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Asian American Women Sexual Assault Survivors' Choice of Coping Strategies: The Role of Post-Assault Cognitive Responses

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Abstract

Even though approximately one in three Asian American (AA) and Pacific Islander women experience sexual assault victimization, there is a dearth of literature examining how AA women sexual assault survivors cope with this traumatic experience. This study examined AA female sexual assault survivors' choice of coping strategies post-assault and how their cognitive responses toward sexual assault victimization (e.g., attributions of self-blame, perceived control over the recovery process) relate to their use of coping strategies. Using the AA subsets of two large community studies, a total of 64 AA women ages 18 to 58 with unwanted sexual experiences after the age of 14 years were included in the analyses. Results indicated that AA survivors used *Acceptance* and *Self-Distract* the most to cope with sexual assault. In addition, those who perceived they had less control over their recovery process tended to use more maladaptive coping strategies, such as substance abuse and behavioral disengagement (e.g., giving up). Discussions include clinical implications and recommendations for using language, modalities, and foci of interventions that are consistent with clients' and their families' worldviews (e.g., indirect inquiries, solution-focused).

Keywords

Asian American women; trauma; sexual assault; coping; help-seeking

Researchers have established that sexual assault has numerous physical and psychological effects on women, including increased risk of chronic pain, sleep difficulties, diabetes, depression, sexual difficulties, posttraumatic stress disorder, suicidality, and substance abuse problems (e.g., Black et al., 2011; Campbell, Dworkin, & Cabral, 2009). Sexual assault is an inclusive term that describes the full range of unwanted sexual experiences, including unwanted sexual contact (e.g., kissing, touching), verbally coerced sexual penetration, and rape, i.e., penetration, no matter how slight, of the vagina or anus with any body part or

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object, or oral penetration by a sex organ of another person, without the consent of the victim (U.S. Department of Justice, 2013). Women are disproportionately affected by sexual assault, with one in five women raped in their lifetime (Breiding, 2014). National data revealed that about one in three Asian American (AA) or Pacific Islander women (29%) reported experiencing sexual assault victimization (Breiding, 2014). However, researchers and practitioners who work with the AA communities suspect that the actual sexual assault rate may be even higher than what's been reported, due to their lack of access or reluctance to use mental health services and public agencies (Kenny & McEachern, 2000). Despite the high prevalence, there is a dearth of literature on AA women's sexual assault victimization experiences and factors influencing how they cope with this trauma.

Coping

Coping strategies encompasses cognitive and behavioral efforts to manage the internal and external demands created by stressful events that are considered to be taxing or exceeding one's resources (Folkman, Lazarus, Gruen, & DeLongis, 1986). Even though coping strategies have been operationalized differently across studies, they have been found to be associated with adjustment to various stressful life events, including sexual assaults. For example, cognitive restructuring (i.e., identifying and disputing maladaptive thoughts, such as over-generalization, all-or-nothing thinking, etc.) was associated with less psychological distress, such as depression, anxiety, and PTSD symptoms (Arata & Burkhart, 1998; Frazier & Burnett, 1994; Frazier, Harlow, Schauben, & Byrne, 1993, August), while avoidant-oriented (e.g., withdrawing, staying at home) strategies were associated with poorer adjustment after sexual assault (Frazier & Burnett, 1994). Racial differences also have been observed in use of coping strategies. Among the college student population, AA female survivors tend to use more maladaptive coping strategies to manage their sexual assault victimization experiences than Black and White female survivors (Ullman & Filipas, 2005).

Cognitive Response

There is vast literature on the role of control-related constructs, including cognitive appraisals of traumatic experiences, in the development of trauma-related psychological difficulties (e.g., see Frazier, Berman, & Steward, 2001 for a review). This study focuses on two specific aspects of cognitive appraisal responses post-assault: *self-blame attributions* of the sexual assault experience (i.e., believing that one is responsible for the traumatic experience or could have controlled the traumatic event from happening) and *perceived control over recovery* (i.e., believing that one currently has control over the recovery process from the traumatic experience) in AA female sexual assault survivors. Some studies suggest that these two post-assault cognitive responses are connected to the impact of sexual assault. For example, self-blame are associated with greater use of maladaptive coping strategies (e.g., Arata & Burkhart, 1998) and greater psychological distress (e.g., Arata & Burkhart, 1996; Frazier, 2003; Koss, Figueredo, & Prince, 2002; Ullman, Filipas, Townsend, & Starzynski, 2007), while greater perceived control over recovery has emerged as a protective factor against PTSD symptoms among sexual assault survivors (Ullman et al., 2007; Ullman & Peter-Hagene, 2014) and leads to better overall adjustment (Frazier, Steward, &

