I, Patrice D DeLeon, hereby submit this original work as part of the requirements for the degree of Doctor of Philosophy in Health Education.

It is entitled:
Campus- and Community- Based Administrators and Mental Health Providers Perspectives on Sexual Assault among College-Age Women

Student’s name:  Patrice D DeLeon

This work and its defense approved by:

Committee chair:  Laura Nabors, Ph.D.

Committee member:  Mei Tang, Ph.D.

Committee member:  Rebecca Vidourek, Ph.D.
Campus- and Community- Based Administrators and Mental Health Providers Perspectives on Sexual Assault among College-Age Women

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By

Patrice D. DeLeon

M.Ed. Kent State University, 2013

B.S Kent State University 2010

B.A. Kent State University 2006

Committee Chair: Laura A. Nabors, PhD., ABPP

Committee Members: Rebecca A. Vidourek, PhD., CHES

Mei Tang, PhD
Abstract

AN ABSTRACT OF THE DISSERTATION FOR THE DOCTOR OF PHILOSOPHY
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TITLE: Campus- and Community- Based Administrators and Mental Health Providers
Perspectives on Sexual Assault among College-Age Women.

DOCTORAL COMMITTEE MEMBERS: Dr. Laura A. Nabors (chair), Dr. Rebecca A.
Vidourek and Dr. Mei Tang

This dissertation consists of two studies. Study one examined community-based sexual
assault program leaders’ perspectives on intervention programs for young adult women. Study
two examined college campus administrators’ perspectives on disclosure and treatment of sexual
assault for college-age women who are African American.

Study One Abstract

The current study examined the perspectives of campus- and community-based
administrators about their perceptions of effective mental health interventions for college-age
women. The sample for this study (n = 20) consisted of campus- and community- based mental
health providers and administrators. Participants were recruited from on- and off- campus
organizations that work closely with students and survivors of sexual assault. Participants were
recruited by telephone or email to inquire as to whether they would participate in an interview.
Content analysis was used to analyze interview data. Results indicated that participants believed
that African American women benefit from culturally appropriate services, a safe atmosphere,
providers knowledgeable in trauma care, and services that were available for a length of time that
would help them work through trauma related to assault. This study is one of the first to assess
perceptions of needs for services for African American women on college campuses and results revealed that access to services and establishing linkages with women to overcome the stigma related to participating in mental health services are important goals. Future research could delve deeper into examining the perceptions of college-age women who have sought mental health treatment for depression or PTSD (and other psychological symptoms of sexual trauma) to uncover best practices for retaining college-age women in mental health treatment post-assault.

Study Two Abstract

The purpose of this study was to gain the perspectives of college and university administrators on strategies for improving reporting and treatment seeking among African American college-age women. A total of 20 campus- and community-based administrators and mental health providers were interviewed in Spring 2017. Results of the present study indicated several themes and sub-themes for five primary areas. Those areas included: key barriers to reporting, ideas for overcoming reporting barriers, barriers to participation in mental health treatment, ideal mental health treatment, and overcoming barriers and enhancing treatment participation. Findings showed critical key barriers to reporting and participation in mental health treatment that are consistent across the board with other research studies (i.e. mistrust of the police, cultural barriers, strong Black woman stereotype). Providing African American college-age women alternative options for mental health treatment that includes a spiritual component, a holistic approach (that helps the survivor heal) and validation could possibly encourage more African American women who have experienced a sexual assault to consider seeking treatment. Future research could examine the impact of having a diverse staff of mental health providers and administrators on sexual assault, sexual assault messaging that is intentionally geared towards students of color, and the impact of empowerment messages
particularly for African American women on speaking out against rape culture and encouraging survivors to come forward.
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This dissertation is dedicated to my heart and soul – my grandmother Delia S. Fairley, and my big brothers – LaMont and Christopher Campbell.
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Study One: Community-Based Sexual Assault Program Leaders: Perspectives on Intervention Programs for Young Adult Women
Introduction

According to the Centers for Disease Control and Prevention [CDC] (2014a) and the Office of Women’s Health (U.S. Department of Health and Human Services [USDHHS], 2015) sexual assault is defined as any type of sexual contact or activity (including unwanted kissing, fondling, forced sodomy, rape, attempted rape, child molestation, and sexual harassment) that occurs without the explicit consent of the recipient. In a nationally representative survey conducted by the CDC (2012) it was estimated that approximately one in five women had been raped at some point over the course of their lives. That same report stated that 12.5% of women had experienced sexual coercion and 27.3% had experienced unwanted sexual contact (CDC, 2012). In terms of ethnicity, a U.S. survey conducted on adult women ($N = 7,758$) showed that 27.5% of American Indian/Alaskan Natives, 21.2% of African Americans, 20.5% of Caucasians, and 13.6% of Hispanics were raped at some time in their lives (CDC, 2014b).

When compared to any other crime on college campuses, sexual assault is the most dominant crime against women (U.S. Department of Justice, 2014). According to the U.S. Department of Justice (2014), there are two sexual assaults on college women for every one robbery. College-age women are amongst the most heavily impacted population by sexual assault in the country. Thirty-seven percent of adult women that were rape victims were first raped between 18-24 years of age (CDC, 2012). Hence, college-age women (non-students), 18-24 years old, are four times more at risk than other women to be sexually assaulted in comparison to female college students of the same age who are three times more at risk (U.S. Department of Justice, 2014). Upon entering college, 19% of undergraduate women have experienced an attempted or completed rape, with 5.2% in the past year (CDC, 2012; CDC 2014a). Of all college students, 8.8% of female graduate and professional students and 23.1% of
female undergraduate students have experienced rape or sexual assault through violence, physical force or incapacitation (alcohol and/or other drug [AOD]-enabled) (Association of American Universities, 2015).

In approximately 80% of rape and sexual assault cases within this population, the victims knew the identity of their perpetrator (e.g., current or previous partner, friend, acquaintance, co-worker or even a classmate; U.S. Department of Justice, 2014). Fifty percent of student victims were more likely to have been acquaintances or friends with their perpetrators, while 24% were intimately involved with their offenders prior to being sexually assaulted (U.S. Department of Justice, 2014). It is estimated that about one in five incidents of sexual assault and rape occur in young adults, with roughly equal numbers for those who are in college versus those who are not in college (U.S. Department of Justice, 2014). Evidence has been made available regarding variations in types of sexual assault that occur on dates. For college women, 12.8% of completed rapes have occurred on dates, 35% of attempted rapes and 22.9% of threatened rapes also took place on dates (U.S. Department of Justice, 2000).

**Impact of Sexual Assault on Women’s Physical Health**

**Physical injuries.** In some instances, physical injuries to the genital area sustained during a sexual assault can mirror those of consensual sex. During consensual sex a woman may experience some vaginal bleeding and obtain some bruising, and minor lacerations or tears in and around the vaginal area as well as the anus. Sexual assault victims may acquire these same injuries but these injuries may be more severe and in different positions. In a research study conducted by Astrup, Ravn, Thomsen, and Lauritsen (2013), in the cases of sexual assault victims, they sustained significantly more abrasions, more bruising and higher frequencies of genital lesions in locations other than the 6’o clock position (such as in between 4’o clock and 7
o’clock positions) compared to women who sustained injury during consensual sex. Sexually assaulted women may present higher frequencies of genital lesions that are often larger than those obtained during consensual sex (McLean, Roberts, White & Paul, 2011).

Apart from injuries to their genital area, women that are sexually assaulted may also receive extra-genital injuries to their breasts, arms, face, mouth, neck, back and hands (Clifton & Feeny, 2014). Bruises to their arms and legs may be from being held down or restrained by their attacker. Injuries sustained to their hands could be defensive wounds or from being thrown to the ground. Lacerations (cuts, scratches, etc.) and bruises to the neck or face could be sustained from being choked, smothered, punched or slapped (Clifton & Feeny, 2014). According to the United States Department of Justice (2000), in approximately one in five completed and attempted rape cases, victims had reported having a black-eye, chipped teeth, scratches and swelling. Other physical health impacts may be sexually transmitted infections [STIs] such as chlamydia, gonorrhea, trichomoniasis, hepatitis and HIV/AIDS (though cases of HIV/AIDS are rare) and unwanted pregnancies (which are rare; Amar 2008; Clifton & Feeny, 2014). In research studies discussing further long-term physical health impacts of sexual assault, victims also reported trauma reactions that further impact mental health; migraine headaches, chronic pelvic pain, reproductive and sexual dysfunction, gastrointestinal issues as well as fibromyalgia (Campbell, Lichty, Sturza & Raja, 2006; Tillman, Bryant-Davis, Smith & Marks, 2010).

Impact of Sexual Assault on Women’s Mental Health

Psychological Effects. Sexual assault victims may suffer from a wide variety of different short- and long-term psychological effects. Short-term effects include nightmares, guilt, sleep disturbances, embarrassment, shame, agitation, confusion or a combination of the aforementioned feelings (Clifton & Feeny, 2014; Eisenberg, Lust, Hannan, & Porta, 2016).
Immediately following an assault, a victim may display emotional and behavioral responses that could range from being talkative to silent, from trembling to calmness, to shock and disbelief, to being aloof, or hysteria (Clifton & Feeny, 2014). They may also exhibit other short-term psychological symptoms, such as withdrawal, isolation, self-harm, have feelings of anger and/or worthlessness, fear, suicidal ideation, anxiety and decreased self-esteem after being sexually assaulted (Tillman et al., 2010). Among ethnically diverse groups, mental health effects related to sexual assault and rape are comparable (such as rates of PTSD, suicidality, and substance use).

**Post-Traumatic Stress Disorder (PTSD) and Depression.** PTSD is an anxiety disorder with symptoms that may include re-experiencing the trauma through flashbacks, avoidance (any trauma-related thoughts, feelings or situations) and hyperarousal that causes sleep difficulties, irritability, and issues concentrating (Clifton & Feeny, 2014). Symptoms may last longer than a month and can hinder a person’s ability to function socially and occupationally (Zinzow et al., 2010). PTSD is the most common psychological disorder resulting from sexual violence; however, up to half of sexual assault victims develop depression or another form of anxiety and almost 1 in 5 have attempted suicide (Eisenberg et al., 2016).

Concurrent data from the American College Health Association’s National College Health Assessment, found that approximately 36.6% of undergraduate females felt depressed, more than fifty percent felt overwhelming anxiety, and 9% had seriously considered suicide (American College Health Association, 2015). In a study conducted by Zinzow et al. (2010), forcibly raped sexual assault victims were at a significantly higher risk for PTSD and depression. Internalized effects of sexual assault trauma can lead to depression and PTSD which can also significantly impact the academic performance of college students. A study conducted by Jordan, Combs, and Smith (2014) revealed that college women who have been sexually assaulted and are
under more psychological distress are more likely to drop out of school. College-age victims with PTSD and depression are likely to be withdrawn and isolated leading to lack of classroom attendance and a drop in their grade-point averages, thereby increasing the likelihood of dropping out of school (Jordan et al., 2014).

**Substance Abuse and Changes in Sexual Behavior.** Findings collected by Bedard-Gilligan, Cronce, Lehavot, Blayney, and Kaysen (2014) on college women suggested that sexual assault and PTSD are associated with greater avoidant coping and complaints about declining physical health. Bedard-Gilligan et al. (2014) also discovered a link between sexually assaulted college women with PTSD and higher alcohol consumption, which, in turn, was associated with complaints of declining physical health. According to data findings by Turchik and Hassija (2014), female college students who were sexually victimized had increased use of drugs, problematic drinking behaviors, and sexual dysfunction. Additionally, their findings revealed that college women who had experienced severe forms of sexual assault (such as rape) were most likely to participate in risk-taking behaviors and have sexual functioning issues (Turchik & Hassija, 2014). Engaging in risky behaviors such as problematic drinking (binge drinking), drug use, and sexual risk behaviors (unprotected sex with multiple partners) also places sexual assault victims at risk of being sexually victimized again (Turchik & Hassija, 2014). Because the psychological outcomes may be significant, it remains very important to examine ideas for developing and delivering optimal mental health treatments for women who have experienced sexual assault.

