QUALITY OF LIFE AND RACIAL IDENTITY AMONG BLACK WOMEN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

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ABSTRACT

The current study investigated the relationship between racial identity and overall quality of life among Black women survivors of childhood sexual abuse (CSA). On one hand, existing literature indicates that Black women as a racial group may experience more serious forms of CSA and report more severe traumatic impact as compared to white women survivors of CSA. On the other hand, research does not suggest lower functioning and quality of life among Black women survivors of CSA compared to their White counterparts. Thus, the researchers need to explore potential protective factors that serve as buffers and enhance the quality of life of Black women survivors of CSA. The findings of such research can guide preventive and intervention endeavors targeting Black women survivors of CSA.

The current study predicted that racial identity is significantly related to quality of life among Black women survivors of CSA. Racial identity was measured by the Cross Racial Identity Scale (CRIS) and quality of life (QOL) was measured by World Health Organization Quality of Life-Brief version (WHOQOL-BREF). Specifically, this study predicted that there would be a positive relationship between overall QOL and Pro-Black reference group orientation and a negative relationship between overall QOL and Non-Black reference group orientation. A sample size of 85 Black women survivors of CSA
was recruited via snowball sampling. The participants responded to measures of this study either on a secure and anonymous website or through regular mail. The results showed significant negative correlation between Non-Black reference group orientation and overall QOL. Furthermore, the Self-Hatred subscale of the CRIS accounted for significant variance (9%) in overall QOL. These results are congruent with previous literature. One important clinical implication of these findings is the need for evaluating racial self-hatred among Black women of survivors of CSA to provide proper treatment if needed. The CRIS seems to be an appropriate measure for this purpose. However, contrary to the second hypothesis, there was no significant correlation between Pro-Black reference group orientation and QOL. A main research implication of this finding might be the need for further exploration of the psychometric properties of the Pro-Black subscales of the CRIS.
DEDICATION

This project is dedicated to all Black women survivors of childhood sexual abuse, the anonymous women who participated in this study, and my dear women/sisters who inspired me to conduct this project by their participation in “From Surviving to Thriving” group for survivors of childhood abuse in spring 2003 during my internship.
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CHAPTER I.

INTRODUCTION

Although the occurrence of child sexual abuse (CSA) transcends race and ethnicity (Bernard, 1998; Kenny & McEachern, 2000; Mennen, 1995), race may play an important role in influencing the circumstances of abuse and in mediating the impact of or responses to CSA (Russell, Schurman, & Trocki, 1988; Sanders-Phillips, Moisan, Waddlington, Morgan, & English, 1995). Research has consistently revealed that the majority of cases of CSA are reported by females from various racial backgrounds (Kenny & McEachern, 2000). Thus, careful examination of the influence of racial factors on female survivors of CSA can provide opportunities in identifying specific risk and protective factors (Wyatt, Loeb, Solis, Carmona, & Romero, 1999) and offer possible explanation for variability observed among survivors of CSA (Lindholm & Willey, 1993; West, 2002b).

Specifically, it is important to investigate CSA among Black women because existing empirical data suggest that this group may experience more serious forms of CSA and report more severe impact of abuse when compared to their White counterparts (Feiring, Coates, & Taska, 2001; Kenny & McEachern, 2000; Russell et al, 1988.; West,
2002b; Wyatt, 1990a; Wyatt, Guthrie, & Notgrass, 1992; Wyatt et al., 1999; Wyatt & Mickey, 1988). Extant literature has proposed that Black women who have been sexually abused in their childhood, in comparison to their non-abused women, are more likely to suffer from the following problems: alcohol and drug use (Jasinski Williams, & Siegel, 2001; Peters, 1998; Wingood & DiClemente, 1997), sexual problems (Fiscella, Kitzman, Cole, Sidora, & Olds, 1998), sexual revictimization (Black, Heyman, & Smith Slep, 2001; Urquiza & Goodlin, 1996; West et al., 2000; Wyatt, 1998; Wyatt et al., 1992), depression (Peters, 1988; Rabon, 1995), low self-esteem and a low sense of mastery over life events (Cecil & Matson, 2001), hopelessness and an increase suicide attempts (Meadows & Kaslow, 2002), and binge eating disorder (Striegel-Moore, Dohm, Pike, Wilfley, & Fairburn, 2002).

Although examining a range of traumatic responses to CSA is an essential component of a study on Black women survivors, it is not sufficient (Grossman & Moore, 1994; Spaccarelli & Kim, 1995). One reason for this inadequacy is that up to two-thirds of Black women survivors of CSA have denied experiencing any severe long-term effects related to their abuse (Wyatt et al., 1999). Furthermore, many survivors report that they manage to maintain their functionality in spite of experiencing a variety of pathological symptoms in different periods of their lives (Anderson, 1997; Grossman, Cook, Kepkep, & Koenen, 1999; Oaksford & Frude, 2003; Spaccarelli & Kim, 1995). Existing literature has attempted to move beyond merely exploring the pathological impact of CSA by using concepts such as resiliency and competent functioning (e.g., Banyard, Williams, Siegel, & West, 2002; Hyman & Williams, 2001), psychological functioning (e.g., Harvey, et al.,
2003), social competence (Sparcarelli & Kim, 1995), psychosocial adjustment (e.g., Rabon, 1995), and mastery over life events (Cecil & Matson, 2001).

One plausible way of exploring CSA survivors’ level of functionality is to assess their quality of life (QOL). The World Health Organization Group (WHOG; 1994) proposed that QOL is “individuals’ perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards, and concerns” (p. 28). According to this definition, QOL includes the domains of physical health, psychological well-being, spirituality/religion, level of independence, social relationships, and environment. Measuring the overall QOL of Black women survivors of CSA can enhance our understanding of their perceived functionality across several domains. Although no study has investigated the QOL of survivors of CSA, a few empirical studies investigated the reports of Black women survivors of CSA about their level of functioning. These studies have provided support that some Black survivors of CSA manage to maintain competent functioning in many domains of life.

For example, Hyman and Williams (2001) and Banyard et al. (2002) in two different publications studied the level of perceived functionality of two different samples of female survivors of CSA and their comparison non-abused groups after 25 years of being seen in the emergency room of a large city hospital. The participants in both studies were predominately Black (84%). Hyman and Williams developed a scale, called “the resiliency scale” to assess the functionality of the participants. However, in fact, this instrument seemed to provide a measure of perceived functionality in the following domains: physical health, mental health, interpersonal relationships, adherence to
community standards, and economic well-being. Banyard et al. reported that 40 survivors (29% of the sample) scored high on the resiliency scale. Twenty-five women (18% of the sample) demonstrated what the researchers referred to as “excellent resilience” by showing competent functioning in almost all of the domains of “resiliency.” Hyman and Williams found that among the 25 “resilient women”, 84% scored low on the traumatic symptom scale, 88% scored above the median on the self-esteem scale, and 88% did not report a substance abuse problem. Furthermore, they found that 80% of the “resilient women” were members of an organization or participated in social activities several times a year, whereas only 38% of non-resilient women participated in such activities or organizations. Also, high functioning or “resilient” females were more likely to hold full-time jobs and earn more money than non-resilient women.

The results of Hyman and Williams (2001) and Banyard et al. (2002) suggest that some sexually abused survivors have external and internal resources that limit or overcome the negative effects of the abuse. In order to enhance and implement appropriate intervention programs for Black survivors of CSA, it is crucial to further investigate the potential factors that help the survivors to maintain, regain, or improve their quality of life in various domains. Therefore, an overview of two qualitative studies that investigated factors that contribute to functionality of Black women survivors of CSA follows.

Dabney (2000), in a study using grounded theory with 16 Black women survivors of CSA, hypothesized that the responses and attitudes of the survivors toward healing would reflect their affinity to extended family and community support system. She found
support for this hypothesis. For example, she reported that despite the initial negative coping strategies such as overeating, workaholism, alcohol and drug addiction, promiscuity; extreme religiosity, and overachieving, eventually the survivors improved their functioning by relying on getting support from community and other healing resources, such as counseling and what she called the “womanist spirituality” of Black women. The concept of spirituality of Black women may suggest that affinity to one’s racial group can enhance survivors’ ability to overcome negative effects of their abuse.

Similarly, Grossman et al. (1999), in their case study with 10 female survivors of CSA, found that the two Black women in their sample grew up with particular strengths that were related to the family style of urban Black families. For example, these women learned that it was necessary and appropriate to take care of themselves, strategically hide their vulnerable feelings, socialize with other Black people, particularly Black professionals, and promote a racial sense of self and what the authors called “Afrocentricism.” The authors did not expand on what they meant by the concept of Afrocentricism, but they mentioned that adherence to Afrocentric values promoted resiliency in Black individuals. The concept of Afrocentricism may indicate that adherence to one’s racial group and its values may promote healing in Black survivors of CSA.

The significance of both of the above qualitative studies is their implied suggestion that affinity to one’s racial group is important in healing from the negative impact of CSA for Black women survivors. Although not directly addressed in the qualitative and quantitative studies, the findings may imply that, for Black women survivors of CSA, strong racial identity may contribute to better quality of life despite
experiencing trauma. Racial identity is most often conceptualized in the literature according to the Nigrescence model; therefore, the current study utilized the Cross Theory of Nigrescence (Cross, 1991; Cross & Vandiver, 2001) for conceptualizing racial identity.

The Nigrescence model suggests that Black people in the U.S. experience a process of “becoming Black” by going through several developmental stages of group identity. According to Nigrescence model, the racial identity stages include Pre-Encounter, Encounter, Immersion-Emersion, Internalization, and Internalization Commitment. Some of the racial identity stages include a few identity clusters. For example, the Pre-Encounter stage consists of Assimilation, Miseducation, and Self-Hatred clusters, the Immersion-Emersion stage includes Intense Black Involvement and Anti-White identity clusters, and the Internalization stage consists of Black Nationalist, Multiculturalist Racial, and Multiculturalist Inclusive clusters (Vandiver, Fhagen-Smith, Cokley, Cross, & Worrell, 2001).

Statement of the Problem

Despite the implied importance of exploring racial identity of Black women survivors of CSA, only one study has directly investigated racial identity of Black women survivors of CSA (Bruce-Morritt, 1997). Bruce-Morritt examined the effects of being sexually abused in childhood on the development of racial identity among survivors. Contrary to her hypothesis, she did not find any significant relationship between history of childhood sexual abuse and racial identity development. Thus, she suggested that CSA
does not hinder the development of racial identity. However, Bruce-Morritt’s study did not explore whether racial identity affects the overall quality of life and functioning of the survivors in adulthood.

Although not investigated among CSA survivors, a few empirical studies have examined the role of racial identity either as a protective factor in dealing with effects of various kinds of adversities or as a factor that may enhance QOL, functionality, or adjustment. These researchers used different conceptual frameworks of racial identity and different instruments to measure racial identity. In spite of these differences, all of the studies provided empirical support for the notion that racial identity is positively associated with competent functioning and adjustment in certain domains of life (Franklin, 2002; Johnson, 2002; Laursen & Williams, 2002; Neville & Lilly, 2000; Wong, Eccles, & Sameroff, 2003). For example, Utsey, Chae, Brown, and Kelly (2002) explored the relationship between QOL and racial identity among 160 Asian, Latino, and Black adults (44% of the sample was Black). Because the sample in this study came from diverse and multiracial backgrounds, the authors used Phinney’s (1992) conceptualization of group identity and the instrument that measures this concept, the Multigroup Ethnic Identity Measure (MEIM). They found that the Black participants reported significantly higher affiliation with their racial group and significantly higher quality of life compared to the other two racial groups. More importantly, they found that for the total sample, adherence to racial group was the best predictor of QOL.

Finally, a personal account that initially inspired me to explore the relationship between racial identity and quality of life among survivors of CSA was my experience in working with a group of Black women survivors of childhood sexual abuse. Frequently,
the group members emphasized their strong reliance on and adherence to their racial identity as “Black women” in seeking empowerment and healing from the negative impact of trauma. The results of studies on populations other than CSA survivors as well as the preliminary qualitative indications and clinical anecdotes, indicate that racial identity may be a source of strengths and healing in survivors of CSA.

General Research Question

Is there a relationship between racial identity and quality of life among Black women survivors of CSA?

Importance of the Study

The current study expands on existing knowledge regarding Black women survivors of childhood sexual abuse by investigating the relationship between QOL and racial identity among a sample of Black women who are survivors of CSA. Current research has provided some evidence that Black women are at higher risk of experiencing severe types of CSA (Feiring et al. 2001; Kenny & McEachern, 2000; Russell et al., 1988; West, 2002b; Wyatt, 1990a; Wyatt et al., 1992; Wyatt et al., 1999; Wyatt & Mickey, 1988). The severity of CSA may be related to severe negative outcomes for Black women adult survivors (e.g., Russell et al., 1988; Wyatt, 1990b).

Despite the severity of trauma and its experienced impact, there is no evidence that a higher percentage of Black women survivors of CSA, at least compared to their White counterparts, is functionally impaired or is less functionally competent in various
domains of life (Wyatt et al., 1999). Therefore, it is critical to explore factors that promote the lives of Black women survivors of CSA despite their abuse and the traumatic impact of their abuse in order to provide empirically informed preventive and intervention programs. Several scholars, as well as some empirical studies on various racial populations in general, and on Blacks in particular, have suggested that positive views of one’s reference group can contribute to quality of life and positive change, despite life adversities (Humphreys, 2003; Laursen & Williams, 2002; White, 1984; White & Parham, 1990). However, the relationship between racial identity and quality of life of Black survivors of CSA has not been directly investigated.

Thus, the current study investigated the relationship between racial identity and overall quality of life among Black women survivors of childhood sexual abuse. Specifically, this study predicted that Black women survivors of CSA with non-Black reference group orientation would be more likely to report lower quality of life, whereas survivors with pro-Black reference group orientation would be more likely to report higher quality of life. Such inquiry is crucial for identifying potential protective and intervening factors that may buffer against negative effects of CSA and for establishing strategies that may enhance the quality of life of Black women survivors of CSA (Bernard, 1998; Dabney, 2000; Fonts, 1995b; hooks, 1989; Metzuka, 1996; Pierce & Pierce, 1987; Wilson, 1993). If it is demonstrated that higher racial identity contributes to healing from negative impact of CSA, then preventive and therapeutic programs need to incorporate strategies that enhance racial identity among this group of survivors.
Definitions and Operational Terms

*Child Sexual Abuse*

The current study used Wyatt and Mickey’s (1988) definition of child sexual abuse in which CSA is defined as sexual activities between a child under 18 years old and an individual five years or older than the child regardless of whether obvious coercion is involved. If the age difference is less than five years, only situations that were nonconsensual and involved some degree of coercion are considered sexual abuse.

In the current study, only those sexual behaviors that involved physical contact between the abuser and the abused are included. Contact CSA may involve force and coercion or may not (West, 2002; Wyatt and Mickey, 1988). Fondling, oral, anal, and vaginal penetration are examples of physical contact. This study did not include non-contact abuse, which is defined as sexual activity between a child and an older person without physical contact. Examples of non-contact abuse are exhibitionism and taking pornographic pictures of a child.

*Race*

Race in this study is not a demographic label; instead it refers to a social concept that connects the group members by a web of behaviors, values, and attitudes (Fontes, 1995). This study will follow Tate and Audette’s (2001) advice that race should be studied as a purely cognitive concept that influences social perception.
**Black**

In this study, Black refers to a self-identified Black person from African American, West Indian/Caribbean, Hispanic Black, African, mixed, or other Black racial backgrounds (Vandiver et al., 2000).

**Racial Identity**

Racial identity refers to the level of identification with a larger group of people who share certain personal characteristic, attitudes, feelings, and behaviors, which is known as the reference group (e.g., Cross, 1971, 1991). In this study, Black racial identity is operationalized based on the expanded Nigrescence model (Cross & Vandiver, 2001) and as measured by the Cross Racial Identity Scale (CRIS; Vandiver et al., 2000). According to Vandiver, Cross, Worrell, and Fhagen-Smith (2002), the two overarching racial identity attitudes are non-Black reference group orientation (Pre-Discovery) and pro-Black reference group orientation (Discovery). Pre-Discovery includes Pre-Encounter Miseducation (PM), Pre-Encounter Assimilation (PA), and Pre-Encounter Self-Hatred (PSH) identity clusters, whereas Discovery includes Immersion-Emersion Anti-White (IEAW), Internalization Afrocentricism (IA) and Internalization Multiculturalist Inclusive (IMCI) identity clusters as measured by the CRIS.
Quality of Life

This study will use a multidimensional concept of QOL proposed by WHOG (1994). According to this concept, QOL is “individuals’ perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards, and concerns” (WHOG, p. 28). This study will utilize the World Health Organization Quality of Life Instrument, Geneva and U.S. brief version (WHOQOL-BREF; Bonomi & Patrick, 1997) to operationalize the QOL of the participants. The WHOQOL-BREF consists of four domains including physical health, psychological well-being, social relationships, and environment.

Assumptions

It is assumed that self-report represent accurate information regarding history of CSA, racial identity and quality of life of the participants. Also, it is assumed that the participants in this study are a representative sample of Black women who have experienced CSA. Finally, for the statistical analyses it is assumed that independent and dependent variables have normal distribution.
CHAPTER II.

LITERATURE REVIEW

This chapter will first examine existing literature on prevalence, characteristics, and negative impacts of CSA among Black women. Then, it will provide rationale for why the exploration of negative impacts of trauma is not sufficient in explaining how CSA survivors manage to maintain their lives. Next, the existing literature on overall functioning that moves past reporting traumatic symptoms among Black women survivors of CSA will be reviewed. In order to provide a comprehensive framework for assessing self-report functionality in several life domains, the concept of quality of life (QOL) will be introduced. An overview of the existing literature regarding QOL will follow. Then, a review of the concept of racial identity development will be presented. Finally, the relationship between QOL and racial identity and the relationship between racial identity and CSA will be discussed.

Child Sexual Abuse within Black Community

This section will provide an overview of existing literature on the prevalence of CSA and demographic and statistical information on characteristics and circumstances of
CSA among Black survivors of CSA as compared to other racial group survivors in the U.S. The consensus among scholars is that despite differences in child-rearing practices, most cultures appear to disapprove sexual behavior toward children (Elliot, Tong, & Tan, 1997). Research has confirmed this statement for the Black community as well. For example, Haskins (1999) found that 93% of a sample of 244 Black adults was non-supportive of sex between an adult and a child. Despite this widespread disapproval, the occurrence of CSA is a social phenomenon that transcends race (Bernard, 1998; Kenny & McEachern, 2000). However, the likelihood of reporting the abuse as well as characteristics of CSA, circumstances around the abuse, and impacts of CSA may be dissimilar for different racial groups (Powell, 1988; Russell et al., 1988; Sanders-Phillips et al., 1995). For example, Hanson, Kievit, Saunders, Smith, Kilpatrick, Resnick, and Ruggiero (2003) documented that one-third of adolescents in general population did not tell anybody about their experiences of CSA. Similarly, Wyatt (1990b) found that over one-third of Black children who were victims of CSA did not disclose their abuse to anyone. This rate for Black adolescents in Hansin et al.’s study was approximately half of the victims. Thus, the next section will provide a review of literature regarding prevalence, characteristics, and impact of CSA among the Black population either as compared to other racial groups or as compared to other Black participants who were not sexually abused.
Prevalence of CSA

Although the U. S. Department of Health and Human Services (DHHS; 2002) did not specify the prevalence of CSA within major racial groups in the U.S., it reported that the substantiated cases of CSA was 88,656 (9.9%) of the 896,000 children victims of maltreatment, or 1.2% of the 72,894,483 children population in the U.S. The DHHS, without breaking down the prevalence of each type of maltreatment, reported that during 2002, 195,924 of 9,710,384 Black children population (i.e., about 2% of Black children) were substantiated cases of all types of maltreatment, Similar to reported cases of substantiated maltreatment for American Indian or Alaska Native children (i.e., 21.7 per 1,000 children of the same race), the rate of maltreatment for Black children is among the highest rates of victimization that has come to the attention of social services. Whereas, the reported prevalence of all maltreatment for White children was 10.7 per 1,000 White children for the same race and for the Asian-Pacific Islander children was as low as 3.7 per 1,000 children for the same race. Similarly, Lodico, Gruber, and DiClemente (1996) found that in their sample of 6624 adolescents, 10.1% reported a history of CSA. The rate of prevalence of CSA for Black adolescents (15.2%) was significantly higher than White adolescents (9%); however, the prevalence of CSA among Black adolescents did not differ significantly from the prevalence of CSA among Native American adolescents (17.2%).

One problem with some existing reports on the prevalence of CSA, like the DHHS report, is that certain minority and lower socioeconomic groups tend to be over-represented in the prevalence of substantiated cases of maltreatment of children one of
which is sexual abuse (Wright, 1982). It seems that when the bias in reporting sources is removed, the racial discrepancy in the prevalence of child maltreatment in general, and CSA in particular, disappears. For example, Sedlak and Broadhurst (1996) concluded that the result of the Third National Incidence Study of Child Abuse and Neglect found no race differences in maltreatment incidence, because this study identified a much broader range of children than those who come to the attention of any one type of service agency such as child protective and other child welfare services. Also, other studies in clinical and nonclinical populations have not found significant or consistent differences in the prevalence of CSA between Black and White samples (e.g., Finkelhor, 1984; Finkelhor & Baron, 1986; Peters, Wyatt, & Finkelhor, 1986; Priest, 1992; Wyatt, 1985; Wyatt, et al., 1992).

Overall, comparable to White samples, the rate of CSA in the Black population in different studies ranges as high as 60% and as low as 5.3% according to different studies (e.g., Banyard, 1999, Cecil & Matson, 2001; Feiring et al., 2001; Kenny & McEachern, 2000; Marcenko, Kemp, & Larson, 2000; Peters, 1988; Stein, Golding, Siegel, Burnam, & Sorenson, 1988; Wyatt et al., 1999). Wyatt (1985) reported that among 248 Black and White women in her study, one in 2.5 Black women and one in 2 White women experienced some form of CSA that involved physical contact. This vast spectrum of the prevalence reports of CSA can be due to several reasons. According to the DHHS (1993) the following factors may contribute to this wide spectrum. First, the data on CSA are usually gathered using a variety of methodologies, such as telephone interviews, face-to-face interviews, and paper and pencil questionnaires. Second, a study may focus entirely on sexual abuse, or sexual abuse may be one of many issues investigated. Third, some
studies include special populations, such as psychiatric patients, sex offenders, and college students, whereas others may recruit participants from the general population. Fourth, the definition of sexual abuse varies from study to study, depending on the maximum age for the victim, the age difference required between the abused and the abuser, and whether the non-contact and/or unwanted types of sexual abuse were included. Furthermore, it is noteworthy that substantiated reports, such as DHHS (2002), are the most conservative reports on the prevalence of CSA, because most cases of CSA do not come to the attention of authorities and many survivors, regardless of their race, do not disclose their abuse to anyone (Wyatt et al., 1999).

In spite of the difference in prevalence of CSA across various studies, the DHHS (2002) reported that, in the 3 years preceding their report, the rate of CSA has been stable. Also, Wyatt et al. (1999) reported that the prevalence of CSA reported by both Black and White women in their study who were born from 1948 to 1956 and women who were born from 1958 to 1976 did not significantly change.

In sum, despite the disapproval of CSA (Elliot et al. 1997), this phenomenon is prevalent enough to create serious concerns in the Black community (Abney & Priest, 1995; Bernard, 2000; Dabney, 2000; West, 2002a). Therefore, as Bernard (1998) has advised, researchers should focus on the “specificity of the experiences” of Black survivors of CSA to understand this phenomenon better. Thus, the next section will examine the differences and similarities in characteristics and circumstances of CSA between Black women and other racial groups in the U.S.
Characteristics of CSA

Characteristics of abuse may include factors such as the sex and age of the victim, the relationship between the perpetrator and the victim, severity and frequency of abuse, family structure, family reaction to abuse, and social environment (e.g., Kenny & McEachern, 2000). Research indicates that some characteristics of and circumstances around abuse are similar and some are different between Black and other racial populations in the U.S (Powell, 1988). For example, Kenny and McEachern reviewed the existing literature and concluded that, in general, despite variation of female to male ratio, the majority of reported cases of CSA are by females across racial groups including the Black population. Wyatt et al. (1992) reviewed existing studies and concluded that the estimates of women who have experienced at least one incident of CSA before age 18 ranged from 1 to 2.5 in 4, regardless of their race. Furthermore, most studies have not found any trend indicating differences in the onset age of being abused between Black and White victims (Kenny & McEachern). Russell et al.’s (1988) finding that the onset of abuse for Black girls was at an older age appears to be an exception.

In terms of the relationship between the perpetrator and the victim, there is some evidence that Black girls are at risk for being abused in their homes by Black males, whereas White girls are more likely to be abused indoors or outdoors by White males (Wyatt, 1985). Furthermore, Black children are less likely to be abused by their biological fathers and grandfathers and more likely to be abused by their parents’ partners and their uncles and by younger perpetrators compared to White children, who are more likely to be abused by their biological parents or babysitters and older perpetrators.
This difference may be because Black children are more likely to be exposed to adult males other than their biological fathers (Abney & Priest, 1995). Regarding family reaction to abuse, Pierce and Pierce reported that compared to White mothers, Black mothers are more likely to be supportive of their children, when the victims disclose their sexual abuse.

Research on the social environment and severity of abuse has revealed that Black teenage girls who live in “dangerous” and poor communities appear to be at increased risk for being sexually abused (Black et al., 2001). Furthermore, Black females are especially at risk for severe and forceful types of childhood sexual abuse (Kenny & McEachern, 2000; West, 2002b). For example, Black females are more likely to experience genital penetration and force during their abuse (Feiring et al., 2001; Huston, et al., 1997; Lindholm & Willy, 1986). Specifically, Wyatt et al. (1999) studied 248 Black (126) and White (122) women in Los Angeles County in 1984. Overall, 34% of the participants reported at least one incident of CSA prior to age 18. In 1994, the authors recruited 338 Black (182) and White (156) women from the same county. This time, 45% of the participants reported. Alarmingly, the researchers found that there were significant increases in very severe types of CSA from 1984 to 1994 both for Black and White women. However, Russell et al. (1988) found that Black women survivors, three times more than White survivors, reported that their incestuous abuse was “very severe.” These authors found that 56% of Black survivors of CSA reported some form of intercourse or attempted intercourse, compared to 18% for White victims. Finally, Shaw, Lewis, Loeb,
Rosado, and Rodriguez (2001) reported that Black girls in their study reported more vaginal penetration as the result of their abuse compared to their Latina counterparts.