Mortensen, 2004). However, no empirical studies have examined whether same dynamics can be applied to the AA sexual assault survivors.

There is an extensive history of blaming women for sexual assault in the United States (Donat & D'Emilio, 1992), and it has been proposed that feelings of self-blame are even stronger in communities that consider sexual assault personal problems (i.e., to be kept to oneself) and that the women are responsible for these assaults (Shalhoub-Kevorkian, 1999). Traditional Asian cultures tend to adhere to the patriarchal hierarchy that endorses a dominant role for males and a submissive role for females. Women are expected to practice modesty and sexual restraint and are held responsible for sexual activities outside of marriage (Abraham, 1999; Okazaki, 2002). There is some evidence indicating that AA college students are more likely than their White counterparts to view rape victims as partially to blame for their sexual assaults (Lee, Pomeroy, Yoo, & Rheinboldt, 2005; Mulliken, 2006), and the less acculturated AA students (e.g., more adherence to patriarchal/traditional gender roles and expectations) are even more likely to blame survivors (Mori, Bernat, Glenn, Selle, & Zarate, 1995). AA women sexual assault survivors were found to have high levels of self-blame and suicidal ideation (Rao, DiClemente, & Ponton, 1992). Compared to White women survivors, AA survivors showed greater symptoms of helplessness, shame, embarrassment, and concerns about family and/or others' reactions, following their sexual assault victimization (Luo, 2000; Ruch & Chandler, 1979).

Perceptions of present control (i.e., perceived control over the recovery process) have been consistently found to be related to less distress as well as greater life satisfaction and physical health for female sexual assault survivors as well as individuals with other traumatic life events (e.g., sudden death of loved ones) (e.g., Frazier, 2003; Frazier et al., 2012; Frazier et al., 2011; Frazier, Mortensen, & Steward, 2005). It also has been associated with fewer PTSD symptoms and binge drinking (Frazier, 2003; Frazier et al., 2011; Ullman, 2007) for female sexual assault survivors. There is some evidence indicating that perceived control over recovery is related to certain coping strategies. In a one-year longitudinal study with female sexual assault survivors, perceiving more control over the recovery process was associated with less social withdrawal and more cognitive restructuring coping behaviors (Frazier, Steward, et al., 2004). However, no studies have specifically examined the role of perceived control over the recovery process in AA sexual assault survivors' choices of coping strategies.

Current Study

The purpose of the current exploratory study was to understand AA women sexual assault survivors' use of coping strategies after sexual assault and the potential relationship between their post-assault cognitive responses toward their sexual assault victimization experiences and choice of coping strategies. More specifically, we examined the roles of self-blame attributions and perceived level of control over recovery in AA women sexual assault survivors' choice and use of coping strategies.

Method

Participants

The present study used survey data from Wave 1 of two large community studies - the Women's Life Experiences Study (WLE, Ullman et al., 2007) and the Women's Stress and Support Study (WSS, Relyea & Ullman, 2015). Data were collected in the Chicago metropolitan area with women age 18 years or older who had experienced unwanted sexual encounters since the age of 14 years. It should be noted that while the unwanted sexual encounters included a broad range of sexual victimization experiences in these two studies, about 65% of the assaults involved completed or attempted rape. The subsample used for analyses for this study included only the Asian American group, comprising 2% of the WLE ($N = 1,084$) and 2% of the WSS ($N = 1,863$) datasets. Please see Ullman et al. (2007) and Relyea and Ullman (2015) for descriptions of the full sampling and recruitment procedures.

