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Applied Research

Sexual Violence in the Lives of African American Women

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"Black women were and continue to be sorely in need of an antirape movement."

— Angela Davis (1989, p. 44)

Applied Research papers synthesize and interpret current research on violence against women, offering a review of the literature and implications for policy and practice.

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According to the 2010 U.S. Census, 13.6% (42 million) of the population self-identified as Black or African American[1] (Rastogi, Johnson, Hoeffel, & Drewery, 2011). African Americans reported substantial rates of criminal victimization, including domestic violence, assault, and robbery (Truman & Planty, 2012). Furthermore, Black women's sexual victimization has occurred in a unique sociohistorical context. Accordingly, in the first section we will provide a historical overview. Next, we will discuss the characteristics of Black rape survivors[2] and the environment in which their assaults occurred. In addition, we will identify risk factors that elevate Black women's vulnerability to rape and review the physical and mental health problems that are associated with their victimization. To conclude, we will offer culturally sensitive techniques that can be used by professionals and highlight the resilience of African American survivors.

Historical Overview

The institutional pattern of rape was well established before the newly enslaved Africans reached the Americas. During the transatlantic voyage, crew members routinely raped and impregnated Black women. In preparation for sale, enslaved women were stripped naked and placed on auction blocks. African American women's economic

[1] African American and Black will be used interchangeably. With an influx of immigrants, more Black Americans trace their origins to African and Caribbean nations. Readers should ask survivors how they self-identify.

[2] The terms victim and survivor will be used interchangeably to describe the recipient of sexual violence.

value was dependent upon their ability to reproduce healthy offspring, which could be sold to increase the slave owner's wealth. According to historians, at least 58% of enslaved women between the ages of 15 and 30 had been sexually assaulted by White men. After slavery ended, the Klu Klux Klan and other White vigilante groups whipped African Americans, destroyed their property, and gang raped Black women (Sommerville, 2004).

Rape laws did not provide equal protection for all women. In fact, during the 1800s some rape laws were race-specific. For example, a rapist was defined as a man who "unlawfully and carnally know [sic] any white woman against her will or consent" (Sommerville, 2004, p. 148). Lynching, castration, and incarceration were possible penalties for a Black man who was accused or convicted of raping a White woman. In contrast, there were no legal sanctions for White men who raped Black women. Also, the legal system did not punish intraracial rape. In 1859, a Mississippi judge overturned the conviction of an older slave who had raped a slave girl who was under the age of 10. The defense attorney argued: "The crime of rape does not exist in this State between African slaves...their intercourse is promiscuous" (Sommerville, 2004, p. 65). Embedded in this court decision, and embraced by the larger culture for more than 500 years, was the belief that Black women's innate hypersexuality made them "unrapeable" and undeserving of protection or sympathy (Tillet & Quinn, 2007).

Throughout history, African American women have used a variety of resistance strategies to combat sexual victimization. Some women physically fought back or ran away. Other women developed a culture of silence that discouraged the disclosure of rape. This code of secrecy often extended to the larger Black community (Sommerville, 2004). In the 1870s, Ida B. Wells and other activists protested the lynching of Black men based on false rape accusations and challenged the stereotype that depicted Black women as promiscuous Jezebels[3] who invited sexual assault. Anti-rape organizing, as part of the larger civil rights movement, continued during World War II and into the 1970s. Rosa Parks and other activists protested against sexual assault that was perpetrated against Black women in their communities, on public transportation, and within White households where Black women worked as domestic servants (McGuire, 2010). Today, a multiracial coalition of advocates have continued this work by addressing racism in the anti-rape movement and unpacking the interconnections between rape and other forms of oppression (Washington Coalition of Sexual Assault Programs, 2007).

Characteristics of Survivors and Assaults

Survivors may experience various forms of sexual victimization across their lifespan. Defined as incest, rape[4], or sexual coercion before age 18, childhood sexual abuse (CSA) has been documented in community samples of Black women recruited from Boston (34.1%) (Amodeo, Griffin, Fassler, Clay, & Ellis, 2006) and Chicago (65%) (Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010). Similarly, high rates of CSA were reported in a predominately Black sample of female veterans (59%) (Campbell, Greeson, Bybee, & Raj, 2008) and in a sample of HIV positive (67%) and

[3] For a historical and contemporary overview of the Jezebel image, see West (2009).