**Mental Health Treatment**

Although colleges and universities across the country have implemented sexual assault prevention programs, new incidences of sexual assault have not subsided. Sexual assault
prevention programming is certainly essential to changing cultural belief systems that seem to condone sexual assault in our society (Neville & Hepper, 2002). However, it is critical that institutions also provide effective mental health interventions designed to treat as well as in some cases prevent any chronic psychological distress among sexual assault survivors (Neville & Hepper, 2002). According to Neville and Hepper (2002), the majority of research thus far has evaluated the effectiveness of cognitive behavioral interventions on survivors’ PTSD, depression and anxiety. Knowledge about best practices for providers and programs will improve treatment. Further, more information is needed to uncover critical supportive behaviors and attitudes for mental health providers who work with survivors of sexual assault. Results of the current study will provide information in this area. Moreover, this study also will provide information about ideas for designing optimal treatment programs for college-age women who experienced sexual assault.

**Study Purpose**

This study examined the perspectives of campus- and community-based administrators about their perceptions of ideal mental health interventions for college-age women. The following research questions were addressed:

1) What are ideal goals for mental health interventions for young adult women who have experienced sexual assault?

2) What qualities should mental health providers have when dealing with young adult women who have been sexually assaulted?

3) How does one retain college-age women in mental health treatment after an assault?
Methods

Participants

The sample for the study consisted of twenty campus- and community-based administrators and mental health providers who were selected through research on local services by this investigator and snowball sampling. Snowball sampling or chain referral sampling is a technique in which participants in the study provide referrals to the researcher to recruit future participants and those future participants provide more referrals to the researcher and so on (Noy, 2008). The participants were from a large Midwestern university and its surrounding community in the United States. Administrators and mental health providers were recruited from on- and off-campus organizations that work closely with students and survivors of sexual assault. Participation in the study was voluntary and a university-based institutional review board approved the study as non-human subjects research (see Appendix A).

Administrators. A total of fourteen administrators from a large Midwestern university and the surrounding community completed interviews. Ten identified as working for campus-based organizations, three identified as being in community-based organizations and one identified as being employed by a campus- and community-based organization. Years worked in the field of sexual assault ranged between zero and nineteen years ($M = 7.21$). Years worked with women who had been sexually assaulted ranged between zero and nineteen years ($M = 8.50$). All participants identified as female; eight were Caucasian/White and six were African American/Black.

Mental Health Providers. A total of six mental health providers from a large Midwestern university and the surrounding community completed interviews. Four identified as working for campus-based organizations and two identified as being members of community-based organizations. Years worked in the field of sexual assault ranged between three and fifteen
years \( (M = 7.83) \). Years worked with women who have been sexually assaulted ranged between three and fifteen years \( (M = 7.83) \). All participants identified as female; four were Caucasian/White and two were African American/Black.

**Procedures**

Participants were recruited by telephone or email (if preferred) to inquire as to whether they would participate in an interview. This initial telephone call was no longer than ten minutes. Participants were informed of the purpose of the research study and then the interview was scheduled (time and location).

The in-person interview typically lasted about 14-50 minutes; however, there was one interview that lasted an hour and seventeen minutes. In-person interviews began in February of 2017 and ended in April of 2017. Prior to the start of the interviews, the researcher provided the participants with the Interview Guide for Study Participants (see Appendix B). Next, participants were asked to provide written and verbal assent for their interview to be audio recorded. In conjunction to the interviews being recorded, the researcher recorded field notes.

The interview questions were provided to the participants at the beginning of each interview. The interview question guide for study participants is presented in Appendix C. Only a portion of the questions on the interview were used for the current study. Specifically, these questions sought to determine the participants’ perspectives about ideal mental health interventions for college-age women who had been sexually assaulted, ideas for helping these women stay in mental health treatment, and qualities that mental health providers should have (see Appendix C). The interview questions are presented in Table 1.

Insert Table 1 here
Prior to answering the interview questions the participants provided demographic information, which included information about: gender, ethnic group, organization (college-based or community-based), how many years the participant had worked in the field of sexual assault, and how many years the participant had worked with women who have been sexually assaulted.

**Data Analysis**

Interviews were transcribed verbatim and all data were de-identified and no names or identifying information were shared. The researcher and a research assistant analyzed the interview transcriptions to identify important themes and statements that would provide a clear understanding of ideas provided by the participants. The interviews were analyzed via content analysis to identify key themes in the interviews. A conventional content analysis is usually used with a research study that is designed to describe a phenomenon. In a content analysis, all the data is read repeatedly to ensure that the researcher is immersed in the data. Data is read word by word to derive codes, key thoughts or concepts (Hsieh & Shannon, 2005).

The researcher then makes notes of her impressions as well as develops a dictionary of terms representing key concepts in the data. (Hsieh & Shannon, 2005). A research assistant also analyzed 60% of the interviews to confirm themes in the data. A list of key themes for each question was developed over six of meetings. The duration of each meeting was approximately two hours (range from 1.5 to 3 hours). Consensus was used to resolve disagreements. Agreement was reached through discussion, checking the researcher’s and the assistant’s spreadsheets with lists of themes and representative quotes, and when needed checking raw data in the transcripts of the interviews. The research assistant had expertise in qualitative coding and had previously worked on three qualitative studies where content analysis was used to determine themes in
interview data. The research assistant was trained in use of content analysis by this researcher’s mentor.

Validity

**Member Checks.** Member checks solicit feedback about the data and conclusions from the people who are being studied. Member checks allow for ruling out possibilities of misinterpreting the meaning behind what the participants said or did. (Maxwell, 2013). Member checks are also an important way to identify the biases or misunderstandings the researcher may have of what was observed (Maxwell, 2013).

For member checking, the major themes and sub-themes were compiled and then placed onto a list. The researcher contacted eight participants (six administrators and two mental health providers) via email with the list of themes and sub-themes attached. Six agreed to participate in member-checking. Five administrators and one mental health provider participated. Four administrators identified as Caucasian/white and one administrator identified as African American/Black. The mental health provider identified as Caucasian. The researcher asked the participants if the themes and sub-themes on the list accurately described their experiences as a campus or community leader working with sexual assault survivors. The researcher also asked if there were anything they wanted to clarify or add.

**Avoiding Question Bias.** In an attempt to avoid question-order bias, the researcher provided the participants with the interview questions prior to beginning the interview. The researcher also informed the participants that they could skip any question if they choose to do so.

**Researcher Bias.** According to Maxwell (2013) researcher bias influences the collection and/or interpretation of data when the selection of data fits the researcher’s existing goals, preconceptions or theories. It is impossible to eliminate the researcher’s theories and beliefs but
it is important to understand how this can influence the participants (Creswell, 2013; Maxwell, 2013). The investigator remained aware of possible culture bias and how that might influence the study. The researcher remained aware of her own cultural assumptions and worked to understand and respect the culture of the participants. The researcher recorded her biases after reporting study results, in a section (e.g., in a position statement placed after study results) devoted to exploring potential researcher bias and how this might have impacted study results.

**Results**

After reviewing the interviews, the researcher and the research assistant found three primary areas for themes: 1) ideal goals for mental health interventions, 2) qualities of mental health providers, and 3) retention efforts for college age women in mental health treatment.

**Ideal Goals for Mental Health Interventions.** Ideal goals with subthemes are presented in Table 2.

Insert Table 2 here

Through analysis of the participants’ interviews, three main sub-themes emerged from the data regarding ideal goals for mental health interventions. 1) creating safe atmosphere, 2) maintaining functionality, and 3) unpacking the trauma. Minor sub-themes included ideas presented about providing a variety of therapy options, while allowing survivors to choose what they feel is best for them and trusting in their ability to do so. Survivors of sexual assault may also feel a sense of disempowerment or that they have lost their voice due to their traumatic experience. Therefore, helping them regain their empowerment or give them back a sense of control during the therapy process was also a sub-theme.

Establishing safety and allowing the survivor to determine what that means for her was one of the essential ideal goals for mental health interventions stated by mental health providers
(see Table 2). Administrators discussed the need to make the survivor feel comfortable while assisting her with beginning the healing process and encouraging self-care as important components of treatment. Both mental health providers and administrators reported that helping the survivor remain stabilized and functional to keep going through life as usual as being a critical ideal goal of mental health interventions (see Table 2). Unpacking the trauma or assisting the survivor with identifying, understanding or making sense of, and processing the trauma was described by mental health providers as being a major goal of mental health interventions (see Table 2). In terms of unpacking the trauma, administrators and mental health providers were talking about the importance of therapy as a space where women could work through their trauma experiences in a safe and supportive environment.

**Qualities of Mental Health Providers.** Four main sub-themes were discovered by the research team after examining the data for qualities of mental health providers. 1) cultural competency, 2) knowledge of rape culture, 3) general factors of therapy, and 4) trauma informed training and this information is presented in Table 3.

Having knowledge of available resources (on campus and within the community), was a minor sub-theme among administrators who felt that mental health providers should possess this quality. They felt that this knowledge would be useful to refer survivors to other services they may need outside of treatment. Cultural competency was reported as being important by both administrators and mental health providers (see Table 3). However, mental health providers also thought it was important that they acknowledged their own limitations that there are “experiences that they have heard about but will never fully understand.” Both administrators and mental health providers reported that having a high level of sexual assault trauma informed
training is an essential quality that mental health providers should have when working with women who have experienced sexual violence (see Table 3). Having the ability to be understanding, trustworthy, supportive, non-confrontational, respectful, and approachable (“being warm and welcoming”) were all qualities endorsed by administrators. In addition, mental health providers stated along with possessing active and reflective listening skills that providers need to be empathic, non-judgmental, patient, and have an unconditional positive regard for their clients (see Table 3).

In regards to a survivor seeking mental health services, both mental health providers and administrators understood the importance of “fit and match.” Participants reported that survivors would need to select a mental health provider who they felt would hear them out, that they could trust, and “could sit with them and walk with them through these difficult pieces.” Finally, for theme two, both administrators and mental health providers reported having knowledge of rape culture, rape myths, and the college culture were key qualities for mental health providers to have (see Table 3).

**Retention Efforts for College-Age Women in Mental Health Treatment.** Theme three involved retention efforts and was represented by three sub-themes: 1) relationship and connection building, 2) financially affordable, and 3) autonomy; and this information is presented in Table 4.

| Insert Table 4 here |

Relationship and connection building were critical to retaining college-age women in mental health treatment after an assault. Points such as trying to keep that connection to a survivor even after a client has left treatment, engaging in a positive, trusting relationship, building a relationship between the counselor and the survivor, having a successful first initial contact, and
being a reference and connecting the survivor with other resources were all mentioned as essential parts of treatment (see Table 4).

Having the financial means to afford to participate in mental health treatment and remain in treatment was also discussed as a way of retaining college-age women in mental health treatment. Administrators noted that college-age women who have experienced a sexual assault could be more open to remaining in treatment if they had the money and/or insurance to do so (see Table 4). The mental health providers described the significance of the client’s autonomy in relation to retention efforts. The mental health providers explained that meeting with a survivor and having an idea of what needs to be done to “fix her” is highly problematic. They also stated that it is in the best interest of the client to respect her autonomy and reinforce the notion that at the end of the day, it is up to her to do what she wants to do (see Table 4).

