African American survivors of childhood sexual abuse:
Perceptions of treatment and treatment providers

by

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Abstract

The current research advancements in sexual abuse literature regarding the mental health treatment of African Americans has been focused heavily on female African Americans survivors with only limited research comparing both genders. The purpose of this quantitative descriptive study was to explore the post childhood sexual abuse (CSA) experiences of African American survivors. This study sought to examine if African American men or women were more likely to receive treatment for CSA, examine by whom treatment was provided, and measure the treatment perceptions regarding treatment effectiveness and impact of religious beliefs for childhood sexual abuse among African Americans when compared by gender groups. The provider of treatment consisted of two treatment provider groups: Licensed Mental Health Professionals (Psychiatrist/MD, Psychologist, Licensed Professional Counselor, Social Worker, or Marriage & Family Therapist) and Religious/Clergy Leaders (Priests, Rabbi, Pastors, Ministers, or Christian Counselors/Non-Licensed). Data was collected from participants residing in the metropolitan area of Atlanta, Georgia, which consisted of 15 counties. There were 249 participants in this study, consisting of 87 males (34.9%) and 162 females (65.1%) who completed an anonymous online survey, which was called the CSA Treatment Perceptions Questionnaire. This newly developed research instrument consisted of 3 questions from the Trauma Assessment for Adults (TAA) to confirm history of childhood sexual abuse, two researcher-developed subscales (the Treatment Perceptions Scale and the Religious Beliefs Impact Scale), and a demographic questionnaire. Statistical analysis revealed that there was no

statistically significant difference between gender in terms of receiving treatment; also that there was no difference among African Americans based on gender when determining the treatment perceptions regarding treatment effectiveness and impact of religious beliefs. African American respondents were significantly more likely to see a Licensed Mental Health Professional (80.7%) versus a Religious/Clergy Leader (19.3%). Regarding treatment effectiveness, the results from the interaction effect found no significant difference between gender and treatment providers among African Americans. Despite this finding, there was a statistically significant main effect for treatment provider, which indicated that when males received treatment from LMHP they had overall higher rating values for treatment effectiveness, whereas females had higher rating values for treatment effectiveness when the treatment provider was a religious/clergy leader. Regarding the impact of religious beliefs, the interaction effect found no significant difference. This overall finding regarding the impact of religious beliefs among African Americans suggested that regardless of the respondent's gender or treatment provider, there was no statistically significant difference. Limitations of this study, implications of this study, suggestions for future research, and suggestions for the counseling profession were noted.

Acknowledgments

I would like to dedicate this dissertation to all survivors of sexual abuse. I am grateful and appreciative for all the survivors who participated in this study. I hope and long for the day when all forms of abuse will cease.

I am truly honored to be where I am and to see all that I have accomplished. I know that it has all been possible because of my faith in God. I am grateful to the support of my parents whom have supported me my entire life. To my siblings and close friends, thank you for always being my faithful supporters throughout all of my career and personal endeavors.

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Style manual used: Publication Manual of the American Psychological Association, 2010 (6th ed.).

Computer software used: Microsoft Office Word 2010; Statistical Product for Social Sciences (SPSS) 21.0.

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List of Abbreviations

AA   African American

APA   American Psychiatric Association

CSA   Child Sexual Abuse

CDC   Center for Disease Control

TAA   Trauma Assessment for Adults

NAMI National Alliance of Mental Illness

NCTSN National Child Traumatic Stress Network

I.   INTRODUCTION

Child sexual abuse (CSA) has been reviewed, evaluated, and studied from a plethora of perspectives. Previous studies have reported alarming factors and essential information as to the occurrences of child sexual abuse within the United States of America and throughout other regions of the world. In a 2005 report, the Center for Disease Control (CDC) (2005), estimated that approximately one in six boys and one in four girls are sexually abused before the age of 18. Additionally, the authors of the CDC report noted that accurate statistics on the prevalence of sexual abuse of children and adolescents are difficult to collect. This report indicated that CSA is vastly underreported, and there are differing definitions of what constitutes sexual abuse. The CDC researchers concluded that this was due to the very sensitive and secretive nature regarding child sexual abuse occurrences; many of these cases are never reported.

According to the officials with the Darkness to Light program, which is a non-profit organization, their program has been pivotal in empowering people to prevent sexual abuse by providing them with strategies to increase awareness of CSA. Researches at the Darkness to Light program (2001-2005) noted that more than 80 percent of sexual abuse cases occur in isolated, and one-on-one situations. The authors of the report suggested that CSA can be minimized by isolating one-on-one situations between children and adults, and children and older youth. One of the more prominent sexual abuse cases of the past decade was the Jerry Sandusky case. He was an active coach and affiliate of Penn State University Football team who

was found guilty of 45 counts of child sexual abuse in June 2012 (Achenbach, 2012). The Sandusky case was one of many highly publicized sexual abuse cases involving 10 boys over a 15 year span. Another highly profiled and publicized case involved the Los Angeles Archdiocese. In this case, Franciscan priests were reported to have molested more than 25 children. As a result, the Roman Catholic Church agreed to pay $28 million to the sexual abuse victims for failing to protect children from predatory priests (Guccione, 2006). In September of 2010, a case involving the African American community and Black church emerged from a lawsuit filed against Bishop Eddie Long for sexual misconduct. Bishop Long is an internationally known African American preacher who pastors the New Birth Missionary Baptist Church, which is a 25,000 member church located in Lithonia, Georgia. Bishop Long was accused of sexual misconduct by four African Americans who were former members of his congregation. The four men reported that they were coerced into having sexual relations with Bishop Long. The news report by Poole (2011) reported that the young men ranged in age of 15-17 years old, and alleged to be taken on lavish trips and given expensive gifts in turn for sexual favors. The Bishop Long lawsuit case was later settled outside of court for an undisclosed monetary amount awarded to each of the accused victims. These examples are only a few of the highly publicized cases that were reported by various media sources over the past decade. However, regardless of the intensity of each case, there were victims involved.

<div align="center">Prevalence and Risk Factors of Child Sexual Abuse</div>

According to U. S. Census Bureau (2012) report there are over 313 million people living in the United States of America. This proportion of Americans consists of White/Caucasian alone (not Hispanic or Latino) 63%, Hispanic or Latino 16.9%, African American 13%, Asian 5.1%, Bi-racial or Multi-racial 2.4%, and American Indian and Alaska Native 1.2%. A

2011Child Maltreatment report published by the U.S. Department of Health and Human Services Children's Bureau (2012), indicated that 61,472 cases of child sexual abuses were reported in the United States. Per this report, sexual abuse consisted of 9.1 percent of the total number of reported maltreatment cases, and 1,545 children died as a result of abuse or neglect that same year. Child sexual abuse affects all people regardless of their age, ethnic background, or religious beliefs. Reports of child sexual abuse come from inner-city urban, suburban, and rural communities. The authors of the 2011 child maltreatment report noted that CSA affects both females and males in all groups, families, neighborhoods, and communities, and in countries around the world. In 2005, the CDC reported that most children are abused by someone they know and trust. Research conducted by the CDC (2005) has estimated that approximately 300,000 children are abused every year in the United States, and those with a prior history of sexual victimization are more likely to be re-victimized. A misperception is that in attempts to prevent child sexual abuse is that the perpetrator is an adult. An estimated 23% of reported cases of child sexual abuse are actually perpetrated by individuals under the age of 18 (Snyder, 2000).

A major conclusion noted in the 2011 child maltreatment report was the acknowledgement that one of the major limitations of research is that CSA is often not reported. In part, this is likely due to the greater legal ramifications associated when reported to authorities. In most states perpetrators can face incarceration and be placed on a sexual offender list for the rest of their lives. Previous research by Finkelhor (1994) suggested that one in five girls and one in twenty boys are victims of child sexual abuse, and that the age of the child plays a significant risk factor in being vulnerable to sexual abuse. In 2010, Sedlak et. al. observed that family home structure and support systems are significant risk factors in CSA cases. Results from their study indicated that children who live with two married biological parents are at low

risk for abuse, and that the risk of CSA increased when children live with step-parents or a single parent. Thus, children who were living without the support of either parent, often foster children, are 10 times more likely to be sexually abused than children that live with both biological parents. The research by Sedlak et. al. (2010) further identified the top risk factors for CSA to occur in single parent homes that has a live-in partner, whereas children are consider to be 20 times more likely to be victims of CSA than living with both biological parents.

Statement of the Problem

For the past two decades there has been a significant increase in published research on the effects of childhood sexual abuse. Finkelhor (1994) found that 20% of adult females and 5-10% of adult males recall a childhood sexual assault or sexual abuse incident. Additionally, Finkelhor reported that children between the ages of seven and thirteen are most vulnerable to sexual abuse. Despite the more prominent gains in literature on examining sexual abuse, assault, and mental health treatment of African Americans, much of the research has been focused on female African Americans survivors with only limited research comparing both genders. Sedlak et al. (2010) extended Finkelhor (1994) findings by suggesting considering the factors of race and ethnicity in identifying the potential of child sexual abuse. Sedlak et. Al. also claimed that African American children are at twice the risk of sexual abuse than Caucasian American children. However, there has been limited research focused on African American survivors of childhood sexual abuse with significant representation from both gender groups. In addition, literature has not been found that focuses on the self-reported perceptions of treatment and selection of treatment providers among African Americans survivors of childhood sexual abuse.

A U.S. Surgeon General report on Mental Health: Culture, Race and Ethnicity (2001) compared various ethnic groups' mental health disparities. The authors noted that African

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Americans were less likely to receive needed mental health care, more likely to receive inadequate quality of care, and were significantly under-represented in mental health research when compared to Caucasian Americans. For example, Snowden (2012) conducted a 10-year follow up study comparing African American and White American mental health disparities. He reported that African Americans with mental illness are at risk of suffering from complex mental disorders and exhibit the symptoms for prolonged durations than other ethnic groups. Snowden (2012) recognized that African Americans have received poor quality treatment. He added by noting that these experiences has increased the impact of disparity among the population when accessing mental health treatment. Additional research supports the notion that African Americans often reject or do not seek mental health treatment, because of the disparities impact of treatment access and prevalent stigmas linked to mental illnesses (Alvidrez, Snowden, & Patel, 2010; Anglin, Link, &Phelan, 2006).

Previous research reported by the National Alliance on Mental Illness (2009) suggests that African Americans tend to rely on family, religious and social communities for emotional support, rather than turning to health care professionals, even though this may at times be necessary. The National Alliance on Mental Illness (NAMI) (2009) indicated that experiences of mental illness vary across cultures and some mental illnesses are more prevalent in the African American community compared to other cultures in the United States. The authors from the NAMI (2009) report suggested that the mental health disparities faced by African Americans has led to frequently stigmatized and misunderstood perceptions of mental illness in the African American community. Considering that there is an ever increasing need to address CSA in the African American community, the current research study sought to explore both female and male gender groups of African American survivors of childhood sexual abuse, their perceptions to

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treatment and treatment providers, and the impact of their religious beliefs. Ultimately, the focus of this study seeks to respond to the lack of information about African American perceptions of treatment effectiveness and selection of treatment providers for CSA. The results of this study may be of interest to licensed mental health professionals, religious/clergy leaders, and counselor educators who seek to further understand the challenges, implications, and trends within the African American community in regards to perceptions of counseling practices and treatment.

<div align="center">Purpose</div>

African American rates of mental illness are similar when compared to other ethnic groups. However, African Americans face disparities in mental health care when compared to Americans who present with identical mental illnesses. African Americans are prone to receive less adequate mental health treatment and often lack access to culturally competent mental healthcare providers (Primm & Lawson, 2010). A SAMSHA National Survey on Drug Use and Health (2010) report on African Americans noted that in 2010, 19.7 percent of Black or African Americans aged 18 or older had a mental illness within that year. Additional findings from this study indicated that 4.4 percent of Black or African Americans ages 18 or older suffered from a serious mental illness in 2010. In addition to the mental health care disparities that African Americans face, one of the important factors leading to these disparities is the barriers to care. For example, in a research study conducted by Aylaon & Alvidrez (2007) common mental health barriers among African Americans consisted of the following:

- The importance of family privacy
- Lack of knowledge regarding available treatments
- Denial of mental health problems
- Concerns about stigmas, medications, and treatment

- Not receiving appropriate information about services or receiving inadequate

- Dehumanizing services

An additional research study by Aylaon & Alvidrez (2007) concluded that it is essential to provide mental health education to the entire public and mental health community, and to increase awareness regarding the nature of mental illness and available treatment services.

The purpose of this study was to explore the post CSA experiences of African American survivors. This study sought to examine if African American men or women were more likely to receive treatment for CSA, examine by whom treatment was provided, and measure the treatment perceptions regarding treatment effectiveness and impact of religious beliefs for childhood sexual abuse among African Americans when compared by gender groups. The provider of treatment consisted of two treatment provider groups: Licensed Mental Health Professionals (Psychiatrist/MD, Psychologist, Licensed Professional Counselor, Social Worker, or Marriage & Family Therapist) and Religious/Clergy Leaders (Priests, Rabbi, Pastors, Ministers, or Christian Counselors/Non-Licensed). This inquiry was worthy of examination due to the growing number of sexual abuse cases that have been exposed through media, multiple lawsuits against various religious leaders, and the disparity data that shows African Americans are underutilizing mental health treatment services.

Significance of the Study

This research study sought to provide new knowledge and further insight into the CSA experiences of African Americans, and to report on the self-reported perceptions regarding treatment effectiveness and impact of religious beliefs among African American survivors of CSA. Multiple research studies have indicated challenges in obtaining accurate and valid representation of children and adult survivors of CSA who are of African American descent. The

data results received from this study may potentially provide further evidence of the detrimental effects of untreated childhood sexual abuse and its lifelong effects on adulthood.

In a previous dissertation study conducted by Lyle (1992), research indicated promising opportunities to study one population, one syndrome, or one method of treatment to the exclusions of all others for CSA. Lyle (1992) stated that the outcome would have the potential to contribute a wealth of extensive knowledge to the field of CSA. For the past 20 years, limited research has examined the occurrences of CSA among African Americans referring to their perceptions to treatment and treatment providers. Few research studies emphasized examining the differences between the history of CSA and African Americans perceptions seeking treatment and selection of treatment providers. The history of CSA studies previously discussed have proposed the notion that there is a moderate to large number of African Americans who have never sought out counseling services. Additionally, this is attributed to many of them still harboring no value for or a stigmatized value for counseling services and mental health providers (NAMI, 2009). This study seeks to explore African Americans treatment provider sought, whether treatment was provided by licensed mental health professional or religious/clergy leaders, and to evaluate the perceptions of treatment effectiveness. The data gathered for this study will come from participants who are age 19 years and older, and reported experiencing sexual abuse prior to the age of 18. The goal of this study is to extend to the counseling literature regarding the experiences of African Americans and effects of CSA. In addition, it is perceived that the information received from this study may potentially assist in bridging the mental health awareness gap regarding misconceptions and stigmas among African Americans; who are still reluctant not to seek treatment from licensed mental health professional or no treatment at all for CSA.