A total of 64 AA adult women ages 18 to 58 ($M = 26.94$, $SD = 8.82$) with unwanted sexual experiences after the age of 14 years were included in the current study analyses. Approximately 30% also had unwanted sexual experiences before they were 14 years old (34.5%). About half of the participants (48.4%) reported having a college degree or beyond, followed by those who had some college education (32.8%), a high school diploma/GED (17.2%), and less-than-12th grade education (1.6%). Regarding their sexual orientation, about one-third reported only having lesbian relationships (35.9%), and one-third reported only having heterosexual relationships (35.9%), with the rest mostly heterosexual (18.8%), bisexual (7.8%), and mostly lesbian (1.6%) relationships. About 30% of the AA women reported income less than \$10,000 (27.0%), followed by 19% reporting income over \$50,000, 19.0% \$20,000 - \$30,000, 14.3% \$10,000 - \$20,000, 12.7% \$30,000 - \$40,000, and 7.9% \$40,000 - \$50,000.

Measures

Sexual assault—The Sexual Experiences Survey (SES, Koss & Gidycz, 1985) was used as a measure of childhood (before the age of 14) and adult victimization experiences. Questions include experiences of unwanted sex acts (e.g., fondled, kissed, or touched sexually), unwanted attempted intercourse, and unwanted intercourse, and whether these unwanted experiences were due to arguments and pressure, position of authority, threats or physical force, and intoxication from alcohol or drugs. The SES has internal consistency of reliability of .69 and test-retest reliability at 1 week apart of 93% (Koss & Gidycz, 1985). For this study, it is used as a selection criterion to include those who endorsed at least one SES item after the age of 14, who may or may not also have experienced unwanted sexual encounters prior to age 14, resulting in a final sample of 64 AA women.

Self-blame attributions—Self-blame attributions were assessed with Frazier's (2003) Rape Attribution Questionnaire (RAQ), with ten 5-point Likert-scale items ranging from 1 (strongly disagree) to 5 (strongly agree) ($M = 3.20$, $SD = .97$). The RAQ measures attributions made by sexual assault survivors about why the assault occurred, including both characterological self-blame (i.e., attributing the assault to their own character, such as "I am unlucky") and behavioral self-blame (i.e., attributing the assault to their own behaviors, such

as “I used poor judgment”). In this study, the mean ratings of characterological self-blame and behavioral self-blame were analyzed to assess overall self-blame. Frazier (2003) has reported alpha coefficients from .77 to .89 with women sexual assault survivors. Higher scores indicate higher level of self-blame. The Cronbach’s alpha coefficient for this study is .88 for the overall self-blame attribution.

Perceived control—Perceived control over recovery from assault was assessed using 7 items from the RAQ supplementary subscales to assess women’s present control over recovery from the assault (Frazier, 2003). Women responded to items such as “I feel like the recovery process is in my control” and “I am confident that I can get over this if I work at it” on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) ($M = 3.49$, $SD = .68$). Frazier (2003) reported an alpha coefficient of .81. The Cronbach’s alpha coefficient for this study is .73.

Coping strategies—Strategies used to cope with the assault were assessed with the 28-item Brief COPE (Carver, 1997) with Likert scale items from 1 (I didn’t do this at all) to 4 (I did this a lot). There were 14 types of coping strategies composed of 2 items each. The Brief COPE measures both behavioral- and emotion-focused strategies as well as dysfunctional versus adaptive strategies, including *Active Coping* (.55), *Planning* (.72), *Positive Reframing* (.69), *Acceptance* (.75), *Humor* (.88), *Religion* (.91), *Using Emotional Support* (.82), *Using Instrumental Support* (.86), *Self-Distraction* (.69), *Denial* (.74), *Venting* (.43), *Substance Use* (.97), *Behavioral Disengagement* (.72), and *Self-Blame* (.77). Numbers in parentheses are the Cronbach’s alpha coefficients for this study. The Brief COPE has been widely used and has good internal consistency reliability (Carver, Scheier, & Weintraub, 1989). However, it should be noted that *Active Coping* and *Venting* have relative low internal reliability in our sample.