The severity of CSA among Black women survivors and the increase of this severity in the past 10 years have motivated several researchers to explore the negative outcome of CSA among Black women survivors. The next section will provide a review of existing literature on the traumatic impact of CSA.

Traumatic Impact of CSA

Despite some dispute among scholars regarding the sequelae of CSA (e.g., Rind, Tromovitch, & Bauserman, 1998; Whitenburg, Tice, Baker, & Lemmey, 2001), it is well documented that up to half of all sexually abused children exhibit serious and long-lasting consequences (Browne & Finkelhor, 1986; Jumper, 1995; Kendall-Tackett, Williams, & Finkelhor, 1993; Putnam, 2003; Tyler, 2002). These effects may be even more serious for Black women survivors. For example, Russell et al., (1988) studied 930 women with 10% Black and 67% White participants. They found that Black women described their experiences of incestuous abuse as “extremely upsetting,” “having great long-term effects,” and falling into the “worse outcome” category, twice more than their White counterparts. The traumatic outcome of CSA can be explained in a model called the Traumagenic Dynamics Model (TDM).

The TDM (Finkelhor & Browne, 1985, 1986, 1988) proposed four traumatic dynamics that account for the impact of CSA. These dynamics include traumatic sexualization, betrayal, stigmatization, and powerlessness. Briefly, sexualization is the
most important and unique dynamic to CSA compared to other types of childhood traumas, because it jeopardizes the child’s sexual capacity. This dynamic shapes the development of a child’s sexuality in an inappropriate and interpersonally dysfunctional way. Psychological impact of this dynamic may include increased salience of sexual issues, confusion about sexual norms and sexual activities, and avoidance of sexual intimacy. Betrayal, which may be present in most types of abuse, is the realization of the child victims that a potential caregiver has caused or wished her harm. The psychological impact of betrayal may include depression, dependency, mistrust (particularly of men), and anger and hostility. Stigmatization dynamic is the accumulation of negative messages about the self that are communicated to the child victims during the abuse experience. The psychological impact of stigmatization can include guilt and shame and low self-esteem, which may be manifested in behaviors such as drug and alcohol abuse, criminal involvement, self-mutilation, and suicide. Finally, powerlessness distorts the child victims’ sense of ability to control their lives. This dynamic has two components. First, the child’s body space, will, wishes, and sense of efficacy are frequently invaded and rejected, either through force or deceitfulness. Second, the child faces threats of being injured, harmed, or destroyed, which may happen in forceful types of CSA. The psychological impact of powerlessness may include anxiety and fear, identification with the aggressor, and need to control. The behavioral manifestations of this dynamic may include problems such as anxiety and phobias, somatic complaints, eating and sleeping disorders, dissociation, work problems, delinquency, vulnerability to subsequent victimization, and becoming abusive.
Both between-group and within group comparison studies have indicated that Black women survivors of CSA may manifest psychological and behavioral problems, which can be categorized under each dynamic of the TDM. Thus, in the next section I will provide an overview of the relevant studies based on the four traumagenic dynamics of the TDM.

**Sexualization.** This category includes studies that suggest survivors of CSA may suffer from sexual problems. Fiscella et al. (1998) studied 1139 unmarried pregnant women who were predominantly Black (89%). They found that only CSA, but not child physical or emotional abuse, had an independent effect on age of first coitus and was a significant risk factor for earlier pregnancy among Black adolescents. Wingood and DiClemente (1997), in a study of 165 Black women, 13.3% of whom reported a history of CSA, found that the abused group was more likely to have had an abortion, a history of anal sex, and being infected with a sexually transmitted disease (twice more than the non-abused group in their lifetime). Furthermore, the abused participants were more worried about acquiring HIV because of their sexual experiences. Wyatt et al. (2002) studied 457 women with HIV positive and negative results. The participants consisted of 155 Black, 153 White, and 149 Latina women. Among other findings, the authors found that Black women who were HIV positive were more likely to report histories of severe CSA. Similarly, Simoni and Ng (2002) studied 230 predominantly poor Black (46%) and Latina (47%) women aged 25 to 61 years with HIV/AIDS. The participants revealed high (39%) levels of sexual abuse before the age of 16.
Betrayal. The results of the existing literature also suggest that Black women survivors of CSA report manifestations of betrayal dynamics of CSA, such as increased depression and mistrust of men. For example, Peters (1988) studied 50 Black and 69 White women, 60% of whom reported at least one incidence of sexual abuse prior to age 18. This study found that the members of the abused group, regardless of their race, were more likely to have at least one major depressive episode since the age of 18. Rabon (1995) studied 112 Black (56) and White (56) women. The author reported that the survivors of CSA, regardless of their race, showed significant elevation on the Depression scale of the Minnesota Multiphasic Personality Inventory (MMPI) compared to the non-abused group. On the other hand, Mennen (1995) studied 134 sexually abused girls 6-18 years old. Of the participants 35 were Black, 38 were Latina, and 51 were White. Although the author found higher levels of depression among Latina girls compared to Black and White girls, both Black and White girls showed high levels of depression with no significant between group differences. Similarly, Sanders-Phillips et al. (1995) reported less depression among 8-13 year old Black girl survivors of CSA compared to their Latina counterparts. The authors concluded that this difference might indicate that Black girls may respond to their abuse by externalizing their symptoms through aggressive and avoidant behaviors rather than internalizing them through depressive symptoms. However, Shaw et al. (2001) did not support this assumption. They studied 159 sexually abused 6 to 18 year old girls, 52% of whom were Black and 48% were Latina. They found that the Black girls were not only less likely to be perceived as depressed by their caregivers, but they also were less likely to be perceived as aggressive, delinquent, or withdrawn compared to their Latina peers.
Research has also indicated problems with trust among Black victims of CSA. For example, Roberts (1999) studied 32 drug using Black women and found that reporting a history of CSA was related to a loss of ability to give and receive love and trust in oneself or others. Wyatt (1990b) studied 126 Black and 122 matched White women between 18 and 36 years old. She reported that Black women survivors of CSA more than their White peers reported a tendency to avoid men who looked like their abuser. Similarly, Wyatt and Mickey (1988) reported that, compared to the White counterparts, Black women survivors of CSA were significantly more cautious and less trusting of men as the result of their abuse.

*Stigmatization.* Relevant research has shown high alcohol and drug abuse, self-esteem problems, and suicidality among Black survivors of CSA. For example, Peters (1988) found that for both Black and White participants, abuse experiences were related to experiencing alcohol and drug abuse, even when deficiencies in family relationships was removed from the equation. Jasinski et al. (2001) re-interviewed 113 Black survivors of CSA as adults and found that having experienced multiple incidents of CSA was an important predictor of adult heavy alcohol use and binge drinking even after controlling for parental drinking. Wingood and DiClemente (1997) studied 165 Black women, 13.3% of whom reported a history of CSA. They found that the abused group was more likely to report having a history of alcohol abuse. Finally, Teets (1995), in a study on 60 recovering chemically dependent women, found that 68% of them reported being sexually abused as children. It is noticeable that the abused women were more likely to be Black.
Furthermore, existing research has reported problems with self-perception among Black, White, and Latina survivors of CSA, with no significant group differences between Black and White girls (Mennen, 1995). In a within group study, Cecil and Matson (2001) investigated a sample of 249 predominately Black adolescent females with low socioeconomic status attending a health clinic. They found that the sexually abused group (22.9% of the total sample) showed lower self-esteem and “mastery” than the non-abused group. The authors defined mastery as “the extent to which one regards one’s life-chances as being under one’s own control in contrast to being fatalistically ruled” (p. 977).

Also, there is some evidence of increased suicidal ideation and behavior among survivors of CSA. For example, Meadows and Kaslow (2002) examined the antecedents of suicidal behavior among an urban group of Black women suicide attempters and found that CSA was correlated with suicide attempts. Also, Thompson, Kaslow, Lane, and Kigree (2000) studied 335 impoverished Black women referred to a large urban hospital. They found that women with a history of CSA and posttraumatic stress disorder (PTSD) were six times more likely to have made a nonfatal suicide attempt compared to women with no history of CSA or PTSD. Women with either a history of CSA or PTSD were three times more likely to have made a nonfatal suicide attempt compared to women with no history of CSA or PTSD.

Powerlessness. Existing studies report problems with anxiety, PTSD, eating disorder, and coercive relationships – either as a victim (revictimization) or as an abuser – among Black women survivors of CSA. For example, Mennen (1995) reported that
although Latina survivors of CSA showed higher levels of anxiety compared to Black and White girls, both Black and White girls showed high levels of anxiety with no significant between group differences. Leifer and Shapiro (1995), in a longitudinal with 64 sexually abused Black girls between the ages of 5 and 15, found that these girls continued to suffer from anxiety and high level of stress, despite some improvement in their affective responses over time. Also, Thompson et al. (2000) found a significant positive relationship between PTSD and history of CSA among Black women who had attempted nonfatal suicide. Finally, Owens and Chard (2003) studied 89 adult women survivors of CSA, 14% of whom were Black. They found that as high as 89% of the total sample suffered from PTSD.

Striegel-Moore et al. (2002) provided evidence for increased eating disorders among Black survivors of CSA. The authors compared 60 Black and 102 White women diagnosed with binge eating disorder and matched them with healthy community and psychiatric comparison groups. They found that Black women with binge eating disorder reported significantly more histories of CSA compared to Black healthy and psychiatric comparison women.

Another long-term impact of CSA that is well documented is continuation of abusive and coercive relationships. Lodico et al. (1996) studied the relationship between CSA and coercive sex among 627 sexually abused and 5597 non-abused Black, Native American, and White male and female adolescents and found that regardless of gender and racial background, adolescents with histories of CSA reported more coercive sex, either as victims or perpetrators, than their non-abused peers (40% versus 8%). Several studies have repeatedly demonstrated increase in sexual revictimization in Black women
adult survivors of CSA (e.g., Hagen, 1998; Simoni & Ng, 2002; West et al. 2000; Wyatt, 1988; Wyatt et al., 1992). Urquiza and Goodlin (1996) studied a sample consisting of 243 Black, White, Latina, and Asian American female undergraduate students and reported that two thirds of the White and Black participants who reported rape in their adulthood had also a history of sexual abuse in their childhood. The revictimization of survivors of CSA may also include physical victimization in adulthood. For example, Wingood and DiClemente (1997), in their study of 165 Black women, reported that sexually abused women were more likely to report having a partner who had been physically abusive to them.

In sum, existing quantitative research has indicated that CSA may result in several negative outcomes, which can be categorized based on the TDM. Qualitative research has supported the results of qualitative studies. For example, Dabney (2000) used grounded theory to study 16 Black women survivors of abuse, who were 18 years old or older, were financially independent, were working and educated beyond high school, and were not in active treatment for mental health or substance abuse problem. She found that the participants, at least initially, suffered from a variety of mental health disorders such as depression, anxiety, suicidal ideation and attempts, flashbacks and post traumatic stress disorder, alcohol and drug problems, problems with eating and body image, self-esteem issues particularly as related to their complexion and skin color, revictimization, interpersonal relationship problems, and mother and daughter relationship issues.
Limitations of the Traumatic Impact Approach

Most research on the impact of CSA has mainly focused on a cluster of symptoms or the severity of these symptoms among Black women from lower SES status and clinical or dysfunctional populations, using measures that may not be sufficiently sensitive to the effects of CSA or overall quality of life of Black women survivors of CSA (Sedlak & Broadhurst, 1996; Wright, 1982; Wyatt, Newcomb, & Riederle, 1993). A different trend in research, using community samples, has revealed that not all those who have been sexually abused demonstrate traumatic impact. In fact, a relatively substantial number of sexually abused children show a decline in symptoms in the months following disclosure of abuse or do not manifest any symptoms on diagnostic measures (Finkelhor, 1990). Overall, reviews of existing literature concluded that about 20% to 49% of sexually abused children, regardless of their racial background, reported no short-term symptoms (Hyman & Williams, 2001; Taylor, 2002). Similarly, Wyatt et al. (1999) found that regardless of the circumstances, at least two-thirds of Black and White women survivors of CSA reported that they did not suffer from any long-term effects of their abuse. Interestingly, although there was no change in reported prevalence of CSA across time for both Black and White women, the odds of Black women reporting no long-term effects of their abuse in 1994 were approximately 14 times greater than in 1984, whereas the odds of White women reporting no long-term effects of their abuse in 1994 were only 2.7 times greater than in 1984 (Wyatt et al.). In fact, Wyatt and Mickey (1988) reported that a small percentage (about 5%) of survivors of CSA in their study reported positive long-term effects.
Thus, Anderson (1997) concluded that even though some sexually abused children’s survival capacities might be either diminished or expressed as dysfunctional behaviors in some life domains, they may maintain competence in other areas of life. Anderson pointed out that sexually abused children are likely to use tremendous energy to self-repair. As a result, their strengths may be overlooked, because their survival abilities are overshadowed by the trauma. Grossman et al. (1999) proposed that adaptation in survivors of CSA does not happen in the absence of pain. Therefore, pathological perspectives may fall short in explaining the variability observed among the CSA survivors and the potential factors that contribute to their survival capabilities. Hence, instead of focusing only on the existence or absence of traumatic impact of CSA among clinical and lower SES populations, an alternative approach is to assume a multidimensional view of the survivors’ overall quality of life in representative samples from the community, in order to explain the variability in survivors’ reactions to their history of trauma and the level of their current functioning. (Harvey et al., 2003).

Survivors’ Functioning

Because of limitations of the research focusing on the traumatic impact of CSA, many scholars have suggested multidimensional approaches in which the researchers evaluate the functioning of the survivors of CSA above and beyond their pathological symptoms. For example, Spaccarelli and Kim (1995) highlighted the need for exploring the CSA survivors’ adequate mastery in a variety of tasks in addition to searching for the absence or presence of clinical or diagnosable psychopathology. Spaccarelli and Kim
suggested that using this approach might provide a more global assessment of the overall functioning of survivors. Similarly, Grossman and Moore (1994) emphasized that the following components need to be considered when assessing survivors of CSA. First, it is important to evaluate the capacity of the survivor to maintain functioning despite psychosocial pain. Second, it is critical to consider the capacity of the survivors to use survival skills in combating traumatic impacts. Third, it is essential to measure the ability of survivors to transform their relationships into a relatively open, trusting, and reciprocal form despite their abuse. Last, it is vital to assess survivors’ potential for giving personal, interpersonal, and social meaning to horrendous experiences of childhood sexual abuse.

Recent empirical research has taken the above considerations into account and has focused not only on exploring the negative impacts of CSA, but also on the survivors’ capability to remain functional and competent despite abuse. For example, Sparccarelli and Kim (1995) studied 43 sexually abused girls who were referred to a nonprofit clinic. Their sample consisted of 74% White, 19% Latina, and 5% Black girls. Although about 81.4% of the sample met at least one criterion for clinical symptomatology, 69.8% of the girls demonstrated adequate social competence. These results supported the proposition that many sexually abused girls maintain social functioning despite suffering from some psychological pathology.

Qualitative studies, using narrative analyses and case studies, have also supported a multidimensional outlook on survivors of CSA. For example, Farris (1997) in a qualitative study on 12 older (57 to 75 year old) female survivors of CSA used narrative analyses and found that all the women in the study exhibited remarkable resourcefulness even though they experienced negative feelings such as guilt, self-blame, sexual
problems, and lost opportunities. Also, in a case study report on 10 female survivors of childhood sexual abuse, Grossman et al. (1999) found that each person in their case study of 10 Black and White women survivors of CSA took different paths to grow and evolve across their life span, despite the negative impacts of their trauma. They suggested that coping with stressful events and developing confidence is a multidimensional process and that survival strategies differ in various contexts and across different points in time. Regardless of this variation, most survivors employed several overarching coping strategies, such as receiving support outside their family, seeking formal treatment, and spirituality to promote functioning. This study proposed that the survivors of CSA might improve their life and maintain their functionality by using various internal and external resources. Existing research has supported this assumption as well.

For example, in a longitudinal study, Banyard et al. (2002) followed a group of female survivors of CSA and a comparison non-abused sample for over 25 years. Their sample was drawn from 206 victims of CSA who were initially examined in an emergency room in a large city hospital from 1973 to 1975. All these girls, whose age ranged from 10 months to 12 years old in the initial encounter, had experienced some type of sexual contact. In 1990-1991, 136 (66%) of the original sample were interviewed. In 1997, 23 years after the abuse, 87 of the original sample were located and re-interviewed. All samples were predominantly Black (84%, 86%, and 89% respectively). The results indicated that 40 survivors (29% of the sample) had high scores on a scale of functionality, called the “resiliency scale,” which in fact measured physical health, mental health, interpersonal relationships, adherence to community standards, and
economic well-being. Among these survivors, 25 women (18% of the sample) demonstrated competent functioning in almost all areas under study.

Hyman and Williams (2001) interviewed 136 women of the original sample of 206 in 1990-1991 and reported on various aspects of the sample’s symptomatology and functionality. They reported that the physical health of functional and nonfunctional women did not differ significantly. However, 80% of functional women were members of an organization or participated in social activities several times a year as opposed to 38% of nonfunctional women’s participation in such activities or organizations. Also, women with high scores on the measure of functionality were more likely to hold full-time jobs and earn more. Therefore, the authors encouraged researchers to investigate proactive behaviors in women’s experiences, rather than merely exploring their passive responses to CSA.

Although in its infancy, research on assessing perceptions of Black women survivors of CSA about their functioning across a wide range of life domains can provide better understanding of their survival capabilities. This trend in research tends to be more respectful of racial group differences as well as the developmental and nonlinear nature of human functioning. One way to assess perceived functioning of CSA survivors is to assess their QOL as defined and measured by the WHOG (1994, 1998). QOL is a multidimensional construct that evaluates self-perceived functioning in a variety of life domains such as psychological, biological, relationship, and environmental areas (Utsey, Bolden, Brown, & Chae, 2001). An explanation of this framework follows.
Quality of Life

Current Western measures of functionality have been criticized for their biased views in favor of individualism (Utsey et al., 2001). An alternative approach would provide a multidimensional construct of functionality, which captures the strengths of survivors in face of adversities. This framework would consider the interplay of intrapersonal and interpersonal domains as well as events and the environment, integrated in an ecological perspective (Harvey et al., 2003). Thus, a concept of functionality would be appropriate for use with Black people only when it is based on a collectivistic perspective (White & Parham, 1990).

In 1991, the Division of Mental Health of the World Health Organization (WHO) initiated a project involving 15 countries to develop a generic quality of life (QOL) instrument to evaluate the effects of program interventions on QOL; compare QOL across countries and subgroups within countries; and measure change over time (Bonomi & Patrick, 1997). According to the World Health Organization Group (WHO, 1994, 1998) concept of quality of life is about the meaning people derive about from the important aspects of their lives which is rooted in the person’s culture (Skevington, 2002). The WHO has acknowledged that in collective cultures, a measure of functionality needs to assess the quality of life based on at least three major components (Utsey et al., 2001). First, it should assess an individual’s internal energy; that is spirit, soul, and vitality. Internal energy, in various cultures, is the “ethereal” source that was bestowed on the creature by the creative force. Second, such a measure needs to account for harmony, which is an essential component of group identity, because many collective cultures view
the universe in harmony with the social community. Harmony maintains the balance between interdependent entities that corresponds with natural rhythms. Third, many collective cultures have a circular time orientation in which the essence of life revolves around spirit. Therefore, being “in time” is fluid and in accordance with harmony and unity with nature. This circular time orientation is the characteristic of connectedness in collective cultures (see Utsey et al.).

After several pilot studies and necessary changes, the final version of the QOL instrument, WHOQOL-100 was introduced. The WHOQOL-100 contains 24 facets grouped into six domains of physical health; psychological functioning; level of independence; social relationships; environment; and spirituality, religion, and personal beliefs. Physical Health facets include pain and discomfort, energy, and sleep. Psychological facets include positive feelings, concentration, self-esteem, body image, and negative feelings. Independence facets include mobility, activities of daily living, medication, and work capacity. Social facets are relationships, social support, and sexual activity. Environment facets include safety, home, finances, social care, new information, leisure, environment, and transportation. Finally, the spiritual domain consists of a spiritual facet (WHOG, 1994, 1998). A shorter version of the WHOQOL instrument, WHOQOL-BREF, with 26 items is also available (Bonomi & Patrick, 1997). Multiple studies have provided support for using the concept of QOL and psychometric properties of its scales, which will be reviewed in chapter III.

Although it is important to explore the quality of life of Black women survivors of CSA for a better understanding the variability among them, it is even more important to investigate the potential factor(s) that enhance their quality of life to formulate
appropriate therapeutic strategies. One of these factors may be survivors’ racial identity. Empirical research appears to provide preliminary support for assuming that affiliation with one’s racial group (or racial identity) may be an important factor in promoting quality of life in general, and in the face of life adversities in particular. Below, a framework for exploring Black racial identity is followed by the relevant literature supporting the relationship between racial identity and QOL. Finally, the results of existing research on the relationship between CSA and racial identity will be reviewed.

Racial Identity

Identity is defined as a form of “self-concept” or “self-system” (Erikson, 1968, pp. 208-209). Based on Erikson’s identity development theory, youths enter late adolescence and early adulthood with four possible states of identity. Some adolescents have unclear ideas about who they are. Erikson called this state “diffused identity.” Some young people internalize their parental teachings without any further examination. This state is called “foreclosed identity.” Other youths, on the other hand, search for their identity. First, they enter a period of exploration that causes them crisis, which is called “moratorium identity.” If conditions are favorable, these young people may reach a state of clarity and achievement called “achieved identity” (Erikson).

As White and Parham (1990) pointed out, during this identity exploration, Black adolescents cannot avoid the reality of living in a racist society. Thus, multicultural scholars and Black psychologists (e.g., Cross, 1971, 1991; Phinney, 1989; White & Parham, 1990) have suggested that Black identity has two components. One component
involves adoption of certain personal characteristic, attitudes, feelings, and behaviors, which is known as personal identity. The other component involves identification with a larger group of people who share those characteristics, which is known as reference group orientation. According to Cross (1991), studies on personal identity address variables that are universal in all human beings, such as intrapersonal and interpersonal characteristics, ego strength, psychological pathology or well being. Whereas studies on reference group orientation focus on race and group related information, including the content, context, symbols, values, and group affiliation of the person. Thus, Cross (1991) proposed a two-factor model of Black identity. Based on this model, a Black person’s self-concept consists of her or his reference group orientation (e.g., racial identity, group identity, race awareness, racial ideology, race evaluation, race esteem, race image, and racial self-identification) and her or his personal identity (e.g., self-esteem, self-worth, self-confidence, self-evaluation, interpersonal competence, ego-ideal, personality traits, and level of anxiety).

In formulating the development of the reference group orientation component of Black identity, Cross (1971) proposed his Nigrescence theory. Nigrescence, which is “a resocializing” experience, “seeks to transform a preexisting identity into one that is Afrocentric” (Cross, 1991, p. 190). This model explains how a Black adolescent transforms from a person who assimilates and internalizes values of a racist society to a more “Black” or Afrocentric being. Nigrescence is a developmental process that happens over time (Parham, 2001). Nigrescence more or less consolidates during adulthood; however, similar to other developmental and multistage models, the stages may recycle (Cross & Fhagen-Smith, 1996; Parham, 1989). Operationalization of the original
Nigrescence theory (Cross, 1971) by measures such as Qsorts, the Stages Questionnaire (Cross, 1972), the Developmental Inventory of Black Consciousness (DIBC; Milliones, 1973), and particularly the Black Racial Identity Attitude Scale (RIAS-B; Helms & Parham, 1981) instigated many studies on racial identity development and its relationship with components of personal identity. The results of these studies have resulted in a revised (Cross, 1991) and ultimately an expanded Nigrescence model (Cross & Vandiver, 2001). The stages of identity development according to the expanded model are Pre-Encounter (PE), Encounter (E), Immersion-Emersion (IE), Internalization (I), and Internalization-Commitment (IC). Each stage may include one or more identity clusters. Cross and Vandiver (2001) and Vandiver et al. (2001) provided the following descriptions of the Nigrescence stages and their identity clusters.

Briefly, the focus of the PE stage is the preexisting identity, which Nigrescence development targets to change. The PE stage is considered to have at least three identity clusters including Miseducation, Assimilation, and Black Self-Hatred attitudes. According to Cross (1991) Miseducation is the core of PE attitudes, due to the formal education of Black children in a Western educational system. The Assimilation cluster represents Black people who show low salience for race and a positive reference group orientation toward being American. Individuals with low salience attitudes value anything other than their Blackness, such as their religion, their lifestyle, their social status, or their profession. Some people with low salient attitudes have not thought about racial issues. Individuals with high salience for race, yet with extremely negative views about Black people, have Self-Hatred identity. These individuals question their own self-worth as Black people.
Despite the tendency of Black people in the Pre-Encounter stage to maintain their identity status, it is usually inevitable that they experience some sort of racist encounter(s) that catches them “off guard.” First, the person experiences the Encounter and then personalizes it. According to Nigrescence theory, the Encounter may result in confusion, guilt, anger, depression, and anxiety. Ultimately, these emotional reactions may stimulate the search for Black identity. The Nigrescence theory proposes that when a Black person encounters with accumulated events of racism, s/he rejects and devalues all previously held values. However, the person is not yet transformed into a new self. Consequently, the person in this stage tends to be very rigid and simplistic and her or his views of the world are very dichotomized. The expanded Nigrescence model (Cross & Vandiver, 2001) stated that the Immersion phase of the Immersion-Emersion stage encompasses two separate, but related, identities. One identity views everything Black or Afrocentric as good, which represents the Intense Black Involvement cluster. During the first phase of the IE stage, the person immerses her or himself in the world of Blackness and experiences a surge in altruism, selflessness, dedication, and commitment to Blackness. The second identity represents an Anti-White cluster which views everything White or Eurocentric as evil. The person in this stage tends to see all White as evil, inferior, and inhuman, and all Black as superior and trustworthy. According to Nigrescence theory, the IE stage can inspire or frustrate an individual. Prolongation of or frustration during this stage may break the person’s spirit and desire to change, in which case the person can regress to previous stages, become fixated in the simplistic views of the IE stage, or simply drop out of the process of Nigrescence transformation.
If the person evolves from the IE stage, his/her new identity would become solidified in the Internalization stage. In the revised Nigrescence model, Cross (1991) underscored the importance of Black acceptance and pride. Although the people with Internalization identity place high salience on Blackness, the degree of this salience is determined by other ideological reflections. The diversity of internalized identities is evidenced by three independent ideologies: Black Nationalism, Biculturalism, and Multiculturalism (Vandiver et al. 2001). Black Nationalism is characterized by intense Black involvement, a focus on Black empowerment, economic independence, and a heightened awareness of Black history and culture. Two primary forms of Black Nationalism are separatism and inclusion. Although it appears that Black Nationalism belongs to the Immersion-Emersion stage, Cross (1991) viewed Black Nationalist ideologies vital for Internalization stage. Black Nationalist views vary from an emphasis on the ability of Black people achieving the same political and civil rights as their White counterparts to political anti-capitalist socialist ideologies to Afrocentricity that does not represent separatist or inclusive attitudes. Cross (1991) included Afrocentricity as a type of Black Nationalism as one possible non-Western worldview. Although Afrocentricity is a form of Black Nationalism, it has a variety of definitions.