**Member-Checking to Audit Themes**

The administrators and a mental provider supported the themes and sub-themes discovered from the interviews. Table 5 represents the list that was emailed to the participants. Both the mental provider and the administrators endorsed the main themes and the sub-themes.

Insert Table 5 here

Administrators reported the list being comprehensive and accurate and the mental health provider reported the list captured the content of the interview.

**Position Statement.** I have worked closely with college students for the past nine years and up until a year ago, I had not paid close attention to the sexual assault incidents that plague college campuses nationwide. However, last year a specific sexual assault case emerged and an all too familiar verdict was handed down in favor of the perpetrator. It was then that I started investigating other sexual assault cases at colleges and universities in the U.S. I was
dumbfounded by the weight of rape culture in our society. I became inquisitive about the physical and mental health effects of sexual violence on victims, what was being done regarding prevention and intervention efforts to assist them, and were those efforts making an impact. After all I had very little experience talking about or researching the topic of sexual assault and its impact on mental health.

After I realized this position and how my passion for helping survivors could potentially impact my objectivity when conducting interviews, I developed an interview guide, with specific probes. The interviews were conducted according to the interview guide and the probes were used to uncover additional information. I monitored my tone of voice and kept my questions open-ended, thus allowing the participants to provide their own views and opinions. I added an additional research assistant to assist in examining themes in the interview data and ensured a member-checking process as mechanisms to improve the objectivity of data analysis. Finally, I transcribed the participants’ answers and had a research assistant review the transcripts to enhance objectivity and rigor in the methods of recording answers and ensuring an objective review of what the participants reported during the interview process.

Discussion

The present study examined campus- and community- based leaders’ perspectives on ideal goals for mental health interventions, qualities of mental health providers, and retention efforts for college age women in mental health treatment. Some findings were consistent with available research for ideal goals for mental health interventions and qualities of mental health providers (McLindon & Harms, 2011). Goals included having accessible services with providers trained in working with trauma. Also, results highlighted the importance of retention efforts, as it may be difficult to maintain survivors in treatment. Access to services and ensuring that
providers were nonjudgmental and provided unconditional positive regard for clients were important facets of treatment.

**Ideal Goals for Mental Health Interventions**

The present study indicated that ideal goals for mental health interventions included: creating a safe atmosphere, maintaining functionality, and unpacking the trauma. Participants endorsed the importance of establishing safety for the survivor and allowing her to determine what that means and where. Osterman, Barbiaz, and Johnson (2001) reported that using a calm and respectful approach can help develop a sense of safety for the survivor. However, their study was aimed towards emergency interventions for rape survivors preparing for their forensic exams following the incident. Similarly, the current study indicated feeling safe in treatment was important to re-experiencing and working through trauma.

**Qualities of Mental Health Providers**

Mental health providers have a critical role in identifying the potential psychological impacts of sexual violence. When responding to a survivor of sexual assault the counselors’ demeanor and the intervention method is crucial as these can impact post-trauma and recovery (McLindon & Harms, 2011). The findings from this study revealed that qualities of mental health providers who work with college-age women who have experienced sexual assault should include: cultural competency, knowledge of rape culture, general factors of therapy, and trauma informed training. (see Table 3 for details). According to the participants in the present study, cultural competency was reported as being an important quality that mental health providers should possess when working with college-age women who have experienced trauma. However, mental health providers acknowledged that it was important for them to be aware of their own limitations and biases. Researchers have suggested when becoming more culturally competent
through training, mental health providers move from “cultural encapsulation (i.e. viewing reality according to a single set of cultural assumptions which is regarded as “right”, no matter how contradictory) to being aware of one’s learned assumptions and knowledge about differences (Pernell-Arnold, Finley, Sands, Bourjolly, & Stanhope, 2012).

Receiving appropriate training and possessing skills for working with survivors were important characteristics mentioned by providers and administrators. Having the ability to be understanding, trustworthy, supportive, non-confrontational, non-judgmental, patient, respectful, approachable and empathetic are all qualities that enhance therapeutic processes (McLindon & Harms, 2011). Participants in the current study discussed the importance of mental health providers having a high level of sexual assault trauma informed training. According to the Office on Violence against Women (2014b) within the U.S. Department of Justice, trauma informed training and trauma informed care programs provide spaces that are culturally and linguistically competent and endorse healing based on empowerment and hope for survivors of sexual violence.

Retention Efforts for College-Age Women in Mental Health Treatment

Research literature on retention efforts for college age women in mental health treatment (following a sexual assault) are sparse. However, according to available research studies, survivors of sexual assault have chosen not to participate in mental health treatment or sought after medical care for fear of re-victimization (Campbell, 2008; Simmel, Postmus, & Lee, 2016). Participants in the current study revealed that ensuring that young women have the financial means to participate and remain in treatment continues to be important as retention in services can be problematic. Campbell (2008) also found that survivors without health insurance or other financial means were significantly less likely to seek mental health services.
Limitations of the Present Study

In terms of limitations, this study was conducted with a sample from only one university in the Midwest and the surrounding community. There were several other limitations for this study, including: 1) there were more administrators (14) than mental health providers (6), 2) the entire sample of participants identified as female, 3) the majority of the participants identified as Caucasian, and 4) most of the participants were affiliated with campus-based organizations ($n = 15$). A social desirability bias could have influenced the participants’ responses. This could have been due to the sensitive nature of the topic. Also, some administrators might have been apprehensive about sharing their perspectives on mental health treatment, because they were not as familiar with existing mental health interventions.

Implications for Health Educators and Researchers

Study findings suggest that there is a need to educate the general population on college campuses about the availability of mental health services and how services work to benefit trauma survivors. Health educators can play a key role in promoting and explaining mental health services for college students. In addition, health educators can provide information about the course and advantages of participating in therapy to address trauma related to sexual assault. Health educators need to become members of trauma teams so that they can understand the impact of trauma and work to develop public health messages that will educate women about steps to take if they experience trauma as well as develop public health messages that will reduce stigma related to participating in treatment.

Future research could examine survivors’ specific needs, goals and outcomes of mental health treatment. Future research could also examine reasons college-age women choose to seek and not seek mental health treatment post-assault. Investigating retention efforts for college-age women experiencing depression or PTSD and other psychological impacts of sexual assault
could lead to uncovering best practices for retaining college-age women in mental health
treatment post-assault. It would be beneficial to gain understanding of women’s reasons to
participate in mental health treatment as well as their reasons not to participate, what qualities
they would prefer a mental health provider to have, and what would influence them to continue
to participate in mental health treatment. Furthermore, examining the availability of culturally
appropriate services and their impact on college-age women post-assault could also provide
insight to improve retention.

Conclusions

Findings of this study indicated that young women may need resources to participate in
and remain in treatment. Moreover, providers need expertise in trauma-based care and services
need to be culturally informed. Currently, research is lacking regarding the importance of
culturally appropriate mental health services. According to findings from this current study, there
is a lack of research available for retention efforts in mental health treatment for college-age
women and ideal goals for mental health treatment.
References


Table 1. Questions and Probes for Study 1

**Q1:** What are ideal goals for mental health interventions, for young adult women (college-age) who have experienced sexual assault? (*Probes: Please provide examples. Please explain what you mean. Tell me more about it.*)

**Q2:** What qualities should mental health providers have when dealing with young adult women (that is college-age women) who have been sexually assaulted? (*Probes: ask for examples, detail, tell me more about it, ask for ideas on cultural competency, etc.*)

**Q3:** How does one keep college-age women in mental health treatment after an assault? (*Probes: What are ideas for ensuring women remain in treatment? Tell me more; can you give me an example to explain what you mean?*)

I wanted to give you an opportunity to add information. Thus, do you have additional ideas about ideal treatment programs for college-age women who have been sexually assaulted? (*Probes: ask for examples and detail*)
### Table 2. Ideal Goals for Mental Health Interventions

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub – themes</th>
<th>Representative Quotes</th>
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<tbody>
<tr>
<td>Ideal goals for mental health</td>
<td>Creating safe atmosphere</td>
<td>&quot;In my experience, the first intervention is to get them to a place of safety. So yes, physical safety is obviously very important, but emotional safety too. So, one woman might consider um, a partner on that list. Another woman might have a partner but not consider them on their safety list. So, really exploring what community, what um, system, is safe for you, and how do we get you to that place consistently.&quot; [Interview 6]</td>
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<td>interventions</td>
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<td>Maintaining functionality</td>
<td>&quot;I think my goals for any client would-would apply for these as well, is making sure they're remaining functional in their lives, so for the young adult population on a college campus, that's gonna be being able to go to school, attend their classes, if they're part of social life on campus either Greek life, or other organizations, that they're able to continue participating in those. That their general sense of self well-being is intact. So, they're eating, they're sleeping, they're taking care of themselves&quot;. [Interview 5]</td>
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<td></td>
<td>Unpacking the trauma</td>
<td>&quot;I think just from my experience would be focusing on making sure that that survivor knows that the assault and that the trauma was not their fault. Kind of having that understanding of trauma&quot;. [Interview 4]</td>
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Note. One quote is presented as an example under representative quotes; however, there are several quotes for each theme.
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<th>Theme</th>
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<tr>
<td>Qualities of mental health providers</td>
<td>Cultural Competency</td>
<td>&quot;...once you have that foundation, you have to overlay, um, I think different cultural identities. Um and sort of see the double lens of sexual violence competency and then you know, how might your practice further need to be developed in your expertise. Further need to be developed by understanding how these issues may be perceived, played out, exacerbated, condoned, whatever it is in all different kinds of communities. So, you know, whether it's a racial or an ethnicity identity, um, whether it's in LGBT communities, um, immigrant populations....&quot; [Interview 15]</td>
</tr>
<tr>
<td>Qualities of mental health providers</td>
<td>Knowledge of rape culture</td>
<td>&quot;I think for providers that are working with this particular population it's really important for them to be knowledgeable about rape culture, consent issues, um, because I think even well-intentioned questions fall into the trap of rape culture. So, you know, a &quot;what were you drinking? What were you wearing? What was going on?&quot; When at the, you know, at the end of the day it doesn't matter what a person was drinking, what they were wearing, what the situation was. If they experienced a non-consensual sexual experience, or intimate experience, um, it-the rest of that doesn't matter&quot;. [Interview 5]</td>
</tr>
<tr>
<td>Qualities of mental health providers</td>
<td>General factors of therapy</td>
<td>&quot;Obviously, a sense of empathy. Um, at making sure that the provider is nonjudgmental. Because, um, in some cases, um, survivors have been blamed for behavior or for putting themselves into a situation that might have been more favorable to sexual assaults or making sure that mental health providers, um, do not, um, have that attitude&quot;. [Interview 7]</td>
</tr>
<tr>
<td>Qualities of mental health providers</td>
<td>Trauma informed training</td>
<td>&quot;...I think mental health professionals who work with sexual assault survivors need to have specific expertise, um, in the unique cultural position that sexual violence plays in our culture, which is different than other trauma. So, you know, if I got into a car accident, you know, there's not systemic and pervasive victim blame for me driving that car, um, that is associated with sexual violence. So, I don't think it's enough to have general trauma knowledge or expertise, but instead to really have, to understand the reality of sexual violence. Who it happens to, who perpetrates, the dynamics, the outcome, the impact, and then those cultural pieces. In other words, just how we all treat it different...&quot; [Interview 15]</td>
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<tr>
<td>Retention efforts for college-age women in mental health treatment</td>
<td>Relationship and connection building</td>
<td>&quot;Um, so I think keeping that connection, um, even if it's just a follow-up call to check in, I think that goes a long way with people to know that, you know, they may have left counseling at this point but you know, a month, two months from now, um, things start reeling up again. If they know that there's that connection, they're gonna be more likely to come back, so I think making sure that's clear, that they can come back at any time&quot;. [Interview 3]</td>
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<td>Retention efforts for college-age women in mental health treatment</td>
<td>Financially affordable</td>
<td>&quot;Provide an opportunity for students to continue to receive services with minimal cost, I think, or none. Um, so here, you can set up appointments every two weeks. So, I don't know that there's a true cap necessarily, but every two weeks you can get on a rotation all year long. Um, and you don't have to pay anything.&quot; [Interview 17]</td>
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<tr>
<td>Retention efforts for college-age women in mental health treatment</td>
<td>Autonomy</td>
<td>&quot;….and if we're coming in already trying to tell the person this is what they need to be, to do, or this is what they should do, um I think is really problematic, and they can continue to play into this whole cycle of disempowering them. So, um, I think one way that could help retain, um, these individuals, these women, is to really reinforce this idea that they have a choice over what it is that they want to do. So, what we can do as mental health professionals is, like, explaining to them the different options that are available to them, and what it is that, like, they have access to. And then reinforcing the idea that at the end of the day it's up to them what it is that they want to do.&quot; [Interview 20]</td>
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<td>2. Maintaining Functionality</td>
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<td>3. Unpack the Trauma</td>
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<tr>
<td>Qualities of mental health providers</td>
<td>1. Cultural Competency</td>
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<td></td>
<td>2. Knowledge of Rape Culture</td>
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<tr>
<td></td>
<td>3. General Factors of Therapy (empathy, patience, non-judgmental, etc.)</td>
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<td></td>
<td>4. Trauma Informed Training</td>
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<td>Retention efforts for college-age women in</td>
<td>1. Relationship and Connection Building</td>
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<td>mental health treatment</td>
<td>2. Financially Affordable</td>
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<td>3. Autonomy</td>
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Study Two: College Campus Administrators’ Perspectives on Disclosure and Treatment of Sexual Assault for College-Age Women who are African American
Introduction