Results

Preliminary Analysis

Age was not related to self-blame attribution or perceived control over recovery and was associated with only one coping strategy – the use of positive reframing (younger survivors used more positive reframing, $r = -.34$, $p = .009$). Income was not related to any coping strategy, but was related to perceived control; women with higher income reported having more control over recovery, $r = .35$, $p = .006$. Finally, education level was related to age ($r = .29$, $p = .021$), and it had an inverse association with the use of *Denial* as a coping strategy ($r = -.34$, $p = .008$).

Analytic Strategy

To explore AA women survivors’ choices of coping strategies to manage their sexual assault experience, each coping strategy was put in rank order from most to least used. Additionally, a series of paired-sample t-tests were conducted to examine if there were significant differences in how much the survivors utilized the strategies. To examine the role of cognitive reactions in coping strategies utilization, 14 hierarchical multiple regression analyses were conducted with each coping strategy as the outcome variable. A Bonferroni

correction for multiple comparisons was made to adjust the significance threshold or p value to .004 (.05/14) for each regression. Age, income, and education level were entered as control variables in the first block, and *self-blame attribution* and *perceived control over recovery* were entered into the second block as predictors. Age, income, and education level are controlled in this study because of their associations with coping and cognitive reactions from the preliminary analyses, as well as past research findings on age differences in sexual assault survivors' coping (e.g., Ullman et al., 2007) and self-blame attributions (e.g., Littleton, Magee, & Axsom, 2007), the role of socioeconomic status in coping (e.g., Abbey, Jacques-Tiura, & Parkhill, 2010; Holzman, 1996; McNair & Neville, 1996), and the link between less education and greater PTSD symptom severity for sexual assault survivors (e.g., Ullman & Filipas, 2001). Sexual orientation was not controlled in this study because there were no significant differences in all measured variables between women who identified as lesbian/bisexual/mostly lesbian and those who identified as heterosexual/mostly heterosexual.

Choice of Coping Strategies

Table 1 outlines the coping strategies AA women survivors utilized from most often to least often. Results from paired-sampled t-tests suggested that AA women survivors in this study utilized *Acceptance* and *Self-Distracton* the most to cope with their sexual assault experiences. The next group of strategies that they tended to utilize included: *Self-Blame*, *Active Coping*, *Use of Emotional Support*, *Venting*, *Planning*, and *Instrumental Support*. The third group included: *Positive Reframe*, *Religious Coping*, *Substance Abuse*, and *Behavioral Disengagement*. Finally, the group of strategies they utilized the least (significantly less than all the other three groups) included use of *Humor* and *Denial*.

Cognitive Reactions and Coping

Hierarchical regressions, controlling for age, income, and education, revealed that perceived control over the recovery process was a significant predictor of utilization of two types of coping strategies, including (1) substance abuse, $\beta = -.44$, $p = .002$, $\eta^2 = .18$ with a medium effect size and (2) behavioral disengagement, $\beta = -.57$, $p < .001$, $\eta^2 = .29$ with a large effect size. Use of self-blame as a coping strategy was predicted by survivors' self-blame attribution cognitive response with a large effect size, $\beta = .62$, $p < .001$, $\eta^2 = .41$ and with perceiving less control over the recovery process as a factor with small effect size ($\eta^2 = .09$) but not statistically significant with Bonferroni correction, $\beta = -.25$, $p = .024$ (Bonferroni correction $p = .004$). Effect sizes were evaluated based on Cohen and colleagues' (Cohen, Cohen, West, & Aiken, 2003) recommendations of η^2 of .02, .13, and .26 as small, medium, and large magnitude of effect sizes. Table 2 includes additional statistics related to the above analyses.