Increased contact with people from diverse cultural backgrounds increased the likelihood that Black individuals in the Internalization stages share universalist and humanist perspectives with acceptance of being Black as their foundation (Vandiver et al. 2001). In Cross's (1991) revision of the Internalization stage, he demarcated bicultural and multicultural reference group orientations and expanded the focus of these identities beyond only race. Thus, the Biculturalist Racial cluster represents people who pride
themselves with another culture in addition to their Blackness. Individuals in this stage describe themselves as being both Black and American. The Multiculturalist Inclusive cluster consists of people who are open to building coalitions with all diverse cultural groups. As with all internalized identity clusters, Black self-acceptance is the core of the Multicultural identity, but at least two other identity categories have salience in the dynamics of the person's identity. For example, a person may stress being Black and at the same time gay, female, male, disabled, or religious and working on causes alongside cultural groups other than African Americans. Individuals in this cluster also accept and embrace others with diverse racial backgrounds (Cross & Vandiver, 2001; Vandiver et al. 2001).

Cross (1991) emphasized that the Internalization stage is not the end of a person’s concern with Nigrescence. In a person’s life span, new encounters may challenge the person’s existing identity and force her or him to negotiate everyday life and become wiser in her or his Blackness. This process may bring about the need to recycle through some of the previous stages or to shift focus to other identity issues such as religion, gender and sexual orientation, career development, social class and poverty, and multiculturalism. After developing a Black identity that serves their personal needs, some Black people do not enter the Internalization Commitment stage which develops by expansion of interest in Black affairs. Others, at least temporarily, commit themselves to provide a plan of action to empower the Black community and fight against institutionalized racism. Beyond this basic difference, Cross (1991) suggested that there is no other difference in Black identity at the Internalization Commitment stage compared to the Internalization stage.
It is important to note that Vandiver et al. (2002), in their attempt to develop a measure for the expanded Nigrescence theory were able to measure only six identity clusters of the Nigrescence model, some of which they had to rename. The identity clusters measured by of the Cross Racial Identity Scale (CRIS; Vandiver et al., 2000) are called Pre-encounter Assimilation (PA), Pre-encounter Miseducation (PM), Pre-encounter Self-Hatred (PSH), Immersion-Emersion Anti-White (IEAW), Internalization Afrocentricity (IA), and Internalization Multiculturalist Inclusive (IMCI). Furthermore, they found items that measured these six identity clusters of racial identity loaded on a higher order two-factor structure called Pre-Discovery and Discovery. Based on this factor structure, identities that belong to Pre-Discovery represent a Non-Black reference group orientation, whereas identities in Discovery describe a Pro-Black reference group orientation. This means that the Pre-Encounter identity clusters loaded on Pre-Discovery factor, whereas the items that represent the Immersion-Emersion and Internalization identity clusters loaded on the Discovery factor. The authors encouraged future researchers to pay attention to a similar structure in their data. The current study will use the distribution of racial identity clusters on the higher order two-factor structure to define low versus high racial identity. The following figure summarizes the racial identity stages and clusters of the revised Nigrescence theory as currently measured by the CRIS:
Although some researchers have suggested that there is no predictable and consistent relationship between racial identity and ego identity components, except for a negative relationship between Pre-Encounter Self-Hatred attitudes and self-esteem (e.g., Cross, 1991; Cross & Fhagen-Smith, 1996; Steen & Bat-Chava, 1996), there is increasing evidence supporting a positive relationship between racial identity, psychological functioning, and overall quality of life (Larsen & Williams, 2002; Utsey et al., 2002). Furthermore, the results of some studies have suggested that racial identity might act as a buffer to protect the individual against a variety of life adversities (Johnson, 2002;
Several studies using the Nigrescence model have suggested there is a positive relationship between racial identity and psychological well-being. For example, Miville et al. (2000) studied 104 Black college students to examine the relationship between racial identity attitudes (as measured by the RIAS-B) and four components of ego identity status, including achievement, moratorium, foreclosure, and diffusion. Regression analyses, in which the racial identity statuses were entered together as a block of independent variables, showed that racial identity predicted significant amounts of variance in three of four ego identities (all but foreclosure). The Pre-Encounter subscale was the best predictor of both moratorium and diffusion. As the authors hypothesized, a positive racial identity significantly predicted ego identity achievement. Thus, they suggested that resolving racial issues (e.g., placing the blame on the system and connecting with others) might help the person deal with conflicts and become committed in personally relevant domains. Furthermore, Pre-Encounter racial identity attitudes correlated with ego identity crisis (moratorium) and confusion (diffusion); that is, people with more assimilated and White-oriented racial identity attitudes experienced more ego identity crisis and exploration.

Neville and Lilly (2000) studied 182 Black college students’ mental health using the RIAS-B. Their findings suggested that Internalization attitudes of a positive Black identity were associated with higher psychological functioning, including psychological closeness, positive self-concept, and goal directed behavior. Also, Johnson (2002) studied the relationship between self-esteem, gender, racial identity, and health-promoting life
style in 224 Black males and females. Johnson’s measure for racial identity was the
Stages Questionnaire (Cross, 1972) a 55-item, 7-point Likert scale that captures pre-
encounter, immersion/emersion, and internalization stages. Her results indicated that
there was a significant relationship between self-esteem and the Internalization stage and
between self-esteem and health-promoting lifestyles. She further found that gender
moderated the relationship between both Pre-Encounter and Immersion racial identity
and a health-promoting lifestyle. Women with higher Pre-Encounter scores reported
lower health-promoting lifestyle scores than men with higher Pre-Encounter scores. Men
and women with low Pre-Encounter scores reported similar health-promoting lifestyle
profile scores. The regression lines indicated that women with higher Immersion scores
had lower health-promoting lifestyle scores than men.

Franklin (2002) studied the relationship between racism-related stress and racial
identity with psychological distress and psychological well-being in 134 Black men and
121 Black women. She found that although both racism-related stress and racial identity,
as measured by the RIAS-B, predicted psychological distress, racial identity accounted
for more of the variance in psychological distress than racism-related stress. Specifically,
she found that individuals with higher Pre-Encounter attitudes were more likely to report
psychological distress, whereas individuals with higher Internalization attitudes were less
likely to report psychological distress. Furthermore, the results indicated that racial
identity, but not racism-related stress, accounted for significant variance in psychological
well-being. Specifically, individuals with higher Internalization attitudes were more
likely to report higher psychological well-being. Although the individuals in the IE stage
reported experiencing significant levels of racism-related distress, there was no
significant relationship between IE attitudes and psychological distress or psychological well-being. Overall, Franklin concluded that racial identity is an important variable to study in understanding the effects of racial stress on psychological distress or psychological well-being.

Other studies used different conceptualizations of racial identity than the Nigrescence model for exploring the relationship between various domains of functioning and racial identity. For example, Laursen and Williams (2002) studied 469 Black, Anglo American, and Cuban American adolescents, using ethnic identity concept as measured by the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992). They found that only for Black adolescents the level of total problem had significant negative correlation with the level of affiliation to their racial group. Also, only for Black adolescents was cumulative GPA positively correlated with higher adherence to their racial group. Wong et al. (2003) supported these findings with 629 Black adolescents. They found that after controlling for socio-demographic and background variables, and perceived discrimination, positive connection to one’s racial group, as measured by a four-item instrument, promoted positive development in school achievement, psychological resiliency, and perceptions of friends’ positive school characteristics. Furthermore, they found that connection to one’s racial group could buffer the negative impact of perceived racial discrimination on the development of African American adolescents.

Only one study (Utsey et al., 2002) directly investigated the relationship between racial identity and QOL, as measured by WHOQOL-BREF (Bonomi & Patrick, 1997; WHOG, 1998). This study used Phinney’s (1992) ethnic identity model as their conceptual framework. They studied 160 Asian and Latino and Black adults (44% of the
sample were Black) and found that the Black group reported significantly higher affiliation with their racial group as measured by the MEIM, as well as higher QOL as compared to the other two racial groups. More importantly, they found that for the total sample, affiliation to racial group was the best predictor of QOL. Ethnic identity accounted for 14% of variance in QOL. These results along with the results of the aforementioned studies on the relationship between racial identity and functioning of Black participants suggest that racial identity may promote quality of life of survivors of CSA and act as a buffer against traumatic impact of their abuse.

Racial Identity and CSA

Although not directly tested on survivors of CSA, based on the results of the above studies it seems reasonable to predict that Black women survivors of CSA may rely on their “racial pride and strong ethnic identity” (Denby, 1996) to improve their quality of life despite the negative effects of their abuse. There are a few studies that provide some preliminary support for such a suggestion. For example, Dabney (2000) studied the impact of CSA and the recovery from it in a qualitative study using grounded theory with 16 Black women who were working, had an education beyond high school, and were not actively in treatment for mental health or substance abuse problems. She hypothesized that the responses and attitudes of the survivors toward healing would reflect adherence to their racial group values, such as affinity to extended family and community support system. The findings indicated that the initial coping strategies for these women consisted of overeating; workaholism; sexual addiction, alcohol, and drug
addiction; promiscuity; extreme religiosity; and overachieving. However, she found that despite these initial negative coping strategies, eventually the survivors improved their functioning by relying on some self-identified support being a person or faith; counseling including individual, group, and spiritual therapy; and what she called “womanist spirituality” of Black women, including Christian and non-Christian denominations. This finding implies that racial group affiliation may have a positive impact on overcoming traumatic outcome of CSA.

Similarly, Grossman et al. (1999) in their case study report on 10 female survivors, found that the two Black women in their sample grew up with particular strengths that were related to the family style of urban Black families. For example, these women learned that it was necessary and appropriate to take care of themselves; strategically hide their vulnerable feelings; socialize with other Blacks, particularly Black professionals; and promote an appropriate sense of their racial self and what the authors called “Afrocentricism.” Although the authors did not expand on what they meant by “Afrocentricism,” this concept appears to be similar to the Internalization Afrocentricism identity cluster in the Nigrescence model.

The significance of both these qualitative studies is in their demonstration of the importance of affinity with one’s racial group in empowering Black women survivors of CSA to heal from the negative impact of their abuse. Although not directly addressed in these studies, their findings may imply that, for Black women survivors of CSA, affiliation with their racial group and strong racial identity may create positive changes in life despite experiencing trauma. Clinical reports and therapeutic experiences seem to support this assumption. For example, Wyatt (1997) in her book *Stolen Women:*
*Reclaiming Our Sexuality, Taking back Our Lives*, used several clinical anecdotes and survey data to conclude that reassessing traditional beliefs while respecting fundamental racial values such as family life, taking responsibility, celebrating Black “womanhood” (p. 228), reaching out to others, spirituality and faith, as well as respecting one’s racial group and rights can help Black women to reclaim their sexuality and survive traumas such as CSA.

On a personal note, this researcher facilitated a therapy group for survivors of childhood abuse in Spring 2003 in a university counseling center. Interestingly, all final group members were Black female survivors of CSA. All these females reported a history of at least one other type of abuse, including emotional abuse, physical abuse, and/or adult re-victimization. The group members were strongly motivated to obtain racially relevant information about Black survivors of abuse in order to promote their healing. Because not many resources were available, exclusive of a few existing publications, the members primarily relied on each other’s experiences, strengths, and their path to recovery and resiliency. Throughout the group discussions, a few themes emerged as the sources of strengths for the members. Some of these themes were strikingly similar to the Hill’s (1972) description of six major characteristics of Black families, including adaptability of family roles, strong kinship bonds, strong achievement motivation, adaptability and flexibility, strong religious and spiritual orientation, and strong work orientation and ethic. Most importantly, the group members frequently reported a strong reliance on their racial identity as “Black women,” in healing from the traumatic impact of CSA.
Only one study has directly addressed the relationship between racial identity and CSA. This study is an unpublished dissertation by Bruce-Morritt (1997), which examined racial identity development among Black women survivors of child sexual abuse. The author stated that Black individuals with a history of CSA are not only exposed to traumatization by racism – similar to other Black people – but they are also victimized by trauma of CSA. Thus, she assumed that the inability to effectively negotiate these victimizations might impede the person’s development of her racial identity. Based on these assumptions, and as Cross (1991) suggested, Bruce-Morritt hypothesized that survivors of CSA would identify with higher levels of Pre-Encounter and Immersion-Emersion racial identity stages as measured by the RIAS-B. Bruce-Morritt further hypothesized a positive relationship between more traumatic CSA (i.e., longer duration, younger age of onset, more intrusive forms, closer relationship to perpetrator, higher number of perpetrators, and greater frequency of abuse) and Pre-Encounter and Immersion-Emersion stages of racial identity.

In order to test these hypotheses, Bruce-Morritt (1997) recruited Black females 18 years or older from community. The sample consisted of 27 women who reported a history of CSA and 44 women who did not report any history of CSA. There were no significant demographic differences between the two groups, except that the sexually abused group reported more history of physical abuse and were more likely to be unmarried. The findings indicated that the survivors of CSA did not demonstrate higher levels of Pre-Encounter or Immersion-Emersion attitudes than those without history of CSA. Furthermore, there was no relationship between more traumatic CSA and higher levels of Pre-Encounter attitudes or Immersion-Emersion. Thus, the author concluded
that, for Black female survivors of CSA, neither the experiences of CSA nor the severity of trauma was correlated with Black racial identity development (at least as measured by the RIAS-B). Overall, Bruce-Morritt’s (1997) study supported the notion that one cannot predict a Black person’s reference group orientation by knowing their history of CSA or by knowing the severity of their abuse experiences.

There were a few limitations to Bruce-Morritt’s (1997) study. One of the methodological problems of this study was the small sample size, especially the size of the sexually abused group. The small sample size decreases the statistical power and as the result the ability to predict the variability of racial identity among the group. Second, the study sample was not random, increasing the possibility of experiment-wise error. Third, Bruce-Morritt used the RIAS-B (Parham & Helms, 1981) to measure racial identity attitudes. The RIAS-B is based on the original model of Nigrescence and has been criticized for its poor psychometric properties (e.g., Yanico, Swanson, & Tokar, 1994; Tokar & Fischer, 1998). Finally, although Bruce-Morritt speculated that the evolvement of a healthy racial identity could act as a buffer for negative effects of CSA in Black females, she did not directly examine this hypothesis. Nevertheless, the author suggested that future researchers should examine the relationship between racial identity and psychological functioning with representative samples of Black women survivors of CSA by using measures that are psychometrically sound.
Summary

Briefly, the results of between group and within group comparison studies indicate that CSA in the Black community is a disapproved and troubling phenomenon. Although research indicates that the prevalence of CSA among the Black population is similar to the prevalence of CSA among the White population, certain characteristics of and circumstances around CSA may be different for these racial groups. The most noticeable finding in the current literature is that Black women survivors of CSA are at higher risk for experiencing more severe types of CSA. Also, Black women survivors tend to report more negative outcomes as a result of their abuse. These traumatic impacts can be categorized into four dynamics of sexualization, betrayal, stigmatization, and powerlessness, as described by the TDM (Finkelhore & Browne, 1985, 1986, 1988).

Even though it is important to investigate the negative impact of CSA among Black survivors of CSA, this line of research does not capture the overall quality of life of these survivors. Recent research has indicated that many survivors of abuse report adequate functioning, at least in some domains of their lives, in spite their abuse. The overall functioning of CSA survivors can be captured in the concept of QOL proposed by the WHOG (1994), which is a multidimensional construct. According to the WHOG, functioning, as perceived by the individual, occurs in various domains of life including physical health; psychological functioning; level of independence; social relationships; environment; and spirituality, religion, and personal beliefs.

Although exploring the QOL of Black women survivors of CSA can provide a more accurate picture regarding this population, it is still limited in providing an
empirical foundation for establishing preventive and intervention programs. Therefore, it is even more important to explore potential factor(s) that contribute to the QOL of the survivors in order to enhance the literature that has some therapeutic implications for Black survivors of CSA. Current data appear to suggest that racial identity, as conceptualized by the expanded Nigrescence model (Cross & Vandiver, 2000), is a potential factor that may enhance the QOL of CSA survivors. Based on the expanded Nigrescence model, racial identity development includes Pre-Encounter, Encounter, Immersion-Emersion, Internalization, and Internalization Commitment stages.

The limited research on CSA and racial identity has not shown any significant relationship between racial identity development and histories of CSA, suggesting that experiencing CSA does not thwart the development of racial identity among Black survivors of CSA. Even though current research may imply a positive relationship between a pro-Black racial identity and the QOL of Black women survivors of CSA, it has not directly investigated this relationship. If this assumption is empirically validated, it may provide guidance for designing programs for improving the QOL of Black women survivors of CSA by enhancing their pro-Black racial identity attitudes.
CHAPTER III.

METHOD

This chapter includes information about participants who were recruited for this study, the measures that were used, and the procedure used for recruiting the participants and gathering data, research hypotheses, and statistical procedures.

Participants

Participants were recruited via two strategies utilizing online and paper and pencil questionnaires. With a statistical power of .80, type I error of .05, effect size of .15, and six independent variables, 85 participants were required to test the hypotheses of this study. This calculation is based on \( N = L (1-R^2)/R^2 + \mu + 1 \) (Cohen 1977), in which \( L \) for the power of .80 is 13.62, \( R^2 \) is the effect size, and \( \mu \) is the number of independent variables. In order to insure anonymity of the participants and the confidentiality of their reports regarding childhood sexual abuse, the recruitment letters invited all Black women 18 years or above to participate in the study. Thus, the responses provided two groups of respondents, a group with a history of CSA and a group without history of CSA. The following criteria were used for inclusion of the respondents in the study (CSA) group:
(a) a report of at least one incidence of sexual abuse before age 18. A report of sexual encounter was defined as CSA only if there was physical contact between the abused and the abuser and at least one of the following conditions were present: (b) the abuser was 5 years or older than the abused or (b) the sexual encounter was unwanted or coercive.

Overall 1100 mail-in packages were distributed. Two hundred seven responses (138 mail-in and 69 online) were returned. All respondents identified themselves as Black female and 18 years or older. Eighty-nine participants (35 online and 54 mail-in) reported experiencing at least one incident of CSA. However, three of the responses (1 online and 2 mail-in) were eliminated from further analyses because they did not meet this study’s criteria for CSA. Another participant (online) omitted too many items to be included in the study; leaving the remaining 85 participants for analysis (33 online and 52 mail-in respondents). This sample size provides a statistical power of .80, type I error of .05, and effect size of .15 with six independent variables.

Demographic Characteristics

The demographic questionnaire in this study asked participants to identify themselves in ethnic subcategories. The data indicates 51.8% of participants identified themselves as “African American,” 24.7% identified themselves as “Black,” and the rest (23.5%) reported belonging to other subcategories including “West Indian/Caribbean Black,” “Mixed,” “Hispanic Black,” and “African.” The average age of the sample was 34.7 with a standard deviation of 12.2. The youngest participant was 18 and the oldest was 82. As Table 3.1 shows, the majority of participants were single (56.5%). Married
participants represented 21.2% of the CSA group. In terms of education, 22.4% of respondents were undergraduates and 24.7% were graduate students at the time of this study. In terms of obtained degree, 17.6% had a high school degree, 18.8% had a college degree and 29.4% had a graduate or professional degree (see table 3.2). Respondents who reported having a job were 72.9% of the sample, and the remaining 27.1% reported that they did not work. The majority of participants (69.41) were Christians, 9.4% were Muslims and the rest (21.2%) reported being either Unitarian, spiritual, or non-religious. Most participants (70.6%) reported that their religion was very important to them and 35.3% stated that they often practiced their religion. The family’s yearly income was less than $30,000 for 25% of participants and 75% of the participants’ family’s yearly income was $30,000 or more (see table 3.3). Most participants were raised in an urban (57.6%) or suburban (30.6%) community. Also most participants were raised in mostly Black (55.3%) or mixed (25.9%) communities. Only 2.4% of the participants were not U.S. citizens. The majority of participants (82.3%) reported that they belonged to at least one ethnic/racial organization. The educational level for mother or female caregiver of majority of the sample was high school (62.4%) or college degree (23.5%). These percentages for father or male caregiver were 59.8% and 20.7% respectively. As Table 3.4 shows, most participants reported that the socioeconomic status of their family of origin was working class (51.2%) or middle class (26.2%). Finally, the number of people living in the house where the participant grew up was 3 to 5 for the majority of the sample (62.4%).
CSA Characteristics

Among the 85 participants, 117 incidents of different types of CSA were reported. Overall, 24.7% of participants reported experiencing more than one type of sexual abuse. As Table 3.5 shows, the reported type of abuse was fondling (69.2%), vaginal sex (18%), oral sex (11.1%), and anal sex (1.7%). Overall, 111 perpetrators of CSA were reported, as 23.5% of participants reported being abused by more than one perpetrator. Table 3.6 indicates that in most cases the perpetrator of CSA was a relative (28.8%), a family friend (21.6%), an acquaintance (20.7%), or a stranger (10.8%). Parents, parental figures and siblings altogether accounted for 18.1% of perpetrators.

The most frequent age of first experience of CSA was age 4 (12.9%) followed by age 7 and 10 (each 10.6%). The youngest age of first CSA was reported to be age 2 and the oldest age was reported to be age 16. Most experiences of CSA ended at age 12 (12.9%) followed by age 11 (10.6%), age 14 (10.6%), and age 10 (9.4%). The latest age of continuation of CSA was age 35. The frequency of CSA was 2-4 times for 41.2% of participants (see Table 3.7). As Table 3.8 indicates, the length of abuse was less than one year for 59% of respondents. Overall, 65.4% of participants reported that someone at least 5 years older than them committed the unwanted sexual act while 34.1% reported that the perpetrator was less than 5 years older than them. The rate of disclosure of CSA was 53%. As Table 3.9 indicates, most of those who disclosed their experience of CSA told their mother (42.1%). Half of those who disclosed CSA told more than one person. Most participants who disclosed their CSA perceived the person very supportive (44.2%)
or somewhat supportive (23.3%); however, 11.6% reported that the person was very unsupportive.

Comparison between Internet and Mail-in Respondents

Comparison between Internet respondents \( (n = 33) \) and mail-in respondents \( (n = 52) \), tested by one-way ANOVA, indicated that the two groups were significantly different only on four demographic characteristics including importance of religion: \( F(2, 28) = 3.62, p < 0.05 \), racial community while growing up: \( F(2, 81) = 4.96, p < 0.01 \), mother’s/female caregiver’s education: \( F(1, 83) = 3.89, p < 0.05 \), and number of organizational affiliation: \( F(1, 74) = 6.06, p < 0.05 \). Tukey post-hoc analyses further revealed the following significant differences between the Internet respondents and the mail-in respondents. The Internet respondents reported that their religion was more “very important,” to them; they were raised in “mostly Black” or “mixed” communities; their mothers had lower level of education; and they belonged to fewer ethnic/racial organizations.

The \( t \)-test for independent samples indicated that the only difference between Internet respondents \( (n = 33) \) and mail-in respondents \( (n = 52) \) on QOL and its subscales was that the Internet respondents were lower on the Social Relationships domain: \( t(83) = -2.088, p < 0.01 \). The \( t \)-test for independent samples indicated that the only difference between Internet respondents \( (n = 33) \) and mail-in respondents \( (n = 52) \) on CRIS subscales was that the Internet respondents were higher on Multicultural Inclusive subscale: \( t(83) = 2.778, p < 0.01 \).
Measures

Demographic Questionnaire

The demographic questionnaire was used for screening respondents for inclusion in the study (e.g., race, sex, and a history of CSA) as well as obtaining information on characteristics of CSA (e.g., age of the victim at the time of abuse, the relationship between the perpetrator and the victim, severity, length and frequency of abuse, family reaction to abuse) and demographic background (e.g., age, education, household income, family structure, support systems, religious affiliation, and community structure) (see Appendix A.).

Quality of Life

World Health Organization Quality of Life Instrument, Geneva and U.S. brief version (WHOQOL-BREF; Bonomi & Patrick, 1997) was used to measure quality of life (see Appendix B.). WHOQOL-BREF is a subset of 26 items taken from the original 100-item World Health Organization Quality of Life Instrument, Geneva and U.S. version (WHOQOL-100; WHOG, 1994; Bonomi & Patrick, 1997). In the initial phases of the project of developing an instrument for measuring QOL, WHO focus groups used a comprehensive list of more than 1800 items. The items were reduced to a 236-item pilot version, including questions about QOL and 41 items assessing the importance aspects of quality of life. This 236-item instrument underwent pilot studies in 15 countries and
resulted in a 100-item version, the WHOQOL-100. The WHOQOL-100 contains 24 facets grouped into the six domains of physical, psychological, independence, social, environment, and spiritual (Bonomi & Patrick, 1997). According to Bonomi and Patrick, the WHOQOL-100 has undergone testing with diverse subgroups in the United States, including African-American patients in the eastern regions and rural patients in Georgia, and many other countries. These studies have provided support for the instrument’s psychometric properties. For example, the correlation between WHOQOL-100 and Subjective Quality of Life Profile (SQLP) and the Short-Form 36-item (SF-36) was moderate to high ($r > 0.45$) providing support for the convergent and discriminant validity of the WHOQOL-100. Overall, the alpha coefficient exceeds .80 for the WHOQOL-100 domains in three groups including healthy, childbearing, and chronically ill samples. Test-retest reliability of the domains are reported .83 or higher for all domains of the WHOQOL-100 in a sample of 64 healthy participants (Bonomi & Patrick, 1997).