[4] For clarity, rape is completed or attempted unwanted vaginal, oral, or anal penetration achieved through physical force, threats, or the use of alcohol/drugs. Sexual coercion is unwanted sexual penetration that is achieved through nonphysical pressure (e.g., repeatedly asked for sex, misuse of authority). Unwanted sexual contact is sexual touching, such as forced kissing and fondling (Black et al., 2011).

HIV negative (60%) Black women who were recruited from four major U.S. cities (The NIMH Multisite HIV/STD Prevention Trial for African American Couples Group, 2010). Commercial sexual exploitation of children (CSEC) is a form of child sexual abuse that has gained recent recognition. It involves sex trafficking or profiting from a minor's involvement in sex acts, such as prostitution, pornography, or stripping. In a sample of Black women with documented histories of CSA, 12% had been prostituted and forced to exchange sex for money before the age of 18 (Reid, 2011).

A substantial number of Black teenage girls also reported sexual victimization. Among students, 11.2% of Black girls in a national high school sample reported have been raped (Thompson, McGee, & Mays, 2012), 52% of a Black midwestern high school and college students reported sexual coercion (French & Neville, 2008), and 14.2% of Black women who were enrolled in historically Black colleges and universities (HBCUs) reported a completed or attempted rape (Krebs, Lindquist, & Barrick, 2011). In a longitudinal study of young African American women (ages 15-21) who sought sexual health services at urban clinics, 25.1% were rape victims. When the study ended 12 months later, an additional 9.5% of the nonvictimized participants had been raped (Lang et al., 2011).

In adulthood, approximately 1 in 5 African American women reported that they had been raped at some point in their lifetime. More specifically, 18.8% of Black women in the National Violence Against Women Survey (NVAWS) (Tjaden & Thoennes, 2006) and 22% of the Black women in the National Intimate Partner and Sexual Violence Survey (NISVS) reported a lifetime rape. Also, the NISVS revealed that 41% of Black women experienced sexual coercion and other forms of unwanted sexual contact. These prevalence rates translate to an estimated 3.1 million Black rape victims and 5.9 million Black survivors of other forms of sexual violence (Black et al., 2011).

There is a great deal of diversity among African American women. Consequently, some groups are especially vulnerable to sexual victimization, including Black women who are low-income, are living with HIV, who identify as sexual minorities, and who are incarcerated. For instance, 67.2% of Black women in a low-income Dallas sample had been sexually assaulted (Temple, Weston, Rodriguez, & Marshall, 2007). HIV-positive Black women (54.2%) were significantly more likely to have a history of adult sexual assault than HIV-negative Black women (40.4%) (The NIMH Multisite HIV/STD Prevention Trial for African American Couples Group, 2010). When compared to Black college women who identified as heterosexual (9.5%), those who identified as bisexual (13.2%) reported higher rates of sexual assault (Krebs et al., 2011). Incarcerated at between 2 and 3 times the rate of White women, Black women are overrepresented in the criminal legal system. Depending on the study, more than half of incarcerated women were raped or experienced CSA before coming to prison. While in custody, women may be strip searched, subjected to sexualized surveillance (e.g., being watched in the shower), or be pressured to provide sexual favors in exchange for privileges or access to resources, such as food or telephone calls (VanNatta, 2010-2011).

In most cases, sexual violence was an intraracial crime (e.g., 91.7% of Black college women were raped by Black men) (Krebs et al., 2011). Most often the perpetrator was someone known to the victim (e.g., 75% of Black women in a Chicago sample knew their rapist) (Long, Ullman, Starzynski, Long, & Mason, 2007). Among Black CSA survivors who were raised in

two-parent families, 43.6% were victimized by a household member. Although 28% were victims of incest, living with a step-father was not associated with higher rates of CSA (Amodeo et al., 2006). Intimate partners also were frequently identified as sexual offenders. In the NVAWS, 7.4% of African American women reported that their rapist was a same-sex or opposite-sex spouse, cohabitating partner, current or former date (Tjaden & Thoennes, 2000). Among Black college women, common perpetrators were classmates (37%), acquaintances (29%), and friends (26%) (Krebs et al., 2011). In addition, group rapes that involved multiple perpetrators have been documented on college campuses (Krebs et al., 2011) and in urban communities. In interviews conducted by Miller (2008), 45% of low-income young Black men had participated in a group rape and 19% of Black victims in an urban emergency department reported a rape that involved multiple assailants (Boykins et al., 2010). Frequently reported locations of sexual assaults included the victim's or perpetrator's home, cars, parties, and outdoors (Boykins et al., 2010; Krebs et al., 2011).

