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B. H. French

H. A. Neville

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Sexual Coercion Among Black and White Teenagers: Sexual Stereotypes and Psychobehavioral Correlates

Bryana H. French[1] and Helen A. Neville[2]

Abstract

The relations between type of sexual coercion (i.e., verbal, substance-facilitated, physical) and psychological and behavioral health were examined among Black (n = 107) and White (n = 114) young women. We also explored the moderating role of sexual stereotypes in understanding the relations between sexual coercion and health. Over half (53%) of the total sample reported experiencing at least one sexually coercive incident. Direct relations were found between sexual coercion type and psychological and behavioral health correlates. Specifically, for both Black and White young women, greater verbal coercion was related to increased risky sexual behaviors. Substance-facilitated sexual coercion was related to lower levels of two indicators of mental health among Black participants (i.e., psychological distress and self-esteem). Endorsement of sexual stereotypes moderated the relations between total sexual coercion experiences and self-esteem for Black young women and between total sexual coercion experiences and psychological distress for White young women.

[1]University of Missouri, Columbia, MO, USA
[2]University of Illinois at Urbana-Champaign, Champaign, IL, USA

Corresponding Author:
Bryana H. French, PhD, Department of Educational, School, and Counseling Psychology, 9 Hill Hall, University of Missouri, Columbia, MO 65211, USA.
Email: frenchbr@missouri.edu

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Sexual coercion is a pervasive problem for girls and women in the United States. Adolescents are at heightened risk, as over 50% of all U.S. rape and sexual assault victims are between the ages of 12 and 20 (Catalano, 2005). According to the Youth Risk Behavior Survey, nationwide prevalence rates of forced sex among high school young women are about 10.5% (Centers for Disease Control and Prevention, 2009). These rates are gross underestimations, as many survivors do not disclose their sexual trauma experiences nor identify their experience as rape (e.g., Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). Moreover, such estimates do not include other types of sexually coercive experiences (e.g., substance-facilitated sexual assault).

Empirical studies with adolescents document the harmful effects of sexual coercion on psychological and behavioral health (Howard & Wang, 2005); however, few studies have explored psychological correlates related to different types of sexual coercion that may help explain these relationships. Understanding the unique influences of specific sexually coercive tactics on psychological and behavioral health will help inform treatment efforts with adolescents and emerging adults. The present study was designed to address the gaps in the literature by examining multiple types of sexual coercion among Black and White young women and their relations to psychological and behavioral health. In this study, we were also interested in extending the research by examining the role of a cultural-related process in explaining this association. We selected sexual stereotypes given the pervasive sexualization of girls in the media. Following recommendations from the Task Force on the Sexualization of Girls (American Psychological Association, 2010) and Szymanski, Moffitt, and Carr's (2011) Major Contribution on sexual objectification, we were particularly interested in ways that this hypersexualization influenced the adjustment correlates of sexual coercion for young women. Specifically, we are interested in understanding how internalizing sexualized stereotypes of women, men, and relationships may be related to health among sexual coercion survivors. As a way of contextualizing the research, we first describe types of sexual coercion identified in the literature. We then review the psychological and behavioral correlates of sexual coercion, followed by a discussion of sexual stereotypes and its theoretical and empirical linkages to sexual coercion-related issues.

Types of Sexual Coercion

Koss and colleagues (Koss, Gidycz, & Wisniewski, 1987) identified four types of unwanted sex: rape (i.e., sexual intercourse due to alcohol/drugs or physical force or threats), attempted rape (i.e., attempted but not completed sexual intercourse by alcohol/drugs or physical force), sexual coercion (i.e., sexual intercourse due to continual arguments, pressure, or abused authority), and sexual contact (i.e., sex play due to arguments, pressure, or abused authority). The majority of studies since this publication have examined sexual coercion by categorizing individuals according to severity of experience. Research generally identifies forcible rape as the most severe form of sexual coercion, which is related to lower levels of psychological and behavioral health than other types of sexual coercion (e.g., Classen, Palesh, & Aggarwal, 2005; Ullman, Townsend, Filipas, & Starzynski, 2007). In the past decade or so, researchers have examined the type of sexual coercion or the tactics used to coerce someone into an unwanted sexual activity, including verbal coercion, physical coercion, and alcohol facilitated coercion.

Psychological and Behavioral Health Correlates of Sexual Coercion

Self-Esteem

The literature on the association between sexual coercion type and self-esteem is equivocal, as some studies found a significant relation with sexual coercion type and in other studies, this relation was not substantiated. For example, Zweig and colleagues (Zweig, Barber, & Eccles, 1997) compared predominantly White young adult women who were raped, pressured to have sex, and not coerced to have unwanted sex and found that women who were pressured to have sex reported lower levels of self-esteem compared to the other two groups of women. Also, Testa and Dermen (1999) found that among primarily White young adult women, women who were verbally coerced to have unwanted sex had significantly lower levels of self-esteem than women who were forcibly raped. In one of the few published studies examining correlates of sexual coercion type and self-esteem among youth, Cecil and Matson (2005) did not find significant associations between verbal coercion and self-esteem among a sample of 14- to 19-year-old Black American girls. It is possible that the relation between verbal coercion and self-esteem is different for teenagers compared to adult women and/or for

Black women compared to White women. Methodological differences exist as well. Testa and Dermen examined women who were coerced, raped, neither, or both, whereas Cecil and Matson categorized girls by their most severe experience. It could be that women with multiple types of coercion experiences have lower self-esteem compared to women who were raped but not coerced. With these mixed findings, the relationship between sexual coercion and self-esteem is inconclusive and worthy of further research.

Psychological Distress

Although various forms of sexual coercion have been positively related to psychological distress (e.g., Cecil & Matson, 2005), forcible rape has been correlated with increased harm compared to other types of coercion. For example, Brown, Testa, and Messman-Moore (2009) found that forcible rape accounted for greater severity in posttraumatic symptoms, with alcohol incapacitated rape showing an intermediate effect between verbal coercion and forcible rape among predominantly White college students and racially diverse community samples. Similarly, Cecil and Matson (2005) found that forcible rape led to more traumatic health outcomes than verbal coercion among Black American adolescent girls. There are studies that contradict this pattern of findings, Zweig and colleagues (1997) found poorer psychological health among predominantly White women who were sexually pressured compared to those who were forcibly raped or not victimized; however, the meaning of "sexual pressure" (p. 296) was not clearly operationalized in this study. McCauley and colleagues (2009), comparatively found that among a nationally representative sample of adolescents (70% White), those who experienced unwanted sex due to alcohol/drug incapacitation showed no differences in reported depression or posttraumatic stress disorder symptoms compared to girls with other sexual assault histories, including rape. With inconsistent findings among adults and the dearth of research with adolescents, this study adds to the literature exploring unique correlations of sexual coercion types and psychological distress.

