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Struggling to Survive: Sexual Assault, Poverty, and Mental Health Outcomes of African American women

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Abstract

A substantial body of research documents the mental health consequences of sexual assault including, but not limited to, depression, posttraumatic stress disorder (PTSD), substance use, and suicidality. Far less attention has been given to the mental health effects of sexual assault for ethnic minority women or women living in poverty. Given African American women's increased risk for sexual assault and increased risk for persistent poverty, the current study explores the relationship between income and mental health effects within a sample of 413 African American sexual assault survivors. Hierarchical regression analyses revealed that after controlling for childhood sexual abuse there were positive relationships between poverty and mental health outcomes of depression, PTSD, and illicit drug use. There was no significant relationship between poverty and suicidal ideation. Counseling and research implications are discussed.

Keywords

sexual assault; poverty; African American; PTSD; depression

Recent scholarship notes that while sexual assault is prevalent across demographic lines, African American women may be at increased risk for sexual assault (Kilpatrick, Resnick, Ruggiero, Conoscenti, & Cauley, 2007). Contrary to some earlier studies that find similar rates across race and ethnicity (Brener, McMahon, Warren, & Douglas, 1999; Wyatt, 1992), Kilpatrick, Resnick, Ruggiero, Conoscenti, and Cauley's (2007) recent national telephone study showed that African American women, in a community sample and a college sample, report higher rates of lifetime forcible rape than Caucasian, Latina, and Asian women. The negative psychological sequelae of sexual assault have been widely studied with findings indicating that survivors of sexual assault are more likely to experience an array of mental health consequences including but not limited to depression, PTSD, substance abuse, and suicidal ideation and attempts (Kilpatrick, Ruggiero, Acierno, Saunders, Resnick, & Best, 2003; Gilboa-Schechtman & Foa, 2001; Ullman & Brecklin, 2002; Ullman & Filipas, 2001; Ullman, Townsend, Filipas, & Starzynski, 2007). However, the mental health effects of sexual assault as experienced by African-American women, including impoverished African American women, have received limited attention in the literature (Bryant-Davis, Tillman,

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Chung, in press; Long, Ullman, Starzynski, Long, & Mason, 2007; & West, 2006). The importance of exploring the socio-cultural context of sexual assault in the lives of impoverished African-American women requires an understanding of both the socio-historical and socio-economic influences on sexual assault in African American women's lives.

Socio-historical Context of Sexual Assault of African American Women

The sociohistorical context of sexual assault is qualitatively different for African American women as compared to women from other ethnic backgrounds. The United States' legacy of slavery and the unabated commodification of African bodies that ensued have invariably influenced the experience of sexual violence perpetrated against African American women. During the slave era, sexual assault and sexual exploitation were utilized as a means to dominate and oppress enslaved African females; the sexual victimization of African women was legal and deemed justified by their status as property belonging to the plantation owner (Talty, 2003). Post-slavery until about the late 1950s African American women working outside the home as maids and washerwomen were routinely the victims of sexual assault and harassment committed by the men in the families for which they worked (Neville & Pugh, 1997). Although legalized slave labor and the resulting sexual violation of women of African descent has ceased, evidence of its impact still remain today in the form of transgenerational trauma. Transgenerational trauma has been defined as historical, and sometimes continuing, traumatic experiences that affect more than one generation (Dass-Brailsford, 2007; Crawford, Nobles, and Leary, 2003).

There was a time in U.S. history in which rape laws were race specific and did not recognize African American women as victims (West, 2006). The laws have since changed, but the legitimacy of African American women as victims of sexual assault still remains questioned and silenced (Danieli, 1998). For instance, scholars have theorized that oppressive and stereotypical images support the racist belief system that African American women are unrapeable (Donovan & Williams, 2002). These images place blame on the victim and not the perpetrator by perpetuating the idea that the survivor's behavior (i.e., sexual promiscuity) somehow warranted victimization.