The WHOQOL-BREF was developed because the WHOQOL-100 is inconveniently long (Carroll et al., 2000; Power, 2003). The new instrument consists of the most general question from each of the 24 original facets of the WHOQOL-100. After needed substitutions of certain items and merging some domains, 26 items were chosen for inclusion in the final version of WHOQOL-BREF (WHOG, 1998). According to the instrument manual (Bonomi & Patrick), the WHOQOL-BREF produces a total score, four domain scores, and two individually scored items about an individual’s overall perception of quality of life and health. However, in the existing version of the WHOQOL-BREF and studies using this instrument, the two items reflecting overall
perception of QOL are not included in total score of QOL, its domains, or statistical analysis. The current study follows this lead. All items are scored on a five-point Likert-type scale ranging from “very satisfied” (5) to “not at all satisfied” (1). Three items of the WHOQOL-BREF are reversed before being scored. Then, the scores of the items on each domain are summed to obtain the raw scores. The possible raw scores range from 7 to 35 for Physical Health, 6 to 30 for Psychological domain, 3 to 15 for Social relationships, 8 to 40 for Environment, and 2 to 10 for the overall quality of life and general health items. These raw scores are transformed to scale scores, using a computer diskette in the manual packet. The scaled scores in each domain range from 5 to 20. Higher scores indicate a higher QOL (Bonomi & Patrick).

The WHOQOL-BREF’s facets for each domain are as follows: a) Physical capacity consists of activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, pain and discomfort, mobility, sleep and rest, and work capacity; b) Psychological domain consists of body image and appearance; negative feelings; positive feelings; self-esteem; spirituality/religion/personal beliefs; and thinking/learning/memory/concentration; c) Social relationships consists of Personal relationships, social support, and sexual activity; and d) Environment consists of financial resources, freedom, physical safety and security, health and social care (accessibility and quality), home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment (pollution/noise/traffic/climate), and transport.

Several studies have supported the psychometric properties of the WHOQOL-BREF. The most important study was conducted by the WHOG (1998). The authors used
data gathered of 4804 participants from the original pilot of the WHOQOL, 4104 participants from 15 original field centers, and 2360 participants from five new field centers. The data added up to 20 field centers from 18 different countries (Bangkok, Barcelona, Bath, Beer Sheva, Harare, Hong Kong, La Plata, Leipzig, Madras, Melbourne, Manheim, New Delhi, Panama City, Paris, Port Alegre, Seattle, St. Petersburg, Tilburg, Tokyo, and Zagreb). The participants included individuals with and without diseases and impairments. Overall, 50% of the participants were males and 50% were females. Almost half of the participants were under age 45 and were above age 45. This study provided strong support for reliability and validity of the WHOQOL-BREF. An overview of the findings of this study along with other relevant studies on the reliability and validity of WHOQOL-BREF will follow.

Reliability. WHOG (1998) reported that WHOQOL-BREF demonstrated good internal consistency in all domains for all three abovementioned subsamples (i.e., the original pilot sample, the original field centers, and the new field centers). Specifically, the internal consistency coefficients were .80 to .84 for Physical health, .75 to .77 for Psychological domain, .66 to .69 for Social relationships, and .80 for Environment in different subsamples. Also, Saxena, Carlson, Billington, and Orley (2001) reported internal consistency coefficients of the WHOQOL-BREF’s domains ranged from .87 to .94 for the data obtained from the original pilot sample (4804 participants). Amir and Lev-Wiesel (2003) compared 43 child Holocaust survivors and 44 persons in a comparison group who had been exposed to at least one traumatic event in their lives using the WHOQOL-BREF. They reported Cronbach’s alphas of .81 for Physical health,
.76 for Psychological, .79 for Social relationships, and .82 for Environment for the total sample. Utsey et al. (2002) also reported good internal consistency for the WHOQOL-BREF in diverse populations consisted of African American, Asian American and Latino participants. In their study of 160 community participants (44% Black, 28% Asian American, and 28% Latino), Utsey et al. reported Cronbach’s alpha of .91 for the overall score on WHOQOL-BREF, .63 for Physical Health, .79 for Psychological, .83 for Social relationships, and .85 for Environment for their total sample. It is notable that Cronbach’s alpha for Physical Health was relatively low for all participants in Utsey et al.’s study. Cronbach’s alphas of the subscales for the Black participants were .48, .68, .81, and .87 respectively, indicating relatively lower internal consistencies for Physical Health and Psychological domains for this subsample.

WHOQOL (1998) assessed test-retest reliability of WHOQOL-BREF on a subsample of 87% well and 13% ill participants from four field centers. They reported that the test-retest reliabilities for items on WHOQOL-BREF ranged from .56 to .84 in a 2-8 week interval. Test-retest reliabilities for domains were .66 for Physical health, .72 for Psychological, .76 for Social relationships, and .87 for Environment. Carroll et al. (2000) also reported that the scores on all domains of the WHOQOL-BREF remained relatively stable over three months following no intervention for the control sample (i.e., the $t$-tests on the domain scores were not significant ranging from $t = 0.25$ for Environment to $t = 1.66$ for Physical health).

Validity. WHOQOL (1998) reported that confirmatory factor analysis supported the construct validity of WHOQOL-BREF. This analysis confirmed that a four-factor
solution was most appropriate for WHOQOL-BREF with a Comparative Fit Index of .901. This finding suggested the need to include all four domains when evaluating overall quality of life. Furthermore, multiple regression analysis determined that WHOQOL-BREF domain scores made a significant contribution to explaining the variance observed in the general facet relating to overall quality of life and general health, with the physical health domain contributing the highest, and the social relationships domain making the least contribution (WHOG).

WHOG (1998) reported that the WHOQOL-BREF is an adequate alternative to WHOQOL-100. Because the validity of the WHOQOL-100 has been well established (for details see Bonomi & Patrick, 1997; WHOG, 1994), high correlations between the WHOQOL-100 and the WHOQOL-BREF total and domain scores have provided support for criterion validity of the WHOQOL-BREF (WHOG, 1998). For example, WHOG (1998) reported that the correlation between WHOQOL-BREF and WHOQOL-100 domain scores ranged from .89 (for Social Relationships domain) to .95 (for Physical Health domain). Carroll et al. (2000) conducted a study on 50 liver transplant patients before and 3 months following liver transplantation and 21 patients with liver disease without transplantation. The transplant patients consisted of 19 males and 31 females with mean age of 49.6 years. The liver controls consisted of 7 males and 14 females with mean age of 53.9 years. Their results showed high correlations between WHOQOL-100 and WHOQOL-BREF domains (from .82 to .92).

The WHOQOL-BREF has also shown good discriminant validity. WHOG (1998) reported that the WHOQOL-BREF was able to discriminate between ill and well respondents in all domains for the three subsamples in their study (i.e., the original pilot
sample, the original field centers, and the new field centers). The $t$-tests comparing the scores of ill and well participants were significant for all domains ranging from $t = 36.4$ for physical health and $t = 2.8$ for Environment. Carroll et al. (2000) confirmed these results for liver transplant and control patients. They found that the WHOQOL-BREF was able to predict improvement in the liver transplantation sample, as indicated by significant $t$-tests ranging from $t = 6.51$ for Psychical health and $t = 5.21$ for Environment. In sum, it appears that the WHOQOL-BREF is a robust and culturally appropriate measure of QOL (Power, 2003; Saxena et al., 2001; Utsey et al., 2002).

**Racial Identity**

The Cross Racial Identity Scale (CRIS; Vandiver et al., 2000) was used to measure racial identity clusters in this study (see Appendix C.). The authors discussed and wrote items based on the identity cluster constructs of the Cross’s (1991) revised Nigrescence model (Vandiver et al., 2001). From the original 250-item pool, 126 items were used to develop the CRIS. Twenty external judges knowledgeable about the revised Nigrescence theory evaluated the contents of these 126 items and rated them. The judges were advanced graduate students, staff psychologists, and university faculty in multicultural psychology (Vandiver et al., 2001). The developers of the CRIS have conducted six studies using five independent samples of college students and community participants (see Cross & Vandiver, 2001; Vandiver et al., 2001; Vandiver et al., 2002; Worrell, Vandiver, & Cross, 2000; Worrell, Vandiver, Cross, & Khagen-Smith, 2004). Vandiver et al. (2001) described the process of item development of the CRIS. Initially,
six identity clusters described by Cross (1991) were used for item development: Assimilation and Anti-Black clusters from Pre-Encounter stage, Intense Black Involvement and Anti-White clusters from Encounter stage, and Black Nationalist and Multiculturalist clusters from Internalization. The authors decided not to include Emersion phase of the Immersion-Emersion stage because this stage does not assume to represent a specific identity cluster. They used Internalization Afrocentricity cluster as a form of Intensive Black Involvement. Also, the authors did not measure the Internalization Biculturalist identity cluster because they assumed that the Internalization Bicultural identity was nested in Internalization Multiculturalist identity cluster. They proposed those who had a Multiculturalist identity would similarly rate the items measuring Biculturalist identity. In addition, the combination of the Internalization stages resulted in the development of Internalization items that captured both the essence of Internalization stage and the activism component of Internalization-Commitment stage (Vandiver et al., 2001).

According to Worrell et al. (2004) the final version of the CRIS contains 40 items, 30 of which measure six of the nine Nigrescence attitudes/clusters proposed in the expanded Nigrescence model with some modifications and renaming. The rest of the items are fillers. The current subscales of the CRIS are called Pre-encounter Assimilation (PA), Pre-encounter Miseducation (PM), Pre-encounter Self-Hatred (PSH), Immersion-Emersion Anti-White (IEAW), Internalization Afrocentricity (IA), and Internalization Multiculturalist Inclusive (IMCI).

Each of the six identity clusters on the CRIS is measured by five items, which are randomly distributed among the other 10 filler items. The items are rated on a 7-point
Likert rating scale ranging from “strongly agree” (7) to “strongly disagree” (1).

According to Worrell et al. (2000) there are two ways to calculate subscale scores. One way, used in the current study, is to sum the scores on the five items in each subscale and obtain subscale scores ranging from 5 to 35. Another way is to divide the sum of the five item scores by five and obtain subscale scores ranging from 1 to 5. The lower scores on a subscale indicate lower racial attitude on that subscales. Based on current research only the scores of subscales can be used; i.e., the scores of subscales cannot be collapsed (Vandiver et al., 2002; Worrell et al. 2000). However, two higher order identity clusters can be measured. These two overarching clusters are Pre-Discovery and Discovery. Pre-Discovery represents a Non-Black reference group orientation and consists of the PA, PM, and PHS subscales. Discovery characterizes a Pro-Black reference group orientation and consists of the IEAW, IA and IMCI (Vandiver et al., 2001). Below, the results of empirical studies on the reliability and validity of the CRIS are reviewed.

**Reliability.** Worrell et al. (2004) conducted a study on the final version of CRIS with 105 adults (71% female) from diverse Black subracial groups. The participants’ ages ranged from 22 to 60 years with a mean age of 34 years. The participants were undergraduate and graduate students (overall 55.2% of participants) or not attending school (44.8%). Among the students, 20% were attending historically Black institutions and 80% were attending historically White institutions. The authors reported that Cronbach’s alphas for the six subscales of the final version of CRIS were .83 for PA, .77 for PM, .70 for PSH, .83 for IEAW, .85 for IA, and .77 for IMCI. Helm (2002) recruited 388 Black college students and employed professionals (12%) from a southern
historically Black institution and two midwestern predominantly White institutions. She reported similar internal consistencies with Cronbach’s alphas of .85 for PA, .82 for PM, .75 for PSH, .85 for IEAW, .80 for IA, and .74 for MICI. Worrell et al. (2004) reported that the construct reliability estimates of the CRIS for the six subscales ranged from .69 to .89. The IMCI reliability estimate was less than .80. Worrell et al. (2000) in the technical manual of the CRIS reported that Cronbach’s alphas were .85 for PA, .78 for PA, .89 for PSH, .89 for IEAW, .83 for IA, and .82 for IMCI. They also reported that structure coefficient reliability estimates from the confirmatory factor analysis of the CRIS’s subscales were .85, .79, .89, .90, .83, and .82 respectively. No test-retest reliability information on the CRIS was found. Although Vandiver et al. (2001) concluded that the IMCI and other subscales of the CRIS are reliable; they cautioned that the IMCI subscale needed further empirical investigation.

Validity. Vandiver et al. (2001) used a four-phase study on three independent samples to develop the CRIS and evaluate its psychometric properties. Although after each study the authors modified and changed the items of the original scale, these studies have provided support for the psychometric properties of the final version of the CRIS. Thus, a review of these studies will follow. The independent samples in Vandiver et al. studies consisted of 119, 142, and 149 Black college students from three predominately White universities (two samples from the same mid-Atlantic universities and one sample from a university in New England). The Mean age of the participants was 21 years. The majority of the participants in all samples were females and undergraduate students. In the final phase of these studies, and after necessary modification of the CRIS items, the
subscale intercorrelations ranged from -.51 to .80 with 7 of 29 intercorrelations above + .30 or below -.30. Although the CRIS in the fourth phase of the study had eight subscales and 64 items, the exploratory and confirmatory factor analyses supported a six-factor solution. Thus, further modified was needed to create the final version of the CRIS.

Vandiver et al. (2002) conducted two more studies on the factor structure of the CRIS. In the first study 296 Black college students (76 males, 212 females, and 8 unspecified) from a mid-Atlantic predominantly White university were recruited. Participants were 90% undergraduate and 9% graduate students ranging from 17 to 43 years old with a mean age of 21. Exploratory factor analysis in this study verified a six-factor solution. Each factor was named after a subscale. The authors modified the instrument based on these findings. Then, in a second study, they recruited 336 (119 males, 212 females, and 5 unspecified) Black undergraduate (93%) and graduate (6%) students from a predominantly White university located in the Northeast. They used 309 responses. The ages of the participants ranged from 17 to 59 years with a mean age of 21. The findings supported a two higher order factor structure for the CRIS. The authors reported that the correlations between Pre-Discovery and PA, PM, and PSH clusters were .56, .51, and .33 respectively. The correlations between Pre-Discovery and IA, IEAW and IMCI were .76, .63, and .42 respectively. Thus, they encouraged the future researchers to see if they find a similar structure in their data (Vandiver et al.). Furthermore, confirmatory factor analyses on this modified version again provided strong support for a six-factor structure with a Comparative Fit Index above .90. The intercorrelations of the six-factor model on this new version ranged from ±.06 to ±.46. Although these intercorrelations showed a significant decrease compared to the oldest version of CRIS
(Vandiver et al., 2001), they still indicated that IEAW shared 21% of the variance with IA and 16% variance with IMCI. Thus, this version of the CRIS was further modified to reduce subscale intercorrelations and more studies were conducted to support the factor structure of the final version.

Worrell et al. (2004) in their study on the final version of CRIS reported that the factor intercorrelations of subscales were all less than ±0.30 supporting the six-factor model. Although the PSH factor was the last factor that emerged, the authors preferred a six-factor to a five-factor solution. They argued that the PSH should be included in the model because it has been a robust factor in other studies using different samples and that it corresponds with Nigrescence theory. They suggested that a possible reason for low coefficients for items that loaded on the PHS was the low endorsement of these items by their sample. They explained that the participants in their study were less likely to have self-hating attitudes, because they were relatively older in age. Helm (2002) also supported a six-factor structure for the final version of the CRIS. In her study, principle component analysis showed that the six components accounted for 57% of the total variance in the CRIS items. All correlations were less than ±0.30. The first component (IEAW) accounted for 17% of the variance and the last component (IMCI) accounted for 5% of the variance. All items loaded on their assigned subscale.

Vandiver et al. (2002), in their second study (see above for details about the study), and Helm (2002) provided support for the convergent validity of the CRIS. Vandiver et al. reported that the convergent validity of the CRIS was supported by high correlations among five subscales of CRIS and seven subscales of the Multidimensional Inventory of Black Identity (MIBI; Sellers, Smith, Shelton, Rowley, & Chavous, 1998).
Specifically, the PA scores were positively correlated with the Humanist scores (.33) and negatively correlated with Centrality and Nationalist scores (-.40 and -.31 respectively) on the MIBI. Also, IEAW and IA scores had positive correlations with the Nationalist scores (.54 and .59 respectively), and IMCI had positive correlations with Humanist and Oppressed Minority subscales (.32 and .30 respectively) on the MIBI. Only the Pre-Encounter Miseducation scale did not show sufficient convergent validity with MIBI. Similarly, Helm (2002), in her unpublished dissertation, compared the CRIS and the MIBI and reported positive relationships between PE and Assimilation, PM and Assimilation, IA and Nationalist, IMIC and Humanist, PA and Humanist, IEAW and Centrality, IEAW and Nationalist, IMIC and Oppressed Minority, and a negative relationship between IA and Humanist. Helm did not find any relationship between PSH and Assimilation, PSH and Nationalist, PM and Nationalist, or IA and Oppressed Minority. She concluded that while the CRIS and the MIBI overlap in some measures, they are two distinct measures. Furthermore, she found that the CRIS subscales predicted 11.3% of the variance in acculturation as measured by the African American Acculturation Scale-33 (AAAS-33; Landrine & Clonoff, 1994, 1995) over and above the variance accounted for by the demographic variables. T-tests for individual regression coefficients showed that all the CRIS subscales were predictive of acculturation except for the IMCI. Specifically, PA and PSH were negative predictors, whereas PM, IEAW, and IA were positive predictors. Helm concluded that the CRIS was psychometrically stronger than the MIBI. However, she expressed some concerns about IA and IMCI items in her study. She noted that the wording of these two subscales (e.g., Afrocentricism and
Multiculturalist) either should be re-examined or they need to be defined in the measure, because of the possibility of creating confusion for respondents.

Vandiver et al. (2002) also provided support for the discriminant validity of the CRIS by finding low relationships between most CRIS subscales and the Big Five Inventory (BFI; John, Donhue, & Kentle, 1991), the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) and the Balanced Inventory for Desirable Responding (BIDR; Paulhus, 1984, 1991) subscales. None of the CRIS subscales had high correlations with subscales of the BIDR, except for the IMCI’s significant correlation with the impression management scale of the BIDR and the PSH’s significant correlation with self-deceptive enhancement scale of the BIDR. Also, none of the correlations between the CRIS and the BFI subscales were significant, except for a positive correlation between PSH and the Neuroticism scale on the BFI (.17). In addition, among all the CRIS’s subscales, only PSH had a significant negative correlation with the RSES (-.34). Vandiver et al. (2001) also reported a high negative correlation between the RSES and BSH on the unrefined version of the CRIS. In that study PSH accounted for about 4% of the variance in RSES.

In sum, all six subscales of the final version of the CRIS have demonstrated sufficient content, convergent, discriminant, and structural validity, as well as good internal consistency for application in research (Worrell et al., 2001). However, Vandiver et al. (2001) pointed out that future research need to further investigate psychometric properties of Pro-Black subscales and their relationships. More research on psychometric properties of CRIS is being conducted. In a personal communication, B. J. Vandiver (personal communication, February 20, 2004) reported that she and her colleagues had
gathered data from over 1000 participants in various studies using CRIS to further evaluate the psychometric properties of the instrument.

Procedure

The sample in this study was recruited in two ways. One method was through distributing packages containing this study’s materials (the recruitment letter; the informed consent; the demographic questionnaire; the WHOQOL-BREF; the CRIS; and a debriefing page containing referral resources with telephone numbers, e-mails, and website addresses, as well as the researcher’s and the advisor’s contact information) to Black women starting mid January 2005 ending mid January 2006. The recruiting strategies for mail-in participants involved distributing packages at conferences, cultural events, Black museums, art exhibitions, beauty salons, Black sororities and residence halls; soliciting participants in high traffic streets in major cities in the east, northeast and southeast regions of the country; and canvassing Black neighborhoods in several cities in the east and northeast regions of the country. Overall 1100 packages were distributed. Participants were informed that returning their responses also would indicate their consent to participate in the study. Respondents were asked to return the completed measures of this study (the demographic questionnaire, the WHOQOL-BREF, and the CRIS) without any identifiable personal information to the researcher in a pre-stamped envelop. Also, respondents were given the option of receiving a summary of the results of the study by contacting the researcher. Participants were asked not to return their
responses more than one time. Once received, the responses were entered into SPSS, a statistical analysis software program for further analysis.

Another method of recruiting participants of this study was online data gathering. This strategy included sending mass e-mails to list-serves serving members of various Black student organizations and Black sororities, a website for Historically Black Colleges and Institutions, several professional Black women organizations, and various organizations serving Black professionals and businesses and Black women and families; posting flyers at conferences, predominately White colleges and universities, Black sororities, residence halls, historically Black colleges and universities, and social events; and personal contacts using a snowball sampling technique. List-serves were found through Internet search engines and personal contacts. The e-mail contained an active website URL address/link available from mid January 2005 to mid January 2006. The participants could directly connect to the survey’s announcement page by clicking on this link or typing the address in their address bar. Participants were asked not to submit their responses more than one time.

After reading the informed consent page, if they agreed to participate in the study, the respondents were asked to click on a “Submit” button that would take them to the secured page containing this study’s measures. Once connected to this page, participants would fill out the Demographic Questionnaire, the WHOQOL-BREF, and the CRIS. Once finished, participants were asked to submit the completed measures by clicking on a “Submit” button. The participants again were informed that submitting their responses would indicate their consent to participate in the study. After the responses were submitted, a debriefing page appeared that contained referral sources (with active URL
links, e-mails, and telephone numbers), as well as the researcher’s and the advisor’s contact information. Also, respondents were given the option of receiving a summary of the results of the study by returning to the link after completion of the study. The data on the measures were automatically imported into SPSS without any identifiable information. At the end of data collection, all study materials were removed from the web site address and was replaced with a message thanking individuals for their interest in the study, stating that the project was ended, and that a summary of the results would be posted on the website after completion of the study.

Research Design

This study used an ex post facto design guided by theoretical and empirical data and specific research hypotheses. The most important reason for choosing an ex post facto design for this study is that it is unethical to manipulate experiences of CSA. Although the findings of an ex post facto study cannot be used to infer causation (Newman & Newman, 1994), the variables of this study were carefully selected from a large set of variables based on current literature, and thus the results may guide future research as well as preventive and intervention programs.
Derivation of Hypotheses

Current research has indicated that Black women are at a higher risk of experiencing severe types of CSA (e.g., Feiring et al., 2001; Kenny & McEachern, 2000; Russell et al., 1988; West, 2002b; Wyatt, 1990b; Wyatt et al., 1992; Wyatt et al., 1999; Wyatt & Mickey, 1988). The severity of CSA often results in severe traumatic outcomes for Black women adult survivors (e.g., Russell et al.; Wyatt, 1990b). On the other hand, despite the severity of trauma and its negative outcomes, research has shown that up to two third of Black survivors of CSA maintain their functionality in many domains of their life (e.g., Banyard et al., 2002; Dabney, 2000; Grossman et al., 1999; Hyman & Williams, 2001; Wyatt et al., 1999). Therefore, it is critical to explore factors that promote the quality of life of Black women survivors of CSA despite their abuse and the traumatic impact of their abuse. Several scholars, as well as some empirical data on Black people, have suggested that positive views of one’s reference group can contribute to quality of life and functioning, despite life adversities (e.g., Franklin, 2002; Humphreys, 2003; Johnson, 2002; Laursen & Williams, 2002; Neville & Lilly, 2000; White, 1984; White & Parham, 1990; Wong et al, 2003). However, the relationship between racial identity and quality of life of Black survivors of CSA has not been directly investigated. Thus, the current study investigated the relationship between racial identity and overall quality of life among Black women survivors of childhood sexual abuse. Specifically, this study predicted that Black survivors of CSA with Pro-Black racial identity would report higher quality of life, whereas survivors with Non-Black racial identity would report lower quality of life.
The current literature implies that PE identity clusters, including PSH, PA, and PM will be negatively related to the quality of life, whereas Internalization identity clusters, including IMCI and IA will be positively related to the quality of life (Franklin, 2002; Neville & Lilly, 2000; Laursen & Williams, 2002; Utsey et al., 2002; Vandiver et al., 2002; Wong et al., 2003). The results of current research on relationship between the IEAW and quality of life are inconclusive. For example, Cross (1991, 1995) proposed that individuals in the IE stage may report more psychological distress as a result of experiencing intense emotions during conversion from a Non-Black group orientation to a Pro-Black group orientation. Some empirical studies have provided support for this proposal using the RIAS-B (e.g., Carter, 1991; Parham & Helms, 1985). However, other studies did not find such relationship (e.g., Bruce-Morritt, 1997; Franklin, 2002). For example, Franklin did not find any significant relationships between IE attitudes, as measured by the RIAS-B, and psychological distress or psychological well-being, although the individuals in IE stage reported experiencing significant levels of racism-related distress. Given that the RIAS-B is based on the 1971 version of Nigrescence theory and has been criticized for its psychometric properties (e.g., Tokar & Fischer, 1998; Yanico et al., 1994), and given that in the new measure of Nigrescence theory, the IEAW items loaded on pro-Black reference group orientation, it is reasonable to assume that the IEAW contributes positively to QOL. Therefore, the following general and specific hypotheses were proposed.
General Research Hypothesis

1. There is a positive relationship between overall quality of life and Pro-Black reference group orientation (Discovery attitudes).

2. There is a negative relationship between overall quality of life and Non-Black reference group orientation (Pre-Discovery attitudes).

In this study, participants’ racial identity and its identity clusters were independent variables whereas their overall quality of life was the dependent variable. Based on the general research hypotheses and previous data on the relationship between racial identity and functioning, adjustment, psychological distress, and psychological well-being, the following specific research hypotheses were proposed.

Specific Research Hypotheses

1. There is a positive relationship between overall QOL, as measured by the WHOQOL-BREF, and the IMCI subscale of the CRIS.

2. There is a positive relationship between overall QOL and the IA subscale of the CRIS over and above the IMCI.

3. There is a positive relationship between overall QOL and the IEAW subscale of the CRIS over and above the IA and the IMCI.

4. There is a negative relationship between overall QOL and the PSH subscale of the CRIS.
5. There is a negative relationship between overall QOL and the PM subscale of the CRIS over and above the PSH.

6. There is a negative relationship between overall QOL and the PA subscale of CRIS over and above the PSH and the PM.

Statistical Procedures

Correlation analyses and linear and hierarchical regressions (McNeil, Newman, & Kelly, 1996) were used to address the hypotheses. The hypotheses were directional; therefore, the analyses are one-tailed. The alpha levels were set at $p = .05$. The power of statistical analysis was .80. The subscales for each construct were entered hierarchically. The first hypothesis predicted that QOL is positively related to Pro-Black racial identity (Discovery). The scores of Discovery identity clusters (i.e., IMCI, IA and IEAW) were the predictor variables, whereas the total score of QOL, measured by summing the scaled scores of four domains of the WHOQOL-BREF divided by four, served as the criterion variable. In the first step of the analysis, the variance in the total score of QOL accounted by the IMCI was calculated. Then, the IA was added to calculate the amount of variance accounted for by this construct over and above the IMCI. Finally, the IEAW was entered to find out the amount of variance added by this construct over and above the MICI and the IA together.