Risky Sexual Behavior

Risky sexual behavior is among the more frequently cited correlates of sexual coercion among young women, and it is of particular importance in this study given the overrepresentation of Black adolescents in HIV and sexually transmitted infection diagnoses (Centers for Disease Control and Prevention, 2007). Scholars have consistently found that unwanted sexual experiences are related to increased sexual activity and unprotected intercourse (e.g., Biglan,

Noell, Ochs, Smolkowski, & Metzler, 1995; Zweig et al., 2002) and subsequently greater risk of obtaining a sexually transmitted infection. Biglan and colleagues (1995) found that forced sex was correlated with higher levels of risky sexual behavior across five samples of racially diverse adolescent girls and adult women. Similarly, Kahn and colleagues' (Kahn, Huang, Rosenthal, Tissot, & Burk, 2005) longitudinal study of 537 racially diverse college women (56% White, 13% Black) indicated that those who were physically forced to have sex showed greater numbers of lifetime sexual partners and greater likelihood of human papillomavirus diagnoses. Moreover, the relation between sexual trauma and HIV has been found among African Americans specifically (Wyatt et al., 2002). There are few studies to our knowledge examining the association between other types of sexual coercion and risky sexual behavior. Understanding this relationship is particularly important given the implications for intervention efforts with young women. At this point, we have little information on whether specific forms of sexual coercion are related to engagement in increased risky sexual behaviors.

The Intervening Role of Sexual Stereotypes

Researchers have explored the role of sexual stereotypes, such as rape myth acceptance, on the link between sexual coercion and psychological health. By *sexual stereotypes*, we mean common contemporary beliefs that support dominant heterosexual and gendered sexual norms, including "men are sex driven," "women's relationship value rests in their sexual attractiveness," and "status and appearance take precedence in dating." In this study, we focused on sexual stereotypes given the pervasive nature of contemporary sexualization of women in the media (American Psychological Association, 2010). To date, few studies have explored the association between sexual stereotypes and sexual coercion sequelae among adolescents.

Internalized traditional sexual ideologies are associated with psychological health for women with sexual coercion experiences. For example, Neville and colleagues (Neville, Heppner, Oh, Spanierman, & Clark, 2004) found that Black women rape survivors were more likely than their White counterparts to endorse the stereotype of the Jezebel (i.e., historical image of Black women as sexually promiscuous, always desirous of sex, and thus incapable of being raped) in understanding why they were raped. This belief in turn mediated the relation between sexual assault and self-esteem. A number of studies also suggest that sexual stereotypes moderate the association between sexual coercion and distress. Gidycz and Koss (1991) found among a national sample of predominantly

White college women sexual assault survivors that greater endorsement of adversarial sexual beliefs and sexual conservatism significantly predicted psychological trauma. Other scholars have found that increased denial of individual, institutional, and cultural discrimination against women moderated the relation between sexist events, including unwanted sexual advances and greater psychological distress among a sample of predominantly White (Moradi & Subich, 2002) and Black and White (Rederstorff, Buchanan, & Settles, 2007). Collectively, these studies suggest that internalizing stereotypes about women, relationships, and/or sexuality can exacerbate the levels of distress among women who have experienced sexual coercion. To date, we know very little about the role of sexual stereotypes in understanding the association between sexual coercion experiences and psychological distress among adolescent young women. Understanding this association seems particularly important for treatment and intervention efforts. When working with young women who have experienced sexual coercion, counselors may assist in the recovery process by incorporating ways to challenge dominant sexual ideologies that often serve to objectify girls and women and blame them for sexual violence.

Rationale, Purpose, and Research Questions

There is a dearth of literature examining the different psychological and behavioral health correlates of sexual coercion types among racially diverse adolescents. To date, the majority of studies that have investigated sexual coercion types among adolescents have assessed victimization rates and focused on factors that predict coercion, such as relationship, personal, and incident characteristics (e.g., Rikert, Wiemann, Vaughan, & White, 2004; Testa, VanZile-Tamsen, & Livingston, 2007). Having a better understanding of the types of coercion (e.g., verbal coercion) and their potential differential relation to health indices can inform intervention efforts in working with young women. Such explorations serve as initial steps in developing more complex models explaining health sequelae of sexual coercion. Of particular relevance is the identification of potential moderators in the sexual coercion and health link. We believe that sexual coercion results from multiple factors, including gender roles and the position of women compared to men in society. Few studies have explored whether internalization of one's gender socialization in such a society influences the way in which one responds to coercive experiences. If, as we expect, gender socialization is significant in understanding the relation between sexual coercion and health among young women, then it seems logical to incorporate this aspect in related interventions.

This study was designed to add to the literature by exploring the health correlates of verbal, substance-facilitated, and physical sexual coercion among Black and White young women. Consistent with conceptualizations of adolescent development until the early 21st century (Arnett, 2000), this study focuses on young women, with one-third of the sample consisting of high school students and two-thirds consisting of college students—groups that are at high risk of sexual assault (Catalano, 2005). We were also interested in (a) exploring the role of sexual stereotypes in understanding health outcomes and (b) determining if increased endorsement of sexual stereotypes exacerbated poor health outcomes among young women with greater levels of sexual coercion experiences. We chose to examine correlates for Black and White young women separately; most studies that include a diverse sample typically control for the potential influence of race by treating it as a covariate. This is problematic because it does not allow for an exploration of within group differences for each sample.

The research questions guiding this study were as follows:

Research Question 1: Do Black and White young women report similar rates and severity of sexual coercion?

On the basis of previous research indicating few differences (e.g., Howard & Wang, 2005), we hypothesized that there would be no significant differences between Black and White samples.

Research Question 2a: Are types of sexually coercive experiences differentially related to psychosocial health indexes (i.e., psychological distress, self-esteem, risky sexual behavior), controlling for childhood sexual abuse?

We controlled for childhood sexual abuse because of its consistent relation to various indices of psychological distress (cf. Webster, 2001).

Research Question 2b: If there are significant associations, how do they differ by and within racial groups?