African American Women, Poverty, & Sexual Assault

Impoverished African American women are confronted with the cumulative stress of race, class, and gender oppression (West, 2002). An estimated 15% of American women are living at or below poverty level and approximately 40% of the homeless population is made up of women (U.S. Census, 2005). Further, higher rates of poverty are also found among some ethnic groups, i.e., African Americans. An alarming 25.6% of African American women are living in poverty (U.S. Census, 2005). It has been well documented that violence against women and girls has an adverse impact on women's economic and overall well-being (Pyles, 2006; Tolman & Rosen, 2001). Moreover, research indicates that women are at increased risk for victimization when their income is below poverty level, and conversely, victimization increases women's likelihood of unemployment and reduced income (Byrne, Resnick, Kilpatrick, Best, & Saunders, 1999). Jenkins (2002) describes the physical, mental, and social consequences of community violence for women living in dangerous neighborhoods. African American women in urban areas are often left to cope with exposure to community violence, witnessing or being aware of physical and sexual assaults in the neighborhood where they reside, as well as the traumatic grief and loss that may result for having a loved one murdered or incarcerated (Jenkins, 2002).

African American women living in poverty (Kalichman, Williams, Cherry, Belcher, &Nachimson, 1998) and African American women who receive public assistance

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(Honeycutt, Marshall, & Weston 2001) experience elevated rates of sexual assault. In an older study, Ingram and colleagues (1996) surveyed primarily African American women who lived in low-income housing and women who were homeless through service agencies in three cities. The prevalence of sexual assault was high for both groups, although homeless women reported higher rates than did women living in low-income housing.

In a study examining risk factors for intimate partner sexual abuse among a sample of 206 women (primarily African American and Latina) in methadone treatment, women in extreme poverty and those who experienced child sexual abuse were at increased risk of experiencing intimate partner sexual abuse in adulthood (Frye, El-Bassel, Gilbert, Rajah, & Christie, 2001). In a sample of impoverished women (primarily African American) who lived in shelter or low income housing, Wenzel and colleagues (2006) found that 41% of the women living in shelters and 21% of the women in living low-income housing reported being sexually assaulted in their lifetime.

As the literature indicates African American women are more vulnerable to persistent poverty and sexual assault. African American women who live in low-income housing complexes or are homeless most often are in communities with high rates of violence and substance use and abuse that ultimately increase their vulnerability to being sexually assaulted (Abbey, Jacques-Tiura, & Parkhill, 2009). These women are more likely to have high levels of cumulative stress (e.g., unemployment, intimate partner abuse, community violence, etc) and limited resources; consequently, the physical and psychological sequelae of the sexual assault may be more severe and long lasting (Ingram et al., 1996). Impoverished women may not be able to seek out assistance to alleviate the distress caused by sexual assault when they are unable to meet basic needs such as feeding their children (Holzman, 1996). Moreover, African American women living in poverty may encounter additional barriers to help seeking from informal and formal services, e.g., victim-blaming based on racism, sexism, classism, or other forms of societal trauma (Bryant-Davis & Ocampo, 2005).

The relationship between victimization and mental health consequences can be influenced by socio-economic identity markers that not only are associated with negative psychological outcomes but also increase the likelihood that a woman will be assaulted (Briere & Jordan, 2004). Examples of this include living in violent, unsafe communities, such as those associated with poverty and limited access to resources (Bryant-Davis, Tillman, Tsong, Chung, Shervey, & Johnson, under review; Kilpatrick, Resnick, Saunders, & Best, 1998). Low-income African-American women (Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998) and African-American women who receive public assistance (Honeycutt, Marshall, & Weston, 2001) experience elevated rates of sexual assault. Furthermore, socioeconomic status issues related to a woman's financial dependence on the perpetrator may decrease disclosure and help-seeking rates for African-American women (McNair & Neville, 1996). Highlighting the bidirectional relationship between sexual assault and income, Monnier, Resnick, Kilpatrick, and Seals' (2002) longitudinal study showed that sexual assault resulted in reduced resources including employment and income; a relationship that was mediated through the level of distress experienced by the survivor in the aftermath of the assault. This body of research establishes impoverished women's exposure to multiple forms of stress, trauma, and oppression, which likely exacerbates the mental health consequences of sexual assault.