The second hypothesis proposed that there is a negative relationship between QOL and Non-Black racial identity (Pre-Discovery). In this analysis the Pre-Discovery identity clusters (i.e., PSH, PA and PM) were predictor variables, whereas the total QOL served as the criterion variable. In the first step of this analysis, the variance in QOL
accounted for by the PSH was calculated. Then, the PM was added to calculate the
amount of variance accounted for by this construct over and above the PSH. Finally, the
PA was entered to explore the amount of variance added by this construct over and
beyond PSH and PA together. $F$ tests were used to determine the percentage of variance
accounted for in the total score of QOL by each racial identity cluster. This procedure
allowed the researcher to better understand the relative contribution of each identity
cluster to the overall QOL of the participants.
CHAPTER IV.

RESULTS OF THE STUDY

This chapter reviews statistics for the WHOQOL-BREF and the CRIS in this study and the results of the statistical analyses for research hypotheses.

WHOQOL-BREF Statistics

The scaled scores for the WHOQOL-BREF and its domains range from 0 to 100. For this study, the mean of scaled score and standard deviations for each domain of QOL were as follow: for Physical Health $M = 71.39$ and $SD = 15.04$ (with a minimum score of $28.57$ and a maximum score of $100$), for Psychological domain $M = 67.94$ and $SD = 15.27$ (with a minimum score of $12.50$ and a maximum score of $100$), for Social Relationships $M = 60.59$ and $SD = 22.58$ (with a minimum score of $0$ and a maximum score of $100$), and for Environment $M = 68.75$ and $SD = 15.93$ (with a minimum score of $28.13$ and a maximum score of $96.88$). For total QOL scaled score, which was calculated by summing the four domains and dividing the sum by 4, $M = 66.55$ and $SD = 13.96$ (with a minimum score of $29.65$ and a maximum score of $95.87$). As Table 4.1 indicates
there are significant positive correlations among all domains of the WHOQOL-BREF and the overall QOL score.

Reliability

Internal consistencies for QOL and its domains as measured by Cronbach’s coefficient alpha for the study group were as follow: all QOL items = 0.90, Physical Health = 0.72, Psychological = 0.77, Social Relationships = 0.56, and Environment = 0.77. It appears that internal consistency of SR was relatively low for the sample in this study.

CRIS Statistics

The scaled scores for subscales of the CRIS range from 5 to 35. For this study, the mean of scaled scores and standard deviations for each subscale of CRIS were as follows: for Assimilation, M = 13.06 and SD = 7.16 (with a minimum score of 5 and a maximum score of 33); for Miseducation, M = 15.82 and SD = 6.94 (with a minimum score of 5 and a maximum score of 34); for Self-Hatred, M = 10.53 and SD = 7.19 (with a minimum score of 5 and a maximum score of 35); for Anti-White, M = 9.14 and SD = 5.40 (with a minimum score of 5 and a maximum score of 26); for Afrocentricism, M = 18.94 and SD = 7.32 (with a minimum score of 5 and a maximum score of 35); and for Multicultural Inclusive, M = 28.68 and SD = 4.79 (with a minimum score of 17 and a maximum score of 35). For Non-Black reference group orientation, which is the sum of Assimilation,
Miseducation and Self-Hatred subscales, $M = 39.41$ and $SD = 14.22$ (with a minimum score of 15 and a maximum score of 82) and for Pro-Black reference group orientation, which is the sum of Anti-White, Afrocentricism, and Multicultural Inclusive subscales, $M = 56.76$ and $SD = 11.05$ (with a minimum score of 35 and a maximum score of 87). As Table 4.2 shows, there are significant positive correlations between Assimilation and Non-Black reference group orientation ($r = 0.598$, $p < 0.01$), Miseducation and Self-Hatred ($r = 0.311$, $p < 0.01$), Miseducation and Non-Black reference group orientation ($0.729$, $p < 0.01$), Self-Hatred and Non-Black reference group orientation ($r = 0.675$, $p < 0.01$), Anti-White and Afrocentricism ($r = 0.551$, $p < 0.01$), Anti-White and Pro-Black reference group orientation ($r = 0.705$, $p < 0.01$), and Afrocentricism and Pro-Black reference group orientation ($r = 0.874$, $p < 0.01$). Also, as this table shows, there are negative correlations between Assimilation and Anti-White ($r = -0.325$, $p < 0.01$), Assimilation and Afrocentricism ($r = -0.508$, $p < 0.01$), Assimilation and Pro-Black reference group orientation ($r = -0.451$, $p < 0.01$), Anti-White and Multicultural Inclusive ($r = 0.343$, $p < 0.01$), and Afrocentricism and Non-Black reference group orientation ($r = -0.246$, $p < 0.05$).

Reliability

Internal consistencies for CRIS subscales as measured by Cronbach’s coefficient alpha for the study group were as follow: $PA = 0.84$, $PM = 0.84$, $PSH = 0.88$, $IEAW = 0.89$, $IA = 0.87$, and $IMCI = 0.68$. 
Correlation between the WHOQOL-BREF and the CRIS

Table 4.3 provides a correlation matrix of QOL and its domains and subscales of CRIS. As this table indicates, there are negative correlations between Self-Hatred and overall QOL and three of its domains (for Physical Health $r = -0.230$, $p < 0.05$; for Psychological $r = -0.352$, $p < 0.01$; for Environment $r = -0.250$, $p < 0.05$; and for total QOL $r = -0.305$, $p < 0.01$). Furthermore, Non-Black reference group orientation had significant negative correlations with Psychological domain ($r = -0.281$, $p < 0.01$), Environment domain ($r = -0.243$, $p < 0.01$), and overall QOL ($r = -0.169$, $p < 0.05$). However, there was no significant relationship between overall QOL and Pro-Black reference group orientation ($r = -0.035$). Furthermore, there were no significant correlations between Pro-Black reference group orientation and any domain of QOL.

Statistical Analyses

*General Research Hypothesis*

1. The first general hypothesis predicted that there would be a positive relationship between overall quality of life and Pro-Black reference group orientation. This hypothesis was not supported. As mentioned in previous section, there was no significant relationship between overall QOL and Pro-Black reference group orientation ($r = -0.035$).
2. The second general hypothesis predicted that there would be a negative relationship between overall quality of life and Non-Black reference group orientation. The result supported this hypothesis \((r = -0.169, p < 0.05)\).

**Specific Research Hypotheses**

1. The first specific hypothesis predicted that there would be a positive relationship between the overall QOL and the IMCI subscale of the CRIS. Correlation analysis was used to test this hypothesis. Total QOL was entered as the dependent variable and the IMCI score was entered as the independent variable. The results did not support this hypothesis: \(r = 0.058, p = 0.298\).

2. The second specific hypothesis predicted that there would be a positive relationship between the overall QOL and the IA subscale of the CRIS over and above the IMCI. Hierarchical regression analysis was used to test this hypothesis. Total QOL was entered as the dependent variable. For independent variables, the IMCI was entered in the first block and the IA was entered in the second block. As Table 4.4 indicates, the results did not support this hypothesis: \(R^2 = 0.003, F(1, 82) = 0.005, p = 0.943\).

3. The third specific hypothesis predicted that there would be positive relationship between the overall QOL and the IEAW subscale of the CRIS over and above the IA and the IMCI. Hierarchical regression analysis was used to test this hypothesis. Total QOL was entered as the dependent variable. For independent variables, the IA and the IMCI were entered in the first block.
and the IEAW was entered in the second block. As Table 4.5 indicates, the results did not support this hypothesis: $R^2 = 0.022, F(1, 81) = 1.531, p = 0.220$.

4. The fourth specific hypothesis predicted that there would be a negative relationship between the overall QOL and the PSH subscale of the CRIS. Correlation analysis was used to test this hypothesis. Total QOL was entered as dependent variable and the PSH was entered as the independent variable. The results supported the hypothesis: $r = 0.305, p < 0.01$.

5. The fifth specific hypothesis predicted that there would be a negative relationship between the overall QOL and the PM subscale of the CRIS over and above the PSH. Hierarchical regression analysis was used to test this hypothesis. Total QOL was entered as the dependent variable. For independent variables, the PSH was entered in the first block and the PM was entered in the second block. As Table 4.6 shows, the results did not support this hypothesis: $R^2 = 0.093, F(1, 82) = 0.001, p = 0.982$.

6. The sixth specific hypothesis predicted that there would be a negative relationship between the overall QOL and the PA subscale of CRIS over and above the PSH and the PM. Hierarchical regression analysis was used to test this hypothesis. Total QOL was entered as the dependent variable. For independent variables, the PSH and PM were entered in the first block and the PA was entered in the second block. As Table 4.7 shows, this hypothesis was not supported: $R^2 = 0.094, F(1, 81) = 0.081, p = 0.776$. 

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Summary

There was no significant correlation between Pro-Black reference group orientation and overall QOL or any of its domains. None of the subscales of Pro-Black reference group orientation contributed to significant amount of variance in overall QOL. Non-Black reference group orientation had negative correlations with P and E domains of QOL. The hierarchical regression analyses showed that PSH contributed to significant amount of variance (9%) in overall QOL. Neither PA nor PM added significant amount of variance to overall QOL above and beyond PSH. Table 4.8 provides a summary of research hypotheses results.
This chapter is divided into three sections. The first section includes summaries of the statement of the problem, procedures, and research hypotheses. The second section highlights the major findings, their significance, and a comparison to the existing literature. The third section includes the implication of the results and suggestions for further research.

Summary of the Study

Statement of the problem

This study investigated the relationship between racial identity and quality of life among Black women 18 years old or older who reported being sexually abused in their childhood. The importance of this study arises from connecting the results of existing research on women survivors of CSA in general and Black women survivors in particular. On one hand, research indicates that Black women survivors of CSA are at
higher risk for experiencing more severe types of CSA (Black et al., 2001; Feiring et al., 2001, Huston, et al., 1997; Kenny & McEachern, 2000; Lindholm & Willy, 1986; Russell et al., 1988; Shaw et al., 2001; West, 2002b) and tend to report more negative outcomes as the results of their abuse (Russell et al., 1988). The negative outcomes of CSA can be described by dynamics of the Traumagenic Dynamics Model (Finkelhor & Browne, 1985, 1986, 1988). These dynamics have been well documented in existing literature on Black women survivors of CSA (Fiscella et al., 1998; Hagen, 1998; Jasinski et al., 2001; Leifer & Shapiro, 1995; Lodico et al., 1996; Matson, 2001; Meadows & Kaslow, 2002; Mennen, 1995; Owens & Chard, 2003; Peters, 1988; Rabon, 1995; Roberts, 1999; Sanders-Phillips et al., 1995; Simoni & Ng, 2002; Striegel-Moore et al., 2002; Teets, 1995; Thompson et al., 2000; Urquiza and Goodlin, 1996; Wyatt, 1990b; Wyatt et al., 2002; Wyatt & Mickey, 1988; Wingood & DiClemente; 1997).

On the other hand, recent research has shown that in spite of the severity of their trauma, most Black women survivors of CSA report adequate functioning, at least in some domains of their lives, similar to their other racial/ethnic counterparts (Banyard et al., 2002; Grossman et al., 1999; Hyman & Williams, 2001; Sparcarelli & Kim, 1995; Wyatt et al., 1999). Therefore, it is critical to explore potential factors that help Black women survivors of CSA to function and maintain adequate and even high QOL. There is some evidence that adherence to one’s racial group has a positive relationship with psychological functioning and overall quality of life (e.g., Larsen & Williams, 2002; Utsey et al., 2002). Furthermore, the results of several other studies suggested that racial identity might act as a buffer to protect the individual against a variety of life adversities (Johnson, 2002; Miville, Koonce, Darlington, & Whitlock, 2000; Neville, & Lilly, 2000;
Utsey et al.; Wong et al., 2003). These preliminary implications along with clinical and anecdotal evidence suggest that racial identity may play a role in buffering against traumatic impact of CSA among Black women survivors; however, there is very little empirical support for this claim.

**Procedures**

In addition to questions related to CSA, two questionnaires were used to measure the dependent and independent variables of this study. Both measures demonstrated adequate psychometric properties in previous research as well as the current study. The dependent variable, QOL, was measured by the WHOQOL-BREF (Bonomi & Patrick, 1997). The WHOQOL-BREF has four dimensions including Physical Health (PH), Psychological (P), Social Relationships (SR), and Environment (E). The overall quality of life (QOL) was calculated by summing the scaled scores on all dimensions divided by four. The independent variables, racial identity and its stages, were conceptualized based on the expanded Nigrescence model (Cross & Vandiver, 2000) and were measured by the CRIS (Vandiver et al., 2000) This scale consists of six subscales including Pre-encounter Miseducation (PM), Pre-encounter Assimilation (PA), Pre-encounter Self-Hatred (PSH), Immersion-Emersion Anti-White (IEAW), Internalization Afrocentricity (IA), and Internalization Multiculturalist Inclusive (IMCI). The first three subscales reflect a Pro-Black (Discovery) reference group orientation and the remaining three subscales reflect Non-Black (Pre-Discovery) reference group orientation.
The sample was recruited in two ways. The mail-in participants were recruited through snowball sampling. The on-line participants responded to the survey via a secure and anonymous website and. All respondents were females, 18 years old or older, who identified themselves in a subcategory of Black racial descent. Overall 207 responses were received. Among them 85 participants met the criteria for experiencing CSA and their responses were sufficient for further analyses. Child sexual abuse was defined by a report of at least one incidence of sexual abuse before age 18 which included physical contact between the abused and the abuser and the presence of at least one of the following conditions: the abuser was 5 years or older than the abused or the sexual encounter was unwanted or coercive.

Hypotheses of this study were derived from implications of current studies on the relationship between racial identity and quality of life. In general, this study predicated that there would be a positive relationship between overall QOL and Pro-Black reference group orientation and a negative relationship between overall QOL and Non-Black reference group orientation. Correlation analyses were used to test these hypotheses.

*Specific Research Hypotheses*

There were six specific hypotheses:

1. There would be a positive relationship between overall QOL and the IMCI subscale of the CRIS.

2. There would be a positive relationship between overall QOL and the IA subscale of the CRIS over and above the IMCI.
3. There would be a positive relationship between overall QOL and the IEAW subscale of the CRIS over and above the IA and the IMCI.

4. There would be a negative relationship between overall QOL and the PSH subscale of the CRIS.

5. There would be a negative relationship between overall QOL and the PM subscale of the CRIS over and above the PSH.

6. There would be a negative relationship between overall QOL and the PA subscale of CRIS over and above the PSH and the PM.

The specific hypotheses were tested by linear and hierarchical regression analyses.

Conclusions

This section will provide the results of the study and will draw conclusions and will discuss general and specific research hypotheses.

Relationship between Pro-Black Reference Group Orientation and QOL

The first general hypothesis of this study was not supported. There was no significant correlation between Pro-Black reference group orientation and overall QOL or any of its domains. These findings were further confirmed by hierarchical regression analyses testing the first three hypotheses of the study. None of the subscales of Pro-Black reference group orientation contributed to significant amount of variance in overall
QOL. These results seem to partially support Cross’s (1991) belief that having information about one’s reference group orientation may only allow us to predict the content of a person’s worldview and ideology and the image of the reference group held by the person, but not to produce, modify, or improve her personal identity and its components. According to Cross, personal or ego identity consists of variables, traits, or dynamics that appear to be in all human beings, regardless of social class, gender, race, or culture (i.e., personal identity refers to more universal components of a person’s psychological realm). On the other hand, racial identity consists of race-related factors such as racial self-identification, race image, race awareness, and racial evaluation.

Cross (1991) reviewed studies on Nigrescence theory in two time periods: from 1968 to 1980 and from 1980 to 1991. He concluded that the studies conducted during the first era suggested that Black individuals experience identity change at both the personal and racial identity levels. But he stated that further studies in the second era revealed that although various dimensions of Black racial identity changed with Nigrescence, basically Black personal identity characteristics did not changed. Thus, Cross proposed that Nigrescence can affect the Black persona and the manner in which s/he chooses to display her/his Blackness publicly, which may alter the internal images and attitudes that they hold toward Blacks as a group. He concluded that an individual’s reference group orientation predicts the kinds of organizations and social causes, problems, and programs to which the person is attracted. Cross stated that in the majority of studies, during the Nigrescence process, the shift was not so much from negative to positive, as from low racial salience to high racial salience; apolitical to political; Eurocentric to Afrocentric; involvement in organizations that did not stress Blackness to healthy and positive
activism in organizations that gave high priority to being Black. He further theorized that findings in the second era of research on the effects of the Nigrescence process on personal identity indicated that personal identity changes from a certain “baseline” in pre-encounter stage to a great deal of perturbation during transition (i.e., immersion-emergence), followed by a return to the baseline at internalization stage in which the basic core of the person’s personality is reestablished.

A study by Parham & Helms (1985) may sum empirical support for this proposal. Parham and Helms found negative relations between Pre-Encounter and Immersion stages with self-actualization and self-acceptance, and negative relations between Pre-Encounter and feeling of inferiority and anxiety. These correlations reversed for Encounter stages indicating positive changes. However, there was no significant relationship between Internalization attitudes and any of the measures of self-actualization or affective states. This recent finding is similar to the findings of the current study that showed no significant relationship between Pro-Black identity clusters and QOL.

Finally, Cross (1995) noticed that in the advanced stages of racial identity, similar to ideological perspectives, there is more diversity in personalities and functioning. This diversity may also explain the lack of significant correlation between Pro-Black and QOL in this study. It is noteworthy that the IMICI had the lowest internal consistency coefficient (.68) of all the subscales (PA = 0.84, PM = 0.84, PSH = 0.88, IEAW = 0.89, IA = 0.87). The IMCI relative low internal consistency may reflect diversity among people who endorse items on this subscale.
Nevertheless, qualitative and quantitative studies conducted after Cross’s review of literature in 1991 appeared to suggest positive correlations between strong racial identity and several indicators of well-being and health. Although the existing literature have not used the same measures of racial identity and quality of life and have not studied Black women survivors of CSA, the first general hypothesis and its related specific hypotheses in this study were inferred from a line of research exploring the relationship between racial identity and a variety of well-being constructs among diverse Black populations. These studies suggested that strong adherence to one’s racial group promotes well-being (Franklin, 2002), health promoting life style (Johnson, 2002), cumulative GPA (Laursen & Williams, 2002), ego identity achievement (Miville et al., 2000), higher psychological functioning (Neville & Lilly, 2000), QOL (Utsey et al., 2002), and psychological resiliency, school achievement and perception of friends’ positive characteristics (Wong et al., 2003) among diverse Black participants. For example, Johnson (2002) found that correlation between Internalization and self-esteem was significant ($r = 0.20, p < .001$). Further regression analysis indicated that Internalization accounted for 4% of the total variance in health promoting lifestyle: $R^2 = 0.11, p < .001$. Utsey et al. (2002) found that ethnic identity accounted for 14% of variance in QOL as measured by the WHOQOL-BREF. Wong et al. (2003) reported that after controlling for socio-demographic and background variables, and perceived discrimination, connection to ethnic/racial group was positively related to changes in school achievement, psychological resiliency, and perceptions of friends’ positive characteristics. However, the present study did not replicate these findings for Black women survivors of CSA regarding the relationship between Pro-Black reference group
orientation, as measured by the CRIS, and quality of life, as measured by the WHOQOL-BREF.

The discrepancy observed among different eras of research as well as between current study and previous research need closer investigation. The first noteworthy issue is that different studies not only used different constructs and measures as dependent variables (e.g., well-being and higher psychological functioning), but also used different measures of racial identity as their independent variable. For example, Franklin (2002), Miville et al. (2000), and Neville and Lilly (2000) used the RIAS-B (Parham & Helms, 1981) for measuring racial identity attitudes. Johnson’s (2002) measure for racial identity was the Stages Questionnaire (Cross, 1972). Both the Stages Questionnaire and the RIAS-B are based on the original model of Nigrescence and do not reflect the revision of the theory based on current literature. In addition, the RIAS-B, which has been used in many studies, has been criticized for its psychometric properties (e.g., Tokar & Fischer, 1998; Yanico et al., 1994). Wong et al. (2003) measured racial identity by a four-item instrument designed for their study, and thus there is no information about the psychometric properties of their measure. Laursen and Williams (2002) used Phinney’s (1992) Multigroup Ethnic Identity Measure (MEIM). Also, Utsey et al.’s (2002) study, which similar to the current study used the WHOQOL-BREF for quality of life, measured ethnic identity using MEIM. Although there are parallels between the Cross (1971, 1991, 1995) and Phinney perspectives (Cross & Fhagen-Smith, 1996), unlike measures such as RIAS-B, the Stages Questionnaire, and the CRIS that are specifically designed to measure Black racial identity, MEIM is designed for measuring ethnic identity of various
social racial/ethnic groups and is suitable for studies that include participants from diverse racial/ethnic backgrounds.

Other trends in the literature that imply a positive relationship between racial identity and QOL are conceptual endeavors, clinical anecdotes, and qualitative research. For example, Denby (1996) suggested that instilling racial pride and strong ethnic identity in Black children shows them that they matter and that they are important to their communities. One implication of such a statement is that these children would grow up to be more resilient in face of life’s adversaries. More specifically, Dabney (2000), in a qualitative study using grounded theory with 16 Black women survivors of CSA, implied that racial group affiliation might have a positive impact on overcoming traumatic outcomes of CSA. Another inference regarding the importance of racial identity in healing from negative impacts of CSA was drawn from Grossman et al.’s (1999) case study report on 10 female survivors, two of whom were Black women. The authors noted that what they called “Afrocentricism,” played a role in promoting an appropriate sense of racial self that contributed to self-care for the Black women in their study.

These theoretical propositions and qualitative results appear to conflict with the findings of the present study. One possible implication of this discrepancy is that respecting fundamental racial values and certain practices along with Afrocentricism and respecting one’s racial group may play more important roles in promoting QOL of Black women survivors of CSA than the unspecific mere adherence to the racial reference group as measured by the subscales of the CRIS reflecting Pro-Black reference group orientation. The specific racial values and practices can include family life and affinity to extended family and community support system, ethnic/racial organizational affiliations,
taking responsibility, celebrating Black womanhood, reaching out to others, spirituality, and faith, which are not measured by the CRIS. For example, all items of the IEAW reflect hatred toward White people. A typical item of the IEAW reads, “I hate the White community and all that it represents.” It is reasonable to state that this subscale does not reflect adherence to Black community and family values and strong sense of taking responsibility and celebrating one’s Blackness. The second subscale of Pro-Black reference group orientation is IA. A typical item of IA reads, “I see and think about things from an Afrocentric perspective.” Although all IA items point out one’s affinity to “Afrocentric” perspectives and values, they do not elaborate on these values and it is up to the reader to define the word. As a matter of fact, a few mail-in respondents made notes about the word “Afrocentric” and asked what the researcher meant by this word. Finally, the items on the third Pro-Black reference group orientation, the IMCI, reflect similar vagueness by using the word “multiculturalism,” for which a few mail-in respondents asked clarity as well. A typical item of the IMCI reads, “As a multiculturalist, I am connected to many groups (Hispanics, Asian-Americans, Whites, Jews, gays & lesbians, etc.).” Similarly, these items may not reflect specific sets of values and beliefs cherished by Black people with strong adherence to their racial identity and community. Another concern regarding the IMCI subscale is the examples provided in the items for the word multiculturalism that include various racial/ethnic groups, sexual orientation, and religion. These examples can possibly create confusion for some respondents who respect and celebrate certain subcultures, but not others. In the current study, a few mail-in respondents crossed out some of the subgroups in the examples given in these items or made comments about them.
Helm (2002) encountered similar concerns regarding IA and IMCI items in her study. She noted that the wording of these two subscales (e.g., Afrocentricism and Multiculturalist) either should be re-examined or they need to be defined in the measure. For example, she stated that if respondents are not supportive of one or more of the exemplified oppressed groups in the IMCI items, they might not endorse the subscale highly even if they see themselves as multiculturalist. This finding suggests the need for further investigation of the IMCI subscale.

Another possible concern regarding Pro-Black reference group orientation is the inclusion of the IEAW identity cluster along with IA and IMCI. While IA and IMCI may reflect an achieved sense of racial identity, individuals in Immersion-Emersion stages of racial identity may experience high level of racial identity confusion and possibly emotional turmoil (Cross, 1991). Parham and Helms (1985) reported that Immersion racial attitudes had negative correlations with measures of self-actualization and positive correlations with feeling of inferiority and anger. It is reasonable to assume that individuals who endorse higher IEAW items may also experience lower levels of quality of life. As a matter of fact, a closer examination of regression analysis in the current study indicates that, although not statistically significant, the direction of association between the IEAW and total QOL is negative.

A preliminary indication of a positive relationship between specific and clear manifestations of racial affinity and QOL among Black women survivors of CSA is evident in a post-hoc finding of the data in the current study. A post-hoc analysis showed a significant positive correlation between overall QOL and the number of ethnic/racial organizations affiliations ($r = 0.23$). Further analysis showed that the only domain of the
WHOQOL-BREF that had significant correlation with the number of membership in ethnic/racial organizations was $P$ ($r = 0.32$). It is reasonable to assume that membership in racial/ethnic organizations may be a more accurate manifestation of internalization of Pro-Black attitudes, because racial/ethnic organizational affiliation may reflect the beliefs and values of the respondent regarding her racial group as well as her behavioral commitment to those values. It is suggested that similar items reflecting cognitive, emotional, and behavioral representations of participants’ attitudes toward their racial community may yield comparable results.

**Relationship between Non-Black Reference Group Orientation and QOL**

The second general hypothesis was supported as indicated by significant negative correlation between Non-Black reference group orientation and overall QOL. Non-Black reference group orientation had negative correlations with two domains of QOL as measured by the WHOQOL-BREF: Psychological (P) and Environment (E) domains. Among the subscales of the CRIS, PSH had significant negative correlations with overall QOL and three of its domains (PH, P, and E). The hierarchical regression analyses testing three remaining specific hypotheses further confirmed that PSH contributed to significant amount of variance (9%) in overall QOL: $R^2 = 0.093$, $F(1,83) = 8.519$, $p < 0.005$. Neither PA nor PM added significant amount of variance to overall QOL above and beyond PSH.