Perpetrators used a variety of physically aggressive actions to gain compliance. Almost 30% of African American rape survivors reported that the perpetrator twisted their arms or held them down (Long et al., 2007). More than one-third (37%) of Black students (French & Neville, 2008) and 77% of Black women in a Chicago sample were victims of verbal coercion (e.g. perpetrator begged, threatened, used his position or authority) (Bryant-Davis et al., 2010). Drug/alcohol facilitated sexual assault is committed when the victim has been incapacitated after consuming substances, either voluntarily or provided by the perpetrator. In a community sample, 43% of Black rape victims reported that they had unwanted intercourse because they were given alcohol or drugs (Bryant-Davis et al., 2010). In student samples, between 6.2% (Krebs et al., 2011) and 9% (French & Neville, 2008) of Black women reported that alcohol or drugs were involved in their sexual assault.

Risk Factors

Before discussing specific risk factors, the following points should be made. First, risk factors for victimization identify individuals who are vulnerable to sexual violence. These are distinct from victim-blaming attitudes that mistakenly assign responsibility for victimization to the survivor. Second, survivors often experience multiple, overlapping risk factors. Third, we must consider risk factors that are unique to each population. For example, Black college women were at increased risk for rape if they were sorority members, attended fraternity parties at least once per month, engaged in binge drinking, or accepted drinks from strangers (Krebs et al., 2011). Finally, poverty and sexual revictimization can be viewed as both risk factors and consequences of sexual violence.

For example, there is a complex interconnection between poverty and sexual violence. This is particularly important for understanding rape in the lives of African American women because 27.7% (10.9 million) of Blacks lived below the poverty level ($23,050 yearly income for a family of four) (DeNavas-Walt, Proctor, & Smith, 2012). Poor women are more likely to live, work, and travel in low-income communities where they are exposed to all forms of violence, including sexual assault. Impoverished women who are employed in low wage jobs are often vulnerable to sexual harassment, while unemployed women may be compelled to trade sex for basic necessities, such as housing or food. After they are

sexually assaulted, higher rates of depression, posttraumatic stress disorder (PTSD), or illicit drug use may further compromise the economic well-being of impoverished Black women by leading to unemployment or homelessness (Bryant-Davis et al., 2010).

Child sexual abuse is a strong predictor of adult rape. Among female veterans, 28% had experienced both CSA and adult rape (Campbell et al., 2008). In a sample of Black women with documented histories of CSA, 27% were later raped during adolescence and 42% were raped in adulthood (Fargo, 2009). A variety of intervening experiences and risk factors may converge to make juvenile sexual assault survivors more vulnerable to adult sexual revictimization. For example, victims of CSA reported more adolescent risk-taking behaviors, such as drug use and running away from home. In addition, they were more likely to participate in risky sexual behaviors: prostitution, consensual sexual behavior with multiple partners, and problematic alcohol use. As a result, CSA victims were at increased risk of being sexually victimized as adolescents and adults (Fargo, 2009).

Physical and Mental Health Consequences

Survivors reported both immediate and long-term physical and sexual health effects that were associated with their rapes. For example, almost one-quarter of Black college women (Krebs et al., 2011) and one-third of Black rape survivors in a Chicago sample (Long et al., 2007) experienced bruises and black eyes. Based on a review of Black rape victim's medical charts, the cervix (26.3%) and the posterior fourchette and labia minora (both 13%) were the most common injury location (Baker, Fargo, Shambley-Ebron, & Sommers, 2010). According to longitudinal studies, a history of sexual assault can also compromise the long-term sexual health of survivors. Compared to nonvictims, Black women who had been sexually abused in the past year were 4.5 times more likely to test positive for Human Papillomavirus (HPV) at the 12 month follow-up (Wingood, Seth, DiClemente, & Robinson, 2009). A pattern of risky sexual behavior may account for the association between sexual assault and future sexually transmitted infections (STIs). When compared to their nonvictimized counterparts, over a 12 month period sexually victimized African American adolescent girls were more likely to engage in sex while intoxicated. Furthermore, they had more sexual partners; yet, they were less likely to use condoms (Lang et al., 2011).