Although there are consistent data showing a link between sexual coercion experiences and health, there is not enough research on the differences among verbal, substance-facilitated, and physical coercion to hypothesize if and where specific differences may lay.

Research Question 3: Do sexual stereotypes moderate the relations between sexual coercion experiences and psychological and behavioral health indexes among Black and White young women?

Consistent with extant literature, we hypothesized that for participants who were sexually coerced, those who endorsed greater sexual stereotypes would have lower levels of psychological and behavioral health and that this pattern would be consistent across Black and White young women.

Method

Participants

Participants were part of a larger investigation examining the sexual coercion experiences among adolescents. The current study analyzed data from 221 Black (n = 107, 48%) and White (n = 114, 52%) young women only. The majority of Black participants identified as African American (n = 97, 90%); the remaining Black participants identified as having African (e.g., Nigerian, Ethiopian, Ghanaian) or Jamaican ancestry. White participants identified a range of European ethnicities, including Irish, Polish, and English. We excluded participants who identified as biracial or multiracial given the small sample size (n = 20), and we did not want to arbitrarily identify these participants as either Black or White. Participant ages ranged from 14 to 19 years (M = 18, SD = 1.3). Participants were recruited from two Midwestern high schools (n = 60, 27%) and a large public university in the Midwest (n = 161, 73%). The samples differed significantly on age; Black participants (M = 18.12, SD = 0.92) were significantly older than White participants (M = 17.88, SD = 1.52; F = 20.25, $p < .001$). See Table 1 for sample demographics.

Measures

Demographic questionnaire. A demographic questionnaire asked participants to indicate their age, year in school, gender, race (i.e., marking all that apply), ethnicity (i.e., open-ended response), grade point average, mother and father education level, and qualification for need-based services (i.e., free or reduced-price lunch for high school students, need-based financial tuition assistance for college students).

Childhood sexual abuse. A slightly modified version of the Sexual Abuse subscale of the Childhood Trauma Questionnaire (Bernstein & Fink, 1998) was used to assess for a history of childhood sexual abuse. The Sexual Abuse

Table 1. Participants: Sample Demographics and Sexual Coercion Rates.

	Total Sample					Black				White			
	%	*n*	*M*	*SD*	*t*	%	*n*	*M*	*SD*	%	*n*	*M*	*SD*
Age[a]	—	—	17.9	1.27	1.41	—	—	18.12	0.92	—	—	17.88	1.52
FN	60	134	0.59	0.48	7.89***	85	91	0.82	0.36	38	43	0.37	0.48
SCI-T	53	116	3.43	5.27	–0.06	51	48	3.41	5.59	54	61	3.45	4.98
SCI-V	41	91	1.88	3.17	0.13	37	40	1.91	3.49	51	45	1.85	2.86
SCI-S	14	30	0.33	1.06	–1.35	9	10	0.23	0.84	18	20	0.42	1.22
SCI-P	44	98	1.24	2.26	.25	44	47	1.29	2.34	45	51	1.21	2.19

Note: FN = financial need; SCI-T = Sexual Coercion Inventory–Total; SCI-V = Sexual Coercion Inventory–Verbal; SCI-S = Sexual Coercion Inventory–Substance Facilitated; SCI-P = Sexual Coercion Inventory–Physical.

[a]Total sample: min = 14, max = 19; Black, min = 15, max = 19; White, min = 14, max = 19.

***$p < .001$.

subscale consists of 5 items rated on a 5-point Likert-type scale (1 = *never true*, 5 = *very often true*). Items were slightly modified such that we replaced the word *someone* with *an adult* to provide greater distinction between peer sexual coercion as measured and childhood sexual abuse (e.g., "An adult tried to make me do sexual things or watch sexual things"). Descriptive instructions were also provided to clarify adults from peers. Subscale scores ranged from 5 to 25, with higher scores representing greater childhood trauma. The Childhood Trauma Questionnaire has shown reliability estimates ranging from .91 to .94 (Bernstein, Ahluvalia, Pogge, & Handelsman, 1997; Scher, Stein, Asmundson, McCreary, & Forde, 2001) with racially diverse adults and adolescents. Construct validity was supported among a sample of racially diverse adolescent psychiatric patients, consistent with therapists' independent ratings of maltreatment type (Bernstein et al., 1997; Bernstein et al., 2003). Alpha coefficient estimates for the current sample were acceptable (.76 for the Black sample, .91 for the White sample) and consistent with previous studies using the Childhood Trauma Questionnaire with African American samples (Bradley, Schwartz, & Kaslow, 2005).

Sexual coercion. To assess participants' experience with sexually coercive incidents, a modified version of the Sexual Coercion Inventory (Waldner, Vaden-Goad, & Sikka, 1999) was used. The scale was modified to assess for attempted intercourse, and it included additional items on voluntary and involuntary substance use. The revised inventory is a 17-item instrument that asks participants whether or not they experienced various sexually coercive incidents through the use of verbal coercion (7 items; e.g., "My partner threatened to stop seeing me"), alcohol or drugs (4 items; e.g., "My partner encouraged me to drink alcohol and

then took advantage of me."), and physical coercion (6 items; e.g., "My partner threatened to use or did use a weapon"). If participants indicated that they did experience an incident, they were then asked to indicate the outcomes of each incident, described on a continuum of sexual behaviors that were ranked in severity (0 = *did not occur*, 1 = *kissing/fondling*, 2 = *attempted oral, anal, or vaginal sexual intercourse*, 3 = *completed oral, anal, or vaginal intercourse*). Responses were then summed for a total coercion experience score, as well as scores on verbal, substance facilitated, and physical coercion, weighted by outcome severity. We chose not to classify participants on the basis of the most "severe" type of sexual coercion (i.e., physical force), because in this study we were most interested in exploring the unique relations across the types of sexual coercion. Participants were asked to provide information for the most significant experience, and explicit instructions were included to distinguish from childhood sexual abuse. Specifically, instructions read,

> "Sometimes in a relationship, one partner wants to become more sexually involved than the other does. For the following list, indicate whether you have ever been pressured by a peer to engage in sexual behaviors (meaning vaginal, oral, or anal intercourse) even though you did NOT want to participate. For this survey, only refer to sexual experiences with a nonrelative peer (such as a boyfriend/girlfriend, friend, acquaintance, etc. but do not include potential sexual experiences with a family member)."