Sexual assault continues to be a significant and very pervasive public health issue for women in the United States (Centers for Disease Control and Prevention [CDC], 2014a). Sexual assault is defined as any type of sexual contact or activity (e.g., unwanted kissing, fondling, rape, or attempted rape) that occurs without the clear consent of the recipient (CDC, 2014a). A survey conducted on adult women \((N = 7,758)\) in the U.S. reported that 13.6% of Hispanic, 20.5% of Caucasian, 21.2% of African American and 27.5% of American Indian/Alaskan Native women had been raped or sexually assaulted at some point in their lifetime (CDC, 2014b). One study conducted by Walsh et al, (2010) discovered that among college students who reported sexual violence during the previous academic year, only 3% who experienced unwanted sexual contact and only 6% who experienced unwanted sexual intercourse sought after some type of support services. Moreover, even less research is available on African American college women seeking mental health services after an assault (Hassija & Turchik, 2016). Although these statistics are available, research is varied when it comes to attempting to identify the prevalence rates of adult victimization among women of color. Some studies have shown that African American women may have reported sexual violence at a slightly higher rate than Caucasian women (Amar, 2008; Hart & Rennison, 2003). Others have reported that African American and Caucasian women experience sexual assault at lower or similar rates except between the ages of 20 to 24, a time period during which sexual violence is greater among African American women (Amar, 2008; Postmus, 2015).

Eighty percent of rape and sexual assault occurrences among college students were more likely to go unreported to law enforcement in comparison to 67% of college-age nonstudents (United States Department of Justice; USDOJ, 2014). Research has found that some of the
underlying barriers to reporting sexual assault are similar among both college students and nonstudents (of the same age) of all racial and ethnic backgrounds. Some of the most common barriers to reporting among college students include fear of not being believed, embarrassment, shame, guilt, confidentiality concerns, and fear of retaliation (Amar, 2008; Sable, Danis, Mauzy & Gallagher, 2006). In a report released by the USDOJ (2014), about 26% of college students and 23% of nonstudents did not report their rape or sexual assault to the police because they believed it was a personal matter, and 20% were fearful of retaliation. The same report revealed that among the college students within the sample, 12% believed it was not important enough to report; 10% did not want to get their perpetrator in trouble; 9% believed the police would not or could not help them; and 4% reported the incident, but not to the police (USDOJ, 2014). Other common barriers to reporting include the victim not recognizing the experience as a crime, being concerned about not being able to prove a crime had occurred, and not having the time to see a health care provider or campus administrator (Amar, 2008). Being required to participate in adjudication, campus prevention programming that unintentionally blames the victim and campus policies on drugs and alcohol are examples of institutional level barriers to reporting (Amar, 2008; Karjane, Fisher & Cullen, 2005).

**Reporting Assaults**

Research has consistently linked college students who engage in alcohol and/or drug use as being more at risk for criminal victimization including sexual assault (Fisher, Daigle, Cullen & Turner, 2003; Kreb, Lindquist, Warner, Fisher & Martin, 2009). Both alcohol and/or drug use by sexual assault survivors have been viewed as barriers to formal reporting to law enforcement, campus administrators, etc. due to some on-campus policies (Fisher et al., 2003). It is plausible that campus policies on drugs and alcohol may prohibit reporting a sexual assault due to the
victim being afraid of being penalized for underage drinking or using drugs (Fisher et al., 2003). In environments, such as colleges and universities where alcohol and/or drugs are easily accessible, there are few research studies that examine these policies as hindrances to reporting sexual assault incidents. Evidence from a research study conducted by Ruback, Menard, Outlaw, and Shaffer (1999) revealed that college students generally believed that crimes against underage, intoxicated students should not be reported to the police.

African American college women may be more likely than Caucasian women to experience sexual assault involving physical force, and in these cases, they could be more likely to report the assault (Amar, 2008; Bryant-Davis, Chung, & Tillman, 2009; Littleton et al., 2013). In a study of college women, in this instance undergraduates attending a historically black college and university [HBCU], 14% of physically forced sexual assault survivors reported their incident to health/crisis-related services (Lindquist, Crosby, Barrick, Krebs, & Settles-Reaves, 2016). Reporting when there are injuries present may occur because women are more likely to think they will be believed (Amar, 2008). Sexual assault incidents involving physical force also could possibly have been committed by intimate partners (i.e., boyfriends, husbands, etc.). When compared to African American women who have only experienced physical abuse, victims who have been raped and beaten were more likely to have been psychologically abused as well (West, 2002).

**Barriers to Reporting Trauma and Seeking Treatment**

Rape myths are often unproven, false, and generalized beliefs about survivors, perpetrators, or sexual assault incidents that either belittle the experience, suggest that a sexual assault did not occur, or often reduces empathy for and even shifts blame to the victim (Hayes-Smith & Levett, 2010). Rape myths are particularly problematic because they can be correlated
to self-reported sexual aggression in males, lead to victim blaming (even by other women), and may result in the victims blaming themselves or not believing an assault actually occurred (even though the incident in question met the legal definition of rape) (Hayes-Smith & Levett, 2010). From a historical and sociocultural standpoint, rape myths regarding African American women can be dated back to slavery in the United States. The sexual victimization and objectification of African American women can be traced from the Middle Passage through the slave era, to the days of Jim Crow to current interracial and intraracial assault (Tillman, Bryant-Davis, Smith, & Marks, 2010). African American women during those days were also stereotyped as being sexually inhibited, exotic, promiscuous, and called “Black Jezebel” which perpetuated the idea that they were willing participants in their own victimization (Washington, 2001; Women of Color Network, 2006). Currently, although legalized slave labor and the sexual victimization that resulted from it has long ceased, belief systems that African American women cannot be legitimate victims of sexual assault still persist. Thus, these cultural rape myths could be related to women of color not reporting assault or seeking treatment for assault. If the treatment is customized to their needs, then women may be more likely to overcome the barriers and seek needed intervention.

There are several other culturally specific barriers that may deter young women who are African American from reporting assault and seeking mental health services. For instance, the stereotypical beliefs of the “Strong Black Woman” persona (emphasizing resiliency and independence); distrust of medical professionals and law enforcement; and feeling culturally mandated to protect African American males may limit reporting (Lindquist, Crosby, Barrick, Krebs, & Settles-Reaves, 2016). In a study conducted by Amar (2008), African-American college-age women were more likely than Caucasian women to not disclose or report their sexual
assault to police officers due to fear of not being believed or concerned about being viewed as “at fault” for what happened. Because young women who are African American may experience violent assaults and have difficulty reporting the incidents and seeking treatment, it remains important to continue to conduct studies to understand important features of treatment and barriers to treatment for African American females.

African American females also may be more likely to rely on informal networks for discussing trauma. Sexual assault survivors within this population have been more likely to disclose their incidents to informal support systems (i.e. family and friends; Bryant-Davis et al, 2009). Seeking help from informal support sources such as family, friends, and clergy members may be positive and encourage the healing process in African American survivors. A study conducted by Filipas & Ullman (2001) indicated that family and friends were the most highly utilized and most helpful support source for African American trauma survivors. Additionally, friends and family were protective factors against depression among African American trauma survivors (Lincoln, Chatters & Taylor, 2005). On the other hand, if a support person’s reaction is not positive, it can be viewed as a negative influence (Ayalon & Young, 2005; Hassija & Turchik, 2016). Also, at times, amongst African American women, formal sources such as medical or mental health professionals and police officers are generally viewed as being less helpful (Bryant-Davis et al, 2009; Fisher, Daigle, Cullen, & Turner, 2003).

**Mental Health Treatment**

Given that the prevalence rates of mental illness among African Americans are comparable to that of their Caucasian counterparts, African Americans are still considerably less likely to seek assistance from professional mental health providers (Barksdale & Molock, 2008). Current research tells us is that African American women may not seek mental health treatment
or report being sexually assaulted (Barksdale & Molock, 2008; Bryant-Davis et al., 2009). The current study used qualitative methods to uncover barriers to seeking mental health treatment as well as qualities in mental health providers and treatment that might facilitate the involvement of African American women in mental health treatment. Due to the dearth of literature on African American women, the following sections of this dissertation address ideas about positive mental health treatment, barriers to mental health treatment and qualities needed in mental health providers irrespective of ethnic groups of women seeking treatment.

While the quality and effectiveness of mental health treatments and services have been drastically improved, people still choose not to utilize these services or do not fully adhere to treatment regimens once they begin (Corrigan, 2004). For women of color, factors such as fear of racism, fear of bringing shame to their families and communities, fear of reinforcing stereotypes, political treatment of ethnic groups, values placed on sexual chastity before marriage, and the need to keep family matters private create barriers to seeking mental health services after experiencing assault/trauma (Postmus, 2015). Stigma related to mental health services being negative has been considered to be the most difficult barrier to future progression in seeking mental health services (Gary, 2005). For people of color that already experience prejudice and discrimination because of their group affiliation(s) they may also experience additional feelings of stigma when they believe they need mental health treatment (Gary, 2005). Other barriers to help-seeking after experiencing trauma include financial limitations, geographical barriers, and low availability of services that are culturally sensitive (Ayalon & Young, 2005).

A study conducted by Postmus (2015) discussed the need for culturally competent, collaborative, and empowering approaches to engaging sexual assault survivors from minority communities in mental health treatment. With the negative mental health sequelae that
accompany sexual assault, such as post-traumatic stress disorder, depression, suicidal ideation, etc. There may be an even greater need for the utilization of mental health care services (Bryant-Davis, et al, 2009; Hassija & Turchik, 2016). However, there is very little research available regarding African American college women seeking mental health services after an assault. Currently, there are few research studies that specifically examine sexual assault among college-age women who are African American. As previously mentioned, further examination of cultural barriers to reporting, help-seeking and participating in mental health treatment is needed (Boykins et al., 2010; Littleton et al., 2013). The current study will provide information about experts’ views of treatment that will work for women in this vulnerable group. Experts for this study were defined as program administrators and mental health providers working in mental health centers specializing in the mental health treatment of young adult women who had experienced sexual assault or rape. This group was selected as a sampling frame in order to gather information from those with experience and expertise in the field.

