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## Sexual Violence Victimization and Associations with Health in a Community Sample of Hispanic Women

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### Abstract

This study sought to add to the limited information currently available on circumstances of sexual violence victimization and associated negative health experiences among Hispanic women. Data come from a community sample of mostly Mexican women in an urban southwestern city. Household interviews were completed with a sample of 142 women during 3 months in 2010. Findings indicate that 31.2% of women reported rape victimization and 22.7% reported being sexually coerced in their lifetime. Victims of rape and/or sexual coercion were significantly more likely to report symptoms of depression and post-traumatic stress disorder (PTSD) during their lifetime. Among victims whose first unwanted sexual experience resulted in rape and/or sexual coercion, perpetrators were almost always someone known to the victims, and were mostly family members or intimate partners, depending on the victim's age. About one-fifth of victims were injured and 17.1% needed medical services. These findings suggest the need for more attention to the physical and mental health needs of sexually victimized Hispanic women.

### Keywords

sexual violence; rape; sexual coercion; Hispanic women; negative health experiences; help-seeking

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The findings and conclusions from this study are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

## LITERATURE REVIEW

Sexual violence (SV) is a major public health problem, and although it occurs across all ethnic and racial groups, national prevalence studies have continued to find high rates of SV victimization among Hispanic women (Black et al., 2011; Tjaden & Thoennes, 2006). For example, findings from the National Intimate Partner and Sexual Violence Survey (NISVS), a recent nationally representative telephone survey, revealed that an estimated 1 in 7 Hispanic women (14.6%) living in the United States has been raped at some point in her life (Black et al., 2011). This finding is consistent with the earlier National Violence Against Women Survey, which found that 11.9% of Hispanic women experienced rape at some time in their lives (Tjaden & Thoennes, 2006). But SV includes more than forced penetrative acts, or rape. SV can include a range of unwanted acts such as unwanted sexual contact, non-physically forced sexually coercive acts, and attempted or forced penetration (Basile, Smith, Breiding, Black, & Mahendra, 2014).

Numerous studies demonstrate the pervasive physical, reproductive, and mental health consequences of SV in women including traumatic injuries, sexually transmitted infections, unintended pregnancy, post-traumatic stress disorder (PTSD), depression, and suicidality (Caetano & Cunradi, 2003; Campbell et al., 2002; Smith & Breiding, 2011; Temple, Weston, Rodriguez, & Marshall, 2007; Ullman & Brecklin, 2003). While there is limited information specifically on Hispanic samples, a few studies suggest that Hispanic and other racial/ethnic minority women may be heavily burdened by SV and related adverse health outcomes (Chen, Rovi, Vega, Jacobs, & Johnson, 2005; Lacey, McPherson, Samuel, Sears, & Head, 2013; Lown & Vega, 2001; Rodriguez et al., 2008; Temple et al., 2007). Related to mental health, one study of ethnically diverse female victims of SV by an intimate partner found significantly higher mean PTSD scores in Hispanic women than their White or African-American counterparts (McFarlane, Malecha, Watson, et al., 2005). However, other studies examining PTSD related to SV victimization have been mixed. An examination of the first wave of data from a longitudinal study of a low-income ethnically diverse population showed only a modest association between sexual assault and PTSD in Mexican-American women (7% of variance) compared to African-American (16%) or Euro-American (18%) women (Temple et al., 2007). In addition, Rodriguez and colleagues (2008) conducted a study of 210 pregnant Latinas who attended a prenatal clinic and found a significant association between experiencing intimate partner violence (IPV) and depression and PTSD. However, after controlling for other factors, IPV was not associated with PTSD but only with depression.

Depression symptoms, on the other hand, seem to be consistently associated with a history of SV or IPV victimization in Hispanic samples, in the small number of studies available. A study by Gonzalez-Guarda and colleagues (2009), of a community sample of Hispanic women in South Florida, found an association between reporting a history of IPV (including sexual violence) by a current or most recent partner and depression symptoms in the past week (Gonzalez-Guarda et al., 2009). A similar relationship was found between IPV and depression for pregnant Latina women (Rodriguez et al., 2008). We know less about the association of SV victimization and suicidality among Hispanic women in particular, although a previous study of female delinquent Hispanic adolescents found a high level of

comorbidity among suicide attempts, self-mutilation, and physical and sexual abuse (Cuellar & Curry, 2007). One study comparing suicidality in an ethnically diverse sample of women (of whom 40% were Hispanic) who were physically assaulted versus women who were both physically and sexually assaulted found that women who experienced both physical and sexual assault were 5.3 times more likely to attempt or consider suicide (McFarlane, Malecha, Gist, et al., 2005).

