices of SV survivors.

Gaps in the literature reflect the need for additional inquiry. The literature is inconclusive regarding how help-sources are utilized (e.g. police, emergency rooms, crisis centers, family, friends, and professional sources of counseling). Additionally, this research often fails to delineate between types of mental health services utilized by survivors. As a result of these gaps, it is difficult to determine help-seeking rates of survivors in conjunction with these sources of help.

Future research must further address what types of psychotherapy interventions are most appropriate, accessible, and beneficial for survivors. Given that up to 30% of survivors do seek psychotherapy, practicing psychologists will encountering survivors of SV experiencing some combination of these aftereffects. There is a critical need for

greater understanding of these processes to inform evidence-based interventions in this area.

Demonstrated differences concerning race and ethnicity's impact on help-seeking suggest the need for research addressing these differences among women seeking psychological treatment related to SV. Although findings are inconsistent regarding ethnic differences in prevalence rates of SV (Neville& Heppner, 2004, Wyatt, 1992), it is clear that non-Caucasian women experience SV (Tjaden & Thoennes, 1998) and that many experience psychological trauma requiring psychotherapy. The research reveals that African American (Wyatt, 1992), Asian and Latina women are less likely to seek professional help as compared to Caucasian women (Akustsu, Snowden & Organista, 1996, as cited in VanHook, 1999) and prefer culturally approved alternatives like prayer and community elders (Mattis, 2002; Chiang, 2004). These variations in help-seeking generate questions about sources of support that non-Caucasian survivors find helpful.

Methodological limitations plague the findings related to diversity and help-seeking among survivors of SV. Inconsistent definitions of SV across studies may have affected detection of racial differences in prevalence rates (George, & Winfield, & Blazer, 1992). Non-white women may label SV behavior differently (Holzman, 1997; Neville & Pugh, 1997; and Wyatt, 1992) which may impact reporting and help-seeking rates. Non-diverse samples have also made it difficult to speculate how help-seeking rates vary among non-white survivors of SV. Additionally, gaps exist in the social support research, specifically regarding specificity of emotional social support, and who African American survivors find as helpful informal sources of support.

To address these limitations, the following studies examined help-seeking attitudes of survivors of SV. The first study used grounded theory and phenomenological qualitative methodology to analyze open-ended interviews with eight ethnically-diverse female SV survivors in order to assess their attitudes toward help-seeking and their perceptions of the social support they received related to their SV experience. The second study examined the survey responses of 108 female African American survivors of SV in attempt to explore the interrelationships among emotional social support, racial identity development, and psychological help-seeking attitudes. Together, these studies provide valuable insight regarding the help-seeking attitudes of women survivors of SV, while attending to the importance of the cultural contexts within which participants develop help-seeking attitudes and enact related behaviors.

Chapter 1

Hearing Important Voices: An Exploration of Help-Seeking and Social Support among Female Survivors of Sexual Violence

Study 1 Introduction and Literature Review

Underutilization of psychological services by SV survivors, coupled with the many possible aftereffects associated with SV, raises important questions regarding the help-seeking attitudes of SV survivors. Future research is needed addressing types of social support that facilitate help-seeking among survivors. Conservative estimates indicate that 1 in 6 women will experience some form of SV in their lifetime (Tjaden & Thoennes, 2000). After such an event, survivors commonly experience sleep disturbances, substance abuse, sexual dysfunction, mistrust, intrusive thoughts, denial, dissociation, helplessness, feeling overwhelmed, fear, guilt, depression, anxiety, impairment of concentration, depression (Delahunta & Baram, 1997; Foa, Rothbaum, & Steketee, 1993; Resick, 1993) at levels severe enough to interfere with their work/academic functioning and emotional well-being. Despite the high price these events extract from victims, it is estimated that only 30% seek crisis therapeutic services, despite the documented benefits of immediate and targeted post-assault counseling services (Miller & Cohen, 1995; George, Winfield & Blazer, 1992).

Given the potentially devastating effects associated with SV and the underutilization of services, it is essential that research investigate factors influencing the help-seeking behaviors women do engage in as well as their effectiveness is reducing harmful after-effects of SV. To address this need, the following study used grounded theory and phenomenological qualitative methodology to analyze open-ended interviews

with eight ethnically-diverse female SV survivors in order to explore the types of social support that facilitated effective help-seeking behaviors among SV survivors.

Help-seeking and Identified Sources of Help

Help-seeking is generally conceptualized as a sharing of problems with others in an attempt to receive aid, guidance, or assistance for problems causing distress (Gourash, 1978). When these behaviors are psychological in nature (i.e. anxiety, depression, and PTSD) it is termed mental health help-seeking (Neal-Barnett & Crowther, 2000). Terminology related to mental health help-seeking is confusing; psychotherapy and counseling have been used in describing such behaviors. Some researchers view counseling, also termed professional counseling, as a more brief intervention (up to 12-15 sessions), and infer that psychotherapy as more long-term (more than 12 sessions), with the term therapy often used interchangeable with psychotherapy (Gelso & Fretz, 2001). Wolf (1977) has defined psychotherapy as the treatment of problems of an emotional nature where a relationship is established between the professional and client with the intent of eliminating/changing/decreasing problems, reconciling disturbed patterns of behavior, and encouraging healthy development. Psychotherapy has also been described as work with more distressed individuals that: 1) attempts to restructure personality; 2) features in-depth examination; and 3) focuses on analytic processes (Gelso & Fretz, 2001). A supportive environment with an emphasis on situational events, and conscious process defines the process of counseling (Brammer, Abrego, & Shostrom, 1993). A combination of these events, which is more common, suggests that the terms counseling and psychotherapy can be used interchangeably (Gelso & Fretz, 2001).

The majority of help-seeking research regarding survivors of SV focuses on the sources of help survivors use (i.e. police, emergency rooms, crisis centers, friends and/or family, and professional sources of counseling). However, the literature is inconclusive regarding how sources of help are utilized and often fails to delineate between the types of mental health services utilized.

As a result of this gap in the current literature, it is difficult to determine the rates at which survivors seek and utilize sources of help as well as variations in utilization due to the type of SV. However, some studies have attempted to address these concerns. For example, Koss, Koss, and Woodruff (1991) found that survivors are more likely to seek help from medical doctors than from mental health care providers or victim assistance organizations. Several studies have also found that the nature of the rape experience influenced help-seeking behavior of survivors, such that survivors of stranger rape were more likely to seek psychological help than survivors of acquaintance rape (Koss et al., 1988; Mahoney, 1999; and Ullman & Siegel, 1993). For example, using a large probability sample, Ullman and Siegel (1993) found that 55% of stranger rape survivors sought help from a "professional helper" while only 30% of women assaulted by an acquaintance sought professional help. Similarly, in a non-random university sample of 489 women, of the percentage of participants that told someone, 1.7 % of survivors raped by an acquaintance and 19.2% of women raped by a stranger sought crisis counseling (Koss et al., 1988). Finally, in a sample of over 100 female sexual assault survivors in the Chicago area, only 39% utilized mental health care services (Campbell, Sefl, Barnes, Ahrens, Wasco, & Zaragoza-Diesfield, 1999). Regardless of the relationship of the assailant to the survivor, survivors underutilize help-seeking sources. Given the

documented benefits of counseling and therapy for survivors of SV, important questions are raised regarding the help-seeking attitudes of SV survivors.

Emotional Social Support

Examining the role of social support among survivors may provide insight into their help-seeking behaviors and attitudes as well as post-SV adjustment. Social support refers to a survivor's belief that she is cared for, loved, esteemed, valued and a member of a group or network that places value on mutual obligation (Cobb, 1976; Cwik, 1996). Friends, family, the community, and romantic partners of the survivor are important sources of social support. Emotional social support has been defined as "demonstrating care or sympathy toward another person; listening to someone or just being there when a person needs a friend" (Birch, 1998). It is often measured via the survivor's perceptions of family members' and partner's/spouse's' sensitivity to her specific needs.

Current investigations of social support demonstrate the need for greater specificity in the examination of emotional aspects of social support (Cramer, 1999; Neville & Pugh, 1997; and Ruch & Leon, 1986). Gaps in the literature related to emotional social support include measurement, specificity, and impact on survivor help-seeking. It has been observed that African American women fail to disclose to others about incidents of rape because they are fearful of receiving negative social support (Neville & Pugh 1997). Although Neville and Pugh (1997) did not address emotional support specifically, fear of receiving negative social reaction may be similar to a survivor's fear of not receiving emotional social support, raising the question whether presence or absence of emotional social support influences post-SV adjustment. Ruch and Leon (1986) argued that perceived social support might buffer against trauma-related

symptomology, yet their measurement of social support was more general and not intended to tap emotional social support. Past research indicates that people tend to seek help when their support network is impaired or ineffective (Cramer, 1999). It is possible that when a survivor's support network is deficient, they may be more inclined to seek more formal sources of help (i.e. psychotherapy and counseling). Literature has minimally addressed how social support influences attitudes towards psychological treatment, supporting the need for a closer examination of the role of emotional social support among survivors, a focus in this study below.

Statement of Purpose

The purpose of this exploratory investigation was to examine the emotional social support and help-seeking experiences of women survivors of SV. The overarching research questions of this study concern; 1) How do survivors describe their help-seeking experiences post SV; and 2) How do survivors describe perceived emotional social support from others in their lives post SV. More specifically, whom do survivors describe as most helpful and their descriptions of why this person (s) was most helpful guide this exploratory investigation. Additionally, this study intended to assess whether family members, partners, and spouses are emotionally supportive of survivors of SV (feminine pronouns are used to refer to survivors' because the current sample is women; However, SV is also prevalent among boys and men).

Chapter 2

Methodology

Qualitative methodology (i.e. in-depth interviews) was employed in this study as an effective method of exploring new constructs and as a method of inquiry that is empowering and validating for participants (Reid, 2003; Campbell & Wasco, 2000; and Kitzinger, 1995). One-on-one semi-structured interviews were used within a phenomenological framework (Creswell, 2000), a method that seeks to understand the subjective everyday experiences and interpretations of those experiences unique to the individual. A grounded theory framework that involves developing theory via observation, conversation, and interviews was also utilized (Glaser, 1992). This framework allowed the investigator to have a better understanding of survivors' experiences, and ultimately provided useful information regarding the help-seeking experiences of survivors of SV.

Qualitative methods have been enumerated in the literature as a feminist research tool, and such methods generate information regarding the unique experiences of an underrepresented population (Wilkinson, 1999; Buchanan & Ormerod, 2002). Intended to empower participants as they share personal experiences, using such methodology generates meaning from those experiences with the participants serving as experts and co-constructors of that meaning. In particular, qualitative methods have been found to be effective when investigating sensitive topics, specifically when exploring cultural variables (Kitzinger, 1995).

Participants

Eight female participants from a large, Midwestern university were recruited for this investigation. To ensure ethnic diversity of the sample, ethnic minorities were over-sampled. Participants ranged from 19 to 22 years in age (M=20, SD 1.41). All participants had some college education, ranging from two years of completed coursework to a four-year college degree. None of the participants were married. All of the participants except one described themselves as being middle class, with the remaining participant describing herself as lower middle class.

Method of Recruitment

A total of 210 flyers were posted in academic buildings, dormitories, gathering spots, and on public bulletin boards on campus inviting women to participate in a study concerning stress and sources of support. Prior research has found differences in labeling incidents of SV as such, particularly across racial/ethnic groups (George Winfield, & Blazer, 1992; Neal-Barnett & Crowther, 2000); therefore, the study's focus on SV was not included in the original flyer in order to reduce labeling effects that could bias the sample. Instead, the focus on unwanted sexual experiences was presented during the pre-screening, which also provided a more private setting within which participants could answer sensitive questions regarding SV.

Prescreening Participants

A total of 69 women contacted the researcher during a 19 day time period; 53 of those women contacted the researcher via email, and 16 participants contacted the researcher by phone. Thirty-five of these women did not return messages or emails (after initially expressing interest in the study) to set up a prescreening interview. Thirty-four women participated in the pre-screening interview; 27 identified as Caucasian, 2

identified as African American, 3 identified as Asian, 1 identified as Latina, and 1 identified as a Vietnamese international student.

The pre-screening interviews were conducted by phone. Participants provided demographic information and were then asked if they had experienced any of five unwanted physical and/or sex-based behaviors. Questions were behaviorally-based to avoid labeling effects and included: 1) Have you ever been hit or grabbed by someone? 2) Has anyone ever tried to touch you without your consent? 3) Has anyone ever touched you in a way that made you feel uncomfortable 4) Have you ever experienced forced touching that was sexual in nature? 5) Have you ever had intercourse against your will? All participants were instructed that they could refrain from answering any questions or discontinue the interview at anytime. Subjects that had experienced unwanted sex-based behaviors were asked to set up an hour-long interview, and were told of their rights as research participants and the legal limits of confidentiality and anonymity. Nine women met criteria, and 8 agreed to participate in further in-depth interviews.

Interviews

At the beginning of the in-depth interview, participants signed an informed consent detailing their rights as a participant (see Appendix A). All participants consented to the interviewer taking written notes during the interview. Participants also chose whether or not to have the interview taped, and were informed that they could ask that it be turned off at any time. All interviews took place in mutually decided upon private locations and 7 of the 8 women agreed to have their interviews audiotaped. Participants were told that tapes would be kept in a secure locked location, transcribed by a member of the research team, and that all identifying information would be removed or

changed to protect their confidentiality.

To ease possible anxiety and increase comfort level, care was taken to establish rapport with each participant including thanking them for talking about potentially personal and painful experiences. Additionally, the investigator spoke about her interest in the proposed research area, and commitment towards working with diverse populations of women in present/future research and clinical endeavors. The interview format was semi-structured, accompanied by appropriate follow-up questions. The first part of the interview included gathering demographic information, including age, socioeconomic status (SES), and level of education. Subsequent questions focused on specific areas related to how participants described their racial/ ethnic background, family, support system, incidences of SV, and what type of help, if any, they sought/received following incidence of SV. Participants were asked to respond to the pre-screening questions a second time to begin the discussion of experiences of unwanted sexual activity. To foster participant empowerment and create a safe environment within which to tell their experiences, participants were given full control over the amount of information shared.

Debriefing and Completion of Interview

Due to the sensitive nature of this topic, participants received information about SV, including phone numbers about local opportunities for counseling and support groups (see Appendix B). At the end of the interview participants were encouraged to discuss the debriefing materials with the researcher. Participants received $15 for their participation, selected a local organization for which a $5.00 donation was made on their behalf, and signed for receipt of reimbursement. Audiotapes were transcribed and all related investigation materials were stored in a secure location.

Data Analyses

Following guidelines outlined by Creswell (2003) regarding qualitative analysis, several steps were taken to analyze interview data. Audio transcriptions were read to get an initial sense of the data. Coding (notes and keywords placed on each transcription) and careful reflection initially identified emerging patterns and the general tone of participants' responses. Charts were used to organize data and connect information in a more systematic manner as abstract categories emerged. Emerging themes and patterns were assessed with certain phrases from each participant grouped together, allowing for a systematic method of examining responses.

Validating Findings

Important strategies outlined by Creswell (2003) have been included in this investigation to support the findings. To validate, and bring credibility to the findings: the bias of the researcher was clarified for participants; careful self-reflection was used as a means of creating an honest and open interpretation of the participants' responses to questions; peer debriefing was employed in an attempt to increase the accuracy of participants' responses; and competing ideas are presented in the discussion section in the attempt to acknowledge that perspectives in the real world are often contradictory.

Chapter 3

Results

Nancy (all names have been changed), age 21, described herself as "Caucasian with several minority friends," having a "close family" and no prior mental illness (self-report). She responded to questions regarding unwanted sexual activity with an account about being "slapped on my butt by a younger boy co-worker," and referenced other incidents, without detailing particulars, regarding incidents of sexual forced touching.

Beth, age 19, described herself as having a close relationship with her family, and reported no history of mental illness. Regarding her racial/ethnic identification, she stated that she was, "White, boring, just American." Beth described three incidents of forced sexual touching that occurred while consuming alcohol. One incident occurred with an older man and resulted in the loss of her virginity.

Claire, age 19, reported a strained relationship with her family and divorced parents. Claire described her racial ethnic background as Caucasian and noted that her stepfather was half Native American. Claire experienced depression during high school and sought the assistance of a counselor for a short time. Claire described an incident of unwanted sexual activity that included oral sex that occurred one evening after a few drinks with a man that she knew casually. She had little recollection of what transpired and stated, "It was really scary not knowing."

Alex, age 19 and Caucasian, grew up with her adoptive father and his wife (not her original adoptive mother), whom she refers to as her mother. Her father sustained brain damage after an accident and has made multiple suicide attempts. Alex's adoptive mother was extremely physically and sexually abusive, and she preferred not to elaborate

on that abuse. In ninth grade Alex suspects that a male classmate put drugs in her soda, recalling that she woke up with the boy on top of her. Alex reported that she was diagnosed with PTSD as a teenager, which she attributed to her father's accident and being sexually abused by her adoptive mother as a young child. Alex was also diagnosed with Bipolar Disorder and took medication for two years, believing that being a hormonal teenager incorrectly contributed to this diagnosis.

Lucy, age 19, identified as Korean American, and reports no history of prior mental illness. Her friends are "pretty diverse" in terms of racial/ethnic background, although she does not "hang out with other Asian Americans," and she has close relationship with her family, which includes extended family. Lucy reported one incident of unwanted sexual activity occurring three months prior to the interview. While at an acquaintances' apartment, a male dragged her down the hallway and began touching her while taking down his pants. This man let her go when she yelled for a female friend.

Susan, age 22, was the only African American participant. She has a close family, no history of mental illness, a deep involvement in her church, and friendships with people "of all races." Susan spoke of three incidents of unwanted sexual activity: 1) When an older married man recently grabbed and touched her breasts; 2) When she was a teenager dancing with a boy that tried to put his hand up her shirt; 3) When a friend of her brother's kissed her without her consent and asked her to have sex with him.

Mary, age 22 and Caucasian, is a recent college graduate. Mary reported estranged family relationships, and that she was diagnosed with Bipolar Disorder. Mary incurred two incidents of sexual touching without her consent: 1) Her grandfather touched her breasts when she was ten; and 2) A younger brother repeatedly molested her

over the period of a week when she was 15 years old. Additionally, she had a lot of "non-consensual sex" in high school and a college boyfriend "pressured" her to have sex.

Lisa, age 19 and Mexican American reported that her friends were all minorities and described her family as, "Not really close, strict, and tied to cultural beliefs." Lisa briefly battled depression as a teenager, and contemplated suicide once. Lisa detailed several instances of unwanted sexual activity. At age five, two separate males touched her on two occasions: a ten year-old male stuck his finger in her anus; and a 16-year-old boy lured her into a bedroom, pinned her down on a bed, and "rubbed himself" on her. At age 11, an older male cousin put his finger in her vagina while riding with her on a bicycle. At age 17, an uncle by marriage placed his hand on her knee and continued to move it up until it almost touched her vagina. Lisa's Godfather acted inappropriately when he took her to dinner when she was 17, he held her hand and asked her sexually related questions which made her feel uncomfortable.

Two Overarching Themes

The findings can be divided into two overarching themes: themes promoting help-seeking, and themes that inhibited help-seeking. Themes promoting help-seeking included being willing to listen, believing survivors' descriptions of what happened, and having a shared-connection. Themes inhibiting help-seeking also emerged: self-blame and shame, others not believing and ignoring/acting like it did not happen, negative interactions with medical support, protecting family members, cultural beliefs, and readiness for counseling. These two overarching themes were evident as survivors described seeking help from friends, parents, psychologists, counselors, medical doctors, and other sources.

Emerging Themes Promoting Help-Seeking

Willing to listen and believing. Participants found friends, older women, romantic partners, and professional counselors helpful because they were willing to listen, available, and believing of their accounts of SV.

Three participants found friends to be most helpful. Lisa remarked, "My best friends don't judge me, they're not going to look down on me because my life is a certain way...So I don't even have to censure anything I tell them." Nancy's friends were most helpful because "they listened to me and they understood that this was the type of guy he was." Claire found a male friend to be most helpful; "I felt more comfortable...it just feels that I would be able to be more honest with him and since he knows me..." Claire's responses also suggested availability and access to friends was helpful. "He [male friend] was there whenever I needed him, unlike the counselor, where I would have to make an appointment."

Other women were also found to be helpful. Alex found her mom as a primary source of help and support; "My mom [father's second wife] took me in when no one else was there. She was just always there...I sometimes just wanted someone to listen, and she was always willing and there to listen." Alex also sought help from a female gynecologist, whom she saw as a small child after the sexual abuse was discovered. She resumed contact with this doctor yearly when she entered high school and reports, "I can always call her if I need something." Lisa found her mentor (an older woman to be most helpful and described her as, "She totally understands...When I would have a problem, whenever I was stressed-out or depressed...she would pull me out from that environment."

Two participants sought help from romantic partners. Susan shared her experience with a boyfriend, and reported that he expressed worry and wanted to know who the person was who assaulted her. Mary found that sharing her experiences with her boyfriend were particularly helpful, stating, "I got to do a lot of things with my emotions. He was really patient.... he was good about hearing me, he was good about how I was being affected."