Research Questions

To examine African American survivors of childhood sexual abuse perceptions of treatment and treatment providers. The CSA Treatment Perceptions Questionnaire was used to empirically assess the history of childhood sexual abuse, confirm if child sexual abuse occurred, measure participants self-reported perceptions to treatment and their selection of treatment provider, evaluate the impact of religious beliefs, and collect demographic information. The CSA Treatment Perceptions Questionnaire was developed based on modified questions from three survey instruments (Trauma Assessment for Adults [TAA], two additional scales developed, and demographics questionnaire). By utilizing the CSA Treatment Perceptions Questionnaire, the researcher sought to answer the following research questions and address the following null hypothesis:

1) What is the difference in the proportion of African American females receiving treatment versus African American males?

2) What is the difference in the proportion among African American receiving treatment from religious/clergy leaders versus licensed mental health professionals? Does this differ by gender?

3) Are treatment perceptions for child sexual abuse different among men and women when provided by religious/clergy leaders versus licensed mental health professionals?

4) Do respondents feel that their CSA experience impacted their religious beliefs? Does this effect differ by gender or treatment provider?

Null Hypotheses

$H_{01:}$ There is no difference in African Americans who has received treatment for child sexual abuse when measured by gender.

$H_{02:}$ There is no difference in African Americans selection of treatment provider when measured by gender.

$H_{03:}$ There is no difference in African Americans treatment perceptions regarding treatment effectiveness for child sexual abuse when measured by gender and treatment provider.

$H_{04:}$ There is no difference in African Americans religious beliefs regarding impact of child sexual abuse when measured by gender and treatment provider.

Definitions of Terms

The following definitions of terms are noted to clarify and were essential for understanding the context of this research study. For the purposes of this study child sexual abuse, childhood sexual abuse, Christian (Christianity), Christian families, licensed mental health professionals, mental health counseling, pastoral counseling, religion, religious/clergy leaders, re-victimization, and stigma were all defined to provide readers with a clear understanding of these terms utilized throughout this research study.

African American or Black: Refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicated their race(s) as "Black, African American, or Negro" or reported entries such as African American; Sub-Saharan African entries, such as Kenyan and Nigerian; and Afro-Caribbean entries, such as Haitian and Jamaican (U.S. Census Bureau, 2010).

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Child Sexual Abuse (CSA): According to the National Child Traumatic Stress Network (2009),

    child sexual abuse may include, but is not limited to any of the following: any interaction

    between a child and an adult (or another child) in which the child is used for sexual

    stimulation of the perpetrator or an observer; Sexual abuse can include both touching and

    non-touching behaviors, Touching behaviors may involve touching of the vagina, penis,

    breasts or buttocks, oral-genital contact, or sexual intercourse; Non-touching behaviors

    can include voyeurism (trying to look at a child's naked body), exhibitionism, or

    exposing the child to pornography.

Childhood Sexual Abuse: Any experience or experiences of any form of child sexual abuse

    (CSA) which has occurred to any individual prior to the age of 18 (National Child

    Traumatic Stress Network, 2009).

Christian (Christianity): For the purposes of this research study, Christian is defined as one who

    proclaims Christianity as their chosen faith/religion/spirituality, and actively engages in

    the practices and/or teachings of Jesus Christ by attending Church or Mass religious

    services or professed Christianity as your religion (Merriam-Webster Online Dictionary).

Christian Families (Christians): For the purposes of this research study, Christian families also

    referred to an individual or family group/household who has engages in the religious

    practices of Christianity or individuals who were raised within a home where you and/or

    your family practiced the religion of Christianity (as Christian definition described

    above).

Licensed Mental Health Professionals: Consists of Psychiatrist/MD, Licensed Psychologist,

    Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), or

    Licensed Marriage & Family Therapist (LMFT).

Mental Health Counseling:

Is the provision of professional counseling services including the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology of mental illness and dysfunctional behavior to individuals, couples, families, and groups for the purposes of promoting optimal mental health, dealing with normal problems of living, and treating psychopathology. The practice of mental health counseling includes, but not is not limited to, diagnosis and treatment of mental disorders, psychoeducation designed to prevent emotional problems, consultation, and research into more effective psychotherapeutic treatment modalities (American Mental Health Counselors Association, 1986, p. 2).

Pastoral Counseling: Aims at helping persons deal constructively with their immediate life problems and crises, make decisions, face responsibilities, and make amends for self-other hurting behavior, as well as expressing, experiencing, and eventually resolving growth-blocking feelings, attitudes, and self-perceptions (Clinebell, 1984).

Religion: Is the belief in a god or in a group of gods. A specific fundamental set of religious attitudes, beliefs and practices, ritual observance of faith, generally agreed upon by a number of persons or sects: *the Christian religion; the Buddhist religion, etc.* (Merriam-Webster Online Dictionary).

Religious/Clergy Leaders: Consists of Priests, Rabbi, Pastors, Ministers, or Christian Counselors/Lay Counselors who are not licensed to practice counseling.

Re-victimization: Those who have experienced childhood sexual abuse, but have also experience some form of sexual assault or rape within their adulthood (Briere & Scott, 2006).

Stigma: Refers to a cluster of negative attitudes and beliefs that motivate the general public to

      fear, reject, avoid, and discriminate against people with mental illness (Corrigan &

      Kleinlein, 2005).

II.   REVIEW OF LITERATURE

This chapter offers a synthesis of research on CSA. The sexual abuse of children whether it occurs in the United States or among other areas of the world should be viewed and approached with the upmost regard as a public health matter. Research reviewed on the status of child sexual abuse and sexual assault is alarming. In 2007 published the Adverse Childhood Experiences study and the authors estimated that 25% of females and 16% of males have experienced sexual abuse as children. The CDC report suggests that sexual abuse has been associated with significant negative short-term and long-term health impacts for the victims. In comparing child sexual abuse to other public health matters, such as sexual assault and rape, the statistics and data on child sexual violence is shocking.

The authors of the National Intimate Partner and Sexual Violence Survey (2011) reported that 42.2% of female rape victims were first raped before age 18; 29.9% of female rape victims were first raped between the ages of 11-17; 12.3% female rape victims and 27.8% of male rape victims were first raped when they were age 10 or younger. The same study reported health disparities among adult women surveyed in 2010 reporting 26.9% of American Indian/Alaska Natives, 22% of non-Hispanic blacks, 18.8% of non-Hispanic whites, 14.6% of Hispanics, and 35.5% of women of multiple races experienced an attempted or a completed rape at some time in their lives. According to the CDC (2012) study on High School Youth Risk Behavior Survey, they found that 11.8% of girls and 4.5% of boys from grades 9-12 reported that they were forced to have sexual intercourse at some time in their lives. The same study reported health disparities

among high school students surveyed in 2010, 12.5% of American Indian/Alaska Natives, 10.5% of Native Hawaiian/Pacific Islander students, 8.6% of black students, 8.2% of Hispanic students, 7.4% of white students, and 13.5% of multiple-race students reported that they were forced to have sexual intercourse at some time in their lives. All of the reported numbers are alarming regarding the facts of sexual violence among children and adults. These two nationally representative survey studies provide concrete data regarding the potential occurrences of sexually violent traumatic experiences.

According to the U.S. Census Bureau (2010) African Americans represent 13% of the entire United States of America population, which equals to 38.9 million living in this country. Out of the 308.7 million Americans indicated by the U.S. Census Bureau (2010), less than 10 percent (9.1%) suffered sexual abuse with 26.3% of the victims being between ages 12-14 and 21.8% were between the ages of 15-17 based on the *child maltreatment 2011* report. No data reported regarding the breakdown of sexual abuse victims based on ethnic group from this study. Nonetheless, the *child maltreatment 2011* report confirmed that 21.5% of African American children experienced some type of child maltreatment consisting of either neglect, physical and sexual abuse. The prevalence rate among African Americans is sufficient to support the need for this study, and confirms the occurrences of child sexual abuse prevalent in the African American community.

The information provided throughout this literature review will elaborate on research focusing on the traumatic experiences of African Americans, more specifically that of relating to childhood sexual abuse. This section of the literature review discusses the various types of major traumas, child sexual abuse, abuse survivors, sexual assault and re-victimization experienced by African Americans. The remaining section of this chapter will discuss the impact of Christian

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Faith influences in African American culture. This section summarizes various Christian faith beliefs and practices, coping methods utilized, and mental health challenges that influence African American viewpoints and perceptions in relation to CSA.

Theoretical Perspective and Conceptual Framework

In developing a theoretical perspective for examining the CSA treatment perceptions of African American survivors, utilizing the self-trauma model by Briere (1996) provides a meaningful framework. Within this framework for understanding the perceptions of CSA survivors, the self-trauma model assumes that major childhood abuse and neglect often disrupts normal child functioning and development, and leads to the development of later mental health symptomatology (Briere, 1996). According to Briere (1996) the symptomatology is produced in several different ways:

1. By altering childhood attachment dynamics

2. Through the effects of early posttraumatic stress on subsequent development

3. By motivating the development of primitive coping strategies

4. By distorting the child's cognitive understanding of self, others, and the future described the therapeutic implications of the self-trauma model in terms of therapeutic process and the specific content and goals of abuse-relevant psychotherapy

The principles of the self-trauma model include respect, positive regard, and the assumption of growth, and these principles allow clinicians to foster safe and supportive environments, opportunities to provide therapeutic feedback, and process through past traumatic experiences (Dass-Brailsford, 2007).

These previously described principles provide a conceptual framework for examining CSA, and open the door to understanding and addressing childhood sexual abuse and other

traumatic experiences encountered by African American survivors. This is primarily due to the

mental health disparities that African Americans face in being receptive to mental health

treatment, also due to the many mental health stigmas prevalent within the African American

community. As previously reported in chapter one by the U.S. Surgeon General report on Mental

Health: Culture, Race and Ethnicity (2001), African Americans are still less likely to seek mental

health care than Caucasian Americans. Snowden (2012) conducted a 10-year follow up study to

the 2001 report by U.S. Surgeon General by reporting inadequate mental health care for African

Americans when seeking treatment. These mental health disparities described among many

others continue to impact the perception of mental health treatment among African Americans.

Furthermore, the self-trauma model lays the groundwork for exploring the concepts of attitudes,

perceptions, and subjective norms as factors that may influence seeking treatment and the

selection of the treatment provider.

The self-trauma model implies that traumatic experiences can never be conceived to be

easily translated or viewed as one simple experience, but has to be examined from the

perspective of a collection of many independent and individual recollections of that traumatic

experience (Briere & Scott, 2006). In an expanded explanation of the self-trauma model, Briere

(2002) states that "a major implication of the self-trauma model is that many adult survivors of

childhood abuse expend considerable energy addressing trauma-related distress and insufficient

self-capacities with avoidance mechanisms" (p. 10). "As a result, avoidance defenses are viewed

as necessary survival responses by some survivors, and overly enthusiastic or heavy-handed

attempts by a therapist to remove such "resistance," "denial," or dissociative symptoms" may be

seen as potential threats to the client's internal equilibrium" (Briere, 2002, p. 10). For this reason,

the self-trauma model perspective helps in understanding how avoidance responses along with

mental health stigmas together would impede African Americans from seeking treatment for CSA.

<center>Traumatic Experiences of African Americans</center>

Types of Trauma

The major types of trauma discussed in this section include natural disasters, mass interpersonal violence, large-scale transportation accidents, house or other domestic fires, motor vehicle accidents, rape and sexual assault, stranger physical assault, partner battery, torture, war, and child abuse. These major types of trauma are briefly defined below from the Principles of Trauma Therapy: A guide to symptoms, evaluation, and treatment book by Briere and Scott (2006):

Natural Disasters: Are large-scale, not directly human-caused, injury- or death-producing

environmental events that adversely affect a significant number of people.

Mass Interpersonal Violence: Involves high numbers of injuries or causalities, but does not occur

in the context of war.

Large-Scale Transportation Accidents: Involve events such as airline crashes, train derailments,

and maritime (for example, ship) accidents.

House or Other Domestic Fires: These include house fires, often caused by smoking in bed or by

electrical short circuits, and gas explosions due to leaking propane tanks, stoves, or

heaters.

Motor Vehicle Accidents: Involves experiencing a serious motor vehicle accident (MVA),

especially more prominent if the accident involved major injury or resulted in the death

of others.

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Rape: Is a nonconsensual oral, anal, or vaginal sexual penetration of an adolescent or adult

through the use of threat or physical force, or when the victim is incapable of giving

consent.

Sexual Assault: Any forced sexual contact short of rape, although some authorities consider

sexual assault to involve any forced sexual contact, including rape and/or peer sexual

assault.

Stranger Physical Assault: Refers to muggings, beatings, stabbings, shootings, attempted

strangulations, and other violent actions against a person not well known to the assailant.

Partner Battery: Also known as wife battering, spouse abuse, or domestic violence, is defined as

physically or sexual assaultive behavior by one adult against another in an intimate,

sexual, and usually (but not inevitably) cohabiting relationship.

Torture and War: Are both considered enduring psychological disturbance that can stem from

severe pain or suffering, or involving a wide range of violent and traumatic experiences,

including immediate threat of death and/or disfigurement, physical injury, witnessing

injury and/or death of others.

Child Abuse: Childhood sexual and physical abuse, ranging from fondling to rape and from

severe spankings to life-threatening beatings, is quite prevalent in North American

society.

Traumatic events can occur at any moment, to any individual, and has the potential to

ultimately alter ones mental, physical, and emotional well-being. Many individuals often

associate trauma with being a single incident or event that causes some substantial forms of

abnormal impairment that affects ones daily functioning. These traumatic episodes can be

contributed to many factors that cause distress to the lives of our loves ones, closes friends,

coworkers, and the diverse people whom we come into contact daily. One thing that is certain about trauma, is that regardless of how the incident or event occurs, trauma does not have a face nor is it directly connected to any one ethnic cultural background. The main point is that traumatic events can happen to anyone.

In further exploring and examining the types of traumatic events, the DSM-5 provides a solid and strictly adhered to description of trauma when making a formal mental health diagnosis. The Diagnostic and Statistical Manual of Mental Disorder, 5th edition, (DSM-5; American Psychiatric Association [APA], 2013) defines Trauma and Stressor-related disorders as:

> Including disorders in which exposure to a traumatic or stressful event is listed explicitly as a diagnostic criterion. These include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorders. Psychological distress following exposure to a traumatic or stressful event is quite variable. In some cases, symptoms can be well understood within an anxiety- or fear-based context. It is clear, however, that many individuals who have been exposed to a traumatic or stressful event exhibit a phenotype in which, rather than anxiety- or fear-based symptoms, the most prominent clinical characteristics are anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, or dissociative symptoms. These variable expressions of clinical distress following exposure to catastrophic or aversive events, the aforementioned disorders have been grouped under a separate category: *trauma- and stressor-related disorders* (DSM-5, 2013, p. 265).

According to the DSM-5 (2013) the essential feature of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events. The directly experienced traumatic events are defined in Criterion A:

> Include, but are not limited to, exposure to war as a combatant or civilian, threatened or actual physical assault (e.g., physical attack, robbery, mugging, childhood physical abuse), threatened or actual sexual violence (e.g., forced sexual penetration, alcohol/drug-facilitated sexual; penetration, abusive sexual contact, noncontact sexual abuse, sexual trafficking), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war, natural or human-made disasters, and severe motor vehicle accidents. For children, sexually violent events may include developmentally inappropriate sexual experiences without physical violence or injury. In addition, witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected by a family member or other close associate (DSM-5, 2013, p. 274).