**Study Purpose**

The purpose of this study was to gain the perspectives of college and university administrators on strategies for improving reporting and treatment seeking among African American college women. This study addressed administrators and/or mental health providers’ perceptions on the following research questions:

1) What are barriers to reporting sexual assault for young adult women who are African American?  
2) What are ideas for overcoming reporting barriers for this vulnerable group?  
3) What are barriers to African American college women participating in mental health treatment after assault?
4) What is ideal mental health treatment for African American college-age women who
have been sexually assaulted?

5) How can we overcome barriers and enhance treatment participation for college-age
women who are African American and who have been victims of assault?

Methods

Participants

The same participants for Study 1 were used in the current study. The sample for the
study consisted of twenty campus- and community- based administrators and mental health
providers. The investigator researched local mental health centers to find participants. Snowball
sampling was also used to recruit participants in this study. Participation in the study was
voluntary and a university-based institutional review board approved the study as non-human
subjects research (see Appendix A).

Administrators. A total of fourteen participants who identified as administrators
completed interviews. Ten of the participants identified as being members of campus-based
organizations, three identified as being members of community-based organizations and one
identified as being in a campus- and community-based organization. Years worked in the field of
sexual assault ranged between zero and nineteen years ($M = 7.21$). Years worked with women
who had been sexually assaulted ranged between zero and nineteen years ($M = 8.50$). Twelve of
the participants had experience working with women who were African American and had
experienced the trauma of sexual assault. Two of the participants had no experience working
with women who were African American and had experienced sexual assault. All participants
identified as female; eight were Caucasian/White and six were African American/Black.

Mental Health Providers. A total of six mental health providers recruited from a large
Midwestern university and the surrounding community completed interviews. Four identified as
working in campus-based organizations and two identified as working in community-based organizations. Years worked in the field of sexual assault ranged between three and fifteen ($M = 7.83$). Five mental health providers interviewed had experience working with women who were African American and had experienced sexual assault. One had no experience working with women who identified as African American and had experienced sexual assault. All participants identified as female; four were Caucasian/White and two were African American/Black.

**Procedures**

The procedures were those described in Study One. Campus- and community-based administrators were recruited by telephone to inquire as to whether they would participate in an interview. Some participants were recruited via email. Participants were informed of the purpose of the research study and then the interview was scheduled (time and location).

The in-person interview usually lasted about 14-50 minutes. There was one interview that lasted approximately an hour and seventeen minutes. In-person interviews began in February of 2017 and were completed in April of 2017. Prior to the start of the interview, the researcher provided the participants with the Interview Guide for Study Participants (see Appendix B). Next, participants were asked to provide written and verbal assent for their interview to be audio recorded.

The interview questions were provided to the participants at the beginning of each interview. The interview for study participants is presented in Appendix C. Prior to answering the interview questions the participants provided demographic information (same information as Study 1). After this the participants answered the questions presented in Table 1.

Insert Table 1 here
Data Analysis

The researcher used the same methods of analyses that were reviewed for Study 1. Specifically, the researcher analyzed the interview transcriptions, using a content analysis, to identify important themes and statements that would provide a clear understanding of ideas provided by the participants. A research assistant read 60% of the transcripts. The researcher then made notes of her impressions and developed a dictionary of terms representing key themes during six meetings with the research assistant (Hsieh & Shannon, 2005). The researcher and the research assistant developed a final set of themes with key quotes representing each theme. Agreement was reached by consensus over a series of six meetings. Each meeting lasted approximately two hours (an average of 1.5 to 3 hours). Consensus was used to resolve disagreements. An agreement was reached following discussion, checking spreadsheets with lists of themes and representative quotes, and checking the raw data in interview transcripts when needed. As mentioned in Study One, the research assistant had expertise in qualitative coding and had previously worked on three qualitative studies where content analysis was used to determine themes in interview data. The research assistant was trained in use of content analysis by this researcher’s mentor.

Validity

Member Checks. To determine the validity of themes from the interview, the researcher conducted member checks. Five administrators and one mental health provider participated in the member checking audits. Four administrators identified as Caucasian/white and one administrator identified as African American/Black. The mental health provider identified as Caucasian. The member checking process involved participants reviewing themes discovered for each interview question. Participants could also add themes during this process.
**Avoiding Question Bias.** In an attempt to avoid bias, the researcher provided the participants with the interview questions prior to beginning the interview. The researcher also informed the participants that they could skip any question if they decided to do so.

**Researcher Bias.** According to Maxwell (2013) researcher bias influences the collection and/or interpretation of data when the selection of data fits the researcher’s existing goals, preconceptions or theories. It is impossible to eliminate the researcher’s theories and beliefs but it is important to understand how this can influence the participants (Maxwell, 2013; Creswell, 2013). Thus, the researcher was cognizant of her own cultural assumptions and made every effort to understand and respect the culture of study participants. The researcher recorded her reflections, in a section devoted to exploring potential researcher bias at the end of the results section.

**Results**

After thorough analysis of the interviews, the research team (researcher and research assistant) found five primary areas for themes: 1) key barriers to reporting, 2) ideas for overcoming reporting barriers, 3) barriers to participation in mental health treatment, 4) ideal mental health treatment, and 5) overcoming barriers and enhancing treatment participation.

**Key Barriers to Reporting.** The research team determined eleven main sub-themes that emerged from the data. These sub-themes include: 1) mistrust of police, 2) fear of retaliation, 3) cultural barriers, 4) self-blame/internalized victim blame, 5) trying to protect Black men, 6) lack of diverse representation in support staff (including mental health providers and reporting allies, 7) strong Black woman persona, 8) hyper-sexualization of African American women stereotype, 9) victim blame from family and community, 10) survivors feeling as though no one would believe them, and 11) lack of understanding of what rape and sexual assault is. Minor sub-themes included survivors feeling: 1) confused about the reporting processes on college
campsues, 2) guilt, shame, and embarrassment, and 3) sexual assault is swept under the rug and is not talked about in the African American community. This information is presented in Table 2.

According to the responses by both mental health providers and administrators extracted from the data, mistrust of the police was one of the main key barriers to reporting for African American women. Although both mental health providers and administrators stated mistrust of the police as a barrier to reporting; the mental health providers mentioned taking this barrier into consideration when assisting survivors to develop a plan for safety that includes trusted individuals. The mental health providers stated that an African American female survivor’s plan for safety may not include the police (see Table 2). Trying to protect African American men and the mistrust of police barriers to reporting go hand in hand for some African American women who have experienced sexual assault. Both the administrators and mental health providers noted that African American women who have experienced a sexual assault may be apprehensive about calling the police to report their assault if the perpetrator is an African American man. They fear what could happen to their perpetrator if the police are called, they do not want to get their perpetrator in trouble, or to be the person to “hand them over to a racist criminal justice system.” Participants reported that survivors could under-report because they were afraid of feeling blamed by their family or community, because they would be viewed as “trying to tear a black man down” if they reported a black man as their perpetrator (see Table 2).

Administrators stated that fear of retaliation was also a major barrier to reporting for African American women (see Table 2). Administrators also reported that African American women may not report victimization because they were taught and/or raised not to say anything regarding sexual assault. An administrator stated, “This stuff just happens…we just have to
endure” (see Table 2). It appeared that this administrator was identifying with the survivors. Both mental health providers and administrators mentioned self-blame/internalized victim blame as being a barrier. This type of blame occurs when the survivor thinks she placed herself in a “bad situation or did something that “caused” the assault to occur (see Table 2).

African American women who have experienced sexual assault also may not report due to a lack of diverse representation among mental health providers and support staff (including reporting allies). Thus, women who are African American may feel distrust in reporting the incident to a provider who is not of color. A lack of representation or reflection of themselves in support staff may further instigate their trust issues (see Table 2). In addition, according to both mental health providers and administrators, African American women may have issues with trust when dealing with sexual assault because it is viewed as being a very personal issue.

Several administrators stated that having the “Strong Black Woman” persona has also prohibited African American women from reporting sexual assault. Portraying themselves as strong, bold, powerful, and placing the needs of others before their own has promoted the idea that anytime something happens to them, they’re supposed to “suck it up and move on” (regardless of the issue). They may feel that they need to show that, “they can take care of themselves.” A belief that it is important to maintain this persona may make it especially hard for African American women to reach out and seek help after they have experienced a sexual assault (see Table 2). The hyper-sexualization stereotype and objectification of African American women’s bodies was also described as being a barrier to reporting by both mental health providers and administrators. This stereotype placed on African American women has also caused a lot of victim blaming from their families and the community as well as feeling like no
one would believe them, because how they dress, how they dance, and even how their bodies are shaped is viewed as “a form of implied consent” (see Table 2).

Both mental health providers and administrators reported that a lack of acknowledging rape and sexual assault as a crime or personal violation, is also a key barrier to reporting for African American women. Since, sexual assault is often swept under the rug within the African American community it is not discussed. Additionally, some women may have had a “very terrible upbringing” that they may not be able to consciously connect that they have been assaulted (see Table 2).

**Ideas for Overcoming Reporting Barriers.** For theme two, the research team discovered three main sub-themes: 1) education, 2) diverse representation, and 3) leadership (see Table 3).

The administrators discussed the importance of education on several fronts as an idea for overcoming barriers to reporting. Schools should educate young people, beginning as early as elementary school. Children need to understand the differences between what types of touch are appropriate and inappropriate. Part of the instruction is also teaching children to report to safe adults such as teachers. As children grow up to be young adults, they should still receive age appropriate education regarding sexual assault, and messages on consent and “if you see something, say something” see Table 3. The administrators also reported the importance of educating students about services and resources, whether on campus or within the surrounding community (see Table 3). Another recommendation was to educate law enforcement officers on how to be supportive of sexual assault survivors and about victim’s rights (see Table 3). One quote illustrated the idea of educating law enforcement officers on how to be supportive of
survivors, “…for the most part, I think officers here have the best intentions, but I don’t think everyone has always been educated to know how to interact. And it’s not about what you’re asking, it’s about how you’re saying it.”

The idea of having diverse representation for support staff and mental health providers was discussed by the mental health providers as an essential idea for overcoming reporting barriers. Changing hiring practices and actively recruiting staff members and mental health providers of color will provide a culturally comfortable experience for some women of color. Having staff members and mental health providers that are more representative of the ethnicity present or represented by the student body matters, particularly when trying to overcome barriers to reporting incidents of abuse. Diverse representation for support staff and mental health providers leads into the main sub-theme of leadership. Having diverse representatives, especially women, men, and students of color visibly leading the charge and starting the conversations about sexual assault in their communities was deemed critical by both mental health providers and administrators. By achieving this, people of color can begin to bring sexual assault “out of the shadows” and be catalysts in changing the culture (see Table 3).

**Barriers to Participation in Mental Health Treatment.** According to the research team, theme three presented four main sub-themes: 1) stigma, 2) lack of support from family, 3) lack of knowledge of resources, and 4) lack of insurance. Survivors not wanting to be perceived as “crazy” or that something is “wrong” with them was presented as a minor sub-theme (see Table 4).