Three participants sought help from professional counselors, and their descriptions also capture the themes of "willing to listen" and "available." Alex's psychologist was, "...always willing to listen. She made time in her schedule for me, I never felt like I was a client. I felt like I was a friend to her." Mary describes her current female therapist of two years as "awesome, there for me...she has been really supportive." Lisa indicated that she saw a counselor briefly in high school regarding family issues and her SV experiences. This interaction was helpful because the counselor, "Told me to look at things from a realistic point of view, like I shouldn't probably expect my family to change their beliefs... hearing the truth was helpful...to keep me focused."

Shared connection. Participants revealed that shared connections with others validated and normalized their experiences and allowed them to see that they could survive. Claire shared her experience with a male debate coach who disclosed that he had been abused as a child. "It made me feel more comfortable telling him, because there was some sort of shared connection, and trust." This coach disclosed to her that he also blamed himself, and she stated, "It was nice to hear him say that he thought it was his fault, and then he realized that it was not." Susan disclosed to one female friend who

later disclosed to her that she also had a history of SV. "Our discussions, that really helped...to say that we're not alone. You can tell people, and if they haven't been through what you have, then you really can't help people." Susan commented on the impact of her friend's strength: "She really is a strong individual, she has her life together, and that's what helped me." Mary worked at a local crisis hotline during college and confided in members of the training group (many who were survivors of SV). The overall experience was the "impetus for change" and she cited the female training leader as most helpful because, "She told me it was okay to be pissed off and express it."

Culturally-bound shared connections were related to positive help-seeking. Claire recently identified as "non-heterosexual" and shared this revelation with a male gay friend. Claire was able to share her history of SV with this male because he really accepted and knew her. Such a connection also existed for Lisa and her mentor: "She totally understands, she has a lot of knowledge about my culture. She knows how to speak Spanish." Shared connections may have a deeper significance; survivors sought others who understood their experiences as a member of a marginalized group. Connections over these similarities provided an avenue for sharing about the SV, knowing that they would not be judged out of misunderstanding their identified group.

Emerging Themes Inhibiting Help-Seeking

Shame and blame. Shame and self-blame were the most salient themes represented by survivors, specifically as they recounted feeling violated as a result of their experiences of SV. For example, Susan stated, "I felt like, violated. He knew my principles [not engaging in sexual intercourse outside of marriage]... I was thinking if you present yourself a certain way, you won't get approached like that." Susan had a similar

reaction when describing another incident, "I just felt so violated by it...I knew about sex, and I knew enough to say no to him.... I was like no." People often sought Susan out to talk about their own experiences and she revealed that she does not disclose her own experiences for fear of portraying weakness. Beth and Claire had difficulty classifying their SV experiences as intercourse against their will and subsequently blamed themselves. Both were under the influence of alcohol, and therefore felt responsible for what happened, even if they were unwilling participants. Beth remarked, "I feel like I should come up with a label for it, to make myself feel better, so I want to play it off like something of the rape nature, so that I can not feel bad for it, or punish myself." In response to whether she had ever had sexual intercourse that was against her will, Beth stated:

> I certainly did not want to; I was not planning on doing it at all.... and I have regretted it so terribly. So maybe it would be called against my will, but I feel that it was my fault anyway, so I am responsible for myself, and if I can't take care of myself, then I think it is my fault. So I say no, I can't be responsible for someone else's actions, but it wasn't like he stopped me and raped me ...but I did try to stop him when he was kissing me.

Similarly, Claire stated:

> I felt bad about the incident because I was like really drunk, and I was not like reactive.... I mean I was like 'no, I don't really want to do that'...But I was just so messed up that I did not do anything about it. I just remember him trying to force me to give him oral sex.

When asked what she would define as rape Claire remarked, "I feel bad defining it, but when someone says no, or is not able to give consent." When asked whether she had ever had sexual intercourse against her will, she stated that:

> I felt really bad because I was drunk, it was partly my fault...I mean I guess that I would say no.... a lot of females in heterosexual relationships maybe don't want to have sex, but are just socialized, are pressured without them even knowing, because of their social situation, into having sex, so I guess in some broad definition, it could fit, yes, but I have never said no, and I mean I have never been raped in that way.

Participants' experiences of help-seeking from parents and family captured themes related to self-blame and shame. When remarking about telling her parents, Beth stated, "I don't tell my family about that; would you tell your family about that? Absolutely not." Similarly, Claire reported that that she did not tell her mother, "How my mom raised me, we didn't have a relationship where we could talk about that." Lucy did not tell her family, including her sister; claiming, "...I did not want her to say I told you so. She is always telling me to be careful, and I didn't really listen. I guess I could be more careful and think about what I am doing sometimes."

Not believing or ignoring/acting like it did not happen. Participants found that some family, friends and counselors ignored what happened or did not believe their interpretation of their experiences. Some encountered family members whose relationships with the perpetrator caused them act as if nothing happened. Lisa's family did not understand: She told her brother about the incident that occurred at age 11, and believes that he has forgotten "because he still hangs out with this cousin (the

perpetrator)." Lisa told her mother about the incidents involving her uncle and Godfather, and stated, "I really didn't receive any support from my mom...because when I told her (about my uncle)...she questioned me was I sure, I just didn't imagine it? Mary's parents were present in the room when her grandfather abused her and did nothing about the abuse, which encouraged her reaction: "I don't feel like I have a right to (say anything)." Mary's stepmother did not initially believe her when she disclosed that she was molested by her brother. "She made me tell my dad... and I felt like I was getting in trouble." Lucy shared her experience with a friend who was present while she was assaulted and reported that this friend "acted like it was not a big deal." Alex told a female friend about the incident that occurred in the 9th grade, but this friend thought that Alex was lying. Regarding telling friends in general, she stated:

> It is really hard for me to find someone to go in depth for, because I have to tell the whole; it is hard too, because a lot of people my age did not experience what I did, and a lot of them are really turned off by it.

Claire sought assistance from two female counselors on campus, but reported that this experience was not helpful. Because of summer availability, she had to see two different counselors. She attributed the support of the counselors to their job specifications, "Because that is their job to do...I just had a hard time making a connection over there."

Negative interactions with medical support. Two participants described negative experiences when seeking help from medical doctors. Negative interactions prior to the SV made it less likely for these participants to seek care. Claire sought medical treatment from an on-campus doctor and reported that "Doctors on campus always assume you are

pregnant or have a STD.... I don't feel comfortable around them at all and the [receptionists] treat you like your time doesn't matter." Alex found that her experience of SV was viewed by her female gynecologist as being extreme, 'strange,' and "difficult to grasp" because a female abused her, but reports that this woman was helpful and available nonetheless.

Protecting others. Some survivors did not seek help as a result of wanting to protect others. Lucy did not tell her family, including her sister; claiming, "She just worries about me." Susan's lack of sharing with her family echoed Lucy's concern about worrying, "I don't want them to worry about me..."

Cultural themes. Cultural beliefs influenced seeking help from family members, specifically parents. Lucy, who identified as Korean American described her parents, in general, to be supportive and understanding. "Culture is so based on school or success, money wise, and education, so there is not much support or open-mindedness to talk about other things." Susan, who identified as African American also cited cultural reasons for not seeking help. She commented:

> You have to be strong to make it in the world; if you are not strong, you are not going to succeed; I felt like they taught me to be strong, and if I was to go to them, it would be that I wasn't presenting that principle of being strong, and they would feel like I need more help, which they really may not have the time to give or the resources. I want to maintain...this whole thing that I am strong.

When inquiring about the use of professional counselors, Susan also commented, "Within our culture we don't go and talk to counselors... we are more religion based.

You can suppress those things you need to get rid of.... you always want to pray about stuff, and not deal with it." She had mixed reactions regarding this practice and indicated that although she did not share specific incidents with her church community, she felt supported by her relationships in the church, especially women.

> Yes, God can resolve stuff in your life.... you get encouragement from the word of God, but I don't believe the bible in essence really wanted us to keep it like that. It is really important for African American women to really be aware that it is okay to talk to people, and that it is not healthy to hold a lot of stuff in.

Readiness for counseling. One participant who was sexually abused as a child indicated that her first experience seeking counseling was not helpful because she was "not ready." On her first counselor during high school, Mary stated, "It didn't work because I was in a situation where there was really no way out.... She didn't have much to work with. I was not in a place where I could admit that my boyfriend was raping me.... I really think it just wasn't the right time."

Chapter 4

Discussion

The results of the qualitative interviews yielded many patterns, and for the sake of this investigation, two overarching themes related to promoting and inhibiting help-seeking are discussed, with an emphasis on the cultural context within which they occurred.

Sources Most Helpful to Survivors

The qualitative interviews revealed several patterns with regard to people survivors found most helpful. Six of the eight survivors interviewed reported friends to be helpful, and 3 reported friends as the most helpful of all sources. Two participants reported that counselors were most helpful. It is important to note that both of these participants worked with these psychologists for several years, and both were sexually abused as children. One participant reported her mother as most helpful. Others identified as helpful included a male debate coach, a mentor, a training leader, and a professor. Overall, sources other than psychologists and counselors were found most helpful.

An examination of the current literature provides insight into the findings. Survivors in this study reported unwanted sexual activity by an acquaintance, which may explain the lack of help-seeking from formal sources of help like rape-crisis centers and mental health professionals. Prior literature posits that the nature of the assault may influence help-seeking behavior of survivors; survivors of stranger rape are more likely to seek help as compared to survivors of acquaintance rape (Koss et al., 1988; Mahoney, 1999; and Ullman & Siegel, 1993). Additional explanations regarding lack of formal

help-seeking have been enumerated. Drauker (1999) reports that survivors may not seek formal treatment for a variety of reasons: 1) inability to assume the patient role; 2) treatment location is not local; 3) natural resistance to talk about the assault; and 4) fear that therapy providers may not meet their needs. All of these reasons may or may not be applicable to the survivors who participated in this inquiry.

The majority of participants in this investigation found friends to be most helpful and studies examining social support corroborate this finding. SV may be related to the need for emotional support, and survivors generally turn to family and friends for this reassurance and validation (Golding, Siegel, Sorenson, Burnam, & Stein et al, 1989). In a study investigating sources of social support for survivors, Golding et al., (1989) observed that 2/3 of the participants disclosed their experiences of sexual assault to others, 59.3% told a family member or a friend, and 16.1% told a mental health professional (the second most frequently told source reported in this study). It was also observed that friends and family were indicated as most helpful (60.3%) and mental health professionals were second most helpful (43.2%) in a study examining social support and sources of support (Ullman, 1996). Popiel and Susskind (1985) observed that survivors found female friends as most helpful, followed by boyfriends and husbands, with support varying according to stressfulness of the assault. The current findings are consistent with past findings regarding social support.

Emerging Themes Related to Why Persons Were Helpful

Phrases such as having a "willing to listen," "available," "believing" and "shared-connection," were used to describe persons that survivors found most helpful. These sentiments were continual throughout the survivors' interviews. Several participants

indicated that it was helpful to talk with someone who had experienced what they had been through, and attributed that help to having a "shared connection." Both Claire and Susan reported that it was helpful to talk about their experiences with people that had been though similar experiences, and who had similar reactions to those experiences, including blaming themselves for what happened. Susan reported having this "shared connection" with a female friend, and Claire reported having this "shared connection" with her debate coach, who also had a history of SV. Phrases like, "to say that we're not alone, and "it was nice to hear that [they thought] it was their fault too," were evident among several participants.

Alex's experiences further support the importance of having a shared connection. She noted that she felt that she often could not seek help from friends because they had not experienced similar trauma in their lives. Alex reported that she found her therapist and mom to be most helpful because they were "always willing to listen," and were "always there for her" when she needed them. Alex's experience of unwanted sexual activity was notably different from other participants (repeated childhood sexual abuse by her father's first wife, the women she describes as her original adoptive mother), which may provide insight into her unwillingness to share her experience with friends. Shame, a salient emotion associated with incest and childhood sexual abuse, may have prevented her from sharing her experience with others.

Lisa and Mary expressed that a mentor and psychologist, respectively, were most helpful. The theme of shared connections transmits to these interactions as well. Lisa worked with an older mentor for over ten years, and found this woman to be most helpful because "she was always there when I had a problem." It is plausible that this shared

connection may be attributed to the length of time and commitment each invested in the relationship, which made it possible for Lisa to seek support from her mentor. Moreover, Mary worked with her therapist for over two years, and described this woman as most helpful. The length of time they worked together may have also contributed to the "shared connection" between Mary and her therapist.

Limited research exists regarding social support, and few studies specifically address emotional social support among survivors of SV. A review of the literature on working alliance may further advance the understanding of help-seeking behaviors among survivors and the role of social support. Working alliance is most often conceptualized as collaboration between the therapist and client, emotional bonds, and agreed upon goals, all of which have been identified as key factors in positive therapeutic outcomes (Howarth & Symonds, 1991).

Although the literature minimally addresses the role of working alliance in the therapeutic process with survivors, the descriptions of helpful emotional social support received by participants in the current study parallel components of the working alliance in the therapeutic relationship: "shared connection, availability, willing to listen, understanding, and joking around." The literature indicates that it takes several sessions for the working alliance to be established, which may explain the difficulty that participants experienced making a "connection" with professional mental health care providers. Claire reported having to see 2 therapists at a counseling center due to summer availability, and reported that she only had a few therapy sessions. The transfer to a new therapist may have impeded the establishment of a strong working alliance, and may have led her to leave counseling prematurely. A prior relationship with friends for

Claire may have felt more comfortable and safe, which may have facilitated seeking help from friends. Mary worked with her therapist for over 2 years, suggesting the existence of a strong working alliance that enabled her to seek help from this psychologist.

A few participants responded that they found friends to be most helpful because they were able to "joke around" with them. This theme was especially true for the two participants that reported that alcohol was involved in their experiences of unwanted sexual activity. Beth and Claire reported male friends were most helpful because they "made it seem like I was not such a big deal," and "he knew it was serious, but he could joke around to make me feel better." Furthermore, initial joking may have allowed for cognitive and/or emotional distancing (i.e. separation or de-identification) from the SV experience.

Cultural Factors and Help-Seeking

Although this qualitative investigation was not comprehensive in terms of the diversity of the participants, results pertaining to cultural variations in help-seeking and social support were evident and merit discussion. The findings indicated that four of the five Caucasian women sought or intended to seek formal sources of help from a professional counselor or psychologist. However, regarding incidents of SV, the three women of color did not seek out or intend to seek out services from a professional counselor or psychologist.

The African American survivor reported that cultural factors influenced her choice to not seek formal sources of help, a finding that mirrors the current literature examining diversity and help-seeking. General help-seeking behaviors of African American women differ from those of Caucasians. For example, Wyatt (1992) reported

that African American women are less likely to seek counseling compared to Caucasian women. As depicted in Susan's experience, research suggests that African Americans have favorable attitudes regarding mental health care centers, yet often underutilize such services (Gary, 1987, Thompson & West, 1992). Susan proclaimed that "African American women should talk to someone and not hold it all in," yet, she did not seek formal sources of help following her own experiences with SV.

Reluctance to seek professional help may result from long-standing differences in how African American and Caucasian women are treated by medical staff and law enforcement officers after SV. Neville and Hammer (2001) assert that social institutions continue to oppress African American women. Herman (2003) posits that longstanding discriminatory practices against persons of color by law enforcement systems (disproportionate arrests of African Americans as compared to Caucasians) may suppress help-seeking from these institutions. Popiel and Susskind (1985) observed that survivors in their study experienced victim-blaming responses from police. Campbell (1998) observed that SV survivors reporting minimal injury, a non-stranger assailant, and mismatch of race between assailant and survivor encountered negative experiences among legal, medical, and mental health institutions. Deviations from accepted definitions (e.g. assailant was a non-stranger) of SV may impact legal, medical, and mental health systems and result in negative experiences for treatment seekers. As a result of such treatment, many African American women may believe that they are not viewed as possible victims of rape by the larger society and therefore shun services to protect themselves from further mistreatment (Collins, 2000, 2004; Holzman, 1996; McNair & Neville, 1996; Wyatt, 1992).

Past legal response to SV also impacts help-seeking. Stranger rape is investigated more thoroughly by the legal system (Kerstetter, 1990) and SV committed by an acquaintance yields a lower conviction rate (Petersilia, 1994, as cited in Sinclair & Bourne, 1998). Low conviction rates related to SV may contribute to decreased psychological help-seeking. Court cases involving SV rarely matriculate to the court room and if they do, non-guilty verdicts reinforce and bolster rape-myth acceptance (Sinclair & Bourne, 1998). Past research revels that women of color are less likely to have cases of SV pursued by the legal system (Campbell 1998; Razack, 1998). The legal systems failure to punish acts of aggression and to protect the rights of people may influence African Americans interpretation of their experience as well as their help-seeking behaviors. African American women survivors may integrate a "why bother" attitude regarding seeking legal or psychological help.

Many African American women do not consider their incident of SV as "real rape," and therefore do not seek counseling (Holzman, 1996; Neville & Pugh, 1997; Wyatt, 1992). Stereotypes depicting female African Americans as being promiscuous and the African American historical context of rape of female slaves may fuel this current belief held by some African American women. It has been observed that African American women internalize the depiction of themselves as promiscuous and wanton (the Jezebel stereotype) as a motive for SV experiences (Neville et al., 2004). Assailant characteristics have been found to impact labeling and interpretations of SV. It has been observed that certain assailant traits (stranger vs. acquaintance) preclude survivors from labeling vaginal, oral, or anal intercourse as rape (Kahn et al, 2003). For African American survivors, SV by a stranger justifies help-seeking from social resources,

including mental health professionals (Ullman and Filipas, 2001). These observations shed light on possible factors associated with Susan's lack of psychological help-seeking and inability so share her experience with family.

African American women may be hesitant to label events as SV in order to protect themselves from negative treatment from others. For example, African American survivors report that they believe others (family, friends, and society) will discount their experience as not "real rape" and therefore various forms of sexual violence is minimized (McNair & Neville, 1996; Neville & Pugh, 1997; Wyatt, 1992). Researchers posit that African American women remain silent about their victimization experiences to protect families and themselves (Ritchie, 1996; Collins, 1998). Collins (1998) asserts that African American women must choose between the protection of Caucasians and being reviled by their own black communities regarding sharing their experiences of violence. A "code of silence" also exists regarding African American women that have endured violence at the hands of African American men. These women may feel the need to protect African American men who have endured longstanding racism (Bell, 1992) and therefore remain silent about their own victimization experiences. Inability to label themselves and needing to protect themselves and their families may prevent them from seeking needed psychological treatment.

African American women may be less inclined to seek counseling services because it could threaten their ability to be a source of strength for their families (McNair & Neville, 1996; VanHook, 1999). Professional help-seeking may threaten internalized self-schemas of themselves given the long-standing tradition of viewing Black women as strong and independent. Susan commented on needing to remain strong, and that her

family raised her to be strong. It has been observed that some African American women support this historical belief that life would be difficult, believe it to be true, and that they must overcome all adversity, suggesting that if you could not meet demands and challenges, treatment seeking would be revered as weakness (Thompson et al., 2004). Although this internalized self-schema can be protective and a source of resilience, it may create an unexpected burden of needing to appear strong, even when in need of care themselves. As such, denying and avoiding negative emotions, such as anxiety or depression, has been found to be an adaptive coping strategy among African American women (Zeal-Barnett & Crowther, 2000) because they allow these women to function in times of adversity.

These data also provide some important preliminary cultural considerations for Latina and Asian women. An examination of prior literature provides insight into the help-seeking behavior and intentions of Latina and Asian survivors. It has been reported that Asians and Latinas are less inclined to seek help from community mental health services and are more inclined to turn to culturally approved alternatives (Akustsu, Snowden & Organista, 1996 as cited in VanHook, 1999) such as prayer, biblical readings, community church elders (Mattis, 2002; Chiang, 2004). Lisa, the only Latina participant, reported that she found her mentor to be most helpful, and may have turned to this woman because she was a culturally accepted source of help, an observation supported by past findings. Among a sample of sexually harassed Latina women, Cortina 2004) observed social reactions by friends and family were received as more helpful as compared to more formal organizational sources. However, Santiago and Morash (1995) observed that 47% of battered Hispanic women did not seek family members as sources

of assistance, and only half of the women seeking help found sources in general as helpful.

Cultural norms may influence help-seeking among Latina women. Cultural beliefs related to acceptance of suffering and respect for authority are inherent among Latinas (Gracia-Petro, 1996; Falicov, 1996, as cited in VanHook, 1999). The notion of *familismo*, kinship among immediate and extended families, and *respeto*, respect of person in positions of higher power (Marin & Marin, 1991) may influence help-seeking (Cortina, 2004). An additional cultural norm possibly impacting help-seeking among Latinas includes *machismo,* actions emphasizing masculinity (Marin & Marin, 1991). Cortina (2004) posits that a women incurring sexual harassment at the hands of a family member may not share their experience with family members for fear of being silenced or not believed. Such sharing may threaten, violate, or contradict the norms of familismo, respeto, and machismo. It is plausible that this finding can be extrapolated to Lisa, who encountered unwanted sexual touching by a male cousin, uncle and godfather. She was met by disbelief when sharing incidents of SV with her mother, yet, found her mentor very helpful and understanding

Statistically, Asian Americans also underutilize mental health professionals as sources of help, partially because the nature of traditional psychotherapy is incongruent with the cultural values of Asian Americans. It is more culturally-acceptable to seek solution-focused short term help for academic reasons, than treatment for non-academic psychological distress (Leong, 1993; Bui & Takeuchi, 1992; Snowden & Cheung, 1990; Uomoto & Gorsuch, 1984, as cited in Atkinson, Lowe & Matthews, 1995). This may explain Lucy's (the only Korean American participant in the current investigation) lack

of disclosure regarding her attempted sexual assault. The findings also support her report about her family's culturally expressed emphasis on academic achievement and general success.