The DSM-5 describes a listing of possible traumatic events, stemming from military combat, violent personal assault (sexual assault, physical attack, robbery, and mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. According to the DSM-5, sexually traumatic events for children can occur as the result of inappropriate sexual experiences without threatened or actual violence or injury. The DSM-5 adds that witnessed events, such as observing the serious injury or unnatural death of another person or unexpectedly witness a dead person has the potential to cause similar traumatic experiences. Nonetheless, the DSM-5 indicated that these traumatic

events discussed can be re-experienced in various ways. These responses commonly occur in the form of recurrent and intrusive recollections of the vent or recurrent distressing dreams during which the event can be replayed or otherwise represented. The DSM-5 contributes these essential symptomatology to that of Posttraumatic Stress Disorder, which is the development of characteristic symptoms following exposure to an extreme traumatic stressor.

Child Sexual Abuse

To understand child maltreatment, the CDC (2013) fact sheet helps by defining child maltreatment as including all types of abuse and neglect of children under the age of 18 by either a parent, caregiver, or another person in a custodial role (e.g., clergy coach, teacher). The CDC (2013) fact sheet defined four common types of abuse, which are listed here:

- Physical abuse is the use of intentional physical force, such as hitting, kicking, shaking, burning or other show of force against a child.

- Sexual abuse involves engaging a child in sexual acts consisting of fondling, rape, and exposing a child to other sexual activities.

- Emotional abuse refers to behaviors that harm a child's self-worth or emotional well-being, consisting of name calling, shaming, rejection, withholding love, and threatening.

- Neglect abuse is the failure to meet a child's basic needs, consisting of failure to provide housing, food, clothing, education, and access to medical care.

Briere and Scott (2006) stated that "childhood sexual and physical abuse, ranging from fondling to rape and from severe spankings to life-threatening beatings, is quite prevalent in North American Society (p. 9)." The reports of child sexual abuse are hard to accurately track, because of the high numbers of unreported claims due to the fear, shame, guilt, and regret that are usually associated with CSA. Thusly, it can be extremely challenging to pin point detailed rates of

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occurrences across the current and past research studies of CSA. Nonetheless, researchers agree that child sexual abuse is a public health matter that needs to be addressed across all spectrums in the United States regardless of age, sex, socioeconomic status, ethnicity, or religion. Tyler and Cauce (2002) found higher rates of sexual abuse for sexual minority youth (i.e., gay, lesbian, bisexual) than that of non-minority heterosexual youth. A multi-year research study has indicated that 40% of children are abused by family members, 60% are abused by people the family trusts, nearly 40% are abused by older or larger children and that more than 80% of sexual abuse cases occur in one-adult/one-child situations (Darkness to Light, 2001-2005). Among the several tasks in identifying a sexually abused child, Miller, Dove, & Miller (2007, October) indicated difficulties due to different variances, reactions, responses, and diverse presenting symptoms exhibited by CSA survivors.

A newspaper article by the New York Amsterdam News report by Jasmin K. Williams (2011), titled, "Sex abuse rampant and silent in the Black Community" discusses this phenomenon. The article was printed after the Penn State and Syracuse Universities sex abuse scandals of 2011, and focused on the issues of sexual abuse in the African American community. Williams (2011) reported that there are roughly 39 million Americans who are survivors of childhood sexual abuse consisting of all races, but one of the major issues is that many of them do not report or discuss their abuse until the latter part of their adulthood. Through the work of Deborah Cooper, who is an expert social researcher and columnist, and advocate in the African American community, she is currently conducting a survey that examines the hidden lives of pedophiles, the secrets families keep, and the long-term impact child sexual abuse has on Black children and African American communities. Cooper (2011) stated in her press release article that "Sadly, many African Americans believe that these types of things happen only in White

families and therefore such statistics don't pertain to us" (para, 4). Cooper (2011) further indicates that many of the victims did not report their abuse at the time it occurred due to having no indication that what was happening to them was sexual abuse.

The National Center for PTSD reported on the effects of childhood sexual abuse by noting that CSA survivors have the potential to exhibit PTSD symptoms, including changes in moods and behaviors including agitation behaviors, frightening dreams, and recollections of the abuse experience (Whealin & Barnett, 2009). According to Whealin and Barnett (2009), if CSA survivors never receive treatment or do not receive appropriate treatment, long-term effects may occur throughout their adulthood. Whealin and Barnett (2009) suggested that the effects of CSA can or may include:

- PTSD and/or anxiety

- Depressed mood and suicidal ideations

- Sexual anxiety and disorders, including promiscuity

- Difficulty maintaining relationships and appropriate boundaries with others

- Poor body image and/or low self-esteem

- Engaging in at-risk behaviors, such as substance abuse, self-mutilation, or bingeing and purging, to help mask painful emotions related to CSA

In a research study by Hunt, Martens, and Belcher (2011) on trauma exposure and rate of PTSD in African American children and adolescents, they found that by having a history of exposure to community violence had a significant impact on potential of having PTSD symptoms in urban Africa American youth. In addition to community violence, Hunt, Martens, and Belcher (2011) reported that exposure to childhood physical abuse almost triples the potential of being exhibiting with PTSD symptoms.

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Although the previously mentioned study did not report the contributing factors of CSA, other research results have confirmed that prior history of CSA increases the likelihood of being sexually abused again and/or sexually or physically assaulted in adulthood, and in addition increases the possibility presenting with PTSD symptoms (Classen, Palesh, & Aggarwal, 2005; Boney-McCoy & Finkelhor, 1995). These findings are alarming regarding the effects of sexual abuse. Nonetheless, Briere (2002) suggested that intrusive and avoidant behaviors are common in PTSD, and traumatic experiences are triggered these behaviors can or may disrupt normal psychological functioning and ultimately impede the recovery in trauma treatment. For example, a study on the impact of race in treatment termination and outcomes in PTSD treatment by Lester, Resick, Young-Xu, and Arts (2010), found that African Americans were 1.5-times more likely to drop out of treatment prior to treatment completion, and were 3-times greater likely to never begin treatment than Caucasian participants. Lester et al. (2010) suggested that the possible explanation for these behaviors was based on the mental health disparities and stigmas among African Americans, and believed that these messages were derived from within the African American community (i.e., relatives, friends, religion, and/or other community leaders). Upon further examination of the perceptions and attributions of sexual abuse of African Americans, a research study by Hestick and Perrino (2009) found significant differences influencing perceptions of sexual abuse based on gender of the participant. Their research results indicated that female participants were more likely to confirm if the vignette case given was actually sexual abuse regardless of the gender of the victim or perpetrator, than male participants who had a hard time confirming if it was sexual abuse when comparing genders. Additional findings from the research of Hestick and Perrino (2009) concluded that female participants rated the perpetrator of CSA responsible regardless of the victims' age or gender, whereas male

participants only felt that the perpetrator was responsible when the victim was a young female or elderly male. The previously presented research studies discussing the behaviors and perceptions of African Americans, whether they are the treatment participant or non-treatment survey responder, confirms the impacts of mental health stigmas and misguided perceptions of CSA effects among African Americans.

Abuse Survivors

According to Williams (2011) influential individuals who are African American survivors of CSA are Oprah Winfrey, Maya Angelou, and Tyler Perry. Cooper (2011) added by stating "child sexual abuse is a dirty little secret in Black America (para, 6), and it bothers me that so many Black families are more concerned about what people will say, protecting their family image and the assailant's reputation instead of focusing on the children these people have hurt" (para, 10). Miller et al. (2007) noted that often times the victims of CSA are at increased risks for physical, emotional, and psychological problems in their adulthood when they fail to report sexual abuse or are in disbelief of the traumatic event. According to the research statistics found by the Darkness to Light program (2001-2005), 70-80% of sexual abuse survivors report excessive drug and alcohol use, more than 60% of teen first pregnancies are preceded by experiences of molestation, rape or attempted rape, and approximately 40% of sex offenders report sexual abuse as children. These findings found by the Darkness to Light program are yet again, alarming and provide an increased knowledge base regarding the effects of CSA.

The American Psychological Association (APA) (2005) report on understanding child sexual abuse, found that the more immediate CSA survivors discuss and report their abusive experience(s), the less likely they are to be severely traumatized than individuals who live into their adulthood with the secret. However, one of the misconceptions impacting the Black

community is that there are African American males who believe that males cannot be sexually abused by woman perpetrators, and that being sexually abused by a male could be perceived as being gay (Stone, 2004). Stone (2004) noted that many African American survivors when abused were advised by the perpetrator that they were being prepared for relationships, and when attempted to open up about their CSA experience they were advised that family business should be kept within the home. Thus, perceptions such as that which was previously described, hinders African American males to report and discuss their CSA experience. APA (2005) noted that negative effects of CSA can potentially affect victims throughout their childhood into their adulthood, but if the victim could confide in a trusted caregiver and provide support for them he or she has the potential to experience a decrease in trauma. The National Child Traumatic Stress Network (2009), further indicates that by receiving treatment for CSA by mental health professionals can minimize the physical, emotional, and social problematic symptoms resulting from the traumatic experience of CSA. APA (2005) reported additional contributing factors that assist with the recovery of CSA experiences, such as family support, high self-esteem, and spiritual support, but noted that the time that passes between the CSA experience and received treatment is pivotal in CSA recovery.

Sexual Assault and Re-victimizations

According to the U.S. Department of Justice's National Crime Victimization Survey (2012), that research results from 2006-2010 indicated that every 2 minutes, someone in the U.S. is sexually assaulted, and that every year the victims ages 12 or older are raped and sexually assaulted at an average of 207,754 yearly. Additional findings from the U.S. Department of Justice's National Crime Victimization Survey (2013), suggested that 9 of every 10 rape victims were female in 2003, and that 1 in every 10 rape victims were male. Another research study

conducted by the U.S. Department of Justice on Female Victims of Sexual Violence (2013) reported that between 2005-2010, 78% of sexual violence involved an offender who was either a family member, intimate partner, friend, or acquaintance, and females age 34 or younger, who lived in lower SES or rural areas were at the highest rates of sexual violence. This same study by the U.S. Department of Justice (2013) indicated that there were few differences in rates of sexual assault and rape victim, but noted that African American females had the highest incidents of sexual assault and rape when compared to Caucasian and Hispanic females.

As previously stated, much of the current research examining the sexual abuse and assault effects of African Americans have been more so focused on African American women versus African American men. In recent study conducted by Bryant-Davis, Ullman, Tsong, Tillman, and Smith (2010), their findings indicated that African American women who had a history of CSA reported low socioeconomic status and were more prone to experience symptoms of depression and PTSD than African American women of middle to high socioeconomic status. Additional findings by Bryant-Davis et al. (2010) revealed that African American women who had a history of CSA and were considered to be low socioeconomic status were also at greater risk of engaging in illicit drug use. These findings provide additional knowledge and insight regarding the predictors for depression, PTSD, and illicit drug use among African American sexual assault survivors. According to an article in Forbes Magazine by Axtell (2012) that reported on the subject of Black woman, sexual assault and the art of resistance, the Black Women's Health Imperative study indicated that about 40% of African American women were sexual assault victims in 2005. The U.S. Department of Justice's National Crime Victimization Survey (2013) suggested that African American women are significantly less likely to report sexual assault than compared to Caucasian American women. Axtell (2012) noted that racial

injustices, such as stereotypes regarding Black men and African American community are contributing factors to African American women refusing to break the silence.

Impact of Religiosity among African Americans

According to the U.S. Religious Landscape Survey, which was conducted in 2007 by the Pew Research Center's Forum on Religion and Public Life, African Americans "are markedly more religious on a variety of measures than the U.S. population as a whole." Their research found that 87% of African Americans versus 83% of all Americans were affiliated with a religion; however, they concluded that 79% of African Americans versus 56% overall say that religion is "very important in their life". The key findings reported by the Pew Forum U.S. Religious Landscape Survey (2008), were that African-Americans were significantly more religious on a variety of measures than the entire U.S. population as a whole. Their key findings regarding this are depicted in Figure 1 found below:

% of each group who...
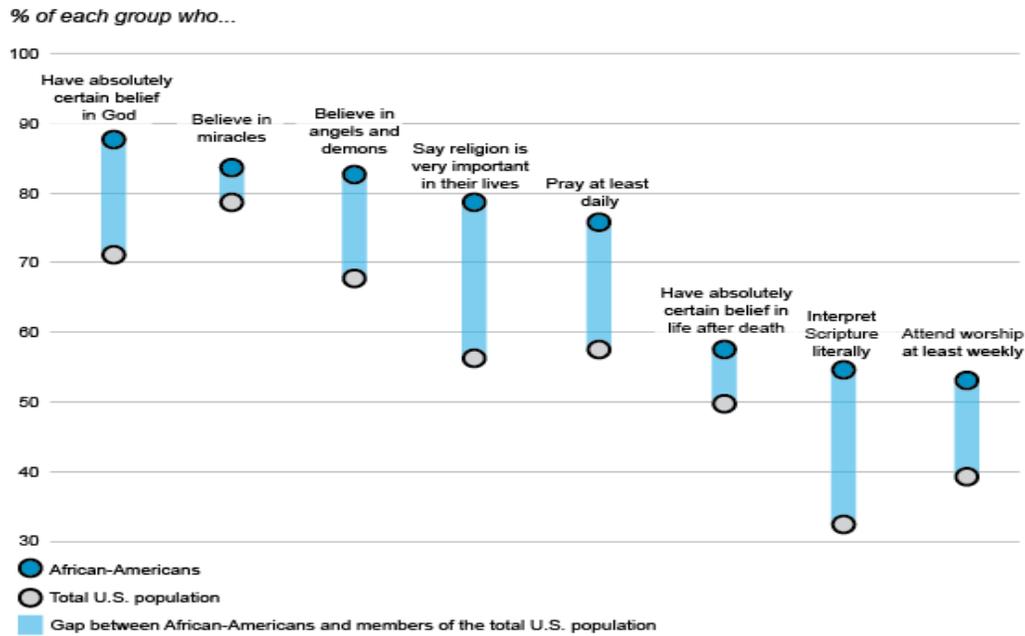
Figure 1. African-Americans and Religion. This figure illustrates that African-Americans have stronger religious beliefs when compared to the U.S. population as a whole. Reprinted from the Pew Forum U.S. Religious Landscape Survey. Reprinted with permission.