Stigma was recognized by the mental health providers and the administrators as being one of the biggest barriers for African American women to seeking and participating in mental health
treatment. An administrator mentioned that for some people, even the term mental health can cause, “people to feel like that means something’s wrong with them” and worried about “how that reflects on them” because they do not want to be perceived as “crazy” (see Table 4). A lack of family support was reported by both administrators and mental health providers as a barrier to African American women participating in mental health treatment particularly if family members might label a person who seeks treatment as being “crazy” or “mentally weak” (see Table 4). The research team noted that explaining confidentiality of mental health treatment and ensuring that women felt a sense of confidentiality related to their mental health treatment was an important sub-theme for participants. Feeling a sense of trust that information would not be shared with others may encourage more women to participate in mental health treatment.

Not being aware of what services and resources are available can hinder someone from seeking or participating in mental health treatment after experiencing trauma. Often, according to both mental health providers and administrators, women or other students in college may not even realize that “counseling services are even available to them” (see Table 4). Even if college students do realize what services and/or resources are available to them, they may run into issues with having a lack of insurance to cover the services. If a college age woman is sexually assaulted and does not feel comfortable seeking treatment on campus and would like do so with a “private practice” her student health insurance (if applicable) may not cover a private therapist (see Table 4).

**Ideal Mental Health Treatment.** Three main sub-themes were presented for theme four. Those main sub-themes include: 1) spiritual component, 2) holistic approach, and 3) validation (see Table 5).

Insert Table 5 here
Several administrators and mental health providers mentioned the idea of incorporating a spiritual component to therapy. Understanding the different ways that African American women seek support within their communities and the significance of spirituality in their lives could be a “key component” to their healing process (see Table 5). Mental health providers supported the idea of using more holistic approaches (e.g., that focus on physical health, spiritual and mental health needs) as women are multifaceted in their health and mental health needs. Often, African American women who have experienced sexual assault do not report or seek mental health treatment because they feel un-validated and that their voices will go unheard. Mental health providers recognized the importance of validating the survivor’s feelings and understanding that they’re not going to be able to tell them what they should do. This quote exemplified the idea of supporting women and not telling them their solution, “Validating, empathizing and encouraging the survivor to speak about what they could do” could help them move towards healing (see Table 5).

**Overcoming Barriers and Enhancing Treatment Participation.** The research team uncovered three main sub-themes: 1) support groups for women of color, 2) extensive outreach, and 3) campus and community partnerships (see Table 6). Having specific, targeted messages on consent, sexual assault, reporting, and seeking mental health care for students of color was presented as a minor sub-theme. The participants reported that it is important to be publicly visible to communities of color so that women understand services are available. Also, creating resources on consent, sexual assault, reporting, and mental health specifically targeting those communities could possibly assist in breaking down barriers to seeking services.

Insert Table 6 here
Both mental health providers and administrators were supportive of forming support groups for women of color. They both emphasized the aspect of having the opportunities for partnerships or mentorships within these groups for survivors who are at various stages in the healing process. For instance, survivors of color could work with young women who had recently been assaulted as recovery mentors. These suggested partnerships could assist women of color by providing empowerment, encouragement, as well as promote the utilization of mental health service (see Table 6). Participants endorsed extensive outreach and going to where the people (specifically students of color) are, as a way to improve access to treatment. Along the same lines, participants reported that women need affordable, accessible services so that they are able to begin and stay in treatment. Both the administrators and the mental health providers also agreed that forming campus and community partnerships would enlarge service networks. These partnerships would allow for different organizations to work together, receive and provide education and trainings, and promote a collaborative effort.

**Member-Checking to Audit Themes**

One mental health provider and five administrators participated in a member-checking audit for this study. Both the mental health provider and the administrators endorsed the themes and sub-themes discovered from the interviews. Table 7 represents the list that was emailed to the participants. The administrators reported that the list was accurate and comprehensive and the mental health provider reported the list capturing what was said during the interview and included themes that she had not thought of (i.e., trying to protect Black men, lack of insurance).

Insert Table 7 here

**Position Statement.** For this study, I recognized my cultural biases and assumptions regarding barriers to reporting and barriers to seeking mental health treatment. Like so many of
the participants in this study, I also believe that in the African American culture, it is not
communicated or taught that seeking mental health treatment, health care treatment or reporting
crimes related to assault to the police is an important step in the hope of gaining justice and
accessing treatment for African American women. However, I also feel as though society has its
own way perpetuating the messages of “you will not be believed” and “you will not gain justice”
even if the incident is reported. I reflected upon those messages and biases that I feel I was
taught by my mother and grandmother that seeking mental health treatment or health care is
challenging for women of color.

I can relate to the strong Black woman ideal/expectation because I constantly carry the
weight of the world on my shoulders and think I can take care of myself. Often, I have even said
“I don’t have time to get sick” or “I don’t have time to rest.” I am not sure if it is spoken aloud in
the Black community, but there this is a mentality that we have to do more to be recognized for
even a portion of what our counterparts have to do. It may not be spoken aloud, but society and
history has relayed that message to the Black community. I realized my point of view, as
discussed in this paragraph, and thus I used an interview guide and specific probes. I remained
aware of my biases and did not ask leading questions or reflect on my views when interviewing
participants. I engaged a research assistant to check themes in the data to add objectivity to the
coding process.

It was interesting to me that the majority of the participants in this study were Caucasian
females and they were able to discuss the issues that African American women and African
Americans as a whole are dealing with in society not just with sexual violence but with violence
in general. Many of the participants, regardless of whether they were African American or
Caucasian, were able to recognize key issues for African American women. I was not sure if this
information would be provided by the Caucasian participants (because of my own bias); but, I was glad that it was. This information was reflected in answers due to the objectivity of the interview and coding process, in my view.

**Discussion**

The purpose of this study was to gain the perspectives of college and university administrators on strategies for improving reporting and mental health treatment seeking among African American college-age women. Findings of this study indicated consistencies with available research regarding barriers to reporting and barriers to participating in mental health treatment. Specifically, findings revealed that women may not report sexual violence due to mistrust of police and feelings as though they are self-sufficient and can handle any difficulties on their own without assistance. Another reason for under-reporting may be to try to protect men of color, whom women may feel are treated unfairly by law enforcement. The aforementioned reasons of underreporting are consistent with current literature (Bryant-Davis et al, 2009; Fisher et al, 2003; Women of Color Network, 2006). A lack of knowledge about the confidential nature of services and a lack of access to mental health facilities may be other barriers impacting women’s reporting and moving forward to seek treatment for the trauma they have experienced. Importantly, stigma related to participating in mental health services may cause women to avoid treatment because they do not want to be labeled as “crazy” by their families or community if it is revealed that they are in treatment.
Key Barriers to Reporting

Participants in the current study reported mistrust of the police as a key barrier to reporting sexual assault. Other research has indicated that survivors of color were more likely to not report to the police due to fear of not being believed, being viewed as “at fault” and felt it was personal issue and did not want to involve the police (Amar, 2008; Thompson, Sitterle, Clay, & Kingree, 2007). Feeling culturally mandated to protect their perpetrator from law enforcement, especially if they were African American males was also discussed by the participants in the present study. This idea is consistent to current studies related to survivors’ concerns over racial discrimination (Lindquist et al., 2016; Thompson et al., 2007).

Results from the present study showed that the portrayal of the “Strong Black Woman” persona may deter women from reporting sexual trauma. By upholding this idea, African American women exhibit the ability to handle everything on their own without assistance from anyone (Lindquist et al., 2016). Many women who have embraced this persona take on the problems of their family and community members. The pride, confidence, and resiliency that comes with this idea can cause some African American women to develop mental and physical health issues. Thus, in this case, it prohibits Black women from reporting incidence of sexual violence (Donovan & Williams, 2002).

Participants of the current study discussed hyper-sexualization as another key barrier to reporting. Hyper-sexualization is another stereotype of Black women which perpetuates the idea that they are exotic and promiscuous such that they are unrapeable and are willing participants of their own victimization. This stereotype also perpetuates the idea that the way an African American woman’s body is shaped, how her clothes fit her body, and even how she dances is a form of implied consent (Donovan & Williams, 2002; Women of Color Network, 2006). The
survivor having feelings of guilt, shame, and embarrassment were key barriers to reporting. This finding was consistent with results reported by Walsh, Banyard, Moynihan, Ward, and Cohn (2010).

**Ideas for Overcoming Barriers to Reporting**

Findings indicated that ideas for overcoming barriers to reporting included education, diverse representation of support staff and reporting allies, and leadership. Available research regarding on education sexual assault, consent issues, how to report or respond to a sexual assault incidence for African American college-age women is sparse. Education and training programs for campus police officers regarding how to respond to reports of sexual violence should include alerting them of the intersectionality of racial discrimination and sexism (Thompson, et al., 2007). The participants in the present study discussed the importance of having diverse representation among support staff and reporting allies. African Americans may prefer to be paired with mental health providers who were also African American (Cabral & Smith, 2011). These results were likely due to a strong racial/ethnic identification and wariness about biases in mental health services provided by white mental health providers (Cabral & Smith, 2011).

**Barriers to Participating in Mental Health Treatment**

Stigma related to seeking mental health treatment has still been considered the most difficult barrier to mental health help-seeking for people of color (Gary, 2005). Findings from the present study are comparable to available research studies concerning African American women and the stigma associated with participating in mental health treatment. Not wanting to be viewed as “crazy”, concerns around confidentiality, and a lack of support from family are all findings that are consistent with those in previous studies (Prospero & Vohra-Gupta, 2008;
Walsh et al., 2010). Having a lack of knowledge of support services that are available on campus and within the community and concerns about lacking health insurance coverage were also indicated as being barriers to participating in mental health treatment (Logan, Evans, Stevenson, & Jordan, 2005).

**Ideal Mental Health Treatment**

Current findings showed ideal mental health treatment for African American college-age women should include a spiritual component, have a more holistic approach, and provide validation. Taylor, Ellison, Chatters, Levin, and Lincoln (2000) suggested that given the pivotal role of clergy within the Black community, the establishment of a collaborative relationship between faith communities and mental health providers is important and could be beneficial in meeting the mental health needs and emotional wellbeing of women.

**Ideas for Overcoming Barriers and Enhancing Treatment Participation**

Results demonstrated that having support groups for female survivors of color, doing extensive outreach that included targeted messages for students of color, and establishing campus and community partnerships were ideas for overcoming barriers and enhancing treatment participation. Creating informative publications specifically for students of color about sexual assault, hosting an outreach event on campus during new student orientation, and providing support services that are easily accessible are ideas for improving awareness (Sabina & Ho, 2014; Walsh et al., 2010). Although research on female support groups of color surrounding sexual assault is scarce, the present study discussed the option of having recovery mentors. In a study conducted by Hassija and Turchik (2016), results revealed that women that indicated knowing someone who was a positive model (that had experienced abuse and grown as a result of their experience) reported higher levels of growth than women who did not have a model. The establishment of campus- and community-based partnerships would work toward the
same ideals and make sure that the response to and prevention of sexual violence is survivor-centered (Payne, 2008).

**Limitations of the Present Study**

Within this sample, limitations that were mentioned in Study One also are applicable for this study and they include: 1) all of the participants were female, 2) the majority identified as Caucasian/white, 3) there were more administrators than mental health providers, and 4) fifteen of the participants were employed by a campus organization (thus, the perspective of community organizations is lacking). The participants for this study were recruited from only one area and many were from one university setting, and therefore the community perspective may need further validation by improving recruitment of community participants in future studies. Due to the sensitive nature of the topic, the participants not wanting to overshare their experiences or the experiences of survivors they had worked with, or having to be mindful of the political climate of their workplace, some participants seemed to be uncomfortable sharing detailed information. The neutral and objective stance of the interviewer was maintained, and most participants were able to express their perceptions as the interview progressed. This study was based on the participants’ perspectives, but some administrators seemed apprehensive about sharing their perspectives on mental health treatment. This could have been due to not being as familiar with existing mental health interventions and specifically those that are geared towards African American college-age women who have experienced sexual assault.