These results are consistent with most existing research. For example, Franklin (2002) found that although both racism-related stress and racial identity, as measured by the RIAS-B (Helms & Parham, 1981), predicted psychological distress, racial identity
accounted for more of the variance in psychological distress than racism-related stress. Specifically, she found that individuals with higher Pre-Encounter attitudes were more likely to report psychological distress. Using the Stages Questionnaire (Cross, 1972), based on the Nigrescence theory, Johnson (2002) found an interaction between gender and racial identity using hierarchical regression analyses. Specifically, her results indicated that women with higher Pre-Encounter and Immersion scores reported lower health-promoting lifestyle scores than men with higher Pre-Encounter scores ($R^2 = 0.11$, $p = .01$ and $R^2 = 0.04$, $p = .03$ respectively). Parham and Helms (1985) reported that Pre-Encounter negatively related with self-actualization as measured by time-competence and inter-directedness. Furthermore, their results indicated that Pre-Encounter attitudes were positively related with feeling of inferiority and anxiety and negatively related with self-acceptance. Vandiver et al. (2002) found that PSH had a strong positive correlation with neuroticism and a moderate correlation with global self-esteem. Worrell et al. (2002) reported that PSH accounted for 8% of the variance observed in self-esteem as measured by Rosenberg Self-Esteem Scale.

As Cross (1991) pointed out, the concept of Black self-hatred is as complex as any other aspect of Black psychological functioning. His review of studies from 1980 to 1991 suggested that Black people in the Pre-Encounter stage of Nigrescence consist of two prototypes: psychologically healthy and self-hating unhealthy. These studies suggested that self-hatred toward one’s racial group and hatred toward one’s self overlap, yet are distinct constructs. As a result, Cross modified his theory and the CRIS was designed to reflect his most recent revisions. The results of current study confirm that the CRIS accurately separated the latter group (PSH) from the first (PA and PM). Overviews
of research on racial identity using different measures of the Nigrescence theory have suggested that the most predictable and consistent relationship between racial identity and ego identity components is a robust negative relationship between PSH attitudes and self-esteem (Cross, 1991; Cross & Fhagen-Smith, 1996; Steen & Bat-Chava, 1996; Worrell et al. 2000). Self-esteem is an important component of overall well-being and QOL. The current study indicates that PSH not only has a negative correlation with overall QOL and its psychological domain, but also it is associated with lower scores on physical health, and environment domains of QOL. Although no casual assumptions can be concluded from these associations, and the underlying factors that contribute to low PSH and QOL can lie outside of these constructs, the strong correlations between PSH and QOL and three of its domains have significant clinical and research implications which will be discussed later. But, first it is important to explore the results of this study on QOL of Black women survivors of CSA and other possible contributing factors in addition to racial identity.

QOL of Black Women Survivors of CSA

This study used a method suggested in the WHOQOL-BREF manual (Bonomi & Patrick, 1997) for transforming the scores for each domain of QOL to a scaled score ranging from 0 to 100. Table 5.1 shows a statistical description of transformed scores for overall QOL and its domains as reported in the manual. Also, this table presents similar statistics for the sample in the current study (CSA). A post hoc analysis compared the overall QOL of participants who reported a history of childhood sexual abuse (CSA) to
the respondents who did not report a history of childhood sexual abuse (NCSA) and were not included in the main statistical analyses of this study. Overall 118 participants reported that they did not experience a history of CSA. Among them 8 surveys missed too many items to be usable for further analysis. For the sake of comparison, a random sample of 85 responses was selected from the remaining 110 surveys. Table 5.1 provides a statistical description of the overall QOL and its domains for this group as well.

As Table 5.1 shows, for the study sample (CSA) M = 66.55 and SD = 13.96 (with a minimum score of 29.65 and a maximum score of 95.87) for the total score of QOL, calculated by summing the four domains and dividing the sum by 4. Although Bonomi and Patrick (1997) did not report the transformed score for total QOL of the data in the manual, based on their suggested calculation, M = 71.5 for the total QOL of their sample. As Table 5.1 shows, except for the PH domain, the transformed score for total QOL and three of its domains (P, SR and E) are lower for the participants in this study compared to the data reported in the manual as well as the NCSA group. The internal consistency of Social Relationships was relatively low (.56) for the current study. Utesy et al (2002) also reported relatively low internal consistency on PH and P for African American participants in their study. The internal consistencies of the WHOQOL-BREF for this racial group were .48 for PH, .68 for P, .81 for SR, and .87 for E

A post-hoc analysis comparing CSA to NCSA respondents indicated that the total QOL of CSA respondents was significantly lower than NCSA respondents: t(168) = -2.859, p < 0.01. Similar differences were found for three of four WHQOL-BREF domains as follows: for PH, t(167) = -2.227, p < 0.05; for P, t(168) = -2.589, p < 0.01; for SR, t(168) = -2.626, p < 0.01. Although the difference between CSA and NCSA
respondents on E domain was not significant at 0.05 level, it was noteworthy: \( t(168) = -1.828, p = 0.069 \). In order to explore this result further, a post-hoc hierarchical regression analysis was conducted. The total QOL was entered as the dependent variable. For independent variables, the PSH was entered in the first block and CSA was entered in the second block. The result indicated that CSA added a significant amount of variance in total QOL above and beyond PSH (see Table 5.2).

*Demographic Characteristics and QOL*

In exploring other factors that contribute to QOL, post hoc analyses for the study sample (CSA) showed that there is a significant positive relationship between participants’ income and their total QOL \( (r = 0.34) \) and three of its domains: for P, \( r = 0.29 \); for SR, \( r = 0.30 \); and for E, \( r = 0.42 \). Also, the more educated participants reported higher total QOL \( (r = 0.27) \). The only domain of QOL that was significantly related with education was E \( (r = 0.30) \). These findings make sense considering that some facets of E reflect financial resources and opportunities for acquiring new information and skills. Also, as noted earlier, the number of racial/ethnic organization affiliation was significantly related to higher total QOL \( (r = 0.23) \) and one of its domains, P \( (r = 0.32) \). No other demographic correlations were found.
Racial Identity of Black Women Survivors of CSA

Table 5.3 shows the comparison between mean and standard deviations for the current study and the manual for the CRIS (Worrell et al., 2000). In order to facilitate this comparison, the means and standard deviations of the subscale scores from manual were multiplied by 5. The reason for this transformation was because the authors of the manual divided the sum of 5 items in each subscale by 5, but the current study used the sum of the subscales without dividing them by 5. As this table shows, the range of scores for all subscales, except for the IMCI, are similar for the participants in the manual of the CRIS, and CSA and NCSA groups in the current study. The IMCI mean scores are higher and the standard deviations are lower for both groups in this study compared to the sample reported in the CRIS manual.

Demographic Characteristics and Racial Identity

There was no significant correlation between Pro-Black racial identity and demographic factors. However, Non-Black racial group orientation had significant negative correlation with income ($r = -0.31, p < 0.005$) and organizational affiliation ($r = -0.32, p < 0.005$). Among Non-Black clusters, individuals with higher Pre-Encounter Assimilation attitudes had lower income ($r = -0.24, p < 0.05$) and fewer organizational affiliations ($r = -0.27, p < 0.05$), and individuals with higher Pre-Encounter Self-Hatred had lower income ($r = -0.26, p < 0.05$).
Implications

Based on the literature review, this study predicted that racial identity contributes significantly to variance observed in overall QOL of Black women survivors of CSA. The results indicated that although stronger Po-Black reference group affiliation is not related to higher QOL and its domains, Non-Black reference group orientation and racial attitudes are associated with lower QOL and two of its domains (P and E). In particular, among Non-Black subscales, PSH had a significant negative correlation with overall QOL and three of its domains (PH, P, and E). In addition, PSH contributed a significant amount of variance (approximately 9%) in overall QOL. These findings have several clinical and research implications that will be discussed below.

Clinical implications. The results of the current study and similar findings in pervious research suggest that treating self-hatred attitudes toward one’s racial group may promote QOL of Black women survivors of CSA. Therefore, it is important to evaluate racial self-hatred of Black women survivors of CSA in clinical assessments. Because the construct of racial self-hatred is well measured by the CRIS, this scale can be used in clinical settings for assessing PSH. It is further suggested that clinicians pay due attention to racial identity development and reduction in Black self-hatred in the course of treatment, because such development may be an important part of healing and enhancement of quality of life.
The lack of relationship between Pro-Black group orientation and QOL may imply that one cannot assume that women survivors of CSA who score higher on Pro-Black reference group orientation as measured by the CRIS do not suffer from negative impact of their childhood trauma. Thus, it is suggested that clinicians remain aware and sensitive to addressing CSA properly, although their clients may appear to be “strong Black women” and hesitate to share their emotional struggles and trauma symptoms. Parham and Helms (1985) cautioned clinicians against inferring adjustment from stated racial attitudes. They encouraged practitioners to explore their clients’ emotional adaptations. Researchers addressing CSA issues in Black communities have provided elaborate accounts of these concerns such as fear of contributing to stereotypes regarding hypersexuality of Black individuals (Abney & Priest, 1995; Wyatt, 1997), fear of further marginalization and isolation from family and community (Bernard, 1997; Mtezuka, 1998), and distrust of legal system (Bernard, 1998; Collin, 1999, 2000; Foley, Evanic, Karnik, King, & Park, 1995; Neville & Pugh, 1997; West, 2002b; Wyatt, 1992). It is suggested that clinicians address these concerns properly and assist their clients to feel empowered dealing with these and similar issues.

Nevertheless, it seems important that clinicians use qualitative data obtained from elaborate and culturally sensitive interviews and interactions to explore their clients’ racial beliefs and attitudes. This clinical approach should provide insight about the degree to which the client respects fundamental racial values and practices. These values and practices may include affinity to extended family, community and ethnic/racial organizations, seeking support and reaching out to others in the community, celebrating Black womanhood, adherence to spirituality and faith and respecting one’s racial group
that may reflect an Afrocentric life style. A preliminary finding of a post-hoc analysis in this study implies that therapeutic strategies may help Black women’s survivors of CSA to enhance racial adherence and celebration not only in values and beliefs, but also in behaviors such as community networking and organizational affiliation.

A related implication of this study is that improvement in income and education may contribute to higher QOL. Furthermore, higher income is related with stronger sense of racial affiliation. Thus, clinicians working with Black women survivors of CSA may help their clients to improve perceptions of the quality of their lives as well as their racial identity by advocating for their financial welfare and education. The clinician may create, seek, identify, or refer to resources either through direct work with survivors of CSA or via engagement in social change and necessary reforms in social services and policies. Both roles may be fulfilled via activities in Black communities and organizations especially the ones geared toward working with Black women. Furthermore, an important role of mental health service providers working with survivors of CSA is preventive work. One of the post-hoc findings of this study was that CSA accounted for significant amount of variance in overall QOL above and beyond PSH (about 15%). This finding implies that experiencing CSA negatively affects QOL of adult women survivors. Thus, it is important to develop preventive and psychoeducational programs to decrease occurrence of CSA in Black communities. For those who survive CSA, providing effective and timely treatment may contribute to promotion of QOL. These finding can imply that programs addressing racial self-hatred and childhood sexual trauma simultaneously may be more successful in improving QOL of CSA survivors.
Research implications. A review of the existing literature shows a strong negative relationship between PSH and self-esteem. The consistency among previous studies as well as between existing literature and the current study reflect consistency and reliability of the Black self-hatred construct across variety of racial identity scales. The results of this study indicate that the CRIS distinguishes and refines PSH even more, making it a good instrument particularly for measuring PSH in future research. The findings of the current study added to the previous literature by indicating that the PSH is negatively correlated with overall QOL as well as three domains of QOL including psychological, physical health, and environment domains among Black women survivors of CSA. These results imply that individuals with lower PSH not only suffer from lower self-esteem, as documented in the previous research, but also endorse more global psychological, physical, and environmental concerns, as indicated in the present study. Replication of this study with other samples of Black women survivors of CSA as well as Black women and men with no history of CSA can provide more clear profile of individuals with PSH racial attitudes.

Unlike the self-hatred construct, Pro-Black reference group orientation subscales do not provide consistent results across different studies. This suggests a re-examination of some of Pro-Black reference group subscales of the CRIS in future research. Several concerns are related to the IMCI subscale. Specifically, the internal consistency of the IMCI subscale in this study was lower than other subscales. In addition, the current study did not find the expected correlation between the IMCI and Pro-Black reference group orientation. The technical manual of the CRIS reported that factor loading of the IMCI items on Pro-Black reference group orientation was 0.91 (Worrell et al., 2000). The
current finding poses questions regarding the structural validity of the IMCI subscale and Pro-Black cluster. Furthermore, inclusion of IEAW subscale in Pro-Black reference group orientation can be problematic, because as the Nigrescence theory (Cross, 1991) pointed out individuals in Immersion stages of racial identity may experience lower levels of self-actualization and higher level of emotional problems such as feeling of inferiority and anger (Parham & Helms, 1985). Therefore, future studies need to provide more information regarding the factor structure of the CRIS and Pro-Black reference group clusters. Furthermore, as mentioned in the previous section, the IA and the IMCI items’ wording (i.e., Afrocentric and multiculturalist) need clarification or replacement. Similar concerns regarding the IA and the IMCI have been presented by other studies (e.g., Helm, 2002). These concerns are reflected in Vandiver et al. (2002) who concluded that the challenges involving delineation of Pro-Black reference group orientation cluster, particularly the IA and the IMCI, need to be addressed in future research.

Another issue with the CRIS as a measure of racial identity is that although this scale is supposed to measure racial attitudes, it does not provide a concrete and clear measure of cognitive, emotional, and behavioral components of these attitudes. For example, the specific values and practices of the respondents who endorse high Pro-Black reference group orientation, as measured by the CRIS, are unclear. Including items that reflect underlying meanings of Afrocentric and multicultural racial attitudes, such as membership in racial/ethnic organizations, religious and spiritual beliefs and practices, and interpersonal, social, family, and community values and behaviors, may better represent racial identity. There is preliminary support for this suggestion in a post-hoc analysis in this study showing a significant positive relationship between racial/ethnic
organization membership and overall QOL and its psychological domain. Future research may further explore this specific relationship as well as the relationship between QOL and other cognitive, emotional, and behavioral representations of affinity to one’s racial group. Also, qualitative studies that explore racial affinity of the participants via in depth interviews can provide valuable information about the relationship between QOL and racial identity.

Other post-hoc analyses investigating the relationship between demographic characteristics of this study’s sample with QOL indicated the importance of income and education. Future research needs to build on these findings both by expanding on and exploring indicators of financial and educational resources and using more elaborate versions of QOL domains reflected on the WHOQOL-100. For example, the WHOQOL-100 environment domain consists of specific items measuring financial resources, freedom, physical safety and security, health and social care (accessibility and quality), home environment, opportunities for acquiring new information and skills, participation in and opportunities for recreation/leisure activities, physical environment (pollution/noise/traffic/climate), and transport.

An important consideration regarding the WHOQOL-BREF is its reliability in using with Black participants. Although test developers have reported robust psychometric characteristics for this instrument, Utsey et al. (2002) reported relatively low internal consistencies for Physical Health and Psychological domains for their African American subsample. Similarly, the Cronbach alpha for Social Relationships domain in the current study was relatively low. Therefore, future researchers need to
further explore the psychometric properties of the WHOQOL-BREF for Black populations.

Finally, an important post-hoc analysis suggested that CSA contributed to QOL above and beyond PSH. This preliminary finding needs further investigation in future research, because this line of study in current literature is open to investigation. Researchers may choose to compare Black women survivors of CSA to their NCSA counterparts or women from other racial/ethnic groups with or without CSA.

Limitations

The sample in this study may have not been representative of Black women survivors of CSA. More specifically, the data gathering did not concentrate on representation of the most severe cases of survivor of CSA who may be better targeted via recruitment from inpatient and treatment settings. In addition, the experiences of CSA among participants ranged from an isolated experience of fondling by a stranger to repeated incidences of vaginal and anal intercourse by parental figures. This variability represents a heterogeneous group of participants who may also differ in their experience of severity of traumatic impact; the level of support they received; the ways in which they deal with these effects; their age, as well as their perception of their quality of life. As a result combining the responses of these survivors may have overshadowed the uniqueness of the relationship between their racial identity and quality of life. Another factor that was not controlled for in this study’s participants was receiving any type of intervention such as counseling. It is possible that the participants who have received
intervention, as a group, would report different level of quality of life compared to the
group who has not received intervention.

The second limitation of this study is the issue inherited in all self-report
instruments. Although self-report measures have the advantage of reflecting participants’
subjective experiences, they relying on respondents’ memory. Reliance on memory can
be particularly disadvantageous and controversial in reporting CSA and its
characteristics. In addition there may be additional concerns regarding measures of this
study. For example, although several studies on the CRIS have suggested adequate
psychometric properties, this measure is relatively new and needs further research to
establish its validity and reliability. Particular questions raised by this study are regarding
structural validly and reliability of the Pro-Black reference group orientation and its
clusters. Similar concerns are related to reliability of some domains of the WHOQOL-
BREF, including PH, P, and SR, in using with African American populations. In
addition, in spite of practicality and several advantages of using the WHOQOL-BREF for
measuring QOL, it does not provide detailed facets of QOL domains as measured in the
WHOQOL-100. As a result, the findings of the current study on QOL and its domains
should be treated cautiously.

The retrospective design of this study does not allow for inferring causal
relationship. Thus, all assumptions regarding direction of relationships are based on
hypotheses developed from considering of existing literature. Finally, the quantitative
design of this study is another limitation. The brevity of quantitative measures does not
allow the respondents to expand on and clarify their responses. Similarly, these measures
do not give the researchers the ability to understand underlying meanings of respondents’
statements such as beliefs, values, behaviors and emotions accurately reflecting their racial identity. Therefore, the current study’s research design limits its ability to explore the relationship between racial identity and QOL, as two complex constructs.

Suggested further Research

1. Being the first study of its kind, it is suggested that the current study be replicated with other samples of Black women survivors of CSA.

2. It is suggested that the current study be replicated with more homogeneous samples of Black women who share similar histories of CSA in terms of characteristics of their abuse.

3. It is suggested that the current study be replicated with representative samples of Black women survivors of CSA in inpatient and treatment settings.

4. It is suggested that future studies ask participants about their experience of receiving any intervention such as counseling.

5. It is suggested that the future studies further explore the reliability of the Social Relationships domain of the WHOQOL-BREF because the reliability of this domain was relatively low in the current study.

6. It is suggested that this study be replicated by using the WHOQOL-100 instead of the WHOQOL-BREF to provide a more accurate and detailed representation of QOL.
7. It is suggested that comparison studies explore if the relationship between racial identity and QOL differ for Black women survivors of CSA from their counterparts without histories of CSA.

8. It is suggested that comparison studies compare QOL of Black survivors of CSA with NCSA counterparts or women from other racial/ethnic groups with or without CSA.

9. It is suggested that the future research explore the underlying factors that contribute to Black self-hatred and negative views of one’s racial group in order to design specific therapeutic strategies. Using qualitative methodology to find these underlying factors may be an initial step. The qualitative research in turn may result in designing self-report measures for further quantitative studies.

10. It is suggested that experimental research design compare therapeutic outcome of interventions targeting self-hatred racial attitudes in Black women survivors of CSA as compared to placebo or other intervention strategies.

11. It is suggested that further studies investigate validity and reliability of the CRIS, particularly the Pro-Black reference group clusters including the IEAW, the IA, and the IMCI. Specifically, IA and IMCI items needs to be revisited and possibly reworded. Re-examination of reliability of the IMCI seems to be warranted as well. Also, future research needs to examine factor loading of the Pro-Black clusters and the relationship among these subscales.

12. Because the results of this study on the relationship between Pro-Black reference group orientation and overall QOL did not support some existing
qualitative and quantitative research, it is suggested that future studies examine the role of more specific racial values and traditions, such as affinity to extended family and community support, taking responsibility, and spirituality and faith, in enhancing QOL of survivors of CSA. To this end the researchers may apply qualitative methodologies or use appropriate measures that explicitly target values, beliefs, and behaviors.

13. It is suggested that the relationship between QOL and certain demographic factors such as income and education will be explored further, because post-hoc analyses of the current study found positive correlations between income and education with QOL for Black women survivors of CSA.
REFERENCES


APPENDIX A.

DEMOGRAPHIC QUESTIONNAIRE

Instructions

Please answer following questions either by typing your responses or checking the appropriate box.

1. Male  Female
2. How old are you?
3. What is your marital status?
   Single  Married  Living as married  Separated  Divorced  Widowed
4. What is your ethnic background (choose only one category):
   a. African American
   b. Black
   c. West Indian/Caribbean Black
   d. Hispanic Black
   e. Mixed
   f. Other
5. Are you: a high school student  an undergraduate  a graduate student
6. If you are no longer a student, what is the highest education level obtained?
   a. Elementary school
   b. High school
   c. College
   d. Graduate or professional degree
7. If you are no longer a student, do you work: Yes  No
8. If you work, what is your current occupation?
9. What is your religious affiliation?
10. How often do you attend religious services? Seldom  Sometimes  Often
11. How important is your religion to you?
    Not important  Somewhat Important  Very Important
12. What is the best estimate of your / your family’s yearly income before taxes?
   a. Less than $10,000
   b. Between $10,000 and $20,000
   c. Between $20,000 and $30,000
   d. Between $30,000 and 40,000
   e. Between $40,000 and 60,000
   f. Over $60,000

13. How would you describe the primary community in which you were raised?
   Rural  Suburban  Urban   Other

14. What is the racial composition of the community in which you were raised?

15. Are you a
   United States citizen a permanent resident of the US  Other

16. How many ethnic / racial organizations do you belong to?
   1  2  3  4  5 More than 5

17. What is the highest education level obtained by your mother (or female guardian) and father (or male guardian)? For mother, check the box for “M” and for father check the box for “F.”
   a. Elementary school  M  F
   b. High school  M  F
   c. College  M  F
   d. Graduate or professional degree  M  F

18. How would you describe your family’s socioeconomic status?
   Poor Working Class Middle Class Upper Middle Wealthy

19. How many people were living in the house before you were 18?

20. Did you ever experience any unwanted or unwelcome behaviors of a sexual nature by someone older than you before age 18?  Yes  No

If you answer to question # 20 is yes, please respond to the following questions, if your answer is no, please proceed to the next section.)

21. What was the nature of the sexual behavior? (Check all that apply.)
   a. Someone fondled your private area
   b. Someone made you fondle their private areas
   c. Oral sex
   d. Vaginal sex (penetration)
   e. Anal sex
   f. Other (please specify):

22. Who did the unwanted or unwelcome sexual behavior to you? (Check all that apply.)
   a. Father
   b. Mother
   c. Male caregiver / guardian
   d. Female caregiver / guardian
   e. Sibling
   f. Relative
23. How old were you when you **first** experienced the unwanted or unwelcome sexual behavior?

24. How old were you when you **last** experienced the unwanted or unwelcome sexual behavior?

25. Approximately how much older than you was the person who did the unwanted or unwelcome sexual behavior to you?
   - Less than 5 years older
   - 5 years older or more

26. Approximately how many times did the unwanted or unwelcome sexual behavior occur?
   - 1 time
   - 2-4 times
   - 5-10 times
   - More than 10 times

27. Approximately how long did the unwanted or unwelcome sexual behaviors last?
   - Less than 1 year
   - 1-2 years
   - 2-5 years
   - More than 5 years
   - Into your adulthood years

28. Did you tell somebody about what happened?  Yes  No

29. Who did you tell to? (Check all that apply.)
   - Father
   - Mother
   - Male caregiver / guardian
   - Female caregiver / guardian
   - Sibling
   - Relative
   - Family friend
   - Acquaintance
   - Stranger

30. If yes, how do you feel they responded to you?
   - Very unsupportive
   - Somewhat unsupportive
   - Neutral, not unsupportive or supportive
   - Somewhat supportive
   - Very supportive
APPENDIX B.

THE WORLD HEALTH ORGANIZATION QUALITY OF LIFE INSTRUMENT-
BRIEF VERSION
(WHOQOL-BREF, GENEVA AND UNITED STATE VERSION)

This questionnaire asks how you feel about your quality of life, health, or other areas of
your life. Please answer all the questions. If you are unsure about which response to give
to a question, please choose the one that appears most appropriate. This can often be your
first response.

Instructions

Please keep in mind your standards, hopes, pleasures, and concerns. We ask that you
think about your life in the last two weeks. For example, thinking about the last two
weeks, a question might ask:

Do you get the kind of support from others that you need:

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<th>Mostly</th>
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You should circle the number that best fits how much support you got from others over
the last two weeks. So you would circle the number 4 if you got a great deal of support
from others:

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You would circle number 1 if you did not get any of the support that you needed from
others in the last two weeks:

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<th>Moderately</th>
<th>Mostly</th>
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Please read each question, assess your feelings, and circle the number on the scale that gives the best answer for you for each question.

1. How would you rate your quality of life?

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<tr>
<th>Very poor</th>
<th>Poor</th>
<th>Neither poor nor good</th>
<th>Good</th>
<th>Very good</th>
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2. How satisfied are you with your health?

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<th>Very dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
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The following questions ask about how much you have experienced certain things in the last two weeks.

3. To what extent do you feel that physical pain prevents you from doing what you need to do?

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<th>A moderate amount</th>
<th>Very much</th>
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4. How much do you need any medical treatment to function in your daily life?

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<th>Very much</th>
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5. How much do you enjoy life?

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6. To what extent do you feel your life to be meaningful?

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7. How well are you able to concentrate?

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<th>Not at all</th>
<th>A little</th>
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8. How safe do you feel in your daily life?

Not at all  A little  A moderate amount  Very much  An extreme amount
1  2  3  4  5

9. How healthy is your physical environment?

Not at all  A little  A moderate amount  Very much  An extreme amount
1  2  3  4  5

10. Do you have enough energy for everyday life?

Not at all  A little  A moderate amount  Very much  An extreme amount
1  2  3  4  5

11. Are you able to accept your bodily appearance?

Not at all  A little  A moderate amount  Very much  An extreme amount
1  2  3  4  5

12. Have you enough money to meet your needs?

Not at all  A little  A moderate amount  Very much  An extreme amount
1  2  3  4  5

13. How available to you is the information that you need in your day to day life?

Not at all  A little  A moderate amount  Very much  An extreme amount
1  2  3  4  5

14. To what extend do you have the opportunity for leisure activities?

Not at all  A little  A moderate amount  Very much  An extreme amount
1  2  3  4  5

15. How well are you able to get around?

Not at all  A little  A moderate amount  Very much  An extreme amount
1  2  3  4  5

The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last two weeks.
16. How satisfied are you with your sleep?