Additional findings by the U.S. Religious Landscape Survey (2008), reported that in 2007, 83% of African Americans were Christians, which consisted of 78% of them attending mainline Protestant Churches and historically black Protestant churches, while only 5% considered themselves to be Catholic. Although Christianity is the dominant religion in the African American community, 12% of African Americans considered themselves to be unaffiliated with any particular religion. The remaining 4% consisted of relatively small proportions of African Americans who were categorized together among other world religions, such as Mormon, Orthodox, Jehovah's Witness, Muslim, Buddhist, Hindu, and other faiths, and only 1% considered themselves to be Muslims. According to the U.S. Census Bureau (2010), there were over 1.7 million African Americans residing in the Atlanta metropolitan area, which

was comprised of 55.7 percent female and 44.3 male. There was no data that provided the religion breakdown for African Americans residing in Atlanta. Due to the majority of African Americans practice Christianity consisting of more than 80% of the U.S. population of African Americans, based on this it can only be assumed that with a large number of historically black churches and mega member churches residing in the Atlanta metropolitan area that the dominant religion would be Christianity. Furthermore, the bases of the rest of information provided in this section will evaluate the impact of religiosity among African Africans in relation to perceptions of CSA treatment and selection of treatment provider. However, the key findings regarding the religious composition of African Americans from the Pew Forum U.S. Religious Landscape Survey (2008) are depicted in Figure 2 found below:

Religious Composition of African-Americans

	African-Americans %	Total Pop. %
Protestant	78	51
Historically black churches	59	7
Baptist	*40*	*4*
Methodist	*5*	*1*
Pentecostal	*6*	*1*
Holiness	*1*	*<.5*
Nondenominational	*2*	*<.5*
Others	*5*	*1*
Evangelical Prot. churches	15	26
Baptist	*5*	*11*
Nondenominational	*3*	*3*
Pentecostal	*2*	*3*
Restorationist	*2*	*2*
Others	*2*	*7*
Mainline Protestant churches	4	18
Catholic	5	24
Mormon	<.5	2
Orthodox	<.5	1
Jehovah's Witness	1	1
Other Christian	<.5	<.5
Jewish	<.5	2
Muslim	1	1
Buddhist	<.5	1
Hindu	<.5	<.5
Other World Religions	<.5	<.5
Other Faiths	<.5	1
Unaffiliated	12	16
Atheist	<.5	2
Agnostic	1	2
Nothing in particular	11	12
Don't Know	<u>1</u>	<u>1</u>
	100	100

Source: Pew Forum U.S. Religious Landscape Survey, conducted in 2007, released in 2008

Figure 2. Religious Composition of African-Americans. This figure illustrates the religious composition of African-American in the United States. Reprinted from the Pew Forum U.S. Religious Landscape Survey. Reprinted with permission.

As previously stated, the National Alliance on Mental Illness (2009) suggested that African Americans tend to rely on family, religious and social communities for emotional support, rather than seeking counseling services from mental health professionals. A documented and substantial impact of Christian faith among African Africans is evident. Elliott (1994) noted that in her attempts to review empirical research on the connection between sexual abuse to those of conservative Christianity groups was nonexistent. Elliott's (1994) study on the impact of Christian faith on the prevalence and sequence of sexual abuse, examined the impact of religious faith and an integrated religious belief system on the prevalence rate of sexual abuse, with a specific emphasis on conservative Christian faith. In earlier research conducted by Davis & Graybill (1983) only limited studies linking abuse survivors to non-abused groups noted that non-abusive families fall higher in the religious and moral emphasis placed on family life. Prior to the study by Elliott (1994), there no published studies were found that examined the impact of religious faith on the clinical perceptions seen by adult sexual abuse survivors who come from conservative Christian faith backgrounds. According to the research conducted by Russell (1986) Christian women who were sexually abused, were also more likely to defect from the religious tradition of their childhood than women who have never been abused. Crisp (2007) suggested that the experiences of sexual abuse result in the outcomes of the survivors feeling betrayal or breach of trust when abused by someone they knew, especially when that someone has or is acting in a protective or caring role, such as a parent or other family member, clergy, teachers, and close family friends. In addition, Crisp (2007) noted that "it may be difficult for survivors to respond positively to images of God which are associated with the abuser or to trust in a loving God (p. 304)."

III. DESIGN AND METHODOLOGY

The purpose of this quantitative descriptive study was to determine which African American gender group was more prone to receive treatment, and examine who was the treatment provider when treatment was received. In addition, this study sought to measure the treatment perceptions regarding treatment effectiveness and impact of religious beliefs for childhood sexual abuse among African Americans when compared by gender groups. This chapter provides a description of the sample population, selection criteria, and pertinent demographic information to be collected and analyzed. A description of each survey instrument utilized has been provided with validity and reliability information where available. This chapter concludes with a review of the research questions, research hypotheses, and data analysis explanation and rational.

Participants

Recruitment of participants for this study included individuals who were who were age 19 years and older. Participants were asked to confirm their ethnic group identification as African American or African descent, and if they believed that they were or may have been sexually abused within their childhood prior to the age of 18. These three preliminary questions were answered and confirmed prior to starting the online anonymous survey. With a statistical chi-square test, power of .80, type I error of .05, effect size of .15, and two independent variables, 235 participants were needed, approximately 85 males and 150 females consisting of a 60/40 split, were required to test the hypotheses of this study. This was necessary in order to

provide us statistical the power essential to predict a 20% difference in those who received

treatment services when comparing proportions among African American females to males. The

breakdown of the previously described calculations was derived from Lenth (2006-2009) java

applets for power and sample size computer software.

The recruitment location for this research study was conducted in the city of Atlanta,

State of Georgia, United States of America because of its large metropolitan city, with 1.7

million African Americans residing there (U. S. Census Bureau, 2010). The Atlanta metropolitan

area consisted of 15 counties (Bartow, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas,

Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Paulding, and Rockdale). Participants were

recruited via postcard flyers, electronic emails, and bulletin announcements at seven places of

worship, five non-profit community organizations, five mental health agencies, five rape and

sexual assault crisis centers, seven Atlanta area media and radio broadcasting stations, and by

electronic methods via three social media outlets (i.e., LinkedIn, Twitter, & Facebook). For a

detailed list of the recruitment sites contacted, please refer to appendix D. Recruitment

advertisements were promoted for a period of 30 days minimum and a maximum of 60 days.

However, due to the minimum cutoff number of 235 participants were reached within the 45

days prior to the final 60 day period, recruiting efforts were ceased and the online anonymous

survey was disabled for any further responses to be recorded.

<div align="center">Instrumentation</div>

CSA Treatment Perceptions Questionnaire

The CSA Treatment Perceptions Questionnaire was a newly developed research

instrument consisting of three questions from the Trauma Assessment for Adults (TAA) only to

confirm history of childhood sexual abuse; two additional subscales (the Treatment Perceptions

Scale and the Religious Beliefs Impact Scale) were developed specifically for this study, and demographic questionnaire items. The CSA Treatment Perceptions Questionnaire consisted of 35 total items with one additional demographic response for outside of Georgia respondents to indicate their two letter state ID. This instrument consisted of some yes or no responses, but for the subscales each were on a Likert-type scale and additional descriptive demographic items consisted of multiple response choices. The three questions embedded from the Trauma Assessment for Adults (TAA) were utilized only for confirming respondent's past history of CSA. The three questions taken from the TAA to confirm experience of CSA are listed below:

1) Did you ever have sexual contact with anyone who was at least 5 years older than you before you reached the age of 13?

2) Before you were age 18, has anyone ever used pressure, coercion, or nonphysical threats to have sexual contact with you?

3) At any time in your life, whether you were an adult or a child, has anyone used physical force or threat of force to make you have some type of unwanted sexual contact?

The answer choices for each of the questions are either Yes or No. The TAA was developed by Resnick, Best, Kilpatrick, Freedy, and Falsetti (1993) at the Medical University of South Carolina. The TAA is a 13-item self-report trauma assessment for adults that examine different types of stressful life events. The TAA assesses various traumatic events such as combat exposure during military service, physical or sexual assault, surviving a serious car accident, and other traumatic events using a yes/no format. In a recent psychometric properties evaluation study of the TAA, Gray, Elhai, Owen, and Monroe (2009) reported that the TAA exhibited adequate temporal stability (r=.80) and satisfactory item-level convergence with existing

measures of trauma history when tested among college students. Gray et al. (2009) found in their clinical sample that the TAA was sufficient in measuring of trauma exposure (r=.65).

The additional two developed subscales (the Treatment Perceptions Scale and the Religious Beliefs Impact Scale) were developed specifically for this study. The Treatment Perceptions Scale was utilized to measure respondents' treatment perceptions regarding treatment effectiveness for CSA based on the first provider of treatment. This scale consisted of 5 questions on a Likert-type scale used to determine an overall score for treatment effectiveness based on the provider of treatment. Due to there was no validity or reliability regarding this instrument, a reliability analysis was ran to acquire some preliminary reliability data. The Treatment Perceptions Scale received a Cronbach's alpha coefficient of .76, which indicated that this scale exhibited good internal consistency and was considered to be reliable across the sample population. The Religious Beliefs Impact Scale utilized to measure any differences among African Americans religious beliefs regarding the impact of CSA. The Religious Beliefs Impact Scale consisted of 7 questions on a Likert-type three-point scale from "no impact" to "major impact." This scale provided an overall score for impact of religious beliefs for CSA. Due to there was no validity or reliability regarding this instrument, a reliability analysis was ran to acquire some preliminary reliability data. The Religious Beliefs Impact Scale received a Cronbach's alpha coefficient of .83, which indicated that this scale exhibited good internal consistency and was considered to be reliable across the sample population.

The demographic items were utilized for screening respondents for inclusion in the study (e.g., gender, age, sexual orientation, relationship status, and county of residence) as well as securing imperative information on the past history of CSA (e.g., age of first and last occurrences, perpetrator relationship identity, treatment history, treatment provider, family

knowledge of CSA, and adulthood re-victimization). Participants were asked the following

demographics information, such as their gender (male or female), age range (19-25, 26-32, 33-

40, 41-50, or 61 & above), sexual orientation (heterosexual, bi-sexual, gay, lesbian, or

transgender), relationship status (single, married, or divorce), and to which indicate Atlanta

Metropolitan area county they reside in (consisting of 15 counties) or if they resided outside of

Georgia. If the participant indicated that they resided outside of Georgia, an additional

demographic question was provided to allow the participant to input their two letter state

abbreviation. The Trauma Assessment for Adults (TAA), additional two subscales developed,

and the demographic questionnaire were all complied together as the CSA Treatment Perceptions

Questionnaire, which was administered via Qualtrics online survey program. SPSS predictive

analytics software was used to analyze the data collected and necessary to test the research

hypotheses. The self-report survey instrument approach has been noted as the best method of

gathering data for gathering data, obtaining information in a timely manner, and to increase the

possibility of acquiring a large sample size (Creswell, 2008).

<center>Procedures</center>

The Auburn University Institutional Review Board (IRB) Office of Research Compliance

for Human Subjects approval was obtained prior to any implementation of research procedures

of this research study. After IRB approval was obtained, the survey was evaluated through

conducting a pilot study prior to recruiting participants used in this research study. During this

pilot study the CSA Treatment Perceptions Questionnaire was reviewed and evaluated by a

cohort of five experts in the field. The experts consisted of four faculty experts in areas related to

trauma counseling, survey design, counselor education, and multicultural competencies related to

counseling African American individuals and families. These experts were retired and current

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faculty members at the following intuitions: John Hopkins University, Howard University, Old Dominion University, and Columbus State University all from the counselor education profession. In addition to the faculty experts, the principal investigator had one full-time pastor of 15 years and who had a Master of Divinity degree to provide a review and evaluation from a religious/clergy leader perspective. The purpose of the pilot study was used to accurately examine and receive expert reviewed feedback regarding the content and face validity, the survey's conceptual framework, and organizational structure of the CSA Treatment Perceptions Questionnaire. All feedback and recommendations received concurred that the CSA Treatment Perceptions Questionnaire exhibited high content and face validity, and that the survey's conceptual framework was adequate enough to test the proposed research hypotheses. The timeline for completion of the final research study with the submission of a full report detailing the necessary information occurred within less than 30 days, following the final 45 days used to recruit the sample population needed to complete the study. The sampling approach used was that of a self-reported survey design. This method was used to attempt to maintain high levels of internal consistency and reliability, and to potentially obtain a large sample.

Participants completed the CSA Treatment Perceptions Questionnaire, which consisted of a total of 30 survey questions and 6 demographic questions to answer. The total time commitment necessary for completion was approximately 10 to 15 minutes if the respondent received treatment and approximately 3 to 5 minutes if the respondent received no treatment. The reason for the difference in completion time was based on the purpose to obtain perceptions to treatment and of the treatment provider of those who received treatment. The participants who received treatment were asked to complete the Treatment Perceptions Scale and the Religious Beliefs Impact Scale, whereas participants who did not receive treatment were asked to provide

demographic information only after indicating "no" for treatment received on the survey. Participants were able to select the option to opt out of any questions or to exit the survey at any time while completing the questionnaire, because of the potentially sever and traumatic recall effect past experience(s) of CSA may cause while completing the survey. Participants were able to access the survey via the internet by going to www.mytraumastory.com. This website link was listed on all forms of written and verbal communication, and approved by IRB.

Participant Recruitment

Step 1: Participants received an electronic written invite and digital postcard flyer via social media outlets, such as Facebook, Twitter, and LinkedIn, and by electronic email to various Atlanta Metropolitan area radio stations, counseling and community-based agencies, sexual assault and abuse centers, and places of worship. The electronic written invite and digital postcard flyer briefly detailed the purpose of the study and criteria for participation in this study along with the website address (www.mytraumastory.com) used to access the link to the online survey. This process in recruiting participants lasted for 3 weeks/21 days.

Step 2: Within the initial 3 week period of recruiting participants, the principal investigator also conducted informal in-person visits to various Atlanta Metropolitan area radio stations, counseling and community-based agencies, sexual assault and abuse centers, and various places of worship to provide them with a written invite letter and printed flyer that briefly detailed the purpose of the study and criteria for participation in this study along with the website address (www.mytraumastory.com) used to access the link to the online survey.

Step 3: The principal investigator conducted follow-ups by sending out a second electronic written invite and digital postcard flyer through social media and electronic email to the previously described recruitment sources after 10 days passed from the initial submission of

the first electronic written invite. A third submission occurred after 20 days passed from the initial submission of the first electronic written invite.

Step 4: After 30 days/4 weeks had passed since the initial submission, the principal investigator checked the completed survey participation numbers to see if the target minimum of 235 has been reached. At this time, the target minimum had not been reached, but was close to reaching the minimum number. The target minimum was reached 10 days after the 30 days of recruiting participants. The principal investigator waited until 45 days had passed before disabling the Qualtrics link, so that no further participation could take place.

Participation in Study

Step 1: Participants were able to participate in the study by visiting the website address (www.mytraumastory.com) used on the electronic written invite and postcard flyer.

Step 2: Once participants access the website address, listed on the homepage of the website and centered in the middle of the page was a sentence that said, "Take part in helping others learn from your trauma story by clicking the link below to take an online research survey," then participants clicked on the link below stating, "Participate in the online research survey."

Step 3: Then the participants reached the research page of mytraumastory.com, which allowed participants to read, review, and printout the letter of intent. The participants were advised to read the letter of intent before scrolling to the bottom to access the link to take the survey. By clicking the bottom link, it was their acknowledgement to participation in this survey.

Step 4: Once the participants clicked on the bottom link to take the online research survey, it opened up a new internet window taking them to the Qualtrics Survey Program, which is a secure password and firewall protected database server.

Step 5: Once the participants entered the survey, they were taken to the preliminary questions. These questions confirmed that the participant was age 19 years or older, and confirm their ethnicity as African American or African descent including Bi-racial, and if they believed that they were or may have been sexually abused within their childhood prior to the age of 18. Once the participant had confirmed "yes" to all three preliminary questions, the online survey allowed the participant to move on to completing the remaining survey items.

Step 6: Participants answered 30 total survey questions. This process took anywhere from 10-15 minutes. The participants who received treatment were able to complete the Treatment Perceptions Scale and the Religious Beliefs Impact Scale consisting of all 30 survey items, where as participants who did not receive treatment were only asked the first 11 survey items and the remaining demographics information after indicating on question item 10, "no" for treatment received. Once the participants completed all of the questions, then the participants clicked on the submit survey button if they decided to have their responses anonymously submitted.