Reliability estimates for the total Sexual Coercion Inventory were $\alpha = .81$ for Black participants and $\alpha = .75$ for White participants, although the reporting of Cronbach's alpha may not be appropriate given that the scale operates as an index of experiences whose items do not necessarily relate to one another like attitudinal measures (Helms, Henze, Sass, & Misfud, 2006). Convergent validity was supported through correlations between subscales on the Sexual Coercion Inventory and the widely used Sexual Experiences Survey (Koss & Oros, 1982), which ranged from $r = .35$, $p < .01$ (substance-facilitated coercion), to $r = .50$, $p < .01$ (verbal coercion), for Black participants and $r = .34$, $p < .01$ (substance coercion), to $r = .59$ (verbal coercion) for White participants.

Sexual stereotypes. The shortened Sexual Stereotypes (Ward, Hansborough, & Walker, 2005) scale measures stereotypical themes about sex and sexual relationships common in the larger culture. The scale was selected for this study because of its inclusion of sexual stereotypes represented in the media and previous validation with racially diverse adolescents. The Sexual Stereotypes scale measures the belief that men are sex-driven creatures, women are sexual objects, and dating is a recreational sport where status and

looks dominate (e.g., "Using her body is the best way for a woman to attract a man."). The scale consists of 14 items rated on a 6-point Likert scale ranging from *strongly disagree* to *strongly agree*; higher scores represent greater endorsement of sexual stereotypes. This scale has shown acceptable reliability estimates with African American adolescents (α = .83; Ward et al., 2005), and subscale reliability ranged from .67 to .77 in a predominantly White sample of adolescents (Ward & Friedman, 2006). Reliability estimates for the current sample were acceptable (α = .83, Black; α = .79, White).

Self-esteem. The widely used Rosenberg Self-Esteem Scale (Rosenberg, 1965) was used to assess participants' level of self-esteem. It is a 10-item Likert-type scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*), with higher scores yielding higher levels of self-esteem. Participants were asked to rate their level of agreement with the given statements (e.g., "On the whole I am satisfied with myself"). The Rosenberg Self-Esteem Scale has demonstrated acceptable internal consistency, ranging from .61 to .84 among ethnically diverse adolescent samples (Chang, Bendel, Koopman, McGarvey, & Canterbury, 2003). Convergent validity has been found with self-confidence among adolescents (Shisslak et al., 1999). Internal consistency estimates for the current study were α = .85 for the Black sample and α = .90 for the White sample.

Psychological distress. The five-item version of the Mental Health Inventory (Berwick et al., 1991; Veit & Ware, 1983) was used to assess participants' level of psychological distress. The inventory is rated on a Likert-type scale that asks participants to indicate how much of the time they felt a specified way during the past month. Response options ranged from 1 (*all of the time*) to 6 (*none of the time*) for the given emotional descriptions (e.g., "Been a very nervous person," "Been a happy person"), with greater scores indicating greater psychological distress. Reliability estimates of α = .90 were found among a sample of predominantly White adolescents (Ostroff, Woolverton, Berry, & Lesko, 1996), and empirical validity has been established (McHorney & Ware, 1995). Reliability estimates for the current study were α = .83 for both Black and White participants.

Sexual risk taking. The Scale of Sexual Risk Taking (Metzler, Noell, & Biglan, 1992) was used to assess participants' engagement in risky sexual behavior; the scale was specifically chosen for this study because of its previous use examining adolescent sexual coercion and risky sexual behavior (Biglan et al., 1995). The 13 items assess participants' level of engagement with sexual risk taking, such as the amount of sex with nonmonogamous partners, number of sexual partners in the past year, and sex associated with alcohol. Response formats include yes/no, Likert type, and numerical indication, depending on the item. Reliability coefficients have ranged from α = .75 to .90 among a sample of racially diverse adolescents (Biglan et al., 1995), and it has

convergent validity with the Scale of AIDS Risk and significant relations to adolescent problem behaviors (Metzler et al., 1992). The alpha reliability estimates for the current sample were acceptable (α = .76, Black; α = .77, White).

Procedures

Institutional Review Board Human Subject approval was received prior to data collection. University participants completed the survey in one of three ways: an online electronic format at their own convenience (n = 45, 18%), a paper-and-pencil format in a classroom setting (n = 82, 33%), or a paper-and-pencil format in private, returning the completed survey to researchers 1 to 2 weeks later (n = 60, 24%). All of the high school participants completed a paper-and-pencil survey in a large classroom setting during regular school hours. The survey took approximately 20 to 30 minutes to complete. Investigators remained present during data collection for all high school participants, in case questions or concerns arose. Participants completing paper-and-pencil surveys were provided with opaque sheets of paper to cover their answers for greater anonymity. To investigate potential effects of data collection format, a multivariate analysis of variance was tested with survey format as the independent variable and with the predictor (i.e., sexual coercion), moderator (i.e., sexual stereotypes), and outcomes (i.e., self-esteem, psychological distress, sexual risk taking) as the criterion variables. No significant differences were found for Black participants, Wilks' λ = .92, F(8, 202) = 1.09, *ns*, or White participants, Wilks' λ = .92, F(8, 216) = 1.13, *ns*.

Participants under 18 years of age were required to provide active parental consent for participation as well as youth assent at the time of the survey. High school students 18 years of age or older were allowed to participate if they provided written consent. All university participants were required to be 18 years of age or older and provide written informed consent to participate. Survey participants received remuneration in the amount of a $5 gift certificate, and participating high schools and teachers received minor compensation as a token of appreciation.

Results

Did Black and White participants experience similar rates and severity of sexual coercion? To answer this research question, we examined descriptive statistics for means and frequencies of experiences and conducted t tests to determine mean differences between groups (see Table 1). Over half of the sample (53%, n = 116) experienced at least one form of sexual coercion, and 4 of 10 experienced

verbal ($n = 91$) or physical ($n = 98$) coercion strategies. Rates were comparable for Black and White young women. Half the sexual coercion experiences for both samples resulted in sexual intercourse.