In addition, sexual violence can negatively impact the long-term mental health functioning of survivors. The majority (89.5%) of Black college women reported that they had sustained emotional or psychological injuries as a result of rape. Nearly three-quarters of participants reported symptoms of PTSD in the 30 days before the survey (Krebs et al., 2011). Impoverished Black women (Bryant-Davis et al., 2010) and Black women who had experienced multiple forms of sexual victimization (e.g., CSA, adult rape, workplace sexual harassment) (Campbell et al., 2008) were especially vulnerable to PTSD, depression, suicidal ideation, pain-related health problems, such as back pain, and nonpain symptoms, including fatigue and nausea. In student samples, researcher discovered a link between the endorsement of sexual stereotypes and self-esteem. Specifically, among Black high school and college sexual coercion survivors, lower rates of self-esteem were reported by those who held beliefs such as women are sexual objects and men are driven by sex (French & Neville, 2012). Likewise, Black college women who endorsed beliefs such as "people think Black women are sexually loose" reported more

victim-blaming. These attitudes, in turn, were related to lower levels of self-esteem (Neville, Heppner, Oh, Spanierman, & Clark, 2004).

Culturally Sensitive Reponses

African American sexual assault survivors face multiple barriers to disclosure. These challenges include: rape myth acceptance that fosters self-blame; the internalization or fear of reinforcing the image of Black women as sexually promiscuous Jezebels; and the cultural mandate that survivors should be "Strong Black Women" who are able to handle trauma without assistance (Tillman, Bryant-Davis, Smith, & Marks, 2010). Although many victims receive positive support and assistance, others reported that professionals expressed victim-blaming attitudes. As a result of "secondary victimization," survivors reported mistrust, depression, and PTSD (Campbell & Raja, 2005). The purpose of this section is to provide examples of culturally sensitive responses and techniques that can be used by mental health, medical, and legal professionals.

Victim Advocates and Counselors

A multiracial coalition of anti-rape advocates, survivors, and stakeholders should have ongoing dialogues about race and rape in diverse communities (Washington Coalition of Sexual Assault Programs, 2007). For example, they could focus on culturally sensitive, nuanced ways to explore the complexity of high profile interracial and intra-racial rape allegations that involve sports figures (Calderon, 2004; Griffin, 2013). Black feminist groups have requested that organizers of "Slut Walks[5]" be "cognizant of the histories of people of color in ways that respect culture, language, and context" (Tanis, 2011). This requires professionals to become more familiar with African American history, particularly the psychological consequences associated with sexual assault and historical trauma (Tillet & Quinn, 2007). These discussions can be used to create culturally sensitive polices, practices, and programs. Educational programs could include information about race-related rape myths (e.g., rape is caused by Black women's hypersexuality). Sexual assault coalitions and agencies could endeavor to hire ethnically diverse staff members and allow them to take leadership roles, which will give them the power to deliver culturally relevant services and programs (Calderon, 2004).

Mental health professionals should conduct comprehensive interviews that document physical and sexual victimization in the survivors' homes, schools, communities, and workplaces. For example, over their lifetimes adult rape victims may have experienced CSA, sexual harassment, and physical intimate partner violence (Campbell et al., 2008). Perpetrators may include employers and teachers. Within extended family households, which are common in African American communities, survivors may be exposed to multiple perpetrators including step-fathers, mothers' boyfriends, uncles, foster parents, and siblings (Amodeo et al., 2006). Professionals should also question the survivor about sexual offenses that were committed by female perpetrators, such as mothers, aunts, babysitters, and teachers (Gannon & Cortoni, 2010).