Step 7: Once the participants completed the survey and clicked on the submit button, the survey recorded the participant's responses and then took the participant to the final page. The final page thanked the participants for their participation in the survey, and then re-advised them that if they had encountered any risks specified in the letter of intent from taking this survey to please refer to the resources page on the mytraumastory.com website. The resource page provided participants with the opportunity to search for a licensed mental health professional in their area or contact numbers to various crisis hotlines. If the participants did not need any of these resources, then they were advised to click the exit button to close the survey window and the mytraumastory.com window as well. After this step had been done, the participant had no further participation in this research study.

The survey was administered via an electronic online survey through using a program

Qualtrics survey software. This method allowed for the possibility of reaching large numbers of

participants, and reduced the format/delivery costs. This method enabled for faster response time

and preparation for data analysis, and has been known to be less intrusive than interviews. The

electronic survey method provided an advantage versus other survey methods in attempting to

reach a large number of participants, and to address the research from a larger platform. This

method provided us with the potential to reach participants who would not normally consent to

participating and agreeing to an in-person interview research method for studying CSA

survivors. This survey method provided the opportunity to potentially reach participants who

have never told their CSA story or who never received any counseling treatment for CSA.

Research Questions

The CSA Treatment Perceptions Questionnaire enabled us to appropriately address and

analyze the following research questions:

1) What is the difference in the proportion of African American females receiving

   treatment versus African American males?

2) What is the difference in the proportion among African American receiving

   treatment from religious/clergy leaders versus licensed mental health

   professionals? Does this differ by gender?

3) Are treatment perceptions for child sexual abuse different among men and women

   when provided by religious/clergy leaders versus licensed mental health

   professionals?

4) Do respondents feel that their CSA experience impacted their religious beliefs? Does this effect differ by gender or treatment provider?

For research question#1, the goal was to examine any gender differences among African Americans who had received treatment for CSA. The objective of research question#1 was to measure the percentage differences based on gender (male vs. females) among African Americans. We initially believed that based on prior research there would be a 20% difference between female and male participants in receiving counseling treatment for CSA. We projected that at least 60% of female African American survivors had received treatment versus at least 40% of males for CSA. For research question#2, the goal was to examine which treatment provider (Licensed Mental Health Professional or Religious/Clergy Leaders) were African Americans more open/prone to receiving treatment from. For research question#3, the goal was to evaluate the self-reported perceptions of treatment effectiveness based on overall scores obtained from the Treatment Perceptions subscale when measured by gender or treatment provider. For research question#4, the goal was to evaluate if African Americans CSA experience had a significant impact on their religious beliefs, and to determine if this effect differed when measured by gender or treatment provider.

Data Analysis

Data was analyzed from the results received via the online Qualtrics survey, and then downloaded into SPSS for analysis. In order to measure the properties of research question#1, a chi-square test was used to compare the difference in the proportions between African American females receiving treatment versus African American males receiving treatment. In order to measure the properties of research question#2, a chi-square test was used to compare the treatment provider differences among African Americans based on those who received treatment

only. In order to measure the properties of research question#3, a two-way between-subjects ANOVA test was used based on a 2x2 between-subjects method to analyze the Treatment Perceptions Scale, and to determine treatment effectiveness differences when measured by gender and treatment provider. In order to measure the properties of research question#4, a two-way between-subjects ANOVA test was used based on a 2x2 between-subjects method to analyze the Religious Beliefs Impact Scale, and to determine if overall effect of religious beliefs when measured by gender and treatment provider. The data analyzed from these two tests will be discussed in the subsequent chapter.

IV. RESULTS

The purpose of this quantitative descriptive study was to determine which African American gender group was more prone to receive treatment, and examine who was the treatment provider when treatment was received. In addition, this study sought to measure the treatment perceptions regarding treatment effectiveness and impact of religious beliefs for childhood sexual abuse among African Americans when compared by gender groups. This chapter presents the participants demographic information, questionnaire responses, as well as the results of the statistical analyses.

In this study, a descriptive research design was utilized in order to obtain a snapshot regarding the CSA experiences among African American survivors. According to Cherry (2000), the main purpose of a descriptive research study is to describe a problem, population, or characteristics of groups, and the focus is placed on the extent of general or specific conditions. For the purpose of this study, gender was the main comparison factor for evaluating differences among African Africans for CSA. A descriptive research design was appropriate for this study because the descriptive approach could potentially produce a clearer picture of a group as a whole or offer a composite picture (Cherry, 2000). In this study, the researcher was interested investigating the proportions between those who received treatment versus no treatment received association between variables, and determining any statistically significant differences. As a result, descriptive statistics, chi-square test, and two-way ANOVA tests were used to analyze the data.

Description of the Participants

There were 249 completed questionnaires submitted in this study, consisting of 87 males (34.9%) and 162 females (65.1%) who completed the survey. There were an additional 23 incomplete questionnaires, which were removed from the total number of participants included. Since the survey was anonymous, there was no way to contact or send messages to the participants who submitted incomplete questionnaires. It was thought of the researcher that if an individual encountered a system error or was unable to complete the survey, that they would restart the survey and recomplete it. Participants had to complete the entire survey to the end, and then submit their responses to be included in the study. The 249 participants included in this study consisted of a variety of age ranges. The age range group with the most participation was the age group of 31-40 (34.1%), followed by the age group of 41-50 (25.3%), 25-30 (19.7), 51-60 (10.4%), 18-24 (7.2%), and 61 and above (3.2%). Over half of the participants were female 162 (65.1%). The previously listed findings regarding gender and age range are both depicted in Table 1.

Table 1

Gender and Age Demographic Description

Descriptor		(N)	(%)
Gender	Male	87	34.9
	Female	162	65.1
Age Range	18-24	18	7.2
	25-30	49	19.7
	31-40	85	34.1
	41-50	63	25.3
	51-60	26	10.4
	61 & Above	8	3.2
	Total	249	100.0

Additional demographic information was collected regarding the participants' relationship status and sexual orientation, which was asked to obtain a snapshot of within groups' diversity of African Americans that reside within the Atlanta metropolitan area. The participant relationship status consisted of single (42%), married (29%), divorced (16%), partner (11%), and widowed (2%). The following sexual orientations were represented within this study: heterosexual (84%), bisexual (4%), gay (6%), and lesbian (7%).

The Atlanta metropolitan area consists of 15 counties (Bartow, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Paulding, and Rockdale). An additional 11 participants were from outside of the Georgia area, consisting of

other states, including Alabama (2), California (3), Florida (1), Illinois (1), North Carolina (1), Texas (2), and Virginia (1). The previously listed findings regarding the Atlanta metropolitan area 15-counties demographic descriptions are both depicted in Table 2.

Table 2

Atlanta Metropolitan Area 15-Counties Demographics

Descriptor		(N)	(%)
Counties	Cherokee	2	.8
	Clayton	19	7.6
	Cobb	29	11.6
	DeKalb	38	15.3
	Douglas	26	10.4
	Fayette	8	3.2
	Fulton	68	27.3
	Gwinnett	26	10.4
	Henry	13	5.2
	Rockdale	9	3.6
	Outside of Georgia	11	4.4
	Total	249	100.0

Of the entire 249 participants included in this research study, only 88 received treatment. Since the basis of the study was examining the "received-treatment" group, only this group was

asked a religious identity demographic survey question, which was stated as, *"Prior to age 18,*

what religious faith did you or your family practice?" Out of the 88 received treatment group, 77

(87.5%) identified their religious faith as Christianity, 6 (6.8%) identified as Islam, 3 (3.4%)

identified as Nonreligious/Secular, and 2 (.8%) identified as other, which could have consisted of

religious practice that were not listed in this survey. Additional religious identities and practices

that were listed, but had no representation, were Judaism, Buddhism, Hinduism, and Atheist.

These demographic findings regarding the religious identity and practices of the sample

population accurately reflected that of the literature regarding Christianity being the denominate

religious practice among African Americans: which was 83% when conducted by the U.S.

Religious Landscape Survey (2008).

<div align="center">Data Analysis of the Research Questions</div>

Research Question 1: What is the difference in the proportion of African American

females receiving treatment versus African American males?

Over sixty-four percent (64.7%) of the sample did not receive any counseling treatment

for their CSA experience, whereas only 35.3% did receive treatment. When the data was

analyzed by a chi-square analysis to compare gender groups in terms of those who received

treatment, the results showed that African American females (35.8%) and males (34.5%)

received treatment in similar proportions (χ^2=.043, p=.835). This did not represent a statistically

significant difference in African Americans who received treatment for CSA when compared by

gender.

Research Question 2: What is the difference in the proportion among African American

receiving treatment from religious/clergy leaders versus licensed mental health professionals?

Does this differ by gender?

Overall, as shown in Table 3, 80.7% of all represented African American participants saw Licensed Mental Health Professionals, whereas only 19.3% saw Religious/Clergy Leaders as the treatment provider.

Table 3

Treatment Provider by Participants as Frequencies and Percentages

Type of Treatment Provider	(N, %)
Licensed Mental Health Professionals (Male/Female)	(71) 80.7 (20 / 51)
Religious/Clergy Leaders (Male/Female)	(17) 19.3 (10 / 7)

When the researcher examined gender and treatment provider type, 20 (66.7%) African American males received treatment from Licensed Mental Health Professionals versus 10 (33.3%) who received treatment from Religious/Clergy Leaders. The results indicated interesting data when examining females to each treatment provider type, 51 (87.9%) African American females received treatment from Licensed Mental Health Professionals versus 7 (12.1%) who received treatment from Religious/Clergy Leaders. When the researcher ran a chi-square analysis in comparing gender groups to treatment provider types, the researcher found a statistically significant difference in African American selection of treatment provider when measured by gender (χ^2=5.736, p<.05).

Research Question 3: Are treatment perceptions for child sexual abuse different among men and women when provided by religious/clergy leaders versus licensed mental health professionals?

The goal of research question 3 was to evaluate the self-reported perceptions of treatment effectiveness based on overall scores obtained from the Treatment Perceptions Scale. A two-way between-subjects Analysis of Variance (ANOVA)was conducted to explore treatment effectiveness among African Americans, as measured by the Treatment Perceptions Scale on the factors of gender and treatment provider. Participants were divided into four groups according to their gender (male and female) and treatment provider (Licensed Mental Health Professionals and Religious/Clergy Leaders). There was a statistically significant main effect for treatment provider [$F(1, 82)=46.2$, $p<.001$], and appeared to yield a moderate effect size (partial $\eta^2=.36$). The main effect for gender [$F(1, 82)=.102$, $p=.750$] and the interaction effect [$F(1, 82)=3.85$, $p=.053$] did not reach statistical significance. Despite these findings, when the researcher took a look at the profile plots of the estimated marginal means of the Treatment Perceptions Scale, there appears to be some possible type of interaction that occurred, but not enough to yield significant difference. Figure 3 provides a visual depiction of these findings, and reveals a trend among respondents regarding their perception of treatment effectiveness.
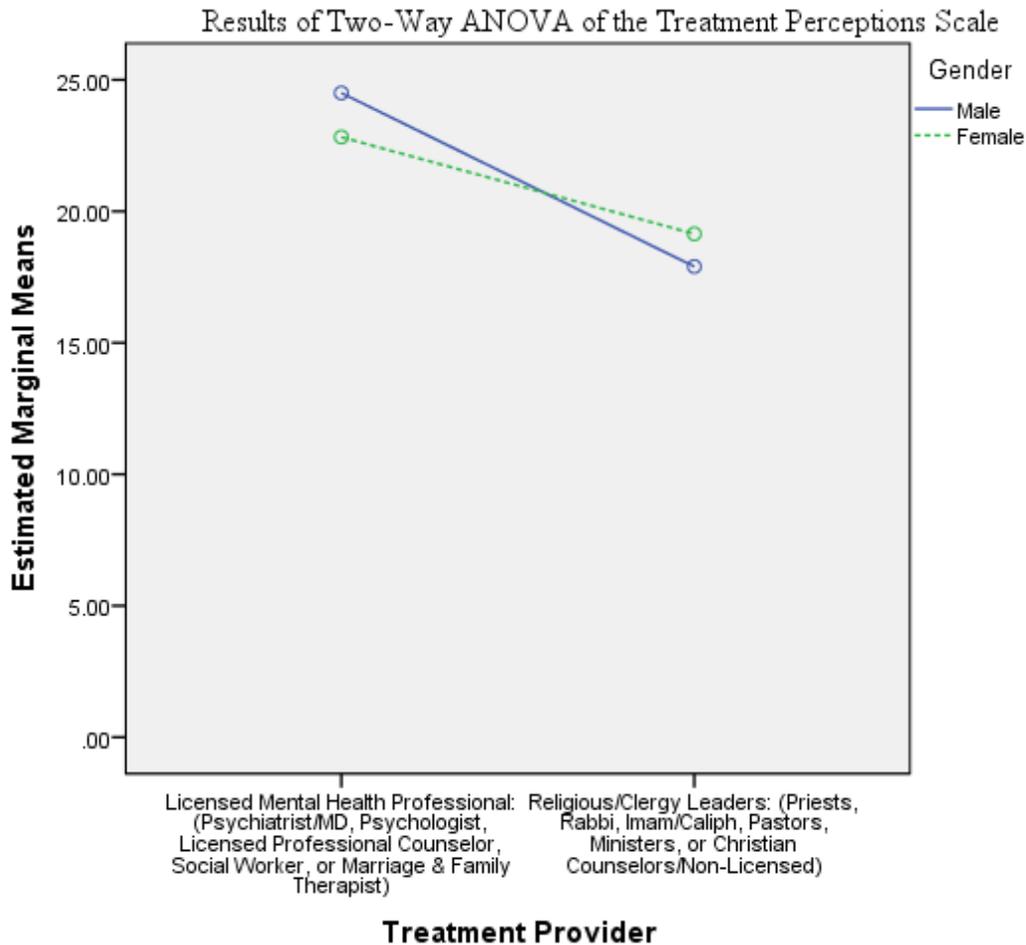
Figure 3. Results of Two-Way ANOVA on the Treatment Perceptions Scale.

Descriptive statistics concerning the mean and standard deviation for the Treatment Perceptions Scale measured by treatment provider were as follows: males who treatment provider were (*N=20)* Licensed Mental Health Professional (*M=*24.50, *SD=*1.00) and for (*N=10)* Religious/Clergy Leaders (*M=*17.90, *SD=* 1.66); females who treatment provider were (*N=51)* Licensed Mental Health Professional (*M=*22.82, *SD=*3.24) and for (*N=7)* Religious/Clergy Leaders (*M=*19.14, *SD=* 2.19). Figure 3, depicts small differences regarding the perception of treatment effectiveness from the Treatment Perceptions Scale. When males

received treatment from Licensed Mental Health Professionals, they had overall higher rating values for treatment effectiveness, whereas females had overall higher rating values for treatment effectiveness than males when the treatment provider was a Religious/Clergy Leader. In addition, the results for males had overall lower rating values when treatment provider was a Religious/Clergy Leader, which their treatment perception may indicate that they perceived treatment to be less effective.