Mental Health Consequences and African American Women's Victimization

While a range of mental health consequences are observed in sexual assault survivors, there are a few that have received greater empirical support as observed specifically among

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African American women; these consequences include depression, PTSD, substance use, and suicidality. As one might predict, depression is a common experience among African-American sexual assault survivors particularly during the weeks following the assault (Rickert, Wiemann, & Berenson, 2000). Demonstrating the complexity of these relationships, Kubiak and Siefert (2008) found in a sub-sample of African American women that trauma exposure, PTSD, alcohol dependence, and having a health condition that prevented one from working were all significantly associated with depression. Several groups have been identified as especially vulnerable to depression. These groups include, but are not limited to, African-American adolescent girls who reported a long duration of childhood sexual abuse (Cecil & Matson, 2001) and African-American battered women who report multiple incidents of sexual assault such as marital rape (Campbell & Soeken, 1999). More recently a study with a primary care population of African Americans found that of those with trauma histories 35% had Major Depressive Disorder (Alim, Graves, & Mellman, 2006).

PTSD is also a major mental health effect observed among African American sexual assault survivors. Alim, Graves, & Mellman (2006) found among African American primary care patients that 51% of those with histories of trauma exposure had PTSD during their lifetime. In regards to sexual assault specifically, a study of African-American females who self-reported a history of child abuse and/or sexual or physical assault in adulthood, Hood & Carter (2008) found that women who were sexually victimized in adulthood experienced more symptoms of PSTD and a greater severity of symptoms. Temple, Weston, Rodriquez, & Marshall (2007) found that for African American women, sexual assault by current partners and nonpartners were significant and positive predictors of PTSD symptoms, accounting for 16% of the variance in PTSD symptoms. An additional study of African American female veteran survivors of multiple traumas including sexual assault found not only the relationship between trauma and PTSD but additionally that PTSD mediated the relationship between trauma and physical health symptoms in this population; this relationship is particularly strong when examining pain-related physical health symptoms as compared to non-pain related physical symptoms (Campbell, Greeson, Bybee, Raja, 2008).

Regarding suicidal ideation and attempts, in findings from a sample of low-income abused African-American women, Kaslow, Thompson, Brooks, & Twomey (2000) found that risk factors for attempting suicide were more severe negative life events, history of child maltreatment, high psychological distress and depression, hopelessness about the future, and alcohol and drug problems. Similarly, Thompson, Kaslow, and Kingree (2000) studied 335 African-American women recruited from an inner-city public hospital and found that sexual assault related PTSD was associated with suicide attempts. In a more recent study, Ullman and Najdowski (2009) found that an ethnically diverse sample of sexual assault survivors, ethnic minority status, along with self blame and substance use, was associated with increased risk for suicidal ideation but not for suicide attempts.

Influence of Child Sexual Abuse

Across racial lines, childhood sexual victimization results in, among other consequences, increased risk for sexual assault during adulthood (Widom, Czaja, & Dutton, 2008; Long, Ullman, Starzynski, Long, & Mason, 2007). Revictimization results in poor physical and mental health indicators (Campbell, Greeson, Bybee, Raja, 2008). Regarding mental health indicators, adult survivors of childhood sexual abuse who have been revictimized are at increased risk for depression, PTSD, substance use, and anxiety (Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007; Bohn, 2003).

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Current Study

Building on findings of (1) numerous documented mental health consequences of sexual assault as well as (2) increased risk for sexual assault and poverty for African American women, this study examined the relationship between income and mental health consequences of sexual assault for African American women. It was hypothesized that, after controlling for child sexual abuse, a known correlate of negative outcomes: poverty be associated with heightened mental health problems. Specifically, we expect that: impoverished sexual assault survivors will report greater symptoms of PTSD, depression, past year illicit drug use, and suicidality than their higher income counterparts. The current study builds on the current literature that establishes that poverty and sexual trauma are related to negative mental health consequences, and examines the cumulative effect of the societal trauma of poverty in addition to sexual assault in a population at increased risk for both poverty and sexual assault, African American women.

Method

Participants

Four hundred and thirteen African American adult women between the age of 18 and 71 ($M = 35.31$, $SD = 11.25$) with unwanted sexual experiences since the age of 14 participated in the study. A little more than half of the participants had at least some college education ($n = 236$, 58.1%), two-thirds were single ($n = 252$, 61.3%), had children ($N = 267$, 66.1%), and most identified as heterosexual ($n = 335$, 81.5%), with fewer lesbian (8.8%), bisexual (6.1%), or unsure (3.6%) about their sexual orientation. Table 1 summarizes the demographic characteristics of the sample.