Very dissatisfied   Dissatisfied   Neither satisfied nor dissatisfied   Satisfied   Very satisfied
1                  2                        3                                   4                   5

17. How satisfied are you with your ability to perform your daily living activities?

Very dissatisfied   Dissatisfied   Neither satisfied nor dissatisfied   Satisfied   Very satisfied
1                  2                        3                                   4                   5

18. How satisfied are you with capacity for work?

Very dissatisfied   Dissatisfied   Neither satisfied nor dissatisfied   Satisfied   Very satisfied
1                  2                        3                                   4                   5

19. How satisfied are you with your abilities?

Very dissatisfied   Dissatisfied   Neither satisfied nor dissatisfied   Satisfied   Very satisfied
1                  2                        3                                   4                   5

20. How satisfied are you with your personal relationships?

Very dissatisfied   Dissatisfied   Neither satisfied nor dissatisfied   Satisfied   Very satisfied
1                  2                        3                                   4                   5

21. How satisfied are you with your sex life?

Very dissatisfied   Dissatisfied   Neither satisfied nor dissatisfied   Satisfied   Very satisfied
1                  2                        3                                   4                   5

22. How satisfied are you with the support you get from your friends?

Very dissatisfied   Dissatisfied   Neither satisfied nor dissatisfied   Satisfied   Very satisfied
1                  2                        3                                   4                   5

23. How satisfied are you with the conditions of your living place?

Very dissatisfied   Dissatisfied   Neither satisfied nor dissatisfied   Satisfied   Very satisfied
1                  2                        3                                   4                   5
24. How satisfied are you with your access to health services?

Very dissatisfied  Dissatisfied  Neither satisfied nor dissatisfied  Satisfied  Very satisfied

1                        2                                      3                                   4                   5

25. How satisfied are you with your mode of transportation?

Very dissatisfied  Dissatisfied  Neither satisfied nor dissatisfied  Satisfied  Very satisfied

1                        2                                      3                                   4                   5

The following question refers to how often you have felt or experienced certain things in the last two weeks.

26. How often do you have negative feelings, such as blue mood, despair, anxiety, depression?

Never   Seldom   Quite often   Very often   Always

1                       2                       3                               4                          5

27. Are you currently ill?   Yes  No

28. If something is wrong with your health, what do you think it is?

_________________________illness / problem

29. Did someone help you to fill out this form (Please circle Yes or NO)   Yes

No

30. How long did it take to fill out this form?
APPENDIX C.

CROSS RACIAL IDENTITY SCALE (CRIS)

*Instructions*

Please read each item and indicate to what degree it reflects your own thoughts and feelings, using the 7-point scale below. There are no right or wrong answers. Base your responses on your opinion at the present time. **To ensure that your answers can be used, please respond to the statements as written,** and place your numerical response on the line provided to the left of each question.

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1. As an African American, life in America is good for me.
2. I think of myself primarily as an American, and seldom as a member of a racial group.
3. Too many Blacks “glamorize” the drug trade and fail to see opportunities that don’t involve crime.
4. I go through periods when I am down on myself because I am Black.
5. As a multiculturalist, I am connected to many groups (Hispanics, Asian-Americans, Whites, Jews, gays & lesbians, etc.).
6. I have a strong feeling of hatred and disdain for all White people.
7. I see and think about things from an Afrocentric perspective.
8. When I walk into a room, I always take note of the racial make up of the people around me.
9. I am not so much a member of a racial group, as I am an American.
10. I sometimes struggle with negative feelings about being Black.
11. My relationship with God plays an important role in my life.
12. Blacks place more emphasis on having a good time than on hard work.
13. I believe that only those Black people who accept an Afrocentric perspective can truly solve the race problem in America.
14. I hate the White community and all that it represents.
15. When I have a chance to make a new friend, issues of race and ethnicity seldom play a role in who that person might be.
16. I believe it is important to have both a Black identity and a multicultural perspective, which is inclusive of everyone (e.g., Asians, Latinos, gays & lesbians, Jews, Whites, etc.).
17. When I look in the mirror at my Black image, sometimes I do not feel good about what I see.
18. If I had to put a label on my identity, it would be “American,” and not African American.
19. When I read the newspaper or a magazine, I always look for articles and stories that deal with race and ethnic issues.
20. Many African Americans are too lazy to see opportunities that are right in front of them.
21. As far as I am concerned, affirmative action will be needed for a long time.
22. Black people cannot truly be free until our daily lives are guided by Afrocentric values and principles.
23. White people should be destroyed.
24. I embrace my own Black identity, but I also respect and celebrate the cultural identities of other groups (e.g., Native Americans, Whites, Latinos, Jews, Asian Americans, gays & lesbians, etc.).
25. Privately, I sometimes have negative feelings about being Black.
26. If I had to put myself into categories, first I would say I am an American, and second I am a member of a racial group.
27. My feelings and thoughts about God are very important to me.
28. African Americans are too quick to turn to crime to solve their problems.
29. When I have a chance to decorate a room, I tend to select pictures, posters, or works of art that express strong racial-cultural themes.
30. I hate White people.
31. I respect the idea that other Black people hold, but I believe that the best way to solve our problems is to think Afrocentrically.
32. When I vote in an election, the first thing I think about is the candidate’s record on racial and cultural issues.
33. I believe it is important to have both a Black identity and a multicultural perspective, because this connects me to other groups (Hispanics, Asian-Americans, Whites, Jews, gays & lesbians, etc.).
34. I have developed an identity that stresses my experiences as an American more than my experiences as a member of a racial group.
35. During a typical week in my life, I think about racial and cultural issues many, many times.
36. Blacks place too much importance on racial protest and not enough on hard work and education.
37. Black people will never be free until we embrace an Afrocentric perspective.
38. My negative feelings toward White people are very intense.
39. I sometimes have negative feelings about being Black.
40. As a multiculturalist, it is important for me to connect with individuals from all cultural backgrounds (Latinos, gays & lesbians, Jews, Native Americans, Asian-Americans, etc.).
APPENDIX D.

SAMPLE RECRUITMENT LETTER FOR MANUAL DISTRIBUTION

Hello,

My name is Mahnaz N. Mousavi and I am a Counseling Psychology doctoral candidate at The University of Akron. I am writing to ask you to distribute including packages for participants for my dissertation research. I am writing to you because I am particularly interested in including Black women who have been left out from much research on my topic in the past. Among other information, this study would ask the participants about any history of sexual abuse in childhood. The survey will take approximately 30 minutes to complete and is also available by logging on to my website:

http://survey.uakron.edu:2929/2wCM86J/Link.html.

Please feel free to look at the survey yourself. This project has been reviewed and approved by The University of Akron Institutional Review Board. If you have any questions about research participants’ rights, you may call Sharon McWhorter, Associate Director for Research Services at (330) 972-7666 or 1-888-232-8790. Thank you for your time and help!
APPENDIX E.

RECRUITMENT LETTER FOR MANUAL PARTICIPANTS

Hello!

My name is Mahnaz Mousavi and I am seeking Black female participants to complete my survey on the Black women’s Quality of Life. I am interested in your responses, if you are a Black woman who is 18 years or older. My research intends to investigate the quality of life of Black women, because they have been left out from much research on this topic in the past. Among other information, this study would ask you about any history of childhood sexual abuse. If you have any questions about your rights as a research participant, you may call Sharon McWhorter, Associate Director for Research Services at (330) 972-7666 or 1-888-232-8790. If you are interested in the results of this study you may contact Mahnaz Mousavi at mm436@cornell.edu or 607-255-5208.

The survey will take you about 30 minutes to complete and all your responses are anonymous. It will be impossible for the researcher to know your name or address unless you wish to disclose this yourself. Please fill out only one survey per person. This study is also available by logging on to my website:

http://survey.uakron.edu:2929/2wCM86J/Link.html.

Please pass this request on to other Black women who are 18 years or older. Thank you for your time and help!
APPENDIX F.

INFORMED CONSENT FOR MANUAL PARTICIPANTS

Please Read The Entire Page Carefully

Thank you for participating in the Black Women's Quality of Life Study! Please read the following informed consent form before beginning the survey. By clicking on the "Submit" link below, you are consenting to participation.

If you are at least 18 years old and are a Black female, you are invited to participate in an online dissertation research project by Mahnaz N. Mousavi, a doctoral student in the Department of Counseling at The University of Akron (Ohio). I am interested in exploring factors that promote the quality of life of Black women. I hope to better understand these factors to develop programs that may promote the quality of life of Black women who were sexually abused in their childhood.

You are asked to respond to a survey consisting of about one hundred items. These items ask questions about your background, history of being sexually abused as a child, racial beliefs, and your current quality of life. The response time to all the items will take about 30 minutes.

The researcher expects no discomfort or risk to you as a result of participating in this study; however, it is possible that you may feel temporarily distressed by responding to items related to childhood experiences of sexual abuse. If you need any assistance in addressing issues related to childhood sexual abuse, emotional and psychological distress, mental health or physical health problems, or if you need any support, I encourage you to contact the sources provided for your view in this package. There are brief descriptions as well as telephone numbers, e-mails, and web site links for these sources.

You will receive no direct benefit from your participation in this study, but your participation may help us better understand the factors that contribute to the quality of life of Black women who were sexually abused in their childhood.
Your participation in this research is voluntary and you may refuse to participate, or discontinue participation at any time before returning your responses to the researcher. However, once you mail your responses, it will be impossible for the researcher to extract or destroy them because your responses remain unidentifiable.

No identifying information will be collected, and your anonymity is further protected by not asking you to sign and return the informed consent form. It is assumed that you agree to participate in this study, once you agree with this informed consent form and return your responses.

This researcher will collect and analyze all participants responses to this study and will report the analyzed results in her dissertation. No data are reported individually. Therefore, it is not possible to identify any participants based on their responses to the items in this study. The researcher will keep the raw data for at least five years in compliance with American Psychological Association guidelines.

If you have any questions about this study or if you would like to learn about the results of this study, you may contact Mahnaz N. Mousavi at mm436@cornell.edu, 607-255-5208, or Counseling and Psychological Services, Student Health Services, Cornell University, Ho Plaza, Ithaca, NY 14853-3101 or check the following website later: http://survey.uakron.edu:2929/2wCM86J/Link.html. You may also contact Dr. John Queener at jqueener@uakron.edu, 330-972-6149 or Counseling Department, The University of Akron, Akron, OH 44325-5007. This project has been reviewed and approved by The University of Akron Institutional Review Board. If you have any questions about your rights as a research participant, you may call Sharon McWhorter, Associate Director for Research Services at (330) 972-7666 or 1-888-232-8790.

Acceptance:

I have read the information provided above and all of my questions have been answered. I voluntarily agree to participate in this study. My completion and electronic submission of this survey will serve as my consent.

YOU MUST BE 18 OR OLDER

TO PARTICIPANTE IN THIS SURVEY
APPENDIX G.

SAMPLE LIST SERVE RECRUITMENT LETTER

Hello,

My name is Mahnaz N. Mousavi and I am a Counseling Psychology doctoral candidate at The University of Akron. I am writing to ask you to post on your list serve the following request for participants for my dissertation research. I am writing to you because I am particularly interested in including Black women who have been left out from much research on my topic in the past. Among other information, this study would ask the participants about any history of childhood sexual abuse. The survey will take approximately 30 minutes to complete and is available by logging on to my website:

http://survey.uakron.edu:2929/2wCM86J/Link.html.

Please feel free to look at the survey yourself. This project has been reviewed and approved by The University of Akron Institutional Review Board. If you have any questions about research participants’ rights, you may call Sharon McWhorter, Associate Director for Research Services at (330) 972-7666 or 1-888-232-8790. Thank you for your time and help!
Hello!

My name is Mahnaz Mousavi and I am seeking Black female participants to complete my survey on the Quality of Life of Black women. I am interested in your responses, if you are a Black woman who is 18 years or older. My research intends to investigate the quality of life of Black women, because they have been left out from much research on this topic in the past. Among other information, this study would ask you about any history of childhood sexual abuse. This project has been reviewed and approved by The University of Akron Institutional Review Board. If you have any questions about your rights as a research participant, you may call Sharon McWhorter, Associate Director for Research Services at (330) 972-7666 or 1-888-232-8790. If you are interested in the results of this study you may contact Mahnaz Mousavi at mm436@cornell.edu or 607-255-5208 or check the study website later.

The survey will take you about 30 minutes to complete and all your responses are anonymous. It will be impossible for the researcher to know your name, e-mail, or address unless you wish to disclose this yourself. Please fill out only one survey per person.

Please pass this request on to other Black women who are 18 years or older. The survey is available in mail packages as well. Please contact me at mm436@cornell.edu or 607-255-5208 if you would like to distribute some packages. Thank you for your time and help!

Click on the link below to participate in my study:

http://survey.uakron.edu:2929/2wCM86J/Link.html.
APPENDIX I.

INFORMED CONSENT FOR ONLINE PARTICIPANTS

Welcome!
Please Read The Entire Page Carefully

Thank you for participating in the Black Women's Quality of Life Study! Please read the following informed consent form before beginning the survey. By clicking on the "Submit" link below, you are consenting to participation.

If you are at least 18 years old and are a Black female, you are invited to participate in an online dissertation research project by Mahnaz N. Mousavi, a doctoral student in the Department of Counseling at The University of Akron (Ohio). I am interested in exploring factors that promote the quality of life of Black women. I hope to better understand these factors to develop programs that may promote the quality of life of Black women who were sexually abused in their childhood.

You are asked to respond to a survey consisting of about one hundred items. These items ask questions about your background, history of being sexually abused as a child, racial beliefs, and your current quality of life. The response time to all the items will take about 30 minutes.

The researcher expect no discomfort or risk to you as a result of participating in this study; however, it is possible that you may feel temporarily distressed by responding to items related to childhood experiences of sexual abuse. If you need any assistance in addressing issues related to childhood sexual abuse, emotional and psychological distress, mental health or physical health problems, or if you need any support, I encourage you to contact the sources provided for your view on the last page of this survey. There are brief descriptions as well as telephone numbers, e-mails, and web site links for these sources.

You will receive no direct benefit from your participation in this study, but your participation may help us better understand the factors that contribute to the quality of life of Black women who were sexually abused in their childhood.
Your participation in this research is voluntary and you may refuse to participate, or discontinue participation at any time before submitting your responses on the last page of this survey. However, once you submit your responses, it will be impossible for the researcher to extract or delete them, because your responses remain unidentifiable.

No identifying information will be collected, and your anonymity is further protected by not asking you to sign and return the informed consent form. It is assumed that you agree to participate in this study, once you agree with this informed consent form and submit your responses.

This researcher will collect and analyze all participants responses to this study and will report the analyzed results in her dissertation. No data are reported individually. Therefore, it is not possible to identify any participants based on their responses to the items in this study. The researcher will keep the raw data for at least five years in compliance with American Psychological Association guidelines.

If you have any questions about this study or if you would like to learn about the results of this study, you may contact Mahnaz N. Mousavi at mm436@cornell.edu, 607-255-5208, or Counseling and Psychological Services, Student Health Services, Cornell University, Ho Plaza, Ithaca, NY 14853-3101 or check this website later. You may also contact Dr. John Queener at jqueener@uakron.edu, 330-972-6149 or Counseling Department, The University of Akron, Akron, OH 44325-5007. This project has been reviewed and approved by The University of Akron Institutional Review Board. If you have any questions about your rights as a research participant, you may call Sharon McWhorter, Associate Director for Research Services at (330) 972-7666 or 1-888-232-8790.

Acceptance:

I have read the information provided above and all of my questions have been answered. I voluntarily agree to participate in this study. My completion and electronic submission of this survey will serve as my consent.

(You may print a copy of this consent form for future reference.)

**YOU MUST BE 18 OR OLDER**

**TO ENTER THE SURVEY**

SUBMIT
APPENDIX J.

VERIFICATION OF DATA SUBMISSION FOR ON-LINE PARTICIPANTS

By clicking on the SUBMIT link, you, the participant, acknowledge that you have been fully informed of the study’s procedure with its possible benefits and risks. You also understand that your responses are used for the purposes of research at the University of Akron and will be kept anonymous. You give your permission for participation in this study and you know that the investigator and her advisor will be available to answer any questions you may have. You acknowledge that you are at least 18 years of age and that you have read and agreed to the information presented on the first page.

SUBMIT

You understand that you are free to withdraw this consent and discontinue participation in this project at any time without penalty by simply closing your web browser. If you would like to view the sources for more support, but do not like to submit your answers click on the link below.

DO NOT SUBMIT
APPENDIX K.

NOTIFICATION OF TERMINATION OF STUDY

Thank you for your interest in the Quality of Life of Black Women Survivors of Childhood Sexual Abuse Study

Data collection for this project ended on (the date when the data collection was ended). The primary investigator of this study, Mahnaz N Mousavi, was a doctoral student at The University of Akron (OH). If you have any questions about this research project you may contact Mahnaz Mousavi at mm436@cornell.edu, 607-255-5208 or Counseling and Psychological Services, Student Health Services, Cornell University, Ho Plaza, Ithaca, NY 14853-3101. If you are interested in the results of this study you may click this website later.
APPENDIX L.

MANUAL THANK YOU PAGE

THANK YOU FOR YOUR PARTICIPATION!

REFERRAL RESOURCES

If you need any assistance in addressing issues related to childhood sexual abuse, emotional and psychological distress, mental health or physical health problems, or if you need any support, I encourage you to contact one of the following resources.

Rape, Abuse, Incest National Network
Help rape and incest victims, media, policy makers, concerned individuals
Phone: 800-656-HOPE (800-656-4673; Ext. 1)
E-mail: rainnmail@aol.com
Website: www.rainn.org

Stop It Now!
A national, nonprofit organization working to prevent and ultimately eradicate child sexual abuse. Stop It Now! challenges adults to take action by calling on abusers, adults at risk to abuse, and their friends and family, to come forward, learn the warning signs, and seek help.
Phone: 1-888-PREVENT or 413-268-3096
E-mail: info@stopitnow.org
Website: www.stopitnow.org
**Sidran Institute**
A nationally focused nonprofit organization devoted to helping people who have experienced traumatic life events. The Institute promotes improved understanding of the early recognition and treatment of trauma-related stress in children, the long-term effects of trauma on adults, and strategies that lead to the greatest success in self-help recovery for trauma survivors. The Sidran Institute also advocates clinical practices considered successful in aiding trauma victims and the development of public policy initiatives that are responsive to the needs of adult and child survivors of traumatic events.
Phone: 410-825-8888  
E-mail: sidran@sidran.org  
Website: www.sidran.org

**Safer Society Foundation, Inc.**
Is a national research, advocacy, and referral center on the prevention and treatment of sexual abuse. The Foundation provides training and consultation, research, sex offender treatment referrals, a computerized program network, and a resource library. It also publishes materials for the prevention and treatment of sexual abuse.
Phone: 802-247-3132  
Website: www.safersociety.org

**Child Abuse Prevention Network**
Provides professionals with online tools and support for the identification, investigation, treatment, adjudication, and prevention of child abuse and neglect.
Phone: 1-800-4-A-CHILD (800-422-4453)  
E-mail: tom@child-abuse.com  
Website: www.child-abuse.com

**Childhelp USA**
Dedicated to meet the physical, emotional, educational, and spiritual needs of abused and neglected children by focusing its efforts and resources in the areas of treatment, prevention, and research. Its programs and services include the operation of the Childhelp USA National Child Abuse Hotline, residential treatment facilities for severely abused children, child advocacy centers that reduce the trauma of child abuse victims during the interview and examination process, group homes, foster family selection, training and certification, Head Start programs for at-risk children, child abuse prevention programs, and community outreach.
Phone: 480-922-8212  
Toll-Free: (800) 4-A-CHILD  
Website: http://www.childhelpusa.org
**National Black Child Development Institute**
An organization whose mission is to improve and protect the quality of life of African American children and families.
Phone: 202-833-2220
Email: moreinfo@nbcdi.org
Website: www.nbcdi.org

**Black Women Of Essence, Inc.**
A nonprofit women of color organization to enhance the quality of life by providing resources, services, education, networking opportunities along with advocacy and promoting self-awareness within our communities.
Phone: 321-279-8784 or 215-432-4210
Email: reneeellis@bwoe.org
Website: www.bwoe.org

**Jack and Jill of America Foundation, Inc.**
A family organization providing cultural, social, civic and recreational activities that stimulate and expand the mind to enhance life.
Phone: 202-667-7010 or 609-384-1081 (Eastern Region)
Email: jackandjill.inc@verizon.net
Website: www.jack-and-jill.org

**The Center for Black Women's Wellness, Inc.**
A community-based family service aiming to improve the mental, physical and spiritual growth of women and their families and the economic growth of communities.
Phone: 404-688-9202
E-mail: mail@cbww.com
Website: www.cbww.org

**Black Health Online, Inc.**
This online service addresses those diseases that disproportionately affect the Black community. A team of physicians who are able to discuss those diseases that afflict people of African descent maintain the site.
Email: webmaster@blackhealthonline.com
Website: www.blackhealthonline.com

**Black Women's Health Imperative**
A leading African American health education, research, advocacy and leadership development institution to promote optimum health for Black women across the life span—physically, mentally and spiritually.
Phone: 202-548-4000
E-mail: nbwhp@nbwhp.org
Website: www.blackwomenshealth.org
**Blackhealthcare.com**  
A culturally oriented and ethnically focused comprehensive internet-based health and medical information provider dedicated to addressing the special health problems of African-Americans.  
Phone:  301-933-9313  
Email:  whitearthur@email.msn.com  
Website:  www.blackhealthcare.com

**National Congress of Black Women**  
A nonprofit political organization that addresses the aspirations and concerns of the African American community, with special attention to the unique and particular needs of African American women and youth.  
Phone:  877-274-1198 or 301-562-8000  
Email:  info@npcbw.org  
Website:  www.npcbw.org

**National Hook-up of Black Women, Inc.**  
A nonprofit organization dedicated to improving the lives of Black families through support of the arts, culture, health and human service programs. Our chapters sponsor voter registration drives, health fairs, legislative forums, AIDS awareness workshops, support to domestic violence shelters, vouchers for the homeless and annual scholarship awards.  
Phone:  773-667-7061  
E-mail:  nhbwdir@aol.com  
Website:  www.nhbwinc.com

**Women of Color Resource Center**  
Promotes the political, economic, social and cultural well being of women and girls of color in the United States. Informed by a social justice perspective that takes into account the status of women internationally, WCRC is committed to organizing and educating women of color across lines of race, ethnicity, religion, nationality, class, sexual orientation, physical ability and age.  
Phone:  510-444-2700  
E-mail:  info@coloredgirls.org  
Website:  www.coloredgirls.org

**Association of Black Psychologists**  
The leader and international resource for addressing the psychological needs of African people in the Diaspora.  
Phone:  202-722-0808  
Email:  admin@abpsi.org  
Website:  www.abpsi.org
The Feminist Majority Foundation
An organization to empower women economically, socially, and politically, with published resources for accessing services.
Phone: 703-522-2214 or 310-556-2500
Website: www.feminist.org

The National Women's Alliance
A multi-issue human rights and social justice organization devoted to addressing the intersections of race, class, gender, ethnicity, nationality, sexual orientation, and other markers of difference. NWA works at the local, state, and national levels to influence public policy outcomes; increase political participation and action among women/girls of color and low-income women; and bring diverse communities and organizations together to work towards a multi-issue agenda for social and political change.
Phone: 202.518.5411
E-mail: generalinfo@nwaforchange.org
Website: www.nwaforchange.org

Clinic for Individual and Family Counseling
Supervised masters and doctoral level trainees at the Department of Counseling in The University of Akron provide individual, couples, family, and group counseling for children, adolescents, and adults from larger community and students of The University of Akron. Services are charged on an “ability to afford treatment” basis. A sliding fee scale is available so clients are charge according to total household income.
Address: Carroll Hall (315 Carroll Street), Room 128
         Department of Counseling, The University of Akron
         Akron, OH 44325-5007
Phone: 330-972-6822
Website: http://www.uakron.edu/colleges/educ/Counseling/clinic.php

The University of Akron Counseling, Testing and Career Services
Free, confidential, and comprehensive psychological services are offered to currently enrolled students of The University of Akron.
Address: Hezzleton E. Simmons Hall, Rooms 304-306
         The University of Akron
         277 E. Buchtel Avenue,
         Akron, OH 44325-4303
Phone: 330-972-7082
Website: http://www3.uakron.edu/counseling

Mahnaz Nowroozi Mousavi, Doctoral Candidate, Primary Researcher
Address: Counseling and Psychological Services, Gannett Health Services
         Cornell University
         Ithaca, NY 14853-3101
Phone: 607-255-5208
E-mail: mm436@cornell.edu
John E, Queener, Ph.D., Research Advisor
Address: Counseling Department
         The University of Akron
         Akron, OH 44325-5007
Phone:    330-972-6149
E-mail:   jqueener@uakron.edu
APPENDIX M.

ON-LINE THANK YOU PAGE UPON SUBMISSION

THANK YOU! YOUR SURVEY HAS BEEN RECEIVED.

REFERRAL SOURCES

If you need any assistance in addressing issues related to childhood sexual abuse, emotional and psychological distress, mental health or physical health problems, or if you need any support, I encourage you to contact one of the following resources. (You may print this page for future references.)

Rape, Abuse, Incest National Network
Help rape and incest victims, media, policy makers, concerned individuals
Phone: 800-656-HOPE (800-656-4673; Ext. 1)
E-mail: rainnmail@aol.com
Website: www.rainn.org

Stop It Now!
A national, nonprofit organization working to prevent and ultimately eradicate child sexual abuse. Stop It Now! challenges adults to take action by calling on abusers, adults at risk to abuse, and their friends and family, to come forward, learn the warning signs, and seek help.
Phone: 1-888-PREVENT or 413-268-3096
E-mail: info@stopitnow.org
Website: www.stopitnow.org
**Sidran Institute**
A nationally focused nonprofit organization devoted to helping people who have experienced traumatic life events. The Institute promotes improved understanding of the early recognition and treatment of trauma-related stress in children, the long-term effects of trauma on adults, and strategies that lead to the greatest success in self-help recovery for trauma survivors. The Sidran Institute also advocates clinical practices considered successful in aiding trauma victims and the development of public policy initiatives that are responsive to the needs of adult and child survivors of traumatic events.

Phone: 410-825-8888  
E-mail: sidran@sidran.org  
Website: www.sidran.org

**Safer Society Foundation, Inc.**
Is a national research, advocacy, and referral center on the prevention and treatment of sexual abuse. The Foundation provides training and consultation, research, sex offender treatment referrals, a computerized program network, and a resource library. It also publishes materials for the prevention and treatment of sexual abuse.

Phone: 802-247-3132  
Website: www.safersociety.org

**Child Abuse Prevention Network**
Provides professionals with online tools and support for the identification, investigation, treatment, adjudication, and prevention of child abuse and neglect.