Additional analyses were conducted based on the results of research question 3. The researcher decided to further evaluate the findings of research question 3 by examining the descriptive statistics regarding each of the 5-items of the Treatment Perceptions Scale. Listed below are list of the questions from the Treatment Perceptions Scale and the frequency results from each question. The first question asked, *"Regarding your counseling experience for CSA, did you feel respected, understood, and heard by the previously selected professional?"* The answer choices ranged from "strongly agree" to "strongly disagree." The results from the first question reported that 64 (72.7%) indicated strongly agree, 21 (23.9%) were agree, 2 (2.3%) were neither agree nor disagree, only 1 (1.1%) indicated disagree, and none indicated that they strongly disagree. The second question asked, *"Regarding your counseling experience for CSA, did you feel that you were working together with the professional in achieving your counseling goals?"* The answer choices ranged from "strongly agree" to "strongly disagree." The results from the second question reported that 54 (61.4%) indicated strongly agree, 29 (33%) were agree, 4 (4.5%) were neither agree nor disagree, only 1 (1.1%) indicated disagree, and none indicated that they strongly disagree.

The third question asked, *"Regarding your counseling experience for CSA, did you feel that the professional's approaches were appropriate for you and he/she appeared to be*

experienced in helping CSA survivors?" The answer choices ranged from "strongly agree" to

"strongly disagree." The results from the third question reported that 52 (59.1%) indicated

strongly agree, 18 (20.5%) were agree, 5 (5.7%) were neither agree nor disagree, 12 (13.6%)

indicated disagree, and only 1 (1.1%) indicated that they strongly disagree. The fourth question

asked, *"How long after starting treatment for CSA occurred did you realize a decrease in*

problematic symptoms that previously impacted your day to day functioning and/or affected

other areas of your life?" The answer choices consisted of timeframe ranges, such as 1-3

months, 4-6 months, 7-18 months, 18-36 months, 3-5 years, 6 years or more, and never/not yet.

The results from the fourth question reported that 54 (61.4%) symptoms decreased in 1-3

months, 20 (22.7%) in 4-6 months, 7 (8.0%) in 7-18 months, 1 (1.1%) in 18-36 months, 1 (1.1%)

3-5 years, 2 (2.3%) in 6 years or more, and 3 (1.2%) reported never/not yet. The fifth question

asked, *"Would you rate the level of treatment services provided to be effective in treating your*

CSA experience(s)?" The answer choices were highly effective, somewhat effective, or not at all

effective. The results from the fifth question reported that 66 (75%) rated their level of received

treatment to be highly effective, 16 (18.2%) indicated somewhat effective, and 6 (6.8%) reported

not at all effective.

 Research Question 4: Do respondents feel that their CSA experience impacted their

religious beliefs? Does this effect differ by gender or treatment provider?

 For research question 4, the goal was to evaluate if African American CSA experience(s)

had a significant impact on their religious beliefs, and to determine if this effect differed when

measured by gender or treatment provider. A two-way between-subjects ANOVA was conducted

to explore religious beliefs impact among African Americans, as measured by the Religious

Beliefs Impact Scale on the factors of gender and treatment provider. Participants were divided

into four groups according to their gender (male and female) and treatment provider (Licensed Mental Health Professionals and Religious/Clergy Leaders). The main effect for gender [F(1, 84)=.007, p=.932], the main effect for treatment provider [F(1, 84)=.021, p=.885], and the interaction effect [F(1, 84)=2.35, p=.129] all failed to show statistical significance. The overall findings indicated that regardless of gender or treatment provider, there was no statically significant difference regarding the impact on religious beliefs among African Americans for CSA.

To further evaluate the findings of research question 4, the descriptive statistics were examined regarding each of the 5-items of the Religious Beliefs Impact Scale. Listed below are the questions from the Religious Beliefs Impact Scale and the frequency results from each question. The answer choices for each item ranged from "major impact" to "no impact." The first question asked, *"Prior to age 18, how much of an impact would you say religion (consisting of religious beliefs and engaging in religious practices) was important in your life after the impact of your CSA experience(s)?"* The results from the first question reported that 78 (89%) indicated major impact, 7 (8%) were moderate impact, and 3 (3%) indicated no impact. The second question asked, *"Prior to the age of 18, how much did your religious beliefs impact the degree to which you or your family felt that your religious practices and beliefs were sufficient enough to cope with your CSA experiences without need for counseling services?"* The results from the second question reported that 73 (83%) indicated major impact, 11 (13%) were moderate impact, and 4 (5%) indicated no impact. The third question asked, *"Prior to the age of 18, how much of an impact did your religious beliefs discourage you from receiving counseling treatment (including religious) or professional treatment for your CSA experience?"* The results from the third question reported that 69 (78%) indicated major impact, 11 (13%) were moderate impact,

and 8 (9%) indicated no impact. The fourth question asked, *"Prior to the age of 18, how much did your religious beliefs impact the degree to which child sexual abuse issues were discussed within your home?"* The results from the fourth question reported that 60 (68%) indicated major impact, 19 (22%) were moderate impact, and 9 (10%) indicated no impact. The fifth question asked, *"How much of an impact did your religious beliefs have on your choice or your family's choice in choosing your treatment provider for CSA?"* The results from the fifth question reported that 47 (53%) indicated major impact, 25 (28%) were moderate impact, and 16 (18%) indicated no impact.

V. DISCUSSION

The purpose of this quantitative descriptive study was to determine which African American gender group was more prone to receive treatment, and examine who was the treatment provider when treatment was received. In addition, this study sought to measure the treatment perceptions regarding treatment effectiveness and impact on religious beliefs for childhood sexual abuse among African Americans when compared by gender groups. Because the majority of current literature focuses on female African Americans survivors, with only limited research comparing both genders, this study was conducted. As previously suggested by Sedlak et al. (2010), new developing research should consider the factors of race and ethnicity in identifying the potential of child sexual abuse, and has further indicated that African American children were at twice the risk of sexual abuse than Caucasian American children. Limited literature has been found that focused solely on the self-reported perceptions of treatment and selection of treatment providers among African Americans survivors of CSA. This research study sought to explore these concerns through investigation.

The previously described purpose of this study and the briefly defined statement of the problem helped to give this research study the essential basis used to form the research questions. The CSA Treatment Perceptions Questionnaire was a newly developed research instrument used to appropriately address and analyze the following research questions:

1) What is the difference in the proportion of African American females receiving treatment versus African American males?

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2) What is the difference in the proportion among African American receiving treatment from religious/clergy leaders versus licensed mental health professionals? Does this differ by gender?

3) Are treatment perceptions for child sexual abuse different among men and women when provided by religious/clergy leaders versus licensed mental health professionals?

4) Do respondents feel that their CSA experience impacted their religious beliefs? Does this effect differ by gender or treatment provider?

For the purpose of this study, gender was the main comparison factor among evaluating differences among African Africans for CSA. A descriptive research design was appropriate for this study because the descriptive approach could potentially produce a clearer picture of a group as a whole or composite picture (Cherry, 2000). In this study, the researcher was interested in investigating the frequency, association between variables, and determining any statistically significant differences. Therefore, descriptive statistics, chi-square test, and two-way ANOVA tests were used to analyze the data.

Discussion of the Findings

The discussion of this descriptive study has been organized into sections based on respective research questions. In addition, various limitations, implications for counseling practice and counselor education, and recommendations for future research were considered.

Research Question 1: What is the difference in the proportion of African American females receiving treatment versus African American males?

The goal of research question one was to examine any gender differences among African Americans who had received treatment for CSA. Based on the findings from this present research study, there was no statistically significant difference in African Americans who received treatment for CSA when compared by gender. However, there were major differences in the number of African Americans from this study, only 88 (35%) who actually received treatment versus the 161 (65%) who reported never receiving treatment. These numbers are not high enough to generalize the outcome of this study to the entire African American population. However, the findings discovered have shed some additional light to the African American community regarding no gender differences in receiving treatment for CSA. In addition, the findings that reveal low numbers of African Americans in the sample receiving treatment for CSA are congruent with the U.S. Surgeon General report on Mental Health (2001), who reported that African Americans were less likely to receive needed mental healthcare. One of the main focus goals for conducting this study was to add to the current CSA literature, more specifically to the literature about African Americans who are underrepresented in mental health research.

Research Question 2: What is the difference in the proportion among African American receiving treatment from religious/clergy leaders versus licensed mental health professionals? Does this differ by gender?

The goal of research question two was to examine which treatment provider (Licensed Mental Health Professional or Religious/Clergy Leaders) African Americans were more open/prone to receiving treatment from. Based on the results, there was a statistically significant difference in African Americans who received treatment from Licensed Mental Health Professionals versus Religious/Clergy Leaders for CSA when compared by gender. The majority of the sample population received treatment from licensed professionals. In addition, the research

results from the non-received treatment group indicated that their preferred provider of treatment were also licensed mental health professionals. These findings somewhat differ from the literature reported by the National Alliance on Mental Illness (2009), which suggested that this ethnic group tends to rely on family, religious and social communities for support, rather than seeking counseling treatment from licensed professionals. This differed from the view that African Americans would more likely rely on family for support, is the hypothesis of this study that the majority of the sample population have received treatment from religious/clergy leaders, rather than licensed mental health professionals. Although it was difficult to generalize the results of this study to the entire African American population, this study did provide a light to the possibility that the use of professional mental health services among African Americans has been increasing.

Research Question 3: Are treatment perceptions for child sexual abuse different among men and women when provided by religious/clergy leaders versus licensed mental health professionals?

For research question three, the goal was to evaluate the self-reported perceptions of treatment effectiveness based on overall scores obtained from the Treatment Perceptions subscale when measured by gender and treatment provider. The original null hypothesis was that there would be no statistically significant difference in African Americans treatment perceptions regarding treatment effectiveness for CSA when measured by gender and treatment provider. When the interaction effect was examined for different treatment providers between genders, there was no significant difference found. Research question three was the only research question that had the most interesting result: which was that the finding was close to achieving a statistically significant difference .053>.05. The main effect for treatment provider did receive a

statistically significant difference among treatment providers regarding the perception of treatment effectiveness. These findings provide some insight regarding this sample population that was different from the current literature. Snowden (2012) reported the impact of disparity among African Americans: which is the tendency not to seek out treatment due to the perception that mental health services provided will be of poor quality. However, the findings of this study revealed that 65 (75%) of the sample population rated their level of treatment to be highly effective, whereas 16 (18%) reported somewhat effective, and only 6 (7%) indicated not at all effective. Regardless of the report from current literature, this study revealed signs that African Americans' perception of treatment maybe improving and the treatment received maybe effective. This result is not to be generalized, but to provide evidence that future research should address mental health awareness and support for culturally appropriate services are provided to this ethnic group. The process of improving stigmas surrounding mental health and services that were reported by the National Alliance on Mental Illness (2009) among African Americans can be enhanced and by helping individuals become more aware of the benefits of mental healthcare.

Research Question 4: Do respondents feel that their CSA experience impacted their religious beliefs? Does this effect differ by gender or treatment provider?

The goal of research question four was to evaluate if African Americans' CSA experiences had a significant impact on their religious beliefs, and to determine if this effect differed when measured by gender or treatment provider. When the researcher examined the interaction effect for different treatment providers between genders, there was no significant difference. However, based on previous research described in the literature review and statement of the problem, and based on the notation that the majority of African Americans have strong Christian religious beliefs, and had relied on spiritual guidance as a method of coping with

challenging and often traumatic experiences: that the majority of the sample population had either received no counseling treatment or had submitted to the consultation and support of their religious/clergy leader. Overall, these previously suggested research findings indicated the lowest numbers from the sample population have received counseling treatment from religious/clergy leaders.

Conclusions and Implications for Counselor Education

These findings from this research study indicate that, on average, African Americans in the sample preferred licensed mental health professionals as the treatment provider of choice for CSA. This finding was not consistent with the National Alliance on Mental Illness (2009) report that suggested this ethnic group would rely mostly on religious support for help, rather than from mental health providers. This research found that gender has no impact in the selection process of treatment provider and if an individual will seek treatment. In addition, post CSA experiences have no impact on individual's religious beliefs. This finding was consistent with the work of Elliot (1994), which found out that the religiosity of the CSA survivors had no impact on their religious beliefs and practices as an adult, but was interceded more so by the religious identity of the family and not the impact of the abuse.

The findings from this research study have come to the following conclusions: African Americans continue to remain underrepresented in mental health research because of a lack of participation in research, and yet, there is still evidence that they may continue not to seek counseling treatment from any type of professional. In addition, many of the individuals who reported receiving treatment in this study, received services beyond 5 or 6 years into their adulthood. Information received from the American Psychological Association (2005) suggested that individuals can potentially reduce the risk of long-term traumatization when they openly

discuss their experiences and seek the appropriate mental health treatment. Regretfully, many individuals will never receive treatment throughout their adulthood or lifespan.

The findings from this research have a few implications for the counseling profession in relation to African American survivors of CSA. First, based on the study findings, the researcher has learned that beyond past literature, mental health providers are perceived as the appropriate treatment provider for CSA and other trauma related experiences among African Americans. There were places of worship that rejected or declined the opportunity to have their parishioners to be recruited anonymously for this research study. A large number of individuals from this study reported never receiving treatment for their CSA experience. All of the previously discussed concerns are calls for the counseling profession to be more visible and accessible within African American communities, and especially within African American places of worship. This is a call for practicing clinicians and counselor educators' outreach: to develop and foster positive professional relationships with religious/clergy leaders and other community leaders to increase mental health awareness. This would help religious organizations with addressing their malpractice liabilities issues that may arise from providing pastoral and Christian counseling services. This would also call for more creative and innovative methods for recruiting participants for research, and marketing mental health treatment services. This may also be a call for counselor educators to expand the knowledge provided to counselors in-training regarding CSA experiences in general, more specifically addressing trauma and providing effective mental health treatment with African American survivors. This outreach would also assist with shifting the report provided by the U.S. Surgeon General report on Mental Health (2001), which stated that African Americans perceived that they would have received better mental health treatment if the provider was of the same race. Additionally, this would promote

diversity in the recruitment of students of various ethnic groups in counselor education programs, which allows for developing culturally competent clinicians for the treatment of CSA. Also, this would promote a need for more active involvement at the national and international counseling organizations to address and promote the need for counselors reaching out to community leaders to discuss mental health and CSA awareness. Outreach opportunities like this would help address how counselors should engage and approach leaders in AA communities about CSA and accessing mental health treatment services. These opportunities among counselor education programs has the potential to help increase the number of African Americans who would seek out and receive treatment, and improve the perception that African Americans have regarding mental health treatment and the counseling professional identity (Snowden, 2012).

<center>Limitations of this Study</center>

The survey goal was reached in 45 days and the survey was closed. The first limitation of this study was the low response rate from individuals who actually received treatment. Another limitation is that the survey should have been monitored more effectively to evaluate the numbers necessary for the received treatment group; rather than the entire (n=249) consisting of both groups (received treatment and non-treatment received). In an effort to increase the response rate of received treatment participants, the recruiting timeframe could have been extended to allow more participants to complete the survey.

The third limitation with this study was the development and implementation of a new survey instrument for CSA research. Because the survey instrument was constructed for this study, it lacked the necessary validity and reliability to be substantiated as the best possible research instrument. The CSA Treatment Perceptions Questionnaire would also need to be subjected to test across other ethnic groups in order to determine its capacity for generalizability.

Both subscale measures used in this instrument would need to be increased, specifically the number of question items used to increase validity. The CSA Treatment Perceptions Questionnaire was only designed for this study. Additional modifications to the survey instrument would have to be made in order to test and effectively answer research questions regarding other mental health issues.