Measures

Sexual assault—The Sexual Experiences Survey (SES; Koss, Gidycz, & Wisniewski, 1987) was used to assess the severity of sexual assault since age 14. Participants were asked to report their most serious experience if they experienced more than one assault. The SES has reported internal consistency reliability of .69 and test-retest reliability at one week apart of 93% (Koss & Gidycz, 1985). In this study, the internal consistency reliability (Cronbach's α) was .81. Seventy-four percent of the women reported having given into unwanted sex acts (fondling, kissing or petting, but no intercourse) due to continual arguments and pressure, 35.8% due to a man using his position of authority (e.g. as a boss), and 64.2% due to threat or physical force. 71%) of the women reported experiencing attempted sexual intercourse with threat or force, and 42 % by being given alcohol or drugs. For those women who reported having unwanted sexual intercourse, 77% were due to man's continual arguments and pressure, 29% were due to a man using his position of authority, 43% were due to being given alcohol or drugs, and 75% were due to threat or force. Lastly, 36% of women reported having sex acts (anal or oral intercourse or penetration by objects other than the penis) due to threat or physical force.

Child sexual abuse—To assess for participants' experiences with sexual abuse before the age of 14, women were asked whether they had experienced completed rape, attempted rape, sexual coercion, or unwanted sexual contact before the age of 14, using a modified version of the SES. The variable was dichotomized (yes/no). Approximately 65% of the women in this sample reported experiencing child sexual abuse.

Income—Participants were asked about their total household income before tax the previous year using an ordinal-scale item. Almost 50% of the participants reported a household income of $10,000 or less (49.1%), followed by 20.2% reporting a household

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income between $10,001 and $20,000, 15.6%, between $20,001 and $30,000, 8.6% between $30,001 and $40,000, 2.7% between $40,001 and $50,000, and 3.7% reporting a household income of $50,001 or above.

Illicit Drug Use—Illicit drug use was measured by asking participants to indicate illicit drug use for the past year for cocaine (coke, crack, coca paste), heroin, and psychedelics (LSD, mescaline, peyote, psilocybin, Ecstasy, PCP, etc.). If they responded to all three items and indicated yes to at least one item, then they were categorized as having used drugs in the past year. Approximately 28% reported having using illicit drugs during the last 12 months.

Suicidal ideation—To measure suicidality one question on suicidal ideation was examined: "Have you ever seriously thought about killing yourself?" Suicidal ideation was reported by 46.2 % of the women in this sample.

Depression—Seven items from the shorter version of the Center for Epidemiologic Studies Depression Scale (CES-D, Radloff, 1977), CESD-10 (Andresen, Carter, Malmgren, & Patrick, 1994), were used to assess participants' level of depression. The three items (I felt hopeful about the future; I feel fearful; I was happy) were not included in the survey as they do not directly assess the positive presence of depressive symptoms. The 7 items included in the survey were rated on a 4-point scale (range = 0 to 3) according to how often the respondent felt that way during the past week. Cronbach's α of the full CES-D has been found to be .85 in the general population and .90 for patients (Radloff, 1977; Weissman, Sholomskas, Pottenger, Prusoff, & Locke, 1977). The content, concurrent, and discriminant validity have been supported. Correlations with the Hamilton rating scale for depression and the Raskin rating scale were good after 4 weeks of treatment ($r = .69$ and .75, Radloff, 1977; Weissman et al., 1977). The CES-D also was found to be more discriminating in determining symptom severity in depressed outpatient sample (Santor, Zuroff, Ramsay, Cervantes, & Palacios, 1995). The CESD-10 correlated highly with the 20-item scale ($r = .97$; Andresen et al., 1994). In this study, Cronbach's α for the 7 CESD items was .84.

PTSD symptoms—The Posttraumatic Stress Diagnostic Scale (PDS), a standardized 17-item self-report instrument, was used to assess the total number of PTSD symptoms women reported experiencing. This scale was selected because it has been validated with sexual assault survivors (Foa, Cashman, Jaycox, & Perry, 1997). Women rated how often each symptom (i.e., re-experiencing/intrusion, avoidance/numbing, hyperarousal) in relation to the adult sexual assault had bothered them during the past 30 days on a scale ranging from 0 (*not at all*) to 3 (*almost always*). The PDS has been shown to have acceptable test-retest reliability ($\kappa = .74$) for a PTSD diagnosis over a two-week interval, 87% agreement, and a Pearson r of .83 between two administrations. The PDS has also demonstrated good internal consistency ($\alpha = .92$) and convergent validity ($\kappa = .59$) with the Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID-I) PTSD module, indicating 79% agreement between the two measures (Foa et al., 1997). In this study, the PDS's internal consistency reliability (Cronbach's α) was .93. Almost three-fourths ($N = 300$, 73.7%) of the participants met the criteria for a diagnosis of PTSD, reporting a range of 0 to 51 symptoms ($M = 20.12$, $SD = 12.26$). Overall symptom severity scores for the participants were: none (4.4%), mild (20.8%), moderate (26.6%), moderate to severe (35.6%), and severe (11.6%).