Is there a link between type of sexually coercive experience and psychological and behavioral health, and do these relations differ by race? Zero-order intercorrelations were used to examine initial relations between sexual coercion experiences and psychological and behavioral health (see Table 2). For Black participants, total sexual coercion and nearly all sexual coercion types showed small to moderate relations ($r = –.27$ to .56) to each psychological and behavioral outcome. For White participants, all types of coercion were positively related to risky sexual behavior ($r = .21$ to .37), and total sexual coercion and physical coercion were negatively related to self-esteem ($r = .21$ to $–.22$) and positively related to psychological distress ($r = .22$ to .23). There were no significant mean differences between samples, with the exception of self-esteem; Black young women ($M = 35.20$; $SD = 4.93$) had significantly higher levels of self-esteem than their White counterparts ($M = 32.43$, $SD = 5.51$), $F(1, 219) = 15.37$, $p < .001$. To explore if patterns of correlations were different between Black and White samples, we conducted a between-group discriminant analysis of the covariance matrices, using LISREL SIMPLIS software. Goodness-of-fit results indicated that the matrices significantly differed from one another (minimum fit function, $\chi^2 = 725.16$, $p < .001$, $df = 55$, root mean square error of approximation = 0.146). Thus, to explore unique associations within and between racial groups, we conducted separate hierarchical regression models for the Black and White samples.

To examine if different types of sexually coercive experiences were associated with health, three hierarchical multiple regression models—with self-esteem, psychological distress, and sexual risk taking as the criterion variables—were conducted separately for Black and White participants using SPSS 19. In the first step of each analysis, childhood sexual abuse and age were entered as control variables. In the second step of each analysis, the three types of sexual coercion (i.e., verbal, substance facilitated, physical) and sexual stereotypes were entered. Results from the hierarchical multiple regression analyses are reported in Table 3.

The self-esteem and psychological distress regression models were significant only for Black participants. Substance-facilitated coercion and childhood sexual abuse negatively correlated with self-esteem among the Black participants, with the second step contributing an additional 7% of the variance, adjusted $R^2 = 18\%$, $F(6, 98) = 4.86$, $p < .001$. Substance-facilitated coercion was a significant positive predictor for psychological distress, with

Table 2. Bivariate Correlations.

	1	2	3	4	5	6	7	8	9	10	*M*	*SD*
1. Age		−.12	.02	−.08	.01	.17	−.17	.09	−.03	−.05	17.99	1.27
2. CTQ	−.15		.37**	.36**	.34**	.24*	.05	−.34**	.23*	.23*	5.62	2.32
3. SCI-T	−.02	.23*		.92**	.63**	.80**	.25*	−.31**	.36**	.56**	3.43	5.27
4. SCI-V	−.05	.16	.90**		.50**	.52**	.29**	−.27**	.32**	.56**	1.88	3.18
5. SCI-S	.19*	.03	.44**	.17		.40**	.26**	−.41**	.39**	.33**	0.33	1.06
6. SCI-P	−.11	.30**	.86**	.65**	.22*		.05	−.18	.24*	.37**	1.24	2.26
7. SS	−.19*	.16	.03	.08	.00	−.03		−.02	.09	.10	39.95	9.87
8. RSES	.14	−.12	−.21*	−.16	−.13	−.22*	−.07		−.54**	−.23*	33.77***	5.41
9. MHI	−.06	.05	.22*	.15	.13	.23*	.05	−.60**		−.23*	12.97	4.27
10. SSRT	.22*	−.05	.37**	.38**	.21*	.22*	.03	−.02	−.09		7.57	7.58

Note: Black participants above diagonal, White participants below. CTQ = Childhood Trauma Questionnaire; SCI-T = Sexual Coercion Inventory–Total; SCI-V = Sexual Coercion Inventory–Verbal; SCI-S = Sexual Coercion Inventory–Substance Facilitated; SCI-P = Sexual Coercion Inventory–Physical; SS = Sexual Stereotypes; RSES = Rosenberg Self-Esteem Scale; MHI = Mental Health Inventory; SSRT = Scale of Sexual Risk Taking.
*$p < .05$. **$p < .01$. ***$p < .001$.

the second step contributing an additional 9% of the variance, adjusted R^2 = 13%, $F(6, 98) = 3.55$, $p < .01$.

The models for sexual risk taking were significant for both Black participants, $F(6, 98) = 8.12$, $p < .001$, and White participants, $F(6, 104) = 4.83$, $p < .001$. The second step accounted for an additional 26% of the variance for Black participants and an additional 14% of the variance for White participants. Verbal coercion had a significant positive regression coefficient in sexual risk taking for both samples.

Do sexual stereotypes moderate the relations between sexual coercion experiences and psychological and behavioral health indexes, and are the pattern of associations similar across racial groups? To test for moderation, we followed guidelines set forth by Baron and Kenny (1986) and further articulated by Frazier and colleagues (Frazier, Tix, & Barron, 2004). Prior to the analyses, sexual coercion and sexual stereotypes were centered to reduce problems associated with multicollinearity (Frazier et al., 2004), and the interaction terms reflected the product of the centered variables. Age and childhood sexual abuse were entered as covariates in the first step of each analysis. In the second step of each analysis, centered total sexual coercion (predictor) and centered sexual stereotypes (moderator) were entered. To increase statistical power due to small sample size constraints, we used total sexual coercion experiences as opposed to sexual coercion types. The third step of each analysis examined interaction effects (i.e., Sexual Coercion × Sexual Stereotypes).

Table 3. Hierarchical Multiple Regression Analyses by Sexual Coercion Type.

	Black Sample					White Sample				
	B	*SE*	β	*F*	Adj. R^2	*B*	*SE*	β	*F*	Adj. R^2
Self-esteem										
Step 1										
Age	0.28	.50	.05			0.42	.36	.12		
CTQ	–0.94	.26	–.34***	7.11**	.11	–0.17	.19	–.09	1.32	.01
Step 2										
Age	0.41	.50	.08*			0.45	.37	.12		
CTQ	–0.58	.27	–.21			–0.06	.20	–.03		
SCI-V	–0.09	.17	–.06			–0.06	.24	–.03		
SCI-S	–1.99	.63	–.34**			–0.51	.45	–.11		
SCI-P	0.04	.23	.02			–0.37	.33	–.15		
ATDR	0.04	.05	.09	4.86***	.18	–0.02	.06	–.03	1.34	.02
Psychological distress										
Step 1										
Age	0.05	.46	.01			–0.22	.28	–.08		
CTQ	0.57	.24	–.24*	2.86	.04	0.05	.15	–.03	0.42	–.01
Step 2										
Age	–0.05	.46	–.01			–0.21	.29	–.07		
CTQ	–0.19	.25	.08			–0.06	.15	–.04		
SCI-V	0.17	.15	.13			–0.03	.18	–.02		
SCI-S	1.47	.58	.28**			0.34	.35	.10		
SCI-P	0.09	.21	.05			0.43	.26	.22		
ATDR	–0.01	.04	–.02	3.55**	.13	0.02	.05	.05	1.24	.01
Sexual risk taking										
Step 1										
Age	–0.07	.80	–.01			0.99	.49	.20		
CTQ	0.97	.41	.23*	2.79	.03	–0.11	.26	–.04	2.40	.03
Step 2										
Age	–0.20	.72	–.02			1.00	.47	.20		
CTQ	0.02	.39	.01			–0.30	.26	–.11		
SCI-V	1.10	.24	.51***			1.03	.30	.39***		
SCI-S	0.57	.91	.06			0.66	.56	.11		
SCI-P	0.29	.33	.09			–0.02	.42	–.01		
ATDR	–0.06	.06	–.08	8.12***	.29	0.04	.08	.04	4.83***	.17