Caucasian cultural values, including individualism and independence are important to consider regarding the help-seeking experience of Caucasian survivors. Prior bodies of literature indicate that White culture is characterized by individualist values, such as self- purpose, self-interest, and self-actualization and individual goals (see Coon and Kemmelmeier, 2001). Individualist cultures also emphasize verbal expression that is direct and expressive, equality in relationships, and consistency between the public and private self. These values are consistent with many components and the overall ideology of individual psychotherapy (e.g., verbal expressiveness, disclosure of private information, self-focused goals, independence, and examination of self). This is not surprising given that, historically, the foundation of psychology was built largely by Caucasians with the intention of serving other Caucasian people (Jackson, 1995). These communalities may promote help-seeking among Caucasian survivors. The incongruity between therapy norms and collectivist ideals, particularly disclosure of private information and self- rather than community-focus may inhibit this form of help-seeking for Africa American survivors (Vontress, 1995).

Significance of study

This study has valuable implications for clinical practice, training, community education and outreach, and research. In general, clinicians should 1) be cognizant of the impact of race and ethnicity and how they may influence the therapeutic process and family reactions to SV; 2) provide a therapy experience that conveys being available,

believing, and willing to listen; and 3) communicate the significance of outside emotional social support that conveys notions of being available, believing, and willing to listen. Group counseling consisting of same racial/ethnic background participants and leaders may promote the "shared connections" that these women desire. Taylor (2000) observed that many African American women survivors of intimate male partner violence participating in therapeutic groups attributed discomfort and lack of investment in the group experience to differences in racial, ethnic, and SES among participants. These same women also reported that they perceived white women as having difficulty understanding their experiences and unable to provide support. It is evident that African American survivors SV may have similar experiences in therapy groups, and therefore may benefit from therapy groups consisting of members from similar racial and ethnic backgrounds.

The results have valuable implications for training and community education and outreach. Future counselors and therapist must engage in training opportunities that educate them about racial/ethnic difference regarding help-seeking and working alliance across cultures. Additionally, an understanding of the role of the working alliance specific to working with survivors, and communicating to clients about its development in the therapeutic relationship may prove beneficial to successful therapy outcomes. Mental health organizations should direct outreach efforts to women of color and promote the use of mentors of similar racial/ethnic backgrounds that have experienced similar trauma in their lives. Promoting such interactions may generate a sense of "shared connections," normalization, and validation of survivors' experiences and feelings.

This exploratory investigation provides the basis for future studies that further explore these concerns. As women of color continue to be understudied populations, future research should increase their recruitment of women of color. Investigations should also focus on examining within culture differences, as variations related to acculturation level, SES, education level, and other demographic factors may provide additional insight to the help-seeking needs and social support experiences of non-majority culture survivors.

Another future research trajectory includes investigating specific definitions women use to describe their SV experiences. For example, this study did not solicit definitions of important terms like sexual intercourse against one's will or rape from all participants, which may provide valuable information regarding how survivors define and share their experiences and seek informal and formal help. More information is required regarding definitions that participants used to describe how certain events impact them. Many participants used "uncomfortable" and "comfortable" concerning interactions with sources of help. Yet, these phrases may have different meanings for participants, and should be explored further when given as responses. In an attempt to better understand survivors' help-seeking experiences, future investigations should help clarify the distinction between "telling" and "disclosing" about the abuse as compared to "help-seeking." Assessment of women's access and knowledge of help resources will also provide valuable information regarding possible barriers professional help-seeking.

Limitations

Several limitations must be considered for this investigation, including external validity. External validity refers to whether the findings can be generalized beyond the

sample to and across populations of interest. Typically, qualitative studies have limited external validity, and in this case, the small number of participants limits the generalizability of the results. Limited diversity among the sample may make it difficult to make assertions about cultural factors. Yet, the exploratory nature of this topic and limited research regarding social support, SV, and help-seeking supports the timeliness of this study. Careful consideration must be applied when generalizing these finding to underrepresented groups, not only because of the varied experiences of sexual violence reported by the participants, but also because of their variations in interpreting/labeling these events as sexual violence. Because participants experienced various forms of unwanted sexual activity occurring at varying times in their lives, it is challenging to develop uniform and comprehensive themes regarding help-seeking attitudes, behaviors and intentions, and social support across all participants. It is possible that differing lengths of time since each occurrence of sexual violence may have influenced participants' responses; therefore this information should be considered when examining the findings. Although qualitative data limits generalizability of the findings, it is essential for exploring new constructs and may have an effect of improving the external validity of a theory by demonstrating the extent to which it applies to other groups.

In addition, use of a self-report interview format may have resulted in relevant information being filtered out by participants. For example, the women in this study provided their own account of how they perceived emotional social support; however, support networks may have intended to be helpful, but were not perceived to be. Further, the presence of the researcher during the interview, as opposed to an anonymous survey, may have generated biased responses. As a white interviewer, it is also plausible that

participants of color may have censored their responses, particularly if they felt they had represented their cultural group or family in a potentially negative manner (e.g. family was not supportive or understanding). As a result, the findings presented here are subjective and alternative interpretations may be plausible. Nevertheless, a qualitative interview format is appropriate for exploratory investigations, particularly when the topic is of a sensitive nature, because it allows for meaning making of experiences in a balanced format that exposes researcher biases, and provides support; framework consistent with feminist methodology (Bergen, 1996, as cited in Campbell & Wasco, 2000).

In summary, hearing the voices of survivor's experiences has powerful implications for clinicians, outreach, training, and future research. The results indicate that survivors of SV, and more specifically, survivors of color, are an underserved population with unique help-seeking attitudes, behaviors, and intentions. This study contributes to the limited extant literature on help-seeking attitudes of survivors of SV, particularly among people of color, and provides a foundation for future studies exploring these concerns.

Specifically, the findings from this study informed the development of study two. For example, several questions related to help-seeking and emotional support among non-white women were raised. Study one revealed that 4 out of 5 Caucasian survivors sought or intended to seek therapy, yet none of the women of color survivors sought counseling for their SV experiences. Friends were found to be a great source of emotional support in the current study, and were reported as helpful by the African American participant. This raises the question of whether a larger sample of African American female survivors

would also find friends and other informal sources as emotionally supportive or not. The long history of the sexual exploitation of African American women would predict that African American survivors of SV would have differing perspectives, coping strategies, and help-seeking practices compared to non-Black women (West, 2002) . Thus, strong connection and identification with Black culture (racial identity) may also impact survivors SV experiences. It is clear that several questions regarding the help-seeking behaviors of African American women remain.

Chapter 5

Study Two African American Female Survivors of Sexual Violence: Emotional Social Support, Racial Identity Development, and Psychological Help-Seeking Attitudes

Introduction and Literature Review

Sexual violence is an all-encompassing construct characterized by any unwanted sexual activity forced by one person upon another, including rape (e.g. stranger, date, acquaintance, marital, and gang), forced sodomy, child sexual abuse, and incest. Incident rates of sexual violence (SV) vary, with estimates ranging from 1 out of 6 women to as many as 1 out of 3 women experiencing some form of SV in their lifetime (Koss & Harvey, 1992; Tjaden & Thoennes, 2000; 1998; Ullman & Knight, 1992). More alarming is the fact that many of these incidents go unreported, suggesting that the available statistics may underestimate the actual number of women who have experienced SV (Mahoney, 1999).

An examination of the short-term and long-term aftereffects experienced by survivors provides initial insight in to the counseling needs of this population. Common aftereffects include: shame, isolation, sexual inhibition, sleep disturbances, mistrust, intrusive thoughts, dissociation, helplessness, feeling overwhelmed, feeling loss of power and autonomy, fear, guilt, anxiety, impairment of concentration, depression, and an exaggerated startle response (Delahunta & Baram, 1997; Foa, Rothbaum, & Steketee, 1993; Resick, 1993). Although it is plausible that psychological counseling contributes to positive post-SV adjustment among survivors, there is limited research on this topic. Neville and Pugh (1997) reported that counseling was associated with increased long-term self-esteem among rape survivors. Moreover, Cohen and Roth (1987, as cited in

Neville & Pugh, 1997) observed that survivors who seek counseling may experience a decrease in intrusive thoughts regarding SV. It was observed that survivors who sought immediate counseling experienced less anxiety and depression as compared to those survivors who delayed seeking treatment (Stewart, Hughes, Anderson, Kendall, & West, 1987). These studies illustrate that counseling may reduce symptomology related to SV among women survivors. As such, these findings encourage the need for continued research regarding help-seeking of SV survivors.

Research has minimally addressed the role of perceived emotional social support, and help-seeking, particularly among African American female survivors. Perceived emotional social support, defined as the belief that love, caring, sympathy, and understanding are available from significant others (Thoits, 1995) may impact post-SV adjustment. Overall, it has been suggested that SV results in the need for emotional support, and survivors often turn to friends and family for this support (Golding et al., 1989). Yet, African American women often fail to disclose their rape experiences to others because they are fearful of receiving negative social support (Neville & Pugh, 1997). Where do African American female survivors get help for incidents of SV if they are unable to get emotional social support needs met?

An examination of racial identity development, the developmental process that involves a person's interpretation of racial information and his/her own attitudes and behaviors towards his/her own racial group and other racial groups (Neville & Lilly, 2000) may provide insight into African American female survivor help-seeking. Previous research has shown that differing racial identity statuses have different beliefs about help-seeking (Austin, Carter, Vaux, 1990; Helms, 1995; Ponterotto, Anderson, & Grieger,

1986). Therefore, an exploration of racial identity and help-seeking will provide insight in to the unique needs of African American female survivors.

Incident rates of SV necessitate research in this area. It is highly likely that practicing psychologists will encounter survivors experiencing some combination of SV aftereffects, which supports the critical need for research in this area. Toward this end, the following study examines the interrelationships among emotional social support, racial identity development, and psychological help-seeking attitudes among female African American survivors of SV. Valuable insight regarding the help-seeking attitudes of women survivors of SV with a special emphasis on racial and cultural context will be generated by this investigation.

Literature Review

The following literature review is organized into the following sections providing information regarding interrelationships among emotional social support, racial identity development, and help-seeking attitudes of female African American survivors of SV: 1) historical context of African American female victimization experiences; 2) incidence rates of SV; 3) sexual harassment and racialized sexual harassment; 4) help-seeking and help-seeking sources; 5) African American help-seeking and theoretical considerations precluding help-seeking; 6) racial identity development; and 7) emotional social support. Inconsistencies and gaps in the prior literature are identified, providing support for continued research in this area.

Historical Context of Sexual Violence and African American Women

An examination of the historical context of African American women and SV provides valuable insight into the current help-seeking behavior and attitudes, coping

behaviors, and reporting rates of African American female survivors of SV. Bodies of literature examining stereotypes and assumptions related to African American women's sexuality (Collins, 2000; West, 2004), sexual harassment, and racialized sexual harassment (Buchanan, 2005; Buchanan & Ormerod, 2002; Martin, 1994; Texiera, 2002), not only provide an important framework for understanding African American female victimization experiences, but also provide significant support for continued research in this area. Additionally, a review of the literature captures the continued oppression and exploited sexuality of African American women at many levels.

Researchers have enumerated many factors as reasons contributing to the limited research regarding mental health issues and psychological disorders among African American women. Relevant factors include: misdiagnosis, financial constraints, and lack of African American researchers (Neal & Turner, 1991), and investigations that combine African American women with African American men or Caucasian females (Neal-Barnett & Crowther, 2000). These factors affirm the necessity of continued research, specifically regarding African American survivors of SV.

Historical context of sexual violence. Current SV experiences are informed by the historical sexual victimization experiences and enslavement of African American women. Davis (1983) provides a historical account of rape within the African American community, describing the sexual assault of African American female slaves during the 1800's as a demonstration of a slave owners property rights over African American people as a whole. The rape of African American female slaves was a demonstration of dominance and also fulfilled slave owners' sexual urges (Davis, 1983). Such exploitation also served to generate productive offspring, meaning the rape of slave women led to

racially mixed progeny who were born enslaved. Slave women's forced procreation was the only way to increase the number of available slaves after their importation was outlawed. Also, lighter slaves that were part Caucasian were more highly valued and could bring higher prices at auction—making their rape not only a form of violence, but an institutionalized means of generating wealth (Brownmiller, 1975, as cited in Adams, 1997). Fredrick Douglass's sentiment, as outlined by Adams (1997) asserted that African American women were victims of forced prostitution, and void of rights. Nevertheless, the myth that enslaved women were accountable for their sexual assault was perpetuated, and the stereotype of the sexually promiscuous female slave shifted blame from slave owners to African American women (hooks, 1981). This shift in blame from perpetrator to victim has had a continual impact on the African American community, as evidenced by the perpetuation of specific stereotypes for African American women.

Stereotypes and assumptions about African American women. Assumptions and stereotypes regarding African American female sexuality are profoundly impacting and longstanding. Since the time of slavery, offensive labels such as Jezebel have been assigned to describe African American women's sexuality and infer that African American women are promiscuous and libidinous. These derogatory descriptions have served as rationale for the sexual exploitation and rape of African American female slaves by white males (Neville & Hammer, 2001). As legal property, enslaved African American women were unable to seek legal justice for their experiences of SV. The Jezebel stereotype inferred that African American women were always welcoming and wanting of sex, and white men were unable to resist and obligated to have sex with them.

Therefore, these experiences of victimization could not be viewed as rape, denying these women the ability to identify as survivors of SV (Neville & Hammer, 2001).

The Mammy is a second pejorative stereotype associated with African American women. An overweight, asexual, dutiful employee of a white family exemplifies this stereotype (Adams, 1997). Society's perception of a happy and compliant woman, often attributed to this label, is historically inaccurate because it is derived from the time of slavery, where women were savagely abused and raped (West, 2004). Out of economic necessity, African American women continued to work as employees in domestic roles in Caucasian households roles during the mid 19th century (Adams, 1997). These work roles vastly contradicted the Caucasian perceptions of femininity associated with Victorian times, which placed greater emphasis on home and family. In these working roles, African American women continued to be perceived as explicitly sexual (Adams, 1997). These domestic roles may have reinforced the Mammy and Jezebel stereotype.

These stereotypes continue to exist. West (2004) attributes the continual adherence to these stereotypes to the media's unfavorable portrayal of African American women, specifically in domestic positions, which continues to exploit power differentials. West (2004) offers the Aunt Jemima image as a recent example of this stereotype, citing that positive characterizations of African American women are greatly limited. Sexual victimization histories of African American women and related pejorative stereotypes have a significant impact on the current labeling of sexually violent behaviors, reporting, and professional help-seeking of African American female survivors.

Incidence of Sexual Violence

Although we know that as many as one-third of all women will experience some form of SV in their lifetime (Tjaden & Thoennes, 2000; 1998), the research findings are inconsistent regarding racial and ethnic differences in prevalence rates. Some researchers argue that there are established racial and ethnic differences in the prevalence rates of SV, yet these differences are rarely investigated (Neville & Heppner, 1999). Some report that women of color are more than 1.7 times likely to be survivors of sexual assault (Mcdermott, 1979 as cited in Howard, 1988) and Wyatt (1997) observed that African American women are more likely to be sexual violated than women of other racial/ethnic groups. In a study examining anxiety among African American women, Neal-Barnett and Crowther (2000) observed that 26% of the sample comprised of 50 women reported an incident of sexual victimization post age thirteen. The sexual victimization rates in this study were slightly higher than the National Violence Against Women Survey (Tjaden & Thoennes, 1998), which revealed that 18.8% of African American women experienced rape at some point in their lives. These rates confirm the prevalence of SV among African American women, and given the earlier reported finding of psychological problems associated with SV (e.g. depression, anxiety, PTSD, and low-self esteem), it is evident that SV is a serious problem detrimental to the health of African American women survivors.

Other investigations found no racial and ethnic differences in prevalence rates of SV. For example, Wyatt (1992) found no disparity in the prevalence of rape among African American and Caucasian women. In a more recent study examining support for the Culturally Inclusive Ecological Model of Sexual Assault Recovery (CIEMSAR),

Neville, Heppner, Oh, Spainerman, and Clark (2004) found similar rates of SV among 97 total participants, 47 identifying as African American and 52 identifying as Caucasian.

Disparities in prevalence findings may be attributed to sampling methods and different operational definitions of SV. Wyatt (1992) used a community-based sample of 55 participants from the Los Angeles area recruited by random digit telephone dialing of 11,834 numbers. The Neville et al., (2004) study utilized random sampling and snowballing from a predominately Caucasian Midwestern University. Differing geographic locations and unique sample characteristics may limit generalizability of the findings, and also provide possible explanations regarding differences in incident rates between African American and Caucasian participants.

Inconsistent definitions of SV across studies may have also affected the detection of the racial and ethnic differences in prevalence rates (George, Winfield, & Blazer, 1992). Use of different terminology may impact whether participants report SV. The term sexual assault includes a wide array of behaviors that may or may not include sexual intercourse, where as the term rape explicitly refers to sexual intercourse (George et al., 1992). Wyatt's (1992) investigation asked participants whether they had experienced any form of sexual abuse, and those participants that responded "yes" were asked additional questions using the term rape. Use of the actual rape definition in Wyatt's (1992) study as opposed to the term "sexual assault" or "sexual violence" may explain why a non-significant difference between Caucasians and African Americans was reported. African American females may have felt that their incidents of SV did not fit the criteria of rape used in Wyatt's (1992) investigation. Neville et al., (2004) used the term rape to assess victimization experiences, which may have limited some women from reporting incidents

of SV as such. Use of a less strict definition of sexual assault in McDermott's (1979, as cited in Howard, 1988) study may explain the report of a racial and ethnic disparity in the incidence of SV.

Broader definitions of sexual assault increase estimates of prevalence (George et al., 1992). In diagnostic interviews conducted by Neal-Barnett and Crowther (2000) African American women were more likely to use phrases like "he forced me to have sex" as compared to using the label "rape" when discussing sexual victimization experiences. This finding supports the earlier assertion that labeling of behavior may impact reporting rates of SV, as African American women may not label their experiences of sexual victimization as rape. Future studies must incorporate an all-encompassing definition of SV when attempting to assess whether racial and ethnic differences exist concerning the prevalence of sexual violence. Regardless of these inconsistencies in prevalence rates, African American women are experiencing sexual victimization at an alarming rate, and with detriment to their physical and psychological well-being (Neal-Barnett & Crowther, 2000; Delahunta & Baram, 1997; Foa, Rothbaum, & Steketee, 1993; Resick, 1993).

Sexual Harassment and Racialized Sexual Harassment

Sexual harassment. Sexual harassment experiences of African American women are worthy of consideration, because these experiences serve as an extension of the abuse of power associated with the SV endured by enslaved women. The Equal Employment 0pportunity Commission's (EEOC, 1980) guiding principles provide a framework for the definition of sexual harassment that is used in the judicial system and in the relevant literature. These guidelines indicate that sexual harassment may include the following

behaviors: *gender harassment* (e.g., assertions that women do not belong in certain professions or college majors), *unwanted sexual attention* (more explicitly sexual behaviors such as repeated requests for dates, lewd gestures, and attempts to touch or kiss someone against his/her will), and *sexual coercion* (also called *quid pro quo* includes performance-related threats or benefits that are intended to coerce sexual cooperation) (Fitzgerald, Gelfand, & Drasgow, 1995; Gelfand, Fitzgerald, & Drasgow, 1995).

Compared to prevalence rates of SV, sexual harassment prevalence rates are equally alarming. The literature denotes that as many as 1 out of 2 women may experience some form of sexual harassment during her lifetime employment history (Fitzgerald & Ormerod, 1993). In one investigation using two samples, one comprised of 447 participants from a large corporation, and 300 participants employed at a large university, 68% and 63% of the women, respectively, indicated that they had experienced at least one incident of sexual harassing behavior within the past 2 years, as measured by the Sexual Experiences Questionnaire (SEQ, Fitzgerald et al., 1988). The aforementioned samples were comprised of predominately Caucasian participants, and therefore may not be generalizable to the experiences of African American women.

Historical stereotypes of African American women impact their sexual harassment experiences, and their labeling and reporting of such experiences. Given the belief that they are sexually promiscuous, African American women often do not want to draw attention to their being targeted with behaviors of a sexual nature, and may not want to label their experiences as sexual harassment (Kalof, Eby, Matheson, & Kroska, 2001, as cited in Buchanan & Ormerod, 2002). This finding supports the notion that the longstanding stereotype depicting African American women as overly sexual beings (The

Jezebel) continues to impact these women. In one investigation of 100 African American women, 52% endorsed at least one item on the SEQ (Fitzgerald et al., 1998), yet 96% did not define their experience as sexual harassment (Mecca & Rubin, 1999). This finding supports the above assertion that African American women may not define or label experiences of sexual harassment as such. Adams (1997) posits that deciphering accurate rates of reporting of sexual harassment experiences among women of varying ethnic backgrounds is hindered as a result of the influence of respective cultural norms related to labeling, reporting, and acceptance. This observation is comparable to the findings concerning the significance of labeling of SV behaviors in research examining victimization experiences of African American women.