Discussion

In this community study of AA women sexual assault survivors, there were significant differences in coping strategies used post-assault. *Acceptance* (i.e., "I accept the reality of the fact that it happened;" "I learned to live with it") and *Self-Distracton* ("I turned to work or other activities to take my mind off things;" "I did something to think about it less") were

utilized significantly more than the other coping strategies, while *Humor* (“I make jokes about it,” “I made fun of the situation”) and *Denial* (“I said to myself this isn’t real,” “I refused to believe that it happened”) were utilized the least. When controlling for age, income, and education, AA women survivors in this study who perceived having less control over their recovery process reported more frequent *use of substances* (i.e., use alcohol or other drugs to “make myself feel better” or “help me get through it”), more *behavioral disengagement* (i.e., “gave up trying to deal with it,” “gave up attempt to cope”), and engagement in more *self-blame* behaviors (i.e., “I criticized myself,” “I blamed myself for things that happened”) as post-assault coping strategies. Not surprisingly, AA women survivors who reported greater use of self-blame attributions also engaged in more *self-blame* coping strategies. However, self-blame attributions were not predictive of any other coping strategies. Post hoc analyses using characterological self-blame and behavioral self-blame as unique predictors did not reveal any differences between the two types of self-blame in their roles in AA survivors’ coping. In addition, characterological and behavioral self-blame were significantly correlated at .60 in this study, suggesting a large common factor underlying these two variables. Therefore, for AA female survivors, the distinctions between self-blame attribution to one’s personal character versus one’s actions may not be as clear as the literature asserts for other populations (Littleton et al., 2007).

Age, Income, and Education

Previous studies have found older female sexual assault survivors engaged in more avoidance coping strategies (denial, self-distraction, behavioral disengagement), but perceived more control over the recovery process (Ullman et al., 2007). For AA women survivors in this study, age and income seem to have different relationships with cognitive responses and coping strategy utilization than previous findings with other populations. Young AA women survivors engaged in more *positive reframing*, and it was the only coping strategy related to age. Further, even though income was not related to any coping strategies, it was associated with perceiving having more control over the recovery process. It has been suggested that for AA women survivors who have fewer economic resources and/or have to rely heavily on their immediate family or community for support, there may be more at stake in seeking support for their sexual assault victimization. Fear of losing economic or social support, especially if their husbands or fathers are the sole providers (Abbey et al., 2010), may be salient concerns, leading to lower sense of control over their recovery process. This may be particularly relevant to AA women who are recent immigrants, refugees, or not English proficient, who often have few economic resources and additional barriers to seeking support for recovery (Cheng, Tu, Li, Chang, & Yang, 2015; Holzman, 1996; Okazaki, 2002).

Education level was not related to income level or either of the cognitive responses of self-blame attributions or perceived control over the recovery process. However, we found that those AA sexual assault survivors with lower educational levels in this study reported greater utilization of *Denial* as a coping strategy, which may offer some explanation of the link between less education and greater PTSD symptom severity found in a previous study with a diverse community sample (Ullman & Filipas, 2001).

Choice of Coping in the Cultural Context

Acceptance and *Self-Distract* were the most frequently used coping strategies by AA women survivors in this study, which seems to be consistent with findings from studies examining stress and coping with nursing students in Japan (Yamashita, Saito, & Takao, 2012), with medical interns in Malaysia (Yusoff, Jie, & Esa, 2011), and in cross-cultural comparison studies on coping styles that find AAs tend to engage in more acceptance and avoidance compared to White Americans (e.g., Bjorck, Cuthbertson, Thurman, & Lee, 2001). This also is supported by practitioners' observations from working with Southeast AA women sexual assault survivors from a refugee community. Specifically, for older female Southeast AA sexual assault survivors, focusing on acceptance, removing blame, and emphasizing that while life has suffering, one can survive misfortunes are keys in their healing (Kanuha, 1987). Many Asian cultures are influenced by Buddhism, Taoism, or Hinduism, which include the belief that one's experiences in this life may be the consequences of their ancestors' behaviors or that of their previous lives, and that suffering is a part of life that one must accept and move forward in life (Zheng & Gray, 2015).

This is not to suggest that AA survivors who utilized acceptance coping do not experience distress. In fact, they may suffer elevated distress from attempting (unsuccessfully) to accept their suffering by engaging in self-distracting behaviors and delaying or denying themselves the opportunity to seek treatment or support. Future studies should examine the degrees of psychological distress AA survivors experience post-assault, and whether they vary according to survivors' cognitive reactions and choice of coping strategies.