Procedure

Data were collected from a convenience sample of women in Chicago and the surrounding metropolitan area. Flyers describing the study were posted at a large urban university, at bookstores in the area, at academic buildings, at dormitories, and at other places where women from the university and the community congregate. Flyers were also posted at

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mental health agencies and rape crisis centers. Advertisements were run in Chicago area newspapers. Women 18 years and older with unwanted sexual experiences since the age of 14 were recruited for a 45-minute, confidential mail survey. Participants were sent a packet containing a cover letter, a referral list of community resources, and information explaining the purpose of the study, in addition to the survey. Women were sent $20 and a list of community referral services upon completion of the survey. Of the surveys mailed out, 1084 women returned completed surveys, for a 90% response rate.

For this study, only African American women were included in the analyses ($N = 495$) and of those, only women who (1) answered affirmatively to at least one of the SES adult sexual assault items, and (2) responded affirmatively to the additional questions regarding physical violence and coercive tactics (final sample N=413).

Results

Hierarchical regression analyses were performed to examine the effects of income on mental health outcomes in African American female sexual assault survivors, when controlling child sexual abuse experiences. Specifically, two hierarchical linear regression analyses were conducted to examine the effects of income, when controlling for child sexual abuse history, on symptoms of depression and PTSD. Two hierarchical logistic regression analyses were conducted to examine the effects of income, when controlling for child sexual abuse history, on the odds of illicit drug use (no/yes) and suicidal ideation (no/yes).

PTSD and Depression Symptoms

Child sexual abuse history was entered on the first step of the hierarchical regression analyses in order to control for its influence before assessing the impact of income on each continuous symptom outcome variable (see Table 2 for the regression coefficients (B) and model statistics). Results indicated that, while child sexual abuse history significantly accounted for 5.8% (F (1, 399) = 24.68, $p < .05$) and 1.3% (F (1, 401) = 5.08, $p < .05$) of the variance in PTSD and depression symptoms respectively, income (entered on the second step) still accounted for an additional 1.6% (F (1, 398) = 6.68, $p < .05$, $\beta = -.13$) and 1.0% (F (1, 400) = 3.97, $p < .05$, $\beta = -.10$) of the variance in PTSD and depression symptoms respectively, above and beyond the its association with the effects of child sexual abuse history. These results suggested that, when controlling for the effects of previous child sexual abuse history, lower income African American adult sexual assault survivors still experienced significantly more symptoms of depression and PTSD than those with higher incomes.

Illicit Drug Use

A hierarchical logistic regression model entering child sexual abuse history as on the first step and income as the predictor variable of interest on second step, was statistically significant, χ^2 (1) = 5.28, p < .05. The final model accounted for 3.4% of the variances in illicit drug use. Table 3 summarizes the regression coefficients (B), Wald, and odd ratio (*OR*) statistics from the final block. Results suggested that, child sexual abuse history itself was predictive of illicit drug use, B = .49, Wald = 3.96, p < .05, *OR* = 1.63 (95% CI 1.00, 2.65). When controlling for child sexual abuse history, income still significantly predicted illicit drug use, B = −.21, Wald = 4.88, $p < .05$, *OR* = .82 (95% CI .68, .98), suggesting those African American women adult sexual assault survivors with less income are more likely to use illicit drug, after controlling for their child sexual abuse history.

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Suicidal Ideation

A final hierarchical logistic regression model, using child sexual history as the control variable as before and income as the predictor variable, was not statistically significant, $\chi^2(1) = .685$, $p > .05$, for African American women adult sexual assault survivors' reported suicidal ideation. Child sexual abuse history was statistically significant in predicting suicidal ideation, B = .70, Wald = 10.46, p < .05, *OR* = 2.01 (95% CI 1.32, 3.07), indicating that those African American women adult sexual assault survivors with a child sexual abuse history were more likely to report suicidal ideation. However, entering income on the second step of the model did not further add to the prediction their suicidal ideation. Table 3 summarizes the regression coefficients (B), Wald, and odd ratio (*OR*) statistics from the final block.