Power dynamics and bonds of oppression also influence reporting of sexual harassment experiences of African American women. Power differentials between the abuser and the victim may also preclude reporting (Adams, 1997). Specifically, this may occur in the case where a female employee is being harassed by a male superior. The shared historical experience of oppression for African Americans also creates an additional dynamic for African American women sexually harassed by African American men (Crenshaw, 1992, as cited in Adams, 1997). Reporting of sexual harassment experiences may be suppressed in an attempt to protect African American men, who have endured centuries of racism (Bell, 1992). Women who break this "code of silence" risk being shunned from the African American community, reinforcing the notion that racism supersedes sexism (Bell, 1992). The highly publicized sexual harassment court case in 1991 of Anita Hill, an African American professor, against Clarence Thomas (who sexually harassed her), an African American Supreme Court judge, is noteworthy. Many

people questioned Hills credibility because she failed to file a formal complaint against Thomas at the time of the alleged harassment. As earlier addressed, when Hill broke the "code of silence" her credibility was questioned.

Racialized sexual harassment. The significance of race within the context of sexual harassment is an important construct that only recently has been explored. Mecca and Rubin (1999) found that half of 100 African American women responded to an inquiry about perceived differences in sexual harassment and indicated that there were racial differences between their experiences and the sexual harassment experiences of Caucasian women. Specifically, participants noted that sexualized racial stereotypes of Black women (e.g. that they are promiscuous) factored into their experiences of sexual harassment.

Buchanan and Ormerod's (2002) qualitative study revealed a unique construct, separate from both sexual harassment and racial harassment: racialized sexual harassment. Thirty-seven African American females shared their experiences of harassment via focus groups. The results indicated that participants were unable to separate experiences of harassment as solely sexually or racially based, and as anticipated by the researchers, participants reported varied dimensions of racialized sexual harassment. Three dimensions of racialized sexual harassment were identified: 1) covert (e.g., conflict with a white secretary in a lower position of power; 2) subtly overt (e.g., assumptions and stereotypes about Black women's sexuality, such as "I bet you are slave to sex." –male co-worker to female co-worker); and 3) overt, which included blatant integration of sexually and racially motivated harassment (e.g., comments about a woman's "Sexy black ass"). Direct allusions to the longstanding victimization

experiences of African American women (e.g. slavery and sexually promiscuous stereotypes) were evident (Buchanan & Ormerod, 2002). These findings indicate the inclusion of racial and cultural variables is meaningful when examining victimization experiences of women and also supports the assertion that sexual victimization experiences of African American women are impacted by the historical experiences of African American female slaves.

Help-seeking and Identified Sources of Help

Help-seeking is generally conceptualized as a sharing of problems with others in an attempt to receive aid, guidance, or assistance for problems causing distress (Goulash, 1978 as cited in Neal-Barnett & Crowther, 2000) and is termed mental health help-seeking when it is psychological in nature (Neal-Barnett & Crowther, 2000). Terminology related to mental health help-seeking is confusing; psychotherapy and counseling have been used in describing such behaviors. Some researchers view counseling, also termed professional counseling, as a more brief intervention (up to 12-15 sessions) and infer that psychotherapy is more long-term (more than 12 sessions), with the term therapy often used interchangeably with psychotherapy (Gelso & Fretz, 2001). Psychotherapy has also been described as work with more distressed individuals that: 1) attempts to restructure personality; 2) features in-depth examination; and 3) focuses on analytic processes (Gelso & Fretz, 2001). A supportive environment with an emphasis on situational events and conscious process defines the process of counseling (Brammer, Abrego, & Shostrom, 1993). The more common combination of these events suggests that counseling and psychotherapy can be used interchangeable (Gelso & Fretz, 2001).

The majority of available research relevant to survivors of SV focuses on the different types of help-seeking available. Help-seeking sources identified and utilized include police, emergency rooms, crisis centers, friends and/or family, and professional sources of counseling. Discrepancies exist regarding how sources of help are utilized; limitations of generalizability, differences in study methodologies, and sample characteristics may account for these inconsistencies. Furthermore, investigations often fail to delineate between the types of mental health services that survivors utilize. Methodological limitations such as these make determining the help-seeking rates of survivors difficult, particularly if one hopes to examine these rates in reference to specific support sources.

The nature of the rape experience may also influence help-seeking behavior of survivors such that survivors of stranger rape are more likely to seek help as compared to survivors of acquaintance rape (Koss et al., 1988; Mahoney, 1999; Ullman & Siegel, 1993). One study using a probability sample of survivors in Los Angeles, California found that 55% of survivors experiencing stranger rape sought help from a "professional helper" whereas 30% of women assaulted by an acquaintance sought professional help (Ullman & Siegel, 1993). In a non-random university sample, 3.1% of survivors raped by an acquaintance, and 24% of women raped by a stranger sought crisis counseling (Koss et al., 1988). Adaptive sampling, defined as sampling that systematically samples locations in which the target population congregate, was used in a study of 102 survivors from the Chicago area (Campbell, Sefl, Barnes, Ahrens, Wasco, & Zaragoza-Diesfield, 1999). Results revealed that 39% of these subjects utilized mental health care services (Campbell, et al. 1999). Elsewhere it was observed that survivors are more likely to seek

help from medical doctors as compared to seeking help from mental health care providers or victim assistance organizations (Koss, Koss, & Woodruff, 1991). Despite many aftereffects associated with SV and the demonstrated need for psychological treatment, survivors underutilize sources of help.

African American Help-Seeking Behaviors and Theoretical Considerations

General help-seeking behaviors of African American women appear to differ from those of Caucasians. African American women are less likely to seek professional counseling as compared to Caucasian women (VanHook, 1999; Wyatt, 1992; Sattler (1977, cited in Boesch & Cimbolic, 1994). Instead these women use family networks and friends (Chiang, 2004; VanHook, 1999), church organizations (Mattis, 2002; Thompson et al., 2004), and alternative sources of coping (Chiang, 2004); only turning to more formal sources of psychological help when those initial sources of help are exhausted (Siegel, 1994).

There are many contributing factors to why African American survivors may not seek professional help for experiences of SV. Theoretical explanations for this lack of help-seeking include: 1) African American female attitudes towards SV; 2) African American male attitudes towards SV; 3) attitudes towards help-seeking; 4) utilization of alternative coping strategies; and 5) conviction rates related to SV.

African American female attitudes towards sexual violence. African American attitudes and beliefs about SV may influence their help-seeking experiences. It has been noted in the literature that African American women survivors may believe that society does not view them as true victims of rape (McNair & Neville, 1996; Wyatt, 1992) and that others (family, friends, and society) will discount their experience as not "real rape"

(McNair & Neville, 1996; Neville & Pugh, 1997; and Wyatt, 1992). Stereotypes depicting African American females as being promiscuous and the African American historical context of rape among female slaves may fuel this current belief among some African American women. As a result of these beliefs, African American women may feel that society does not view African American females as plausible victims of SV (Holzman, 1996; McNair & Neville, 1996;Wyatt, 1992) and therefore do not seek counseling (Wyatt, 1992).

Attitudes towards SV provide insight into African American survivors' help-seeking behavior, such as the degree to which an individual ascribes to rape myths. Rape myths are defined as a set of beliefs about rape that place blame on the victim and not the perpetrator. Two common examples of rape myths are the idea that a woman who dresses provocatively invites rape, and that women often falsely accuse men of rape (Giacopassi & Dull, 1986). Acceptance of rape myths may support the lack of help-seeking among African American female survivors of SV.

Earlier research posits that rape myth acceptance differs among African American and Caucasians, and limited psychological help-seeking among African American female survivors of SV may be influenced by this rape myth acceptance. Compared to Caucasian women, African American women have been found to view survivors of sexual assault as more blame-worthy, and are more likely to believe that women cannot be forced to have sex against their will (Giacopassi & Dull, 1986). These findings support the earlier discussed belief that African American women do not view rape as "real rape." If African American female survivors believe that they cannot be forced to have sex against their will and that their experiences do not constitute rate, help-

seeking attitudes may differ (Giacopassi & Dull, 1986). However, their findings have been challenged recently.

Carmody and Washington (2001) investigated adherence to rape myths among college women (178 African American females; 445 Caucasian females), 34.3% of who identified as survivors of sexual assault, and observed no significant statistical differences in rape myth acceptance between African American and Caucasian participants. Additionally, the researchers observed no difference in rape myth acceptance among survivors and non-survivors. Their results also support past findings that prior victimization experiences do not impact rape myth acceptance. Interactive effects of race and SES may explain disparities in the findings (Nagel, Matusuo, McIntyre, & Morrison, 2005). The length of time between the two studies (10 plus years) and an increase in sexual assault awareness and prevention programs may account for some differences and limit generalizability outside of a college (Carmody & Washington, 2001; Giacopassi & Dull, 1986).

Other studies illustrate the possible impact of rape myths on help-seeking. It was observed that individuals that have experienced SV or who are acquainted with a survivor are less accepting of rape myths (Burt, 1980, cited in Anderson, Cooper, & Okamura, 1997). Beliefs that a woman is at fault and that SV is not a criminal behavior may exacerbate the aftereffects of SV on African American survivors and prevent them from seeking helpful counseling. In a study comprised of 47 African American females and 52 Caucasian females ranging in age from 18-59 years of age, factors influencing rape survivors' self-esteem were examined. Participants were similar regarding demographic and psychological features, and in general post-rape responses, yet differed regarding

cultural blame attributions (Neville et al., 2004). In this study, African American participants endorsed cultural attribution statements associated with the Jezebel stereotype, and internalized the depiction of African American women as promiscuous as a motive for why they were sexually assaulted (Neville et al., 2004). Additionally, the findings revealed these cultural-blame attributions were associated with increased victim-blame attributions. Women may not seek professional help because they view themselves as blame-worthy and that the SV was their fault. Beliefs about how they acted, dressed, or talked may prevent them from seeking help because they feel that these factors brought on the SV.

African American male attitudes towards sexual violence. African American males provide potential support as romantic partners or family members of a survivor, which supports the examination of their attitudes towards SV. Their attitudes towards SV may impact the help-seeking behaviors of African American female survivors. It has been observed that African American males, as compared to Caucasian males, agree more strongly with the following rape myths: 1) that SV is an act of passion rather than criminal behavior; 2) that females cannot be forced to engage in sexual activity against their wills; and 3) and that females may often falsely accuse males of rape (Giacopassi & Dull, 1986). Because of their inability to see rape as criminal behavior, African American males may not believe African American female survivors' claims of SV.

A recent study examining attitudes towards rape among males and females of varying SES and race merits discussion. In a study of randomly selected participants from a community sample comprised of 104 males and 101 females, it was observed that African American males had less sympathetic attitudes towards female survivors as

compared to Caucasian males and females and African American females. (Nagel, Matusuo, McIntyre, & Morrison, 2005). However, the effect of race becomes insignificant when SES and education are controlled for, suggesting that education and SES are better at explaining variance in attitudes towards rape as compared to race. African American female survivors who internalize these messages may reaffirm their own beliefs that their experience of SV was not a criminal act. Failure to recognize incidents of SV as such and lack of sympathy from some African American males in their lives may prevent African American female survivors from seeking the emotional social support and psychological help needed to facilitate post-SV adjustment.

African American male attitudes towards domestic violence are also relevant because historical stereotypes associated with African American female sexuality continue to be endorsed by African American males regarding justification of domestic violence. Gillum (2002) investigated the link between male acceptance of negative stereotypes of black women and violence against African American women. Two stereotypes investigated included: 1) the matriarch, operationally defined as aggressive, unfeminine, and emasculating; and 2) the jezebel, defined as sexually aggressive and promiscuous (Gillum, 2002). The study was comprised of 221 African American male participants with varied SES, education, and relationship demographics. The results indicated that 48% of the sample accepted the Jezebel stereotype, 71% accepted the Matriarch stereotype, and 33% endorsed both stereotypes. Endorsement of these stereotypes was positively related to justifying domestic violence. Although this study investigated domestic violence, it is likely that this relationship holds for other forms of

violence as well. Women may internalize these beliefs, fear that others will have similar beliefs, and avoid seeking help as a result.

African American help-seeking attitudes. African American attitudes concerning help-seeking vary. Some authors suggest that African Americans have favorable attitudes regarding mental health care centers; yet often underutilize such services (Gary, 1987, cited in Thompson & West, 1992). While others have observed that African American's have unfavorable attitudes towards help-seeking (Thompson et al, 2004; Chiang, 2004). A study utilizing 24 focus groups comprised of a total of 134 female and 66 male participants investigated African American community attitudes towards psychotherapy and psychotherapists (Thompson et al., 2004). Participants were not opposed to seeking treatment from mental health services, yet had several negative attitudes and beliefs related to seeking services that ultimately precluded seeking treatment. Participants identified schizophrenia, depression, substance abuse, SV, and suicidal ideation as serious mental health concerns, warranting mental health services. Substance abuse/dependence and SV were also seen as mental health issues necessitating intervention. Participants preferred mental health service interventions that they viewed as counseling (which is perceived as assistance and focused on problem solving) rather than psychotherapy (perceived as unknown and more stigmatizing), and also felt counseling was less stigmatizing. Another investigation found that African American and Latino college students possess less favorable attitudes towards counseling and more positive attitudes towards family and social support (Chiang, 2004).

An earlier study examining attitudes towards help-seeking is relevant. Using an analogue design, 155 African American adult attitudes towards the need for treatment in

cases of rape were examined. The participants reported favorable help-seeking attitudes (Thompson & West, 1992), and the findings indicate that African Americans participants were indeed aware of the need for psychological treatment in cases of sexual assault. However, female participants did not recognize the short-term symptoms associated with rape. Not recognizing the symptoms associated with SV may cause survivors to delay seeking counseling (Thompson & West, 1992). It is also important to note that this was an analogue study of hypothetical events; therefore this may not be indicative of whether or not they would actually seek counseling if they experienced SV.

Several barriers to professional help-seeking among African Americans' have been identified. These include mistrust of law enforcement and medical professionals, lack of access to health insurance, stigma associated with sexual victimization, concerns that therapists may hold race-based stereotypes, and cultural beliefs such as desires to be the strength of the family, cultural mandates regarding resolving family problems within the family, and pride (Thompson et al., 2004). Noteworthy are the findings that indicated that many African American women are less inclined to seek counseling services because they need to remain strong, and seeking professional help may threaten their ability to be the strength of the family (McNair & Neville, 1996; VanHook, 1999). Additionally, a majority of participants in the Thompson et al., (2004) study supported the historical belief that life would be difficult and that they must overcome all adversity, a sentiment suggesting that if one cannot meet demands and challenges, seeking treatment is an indication of weakness. These culturally relevant beliefs may influence help-seeking attitudes, behaviors and intentions of African American female survivors.

Coping and non-traditional forms of help-seeking. Alternative coping strategies commonly employed by African American women may preclude them from seeking professional psychological help. Historically, African American women have turned to spirituality, prayer, biblical readings, and other religious practices to cope with oppression and racism (Mattis, 2002). Other coping strategies identified include exercise, hobbies, activities with family, religious activities, studying, and social activities (Chiang, 2004), and mind/mood altering substances (Zeal-Barnett & Crowther, 2000). Past research indicates that African American women turn to non-professional sources of help in times of need (e.g., community elders, the Black religious community and prayer, and beauty shops; Chiang, 2004, Mattis, 2002) and as a coping strategy for personal problems, such as grief and loss, cancer, substance abuse recovery, and bipolar disorder (see El-Khoury, Dutton, Goodman, Engel, Belamaric, & Murphy, 2004).

Recent studies support the above findings. In a qualitative investigation comprised of 23 African American women, eight themes emerged related to meaning-making and coping with misfortune (Mattis, 2002). Most notably, content analysis revealed that 70% of the participants recognized religion and prayer as the emotional resource that promoted acceptance of reality, and 57% engaged in "spiritual surrender," described as "turning things over" to a greater authority (Cole & Argument, 1999, as cited in Mattis, 2002), when uncertain how to cope (Mattis, 2002). Another investigation examining sources of help among African Americans observed that religious participants often turned to prayer and the church as resources, and were likely to address relationship concerns with a church official (Thompson et al., 2004). In an investigation comprised of 324 African American women and 52 Caucasian women examining ethnic differences,

intimate partner violence, and the use of resources (medical, mental health, and spiritual) it was observed African American women, as compared to Caucasian women, were more likely to use prayer as a means of coping and less inclined to seek professional mental health resources (El-Khoury et al., 2004). Because they are culturally accepted sources of help, and are widely used by this population in times of need, African American survivors of SV may turn to prayer and religion as a source of coping, as opposed to seeking more professional sources of help.

Avoiding is another adaptive coping behavior employed by African American women. When examining anxiety and panic disorder among African American females, Neal-Barnett and Crowther (2000) found that middle class African American women were unlikely to seek professional help for psychological problems, and were only more likely to seek professional help when relationship concerns or bereavement issues elevated to crisis levels. Participants were able to recognize anxiety related issues as problematic, yet still did not seek professional help. An analysis of diagnostic interviews revealed two additional explanations for this finding. First, African American women do not seek professional help because of the belief that anxiety is a part of being a Black women and that as such they must "'keep on keeping on.'" Second, the authors posit that African American women may recognize that anxiety is problematic, yet they choose not to recognize such feelings because doing so will hinder their ability to function, and denying such emotions is viewed as adaptive behavior (Zeal-Barnett & Crowther, 2000). The practice of avoidant coping may prevent African American female survivors of SV from seeking psychological help.

Other theoretical considerations. Disparate treatment by the legal and therapeutic community may also prevent African Americans from seeking professional help. Neville and Hammer (2001) assert that structural (political, economic, and social institutions) and ideological mechanisms uniquely oppress African American women. Law enforcement systems have engaged in longstanding discriminatory practices against people of color (e.g., disproportionate arrests of African Americans) which may suppress help-seeking from these institutions and increase victim-blame when the survivor is Black (Herman, 2003). Popiel and Susskind (1985) observed that participants in their sample experienced victim-blaming responses from police regarding their experiences of SV.

Conviction rates of perpetrators of SV may not only contribute to low reporting rates among African American survivors, but may also contribute to decreased psychological help-seeking. Reporting rates that have resulted in conviction have ranged from 2.5% to 19.85% (for complete listings see Sinclair & Bourne, 1998). Court cases involving SV rarely matriculate to the court room and if they do, non-guilty verdicts reinforce and bolster rape-myth acceptance (Sinclair & Bourne, 1998). For example, SV committed by an acquaintance yields a lower conviction rate (Petersilia, 1994, as cited in Sinclair & Bourne, 1998). Past research revels that women of color are less likely to have cases of SV pursued by the legal system (Campbell 1998; Razack, 1998), which may discourage African American women from using legal redress.

A final consideration involves the focus on individual counseling as a mode of treatment. In many ways, the premise of this paper rests on the assumption that traditional individual counseling is one of the primary intervention strategies for SV survivors. However, values within African American culture may make other modes of

therapy more beneficial. For example, the focus on the community as a collective, rather than an individualistic focus, and the use of extended kin networks (McAdoo, 1978), as a source of support may be counter to the traditional dyadic therapy intervention. Taylor (2000) suggests that group social support networks enable women survivors of intimate partner violence to fluctuate between both individual and collective experiences, providing an avenue for healing, and thus, may be more culturally-congruent for African American women. Taylor (2000) posits that sharing experiences of violence in a group of other African American women, also seeking self-healing and recovery, enables these women to publicly share and disclose themselves and their partners, ultimate leading to healing, and integration of their experiences at a social and personal level. Such an experience of social and personal healing may not occur in a one-on-one counseling experience.

Racial Identity Development

Examining racial identity development may provide additional insight into the help-seeking attitudes of African American survivors of SV. Racial identity development refers to a developmental process that involves a person's interpretation of racial information and his or her own attitudes, cognitions and behaviors towards his or her own racial group, other racial groups, and the majority culture racial group (Neville & Lilly, 2000). Cross (1971) proposed an initial model of racial identity that includes the following four stages: preencounter, encounter, immersion-emersion, and internalization. Different levels of Black and White culture identification characterize each of the stages.

The Racial Identity Scale, RIAS-B (also termed BRIAS, Helms & Parham, 1990) is a widely used scale that uses four dimensions based on Cross's (1971) model to assess

African American's racial identity development. Healthy Black racial identity development occurs when African Americans' progress through the four stages and move from initial negative feelings into more positive feelings about themselves, their racial group and other racial groups. The first stage of conformity (pre-encounter) is characterized by an individual's internalization of racial stereotypes and an idealization of Caucasians. At this stage African Americans believe that they are inferior to Caucasians. The second stage, dissonance (encounter) is characterized by an increased awareness of racism, and a "pro-Black" attitude. The third stage of immersion/emersion is characterized by an adulation of Blackness and a condemnation of Caucasian beliefs, attitudes, and ideals. Internalization, the final stage, is characterized by an incorporation of Black identity and greater respect for others (Helms, 1990; Neville & Lilly, 2000).