**Implications for Health Educators and Researchers**

Health educators can collaborate with a sexual assault response team to create public health messages and develop needs assessments to find out survivors’ goals for mental health treatment. Moreover, due to their advocacy training, health educators are in a unique position to network with insurance companies to ensure the perspectives and needs of survivors are
conveyed. This may improve service availability by enhancing understanding among insurance providers of survivors’ needs for optimal, trauma-informed care. Furthermore, health educators have extensive training in program evaluation and may benefit the team in examining the effectiveness of services as well as client satisfaction with treatment. Finally, health educators have expertise about healthy lifestyle and healthy living that may help survivors in developing resilience plans to optimize their personal health.

Future research could examine these specific areas: 1) the impact of having a diverse staff of mental health providers and administrators, 2) more campus and community leaders of color leading the conversations around sexual assault, consent issues, and reporting, 3) sexual assault messaging that is intentionally geared towards students of color, and 4) the impact of empowerment messages particularly for African American women. In addition, future research could examine the perceptions of mental health providers and services for trauma and assault in HBCUs versus other campuses, in order to determine differences in perceptions in these two environments. After this research was completed, a next study would be to design and evaluate the effectiveness of culturally appropriate mental health treatment in each of these unique settings.

Conclusions

Some major findings (e.g., key barriers to reporting and barriers to participating in mental health treatment) may prohibit women from seeking treatment. However, there are still gaps in the research surrounding sexual assault among African American college-age women. There is a need for the provision of a multi-faceted mental health treatment that includes more holistic approaches, a spiritual component, and validation for Black women. There is a lack of sexual assault prevention programming and education (including messages about consent) specifically for students of color. Health educators, community, and campus leaders (e.g., students, faculty
and staff, law enforcement, etc.) can work together to fill in these gaps. Educational materials should include targeted information for college students of color to encourage conversation about sexual assault with their families. These materials should provide information on resources that are available on-campus and within the community, clear instructions on who, how, where to report a sexual assault, and also provide information on confidentiality and mandated reporting.
References


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Table 1. Questions and Probes for Study 2

**Q1:** What are barriers to reporting sexual assault for young adult women (college-age) who are African American? *(probes: ask for examples and detail)*

**Q2:** What are ideas for overcoming reporting barriers for this vulnerable group *(probes: ask for examples and detail)*

**Q3:** What are barriers to African American college-age women participating in mental health treatment after they have been assaulted? *(probes: ask for examples and detail)*

**Q4:** What is ideal mental health treatment for African American women who have been sexually assaulted? *(Probes: How should existing strategies be enhanced or made more culturally relevant for African American women? What would you recommend to improve strategies to reach African American women of college age?)*

**Q5:** How can we overcome barriers and enhance treatment participation for college-age women who are African American and who have been victims of assault? *(probes: ask for examples and detail)*
<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub – themes</th>
<th>Representative Quotes</th>
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<tbody>
<tr>
<td>Key barriers to reporting for African American college-age women</td>
<td>Mistrust of Police</td>
<td>&quot;Just the mistrust of what's gonna happen with the process. Um, if I report to the police, what does that mean? A lot of people, and especially with the African American community, you know, distrust of the police, understandable. Um, so reporting to the police, there are, there are many barriers concerning, um ... that's in people's minds&quot;. [Interview 3]</td>
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<tr>
<td>Key barriers to reporting for African American college-age women</td>
<td>Fear of Retaliation</td>
<td>&quot;So, they're concerned about retaliation. &quot;If I report this incident,&quot; um, &quot;How will these people in this program respond?&quot; Um, if the person is an athlete, &quot;Will I get adverse treatment from any other athletes or friends?&quot; And something that I've seen on a regular basis, which is extremely disheartening, um, is the adverse impact that many reporters have experienced from other women who identify as African American. It's a smear campaign.&quot; [Interview 11]</td>
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<tr>
<td>Key barriers to reporting for African American college-age women</td>
<td>Cultural Barriers</td>
<td>I think a lot of Black women do not report sexual assault because they don’t even value themselves enough to know they’ve been freaking assaulted. This is just something that happens. From hearing, how many Black women, just hearing it from close friends who’ve been molested. This stuff happens, so we’ll just move on. It just happens. White women get raped. White women get assaulted. White women get victimized. White women, white women, white women. That’s what’s important. So, when things happen to us, regardless if it’s sexual assault or just whatever else we just have to endure. [Interview 9]</td>
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<tr>
<td>Key barriers to reporting for African American college-age women</td>
<td>Self-blame</td>
<td>&quot;Um, and I even think like the sense of maybe, maybe these young women might've internalized too, that it's their fault. So, if you're thinking that it's your fault, um, what would you report it?&quot; [Interview 20]</td>
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<tr>
<td>Key barriers to reporting for African American college-age women</td>
<td>Trying to Protect Black Men</td>
<td>&quot;Probably an impulse to try to protect black men. Um, because if you, if- black women are assaulted by African-American men, I- I think that a lot of the times- and we've seen this play out time and time again, people don't believe women, right? And so even in black communities, we see this with Nate Parker, we see this with Bill Cosby, we see this with Clarence Thomas and Anita Hill. Black women are coming out and saying that they are assaulted and instead they're being dismissed as trying to tear the black man down.&quot; [Interview 12]</td>
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<tr>
<td>Key barriers to reporting for African American college-age women</td>
<td>Lack of Diverse Representation in Support Staff (mental health providers &amp; reporting allies)</td>
<td>&quot;I also think that it's a huge, huge issue of, um, like, who the support services are, right. Like, if you can't, um, if you don't feel comfortable or you don't see yourself in the people who are providing your care. That, that could be a huge, huge stigma. Right. So, for example, I know years ago, um, there were a lot of support services for survivors of sexual assault in the women's center and just based off of what I know, the women's center was a really, like, white space. Right. And so, what does that signal to a survivor? Right. A survivor has this experience, um, maybe they know to go to the women's center - to go to this certain place to receive help but they also have that knowledge that, like, that space hasn't been for them before ...&quot; [Interview 18]</td>
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<tr>
<td>Key barriers to reporting for African American college-age women</td>
<td>Strong Black Woman Stereotype</td>
<td>&quot;I think there's a ... I don't know who, who said this first. I'm not sure. There's this thing about, you know, this strong black woman. There's this thing in the atmosphere that we are just this strong rock, and that, that some of us are not. But I don't know, not that we're not strong, but some of that stuff is a myth. Yes, we can be strong, but things happen to us. And I think if, if, if you're out there as this bold black woman and this thing happened to you, like someone took something away from you and you had zero control over that, that, that by itself is just really, um, it's, it's really a sting. It's a stab to the heart. And so, um, because I, I portray myself as this powerful black woman, but I was able ... Or it may seem as if there was a weak moment where I couldn't control myself or I couldn't do anything about it because this person violated me- ... and took something away from me that I can't take back.&quot; [Interview 14]</td>
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Table 2. Key Barriers to Reporting for African American College-Age Women (continued)

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<th>Representative Quotes</th>
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<tr>
<td>Key barriers to reporting for African American college-age women</td>
<td>Hyper-sexualization of African American Women Stereotype</td>
<td>“Um, I’ve been talking mostly about Black women who are assaulted by Black men, but I think it’s also important to acknowledge that white men are also some of the people assaulting Black women. Um, and I think that in that case, I think that even-that opens up the possibility even more for Black women to be stereotyped as, um, as hyper-sexual or to be dismissed as not being rape-able by some white men…” [Interview 12]</td>
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<td>Victim Blame from Family &amp; Friends</td>
<td>&quot;She was wearing this.&quot; So ... &quot;What did she expect?&quot; Um, so a lot of blame from the community, uh from, um, even family members. I've seen family members discourage women from reporting. Especially if a student is an athlete, um. They may think that this will be a meal ticket for them. I've had two cases where athletes were accused of sexually assaulting African American women ... And I've actually had mothers (of the victim) say, &quot;Don't talk.&quot; Or ... mothers, um, working with the accused and lawyering up and even signing affidavits saying, &quot;I said that this happened, but this is no longer the case.&quot; So, there hasn't been a lot of support for a lot of African American women.&quot; [Interview 11]</td>
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<td></td>
<td>Victims feeling as though no one will believe them</td>
<td>&quot;.... they would have been um, told you know, you shouldn't have put yourself in that situation. Um, I have worked with a lot of African American women who report that the men in their lives are very kind of dominant in a way, and that they've been with, or that have been, they've been assaulted by. Um, and they just didn't feel like anybody would believe them. They would take the man's side. Um, this is just solely my experience.&quot; [Interview 6]</td>
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<td></td>
<td>Lack of understanding of what sexual assault is</td>
<td>&quot;And then also lack of awareness of what an assault actually is. You know. Knowing when they've been violated because again some of these women, while they may be in college, they may have had some very terrible upbringings and some histories that ... Will make the lines between assault versus consensual behavior, kind of blurred for them. Because if I grew up in a home where, or in a community or culture, where anyone was able to touch your body and that was normalized - I may not know what an assault is when I am college age, when I'm away from family. I may not even have a concept of what's normal and what isn't.&quot; [Interview 19]</td>
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Note. One quote is presented as an example under representative quotes; however, there are several quotes for each theme.
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<th>Theme</th>
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<tbody>
<tr>
<td>Ideas for Overcoming Reporting Barriers for African American College-Age Women</td>
<td>Education</td>
<td>&quot;I think education is key, so education on two fronts, in just my opinion. We need to have education in the school system, so starting at a very young age, you know, you need to have teachers saying some things age appropriate over time so they know, &quot;oh, you must tell an adult,&quot; in elementary school. In junior high school, maybe it’s something else, or middle school. And then of course in college it's something completely different. So, um, of course the whole if you see something, say something, same, same thing, but we have to have education in schools.&quot; [Interview 14]</td>
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<td>Ideas for Overcoming Reporting Barriers for African American College-Age Women</td>
<td>Diverse Representation</td>
<td>&quot;Hire people of color, um, uh, so I can speak for the counseling center. I think there are other student affairs groups on campus who do a better job with this, so I don't wanna, um, make it seem like I'm calling everyone out. I wanna, you know, speak for my department. Um, but I think we have to prioritize and put money where, uh, next to what we say is important. Um, I think we need to actively recruit. Um, I think, um, being more vocal about what we see happening, um...In the sense of just kind of acknowledging, um there are students who belong to certain identity groups who have a vastly different experience on campus. And to not acknowledge that, um says something.&quot; [Interview 8]</td>
</tr>
<tr>
<td>Ideas for Overcoming Reporting Barriers for African American College-Age Women</td>
<td>Leadership</td>
<td>&quot;…I think that, for this group, we have to have to have more people that look like them that are, one, building awareness of services, letting them know that it's okay to engage in these services, and supporting them through these services...And then as more of us get on the other side of things, in terms of, of these systems are developed, right...If we can get on that side, and, push back and help create new models, help create, uh, prevention and awareness programs...that will affect it, then I think we'll start to tackle this issue&quot;. [Interview 13]</td>
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Note. One quote is presented as an example under representative quotes; however, there are several quotes for each theme.
Table 4. Barriers to Participation in Mental Health Treatment for African American College-Age Women