Perceived Control Over the Recovery Process as an Intervention

Past research found that adult sexual assault survivors generally reported more problems with substances (e.g., alcohol and drug abuse or dependence) and psychological distress (e.g., depression, anxiety) than those who had not experienced sexual assault victimization (e.g., Burnam et al., 1988; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). Results from this study suggest that substance abuse may be a way of coping, albeit maladaptive, for AA survivors to manage their traumatic experience, especially when they do not think they have control over the recovery process. Additionally, AA survivors who perceived having little control over the recovery process coped with their sexual assault trauma by disengaging behaviorally (i.e., gave up trying or attempting to cope). This may be another maladaptive way of coping by AA survivors post-assault, and one of the reasons past studies found AA female survivors with high levels of suicidal ideation (Rao et al., 1992) and feelings of helplessness (Luo, 2000), because they have given up trying to manage their distress or seek support when they do not feel they have control over their recovery process.

Female sexual assault survivors who perceive having more control over the recovery process have better psychological adjustment (Frazier, Tashiro, Berman, Steger, & Long, 2004) and greater posttraumatic growth (Ullman, 2014). Therefore, focusing on what one can do in the present to recover may be more productive than focusing on how one could have prevented the trauma in the past, or even how one can prevent future traumas, especially if future traumas are not really preventable. Given this study's finding that AA survivors who perceived having more control over the recovery process used less maladaptive coping

behaviors (e.g., substance abuse, giving up), interventions that focus on having more control over the healing process may be more helpful than putting the focus on asking AA women survivors to disclose or discuss their sexual assault victimization experiences, particularly given the shame and stigma that may be involved in openly discussing such experiences with those outside the family. Some researchers had proposed that the low disclosure of reported sexual assaults among AA survivors is associated with AA communities' value of saving face and avoiding shame (Okamura, Heras, & Wong-Kerberg, 1995). In other words, an AA family can also lose face when a member of the family fails to conform to cultural norms (e.g., female chastity, seeking "outside" help for something personal) because feelings of shame, failure, and inadequacy are not just felt by the survivor herself, but collectively by the entire family. Therefore, labeling their reluctance to discuss the victimization as being "in denial" or "resistance" may further alienate the survivor and her family. AA survivors or their families may not want to discuss their victimization experiences because they want to move on based on their worldviews and beliefs that if they "fixate on the past," they can't move on (Heras, 1992). Thus, it may be helpful to use language and employ therapeutic strategies more consistent with AA female survivors and their families' worldviews, levels of acculturation, or cultural adjustment regarding seeking help (e.g., collective, solution-focused). For example, language using "we" instead of "I" or "you" and focusing on "solutions" instead of discussing the details of the traumatic events, such as: "how can *we* make *our situation* better?", are recommended (Heras, 1992).

Treating Sexual Assault Trauma in Cultural Context

To understand experiences of trauma, Brown (2008) proposed that we need to broaden the definition of "trauma," and as clinicians, we need to pay attention to what might constitute a trauma for the particular client in front of us. To do this, we need to take into consideration individuals' multicultural sociocultural identities, including age, disability, religion and spirituality, ethnicity and culture, social class, sexual orientation, indigenous heritage and colonization, national origin, immigration and refugee status, and gender and sex. Ho and her colleagues (Ho, Dinh, & Smith, 2015) applied Resnick and colleagues' (Resnick, Acierio, & Kilpatrick, 1997) model of violence and health to highlight the importance of understanding the impact of sexual violence and rape attributions along with cultural and contextual factors when working with Southeast Asian American women. In addition to the somatic symptoms often manifested from culturally-bound expressions of posttraumatic stress symptoms (Ho et al., 2015), multiple traumas further exacerbate health problems (Resnick et al., 1997). Therefore, stress and trauma from discrimination experiences due to AA women's other socio-cultural-political identities (e.g., refugee immigration history, language proficiency, disability, lower SES, sexism, heterosexism, racism) must also be taken into account when we work with AA female sexual assault survivors.