The fourth limitation was the challenge associate with recruiting African Americans for a study that had the potential to be controversial, and the potential to expose opened/unresolved interpersonal concerns. Despite the creative and assiduous survey methods used to reach a large number of sample participants, recruiting African American participants still remains difficult. There were a number of places of worship who declined to have the postcard flyer or any information regarding this study distributed to their parishioners. Due to this issue, the population may likely to continue to remain underrepresented until more effective ways of recruiting participants are developed. In this current study, the researcher sought to have a higher number of individuals who received treatment, rather than the majority who had never received treatment. If this study would have been able to access greater numbers of participants, then it may have been possible to obtain statistically significant difference for all research questions, especially research question three. This present research study only examined the individuals who received treatment. Because the largest group among the sample population were individuals who never received treatment (n=161), the research design and questions of this study could have been modified to address the perceptions of the non-treatment received group as to the reasons why treatment was not received. The information received from their responses would have provided valuable and additional groundbreaking information for the counseling

profession. This study provided an opportunity to collect that information, but the structure of the research questions and survey designed failed to collect data from this group.

<div align="center">Recommendations for Future Research</div>

Based on the findings of this study, for the population sampled, African Americans survivors of CSA are seeking counseling treatment from licensed professional more than that of religious/clergy leaders. In addition, the findings from this study indicated no differences regarding the impact of CSA on individual's religious beliefs. However, the sample population of received treatment group was low, but if the numbers were higher and open to large numbers of individuals who received treatment would the findings still remain the same? To answer this question and to derive either the same or a different conclusion, further research is strongly needed to investigate and address these concerns. Research question three received the most interesting result out all four research questions. This was because it almost reached statistically significant difference on the interaction effect between gender and treatment provider. The challenge in reaching significance was due to the low participant group who received treatment (n=88). In this case for research question three, this study would have to be duplicated with a larger sample size to obtain a stronger statistical power and effect size. Furthermore, additional research would have to occur in order to generalize this study to a larger group of African Americans, because there are many culture dynamics and trends within this ethnic group. Qualitative research methods to further study African Americans survivors of CSA, and to examine their perceptions of treatment effectiveness could also be useful. Grounded theory or phenomenological qualitative methods may potentially be extremely useful in examining the impact of religious beliefs among African Americans after post CSA and other reactions to trauma experiences. The final question of this survey instrument, which was an opened-ended

question type, provided this study with additional information regarding African Americans perception of their CSA experience. The information received from this one question provided volumes of individual knowledge and insight into the overall CSA experience of survivors. These responses received further imply the need for qualitative research analysis in this topic of interest.

This study also found and confirmed that there are still many individuals who have never received counseling treatment for CSA. Therefore, it is recommended that future research investigate the types of concerns, stigmas, and perceptions to seeking treatment that are barriers to African Americans seeking mental health treatment for CSA experiences. In addition, further research would also be recommended to investigate religious/clergy leader's practices for addressing sexual abuse issues, and methods for making adequate referrals to child protection services and mental health services to effectively treatment the trauma from CSA experiences. Additionally, by replicating this study it may potentially add to the CSA body of research to split the demographic groups and examine age groups (young adults versus older adults) or location area groups (rural versus metropolitan) in regards to perceptions of treatment and treatment providers. This research would also provide an impetus for outreach and education to religious/clergy leaders and counselor educators on recognizing symptoms of CSA. This would also help to increase awareness of the associated traumatic reactions and behaviors that come with these experiences. This could potentially make an impact within the African American community by bridging the mental health disparity and awareness gap between places of worship and the mental health community. This study revealed that African Americans are willing to seek counseling services for CSA experiences. Future research should focus on the attitudes, beliefs, and perceptions of mental health professionals regarding African American religious/clergy

leaders and their impact of making their parishioners aware of the benefits of mental health

services. This would also give way to opportunities for mental health professionals and

religious/clergy leaders to collaborate together in addressing the barriers to seeking mental health

treatment.

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Appendix

Appendix A

Recruitment Letter of Intent

AUBURN UNIVERSITY
COLLEGE OF EDUCATION

Letter of Intent

<u>For participation in Research Study entitled</u>
"African American Survivors of Childhood Sexual Abuse:
Perceptions of Treatment and Treatment Providers"

You are invited to participate in a research study for participants who meet the following criteria: individuals who reside in the Atlanta metropolitan area including its 14 surrounding counties, are age 19 years and older, identify their ethnicity as African American or African descent including Bi-racial, and who believe they have or may have experienced sexual abuse prior to the age of 18 years old. The purpose of this study is to examine the number of those who self-report their ethnicity as African American and have experienced childhood sexual abuse (CSA); a) to examine any differences between those who have received treatment versus never receiving treatment for CSA; b) to determine the different perceptions among African Americans who have received counseling treatment from licensed mental health professionals (Psychiatrist/MD, Psychologist, Licensed Professional Counselor, Social Worker, or Marriage & Family Therapist) versus Religious/Clergy Leaders (Priests, Rabbi, Pastors, Ministers, or Christian Counselors/Non-Licensed) for CSA; and c) to evaluate any differences among the sample population regarding self-reported perceptions of treatment effectiveness for CSA. This inquiry is worthy of examination due to the growing number of sexual abuse cases that have been exposed through media, multiple lawsuits occurred suing various religious leaders, and the disparity in data that shows African Americans are underutilizing mental health treatment services.

The study is being conducted for dissertation purposes by Ryan T. Day, LPC, NCC; who is a doctoral student at Auburn University, under the dissertation committee led by my advisor Dr. Chippewa Thomas, LPC, NCC in the Auburn University Department of Special Education, Rehabilitation, and Counseling (SERC).

You were selected as a possible participant because you agree to meeting the previously described criteria for participation in this study. Your total time commitment will approximately be 10 to 15 minutes to complete this survey. You have the right to select one answer for each survey question or to decline by skipping any question you wish not to answer. However, the more information you choose to provide assists our research efforts in understanding your self-reported perceptions to treatment and treatment providers for child sexual abuse. Once you have completed the last question, please click the submit button to complete and submit your survey responses. The information received will be gathered via the internet to Qualtrics Survey System, which has a secure password and firewall protected server. All information is kept anonymous and does not have any identifying information about you that can link you or your responses directly to this survey.

The risks associated with participating in this study may include: the possibility of recanting past traumatic experiences, which may have occurred within your childhood. To minimize the risks of any damaging, discomforting memories, or recall effect any participant may experience with this research

study, we request that you access our resource page via the mytraumastory.com website. Listed on this page you will find resources utilized to contact a local mental health professional in your area or contact numbers to various crisis hotlines. You are responsible for any costs associated with services provided by any medical or mental health professionals.

There is no cost to you to participate in this research study nor will any compensation be provided for participating in this research study. However, if you participate in this study, you can expect to have your voice heard through the data received by this research study regarding the effects of childhood sexual abuse. I cannot promise you that you will receive any or all of the benefits described.

If you change your mind about participating while completing the online study, you can at any time withdraw by exiting the survey and refraining from submitting your survey. Your participation is completely voluntary and all information is totally anonymous without requesting any self-identifying information to identify you. Any data obtained in connection with this study will remain anonymous. Information collected through your participation may be used to fulfill educational requirements, publications in a professional journal, and/or presentations at professional meeting, etc.

If you may have any questions about this study, please contact Ryan Day at rtd0006@auburn.edu or (678) 800-1329 or Dr. Chippewa Thomas at thoma07@auburn.edu or (334) 844-5701.

If you have any questions about your rights as a research participant, you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone (334) 844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO. THIS LETTER IS YOURS TO KEEP AS A RECORD OF OUR LETTER OF INTENT.

THANK YOU FOR YOUR TIME, COOPERATION, AND PARTICIPATION IN ASSISTING OUR RESEARCH EFFORTS.

Ryan T. Day, LPC, NCC   **1/15/2014**
Ryan T. Day, LPC, NCC
Student Principal Researcher/Investigator

The Auburn University Institutional Review Board has approved this document for use from ___1/29/2014___ to ___1/30/2015___. Protocol #__14-019 EP 1401____

Appendix B :

Social Media and E-Mail Invitation Letter

Social Media and E-Mail
Invitation for Online Survey

Greetings Mr/Ms,

My name is Ryan T. Day, and I am a doctoral student in the Counselor Education program at Auburn University. I would like to <u>invite you or someone you may know</u> to participate in my research study on "African American Survivors of Childhood Sexual Abuse: Perceptions to Treatment and Treatment Providers." The purpose of this study is to examine the self-reported experiences of African Americans who have experienced childhood sexual abuse (CSA), and to examine their perceptions to receiving treatment and selection choice for treatment provider. You may participate in this study if you reside in the Atlanta metropolitan area including its 14 surrounding counties, are age 19 years and older, identify your ethnicity as African American or African descent including Bi-racial, and believe that you have or may have experienced sexual abuse prior to the age of 18 years old.

If you or someone you may know meets the criteria, please participate or invite them to participate in this anonymous online survey. All it takes is 10 minutes to contribute your time and participate in a research study that could potentially make a positive impact in the African American community. If you would like to participate or to know more information about this study, an information letter can be obtained by visiting this link http://www.mytraumastory.com/.

Please feel free to repost this info or forward this information to others you may know who meet the criteria. If you may have any questions about this study, please contact Ryan Day at rtd0006@auburn.edu or (678) 800-1329.

Thank you for your time, support, and consideration.

Ryan T. Day, LPC, NCC
Ryan T. Day, LPC, NCC
Student Principal Researcher/Investigator

Appendix C :

Digital Copy of Postcard Flyer

Frontside of Flyer

MyTraumaStory.com

Participate in a free 10-minute online anonymous research survey on the experiences of African American Survivors of Childhood Sexual Abuse

Shatter the silence!!!

Before they turn 18...

1 in 6 boys experience some form of sexual abuse

1 in 4 girls experience some form of sexual abuse

Participant Criteria:

1) Must be 19 years or older

2) Believe to have experienced some form of sexual abuse prior to age 18

3) Reside within the Atlanta Metropolitan area consisting of 15 counties

4) Identify yourself as African American or African descent including Bi-racial

Backside of Flyer

MyTraumaStory.com

Dissertation Research Study by Ryan T. Day:
African American Survivors of Childhood Sexual Abuse: Perceptions to treatment and treatment providers

AUBURN UNIVERSITY
COLLEGE OF EDUCATION

Ryan T. Day is an African American doctoral student in Counseling Education at Auburn University. To learn more about his dissertation research study, please visit mytraumastory.com

Appendix D

Recruitment Sites Source List

AUBURN UNIVERSITY
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Recruitment Sites Source List
For recruiting participants in the research study entitled
"African American Survivors of Childhood Sexual Abuse:
Perceptions to Treatment and Treatment Providers"

1) Social Media Outlets: (Facebook, Twitter, & LinkedIn)

2) Atlanta Market Radio Stations: (Hot107.9, MAJIC 107.5, Praise 102.5, & Jazz 91.9 WCLK)

3) Atlanta's Channel 57 Community Television, Inc.; Atlanta, GA

4) Atlanta Mission, Inc.; Atlanta, GA— Homeless Shelters

5) Aid Atlanta, Inc.; Atlanta, GA—HIV & Aids Support Center

6) Families United Services, Inc.; Fayetteville, GA—Mental Health Agency

7) Ridgeview Instituted; Smyrna, GA—Mental Health Agency

8) Highpoint Christian Tabernacle Church; Smyrna, GA

9) Greater Travelers Rest Baptist Church; Decatur, GA

10) Antioch AME Church; Stone Mountain, GA

11) Word of Faith Church; Austell, GA

12) Berean Christian Church; Lithonia, GA

13) Eta Lambda Chapter of Alpha Phi Alpha Fraternity, Inc.; Atlanta, GA

14) Atlanta Masjid of Al-Islam; Atlanta, GA

15) Grady Rape Crisis Center; Atlanta, GA

16) DeKalb Rape Crisis Center; Decatur, GA

17) Aniz, Inc; Atlanta, GA

18) Positive Growth Counseling Center; Clarkston, GA

19) Argosy University Atlanta; Atlanta, GA

20) Morehouse School of Medicine; Atlanta, GA

21) Men Stopping Violence, Inc.; Decatur, GA

22) Douglas County Task Force/Crisis Center; Douglas, GA

23) Gwinnett Sexual Assault Center; Duluth, GA

24) Southern Crescent Sexual Assault Center; Jonesboro, GA

25) World Changers Church International; College Park, GA

26) Atlanta Voice Newspaper; Atlanta, GA

27) Atlanta Journal Constitution; Atlanta, GA

28) The GA Voice Media; Atlanta, GA

29) WSB-TV Channel 2 News; Atlanta, GA

30) WXIA-TV Channel 11 News; Atlanta, GA

Appendix E :

The CSA Treatment Perceptions Questionnaire

The CSA Treatment Perceptions Questionnaire

GENERAL DIRECTIONS:

Your total time commitment will take approximately 10 to 15 minutes to complete this survey. You have the right to select one answer for each survey question or to decline by skipping any question you wish not to answer. However, the more information you choose to provide assists our research efforts in understanding your self-reported perceptions of treatment and treatment providers for child sexual abuse. Once you have completed the last question, please click the submit button to complete and submit your survey responses. The information received will be gathered via the internet to Qualtrics Survey System, which has a secure password and firewall protected server. All information is kept confidential and does not have any identifying information about you that can link you or your responses directly to this survey.

CONSENT AGREEMENTS:

Are you 19 years old or older? If not, please close the window to end the survey now.

☐ Yes ☐ No

Do you classify your ethnicity to be African American or African descent including Bi-racial?

☐ Yes ☐ No

Do you believe that you have or may have been sexually abused prior to the age of 18 years old?

☐ Yes ☐ No

* IF YOU HAVE ANSWERED YES TO ALL PROCEEDING ITEMS, YOU MAY NOW START THE SURVEY *

CSA Treatment Perceptions Questionnaire

1) Did you ever have sexual contact with **anyone who was at least 5 years older** than you **before you reached the age of 13**?

(Sexual contact can mean any interaction between a child and someone else in which the child has been engaged in either touching of your sexual organs—(penis or genital area for men; vagina, genital area, or breasts for women), -or between you and someone else's sexual organs (a male or female's genital area, or a woman's breasts, -or non-touching behaviors including voyeurism (trying to look at a child's naked body, exhibitionism, or exposing the child to pornography).

☐ Yes ☐ No

2) **Before you were age 18**, has anyone ever used pressure, coercion, or nonphysical threats to have sexual contact with you?

☐ Yes ☐ No

3) At any time in your life, whether you were an adult or a child, has anyone used <u>physical force or threat of force</u> to make you have some type of unwanted sexual contact?

☐ Yes ☐ No

==****** If the participant did not fit the criteria validating CSA based on the CSA (#1-3), then the assessment will skip the demographics questions (#31-35) and continue to the end. (These participants will not be included within my final analysis in SPSS ******==

==****** The abbreviation for CSA is Childhood Sexual Abuse ******==

4) At what age did the sexual abuse 1st occur?

Dropdown Menu ☐ 4-18

5) Please indicate at what age the last sexual abuse occurred during childhood?

Dropdown Menu ☐ 4-18

6) What was the relationship of the individual or individuals who sexually abused you?

☐ Pastor/Minister/Priest/Clergy/Imam/Caliph ☐ Father/Stepfather
☐ Mother/Stepmother ☐ Stranger ☐ Sibling ☐ Family Relative
☐ Family Friend ☐ Neighbor ☐ Boyfriend/Girlfriend
☐ Mothers Boyfriend/Partner ☐ Fathers Boyfriend/Partner

7) Did you ever receive counseling treatment for the CSA experience(s)?