Research examining African American racial identity development and help-seeking attitudes has yielded inconsistent findings. The most favorable attitudes toward counseling have been found among males and females in the internalization stage of racial identity development, and it has been observed that males and females in the internalization stage and females in the encounter stage rank friends and parents as preferred sources of help (Ponterotto et al., 1986). These findings suggest that African Americans at higher levels of racial identity development (internalization stage and encounter stage) may be more inclined to seek help from friends, partners, and family as opposed to seeking psychological services when experiencing SV. Another study hypothesized that pre-encounter attitudes, where an individual adopts a majority culture worldview, would be related to willingness to use psychological counseling services and would also be related to more positive attitudes towards counseling (Austin et al., 1990).

It was observed that higher levels of pre-encounter attitudes are related to perceptions of counseling being effective, and higher levels of internalization attitudes are related to perceiving counseling as less effective. The authors posit that individuals identifying with the internalization stage may need more information about the counseling process in a manner that fits their cultural worldview to facilitate utilization of those resources (Austin et al., 1990).

One's racial identity development also relates to their mistrust of counseling. Helms (1995) observed that African Americans at the immersion/emersion status are more likely to underutilize mental health centers on predominately Caucasian campuses, as a result of general mistrust towards counseling staff. It was also observed in another study that African American's identifying with the immersion/emersion status prefer counselors of the same race, and are more likely to utilize counseling centers if African Americans are on staff (Want, Parham, Baker, & Sherman, 2004). Research also reveals that higher endorsement of Dissonance/Anti-White ideals associated with the immersion/emersion status is related to more negative problem-solving appraisals, defined as lacking confidence and avoiding problems (Neville, Heppner & Wang, 1997). This body of research suggests that African American female survivors at the immersion/emersion stage are unlikely to seek professional help.

Emotional Social Support

Social support refers to a survivor's belief that she is a cared for, loved, esteemed, valued, and a member of a group or network that places value on mutual obligation (Cobb, 1976, cited in Cwik, 1996). Friends, family, the community, and romantic partners of the survivor are important sources of social support. Social support was

conceptualized in more specific terms in this investigation to address emotional aspects of social support. Emotional social support has been defined as "demonstrating care or sympathy toward another person; listening to someone or just being there when a person needs a friend" (Birch, 1998).

Most of the social support literature is conceptually focused, or evaluates measures of general social support. Four types of social support have been discussed in the general social support literature: informational, instrumental, appraisal, and emotional (Birch, 1998; Tardy, 1985). Informational support refers to knowledge and providing information; instrumental support refers to providing tangible help like money and transportation; appraisal support refers to letting individuals know how they are doing in the form of praise and feedback; and emotional social support refers to demonstrating care or sympathy toward another person, listening to someone, or just being there when a person needs a friend (Birch, 1998). Emotional social support also involves trust, empathy, and love (Tardy, 1985). Perceived emotional support has been defined as a belief that love and caring, sympathy and understanding and/or esteem and values are available from significant others (Thoits, 1995). Some have suggested that SV results in the need for emotional support (validation, and reassurance) and survivors are more likely to turn to family and friends for this reassurance and validation (Golding et al., 1989). Yet, only one empirical study examining perceived emotional support and survivors exists.

Empirical research regarding social support, emotional social support, and survivors is scarce. Golding et al. (1989) investigated possible social support sources of survivors. The results indicated that 2/3 of the participants disclosed the SV to others.

Of these, 59.3% told a family member or a friend, and 16.1 % told a mental health professional (the second most frequently told source reported in this study). However, although this investigation used a large random sample, it did not provide information about satisfaction with social support sources or what type of social support was provided. The investigation merely considered to whom survivors disclosed.

Only one investigation has examined the relationship between emotional social support and SV survivors. Ullman (1996) examined whether social reactions to survivors vary by support provider using a convenience sample of 155 survivor participants from Los Angeles County. Emotional social support was hypothesized to be more common among women telling friends and family members as compared to more formal sources of support (e.g. police, rape crisis centers, mental health counselors). Emotional support was associated with better survivor adjustment when received from friends as compared to other support sources. It was observed that friends and family were indicated as most helpful (60.3%) and mental health professionals were second most helpful (43.2%). The survivors in this study reported more emotional support and validation from rape crisis centers as compared to telling friends and family. The findings indicated that survivors need to be encouraged to disclose and seek help from friends, family, mental heath care providers, and rape crisis centers, as these sources of help have been found to be beneficial in providing helpful responses to survivors (Ullman, 1996).

Social support may act as a buffer against psychological effects of stress including stress related to SV (Golding et al., 1989; Popiel & Susskind, 1985; Ruch & Leon, 1983). Using a sample of 25 survivors, Popiel and Susskind (1985) examined social support as a moderator of stress among rape survivors. All participants were assaulted within three

months prior to data collection. The sample was representative of national statistics regarding age, weapon involvement, injury, and percentage of assaults completed, yet their sample had a significantly higher rate of interracial assaults compared to national statistics (Popiel & Susskind, 1985). Results indicated that female friends were most supportive, support from boyfriends and husbands was ranked second (although support from this source varied greatly across subjects), and female family members provided more support as compared to male family members. Amount of perceived support varied according to the stressfulness of the assault. Despite the finding that their adjustments were equally difficult, survivors of completed rape received more support compared to those survivors of non-completed rape. The researchers found that survivors found providers of social support helpful, findings relevant to the current inquiry (Popiel & Susskind, 1985).

One investigation examined social support and use of psychological services as moderators on psychological distress, severity of physical symptoms, subjective health ratings, and the use of medical services (Kimerling & Calhoun, 1994). It was observed that survivors did not seek professional psychological services at any greater frequency than women who were not survivors. Additionally, survivors confiding in friends and family experienced less somatic symptoms associated with stress and were more likely to perceive herself as healthy as compared to those who did not have strong social support (Kimerling & Calhoun, 1994). Social support may impact post-SV adjustment, although information regarding a more specific aspect of social support, emotional social support, requires additional investigation.

The findings of Kimerling and Calhoun (1994) and Popiel and Susskind (1985) have several limitations. Small sample sizes and urban location of both studies threaten the generalizability of the findings. Popiel and Susskind (1985) studied survivors at three months post- trauma, and their findings regarding social support may not be applicable to survivors at differing times/stages post trauma.

Research examining the relationship between emotional social support and post-rape adjustment is limited and outdated, and several questions remain unanswered regarding the role of emotional social support for African American survivors. It has been observed that African American women fail to disclose their rape experience to others because they are fearful of receiving negative social support (Neville & Pugh 1997). Although Neville and Pugh (1997) did not address emotional support specifically, it is plausible that fear of receiving negative social reaction is similar to a survivor's fear of not receiving emotional social support, raising the question whether presence or absence of emotional social support influences post-SV adjustment and help-seeking among female African American Survivors. Literature has minimally addressed how emotional social support influences attitudes towards psychological treatment; a closer examination of the role of emotional social support among survivors is required.

The question is raised whether African American female survivors view their family members, partners, and spouses as emotionally supportive and as providing the emotional support that they need in response to sexual victimization. More specifically, does the survivor perceive that family members or their partner is willing and able to discuss the survivors feelings related to the sexual violence?

Summary

Limited research in the areas of help-seeking, emotional social support, and SV among women in general, and more specifically among African American survivors, speaks to the need for continued research in this area. Previous research on SV has failed to address racial identity development, despite its relevance to both the interpretation of SV and to psychological help-seeking. The purpose of this preliminary investigation was to examine interrelationships among racial identity development, emotional social support, and help-seeking attitudes of African American women survivors of SV.

Statement of Purpose and Research Questions

Existing research supports the importance of examining the impact of racial identity development and emotional social support on psychological help-seeking. However, to date, minimal attention has been given the potential interaction of racial identity development and emotional social support on psychological help-seeking among African American female survivors of SV. Accordingly, the following research questions and hypotheses have been proposed within a population of African American female survivors of SV:

1) Is there a relationship between emotional social support and psychological help-seeking? This question is intended to be exploratory in nature, and as such, no hypothesis is offered as this is one of the first investigations to explore perceived emotional social support and help-seeking among African American female survivors. Research has demonstrated that general social support is positively related to help-seeking, but the current investigation seeks to explore whether a specific form of social support, emotional social support has a relationship with help-seeking among African American survivors.

2) Is there a relationship between racial identity development and psychological help-seeking? To test the role of racial identity development the following hypotheses were proposed:

Hypothesis 2a: As racial identity development status becomes more consolidated, (racial integration of ones Black identity and respect for others, associated with identification with internalization status), survivors will have less favorable psychological help-seeking attitudes.

Hypothesis 2b: As African American female survivors identify more with the immersion/emersion status, they will have less favorable psychological help-seeking attitudes.

3) Does emotional social support significantly contribute to the prediction of psychological help-seeking above and beyond that of racial identity development? To test the incremental validity of emotional social support, the following hypothesis was proposed:

Hypothesis 3: Emotional social support will add incremental validity in the prediction of psychological help-seeking attitudes above and beyond the effects of racial identity.

4) Does racial identity development moderate the relationship between emotional social support and psychological help-seeking? To test the incremental validity of the effect of their multiplicative interaction above the additive contributions of emotional social support and racial identity development together, the following research hypothesis was proposed:

Hypothesis 4: The multiplicative interaction of emotional social support and racial identity development will improve the prediction of psychological help-seeking above and beyond the additive effects of emotional social support and racial identity development.

To explore these questions, correlational analyses and a series of hierarchical regressions for the four subtypes of attitudes towards seeking psychological help (Need: perceived need for professional psychological help, Stigma: tolerance of stigma associated with receiving psychological help, Openness: openness about disclosing personal problems, and Confidence: confidence psychological professionals to be useful assistance) were conducted. First, the role of racial identity development was examined in a regression model predicting each of the subtype's related psychological help-seeking. Second, emotional social support was added to the models above to determine the incremental validity of emotional social support to each of the four types of help-seeking. Finally, the contribution of the multiplicative interaction was added to the model containing each of the main effects (RID and ESS) to determine if their interaction added incremental validity to the model.

Chapter 6

Methodology

Participants

The goal of this study was to explore racial identity development, emotional social support and psychological help-seeking among adult African American women. There were four criterion for inclusion in this study. Participants had to: 1) be African American, 2) be female, 3) be 18 years old or older, and 4) have experienced at least one sexually violent event. To acquire a sufficient sample of women meeting these criteria, 253 surveys were collected, 108 of which met all four of the criteria for inclusion in the study. Participants meeting criteria for inclusion ranged in age from 18 to 57 years old ($M = 22.16$, $SD=6.23$). Approximately 79% of the participants were current college students, 5.6% were college graduates, and 16.7% percent of the sample were currently enrolled in or had completed graduate or professional school. Self-reported socioeconomic status (SES) indicated that 9.3% of the sample identified their family as lower SES, 28.7% as lower-to-middle SES, 39.8% were middle SES, 21.3% identified as upper middle SES, and 1% identified as upper SES.

Procedure and Method of Recruitment

Participants were recruited to complete the survey hosted on an independent website (herein described as the "subject pool" and "website pool," respectively) via the psychology subject pool of a large Midwestern university, email solicitations, and respondent referrals (snowballing).

Psychology subject pool. The sub-sample drawn from the university subject pool consisted of 196 women, 79 of which met the four inclusion criteria. These participants received course credit for their participation in this study.

Website subject pool. The survey was also available on an independent website, resulting in a total of 57 participants, 29 of which met the study. Participants were solicited by email from university and private sector organizations and by respondent referrals. Targeted email and list-serve postings were used to over-sample African American women. These solicitations asked those interested in participating to contact the investigator for the web address of the study and a unique password that provided access to the survey. A unique respondent ID number was automatically and randomly assigned to each subject, ensuring participant anonymity and confidentiality.

Preliminary analyses were conducted to compare demographic characteristics of the two subject pools. T-tests revealed no statistically significant differences between the university subject pool or the website subject pool participants for SES, but statistically significant differences for age (t= 7.62 and p= .00), level of education (t= 13.61 and p= .00), and trauma scores (t= 2.72 and p=.001) were found.

Prior to starting the survey, participants from both recruitment sites were provided with an overview of the study, and a consent form that outlined their rights as research participants. After completion of the study, all participants were provided with a full debriefing regarding the purpose of the study and they were also provided a list of national and local resources. As compensation for their time, a $1 donation was made on behalf of each participant to a women's organization and, based on voluntarily provided email addresses, participants were entered into a raffle to win one of four $50 prizes.

Responses were automatically encrypted and stored on a computer server, which could only be accessed by the researcher, and personal information was stored separately from the data. Copies of the consent forms, survey, debriefing, and reference materials are available in Appendices C-G.

Measures

Participants first completed a demographic questionnaire asking participants to report their age, level of education and socioeconomic status. The Attitudes Towards Professional Psychological Help-Seeking Scale (ATPPHS, Fischer & Turner, 1970) was completed second. A sexual trauma history assessment (e.g., type of sexual violence, length of time since the incident of sexual violence, degree and nature of the assault, and whether they sought counseling, including the type of counseling sought) followed the ATPPHS. The remaining measures were completed in the following order by all participants: Social Support Questionnaire (SSQ, Sarason, Levine, Basham, & Sarason, 1983), Feminism and the Women's Movement Scale (FMW, Fassinger 1994), and Racial Identity Attitude Scale (RIAS-B, Helms & Parham, 1990) (see Appendix G),

Help-seeking attitudes. Help-seeking attitudes represented the outcome variable under investigation and was operationalized as sexual violence survivors' general attitudes about seeking psychological help. Attitudes about counseling specifically refers to general beliefs regarding counseling and seeking psychological treatment. The 29-item Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970) was used to assess this variable. This measure was developed to reflect general attitudes towards seeking professional psychological help and uses a 4-point scale (0= disagreement and 3=agreement) with higher summed total scores indicating more

favorable attitudes towards seeking psychological help. Sample items include: "At some future time, I might want to have psychological counseling" and "There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help." Test-retest reliability for 5 days and two months were .86 and .84 respectively (Fischer & Turner, 1970).

The following mean scores and internal reliability estimates were observed for the total ATSPPHS and its four subscales (need, stigma, openness, and confidence): total summed score of the ATSPPHS (M=55.16, SD=10.96, α=.85), need (perceived need for professional help) (M=15.21; SD=4.00, α=.71), stigma (tolerance of stigma associated with receiving psychological help) (M=9.37; SD=3.09, α=.69), openness (openness about disclosing personal problems) (M=13.59, SD=3.71, α=.63), and confidence (confidence in psychological professionals to be useful assistance) (M=16.82, SD=4.29, α=.68). The coefficient alphas found for this sample are comparable to those reported by Fischer and Turner (1970).

Sexual violence and trauma assessment. Trauma scores were generated by adding the affirmative responses to behavior-based questions (out of a possible 7) to the affirmative responses to questions addressing the nature/degree of the SV (out of a possible 8) for a total possible score of 15. The total score reflects the number of the different kinds of experiences participants experienced, endorsement of attempted or completed SV, and the severity of the attempted and/completed SV (M=3.80, SD=2.89). Questions assessing different trauma experiences included: 1) Have you ever been hit or grabbed by someone? 2) Has anyone ever tried to touch you without your consent? 3) Has anyone ever touched you in a way that made you feel uncomfortable 4) Have you

ever experienced forced touching that was sexual in nature? 5) Have you ever had intercourse against your will? In addition to the behavior-based questions, two additional questions assessing SV trauma were asked: 1) Have you ever experienced attempted sexual violence (any attempted unwanted sexual activity forced by another person including anal, vaginal, or oral penetration; stranger rape, acquaintance rape, date rape, martial rape, gang rape, and/or incest)? 2) Have you ever experienced completed sexual violence (see Appendix G)? For these two final questions participants were asked to denote whether they experienced the following by the assailant: 1) verbal threats; 2) threats to use a weapon; 3) threats to use physical force; and 4) physical force (e.g. punching or choking).

Perceived emotional social support. The Social Support Questionnaire, SSQ, developed by Sarason et al., (1983) was used to assess participant perceptions of social support. Research indicates that this measure addresses emotional social support (Tardy, 1985), such as the availability of and satisfaction with the support they received from others. The measure lists 27 items (e.g., "Who accepts you totally, including both your worst and best points?" and "Who will comfort you when you need it by holding you in their arms?") and participants list the name of someone who provided that form of support. Participants then rate their satisfaction with the support received for each statement using a 6-point rating scale ranging from 1="very satisfied" to 6="very dissatisfied." The availability of social support is calculated by dividing number of people providing support by number of items (27) and has a four-week test-retest reliability of .90 (Sarason, 1983). Participant satisfaction with social support is calculated by dividing the summed score of overall satisfaction received for each item by

the number of items (27). Scores of the two subscales were aggregated to provide a total perceived emotional support score (M=7.65 SD=2.26, α=.97).

Because the SSQ does not address those who were *not* helpful, an additional item was added which asked, "Who was not helpful in regards to your experience of sexual violence?" This item was modeled after the SSQ questions, such that participants were asked to provide the initials of those who were not supportive and their relationship with that person. For this added item, space was also permitted for additional comments and for participants to state whether these individuals were later found to be helpful.

Attitudinal scale. Fassinger's (1994) Feminism and the Women's Movement Scale (FMW) was used as an additional attitudinal measure. This measure was not the focus of the analysis, but was included to deflect the oddity of the use of the one racial attitude scale (RIAS-B, Helms & Parham, 1990) and to make the point of the survey less obvious. The FMW consists of 10 items measuring affective attitudes towards the feminist movement on a five-point likert-like scale (1=strong disagreement and 5=strong agreement). Sample items include, "The leaders of the women's movement may be extreme, but have the right idea," and "I am overjoyed that the women's liberation is finally happening in this county." Fassinger (1994) reports for her sample an internal reliability estimate of α=.89 (.90 for men, .86 for women).

Racial identity development. The 50–item Racial Identity Attitudes Scale RIAS-B, long-form (Helms & Parham, 1990) is based on Cross's (1971) model of racial identity development and was used to assess participants' agreement with each of four stages (referred to as status) of racial identity development: conformity (preencounter), dissonance (encounter), immersion-emersion, and internalization. This measure

examines an individual's interpretation of racial information and his or her own attitudes, cognitions and behaviors towards his or her own racial group, other racial groups, and those of the majority culture (Neville & Lilly, 2000). *Conformity* (*M*=2.09, *SD*=.47, α=.80) is the equivalent of Cross's preencounter stage and is typified by pro-white and anti-black attitudes (e.g., "I feel Black people do not have as much to be proud of as White people."). *Dissonance* (*M*=2.69, *SD*=.58, α=.55) represents racial confusion and commitment to explore Black racial identity (e.g., "I am determined to find my Black identity."). *Immersion-emersion* (*M*=2.59, *SD*=.52, α=.71) represents pro-Black and anti-White attitudes, sample item: "I believe that everything that is Black is good, and I limit myself to Black activities. *Internalization* (*M*=4.05, *SD*= .4127, α=.67) represents the internalization of positive Black identity sample item: "I feel good about being Black, but not limiting myself to Black activities." For each subscale, participants responded using a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Items were summed such that higher summed scores represent greater identification with the status. The majority of the sample identified with the internalization status of the BRIAS (n=100), 5 identified with the encounter stage, and 3 participants had identical high scores on 2 or more subscales. The coefficient alphas found in this study are comparable to the reliability reported by Helms (1990).

Confounds and covariates. Possible confounding variables were considered in the analyses. Trauma history varied for each of the participants, including the nature of the violence, and degree of force used. Given these variations, these variables were controlled in the regression analyses. Socioeconomic status, SES, represented a second confound/ covariate impacting general help-seeking attitudes. Thus, SES was controlled

in the data analyses. Low SES has been identified in the literature as a factor associated with reluctance to seek professional psychological help (Tessler & Schwarts, 1972).

Chapter 7

Results

Table 1 displays the correlation matrix, means, standard deviations, and internal consistency reliability estimates for the variables under study. Trauma and openness to disclosing personal problems were significantly and positively correlated (r=.24). Indicating that as women reported more trauma they were more open to disclosing personal problems. A significant and negative relationship existed among openness to disclosing personal problems and Preencounter attitudes (r=-.21) and among immersion/emersion attitudes (r=.-24). As women endorsed less pro-white/anti-black (preencounter) attitudes, women were more open to disclosing problems. Additionally, as Pro-Black/anti-White (immersion/emersion attitudes) identification decreased, participants reported more openness to disclosing problems. There was a significant inverse correlation among preencounter attitudes (pro-white/anti-black attitudes) and perceived need for professional help (r=-.30). As women reported less pro-white/anti-black attitudes they reported a greater perceived need for professional help.

Significant correlations were observed among tolerance of stigma associated with receiving psychological help and several predictor variables. A significant inverse relationship existed for tolerance of stigma associated with receiving psychological help and two of the racial identity statuses: encounter and immersion/emersion. As women reported less encounter attitudes (characterized by racial confusion and commitment to explore Black racial identity), they reported more tolerance of stigma associated with receiving psychological help (r=-.21). Additionally, as Immersion/Emersion attitudes (pro-black/anti-white) decreased, tolerance of stigma related to psychological help

increased (r=-.20). A positive correlation between social support and tolerance of stigma associated with receiving psychological help was also significant (r=.20). Specifically, as women reported more satisfaction and availability of social support, tolerance of stigma associated with psychological help-seeking increased.