Discussion

Our findings indicate that among African American sexual assault survivors, poverty was positively related to depression, PTSD, and illicit drug use, while no relationship with suicidality was found. It should be noted that, although the results conformed to predictions, the odds ratios and variances accounted for were small, except for the odds ratio for the revictimization effects for suicidal ideation. The relationship between income and both symptoms of depression and PTSD can be understood in three primary ways. First women who are impoverished are more likely to have been exposed to community violence and as a result their mental health symptoms are based on exposure to multiple traumatic events as opposed to an isolated event (Kiser & Black, 2005). Additionally poverty or lack of income can serve as a barrier to access to mental health services (Ngui & Flores, 2007). A number of evidence-based interventions have demonstrated effectiveness in reducing post-assault symptoms (Russell & Davis, 2007). When women do not have access to these and other services they cannot benefit from their therapeutic impact. A final and equally important dynamic is the experience of societal trauma related to the intersecting identities of being female, African American, and impoverished (Bryant-Davis & Ocampo, 2006). Experiences of sexism, racism, and classism have a deleterious impact on well-being (Carter, 2007; Zucker & Landry, 2007; Smith, 2005; Loo, Fairbank, Scurfield, Ruch, King, Adams, et al., 2001). These experiences include, but are not limited to, daily hassles, discrimination, stigmatization, hate crimes, and intergenerational trauma, all of which can heighten depressive and PTSD symptoms (Bryant-Davis & Ocampo, 2005).

The relationship between income and illicit drug use can be seen as a form on unhealthy coping by women facing trauma and the stress of poverty (Ford & Smith, 2008). Impoverished persons may face a number of barriers to help-seeking including but not limited to: cost of services, transportation, child care, prior experiences with poor quality health/mental health care (resulting from both lack of cultural competence and/or lack of sufficient funds to maintain quality care), stigma surrounding help-seeking, and inaccessible mental health agencies (Brown, 2008; Smith, 2005). Other factors that may promote use of illicit drugs are accessibility, immediate relief from symptoms, and in some personal networks, social acceptance of certain drugs as a means of coping (Wu, Eschbach, & Grady, 2008). Another potential interpretation is that the substance use of the participants increased their risk for sexual assault, as in Kilpatrick, Acierno, Resnick, Saunders, and Best's (1997) study showing a bi-directional relationship between sexual assault and illicit drug use.

A number of factors, such as religiosity, social responsibility, and community values, may serve as a protective factor between poverty and suicidal ideation. The first is the high rate of religiosity reported by African American women in general (Jang & Johnson, 2005); most religious teachings strongly discourage suicide as an option and conversely promote hope and a sense of future progress (Lizardi, Dervic, Grunebaum, Burke, Mann, & Oquendo,

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2008). Additionally, social support is a coping strategy endorsed highly among African American women (Fraser, McNutt, Clark, Williams-Muhammed, & Lee, 2002). Social networks have people women can turn to for support, but women can also serve as a support to community and family members (Kubiak & Siefert, 2008). This awareness of others' reliance on the assault survivor may serve as a deterrent to suicidality. In addition to religion and social responsibility, African American women have often been socialized to embrace particular values, such as perseverance and strength (Wyatt, 2008). While African American women are at increased risk for a number of negative consequences, suicide rates are actually higher for White Americans and males than for African Americans and females (Garlow, Purselle, & Heninger, 2005). Although stressors may be numerous, African American females may receive racial and gender-based socialization messages that inspire them to find survival strategies. While these messages may be protective factors against suicide, they may also create stress by not permitting African American women to express their needs to themselves or others thus delaying help seeking (Beauboeuf-Lafontant, 2007).