Meanings of sexual assault experiences—Holzman (1996) argued that issues of power, dominance, and oppression based on race, ethnicity, and class must be a part of the conceptualization and treatment of sexual assault. Thus, to guide survivors through the recovery process, clinicians must try to understand the meaning and consequences of their sexual assault victimization experiences in the specific sociocultural context of the survivor's community. In her work on cultural competence and trauma therapy, Brown

(2008) also discussed the importance of looking for added meanings of traumatic sexual assault victimization experiences. For example, if a woman is assaulted by a trusted member of her community, her pain and distress may be further heightened from the added weight of her being violated by someone who shares her culture and who is supposed to protect her from external oppressions. Therefore, clinicians should consider how traumatic experience “might evoke other meanings that resonate with this individuals’ multiple identities.”

(Brown, 2008, p. 111)

Assessment and intervention modality—With the understanding that no recommendations can be applied to every AA female sexual assault survivor, clinicians, service providers, and community members have offered some strategies that consider the complex multiple realities of AA women sexual assault survivors (e.g., Brown, 2008; Kanuha, 1987). First, indirect methods of inquiry during the initial contact may be a more culturally appropriate way to decrease the level of shame and stigma felt by survivors when disclosing and discussing their experiences, such as the use of metaphors, third-party references, or discussions of other conditions. For example, when working with the Southeast Asian communities in Minnesota, bilingual case workers talked to refugee sexual assault survivors about fictitious friends who had been sexually assaulted and the ways those friends were given help (Kanuha, 1987) as a way to allow the survivors to save face and for the service providers to offer resources and recommendations in a less threatening manner. Second, even though support groups are a common, and sometimes primary, form of intervention for sexual assault survivors, this modality may not be as helpful for those AA female sexual assault survivors who experience shame from public admissions of sexual assault. One-on-one interventions, such as individual counseling, may offer survivors a greater sense of safety.

Limitations and Recommendations for Future Studies

One of the major limitations of this study is the definition and interpretations of the “Asian American” sample. There are more than 48 distinct ethnic groups with different languages, histories, cultural practices, religions, and physical features. Cultural definitions and attitudes toward sexual assault cannot be assumed to be the same for this broad category of “Asian heritage.” Studies should be conducted on the different subcultural groups (e.g., immigration history and status, ethnic groups, social class, religions, sexual orientations, etc.) within the AA communities to focus on the specific cultural risk and protective factors of sexual assault experiences, coping, and help seeking behaviors of AA women survivors. In a 2010 review, Abbey and colleagues (2010) identified 14 studies that include sexual assault victimization prevalence information for women of color, and only 4 studies included Asian American and Pacific Islander participants. All, except for one, also included Pacific Islanders and Native Hawaiians as one Asian/Pacific Islander category, but differences have been found in their sexual assault experiences and health outcomes (e.g., Crisanti, Frueh, Gundaya, Salvail, & Triffleman, 2011). Even though this study attempts to focus only on the “Asian American” women experiences, future studies should not only examine the specific ethnic and cultural groups’ experiences and help seeking behaviors within the AA and PI communities, but also the disparities between and amongst these groups.

Another limitation is the small cross-sectional sample, which may not have adequate power for the analyses conducted in this study. The data is also based on retrospective self-report from a convenience sample of women who chose (self-selected) to participate in a study about unwanted sexual experiences. For some women, it may have been a long time since the unwanted sexual assault experience, and the recall of their cognitive responses and coping strategies may not be entirely accurate. In addition, other pre-assault, assault, and post-assault factors that may also affect AA women survivors' coping were not examined in this study, such as pre-assault substance abuse, child sexual abuse history, history of multiple unwanted sexual experiences, pre-existing perception of self and other, perpetrator characteristics (e.g., stranger vs. family members), severity of unwanted sexual assault experiences, post-assault social support, and additional victimization experiences. Future studies should also take these factors into consideration when examining AA women survivors' coping strategies, as well as the effectiveness of chosen strategies in reducing psychological distress (e.g., PTSD, depression) and promoting posttraumatic growth.

Given the high use of acceptance coping among AA female survivors, the role of resilience in the cultural context would be important to examine in future studies. The shared experiences of collective resilience in processing racial and immigration trauma may play an important role in AA female SA survivors' recovery process. In a case study, an Indian American female sexual assault survivor expressed her resilience and coping in her ability to drawn upon critical resources from both of her family and college friends, two different cultural worlds, and engaged the two communities with different aspects of her traumatic and other stressful experiences (Tummala-Narra, 2007). A qualitative study with 13 South Asian adult child sexual abuse survivors also found the safe social support within the South Asian community facilitated healing, despite the cultural taboos surrounding child sexual abuse (Singh, Hays, Chung, & Watson, 2010).