Multiple Regression

Four hierarchical multiple regressions were used in this investigation, one for each of the four subscales of the ATSPPHS (Need, Stigma, 0penness, and Confidence). Data were entered in the following order for each of the four subscales of the ATSPPHS. Trauma scores and SES were entered as control variables in block 1. In block 2, each of the 4 RIAS-B subscale scores was entered as a block (to test the main effect of racial identity development). Scores from the SSQ were entered at step three. At step four the interaction of each status of racial identity development multiplied by the social support score was entered as a block (to test the multiplicative interaction). To reduce multicollinearity, the continuous predictors (SSQ, perceived emotional support; racial identity subscales: preencounter, encounter, immersion/ emersion, internalization) were centered before computing interaction terms (Aiken & West, 1991). The centered scores for social support and each racial identity development status were multiplied to create 4 interaction variables.

For each analysis, the models were examined to determine their contribution to explaining additional percentages of variance. The significance level of the beta weights of the subscales for the RIAS-B were examined to determine which of the racial identity subscales (i.e. Preencounter, Encounter, Immersion-Emersion, or Internalization) significantly contributed to the variance explained in the dependent variable, the

ATPPHS subscale. Despite the possibility that multiple analyses can inflate Type 1 error, a Bonferonni's correction was not utilized, because statistical corrections are not essential when analyses are pre-determined (Perneger 1998). Standardized regression coefficients (β), which speak to effect size, and R^2, a measure of the strength of the relationship, are provided in an attempt to minimize Type II errors when interpreting null results (Cohen, 1988). Statistical assumptions regarding data normality, multicollinearity, and homoscedasity of residuals were all met.

Tables 2 and 3 provide the results for the hypotheses related to the four research questions. One of the exploratory purposes of the study was to examine the relationship between emotional social support and psychological help-seeking (research question 1). However, as seen in tables 2 and 3, emotional social support, entered at step 3, did not account for any additional significant portion of explained variance in any of the regression models. However, in the regression models examining the stigma subscale (tolerance of stigma associated with receiving psychological help) the contribution of emotional social support was significant. These results reveal that there is a relationship between tolerance of stigma associated with help-seeking and emotional social support such that as emotional social support increases, tolerance of stigma associated with receiving psychological help increases. Finally, hypothesis 3, which posited that emotional social support would add incremental validity above and beyond the effects of racial identity was not supported, suggesting that emotional social support does not predict help-seeking attitudes related to the four subscales beyond that of when racial identity has already been accounted for.

Research question 2 inquired about the relationship of racial identity development and help-seeking attitudes among African American female survivors of SV. Hypothesis 2a, which speculated that as racial identity development consolidates (identification with internalization status), attitudes towards psychological help-seeking attitudes become less favorable, was not supported. Hypothesis 2b, which posited that African American female survivors identifying with the immersion/emersion will have less favorable psychological help-seeking attitudes was partially supported. Racial identity development, lower status identification predicted statistically significant amounts of variance in 2 of 4 of the help-seeking subscales: Openness (openness about disclosing personal problems), and Need (perceived need for professional psychological help). Hypotheses 3 and 4 were also not supported, such that emotional social support was not found to add statistically significant incremental validity above the effects of racial identity development. Additionally, a multiplicative interaction of emotional social support and racial identity development was not statistically significant.

Openness. The adjusted R^2, a conservative estimate considering the small sample size (Tabachnick & Fidell, 2001), indicates that the RIAS-B explained 11.2% of the variance in the openness (openness about disclosing personal problems) subscale, $F(6,101) = 3.24, p < .05$, with Immersion/Emersion significantly contributing to the amount of variance explained, $\beta = -.30$, $t(101) = -2.51, p < .014$. Trauma scores also significantly contributed to the amount of variance explained: beta = .23, $t(101) = 2.48$ $p<.015$ (see Table 2). Lower immersion/emersion attitudes and higher trauma scores were associated with stronger openness about disclosing personal problems.

Need. The adjusted R^2 indicates that RIAS-B scores explained 6.5% of the variance in the need (perceived need for professional psychological help) subscale, F (6,101) = 2.23, $p < .05$, with Pre-encounter significantly contributing to the amount of variance explained, $\beta = -.26$, t (101) = -2.430, $p < .017$ (see Table 3). Lower pre-encounter attitudes were associated with a stronger perceived need for professional psychological help.

Stigma and confidence. None of the models for the remaining two help-seeking subscales were found to be statistically significant. Additionally, no simple effects for racial identity attitudes were found in the two remaining ATPHSS subscales (see table 3): stigma (tolerance of stigma associated with receiving psychological help) and confidence (confidence in psychological professionals to be useful assistance).

Emotional social support x racial identity development. Hypothesis 4 asserted that the multiplicative interaction of emotional social support and racial identity development would improve the prediction of psychological help-seeking above and beyond the additive effects of emotional social support and racial identity development. Analyses revealed that the interaction terms (comprised of emotional social support and each of the 4 subscales of racial identity development) did not explain additional variance for any of the help-seeking subscales, indicating that this hypothesis was not supported.

Trauma Responses

The mean of trauma scores was 3.80 (SD=2.89). This mean does not reflect the number of SV experiences participants encountered, but reflects responses to behavior-based questions. Participants' responses to questions assessing prior physical trauma and sexual violence revealed that: approximately 60% of the sample indicated that they had

been aggressively hit or grabbed by someone; 55% responded that someone had tried to touch them without their consent; 71% responded that someone had touched them in a way that made them feel uncomfortable; 46% responded that they had experienced forced touching that was sexual in nature; and 16% responded that they had sexual intercourse against their will. Participants were also asked to respond to questions that used a more global label: sexual violence, and 27.8% responded that they had experienced attempted SV, and 16% responded that they had experienced completed SV. Regarding experiencing attempted SV, 12% of the sample reported that they experienced verbal threats, 1% reported threats to use a weapon, 11% reported threats to use physical force, and 19.4% reported the use of physical force. Regarding completed SV, the sample reported experiencing the following: verbal threats (8%), threats of use of a weapon (1%), threats to use physical force (6.5%), and the use of physical force (11%).

When assessing familiarity with assailant, it was observed that a small percentage perceived the assailant as a stranger, and many denoted "other" as their level of familiarity. Regarding the question assessing attempted SV, 81 participants responded, with 1.1% indicating a stranger, 19.1% indicating an acquaintance, 11.2% denoting a romantic partner, 2.2% indicating a spouse, and 66.3% noting "other" as the assailant. Familiarity with the assailant concerning completed SV was reported by 81 participants: 2.5% noted stranger, 12.3% indicated acquaintance, 4.9% reported romantic partner, and 80.2% reported "other" as the assailant.

Reported Help-Seeking

Help-seeking behaviors varied by the type of sexual violence participants experienced. Women who experienced attempted SV reported the following help-

seeking behaviors and sources for help: 4.6 % sought help from a private therapist, with (1%) utilized crisis counseling (4 or fewer sessions), 2.8% utilized short-term counseling (5-12 sessions), and 1% used long-term counseling (13 or more sessions). One percent of the sample utilized an Employee Assistance Program and Rape Crisis Center for short-term counseling. Approximately 2.8% of the sample sought help from a University Counseling Center for short-term counseling, and none of the participants sought help from a Community Mental Health Center or Veterans Administration. Approximately 6% sought help from another source, which included: a close friend, an adult friend, a friend who is a therapist, God, Jesus, and their mother.

The following help-seeking behavior was reported in response to incidence of completed SV. Approximately 4% of the sample sought help from a private therapist, with 2% of those participants utilizing short-term counseling, and 1% utilizing both crisis and long-term counseling. None of the sample utilized an Employee Assistance Program or Veterans Administration. One percent of the sample sought help from a Rape Crisis Center and University Counseling center, and utilized crisis counseling at these sources. One percent of the sample sought help from a Community Mental Health center, and engaged in both crisis and long-term counseling. Two percent of the sample reported that they sought help from other sources, which included a close friend and God.

Who Was Not Helpful

Website participants had the opportunity to provide information concerning who was not helpful surrounding their incidents of SV. Seven participants responded to this inquiry and varied in both the number of people who were not helpful to them and the people they listed as being unhelpful. Three listed one person as unhelpful, another 3

listed two people, and one stated that four people were not helpful. Participants listed parents, other family members, romantic partners, therapists/counselors, friends, and religious persons when naming those who were not helpful.

Chapter 8

Discussion

Results indicate that racial identity status is significantly linked with help-seeking attitudes among African American survivors of SV. Greater identification with Caucasian ideals and racial stereotypes was associated with greater perceived need of psychological help, and greater tolerance of stigma associated with receiving such help. Additionally, as SV trauma scores increase in conjunction with greater identification of Caucasian ideals, African American survivors are more inclined to disclose personal problems.

The primary purpose of the study was to explore the emotional social support and help-seeking attitudes of African American survivors of SV. It was hypothesized that emotional social support would add statistically significant incremental validity beyond the effects of racial identity development. Despite the lack of support for the hypothesis, the findings of this investigation generate valuable preliminary insight regarding emotional social support and African American female survivors of SV. African American women in this study may not have found informal sources, such as parents and family, as providing of emotional social support. This finding may be explained in terms of historical stereotypes associated with African American women. Researchers posit that stereotypes associated with African American women's sexuality may result in less support from community members (Ullman and Filipas, 2001). African American women survivors may believe that society does not view them as true victims of rape (McNair & Neville, 1996; Wyatt, 1992) and that others (family, friends, and society) will discount their experience as not being a "real rape" (McNair & Neville, 1996; Neville & Pugh, 1997; and Wyatt, 1992). Stereotypes depicting African American women as

promiscuous, in conjunction with the historical sexual exploitation female slaves being commonplace and legal may fuel this current belief.

The second explanation for this finding may relate to cultural interpretations of emotional social support. Ullman and Filipas (2001) hypothesized that assessments of social support may find that ethnic minority women receive less emotional support from informal sources because of differing conceptualizations and perceptions of the definition of emotional social support. The definition of emotional social support in current assessment instruments may reflect "westernized" ideals and may not represent ways in which African Americans support one another. The lack of satisfaction with informal sources of emotional social support combined with the results of this study is concerning. Taken together, these findings suggest that African American female survivors may not be getting the post-SV support they need, formally or informally. The results of this study indicate African American survivors are unlikely to seek support from formal sources, such as therapists and counselors, causing one to wonder how these survivors will recover if the adequacy of their support is insufficient.

Although inconsistent with the proposed hypotheses regarding racial identity development, the hierarchical multiple regression analysis revealed statistically significant findings regarding the relationship among status of racial identity and survivors' psychological help-seeking attitudes. Lower immersion/emersion scores and higher trauma scores were related to openness about disclosing personal problems within a traditional therapy setting. The fact that increased trauma does not lead to a decrease in willingness to disclose problems is a surprising finding, given the possible consequences that survivors may face as a result of sharing multiple experiences of trauma. Increased

trauma may create more opportunities for others to send victim-blaming messages. Further, often SV is intra- rather than interracial, increasing the likelihood that the assailant was also the same race, which may cause survivors to protect the larger community by not reifying stereotypes of African American men as sexually violent (West 2004). These two factors would appear to suppress disclosure, making it surprising that survivors reporting more trauma were more willing to disclose. Hypothesis 2b, posited that African American female survivors identifying with the immersion/emersion status will have less favorable psychological help-seeking attitudes. The immersion/emersion stage of racial identity development is characterized by an adulation of Blackness and a rejection of Caucasian beliefs and attitudes (Helms, 1990; Neville & Lilly, 2000). The current findings suggest that greater identification with Caucasian beliefs, ideals, and attitudes is associated with a greater willingness to disclose personal problems. Otherwise stated, a decrease in identification with the immersion/emersion status will be related to more favorable attitudes concerning openness to disclosing personal problems. This finding is consistent with previous research findings (Neville, Heppner & Wang, 1997). For example, higher immersion/emersion status and endorsement of anti-White ideals was found to be related to more negative problem-solving appraisals, which the authors defined as having less confidence in their problem-solving abilities and avoiding problems as a result (Neville, Heppner, & Wang 1997). In the current sample, survivors who endorsed less Dissonance/anti-White ideals, were more open to professional help and perhaps more likely to receive it as a result.

It was also observed that lower pre-encounter scores were associated with a stronger perceived need for professional psychological help. The pre-encounter stage is

characterized by an individual's internalization of racial stereotypes and an idealization of Caucasians (Helms, 1990; Neville & Lily, 2000). Lower pre-encounter scores suggest that less African American-centered values, characterized by greater internalized stereotyping and identification with Caucasian culture, leads to greater recognition of psychological help. This finding implies that African American survivors may be impacted by the historical context of counseling as a White profession, suggesting that the more one identifies with white culture, the more likely one is to seek counseling.

Despite a significant and positive correlation among emotional social support and tolerance of the stigma associated with receiving psychological help, the relationship between emotional social support and psychological help-seeking attitudes was not significant in the regression models. Similarly, Neville et al., (2004) found no relationship between social support and psychological adjustment, which invites the question of what happens to the women who do not seek psychological help?

Factors Facilitating and Inhibiting Labeling

Research indicates that African American women are less likely than Caucasian women to classify sexually violent incidents as rape or sexual assault (Holzman, 1997; Neville & Pugh, 1997; Wyatt, 1992), which is consistent with the results found here. In the current study, almost half of the respondents experienced forced touching that was sexual in nature (which constitutes SV), yet only slightly more than half of this group labeled their experience as attempted SV and only a third of the group labeled it as a completed SV. Rather than labeling these incidents as SV, the women in this study felt more comfortable disclosing their experiences when questions were behaviorally-based rather than using the term "sexual violence." SV may be a term that respondents are

reticent to use, similar to the findings on the use of "rape" and "sexual assault." This finding has important implications for future studies and survivor assessments in clinical and legal settings. Specifically, researchers and practitioners are likely to obtain a more accurate assessment of SV if they allow survivors to label their own experiences, instead of providing those labels for them. Such practices will enable emphasis to be placed on the sequalea associated with the behaviors, opposed to the labeling of behavior.

Other factors may contribute to participants' reluctance to label their experiences as SV. One such factor is whether or not the survivor knew the assailant. Research has found that when the assailant is someone a woman knows, survivors are less likely to label vaginal, oral, or anal intercourse as rape (Kahn et al, 2003). Only a small percentage of women reported a stranger as the assailant in this study and being assaulted by an acquaintance may have inhibited their willingness to label such behaviors as SV. The degree of force used by the assailant may also impact participants' labeling of SV as such. Past findings indicate that survivors experiencing force during SV are more likely to label the experience as rape (Bondurant, 2001; Koss & Dinero, 1989). In this sample, use of physical force was uncommon and it is possible that this hindered women from labeling their experiences as SV. Finally, use of alcohol during the SV experience is another factor that may have impacted participants' labeling of their experiences as SV. The research reveals that women who report intoxication at time of a sexual assault are less likely to label the assault as rape (Kahn & Mathie, 2000, as cited in Kahn et al., 2003). In this study alcohol consumption was not assessed, but if labeling SV is similar to the labeling of rape, it is possible that women were unlikely to label an experience as SV if inebriated at the time.

Reported Help-Seeking

The extant literature suggests that 30% of SV survivors enter psychotherapy as a result of their trauma (Miller & Cohen, 1995; George, Winfield & Blazer, 1992), but the rates of psychological help-seeking among women in this study were lower than these estimations would suggest. Of the participants reporting attempted SV, approximately 8.4% sought counseling from a private therapist, Employee Assistant Programs (EAP's), or a university counseling center. Among participants reporting completed SV, 6% sought counseling from a private therapists, rape crisis center, and/or community mental health organization.

The differences between previous research findings and the current study may be related to racial and ethnic differences between these participants and those of earlier investigations. Previous estimations are intended to be general across all SV survivors, but are based primarily on Caucasian samples (e.g., Miller & Cohen, 1995; George, Winfield & Blazer, 1992), while this study is comprised solely of African American survivors. Researchers posit that African American women remain silent about their victimization experiences to protect families and themselves (Ritchie, 1996; and Collins, 1998). Collins (1998) asserts that African American women may feel conflicted between their own self care (e.g., seeing a therapist) and the values of the black community, which may discourage sharing experiences of sexual violence, particularly with out-group members. If the perpetrator is an African American man the "code of silence" may be even more strictly enforced, with dire consequences for those who chose to disclose such events. The confirmation hearing of Supreme Court Judge Clarence Thomas and the treatment of Dr. Anita Hill (a woman he sexually harassed) is one example of the

negative treatment a Black woman may face if she breaks this code. In addition, women may remain silent out of a desire to protect African American men because of the history of racism they have faced (Bell, 1992) and to avoid reinforcing stereotypes of black men as sexually violent predators (Adams, 1997).

There has been a long-standing tradition of viewing Black women as strong and independent, which has often been a source of pride (McNair & Neville, 1996; VanHook, 1999). Seeking psychological help may threaten these internalized self-schemas and their ability to be a source of strength for their families; making them less inclined to seek counseling services (McNair & Neville, 1996; VanHook, 1999). Under such circumstances, denying negative emotions, such as depression or anxiety, has been an adaptive coping strategy among African American women (Zeal-Barnett & Crowther, 2000). Use of denial and avoidance may be protective because they allow women to function in times of adversity, but they may also prevent them from seeking needed psychological assistance.

Participants' help-seeking behaviors may have been inhibited for some of the same reasons women did not label their experiences as SV. In addition to cultural considerations, factors such as being unaware of SV symptomology, having negative attitudes towards seeking services, labeling experiences as a SV or not, and experiencing greater force during the SV may have impacted help-seeking. In a study of African American women, participants were aware of the need for psychological services following sexual assault, but often did not recognize the short-term symptoms associated with sexual assault and trauma (Thompson & West, 1992). In the current sample, it is possible that the women had favorable attitudes regarding psychological help-seeking,

but did not pursue psychological services because they did not associate their symptoms with their experience of SV. Negative attitudes and beliefs regarding the cultural sensitivity of psychologists may also hinder seeking treatment (Thompson et al., 2004). Most notably, the focus group members in their study viewed psychologists as being largely absent from community education and outreach in the African American community. Additionally, focus group participants also indicated concern about a highly educated Caucasian's ability to understand and relate to their experiences. To the extent that participants in this study also held such attitudes, they may have contributed to help-seeking avoidance.

Problem severity is a factor influencing treatment-seeking among African American women (Thompson et al., 2004). Not labeling experiences as SV may impact help-seeking because participants may not recognize its severity or see the need for treatment. In this study, help-seeking was assessed in response to the terms "attempted SV" and "completed SV" as opposed to assessing help-seeking in response to the specific behavior-based questions. Given the discrepancies in responses regarding labeling of SV behavior with formal terminology or behavior-based items, it is possible that asking this information with the latter would have changed the findings.

Assailant characteristics and the presence of physical injury (not assessed in this inquiry) have also been found to impact help-seeking behaviors. In a study examining 323 SV survivors, 26.1% of which were African American, it was observed that the presence of physical injury and greater perceived threat made women more likely to seek help from various sources, including mental health professionals (Ullman and Filipas, 2001). The researchers posit that an unknown perpetrator and visible injury generate

legitimacy for survivors seeking help, as both function as objective evidence that can be seen by help sources. In the current study, few women reported threats of force or assaults by strangers, which may have inhibited their help-seeking and increased their fear that they would not be viewed as legitimate survivors. Consistent with this theory, women sexually assaulted by a stranger were 78% more likely to use formal support sources as compared to women assaulted by acquaintances (57.6%).

Participants' degree of racial identification may have contributed to the low rates of psychological help-seeking among this sample. The majority of the sample identified with the internalization status of racial identity development, which has been associated with preferring friends and parents as sources of help (Ponterotto, Anderson & Grieger, 1986) and perceiving counseling as ineffective (Austin, Carter, & Vaux, 1990). It is possible that the low rate of psychological help-seeking was due to participants seeking help from other sources, such as family, friends, and parents. Individuals at this status may need information about the counseling process that is culturally-congruent with their worldview (Austin et al., 1990) and that additional information about culturally-sensitive resources and sources of support would increase utilization of therapeutic services.

Conversely, higher racial identity development may act as a buffer, protecting women from high levels of psychological distress and precluding the need for therapeutic services. Sellers and Shelton (2003) observed that greater identification with one's racial group buffered participants from negative outcomes following racial discrimination, which supports prior studies (e.g. Branscombe, Schmitt, & Harvey, 1999). Such group identification and connection allows the individual to direct attention to what is affirmative about that group as opposed to discrimination. As participants identified more

with being Black, they reported more perceived racial discrimination. Similarly it is possible that in the current study, as women in the internalization stage incorporate a Black identity, it buffers them from the adverse effects of sexual victimization, ultimately making help-seeking unnecessary.