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<tr>
<th>Theme</th>
<th>Sub – themes</th>
<th>Representative Quotes</th>
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<tbody>
<tr>
<td>Barriers to Participation in Mental Health Treatment for African American College-Age Women</td>
<td>Stigma</td>
<td>“…something I've seen in this work is sometimes there's this stigma around accessing mental health services. Um, even though that's a really common and normal thing to do when you've experienced a trauma. Sometimes just the-the term like mental health, people feel like that means, Somethings wrong with me,&quot; or, &quot;How does that reflect on me ...&quot; &quot;... if I'm seeing a therapist?&quot; So, I think sometimes stigma is a barrier.” [Interview 1]</td>
</tr>
<tr>
<td>Barriers to Participation in Mental Health Treatment for African American College-Age Women</td>
<td>Lack of Family Support</td>
<td>“…Um, even in my own family, my sister started going to therapy and my mother, she, she's- I'm trying to remember what she called it. I think my mother used the term &quot;mentally weak,&quot; and so I tried to correct her, I was like, &quot;Mom, like, what are you talking about?&quot; Like, my sister, she has anxiety. I said, &quot;Have you actually looked up a medical definition of what it means to have anxiety? “No”, &quot;Okay, well I would suggest that you do that because you're here and you're- you're completely dismissing your own child's experiences and calling it 'mentally weak'.&quot; [Interview 12]</td>
</tr>
<tr>
<td>Barriers to Participation in Mental Health Treatment for African American College-Age Women</td>
<td>Lack of Knowledge of Resources</td>
<td>&quot;One of the biggest one that I've actually, um, encountered has been, um, young women saying that they weren't aware that those services were available. Um, and that-that really breaks my heart. Like, kind of… I mean women in college not aware, that, um, like there's a counseling center, for example.&quot; [Interview 20]</td>
</tr>
<tr>
<td>Barriers to Participation in Mental Health Treatment for African American College-Age Women</td>
<td>Lack of Insurance</td>
<td>&quot;Um, I think, that again, in general, um, if you're not on a college campus, um, just lack of insurance or lack of access to health care. Mental health treatment is really expensive. And a lot of insurance programs don't cover it&quot;. [Interview 7]</td>
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<tbody>
<tr>
<td>Ideal Mental Health Treatment for African American College-Age Women</td>
<td>Spiritual Component</td>
<td>&quot;I think something that is very powerful in treatment for us, is that we are also a spiritual people. And I think we lack the GOD-ness in treatment because we've taken everything so secular. I'm saying that we're missing a spiritual part of the healing because our essence is spiritual as well. And so, I look at healing as mind, body, and soul. And I know that some may not see it like that based on their educational training. But as a community of people who have prided ourselves on our spirituality, I'm not talking about religion. But on our spiritual-ness. Umm and our connection to a Higher Power. I think that's missing a lot in mental health treatment. That...ok...for me GOD is over here and mental health treatment is over here. But why can't there be some kind of cohesiveness? I need GOD in my treatment. I need who I serve in my treatment.&quot; [Interview 9]</td>
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<td></td>
<td>Holistic Approach</td>
<td>&quot;I think it needs to be holistic and not only focused on the sexual assault but understand that this woman is multi-faceted. And just kind of understand the various roles she plays as one person and treat the whole individual - not just the part of her that's been sexually assaulted. Not just the area because what we know about trauma is that it impacts us across various aspects of our life. It has to be more holistic. It has to be very, again, sensitive to the fact that African American women have different struggles than their counterparts.&quot; [Interview 19]</td>
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<td>Validation</td>
<td>“…and not seem like you're some…like, excuse me for saying this, but sometimes I, I can't come across as this white lady who's gonna tell me what to do. I can't come across that way. I just can't. That's not going to help anybody, um so I think some that needs to be taken into account. You have to come in as an equal, and validate and empathize and encourage them to speak about what they feel they could do.” [Interview 6]</td>
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<tr>
<td>Overcoming Barriers and Enhancing Treatment</td>
<td>Support Groups for Women of</td>
<td>&quot;So for instance, um, support groups that might be catered to people of color or, um, you know, mentorships, or partnerships between, um, survivors of color who are 5 years, 10 years, 15 years out from their experience, uh, alongside folks who have very recently experienced trauma. I think that might be, uh, a highly, highly effective and meaningful option. Um, just the ability to, to look at ... to see someone who looks like me, who has shared many aspects of my experience and who has survived, and who is thriving, and doing well&quot;. [Interview 10]</td>
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<tr>
<td>Participation for African American College-Age</td>
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<td>Women</td>
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<tr>
<td>Overcoming Barriers and Enhancing Treatment</td>
<td>Extensive Outreach</td>
<td>“Like, we don't have to wait until people are there. Like, there's a lot of outreach that can be done. So, going and meeting students where they are on campus and, uh, talking to them a little bit about, like, what we do, what are the services that we offer, um, what are some of the things that can be discussed and talked about in therapy. Talking about confidentiality, talking about other resources that are available to them. So, going to the students and letting them know what's available to them.” [Interview 20]</td>
</tr>
<tr>
<td>Participation for African American College-Age</td>
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<tr>
<td>Women</td>
<td>Campus and Community</td>
<td>“And so, as a center, we're constantly trying to find how we can better support students, what are the resources out there period, right. And so, we're trying to connect and partner with each of those, so that way if I do, have a discussion with a student that has experienced that, I know what I can support, how I can support them. And there's going to be resources that I can trust, right.” [Interview 13]</td>
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<tr>
<td>Partnerships</td>
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| Key barriers to reporting for African American college-age women | 1. Mistrust of the Police  
2. Fear of Retaliation  
3. Cultural Barriers  
4. Self-blame / Internalized victim blame  
5. Trying to Protect Black Men  
6. Lack of Diverse Representation in support staff (mental health providers & reporting allies)  
7. Strong Black Woman Stereotype  
8. Hyper-sexualization of African American Women Stereotype  
9. Victim Blame from family & community  
10. Victims feeling as though no one will believe them  
11. Lack of understanding of what rape & sexual assault is |
| Ideas for overcoming reporting barriers for African American college-age women | 1. Education  
2. Diverse Representation  
3. Leadership |
| Barriers to participation in mental health treatment for African American college-age women | 1. Stigma  
2. Lack of Family Support  
3. Lack of Knowledge of Resources  
4. Lack of Insurance |
| Ideal mental health treatment for African American college-age women | 1. Spiritual Component  
2. Holistic Approach  
3. Validation |
| Overcome barriers and enhance treatment participation for African American college-age women | 1. Support groups for women of color  
2. Extensive Outreach  
3. Campus and Community Partnerships |
Appendix A
Approval from the Institutional Review Board at the University of Cincinnati

Institutional Review Board - Federal Wide Assurance #00003152
University of Cincinnati

Date: 9/20/2016
From: UC IRB
To: Principal Investigator: Patrice Deleon
CECH Academic Affairs

Study ID: 2016-7297
Re: Study Title: Interviews of Administrators about Setting up Ideal Sexual Assault Prevention Programs

The Institutional Review Board (IRB) acknowledges receipt of the above referenced proposal. It was determined that this proposal does not meet the regulatory criteria for research involving human subjects (see below): Not generalizable – case study that may help the PI develop a good sexual assault prevention program in the future. Ongoing IRB oversight is not required.

Please note the following requirements:

Statement regarding International conference on Harmonization and Good Clinical Practices. The Institutional Review Board is duly constituted (fulfilling FDA requirements for diversity), has written procedures for initial and continuing review of clinical trials: prepares written minutes of convened meetings and retains records pertaining to the review and approval process; all in compliance with requirements defined in 21 CFR Parts 50, 56 and 312 Code of Federal Regulations. This institution is in compliance with the ICH GCP as adopted by FDA/DHHS.

Thank you for your cooperation during the review process.

45 CRF § 46.102(d): Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

45 CRF § 46.102(f): Human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains:

1. data through intervention or interaction with the individual, or
2. identifiable private information.
Intervention includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.

Interaction includes communication or interpersonal contact between investigator and subject.

Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.

FDA regulations apply whenever an individual is or becomes a participant in research, either as a recipient of a FDA-regulated product or as a control, and as directed by a research protocol and not by medical practice. FDA-regulated activities involve individuals, specimens, or data, as patients or healthy controls, in any of the following:

a. any use of a drug or biologic, other than the use of an approved drug or biologic in the course of medical practice
b. any use of a device (medical or other devices, approved or investigational) to test the safety or effectiveness of the device
c. any use of dietary supplements to cure, treat, or prevent a disease or bear a nutrient content claim or other health claim
d. the collection of data or other results from individuals that will be submitted to, or held for inspection by, the FDA as part of an application for a research or marketing permit (including foods, infant formulas, food and color additives, drugs for human use, medical devices for human use, biological products for human use, and electronic products.)
e. activities where specimens (of any type) from individuals, regardless of whether specimens are identifiable, are used to test the safety or effectiveness of any device (medical or other devices, approved or investigational) and the information is being submitted to, or held for inspection by, the FDA.
Appendix B
Interview Guide

INTERVIEWER: Formally introduce yourself [shakes hands]

Provide participant with a copy of the interview questions.

Have participant “checkmark” whether they are male or female and whether their organization is campus-based or community-based.

Have participant “checkmark” whether their interview can be audio recorded.

INTERVIEWER: “Thank you for agreeing to participate in this study. Our goal is to obtain college and university administrators’ perspectives on developing ideal sexual assault prevention and intervention efforts.”

INTERVIEWER: “Do I have your permission to audio record the interview?”

If participant checks “YES” to audio record the interview, obtain VERBAL consent on the audio recording prior to beginning the interview.

If participant checks “NO” to audio record the interview, interviewer will take field notes.
Appendix C
Semi-Structured Interview for Study Participants

Demographics:

What is your gender?

☐ Male
☐ Female

What is your ethnic group? ________________________________

Is your organization college campus-based or community-based?

☐ College Campus-based
☐ Community-based

How many years have you worked in the field of sexual assault?
______________

How many years have you worked with women who have been sexually assaulted?
________

Do you have experience working with women who are African American and have experienced the trauma of sexual assault?

☐ Yes
☐ No

Permission to audio record the interview?

☐ Yes
☐ No
Introduction: Please note that these questions are meant to focus on young women of college age, between about 18 to 24 years of age. You may skip questions if you do not wish to answer them. Our focus will be to review your perceptions of programs for college-age women.

Q1: What are ideal goals for mental health interventions, for young adult women (college-age) who have experienced sexual assault? *(Probes: Please provide examples. Please explain what you mean. Tell me more about it.)*

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Q2: What qualities should mental health providers have when dealing with young adult women (that is college-age women) who have been sexually assaulted? *(Probes: ask for examples, detail, tell me more about it, ask for ideas on cultural competency, etc.)*

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Q3: How does one retain college-age women in mental health treatment after an assault?
(Probes: What are ideas for ensuring women remain in treatment? Tell me more; can you give me an example to explain what you mean?)

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I wanted to give you an opportunity to add information. Thus, do you have additional ideas about ideal treatment programs for college-age women who have been sexually assaulted? (Probes: ask for examples and detail)

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Q5: What are barriers to reporting sexual assault for young adult women (college-age) who are African American? *(probes: ask for examples and detail)*

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Q6: What are ideas for overcoming reporting barriers for this vulnerable group *(probes: ask for examples and detail)*

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Q7: What are barriers to African American college-age women participating in mental health treatment after they have been assaulted? (probes: ask for examples and detail)

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Q8: What is ideal mental health treatment for African American women who have been sexually assaulted? (Probes: How should existing strategies be enhanced or made more culturally relevant for African American women? What would you recommend to improve strategies to reach African American women of college age?)

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**Q9:** How can we overcome barriers and enhance treatment participation for college-age women who are African American and who have been victims of assault? *(probes: ask for examples and detail)*

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**Q10.** Do you have any additional comments or suggestions that you would like to mention before we end the interview?

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______________________________________________________________________________

**INTERVIEWER:** Thank you again for your participation. *[shakes hands, again]*. Interview ends.