There are several limitations to this study. This was not a representative sample, so it is unclear whether the results would generalize to African American sexual assault survivors in the general population. Given the nonrepresentative sampling strategy, it is not surprising that the income variable was skewed towards lower-income women, which likely resulted in a sample of more vulnerable survivors characterized by greater trauma exposure. This restricted range on the income variable may have actually led to weaker relationships of income with mental health outcomes in this study, so replication of these findings is needed with a more representative sample of survivors. The study relied on self-report survey data, which may be subject to social desirability bias and was retrospective in design, limiting our ability to know the direction of effects between child sexual abuse, poverty, and mental health outcomes. Given the stigma associated with sexual assault, substance use, poverty, and even mental health difficulties, it is possible that a number of participants under-endorsed these items. Another limitation is the study's findings are significant but do not illuminate the underlying pathways that may explain the demonstrated relationships. Future research needs to examine the moderators and mediators of the relationship between poverty and mental health outcomes, such as social support, religiosity, and trauma history. Additionally the experiences of African American sexual assault survivors who face additional forms of oppression and trauma should be explored such as lesbian and bisexual women, immigrant women of African descent, as well as women with disabilities.

These findings have several counseling implications that lend support to the adoption of multicultural feminist therapy principles, namely the promotion of liberation from every form of oppression (Enns & Byars-Winston, 2009); these forms of oppression include but are not limited to sexism, racism, classism, colonialism, heterosexism, ethnocentrism, privilege, ageism, and ableism. As counselors consider the applicability of these findings to female clients, it is imperative that any healing work that is to be done centralize the varying and intersecting aspects of women's identity (Ballou, Hill, & West, 2008). Counselors should be sensitive to the impact of stereotypes, discrimination, and oppression in diverse women's lives and engage in practices that are culturally sensitive and affirming (Enns & Byars-Winston, 2009). This requires a level of self-awareness of one's biases and attitudes as well as a commitment to adopting a strengths-based approach to counseling (Enns & Byars-Winston, 2009). Regarding a strengths-based approach, indigenous healing strategies such as positive religious coping, social support, story telling, and social activism should be assessed and encouraged (Enns & Byars-Winston, 2009; Bryant-Davis, 2005; Jenkins, 2002; Comas-Dias, 2000). Additionally, traditional diagnostic categories should be contextualized by an ecological or systems-based understanding of women's lives. This is particularly noteworthy given the fact that African American women are challenged by multiple physical and mental health disparities when compared to White women (Clark, 2003). To be

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effective, ethical, and culturally aware, therapists must seek to better understand the context from which African American women strive to recover from the negative impact of sexual assault.

It is critical for counselors to consider the stressful and sometimes traumatic experiences associated with poverty (Brown, 2008). Impoverished African American women exhibit negative mental health consequences that are closely linked with such challenges as limited access to mental health care, barriers to educational and economic opportunities, and a host of socially mediated stressors, especially when compared to socioeconomic groups with more opportunities (Takeuchi & Williams, 2007; Kaslow et al., 2004). Lack of attention to the socio-economic context in which clients are seeking mental health services is negligent and may undermine some of the potential benefits of treatment. Culturally competent care that is responsive to socioeconomic challenges allows for such modifications as assistance with transportation, assistance with childcare, community-based or home-based interventions, and clinical examples and homework assignments that reflect awareness of clients' economic condition. Additionally, recognition of the potential exposure to additional traumas supports the argument for a full trauma history assessment as a central component of standard intake procedures at every agency.

In addition to attending to the additional stress of poverty and potential trauma of classism, it is important for counselors to take a strengths-based approach in acknowledging the ways impoverished African American women survive. Higher rates of intrinsic religiosity and spirituality (Alim et al, 2008; Anglin, Gabriel, & Kaslow, 2005; Griffin-Fennel & Williams, 2006), affirmation of ethnic identity, adaptive cognitive processes, and family social support are four major protective factors that African American women, living in low socioeconomic conditions, employ to protect themselves from suicide in the face of global adversity (Early, 1992; Kaslow, et al., 2004). Specifically, self-perception of religion and a sense of spiritual well-being (Griffin-Fennell & Williams, 2006), a feeling of affirmation and connectedness among other African Americans (Walker, 2007), flexible and adaptive problem solving strategies, and maintaining close personal connections with family and friends are examples of impoverished African American women's resilience (Kaslow, et al., 2004; Compton, Thompson, & Kaslow, 2005).