The fluidity of Racial Identity statuses described by Helms (1990) is also worthy of consideration when examining the relationship among help-seeking attitudes and racial identity development. Helms (1990) posited that individuals cycle though statuses throughout their lives. When interpreting whether certain attitudes towards help-seeking are associated with a specific racial identity status, one must consider whether these attitudes towards help-seeking change as a function of the racial identity status changes. More specifically, do help-seeking attitudes also fluctuate? If help-seeking attitudes fluctuate as frequently as that of the racial identity development statuses, it would be reasonable to consider that help-seeking attitudes are reliably associated with a variable as fluid as racial identity development. However, if help-seeking attitudes are found to be relatively stable compared to the identity stages, it may suggest that the relationship between racial identity status and help-seeking behaviors are mediated by an unknown variable. Additional research examining the stability of help-seeking attitudes will provide additional insight regarding the relationship among these two variables.

Most of the sample scored in internalization stage of identity development defined by the BRIAS (Helms & Parham, 1990). The homogenous nature of the sample regarding racial identity development may have been impacted by several factors including education level, SES, and geographic location. Collins and Lightsey (2001) observed that income was positively associated with internalization attitudes among a sample of

African American women when examining self-esteem and self-efficacy. In the current study, approximately 62% of the women reported and SES of middle class or higher, which may indicate that like income, as higher SES may be associated with greater internalization attitudes, which was reflected in the correlational analyses.

Although one-on-one counseling has been related to positive post-rape adjustment (Stewart, Hughes, Anderson, Kendall, & West, 1987), the assumption that it may also be helpful for African American women may be inaccurate. Taylor's (2000) research explored the role of group social support experiences among African American survivors of intimate partner violence. Such group experiences enable women to share their experience in a group setting, allowing them seek support, validation, and ultimately healing in both a private and social arena. Perhaps alternative interventions, such as support networks comprised of similar participants in terms of race, SES, and ethnicity, may serve as a better means of psychological improvement among African American survivors.

General Implications of Findings

Applied implications. These findings have implications for clinical practice, training, community education and outreach. Clinicians should be cognizant of the roles of race and ethnicity and their relationship to help-seeking among this population. Greater awareness is needed of the cultural concerns of African American women that may act as barriers to help-seeking and labeling sexually violent behaviors as such. For example, using behavior-based questions to assess trauma, as opposed to using the terms, "sexual assault", "sexual violence", or "rape," may elicit more accurate reports of SV experiences. Clinicians should be skilled in understanding racial and ethnic differences

in help-seeking, including the role of racial identity development, the historical context of African American female victimization and its impact on labeling behavior. With this information, counselors may be better equipped to help survivors understand the meaning and influence of emotional social support on post-SV adjustment. If participants are not getting their emotional support needs met by informal sources, exploring this phenomenon may enable survivors to better communicate these needs to others.

Outreach programs can be instrumental in efforts to better serve this population. Rape crisis centers and counselors can promote psychological services for African American survivors via targeted educational campaigns designed for the African American community. Informing the community of the realities and stereotypes surrounding SV, symptoms following SV, and the emotional social support needs of survivors may increase the effectiveness of informal social support sources. Depathologizing therapy services should also be an emphasis of educational outreach programs in order to reduce the stigma associated with formal support sources. It is also important that formal sources of support utilize more culturally-congruent therapy modalities, such as racially homogenous psychoeducational groups. Creating community-based support networks comprised of other African American women with SV histories may further reduce the stigma associated with help-seeking. Taylor (2000) observed that many African American women survivors of intimate male partner violence participating in therapeutic groups attributed discomfort and lack of investment in the group experience to differences in racial, ethnic, and SES among participants. These same women also reported that they perceived white women as having difficulty understanding their experiences and unable to provide support. Such culturally-sensitive

interventions can facilitate psychological help-seeking over time, particularly when others have participated in these programs and can testify to their benefit.

Research implications. The findings of this exploratory investigation highlight several possible directions for future research. Studies should focus on increasing sample diversity along multiple domains, such as ethnicity, SES, geographic location, age, and education. Further explorations of the interrelationships of SV, psychological help-seeking, emotional social support, and racial identity will enhance generalizability of the findings and their appropriateness for African American survivors. Focus groups comprised of survivors that label their experiences of sexual violence compared with survivors that do not label their experience is another future research direction. An exploration of the differences and similarities of these groups in a setting that provides an opportunity for dialogue among several survivors will yield valuable insight regarding the relationship among help-seeking and labeling. Research should also address African American men, as they are also victims of SV, and are likely to have unique psychological needs.

Future research should investigate help-seeking sources. Assessing accessibility to help-sources, including informal sources, will provide information regarding help-seeking among African American female survivors. Future studies should continue to examine who survivors find unhelpful. Only 16% of the website participants (6% of the overall sample) responded to questions about who was *not* helpful. It is curious that so few chose to answer these questions and may be worthy of investigation. Too few respondents completed this section, but understanding why some sources and manners of support do not help may be as informative as explorations of what types of support are.

Limitations

Design and internal validity. Using a field correlational design, this study investigates the interrelationships between and among characteristics of the person (e.g., racial identity development, emotional social support, trauma history, and psychological help-seeking). Given the exploratory nature of the study, these correlations allow conclusions to be drawn about how emotional social support, SV, help-seeking attitudes and racial identity are interrelated and supports further research of the interrelationships. A correlational field design typically has low internal validity and high external validity, and prohibits the researcher from making inferences regarding causal relationships. Therefore, although some racial identity development statuses and help-seeking attitudes are significantly correlated, one cannot assume that identification with a particular racial identity status causes certain help-seeking attitudes or vice versa.

External validity and generalizability. External validity refers to whether the findings can be generalized beyond the sample to and across populations of interest. Sampling methods may limit the external validity of this study. However, emic (within-group) research, using culturally relevant theory, provides critical understanding in factors, including the role of race and culture, associated in help-seeking among African American survivors. Such understanding improves the depth of information on these phenomena for this group, which in some way increases information on the generalizability of the construct, because we know the extent and limit to which it generalizes.

Sexual victimization is common among college students, which speaks to the relevance and importance of studying this population. However, use of a non-random

sample predominately from a large Midwestern university limits the generalizability of the findings to the general African American female population. Subject pool participants enrolled in introductory and intermediate level psychology classes may have had unique characteristics that influenced their responses. These women may have been exposed to information about SV and psychological help-seeking, which may decrease their perceptions of stigma associated with psychological help-seeking. The website pool participants were recruited from locations off-campus, which helps increase the study's external validity; however participants from both recruitment pools were currently attending or had completed college or graduate degrees. The high educational attainment and SES of the sample may limit the ability to generalize these findings to African American women who do not matriculate into college or are not middle-class.

The use of a web-based survey may also threaten the external validity of the study. Although common among college students, many people in the United States do not have access to email and computers. Those that do may have demographic characteristics that bias the sample, such as higher educational attainment and higher SES. Nevertheless, Kraut et al., (2004) enumerates the benefits of web-based research including: reduction of data collection costs, ability to examine unique phenomenon, and increased recruitment of diverse populations. The web-based survey provided a sense of anonymity (the researcher did not see respondents) and privacy, increasing access to understudied populations. Further, use of passwords and unique respondent codes further protected the integrity of the data by eliminating repeat responders.

Obtaining a sufficient number of participants to achieve adequate power ensures statistical conclusion validity. The use of a large and representative sample generates

variability on key variables. Based on Tabachnick and Fidell's (2001) general rule regarding sample size for multiple regression, the use of 108 participants was sufficient. However, using a convenience sample compromises variability and the number of women in the internalization stage was over-represented. Given the paucity of research, a convenience sample advances research by allowing the researcher to glean insight into help-seeking among African American survivors.

This investigation adheres to the "maxmincon" theory (Kerlinger, 1986, as cited in Gelso & Fretz, 2001) by maximizing the variance (the measure of dispersion of the data) on variables pertaining to the research questions by finding the best fit of data, which is necessary to detect relationships. Restricting variability increases type I and type II error and using a large enough sample of 108 participants satisfies the requirement of maximizing variance. However, an unstandardized method of gathering data may compromise the goal of minimizing error variance.

Measurement limitations. Use of reliable and valid measures is also relevant to maximizing variance and therefore limitations of the measures used for the independent and dependent variables must be considered. The RIAS-B is commonly used to assess racial identity development; however, its psychometric properties may contribute to error variance (Swanson, Tokar & Davies, 1994; Tokar & Swanson, 1991; cited in Lemon & Waehler, 1996). For example, the low reliability coefficient of the encounter subscale has been criticized and minimal factorial validity has been observed for this stage (Ponterotto & Wise, 1987, as cited in Lemon & Waehler, 1996). The instability of subscales may be explained by: 1) the fact that individuals cycle through the stages at different times in their lives; and 2) that the subscales have few items (Parham, 1989, as

cited in Lemon and Waehler, 1996). The modest reliability coefficient of the encounter stage "may be attributable to the dynamic changeable nature of these attitudes." The measure's developer posits that it is difficult to measure a phenomenon consistently if the "phenomena itself is not consistent" (Helms, 1990, p. 44).

There are also several limitations of the SSQ measure. First, it was designed using a college population, and although this study attempts to tap a college population, it might not be appropriate for older participants. Second, the SSQ only includes people that were helpful, and does not assess significant others that were not helpful (Popiel & Susskind, 1985). Third, the SSQ uses a non-specific stressor; however, for this study, participants were instructed to respond to the items specific to their SV experiences. As the first study investigating such constructs among African American survivors, the benefits of using this measure may outweigh its limiting factors.

Other measure limitations exist. The Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970), used to assess help-seeking attitudes, has modest reliability coefficients. However, it is a widely used measure and deemed acceptable for this investigation. The use of a non-standardized method of assessing trauma also poses limitations, yet further supports the need for a more encompassing, uniform, and behavior-based measure of SV.

Conclusion

The inclusion or racial and cultural variables continues to be meaningful when exploring the sexual victimization experiences of African American women and also supports the assertion that these experiences are impacted by the longstanding historical experiences of enslaved women. African American are less likely to label their

experiences of SV as such, which supports prior findings (Holzman, 1997; Neville & Pugh, 1997; Wyatt, 1992). Racial identity development, specifically the internalization status, may serve to protect these women from the adverse consequences of SV. Additionally, low rates of help-seeking among this sample of survivors may indicate that African American survivors are not receiving needed psychological intervention. If their emotional social support needs are not being met, it may impact the psychological health of this population as a whole. Conversely, it is possible that these low rates are an indication that their psychological well-being was successfully buffered, perhaps as a result of their racial identity development.

In sum, these findings generate valuable insight regarding the nature of help-seeking behaviors of African American women who have survived SV. They also create the basis for future research, interventions, and outreach programming. Continued exploration of these constructs and related phenomena will enable therapist, researchers, and others to meet the unique needs of this population. Generated knowledge can serve as the foundation for important changes regarding how therapists, physicians, the legal system, and others and provide support and help for these women.

APPENDIX A

Attitudes Towards Help-Seeking among Women
INFORMED CONSENT

Thank you for your interest in this research project. This project is being conducted by Sarah Raymond, a doctoral candidate in Counseling Psychology, under the supervision of Dr. NiCole Buchanan, professor in the Department of Psychology.

The purpose of this investigation is to learn more about factors related to help-seeking attitudes of women. If you choose to participate in this study, you will be asked to participate in an hour long audiotaped interview. If you do not feel comfortable having the interview taped, and feel that you would still like to share your experience, you can indicate so at the end of this consent form. During the interview you will be asked about your personal experiences and beliefs, including attitudes towards help-seeking, and social support. You will also be asked to discuss possible past experiences, including incidence of sexual violence and unwanted sexual activity.

Please answer each question as thoroughly and honestly as possible. Although most people report appreciation for the opportunity to share their experiences, there is a risk that you may feel uncomfortable answering some questions. For example, some of the questions will ask you about your thoughts and feelings, and about negative experiences you may or may not have had in your lifetime. Your participation in this study is completely voluntary. You are under no obligation to answer any of the questions. **There are no right or wrong answers.** You may refuse to participate at all, or decline to participate in certain portions of the interview. At any time during your participation, you have the right to discontinue your participation without penalty or loss of benefits to which you are entitled. You will be reimbursed $15 for your time, and we will make a $5 donation towards a local women's organization of your choice on your behalf. You will receive this reimbursement immediately at the end of the interview, and you will still receive reimbursement if you refrain from answering some/all questions.

Your responses will be completely confidential. Your name will not at anytime be attached to the answers you provide to the questions. All related investigation materials, including audiotapes, would be stored in a secure location (a locked cabinet in the lab of the investigators). This location requires one key to enter the floor on which the room is located, and a separate key to open the door itself. Audiotapes will be transcribed and data will be stored on computers in the lab. Each member of the lab is designated a unique password, and only the primary and secondary investigator will have access to the computer files and audiotapes. At completion of the project, data will be transferred to disks, and these disks and the audiotapes will be stored in the locked cabinet. Data and audiotapes will be retained for a minimum of five years in this secure location and destroyed after 5 years. Only the primary investigator and secondary investigator listed below will have access to these audiotapes. At no time will your name be released in association with this study. Your privacy will be protected to the maximum extent allowable by law.

If you are distressed while answering some of the questions, or later after the interview, you may want to contact the Counseling Center at 335 Olin Student Health, (517) 355-2319 or 353-7278 (TDD) to consult with a professional. There is no charge for students carrying one or more credits. Furthermore, you will receive a referral pamphlet with other people you may contact when you are done with the interview. During and after the interview, you can also discuss the survey and pamphlet with the interviewer. If you have questions about this study, please ask the person conducting the interview or contact Sarah Raymond by phone: (517) 381-9822 or email: raymon34@msu.edu or Dr. NiCole Buchanan at (517) 355-7677, or email: Nbuchana@msu.edu **If you have questions or concerns about your rights as a study participant, or are dissatisfied at anytime with any aspect of this study, you may contact-anonymously if you wish- Peter Vasilenko, Ph.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) by phone: (517) 355-2180, fax: (517) 432-4503, email: ucrihs@msu.edu, or regular mail: 202 Olds Hall, East Lansing, MI 48824.**

My signature below indicates that I voluntarily agree to participate in the above described research study and **choose yes** to have the interview audiotaped:

_____ _____

(Print name here) (Sign your name here) (Date)

My signature below indicates that I voluntarily agree to participate in the above described research study and **choose not** to have the interview taped:

_____ _____

(Print name here) (Sign your name here) (Date)

If you would like the results of this research study, please provide your address below:

_____

_____

_____

PLEASE SEE REVERSE SIDE

APPENDIX B

Debriefing and Resources

THANK YOU FOR YOUR PARTICIPATION IN TODAY'S STUDY.

In the United States, as many as 1 out of 3 women will be raped in her lifetime. Currently, limited research in the areas of help-seeking, social support, and sexual violence among women speaks to the need for continued research in this area. The purpose of this investigation is to examine, emotional social support and help-seeking attitudes of women survivors of sexual violence. It is hoped that the findings of this investigation might have valuable implications for training, community education, and clinical practice. This new information can be used by counselors to facilitate the healing process of survivors. Additionally, outreach programs, clinicians, and educators may be able to use findings from this investigation to better serve women survivors of sexual violence. Thank you again for your time and participation, on the backside of this handout there are local resources and information regarding sexual violence.

Sexual violence affects the lives of survivors in many ways. The symptoms or reactions to the violence vary from person to person and can be similar to the symptoms of other problems. There are several aftereffects associated with sexual violence, yet not all survivors experience the same effects. Survivor aftereffects may include: feelings of powerlessness, sexual dysfunction, low self-esteem, overeating, bulimia, loss of appetite, problems with authority figures, depression, guilt, shame, blame, need for control, intimacy problems, trust issues, promiscuity, Post Traumatic Stress Disorder (PTSD), somatic complaints, feelings of isolation, substance use, denial, sleep disturbances and poor social adjustment. If you have experienced these symptoms or if you know someone who has, talking with a mental health professional may be helpful.

If you are interested in learning more about sexual violence and previous research in this area, you may want to read some of the following:

Bass, E., & Davis, L. (1988). *The Courage to Heal.* New York: Harper and Row.

Golding, J., Siegel, J., Sorenson, S., Burnham, A., & Stein, J. (1989). Social support sources following sexual assault. *Journal of Community Psychology, 17,* 92-107.

Kimerling, R. & Calhoun, K.S. (1994). Somatic symptoms, Social support, and treatment seeking among sexual assault victims. *Journal of Counseling and Clinical Psychology, 62,* 333-340.

SEE REVERSE SIDE FOR LOCAL RESOURCES AND INFORMATION

Resources

Domestic Violence Services:
MSU Safe Place
G-55 Wilson Hall, MSU campus
www.msu.edu/~safe/
Business Phone: 355-1100
Crisis Line: 372- 5572

Provides temporary and safe shelter, advocacy, support, and referrals for MSU students, staff, faculty and partners who experience domestic violence, including minor children of those who are abused.

Sexual Violence Services:
MSU Counseling Center
207 Student Services Building
SSB branch phone: 355-8270

Counseling services available by appointment. Services are free for enrolled MSU students.

MSU Sexual Assault Crisis and Safety Education Program
207 Student Services Building
24-hour Crisis hotline: 372-6666
Business phone: 355-8270

Crisis hotline available 24 hours a day, 7 days a week. Counseling services available on appointment basis.

Listening Ear Crisis Intervention Center
1017 E. Grand River, East Lansing, MI 44423
24-hour Crisis Hotline: 337-1717
Business phone: 337-1728

Crisis hotline available 24 hours a day, 7days a week and referral services for counseling.

Web Resources:
Michigan Coalition Against Domestic and Sexual Violence
www.mcadsv.org/

This website has local resources and information regarding domestic and sexual violence in the state of Michigan.

SEE REVERSE SIDE FOR INFORMATION REGARDING INVESTIGATION

APPENDIX C

Informed Consent Subject Pool

Attitudes Towards Help-Seeking Among Women
INFORMED CONSENT (Psychology Subject Pool)

Thank you for your interest in this research project. This project is being conducted by Sarah Raymond, a doctoral candidate in Counseling Psychology, under the supervision of Dr. NiCole Buchanan, professor in the Department of Psychology.

The purpose of this investigation is to learn more about factors related to psychological help-seeking attitudes of women. If you choose to participate in this study, you will be asked a series of questions about your personal experiences and beliefs, including attitudes towards help-seeking and social support. You will also be asked to report possible past experiences, including incidence of sexual violence and unwanted sexual activity. The entire process should take about one hour and all of these questionnaires will be completed over the computer.

Please answer each question as thoroughly and honestly as possible. Although most people report appreciation for the opportunity to share their experiences, there is a risk that you may feel uncomfortable responding to some questions. For example, some of the questions will ask you to report about thoughts and feelings, and about negative experiences you may or may not have had in your lifetime. Your participation in this study is completely voluntary. You are under no obligation to answer any of the questions. You may refuse to participate at all, decline to participate in certain portions of the study, or not answer certain questions. **There are no right or wrong answers.** At any time during your participation, you have the right to discontinue your participation without penalty or loss of benefits to which you are entitled. If you decided to withdrawal from this study, it will not affect your future participation in Subject Pool experiments. You may either participate in other studies within the Psychology Department, or receive credit by other means, as stated in your psychology course syllabus. A $1 dollar donation to a local women's organization will be made on behalf of each participant. This donation will be made even if you refrain from answering some/all questions.

Your responses will be completely confidential. Your name will not at anytime be attached to the answers you provide to the information; an identification number will be marked instead. No individual results will be reported. We will only provide information as a general sample. All related investigation materials will be stored in a secure location (a locked cabinet in the lab of the investigators). This location requires one key to enter the floor on which the room is located, and a separate key to open the door itself. Questionnaire data will be entered into a computer, analyzed, and stored on computers in the lab. Each member of the lab is designated a unique password, and only the primary and secondary investigator will have access to the computer files. At completion of the project, data will be transferred to disks, and these disks will be stored

in the locked cabinet. Data will be retained for a minimum of five years in this secure location and destroyed after 5 years. At no time will your name be released in association with this study. Your privacy will be protected to the maximum extent allowable by law.

If you are distressed while answering some of the questions, or later after completing the assessment, you may want to contact the Counseling Center at 207 Student Services Building, (517) 355-8270 or 353-7278 (TDD) to consult with a professional. There is no charge for students carrying one or more credits. Furthermore, you will receive a referral pamphlet with other people you may contact. After your participation, you can also discuss the survey and pamphlet with the researchers. If you have questions about this study, please feel free to contact Sarah Raymond by phone: (574) 247-9971 or email: raymon34@msu.edu or Dr. NiCole Buchanan at (517) 355-7677, or email: Nbuchana@msu.edu **If you have questions or concerns about your rights as a study participant, or are dissatisfied at anytime with any aspect of this study, you may contact-anonymously if you wish- Peter Vasilenko, Ph.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) by phone: (517) 355-2180, fax: (517) 432-4503, email: ucrihs@msu.edu, or regular mail: 202 Olds Hall, East Lansing, MI 48824.**

I voluntarily agree to participate in this study. YES NO

APPENDIX D

Informed Consent Website Pool

Attitudes Towards Help-Seeking Among Women
INFORMED CONSENT (Internet-based Website Survey)

Thank you for your interest in this research project. This project is being conducted by Sarah Raymond, a doctoral candidate in Counseling Psychology, under the supervision of Dr. NiCole Buchanan, professor in the Department of Psychology.