Note: CTQ = Childhood Trauma Questionnaire; SCI-V = Sexual Coercion Inventory–Verbal; SCI-S = Sexual Coercion Inventory–Substance Facilitated; SCI-P = Sexual Coercion Inventory–Physical; ATDR = Attitude Toward Dating Relationships–Sexual Stereotypes.
*$p < .05$. **$p < .01$. ***$p < .001$.

Table 4. Moderation Analyses Using Hierarchical Multiple Regression.

	Black Sample					White Sample				
	B	*SE*	β	*F*	Adj. R^2	*B*	*SE*	β	*F*	Adj. R^2
Self-esteem										
Step 1										
Age	0.24	.50	.05			0.49	.34	.14		
CTQ	–0.94	.26	–.34***	7.11**	.10	–0.16	.19	–.08	1.60	.01
Step 2										
Age	0.37	.50	.07			0.49	.35	.14		
CTQ	–0.70	.28	–.25*			–0.06	.20	–.03		
SCI-T	–0.20	.09	–.23*			–0.22	.11	–.20*		
ATDR	0.02	.04	.05	4.81**	.13	–0.01	.06	–.01	1.96	.03
Step 3										
Age	0.34	.49	.06			0.53	.34	.15		
CTQ	–0.78	.27	–.28**			–0.12	.20	–.06		
SCI-T	–0.08	.10	–.09			–0.16	.11	–.14		
ATDR	0.03	.04	.07			–0.00	.06	–.00		
SCIT × ATDR	–0.02	.01	–.28**	5.62***	.18	0.02	.01	.19	2.32*	.06
Psychological distress										
Step 1										
Age	0.05	.46	.01			–0.14	.27	–.05		
CTQ	0.56	.24	.24*	2.88	.04	0.06	.15	.04	0.27	–.01
Step 2										
Age	–0.03	.45	–.01			–0.14	.27	–.05		
CTQ	0.27	.25	.11			–0.02	.15	–.01		
SCI-T	0.24	.08	.31**			0.19	.08	.22*		
ATDR	0.01	.04	.04	4.07**	.11	0.01	.05	.03	1.45	.02
Step 3										
Age	–0.02	.46	–.01			–0.18	.26	–.06		
CTQ	0.30	.25	.12			0.05	.15	.03		
SCI-T	–0.21	.09	.26			0.10	.08	.12		
ATDR	0.00	.04	.00			0.01	.05	.02		
SCIT × ATDR	0.01	.01	.10	3.44**	.10	–0.03	.01	–.29**	3.08*	.09
Sexual risk taking										
Step 1										
Age	–0.14	.80	–.02			1.03	.47	.21*		
CTQ	0.97	.41	.23*	2.88	.04	–0.11	.26	–.04	2.74	.03
Step 2										
Age	–0.50	.70	–.06			1.06	.44	.21*		
CTQ	0.06	.38	.01			–0.38	.25	–.14		
SCI-T	0.77	.13	.56			0.61	.13	.40***		
ATDR	–0.03	.06	–.04	11.6***	.29	0.05	.08	.06	6.92***	.17
Step 3										

(continued)

Table 4. (continued)

	Black Sample					White Sample				
	B	*SE*	β	*F*	Adj. R^2	*B*	*SE*	β	*F*	Adj. R^2
Age	–0.48	.70	–.06			1.06	.44	.21		
CTQ	0.10	.39	.02			–0.38	.25	–.14		
SCI-T	0.71	.14	.52***			0.61	.14	.40***		
ATDR	–0.04	.06	–.05			0.05	.08	.06		
SCIT × ATDR	0.01	.01	.09	9.44***	.29	0.00	.02	.00	5.48***	.17

Note: CTQ = Childhood Trauma Questionnaire; SCI-V = Sexual Coercion Inventory–Verbal; SCI-S = Sexual Coercion Inventory–Substance Facilitated; SCI-P = Sexual Coercion Inventory–Physical; ATDR = Attitude Toward Dating Relationships–Sexual Stereotypes.
*$p < .05$. **$p < .01$. ***$p < .001$.

Findings indicated a significant Sexual Coercion × Sexual Stereotypes interaction for both Black and White samples (see Table 4 and Figures 1 and 2). For Black participants, as expected, those with high experiences of sexual coercion and high endorsement of sexual stereotypes had the lowest levels of self-esteem. Rejection of sexual stereotypes seemed to buffer the relationship, as participants reporting more sexual coercion experiences and low endorsement of sexual stereotypes had higher levels of self-esteem compared to sexually coerced participants with moderate or high endorsement of sexual stereotypes. The tests of simple slopes were significant for high levels of sexual stereotype endorsement ($t = 22.92$, $p < .001$) and low ($t = -22.91$, $p < .001$).

For White participants, lower endorsement of sexual stereotypes magnified the association between sexual coercion and psychological distress. Specifically, White participants with greater sexual coercion experiences and low endorsement of sexual stereotypes showed the highest level of psychological distress. The tests of simple slopes were significant for low levels of sexual stereotypes ($t = 3.84$, $p < .001$). Moderation was not significant for self-esteem among White young women or for sexual risk taking among either sample.