Along with being strengths-based, socio-economically informed counseling should directly address ways for women to counter poverty. Some factors that have been significant in promoting recovery and resilience among African American trauma survivors include a sense of purpose, mastery, positive religious coping, optimism, and social support (Alim et al, 2008). Combating poverty through wrap around interventions such as economic empowerment, advocacy, and vocational/educational skills enhancement can reduce the risk of sexual assault and reduce its deleterious effects when it does occur (Kilpatrick, Resnick, Saunders, & Best, 1998). Assessment and interventions with African American trauma survivors should include sensitivity to both the occurrence of cumulative stress, chronic trauma, and various forms of coping such as positive religious coping and community activism (Bryant-Davis & Ocampo, 2006; Fallot & Heckman, 2005; Jenkins, 2002). These findings and their implications highlight the fact that counselors and researchers have an important role to play in enhancing the survival and recovery of impoverished victims of violence.

Regarding future research, investigators could locate other data sets that may have relevant variables that could be analyzed for differences within African American participants. This would be beneficial in demonstrating the heterogeneity of the African American community and allowing researchers to determine in greater detail the risk and protective factors of diverse African American women. Additionally, to the extent that child sexual abuse is also

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correlated with low income, the amount of variance left to be explained by income may have already been captured by the CSA variable. Future studies could enter income first in the hierarchical linear regression to see what the influence it has on the odds ratios and the variance accounted for by different predictors. Such an analysis addresses a different theoretical argument than the current study but may be important to consider, as one could argue that low income may influence one's mental health outcome regardless of the violation of child sexual abuse.

Conclusion

The current study finds that increased poverty is associated with heightened negative mental health outcomes among African American sexual assault survivors. These findings build on the literature by examining the intersecting identities of race and class. In contrast with much of the literature that either pays minimal attention to culture or views cultural groups as homogenous groups, this study examines the intersection of race, gender, and class, which are critical aspects of African American women's lives. This study serves to decentralize the experiences of Caucasian sexual assault survivors whose recovery process is often privileged in the literature (Enns & Byars-Winston, 2009). By centralizing the experiences of African American women, the authors seek to contribute to the understanding that trauma does not eclipse socio-cultural identity (Bryant-Davis, 2008). The cumulative impact of trauma, oppression, and poverty, as evidenced by the mental health consequences observed in this study, furthers the call to action for mental health professionals to actively address the needs of women.

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Table 1

Demographic Characteristics

Variable	Frequency	Percentage
Education (n = 406)		
Less than 12th grade	88	21.7%
HS graduate	82	20.2%
Some college	169	41.6%
College graduate and beyond	67	16.5%
Currently in School (n = 411)		
No	318	77.4%
Yes	93	22.6%
Current Employment Status(n = 404)		
No	223	55.2%
Yes	181	44.8%
Sexual Orientation (n = 411)		
Heterosexual	335	81.5%
Gay/Lesbian	36	8.8%
Bisexual	25	6.1%
Unsure	15	3.6%
Marital Status (N = 411)		
Single	252	61.3%
Cohabiting/Living with Someone	49	11.9%
Married	37	9.0%
Divorced/Separated	66	16.1%
Widowed	7	1.7%
Children (n = 404)		
No	137	33.9
Yes	267	66.1

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Table 2

Hierarchical Multiple Regression Models Predicting PTSD and Depression Symptoms when Controlling Child Sexual Abuse History

Variables	**R^2**	**R^2Change**	**F Change**	**B**	**SE**	**β**	***p***
PTSD	.074						
Step 1: CSA		.058	24.68	6.22	1.25	.24	.000
Step 2: Income		.016	6.68	−1.13	.44	−.13	.010
Depression	.149						
Step1: CSA		.013	5.08	.17	.08	.11	.025
Step 2: Income		.010	3.97	−.05	.03	−.10	.047

Note. PTSD = Posttraumatic Stress Disorder; CSA = Child Sexual Abuse;

* $p < .05$;

** $p < .01$;

*** $p < .001$

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Table 3

Final Hierarchical Logistic Regression Models Predicting Illicit Drug Use and Suicidal Ideation

Variables	*B*	*Wald*	*p*	**OR**	*CI 95% Low*	*High*
Illicit Drug Use						
CSA	.45	3.27	.071	1.57	.96	2.56
Income	−.21	4.88	.027	.82	.68	.98
Suicidal Ideation						
CSA	.72	10.86	.001	2.05	1.14	3.32
Income	.06	.68	.409	1.07	.92	1.24

Note. CSA = Child Sexual Abuse;

* $p < .05$;

** $p < .01$;

*** $p < .001$