Recognizing the diversity within the Black community, professionals should work in collaboration with survivors to create a path of recovery that is best suited for their needs (Bryant-Davis, 2011) Post-assault reactions and experiences can vary based on the victim's income, age, educational level, immigration

[5] Slut Walk protest marches began on April 3, 2011 after a Toronto police officer suggested that "women should avoid dressing like sluts" to prevent rape (Tanis, 2011).

status, and sexual orientation. For instance professionals can become familiar with community services that help low-income women access financial assistance, housing, and job training (Bryant-Davis et al., 2010). Older and less educated Black women are more likely to engage in self-blame and to lack a support network. Consequently, they may require special outreach efforts (Long et al., 2007).

Prior to immigration, African women may experience rape and other forms of sexual violence, such as female genital mutilation and forced marriage. Lesbians in South Africa, have reported "corrective rapes," a hate crime in which sexual minorities and gender nonconforming women are raped to "cure" them of their homosexuality (Di Silvio, 2011). Appropriate intervention requires awareness of these culturally specific forms of sexual assault. Likewise, professionals should be sensitive to the needs of all sexual minorities, including African American bisexual, lesbian, and transgender women.

Legal Professionals

Throughout history, the legal system did not punish, or even recognize, sexual assaults that were committed against African American women (Sommerville, 2004). In contrast, the legal system, sometimes without evidence, swiftly and severely punished Black men who were accused of rapes that involved White women (e.g. Scottsboro Boys in the 1920s, Emmett Till in the 1950s, and the Central Park 5 in the 1980s) (Duru, 2004). As a result, African American victims and community members are often reluctant to report sex crimes. Law enforcement staff should learn about rape and race in the legal system and work collaboratively with medical and mental health professionals to establish crime reporting procedures that ensure that all survivors are treated with respect and sensitivity.

Specifically, marginalized Black women are often ignored by the criminal legal system, this includes those who are low-income, identify as transgender, reside in urban areas, use drugs, engage in prostitution, or suffer from mental illness. Despite the challenges, legal professionals should investigate the complaints of these vulnerable victims and attempt to prosecute their perpetrators (Irving, 2008). Law enforcers should be trained to recognize the commercial sexual exploitation of children (CSEC). Running away from home, involvement with pimps, and posting photos on websites that offer escort services are behaviors that are indicative of CSEC.[6] Rather than arresting these victims, they should be referred to social services (Chaloner, 2010). As the African American female prison population continues to swell, law enforcers should strive to identify, report, and assist in the prosecution of inmates and prison staff who sexually assault incarcerated women [see the Prison Rape Elimination Act of 2003 (PREA)] (VanNatta, 2010-2011). In addition, legal officials who work on military bases (Campbell & Raja, 2005) and college campuses (Krebs et al., 2011) can endeavor to create appropriate protocols and policies to investigate sexual assault, particularly those that involve alcohol and drugs.

Medical Professionals

Approximately 20% (7.7 million) of African Americans lack health insurance (DeNavas-Walt et al., 2012). Yet, medical professionals, particularly those who provide gynecological, obstetrics, and primary care to Black women should routinely screen

[6] See documentary Very Young Girls, which chronicles the work of Girls Educational & Mentoring Services (GEMS) (http://www.gems-girls.org/)

for sexual and physical victimization. They could incorporate questions about sexual risk behaviors, condom use practices, frequency of sex while under the influence of alcohol/drugs, number of sexual partners, history of rape and CSA, and experience with current sexual victimization. When victims are identified, medical professionals should strive to detect and document genital injuries (Baker et al., 2010). In order to avoid miscommunication and to enhance the client's sense of safety, medical professionals should explain invasive procedures and ask permission before touching the survivor. It would be beneficial to recruit more ethnically diverse sexual assault nurse examiners and to provide culturally sensitive training to all medical providers (Maier, 2012). For example, the medical community has a long history of conducting risky experiments and procedures on African Americans that involve their sexual and reproductive functioning (e.g., Tuskegee syphilis experiment, forced sterilization) (Washington, 2006). Learning about this history can help medical providers craft more sensitive intervention efforts.