The purpose of this investigation is to learn more about factors related to psychological help-seeking attitudes of women. If you choose to participate in this study, you will be asked a series of questions about your personal experiences and beliefs, including attitudes towards help-seeking and social support. You will also be asked to report possible past experiences, including incidence of sexual violence and unwanted sexual activity. The entire process should take about one hour and all of these questionnaires will be completed over the computer.

Please answer each question as thoroughly and honestly as possible. Although most people report appreciation for the opportunity to share their experiences, there is a risk that you may feel uncomfortable responding to some questions. For example, some of the questions will ask you to report about thoughts and feelings, and about negative experiences you may or may not have had in your lifetime. Your participation in this study is completely voluntary. You are under no obligation to answer any of the questions. You may refuse to participate at all, decline to participate in certain portions of the study, or not answer certain questions. **There are no right or wrong answers.** At any time during your participation, you have the right to discontinue your participation without penalty or loss of benefits to which you are entitled. A $1 dollar donation to a local women's organization will be made on behalf of each participant. This donation will be made even if you refrain from answering some/all questions. You will also have the chance to enter a raffle for one of 4 cash prizes of $50. One email address (kept separate from your survey responses) will be drawn at random.

Your responses will be completely confidential. Your name will not at anytime be attached to the answers you provide to the information; an identification number will be marked instead. No individual results will be reported. We will only provide information as a general sample. This website uses a unique respondent ID number, which is automatically assigned to each subject. Personal information (for purposes of contacting the winners of the raffle) will be stored separate from the data. Participants' individual responses will be confidential (e.g. data and back-up files will be secure; individual cases will only be seen by involved researchers, and will never be discussed with others; data will only be presented as a group for publication). IP addresses will not be stored or included with your responses. This website encrypts responses and stores them on a server, which can only be accessed by the researcher, with the correct username and password. The researcher will have complete control over the data, and its

deletion. Once deleted, it will be permanently deleted from the website. Data will be transferred to disk.

All related investigation materials will be stored in a secure location (a locked cabinet in the lab of the investigators). This location requires one key to enter the floor on which the room is located, and a separate key to open the door itself. Data will be retained for a minimum of five years in this secure location and destroyed after 5 years. At no time will your name be released in association with this study. Your privacy will be protected to the maximum extent allowable by law.

If you are distressed while answering some of the questions, or later after completing the assessment, you may want to contact the Counseling Center at 207 Student Services Building, (517) 355-8270 or 353-7278 (TDD) to consult with a professional. There is no charge for students carrying one or more credits. Furthermore, you will receive a referral pamphlet with other people you may contact. After your participation, you can also discuss the survey and pamphlet with the researchers. If you have questions about this study, please feel free to contact Sarah Raymond by phone: (574) 247-9971 or email: raymon34@msu.edu or Dr. NiCole Buchanan at (517) 355-7677, or email: Nbuchana@msu.edu **If you have questions or concerns about your rights as a study participant, or are dissatisfied at anytime with any aspect of this study, you may contact-anonymously if you wish- Peter Vasilenko, Ph.D., Chair of the University Committee on Research Involving Human Subjects (UCRIHS) by phone: (517) 355-2180, fax: (517) 432-4503, email: ucrihs@msu.edu, or regular mail: 202 Olds Hall, East Lansing, MI 48824.**

I voluntarily agree to participate in this study. YES NO

APPENDIX E

Debriefing and Resources

THANK YOU FOR YOUR PARTICIPATION IN TODAY'S STUDY.

In the United States, as many as 1 out of 3 women will be raped in her lifetime. Currently, limited research in the areas of help-seeking, social support, and sexual violence among women speaks to the need for continued research in this area. The purpose of this investigation is to examine emotional social support and help-seeking attitudes of women survivors of sexual violence from varied cultural, racial and ethnic backgrounds.

It is hoped that the findings of this investigation might have valuable implications for training, community education, and clinical practice. This new information can be used by counselors to facilitate the healing process of survivors. Additionally, outreach programs, clinicians, and educators may be able to use findings from this investigation to better serve women survivors of sexual violence.

Thank you again for your time and participation, on the backside of this handout there are local resources and information regarding sexual violence.

Sexual violence affects the lives of survivors in many ways. The symptoms or reactions to the violence vary from person to person and can be similar to the symptoms of other problems. There are several aftereffects associated with sexual violence, yet not all survivors experience the same effects. Survivor aftereffects may include: feelings of powerlessness, sexual dysfunction, low self-esteem, overeating, bulimia, loss of appetite, problems with authority figures, depression, guilt, shame, blame, need for control, intimacy problems, trust issues, promiscuity, Post Traumatic Stress Disorder (PTSD), somatic complaints, feelings of isolation, substance use, denial, sleep disturbances and poor social adjustment. If you have experienced these symptoms or if you know someone who has, talking with a mental health professional may be helpful.

If you are interested in learning more about sexual violence and previous research in this area, you may want to read some of the following:

Bass, E., & Davis, L. (1988). *The Courage to Heal.* New York: Harper and Row.

Golding, J., Siegel, J., Sorenson, S., Burnham, A., & Stein, J. (1989). Social support sources following sexual assault. *Journal of Community Psychology, 17,* 92-107.

Kimerling, R. & Calhoun, K.S. (1994). Somatic symptoms, Social support, and treatment seeking among sexual assault victims. *Journal of Counseling and Clinical Psychology, 62,* 333-340.

Resources

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Web Resources:

Michigan Coalition Against Domestic and Sexual Violence
www.mcadsv.org/

This website has local resources and information regarding domestic and sexual violence in the state of Michigan.

APPENDIX F

Demographic Information

Age:_____

Race: please circle:
African American
Caucasian
Asian
Latina
Native American
Other (please specify)_____

Ethnicity:_____

Please indicate the percentage of your university who are of your same ethnicity:_____

Level of education:
Some College (Current College Student)
College Graduate
Graduate/Professional School

Family of Origin Socioeconomic status:
Lower economic status
Lower middle economic status
Middle economic status
Upper middle economic status
Upper economic status

Appendix G

Measures

The Attitudes Towards Seeking Professional Psychological Help Scale, ATSPPHS

Directions: Below are a number of statements pertaining to psychology and mental health issues. Read each statement carefully and indicate your agreement, probable agreement, probable disagreement, or disagreement. Please express your frank opinion in rating the statements. There are no "wrong" answers, and the only right ones are whatever you honestly feel or believe.

1. Although there are clinics for people with mental troubles, I would not have much faith in them.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

3. I would feel uneasy going to a psychologist because of what some people would think.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional concern.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

9. Emotional difficulties, like many things, tend to work out by themselves.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

10. There are certain problems that should not be discussed outside of one's immediate family.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

12. If I believed I was going to have a mental breakdown, my first inclination would be to get professional attention.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

14. Having been a psychiatric patient is a blot on a person's life.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

16. A person with an emotional problem is not likely to solve it alone; he *is* likely to solve it with professional help.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

17. I resent a person-professionally trained or not-who wants to know about my personal difficulties.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

18. I would want to get psychiatric attention if I was worried or upset for a long period of time.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

20. Having been mentally ill carries with it a burden of shame.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

21. There are experiences in my life that I would not discuss with anyone.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

22. It is probably best not to know *everything* about oneself.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears *without* resorting to professional help.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

25. At some future time I might want to have psychological counseling.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

26. A person should work out his own problems; getting psychological counseling would be a last resort.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

28. If I thought I needed psychiatric help, I would get it no matter who knew about it.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.

0	1	2	3
Disagreement	probable disagreement	probable agreement	agreement

---

Trauma History

Please indicate whether you have ever experienced any of the following frightening/uncomfortable experiences by circling Yes, No, or Unsure. If you answer yes to any of these questions, please also indicate at what age the incident occurred.

1) Have you ever been aggressively hit or grabbed by someone?
Yes No Unsure Age(s)_____

2) Has anyone ever tried to touch you without your consent?
Yes No Unsure Age(s)_____

3) Has anyone ever touched you that made you feel uncomfortable?
Yes No Unsure Age(s)_____

4) Have you ever experienced forced touching that was sexual in nature?
Yes No Unsure Age(s)_____

5) Have you ever had sexual intercourse against your will?
Yes No Unsure Age(s)_____

Please indicate whether you have ever experienced the following by circling Yes, No, or Unsure. If you answer yes to any of these questions, please also indicate at what age the incident occurred.

1) Have you ever experienced <u>attempted</u> sexual violence (any attempted unwanted sexual activity forced by another person including anal, vaginal, or oral penetration; stranger rape, acquaintance rape, date rape, martial rape, gang rape, and/or incest)?
Yes No Unsure Age____

If yes, please circle whether the experience included any of the following (circle all that apply):
Verbal threats Threats to use a weapon Physical threats Physical force

If yes, please indicate your level of familiarity with the assailant:
Stranger Acquaintance Romantic Partner Spouse Other (please specify):_____

Please report by circling whether you sought help from any of the following, for the attempted sexual violence and what type of counseling you received:

1) **Private Therapist/Counselor**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

2) **Employee assistance program**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

3) **Rape crisis center**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

4) **University Counseling Center**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

5) **Community Mental Health Center**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

6) **Veterans Administration**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

7) **Other** (please specify):_____ Yes
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

Please use the space below to provide additional information (if any) regarding any of your specific experiences:

2) Have you ever experienced completed sexual violence (any completed unwanted sexual activity forced by another person including anal, vaginal, or oral penetration; stranger rape, acquaintance rape, date rape, martial rape, gang rape, and/or incest)?
Yes No Unsure Age____

If yes, please circle whether the experience included any of the following (circle all that apply):
Verbal threats Threats to use a weapon Physical threats Physical force

If yes, please indicate your level of familiarity with the assailant:
Stranger Acquaintance Romantic Partner Spouse Other (please specify):_____

Please report by circling whether you sought help from any of the following, for completed sexual violence and what type of counseling you received:

1) **Private Therapist/Counselor**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

2) **Employee assistance program**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

3) **Rape crisis center**: Yes
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

4) **University Counseling Center**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

5) **Community Mental Health Center**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

6) **Veterans Administration**: Yes No
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

7) **Other** (please specify):_____ Yes
Crisis(4 or fewer sessions) Short-term(5-12 sessions) Long–term(13 or more sessions)

Please use the space below to provide additional information (if any) regarding any of your specific experiences:

The Social Support Questionnaire, SSQ

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person's initials and their relationship to you (See Example). Do not list more than one person for each of the numbers beneath the question. For the second part, circle how satisfied you are with the overall support you have. If you have no support for a question, circle the words "No one," but still rate your level of satisfaction. Do not list more than nine persons per question. Please answer all questions as best you can. There are no right or wrong answers, and all of your responses will be kept confidential.

EXAMPLE
Who do you know whom you can trust with information that could get you in trouble?

No one	1) T.N. (brother)	4) T.N. (Father)	7)
	2) L.M. (friend)	5) L.N. (employer)	8)
	3) R.S. (girlfriend)	6)	9)

How satisfied?
6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

1. Whom can you really count on to listen to you when you need to talk?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?
6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

2. Whom could you really count on to help you if a person whom you thought was a good friend insulted you and told you that he/she didn't want to see you again?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?
6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

3. Whose lives do you feel that you are an important part of?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?
6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

4. Whom do you feel would help you if you were married and you had just separated from your spouse?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?
6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

5. Whom could you really count on to help you out in a crisis situation, even though they would have to go out of their way to do so?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?
6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

6. Whom can you talk with frankly, without having to watch what you say?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

7. Who helps you feel that you truly have something positive to contribute to others?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

8. Whom can you really count on to distract you from your worries when you feel under stress?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

9. Whom can you really count on to be dependable when you need help?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

10. Whom could you really count on to help you out if you had just been fired from you job or expelled from school?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

11. With whom can you totally be yourself?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

12. Whom do you feel really appreciates you as a person?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

13. Whom can you really count on to give you useful suggestions that help you to avoid making mistakes?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

14. Whom can you count to listen openly and uncritically to your innermost feelings?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

15. Who will comfort you when you need it by holding you in their arms?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

16. Whom do you feel would help if a good friend of yours has been in a car accident and was hospitalized in serious condition?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

17. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

18. Whom do you feel would help if a family member very close to you died?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

19. Who accepts you totally, including both your worst and best points?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

20. Who can you really count on to care about you, regardless of what is happening to you?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

21. Whom can you really count on listen to you when you are very angry at someone else?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

22. Whom can you really count on to tell you in a thoughtful manner, when you need to improve in some way?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

23. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

24. Whom do you feel truly loves you deeply?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

25. Whom can you count on to console you when you are very upset?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

26. Whom can you really count to support you in major decisions you make?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

27. Whom can you really count on to help you feel better when you are very irritable, and ready to get angry at almost anything?

No one 1) 4) 7)
2) 5) 8)
3) 6) 9)

How satisfied?

6-very satisfied 5-farily satisfied 4-a little satisfied 3-little dissatisfied 2-fairly satisfied 1-very dissatisfied

---

Feminism and the Women's Movement Scale, FWM

1) The leaders of the women's movement may be extreme, but the have the right idea.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

2)There are better ways for women to fight for equality than through the women's movement.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

3) More people would favor the women's movement if they knew more about it.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

4) The women's movement has positively influenced relationships between men and women.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

5) The women's movement is too radical and extreme in its views.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

6) The women's movement has made important gains in equal rights and political power for women.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

7) Feminists are too visionary for a practical world.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

8) Feminist principles should be adopted everywhere.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

9) Feminists are a menace to this nation and the world.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

10) I am overjoyed that women's liberation is finally happening in this country.

Strongly Disagree	Somewhat DIS agree	Neutral	Somewhat Agree	Strongly Agree

Black Racial Identity Attitude Scale (Form RIAS-B)

This questionnaire is designed to measure people's social and political attitudes. There are no right or wrong answers. Use the scale below to respond to each statement. Circle the number that corresponds with how you feel for each question.

1. I believe that being Black is a positive experience.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

2. I know through experience what being Black in America means.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

3. I feel unable to involve myself in white experiences and I am increasing my involvement in Black experiences.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

4. I feel that a large number of Blacks are untrustworthy.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

5. I feel an overwhelming attachment to Black people.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

6. I involve myself in cases that will help all oppressed people.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

7. I feel comfortable wherever I am.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

8. I believe that White people look and express themselves better than Blacks.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

9. I feel very uncomfortable around Black people.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

10. I feel good about being Black, but do not limit myself to Black activities.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

11. I often find myself referring to White people as honkies, devils, pigs, etc.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

12. I believe that to be Black is not necessarily good.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

13. I believe that certain aspects of the Black experience apply to me, and others do not.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

14. I frequently confront the system and the man.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

15. I constantly involve myself in Black political and social activities (art shows, political meetings, Black theater, etc.)

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

16. I involve myself in social action and political groups even if there are not other Blacks involved.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

17. I believe that Black people should learn to think and experience life in ways which are similar to White people.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

18. I believe that the world should be interpreted from a Black perspective.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

19. I have changed my style of life to fit my beliefs about Black people.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

20. I feel excitement and joy in Black surroundings.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

21. I believe that Black people came from a strange, dark, and uncivilized continent.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

22. People regardless of their race, have strengths and limitations.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

23. I find myself reading a lot of Black literature and thinking about being Black.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

24. I feel guilty and/or anxious about some of the things I believe about Black people.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

---

25. I believe that a Black person's most effective weapon for solving problems is to be part of the White person's world.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

26. I speak my mind regardless of the consequences (e.g., being kicked out of school, being imprisoned, being exposed to danger).

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

27. I believe that everything Black is good, and consequently, I limit myself to Black activities.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

28. I am determined to find my Black identity.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

29. I believe that White people are intellectually superior to Blacks.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

30. I believe that because I am Black, I have many strengths.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

31. I feel that Black people do not have as much to be proud of as White people do.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

32. Most Blacks I know are failures.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

33. I believe that White people should feel guilty about the way they have treated Blacks in the past.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

34. White people can't be trusted.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

35. In today's society if Black people do not achieve, they have only themselves to blame.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

36. The most important thing about me is that I am Black.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

37. Being Black just feels natural to me.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

38. Other Black people have trouble accepting me because my life experiences have been so different from their experiences.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

39. Black people who have any White peoples' blood should feel ashamed of it.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

40. Sometimes, I wish I belonged to the White race.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

41. The people I respect the most are White.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

42. A person's race usually is not important to me.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

43. I feel anxious when white people compare me to other members of my race.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

44. I can't feel comfortable with either Black people or White people.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

45. A person's race has little to do with whether or not he/she is a good person.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

46. When I am with Black people, I pretend to enjoy the things they enjoy.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

47. When a stranger who is Black does something embarrassing in public I get embarrassed.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

48. I believe that a Black person can be close friends with a White person.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

49. I am satisfied with myself.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

50. I have a positive attitude about myself because I am Black.

1	2	3	4	5
Strongly disagree	Disagree	Uncertain	Agree	Strongly Agree

Appendix H

Tables

Table 1
Correlation Matrix of Outcome Predictor Variables in Regression Analysis

Var	Trauma	Preenc	Enc	Im/em	Inter	ESS	Stigma	Need	Open	Conf	SES
Trauma											
Preenc	-.02	(.79)									
Enc	.06	.25*	(.55)								
Imem	.01	.13	.60**	(.71)							
Inter	.04	-.42**	.03	.04	(.67)						
ESS	-.06	.12	-.12	-.14	.09	(.97)					
Stigma	-.04	-.07	-.21*	-.20*	.04	.20*	(.69)				
Need	.14	-.30**	-.10	-.10	.18	-.05	.26**	(.71)			
Open	.24*	-.21*	-.09	-.24*	.15	-.02	.20*	.49**	(.63)		
Conf	-.02	-.15	-.01	-.05	.14	.05	.41**	.62**	.39**	(.68)	
SES	-.08	-.81	.09	-.25*	.20**	.26**	-.07	.09	.02	-.05	
M	3.80	2.09	2.69	2.59	4.05	7.65	9.37	15.21	13.59	16.82	2.76
SD	2.89	2.26	.58	.52	.41	2.26	3.09	4.00	3.71	4.29	.93

Note. Alphas appear along diagonals with bivariates below. Preenc=Preencounter status; Enc=Encounter status; Imem=Immersion/Emersion status; Inter=Internalization status; ESS=Emotional Social Support; Stigma= Tolerance of stigma associated with receiving psychological help; Need=Perceived need for professional help; Open=Openness about disclosing personal problems; and Conf=Confidence in psychological professionals to be useful assistance; SES=Socioeconomic Status.

**p <.01*
**p<.05*

Table 2
Summary of Hierarchical Regression Analyses for ATPHSS Openness and Need Subscales:

	Openness				Need			
Variables	ΔR^2	B	SE β	β	ΔR^2	B	SE β	β
Step 1	.06*				.03*			
Family SES		.17	.38	.04		.43	.42	.10
Trauma History		.32	.12	.25*		.20	.13	.15
Step 2	.16*				.12*			
Preencounter		-1.18	.82	-.15		-2.21	.91	-.26*
Encounter		.63	.76	.10		-.05	.84	-.01
Im/Em		-2.09	.84	-.30*		-.42	.93	-.06
Internalization		.88	.93	.10		.51	1.03	.05
Step 3	.16				.12			
ESS		-.03	.16	-.02		-.07	.18	-.04
Step 4	.18				.13			
ESS x Preencounter		.35	.40	.11		.28	.45	.08
ESS x Encounter		.21	.37	.07		-.41	.41	-.13
ESS x Im/Em		-.25	.35	-.08		.13	.39	.04
ESS x Internalization		.22	.42	.08		.43	.46	.14

Note. Preenc=Preencounter status; Enc=Encounter status; Imem=Immersion/Emersion status; Inter=Internalization status; ESS=Emotional Social Support; Stigma= Tolerance of stigma associated with receiving psychological help; Need=Perceived need for professional help; Open=Openness about disclosing personal problems; and Conf=Confidence in psychological professionals to be useful assistance.

* $p < .05$.

Table 3
Summary of Hierarchical Regression Analyses for ATPHSS Stigma and Confidence Subscales:

	Stigma				Confidence			
Variables	ΔR^2	B	SE β	β	ΔR^2	B	SE β	β
Step 1	.01				.00			
Family SES		-.21	.33	-.06		-.22	.45	-.05
Trauma History		-.05	.10	-.05		-.03	.15	-.02
Step 2	.07				.04			
Preencounter		-.01	.72	-.00		-1.03	1.01	-1.02
Encounter		-.67	.66	-.13		.53	.93	.07
Im/Em		-.94	.73	-.16		-.88	1.03	-.11
Internalization		.57	.82	.08		1.14	1.15	.11
Step 3	.11				.05			
ESS		.28	.14	.21*		.15	.20	.08
Step 4	.15				.06			
ESS x Preencounter		-.33	.34	- .12		-.15	.50	-.04
ESS x Encounter		-.41	.32	-.16		.01	.46	.00
ESS x Im/Em		.12	.30	.05		-.20	.43	-.06
ESS x Internalization		-.07	.35	-.03		.23	.52	.07

Note. Preenc=Preencounter status; Enc=Encounter status; Imem=Immersion/Emersion status; Inter=Internalization status; ESS=Emotional Social Support; Stigma= Tolerance of stigma associated with receiving psychological help; Need=Perceived need for professional help; Open=Openness about disclosing personal problems; and Conf=Confidence in psychological professionals to be useful assistance.

* $p < .05$.

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