Discussion

Sexual coercion is a major societal concern for young women in the United States. Consistent with findings on adolescents and young adults (e.g., Cecil & Matson, 2005; Koss et al., 1987), findings in this study indicate that over

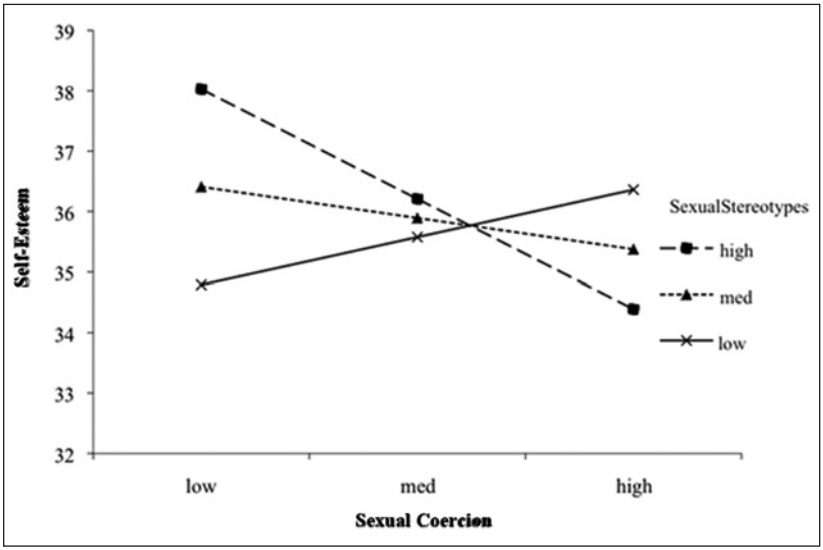

Figure 1. Plot of moderation effect for self-esteem with Black sample.

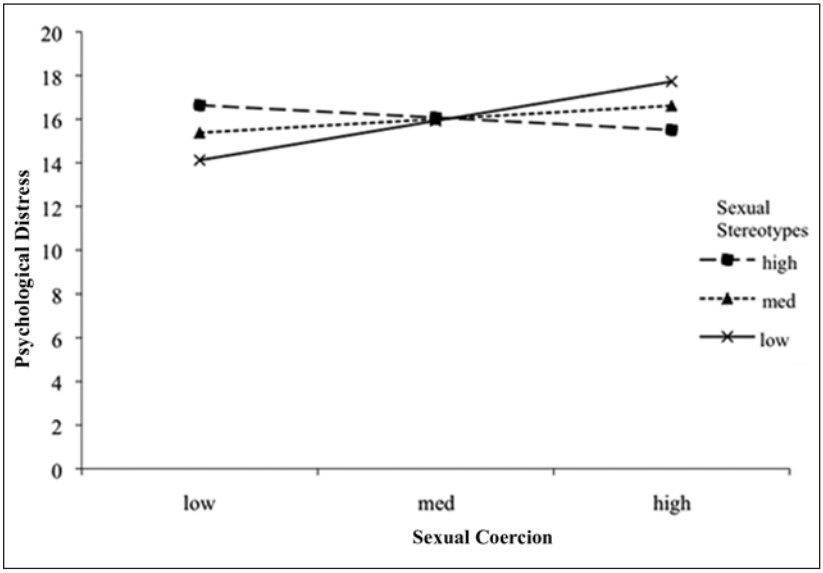

Figure 2. Plot of moderation effect for psychological distress with White sample.

half the sample experienced at least one type of sexual coercion, with physical and verbal coercion being most common tactic used. Although Black and White participants reported similar levels of sexual coercion, the associations between sexual coercion experiences and psychological health differed across the two samples. There were more significant predictors of health indices for Black young women compared to their White counterparts. For both samples, verbal coercion was significantly related to increased sexual risk taking. Additionally, substance-facilitated coercion was significantly related to both lower self-esteem and increased psychological distress among Black young women only. Results also suggest that lower endorsement of sexual stereotypes buffered the relation between sexual coercion and psychological health, with unique relations for Black participants (self-esteem) and White (psychological distress).

Reports of experiences with physical and substance-facilitated sexual coercion in this study both supported and contradicted the extant literature. We found that 4 in 10 participants reported some type of physical sexually coercive experience, which far surpasses the rates in the Centers for Disease Control and Prevention's Youth Risk Behavior Survey but is comparable to smaller-scale studies (Cecil & Matson, 2005). Broadening the definition and assessment of sexual coercion produced larger reports and may reflect young women's vulnerability to sexual victimization. Consistent with college, community, and high school samples, about 40% of the participants in this study reported at least one form of verbal coercion (e.g., Brown et al., 2009; Cecil & Matson, 2005; Zweig et al., 2002). Yet, the reports of substance-facilitated coercion in this study were much lower than those reported in other research (Brown et al., 2009; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007). Our sample was younger than previous samples and may not have had as much exposure or access to drinking and/or drug use compared to older adolescents and adults. Given the small sample sizes, few inferences about the prevalence of sexual coercion can be made, however, and results should be interpreted with caution.

Young women in the present study reported being coerced into sexual situations in a variety of ways, and these experiences were related to negative psychological and behavioral health for both Black and White participants. In this study, we found that verbal coercion, compared to physical force and substance-facilitated coercion, played a unique role in increased engagement in risky sexual behaviors. Other studies have found that forced sex among adolescents has been linked to greater sexual risk taking and acquisition of sexually transmitted infections (Noell, Rohde, Seeley, & Ochs, 2001). Young women who have experienced more subtle forms of coercion, such as verbal

tactics, may have difficulty resisting and may experience increased powerlessness in sexual situations—and thus "give in" to sexual demands and face challenges asserting condom negotiation. Studies have found that women who were verbally coerced reported lower levels of sexual assertiveness (Testa & Dermen, 1999). However, given the cross-sectional nature of the study, it is unclear whether sexual risk taking is a consequence of sexual coercion or a risk factor. Engaging in promiscuous sex, for example, also increases exposure to partners and the risk for sexually coercive situations.

We also found that for Black young women, greater substance-facilitated coercion accounted for a unique amount of variance in psychological distress and self-esteem. These findings are consistent with the literature. For example, Zinzow and colleagues (2010) found among a national sample of adult women that drug- and alcohol-facilitated rape was significantly related to posttraumatic stress disorder symptoms, whereas Brown et al. (2009) found that substance-facilitated rape was related to greater self-blame.

We did not, however, find a significant relation between verbal coercion and self-esteem, as have other researchers (e.g., Testa & Dermen, 1999). It is plausible that because verbal coercion is a more subtle form of manipulation, victims/survivors may engage in greater self-blame for the incident, which in turn influences self-esteem. Neville and colleagues (2004) found that personal attributions of blame significantly mediated the relation between sexual assault and self-esteem. The lack of significant relation between any type of sexual coercion and self-esteem for White young women in this study is also an unexpected finding. It may be that an intervening variable (e.g., self-blame) that was not investigated in this study may help explain the link between verbal coercion and self-esteem among young White women. Also, in this context, Black young women may have a different experience of self-esteem compared to White young women. Researchers have speculated about the different roles of self-esteem across racial groups (e.g., Greene & Way, 2005). More empirical research is needed to explore potential cultural factors that may be related to the expression of self-esteem among young women who have experienced sexual coercion.