Conclusion

This study is the first, to our knowledge, to directly examine AA women sexual assault survivors' cognitive responses and their use of coping strategies in a community sample. As the number of Asian Americans continues to increase, given the high prevalence of sexual assault victimization against women, it is essential for clinicians to understand the complex culturally contextualized experiences of AA sexual assault female survivors in order to provide culturally appropriate and effective prevention and intervention approaches to this underserved population. Results from this study indicate that AA female survivors' perceived control over the recovery process, or the lack thereof, is a key factor in their use of maladaptive coping strategies (e.g., substance abuse, behavioral disengagement of giving up, blaming oneself), which has significant clinical implications in shaping the focus and strategies of sexual assault intervention with this population. Moreover, literature has already shown that AAs have significantly lower mental health services utilization rates compared to other racial/ethnic groups (Smith & Trimble, 2016). To prevent AA female survivors from feeling re-traumatized by interactions that are not culturally appropriate or psychologically beneficial when they do seek services (Campbell & Raja, 1999), findings from this study suggest clinicians should attend to the various socio-psycho-political-cultural factors that contribute to AA survivors' cognitive responses to their sexual assault experiences and

employ intervention techniques that are consistent with AA female survivors' worldviews and specific needs in the recovery process. Finally, the role of resilience in the cultural context should be further explored to identify strengths and factors that promote healing among AA female survivors.

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Table 1

Descriptive Statistics Regarding Extent of Coping Strategies Utilization

Coping		<i>M</i>	<i>SD</i>	<i>M</i>	<i>t</i>	<i>p</i>
Group 1						
1	Acceptance	5.87	1.59			
2	Self-Distraction	5.49	1.85	$M(1 - 2) = .38$	1.59	.118
Group 2						
3	Self-Blame	4.70	2.00	$M(1 - 3) = 1.17$	3.43	.001
4	Active Coping	4.66	1.70	$M(3 - 4) = .04$	.16	.870
5	Use of Emotional Support	4.60	1.96	$M(3 - 5) = .10$	.26	.777
6	Venting	4.44	1.57	$M(3 - 6) = .26$	1.03	.306
7	Planning	4.13	1.82	$M(3 - 7) = .57$	1.96	.055
8	Instrumental Support	4.03	1.93	$M(3 - 8) = .67$	2.00	.050
Group 3						
9	Positive Reframing	3.97	1.82	$M(3 - 9) = .73$	2.57	.013
10	Religious Coping	3.88	2.11	$M(9 - 10) = .09$	.24	.809
11	Substance Abuse	3.54	2.12	$M(9 - 11) = .43$	1.02	.313
12	Behavioral Disengagement	3.42	1.73	$M(9 - 12) = .55$	1.64	.107
Group 4						
13	Humor	3.18	1.74	$M(9 - 13) = .79$	3.44	.001
14	Denial	3.13	1.44	$M(13 - 14) = .05$	.25	.806

Note. Range of coping strategies ratings were from 2 to 8, with higher rating indicating higher frequency of utilization.

Table 2

Hierarchical Regression Analysis Predicting Coping Strategies Utilization

Coping	<i>B</i>	β	<i>R</i> ²	<i>F</i>	<i>p</i>	η^2
Self-Blame			.41	20.58	.000	
SBA	1.31	.62			.000	.41
PCR	-.74	-.25			.025	.09
Substance Abuse			.18	6.21	.004	
SBA	.38	.17			.164	.04
PCR	-1.37	-.44			.002	.18
Behavioral Disengagement			.30	11.77	.000	
SBA	.32	.18			.122	.04
PCR	-1.44	-.57			.000	.29

Note. Significance level is adjusted to .004. SBA = Self-Blame Attribution; PCR = Perceived Control over Recovery Process. Only significant results are included in the table. Controlled variables (Age, Income, Education) are entered in Step 1.