Resilience of Black Survivors

Service providers should consider taking a strengths-based approach that acknowledges the healing strategies that have been successfully used by African American women. For example, service providers can enhance the psychological well-being of survivors by educating their family members and friends about the immediate and long-term consequences of sexual violence. A strong social support network, including participation in faith communities, can help survivors cope with depression and PTSD (Bryant-Davis, Ullman, Tsong, & Gobin, 2011). Participation in various forms of activism has been instrumental in the healing journey for many survivors. For instance, survivors have testified about their victimization in churches, courtrooms, and congressional hearings (West, 2010). Black women also have used online technologies to mobilize a multiethnic coalition of activists, raise awareness about sexual assault, and provide support for survivors (Rapp, Button, Fleury-Steiner, & Fleury-Steiner, 2010). Finally, service providers should promote holistic healing practices. For example the SASHA (Sexual Assault Services for Holistic Healing and Awareness) Center in Detroit uses a mind, body, spirit approach (http://www.sashacenter.org). Storytelling, journal writing, creating and listening to music are all artistic expressions that can help survivors to heal themselves. To conclude, with culturally sensitive and appropriate services, African American survivors can simultaneously express their vulnerability and celebrate their resilience. They can be both sexual assault victims and resilient survivors.

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Additional Resources

Books

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Organizations

SASHA Center
http://www.sashacenter.org
Phone: 1-888-865-7055

National Organization of Sisters of Color Ending Sexual Assault (SCESA)
www.sisterlead.org

Girls Educational & Mentoring Services (GEMS)
(212) 926-8089
www.gems-girls.org
info@gems-girls.org
Producer of the documentary "Very Young Girls" on commercial sexual exploitation of children

Video/DVD

NO! The Rape Documentary (2006)
Aishah Shahidah Simmons
AfroLez Productions
P.O. Box 58085
Philadelphia, PA 19102-8085
215-701-6150
http://www.notherapedocumentary.org

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In Brief: Sexual Violence in the Lives of African American Women

Carolyn M. West, Ph.D. and Kalimah Johnson, LMSW, ACSW

Historical Overview: Throughout much of U.S. history, the rape of Black women was widespread and institutionalized. The legal system offered little protection and stereotypes about Black women's hypersexuality were used to justify limited social support for Black rape victims. Black women developed a culture of silence and engaged in anti-rape organizing to cope with their victimization.

Characteristics of Black Rape Survivors: In community samples, 34.1%-65% of reported childhood sexual abuse (CSA) and 12% reported commercial sexual exploitation of children (CSEC). In student samples, 11.2% of high school girls and 14.2% of college women reported rape. In national studies, approximately 1 in 5 Black women had been raped in their lifetime. Black women who were low-income, HIV-positive, bisexual, or incarcerated were at elevated risk. Most rapes were intraracial and involved someone known to the victim: family member, intimate partner, or acquaintance. Perpetrators used physical force, coercion, or substances to gain compliance.

Risk Factors: Poverty and revictimization were both risk factors and consequences for adult sexual violence. Being poor increased the likelihood of being raped and being raped increased the likelihood of becoming more economically disadvantaged. Among CSA survivors, 27% were raped during adolescence and 42% were raped in adulthood. Adolescent risk-taking (e.g., drug use, running away) and risky sexual behaviors (e.g., prostitution, alcohol use) increased the probability of adult rape.

Physical and Mental Health Consequences: Survivors reported both immediate and long-term physical and sexual health effects: bruises, black eyes, genital injuries, and sexually transmitted infection, which may be caused by risky sexual behavior (e.g., multiple sexual partners, less condom use). Mental health problems included posttraumatic stress disorder, depression, suicidal ideation, pain-related health problems, and low-self-esteem.

Culturally Sensitive Responses: All professionals should strive to learn more about African American history, sexual assault, and historical trauma. Mental health professionals can conduct comprehensive interviews that document sexual victimization and survivors' homes, schools, communities, and workplaces and work to create a path to recovery that is best suited to the victim's needs. Legal professionals should be trained to recognized commercial sexual exploitation (CSEC) and endeavor to investigate sex crimes that involve marginalized Black women (e.g., those who are low-income, transgender, suffer from mental illness). Medical professionals can screen for sexual and physical victimization and document genital injuries.

Resilience: Service providers can use a strengths-based approach to help survivors heal: educating community members about sexual assault, encouraging them to use their social support network or to participate in activism, and promoting holistic healing practices.

See the full Applied Research paper: West, C. & Johnson, K. (2013, March). Sexual Violence in the Lives of African American Women. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence. Available at: http://www.vawnet.org

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