☐ Yes ☐ No

<mark>***** If said NO (*Non-Treatment*) to Q7, then it goes to different Q8A & Q9A, which is listed below then concludes to Q26 to end of survey after completing Q9A *****</mark>

8) Are you open to receiving counseling treatment for the CSA experience(s)?

☐ Yes ☐ No

9) If you have not received counseling treatment for your childhood sexual abuse, from who would you be more open to receiving counseling treatment from?

☐ **Licensed Mental Health Professional**
(Psychiatrist/MD, Psychologist, Licensed Professional Counselor, Social Worker, or Marriage & Family Therapist)
☐ **Religious/Clergy Leaders**
(Priests, Rabbi, Imam/Caliph, Pastors, Ministers, or Christian Counselors/Non-Licensed)
☐ **Not Interested**

<mark>*** If said YES (*Received Treatment*) to Q7, then it goes to the original Q8B, which is listed below ***</mark>

8) At what timeframe during your life did you first receive treatment for CSA?

☐ **Childhood** (prior to the age of 18)   ☐ **Adulthood** (after the age of 18)

9) How much time passed after the first instance of CSA occurred that you started receiving treatment?

☐ 0-3 months   ☐ 4-6 months   ☐ 7-18 months   ☐ 18-36 months   ☐ 3-5 years   ☐ 6 years or more

10) Was the treatment **first** provided by one of the following professionals?

☐ **Licensed Mental Health Professional**

(Psychiatrist/MD, Psychologist, Licensed Professional Counselor, Social Worker, or Marriage & Family Therapist)

☐ **Religious/Clergy Leaders**

(Priests, Rabbi, Imam/Caliph, Pastors, Ministers, or Christian Counselors/Non-Licensed)

☐ **Unaware/Not sure**

(Unsure of the credentialing or licensing of the treatment professional)

11) Who decided or helped to influence your selection in **first** provider of treatment? *(Please select all that apply)*

☐ Pastor/Minister/Priest/Clergy/Imam/Caliph   ☐ Father/Stepfather

☐ Mother/Stepmother ☐ Stranger ☐ Sibling ☐ Family Relative

☐ Family Friend ☐ Neighbor ☐ Boyfriend/Girlfriend ☐ Mothers Boyfriend/Partner

☐ Fathers Boyfriend/Partner ☐ Depart of Children & Family Services (DFCS) Caseworker
☐ Police Officer/Detective

	Myself		Other

12) If you received any additional treatment for CSA (after the first instance indicated above) was the treatment provide by one of the following professionals? (*Please choose all that apply*)

☐ **Licensed Mental Health Professional**

(Psychiatrist/MD, Psychologist, Licensed Professional Counselor, Social Worker, or Marriage & Family Therapist)

☐ **Religious/Clergy Leaders**

(Priests, Rabbi, Imam/Caliph, Pastors, Ministers, or Christian Counselors/Non-Licensed)

☐ **Unaware/Not sure**

(Unsure of the credentialing or licensing of the treatment professional)

☐ *Did not receive other treatment.*

==**For the following questions, we would like you to consider the first person that provided you with treatment.**==

13) Regarding your counseling experience for CSA, did you feel respected, understood, and heard by the previously selected professional?

☐ Strongly agree   ☐ Agree   ☐ Neutral   ☐ Disagree   ☐ Strongly disagree

14) Regarding your counseling experience for CSA, did you feel that you were working together with the professional in achieving your counseling goals?

☐ Strongly agree   ☐ Agree   ☐ Neutral   ☐ Disagree   ☐ Strongly disagree

15) Regarding your counseling experience for CSA, did you feel that the professional's approaches were appropriate for you and he/she appeared to be experienced in helping CSA survivors?

☐ Strongly agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly disagree

16) How much did the CSA experience result in problematic symptoms that impacted your day to day functioning and/or affecting other areas of your life? *(**Impact**, such as exhibiting abnormal behaviors not limited to having more than normal difficulty concentrating, frequently frustrated/irritated, constant challenges managing emotions, depressed moods, panic attacks, fear, shame, guilt, shutting down/withdrawn or confrontational behaviors, etc.)*

☐ Extreme impact ☐ Moderate impact ☐ Some impact ☐ No impact

17) How long after starting treatment for CSA occurred did you realize a **decrease in problematic symptoms** that previously impacted your day to day functioning and/or affected other areas of your life?

☐ 1-3 months ☐ 4-6 months ☐ 7-18 months ☐ 18-36 months ☐ 3-5 years ☐ 6 years or more

☐ Never/Not Yet

18) Would you rate the level of treatment services provided to be effective in treating your CSA experience(s)?

☐ Highly Effective ☐ Somewhat Effective ☐ Not at all Effective

19) How would you describe your traumatic reactions as a **child (age prior to 18)** to your CSA experience(s)? *(Please select all that apply)*

☐ **Re-experiencing**: *(Thinking a lot (unwanted, intrusive thoughts) about the traumatic event)*

☐ **Avoidance**: *(Avoiding thinking or talking about the traumatic event; Displaying less interest in usual activities; Feeling emotionally numb or detached from others)*

☐ **Hyper-arousal**: *(Increased irritability; Trouble concentrating or sleeping; Exaggerated startle response; "Hyper-vigilance"—always expecting danger)*

☐ **Other Reactions**: *(New fears related to the traumatic event, New somatic complaints*

> *(bellyaches, headaches); Feeling in a daze or "spacey")*
>
> ☐ **No Impact:** *(Prior to my CSA experience and after there has been no impact to my daily functioning or change in my emotional, behavioral, and psychological condition)*

20) Prior to the age of 18, did your family know that you were sexually abused in your childhood?

> ☐ Yes   ☐ No

21) After the age of 18 or older, has something sexual ever been done to you against your will or when you couldn't defend yourself? *(Ex. being sexually assaulted, forced coercion and/or raped)*

> ☐ Yes   ☐ No

22) Prior to age 18, what religious faith did you or your family practice?

> ☐ Christianity   ☐ Judaism   ☐ Islam
>
> ☐ Buddhism   ☐ Hinduism   ☐ Nonreligious/Secular   ☐ Atheist   ☐ Other

23) Prior to age 18, how much of an impact would you say religion (consisting of religious beliefs and engaging in religious practices) was important in your life after the impact of your CSA experience(s)?

> ☐ Major Impact   ☐ Moderate Impact   ☐ No Impact

24) Prior to the age of 18, how much of an impact did your religious beliefs discourage you from receiving counseling treatment (including religious) or professional treatment for your CSA experience?

> ☐ Major Impact   ☐ Moderate Impact   ☐ No Impact

25) Prior to the age of 18, how much did your religious beliefs impact the degree to which you or your family feel that your religious practices and beliefs were sufficient enough to cope with your CSA experience without need for counseling services?

☐ Major Impact ☐ Moderate Impact ☐ No Impact

26) Prior to the age of 18, how much did your religious beliefs impact the degree to which child sexual abuse issues were discussed within your home?

☐ Major Impact ☐ Moderate Impact ☐ No Impact

27) How much of an impact did your religious beliefs have on your choice or your family's choice in choosing your treatment provider for CSA?

☐ Major Impact ☐ Moderate Impact ☐ No Impact

28) Prior to the age of 18, how did you feel your religious beliefs impacted your ability to openly discuss your CSA experience?

☐ Major Impact ☐ Moderate Impact ☐ No Impact

29) How would you rate the overall impact of your CSA experience(s) on your religious beliefs?

☐ **Major Impact**: *(Prior to my CSA experience I was involved in my religious practices, now I no longer engaged in religious practices or follow the teachings)*

☐ **Moderate Impact**: *(Prior to my CSA experience I was involved in my religious practices, now I somewhat engage in religious practices or follow the teachings)*

☐ **No Impact:** *(Prior to my CSA experience and after there has been no change in my engagement in religious practices or follow the teachings)*

30) Is there anything else you would like to express or say about your perception on the counseling treatment received for CSA and/or to the selection of your treatment provider?

150-300 characters max.

Demographic Information: *(Please indicate all current information)*

31) **Gender:** <u>Checkboxes</u> Male or Female

32) **Age Range:** <u>Checkboxes</u> (18-24, 25-30, 31-40, 41-50, 51-60, or 61 & above)

33) **Sexual Orientation:** (Heterosexual, Bisexual, Gay, Lesbian, or Other)

34) **Relationship Status:** (Single, Married, Divorced, Partner, or Widowed)

35) **Select the Atlanta Metropolitan County you reside in:** <u>Dropdown Menu</u> (Bartow, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Paulding, Rockdale, or neither)

36) If not residing in Atlanta, where do you live? _____

Submit Survey

Appendix F :

Pilot Study Endorsement Letters

![Johns Hopkins School of Education]

Dr. Norma L. Day-Vines
Professor
Counseling and Human Development
School of Education

2800 N. Charles St.
Baltimore, MD
410.516.7990
norma.dayvines@jhu.edu

February 16, 2014

Dr. Chippewa Thomas
Auburn University College of Education
3084 Haley Center
Auburn, Alabama 36849-5218

Dear Dr. Thomas:

It is with a great deal of pride and pleasure that I write a letter of support for Mr. Ryan Day whose groundbreaking research agenda will serve as a major contribution to the counseling literature. A dearth of literature has addressed the experiences of African American child sexual abuse survivors. This study has important implications for theory, research, and practice, especially in light of the spotlight that has recently been cast on this issue. Moreover, Ryan's research can promote healing and wellness among a group of individuals who heretofore have suffered in silence.

Ryan's instrument adheres to guidelines prescribed by psychometrists as it pertains to the face and content validity. More specifically, items are aligned with the subject area they are intended to assess.

Sincerely,

Norma L. Day-Vines

Norma L. Day-Vines, Ph.D.
Professor
Program Lead

THE FAMILY CENTER
WHERE FAMILIES MATTER

inspire
transform
strengthen
empower

building foundations, encouraging dreams

Our Programs:
- Big Brothers Big Sisters
  of the Chattahoochee Valley
- Consumer Credit Counseling Service
  of West Georgia/East Alabama
- Families and Schools Together (FAST)
- Family Counseling of Columbus

1350 15th Avenue • P.O. Box 1825 • Columbus, GA 31902 • 706-327-3238

Lisa C. Scrivner
Chief Executive Officer

United Way

Community Partner

February 11, 2014

RE: Ryan Day Dissertation Pilot Study Endorsement Letter

To Whom It May Concern:

I have read Ryan's letter of intent and survey questions. His intent is clear, the survey questions are well thought out. His survey instrument fits the criteria for good survey design, thus potentially exhibiting high face and content validity. In some ways I was surprised that in 2014 we are not further along in exploring this issue, but am reminded that this week an African American professional football player disclosed his sexual preference along with a history of trauma related issues. Therefore, Ryan's approach will be contributing to the sexual abuse literature, specifically for a defined population. In closing, I endorse Ryan's plan to gather data at this stage.

Feel free to contact me at 706 327-3238, if you have additional questions about this principled young man.

Sincerely,

Richard P. Long, Ph.D., LMFT
Clinical Director

February 14, 2014

Mr. Ryan Day
Auburn University
College of Education

Mr. Day:

I have read your dissertation questions, survey instrument, and your letter of intent with IRB approval. In my view, your instrument appears to be appropriate to answer the research questions you have posed. Your survey shows face validity, as it measures what it is intended to measure and arranged so that it will consistently measure data intended.

I endorse this dissertation project as it will increase the body of knowledge and improve on the paucity of studies and resulting data for this topic and population. This study is necessary to assist those of us in the field that discover daily, the increasing number of African American men and women who have come forth with claims of childhood sexual abuse. It will help us to understand the underlying cultural implications of therapy to address CSA with this population.

You have my support.

Sincerely,

Vivian J. McCollum

Vivian J. McCollum, PhD., LPC
CEO and Clinical Director
Retired Counseling Education Professor at Old Dominion University

Rev. Pate H. Pearson	Gerald Costley	Betty Scott	Lisa Scott
Pastor	Chairman, Steward's Ministry	Church Clerk	Corresponding Secretary
(804) 530-0776 (home)	(804) 733-4932 (home)	(804) 590-9127 (home)	(804) 914-1900 (home)

February 15, 2014

To: Whom it may concern:

Per the request of Ryan Day, I have thoroughly reviewed and examined his Pilot Study entitled "African American Survivors of Childhood Sexual Abuse: Perceptions to treatment and treatment providers" and would like to share some observations regarding the survey. I will be sharing in relation to the survivors of sexual abuse, treatment for survivors of sexual abuse, and treatment providers for those that have experienced sexual abuse.

First of all, after reviewing the survey, it is clear that sexual abuse is major problem with many nameless victims. Ryan has carefully constructed a tool that allows a victim of sexual abuse to share their experiences and remain anonymous. He uses the survey as a skillfully crafted tool to address a subject that has been regarded as taboo, while showing concern and protection for people that have suffered abuse. Ryan provides an outlet for survivors to be heard as well as an avenue for them to receive help.

Second, Ryan dares to not only hear from the survivors, but to bring a keen awareness of the need for treatment for survivors of sexual abuse. He has structured his survey in a manner so that it gains valuable feedback regarding treatment of the sexually abused or the lack thereof. The tool is structured with various survey questions and employs a great mixture of analysis by which to measure the information.

Finally, he inquires about the quality of treatment received from treatment providers. He objectively explores the difference between treatment rendered by Religious/Clergy Leaders versus Licensed Professionals, and he seeks to find facts so that he can distinguish between the treatment provided by the two. Ryan is able to ask questions that give insight and gather data in order to determine where the sexually abused have gone to seek treatment or if they have sought any treatment at all.

Therefore, based the work performed, and the analysis outlined in this study, I heartily offer my full endorsement of Ryan Day for his Dissertation Pilot Study. Should you need further assistance or information, please contact me at 804-212-7324.

Sincerely,

Pate H. Pearson, M.Div., Senior Pastor

HOWARD
UNIVERSITY

School of Education
Office of the Dean

February 18, 2014

Mr. Ryan Day, NCC, CSC, LPC
210 East Thach Avenue
Apt. 30-E
Auburn, AL 36830

RE: Mr. *Ryan Day - Dissertation Pilot Study Endorsement Letter*

Dear Mr. Day,

I am in receipt of and I have reviewed your letter of intent and your dissertation research survey questions. Your research intent is clear and the survey questions are well thought out. Your survey instrument fits the criteria for good survey design, thus potentially exhibiting high face and content validity. It appears that your research and approach will provide invaluable contributions to the sexual abuse literature, specifically for a defined population. In closing, I endorse and support your plan to gather data at this stage of your dissertation research. Best wishes in your research journey.

Sincerely,
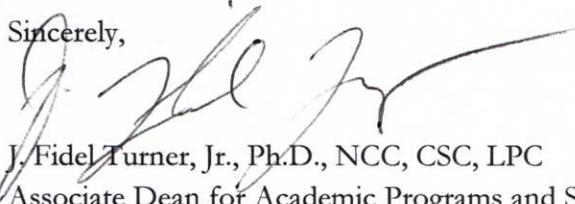
J. Fidel Turner, Jr., Ph.D., NCC, CSC, LPC
Associate Dean for Academic Programs and Student Affairs
Associate Professor of Counseling
School of Education