Phone: 1-800-4-A-CHILD (800-422-4453)  
E-mail: tom@child-abuse.com  
Website: www.child-abuse.com

**Childhelp USA**
Dedicated to meet the physical, emotional, educational, and spiritual needs of abused and neglected children by focusing its efforts and resources in the areas of treatment, prevention, and research. Its programs and services include the operation of the Childhelp USA National Child Abuse Hotline, residential treatment facilities for severely abused children, child advocacy centers that reduce the trauma of child abuse victims during the interview and examination process, group homes, foster family selection, training and certification, Head Start programs for at-risk children, child abuse prevention programs, and community outreach.

Phone: 480-922-8212  
Toll-Free: (800) 4-A-CHILD  
Website: http://www.childhelpusa.org
National Black Child Development Institute
An organization whose mission is to improve and protect the quality of life of African American children and families.
Phone:  202-833-2220
Email:   moreinfo@nbcdi.org
Website:  www.nbcdi.org

Black Women Of Essence, Inc.
A nonprofit women of color organization to enhance the quality of life by providing resources, services, education, networking opportunities along with advocacy and promoting self-awareness within our communities.
Phone:  321-279-8784 or 215-432-4210
Email:   reneeellis@bwoe.org
Website:  www.bwoe.org

Jack and Jill of America Foundation, Inc.
A family organization providing cultural, social, civic and recreational activities that stimulate and expand the mind to enhance life.
Phone:  202-667-7010 or 609-384-1081 (Eastern Region)
Email:   jackandjill.inc@verizon.net
Website:  www.jack-and-jill.org

The Center for Black Women's Wellness, Inc.
A community-based family service aiming to improve the mental, physical and spiritual growth of women and their families and the economic growth of communities.
Phone:  404-688-9202
E-mail:  mail@cbww.com
Website:  www.cbww.org

Black Health Online, Inc.
This online service addresses those diseases that disproportionately affect the Black community. A team of physicians who are able to discuss those diseases that afflict people of African descent maintain the site.
Email:   webmaster@blackhealthonline.com
Website:  www.blackhealthonline.com

Black Women's Health Imperative
A leading African American health education, research, advocacy and leadership development institution s to promote optimum health for Black women across the life span—physically, mentally and spiritually.
Phone:  202-548-4000
E-mail:   nbwhp@nbwhp.org
Website:  www.blackwomenshealth.org
**Blackhealthcare.com**  
A culturally oriented and ethnically focused comprehensive internet-based health and medical information provider dedicated to addressing the special health problems of African-Americans.  
Phone:  301-933-9313  
Email:  whitearthur@email.msn.com  
Website:  www.blackhealthcare.com

**National Congress of Black Women**  
A nonprofit political organization that addresses the aspirations and concerns of the African American community, with special attention to the unique and particular needs of African American women and youth.  
Phone:  877-274-1198 or 301-562-8000  
Email:  info@npcbw.org  
Website:  www.npcbw.org

**National Hook-up of Black Women, Inc.**  
A nonprofit organization dedicated to improving the lives of Black families through support of the arts, culture, health and human service programs. Our chapters sponsor voter registration drives, health fairs, legislative forums, AIDS awareness workshops, support to domestic violence shelters, vouchers for the homeless and annual scholarship awards.  
Phone:  773-667-7061  
E-mail:  nhbwdir@aol.com  
Website:  www.nhbwinc.com

**Women of Color Resource Center**  
Promotes the political, economic, social and cultural well being of women and girls of color in the United States. Informed by a social justice perspective that takes into account the status of women internationally, WCRC is committed to organizing and educating women of color across lines of race, ethnicity, religion, nationality, class, sexual orientation, physical ability and age.  
Phone:  510-444-2700  
E-mail:  info@coloredgirls.org  
Website:  www.coloredgirls.org

**Association of Black Psychologists**  
The leader and international resource for addressing the psychological needs of African people in the Diaspora.  
Phone:  202-722-0808  
Email:  admin@abpsi.org  
Website:  www.abpsi.org
The Feminist Majority Foundation
An organization to empower women economically, socially, and politically, with published resources for accessing services.
Phone: 703-522-2214 or 310-556-2500
Website: www.feminist.org

The National Women's Alliance
A multi-issue human rights and social justice organization devoted to addressing the intersections of race, class, gender, ethnicity, nationality, sexual orientation, and other markers of difference. NWA works at the local, state, and national levels to influence public policy outcomes; increase political participation and action among women/girls of color and low-income women; and bring diverse communities and organizations together to work towards a multi-issue agenda for social and political change.
Phone: 202.518.5411
E-mail: generalinfo@nwaforchange.org
Website: www.nwaforchange.org

Clinic for Individual and Family Counseling
Supervised masters and doctoral level trainees at the Department of Counseling in The University of Akron provide individual, couples, family, and group counseling for children, adolescents, and adults from larger community and students of The University of Akron. Services are charged on an “ability to afford treatment” basis. A sliding fee scale is available so clients are charge according to total household income.
Address: Carroll Hall (315 Carroll Street), Room 128
Department of Counseling, The University of Akron
Akron, OH 44325-5007
Phone: 330-972-6822
Website: http://www.uakron.edu/colleges/educ/Counseling/clinic.php

The University of Akron Counseling, Testing and Career Services
Free, confidential, and comprehensive psychological services are offered to currently enrolled students of The University of Akron.
Address: Hezzleton E. Simmons Hall, Rooms 304-306
The University of Akron
277 E. Buchtel Avenue,
Akron, OH 44325-4303
Phone: 330-972-7082
Website: http://www3.uakron.edu/counseling

Mahnaz Nowroozi Mousavi, Doctoral Candidate, Primary Researcher
Address: Counseling and Psychological Services, Gannett Health Services
Cornell University
Ithaca, NY 14853-3101
Phone: 607-255-5208
E-mail: mm436@cornell.edu
John E. Queener, Ph.D., Research Advisor
Address: Counseling Department
The University of Akron
Akron, OH 44325-5007
Phone: 330-972-6149
E-mail: jqueener@uakron.edu
APPENDIX N.

TABLES

Table 3.1 - Marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>48</td>
<td>56.5</td>
</tr>
<tr>
<td>Married</td>
<td>18</td>
<td>21.2</td>
</tr>
<tr>
<td>Living as married</td>
<td>5</td>
<td>5.9</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>4.7</td>
</tr>
<tr>
<td>Divorced</td>
<td>8</td>
<td>9.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
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<td>100</td>
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</table>

Table 3.2 - Education degree

<table>
<thead>
<tr>
<th>Degree</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>High school</td>
<td>15</td>
<td>17.6</td>
</tr>
<tr>
<td>College degree</td>
<td>16</td>
<td>18.8</td>
</tr>
<tr>
<td>Graduate or professional degree</td>
<td>25</td>
<td>29.4</td>
</tr>
<tr>
<td>Missing</td>
<td>29</td>
<td>34.1</td>
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<tr>
<td>Total</td>
<td>56</td>
<td>100</td>
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</table>
Table 3.3- Family yearly income

<table>
<thead>
<tr>
<th>Income</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $10,000</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Between $10,000 and $20,000</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Between $20,000 and $30,000</td>
<td>8</td>
<td>9.5</td>
</tr>
<tr>
<td>Between $30,000 and $40,000</td>
<td>11</td>
<td>13.1</td>
</tr>
<tr>
<td>Between $40,000 and $60,000</td>
<td>21</td>
<td>25.0</td>
</tr>
<tr>
<td>Over $60,000</td>
<td>31</td>
<td>36.9</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
<td><strong>100.0</strong></td>
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</tbody>
</table>

Table 3.4- Socioeconomic status of family of origin

<table>
<thead>
<tr>
<th>SES</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>13</td>
<td>15.3</td>
</tr>
<tr>
<td>Working class</td>
<td>43</td>
<td>50.6</td>
</tr>
<tr>
<td>Middle class</td>
<td>22</td>
<td>25.9</td>
</tr>
<tr>
<td>Upper middle class</td>
<td>5</td>
<td>5.9</td>
</tr>
<tr>
<td>Wealthy</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
<td><strong>100</strong></td>
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</table>

Table 3.5- Types of CSA

<table>
<thead>
<tr>
<th>Type of abuse</th>
<th>Frequency</th>
<th>Percentage of abuse</th>
<th>Percentage of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondling</td>
<td>81</td>
<td>69.23</td>
<td>94.12</td>
</tr>
<tr>
<td>Vaginal sex</td>
<td>21</td>
<td>17.95</td>
<td>24.7</td>
</tr>
<tr>
<td>Oral sex</td>
<td>13</td>
<td>11.11</td>
<td>15.3</td>
</tr>
<tr>
<td>Anal sex</td>
<td>2</td>
<td>1.71</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>117</strong></td>
<td><strong>100</strong></td>
<td></td>
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</tbody>
</table>
### Table 3.6-Perpetrator

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Percentage of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Father</td>
<td>4</td>
<td>3.60</td>
<td>4.7</td>
</tr>
<tr>
<td>Female caregiver</td>
<td>4</td>
<td>3.60</td>
<td>4.7</td>
</tr>
<tr>
<td>Male caregiver</td>
<td>7</td>
<td>6.31</td>
<td>8.2</td>
</tr>
<tr>
<td>Sibling</td>
<td>5</td>
<td>4.50</td>
<td>5.9</td>
</tr>
<tr>
<td>Relative</td>
<td>32</td>
<td>28.83</td>
<td>37.7</td>
</tr>
<tr>
<td>Family friend</td>
<td>24</td>
<td>21.63</td>
<td>28.2</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>23</td>
<td>20.72</td>
<td>27.1</td>
</tr>
<tr>
<td>Stranger</td>
<td>12</td>
<td>10.81</td>
<td>14.1</td>
</tr>
<tr>
<td>Total</td>
<td>111</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3.7- Frequency of CSA

<table>
<thead>
<tr>
<th>Frequency of CSA</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 time</td>
<td>23</td>
<td>27.1</td>
</tr>
<tr>
<td>2-4 times</td>
<td>35</td>
<td>41.2</td>
</tr>
<tr>
<td>5-10 times</td>
<td>14</td>
<td>16.5</td>
</tr>
<tr>
<td>More than 10 times</td>
<td>13</td>
<td>15.3</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Table 3.8-Length of CSA

<table>
<thead>
<tr>
<th>Length of CSA</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year</td>
<td>49</td>
<td>57.6</td>
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<tr>
<td>1-2 years</td>
<td>16</td>
<td>18.8</td>
</tr>
<tr>
<td>3-5 years</td>
<td>9</td>
<td>10.6</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Into your adulthood years</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 3.9- Person to whom CSA was disclosed

<table>
<thead>
<tr>
<th>Disclosed to</th>
<th>Frequency</th>
<th>Percentage</th>
<th>Percentage of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>32</td>
<td>42.11</td>
<td>37.6</td>
</tr>
<tr>
<td>Father</td>
<td>5</td>
<td>6.58</td>
<td>5.9</td>
</tr>
<tr>
<td>Female caregiver</td>
<td>1</td>
<td>1.32</td>
<td>1.2</td>
</tr>
<tr>
<td>Male caregiver</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sibling</td>
<td>6</td>
<td>7.89</td>
<td>7.1</td>
</tr>
<tr>
<td>Relative</td>
<td>11</td>
<td>14.47</td>
<td>12.9</td>
</tr>
<tr>
<td>Family friend</td>
<td>8</td>
<td>10.53</td>
<td>9.4</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>9</td>
<td>11.84</td>
<td>10.6</td>
</tr>
<tr>
<td>Stranger</td>
<td>4</td>
<td>5.26</td>
<td>4.7</td>
</tr>
<tr>
<td>Total</td>
<td>76</td>
<td>100</td>
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</tbody>
</table>

Table 4.1- Correlation matrix WHOQOL-BREF domains

<table>
<thead>
<tr>
<th></th>
<th>PH</th>
<th>P</th>
<th>SR</th>
<th>E</th>
<th>QOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH</td>
<td>1</td>
<td>.541**</td>
<td>.392**</td>
<td>.511**</td>
<td>.721**</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>1</td>
<td>.597**</td>
<td>.656**</td>
<td>.848**</td>
</tr>
<tr>
<td>SR</td>
<td></td>
<td></td>
<td>1</td>
<td>.566**</td>
<td>.834**</td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>.831**</td>
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<tr>
<td>QOL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (1-tailed).
PH=Physical Health, P= Psychological, SR= Social Relationships, E= Environment, QOL= Quality of Life total score
Table 4.2- Correlation matrix of CRIS subscales

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>PM</th>
<th>PSH</th>
<th>IEAW</th>
<th>IA</th>
<th>IMCI</th>
<th>PB</th>
<th>NB</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>1</td>
<td>.159</td>
<td>.032</td>
<td>-3.352**</td>
<td>-3.508**</td>
<td>.133</td>
<td>-3.451**</td>
<td>.598**</td>
</tr>
<tr>
<td>PM</td>
<td>1</td>
<td>.311**</td>
<td>.028</td>
<td>.034</td>
<td>.034</td>
<td>.051</td>
<td>.729**</td>
<td></td>
</tr>
<tr>
<td>PSH</td>
<td>1</td>
<td>.162</td>
<td>-.015</td>
<td>-.025</td>
<td>.058</td>
<td>.675**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IEAW</td>
<td>1</td>
<td>.551**</td>
<td>-.343**</td>
<td>.705**</td>
<td>-.081</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IA</td>
<td>1</td>
<td>-1.35</td>
<td>.874**</td>
<td>-.246*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IMCI</td>
<td>1</td>
<td>.177</td>
<td>.071</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PB</td>
<td>1</td>
<td>-.172</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NB</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (1-tailed).
* Correlation is significant at the 0.05 level (1-tailed).
PA= Assimilation, PM= Miseducation, PSH= Self-Hatred, IEAW= Emersion Anti-White, IA=Afrocentricism, IMCI= Multiculturalist Inclusive, PB= Pro-Black reference group orientation, NB= Non-Black reference group orientation

Table 4.3- Correlation matrix of WHOQOL-BREF and CRIS

<table>
<thead>
<tr>
<th></th>
<th>PA</th>
<th>PM</th>
<th>PSH</th>
<th>IEAW</th>
<th>IA</th>
<th>IMCI</th>
<th>PB</th>
<th>NB</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH</td>
<td>-.077</td>
<td>-.030</td>
<td>-.230*</td>
<td>-.163</td>
<td>-.135</td>
<td>.032</td>
<td>-.155</td>
<td>-.169</td>
</tr>
<tr>
<td>P</td>
<td>-.044</td>
<td>-.165</td>
<td>-.352**</td>
<td>-.130</td>
<td>-.014</td>
<td>.012</td>
<td>-.067</td>
<td>-.281**</td>
</tr>
<tr>
<td>SR</td>
<td>.022</td>
<td>.017</td>
<td>-.188</td>
<td>-.087</td>
<td>.077</td>
<td>.019</td>
<td>.016</td>
<td>-.075</td>
</tr>
<tr>
<td>E</td>
<td>-.058</td>
<td>-.179</td>
<td>-.250*</td>
<td>-.030</td>
<td>.032</td>
<td>.135</td>
<td>.065</td>
<td>-.243*</td>
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<tr>
<td>QOL</td>
<td>-.040</td>
<td>-.097</td>
<td>-.305**</td>
<td>-.123</td>
<td>.000</td>
<td>.058</td>
<td>-.035</td>
<td>-.222*</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (1-tailed).
* Correlation is significant at the 0.05 level (1-tailed).
PH=Physical Health, P= Psychological, SR= Social Relationships, E= Environment, QOL= Quality of Life total score, PA= Assimilation, PM= Miseducation, PSH= Self-Hatred, IEAW= Anti-White, IA=Afrocentricism, IMCI= Multiculturalist Inclusive, PB= Pro-Black, NB= Non-Black.
Table 4.4 Hierarchical regression analysis for the second hypothesis

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Change Statistics</th>
<th>R Square</th>
<th>F Change</th>
<th>df1</th>
<th>df2</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>R Square Change</td>
<td></td>
<td>F Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.003</td>
<td>.280</td>
<td>1</td>
<td>83</td>
<td>.598</td>
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<tr>
<td>2</td>
<td>.059</td>
<td>.003</td>
<td>.000</td>
<td>.005</td>
<td>1</td>
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<td>.943</td>
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</table>

Predictors: (Constant), Multiculturalist-Inclusive
Predictors: (Constant), Multiculturalist-Inclusive, Afrocentricism
Dependent Variable: total QOL

Table 4.5- Hierarchical regression analysis for the third hypothesis

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Change Statistics</th>
<th>R Square</th>
<th>F Change</th>
<th>df1</th>
<th>df2</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>R Square Change</td>
<td></td>
<td>F Change</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>.003</td>
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<td>.869</td>
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</tr>
<tr>
<td>2</td>
<td>.148</td>
<td>.022</td>
<td>.018</td>
<td>1.531</td>
<td>1</td>
<td>81</td>
<td>.220</td>
<td></td>
</tr>
</tbody>
</table>

Predictors: (Constant), Afrocentricism, Multiculturalist-Inclusive
Predictors: (Constant), Afrocentricism, Multiculturalist-Inclusive, Anti-White
Dependent Variable: total QOL

Table 4.6- Hierarchical regression analysis for the fifth hypothesis

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Change Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R Square</td>
<td>R Square Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>F Change</td>
</tr>
<tr>
<td>1</td>
<td>.305</td>
<td>.093</td>
<td>.093</td>
</tr>
<tr>
<td>2</td>
<td>.305</td>
<td>.093</td>
<td>.000</td>
</tr>
</tbody>
</table>

Predictors: (Constant), Self-Hatred
Predictors: (Constant), Self-Hatred, Miseducation
Dependent Variable: total QOL
Table 4.7- Hierarchical regression analysis for the sixth hypothesis

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Change Statistics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>R Square Change</td>
<td>$F$ Change</td>
</tr>
<tr>
<td>1</td>
<td>.305</td>
<td>.093</td>
<td>.093</td>
<td>4.209</td>
</tr>
<tr>
<td>2</td>
<td>.307</td>
<td>.094</td>
<td>.001</td>
<td>.081</td>
</tr>
</tbody>
</table>

Predictors: (Constant), Miseducation, Self-Hatred
Predictors: (Constant), Miseducation, Self-Hatred, Assimilation
Dependent Variable: total QOL

Table 4.8- Summary of results

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Dependent variable</th>
<th>Predictor variables</th>
<th>Supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>General QOL</td>
<td>Pro-Black</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>General QOL</td>
<td>Non-Black</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>1 QOL</td>
<td>IMCI</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>2 QOL</td>
<td>IA + IMCI</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>3 QOL</td>
<td>IEAW + IA + IMCI</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>4 QOL</td>
<td>PSH</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>5 QOL</td>
<td>PM + PSH</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>6 QOL</td>
<td>PA + PM + PSH</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Table 5.1- Descriptive Statistics for the WHOQOL-BREF

<table>
<thead>
<tr>
<th>Domain (Manual)</th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>64</td>
<td>32.14</td>
<td>92.86</td>
<td>66.80</td>
<td>14.55</td>
</tr>
<tr>
<td>Psychological</td>
<td>64</td>
<td>37.50</td>
<td>95.83</td>
<td>73.50</td>
<td>13.72</td>
</tr>
<tr>
<td>Social Relationships</td>
<td>64</td>
<td>25.00</td>
<td>100.00</td>
<td>73.18</td>
<td>17.09</td>
</tr>
<tr>
<td>Environment</td>
<td>64</td>
<td>28.13</td>
<td>100.00</td>
<td>72.80</td>
<td>14.16</td>
</tr>
<tr>
<td>Total QOL (Not reported)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain (Current Study, CSA group)</th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>85</td>
<td>28.57</td>
<td>71.43</td>
<td>71.39</td>
<td>15.04</td>
</tr>
<tr>
<td>Psychological</td>
<td>85</td>
<td>12.50</td>
<td>87.50</td>
<td>67.94</td>
<td>15.27</td>
</tr>
<tr>
<td>Social Relationships</td>
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<td>.00</td>
<td>100.00</td>
<td>60.59</td>
<td>22.58</td>
</tr>
<tr>
<td>Environment</td>
<td>85</td>
<td>28.13</td>
<td>68.75</td>
<td>66.29</td>
<td>15.93</td>
</tr>
<tr>
<td>Total QOL</td>
<td>85</td>
<td>29.65</td>
<td>66.22</td>
<td>66.55</td>
<td>13.96</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain (Current Study, NCSA group)</th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
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<td>35.71</td>
<td>100.00</td>
<td>76.68</td>
<td>15.95</td>
</tr>
<tr>
<td>Psychological</td>
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<td>25.00</td>
<td>100.00</td>
<td>73.77</td>
<td>14.08</td>
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<td>Social Relationships</td>
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<td>100.00</td>
<td>69.12</td>
<td>19.66</td>
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<tr>
<td>Environment</td>
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<td>100.00</td>
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<td>15.54</td>
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<tr>
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<td>32.92</td>
<td>100.00</td>
<td>72.58</td>
<td>13.48</td>
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Table 5.2- Hierarchical regression analysis for PSH and CSA

<table>
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<tr>
<th>Model</th>
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<th>R Square</th>
<th>R Square Change</th>
<th>Change Statistics</th>
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</thead>
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<tr>
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</tr>
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<td></td>
<td>Change Statistics</td>
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<td>F</td>
</tr>
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<td></td>
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<td>2</td>
<td>.382</td>
<td>.146</td>
<td>.135</td>
<td>14.24</td>
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Predictors: (Constant), Self-Hatred
Predictors: (Constant), Self-Hatred, CSA
Dependent Variable: total QOL
Table 5.3- Descriptive Statistics for the CRIS

<table>
<thead>
<tr>
<th>Subscales (Manual)</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Assimilation</td>
<td>336</td>
<td>13.6</td>
<td>6.05</td>
</tr>
<tr>
<td>Miseducation</td>
<td>336</td>
<td>13.7</td>
<td>5.60</td>
</tr>
<tr>
<td>Self-Hatred</td>
<td>336</td>
<td>9.75</td>
<td>5.50</td>
</tr>
<tr>
<td>Anti-White</td>
<td>336</td>
<td>10.15</td>
<td>5.40</td>
</tr>
<tr>
<td>Afrocentricity</td>
<td>336</td>
<td>19.45</td>
<td>5.40</td>
</tr>
<tr>
<td>Multicultural Inclusive</td>
<td>336</td>
<td>17.95</td>
<td>4.50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscales (Current study, CSA group)</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assimilation</td>
<td>85</td>
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<td>7.16</td>
</tr>
<tr>
<td>Miseducation</td>
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</tr>
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<td>Self-Hatred</td>
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<td>10.53</td>
<td>7.19</td>
</tr>
<tr>
<td>Anti-White</td>
<td>85</td>
<td>9.14</td>
<td>5.40</td>
</tr>
<tr>
<td>Afrocentricity</td>
<td>85</td>
<td>18.94</td>
<td>7.32</td>
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<td>Multicultural Inclusive</td>
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<td>28.62</td>
<td>4.79</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Subscales (Current study, NCSA group)</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assimilation</td>
<td>85</td>
<td>14.68</td>
<td>7.28</td>
</tr>
<tr>
<td>Miseducation</td>
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<td>14.91</td>
<td>6.29</td>
</tr>
<tr>
<td>Self-Hatred</td>
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<td>9.64</td>
<td>5.17</td>
</tr>
<tr>
<td>Anti-White</td>
<td>85</td>
<td>8.31</td>
<td>3.93</td>
</tr>
<tr>
<td>Afrocentricity</td>
<td>85</td>
<td>17.18</td>
<td>6.20</td>
</tr>
<tr>
<td>Multicultural Inclusive</td>
<td>85</td>
<td>26.84</td>
<td>6.28</td>
</tr>
</tbody>
</table>
LETTER OF PERMISSION FROM THE UNIVERSITY OF AKRON
INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN
SUBJECTS-2005

Office of Research Services and Sponsored Programs
Akron, OH 44325-2102
(330) 972-7666 Office
(330) 972-6281 Fax

February 16, 2005

Mahnaz Nowroozi Mousavi 116
Sapsucker Woods Rd. #1A
Ithaca, New York 14850

Ms. Mousavi:

The University of Akron’s Institutional Review Board for the Protection of Human Subjects (IRB) completed a review of the protocol entitled “Quality of Life and Racial Identity Among Black Women Survivors of Childhood Sexual Abuse”. The IRB application number assigned to this project is 20050102.

The protocol qualified for Expedited Review and was approved on February 16, 2005. The protocol represents minimal risk to subjects and matches the following federal category for expedited review:

(7) Research on individual or group characteristics or behavior or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation or quality assurance methodologies

This approval is valid until February 16, 2006 or until modifications are proposed to the project protocol, whichever may occur first. In either instance, an Application for Continuing Review must be completed and submitted to the IRB.

Enclosed is the informed consent document, which the IRB has approved for your use in this research. A copy of this form is to be submitted with any application for continuation of this project.
In addition, your request for a waiver of documentation of informed consent, as permitted under 45 CFR 46.117(c), is also approved.

Please note that within one month of the expiration date of this approval, the IRB will forward an annual review reminder notice to you by email, as a courtesy. Nevertheless, it is your responsibility as principal investigator to remember the renewal date of your protocol's review. Please submit your continuation application at least two weeks prior to the renewal date, to insure the IRB has sufficient time to complete the review.

Please retain this letter for your files. If the research is being conducted for a master's thesis or doctoral dissertation, you must file a copy of this letter with the thesis or dissertation.

Sincerely,

Sharon McWhorter, Associate Director

Cc: James Rogers, Interim Department Chair
    John Queener, Advisor
    Phil Allen, IRB Chair

The University of Akron is an Equal Education and Employment Institution
LETTER OF PERMISSION FROM THE UNIVERSITY OF AKRON
INSTITUTIONAL REVIEW BOARD FOR THE PROTECTION OF HUMAN
SUBJECTS-2006

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Akron, OH 44325-2102
(330) 972-7666 Office
(330) 972-6281 Fax

February 10, 2006

Mahnaz N. Mousavi
116 Sapsucker Woods Road, #1A
Ithaca, New York 14850

Ms. Mousavi:

The University of Akron’s Institutional Review Board for the Protection of Human Subjects (IRB) completed a
review of your application for continuing review entitled “Quality of Life and Racial Identity among Black Women
Survivors of Childhood Sexual Abuse”. The IRB application number assigned to this project is 20050102-2.

The protocol qualified for Expedited Review and was approved on February 10, 2006. The protocol represents
minimal risk to subjects and matches the following federal category for expedited review:

(7) Research on individual or group characteristics or behavior or research
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factors evaluation or quality assurance methodologies

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