The most interesting finding is the moderating role of internalized sexual stereotypes in the association between sexual coercion and health. In this study, endorsing beliefs that women are sexual objects and men are driven by sex was related to lower levels of health for women with a larger number of sexual coercion experiences. As expected, Black young women who experienced greater levels of sexual coercion reported lower levels of self-esteem. Our finding partially supports previous mediation studies with Black adult women, where researchers found that those who believed they

were sexually assaulted because of the stereotype that Black women are sexually promiscuous in turn showed lower levels of self-esteem (Neville et al., 2004). Unexpectedly, internalization of sexual stereotypes among White young women appeared to buffer the relations between sexual coercion and psychological distress. As such, women with greater experiences of sexual coercion had the highest levels of psychological distress when their belief in sexual stereotypes was low. However, the magnitude of this finding was small. There may likely be a moderating variable that we have not examined in this study, which may explain this relationship. Perhaps by rejecting sexual stereotypes, women may feel as though they have less control and are more vulnerable to sexual coercion, thus experiencing increased distress. Frazier (2003) found that women survivors who focused on level of past control, either through behavioral self-blame or blaming the rapist, showed increased distress. More research is needed to replicate and extend these findings for greater understanding of the relationship among psychological distress, sexual stereotypes, and sexual coercion.

Taken together, these findings suggest a potential cultural mechanism operating in understanding the association between sexual coercion and health. These results suggest that the pressure for young women to fit the narrow socially prescribed definitions of sexuality and relationships may further intensify the trauma of sexual coercion. Young women who endorse more stereotypical beliefs about sex and sexual relationships are more likely to support myths about rape and sexual violence (see Ward, 2002, for a review). It may be that conservative sexual stereotypes serve to support a culture blaming women for sexual coercion; women who blame themselves for their victimization are more likely to report lower psychological health (Frazier, 1990). The unique relations to self-esteem and psychological distress for Black and White young women, respectively, may suggest cultural differences in the ways that young women process these sexual stereotypes. For Black young women, such internalization may contribute to how they see themselves as women in this society, whereas for White young women, such stereotypes may lead to a more global sense of sadness or distress but not necessarily influence their self-concept.

Limitations and Future Research Directions

Although findings from this study contribute to the literature, there are noteworthy limitations. In this study, we used the Sexual Coercion Inventory because it provides detailed information about various types of sexual coercion and it uses a continuum of sexual behaviors. Unfortunately, there is

limited available psychometric information to support the scale, although the inventory showed convergent validity with the widely used and psychometrically sound Sexual Experiences Survey (Koss & Oros, 1982). Other limitations were related to sample size, sampling bias, and data collection method. This study could have been strengthened with greater sampling of high school young women; however, constraints in data collection and gaining access to populations under 18 with sensitive topics made it difficult to increase our sample size with this age group, despite spending 2 years gaining access to public high schools and obtaining parental consent for students to participate. The sample sizes for Black and White young women independently were also small. We thought it important that research explore unique cultural processes of sexual coercion recovery rather than merely control for race or ethnicity as a confounding variable in the analyses. In addition, findings might be influenced by sampling bias such that participants who experienced some form of sexual coercion were more likely to agree to participate in the study compared to nationally representative samples. Also, we did not counterbalance the surveys, so we cannot determine order effects.

The results of this cross-sectional study are correlational; thus, inferences about their causal nature cannot be made. We encourage researchers to conduct longitudinal studies to test complex models predicting the relations between various types of sexual coercion experiences and psychological and behavioral adjustment among young women. This type of longitudinal work should explore earlier adolescents, such as middle school, given that youth at this development stage are beginning to form romantic and sexual interests. In addition to increased methodological sophistication, the use of more sophisticated analyses (e.g., cluster or latent class analyses) is needed to better explore interrelations between multiple types and severity of coercion and related sequelae. We know very little about the potential cultural variables that may help explain racial differences among young women and encourage future studies replicate and extend our findings by including potential mediating (e.g., self-blame) and moderating variables (e.g., racial-gender stereotypes) in understanding the relations between sexual coercion type and health outcomes.

Implications for Practice

Despite these limitations, the study offers important implications for intervention efforts with young women who have experienced sexual coercion. Sexual coercion occurs in various degrees of severity, and regardless of the severity level, these experiences are related to deleterious psychological and behavioral health indicators. The findings from this study can inform psychoeducational interventions about sexual coercion and consensual sex to raise awareness

among high school and college students about subtle forms of sexual coercion and their psychosocial correlates. Interventions should work to challenge sexual stereotypes and sexual objectification to promote healthier self-identities and interpersonal relationships (Szymanski, Carr, & Moffitt, 2011). It seems reasonable to include media literacy skills in such interventions. As such, participants could learn how to critically examine the messages and the sources of the messages they receive about girls, women, sex, and relationships. Participants could also explore the sexual messages they have internalized and those they challenge. Given the disproportionate rates of sexually transmitted infection and HIV among Black young women, understanding ways that pressured and coerced sex inform sexual behavior creates a more complete picture and helps to inform future research and culturally relevant prevention interventions. Prevention and intervention efforts that promote racial and gender pride, educate on the historical context of women's sexual oppression, and teach critical media literacy to challenge negative stereotypes could promote positive self-esteem and decrease psychological distress and sexual risk taking.

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Author Biographies

Bryana H. French is an assistant professor in the Department of Educational, School, and Counseling Psychology and the Black Studies program at the University of Missouri at Columbia. She is also an affiliate of the Women and Gender Studies Department. She is a member of Divisions 17, 35, and 45 of APA and of the Association of Black Psychologists. She is an MFP Fellow and prior MFP Policy intern with SAMHSA. Her research interests include adolescent sexual coercion, sexual scripting, and sexual health.

Helen A. Neville is a professor in the Departments of Educational Psychology and African American Studies at the University of Illinois at Urbana-Champaign. She is a member of Divisions 17 and 45 of the APA and of the Association of Black Psychologists. Her research on racial identity and beliefs have been published in a wide range of outlets and she is the lead editor of the Handbook of African American Psychology.