In addition to mental health, there are also physical and reproductive impacts of SV, and even less is known about these impacts in the Hispanic community. Although there is a dearth of information that describes the pregnancy impact of SV on Hispanic women, a study on IPV by McFarlane, Malecha, Watson, and colleagues (2005), focused on 148 African-American (33.1%), White (26.3%), and Hispanic women (40.5%) revealed that 20 of the 148 women reported having 32 pregnancies resulting from a sexual assault by an intimate partner. Of these 32 pregnancies 81% of the women had a live birth, 16% elected to have an abortion, and 1% had a stillborn. While there is less detail in the literature about physical injuries or sexually transmitted disease (STD) acquisition of Hispanic victims of SV, others have examined the association of SV victimization and overall health and certain chronic health problems. In a community sample of 1,155 Mexican-origin women currently living with a male partner, SV was positively associated with poorer self-assessed overall health, heart problems (including heart attacks), and chronic health problems (Lown & Vega, 2001). More recently, Lacey and colleagues (2013) used data from the National Violence Against Women Survey and found that among victims of abuse, Hispanic women reported having higher levels of poor general health than White or Black victims.

Previous work reveals that SV victimization of the general population of women starts early in life (Black et al., 2011; Tjaden & Thoennes, 2006). Although no literature to our knowledge documents the early onset of SV victimization of Hispanic women in particular, we would expect this to be the case given the heavy burden of SV among Hispanic populations. Extant literature suggests that family members may be a common perpetrator of SV against female Hispanic adolescents. One study of Black and Hispanic sexually abused girls and their caretakers found that Hispanic girls who had been sexually assaulted were more likely to be assaulted by their father or stepfather (Shaw, Lewis, Loeb, Rosado, & Rodriguez, 2001). However, previous work suggests that SV victimization *in adulthood* is most likely perpetrated by an intimate partner. Sorenson and Telles (1991) found in their community sample of Mexicans in Los Angeles that Mexican-born Mexican-American women who were sexually assaulted in adulthood were sexually assaulted by an intimate partner 31% of the time in which force was used by the partner and intercourse occurred. This was a higher rate than the same scenario among non-Hispanic White women (13%).

Some have argued (Bryant-Davis, Chung, & Tillman, 2009; Campbell et al., 2002; Kelly, 2010; Lacey et al., 2013; Lown & Vega, 2001; Sorenson & Telles, 1991) that both ethnic minority status and immigrant status may make Hispanics more prone to stressors that lead to or are associated with victimization. For example, given the relationship between poverty, as a risk factor for victimization (Caetano, Field, Ramisetty-Milker, & McGrath, 2005), and race/ethnicity, ethnic minority women are disproportionately more likely to be poor compared to their White counterparts, and are placed at particular risk for victimization and

poor outcomes. In addition, the cultural context of Hispanic women's lives may impact help-seeking after victimization. Previous research has shown mixed findings on the utilization of services among Hispanics, with some suggesting a possible pattern of low utilization of services by Hispanics (see Yoshioka, Gilbert, El-Bassel, & Baig-Amin, 2003). Analysis of a subset of victimized Hispanic women from a national sample of Latinas found that Hispanic female victims of SV were more likely to seek help from informal resources (58.3%) such as friends and family than formal resources (20.8%) such as medical care (Sabina, Cuevas, & Schally, 2012). In contrast, in a study of predominantly Mexican women who were battered, nearly half sought assistance from social services (Santiago & Morash, 1995). Moreover, in a more recent study of Hispanic women (Yoshioka et al., 2003), more than 40% sought help from a counselor, lawyer, or the police. For immigrant women, victimization can occur in the context of cultural isolation where such issues as language barriers, undocumented status, and fear of deportation can make access to resources difficult and often non-existent (Grossman & Lundy, 2007). Hispanic SV survivors with low income and resource challenges can be subjected to housing and food insecurity, as additional adverse conditions for themselves and their children. Although housing and food insecurity have not been directly explored in the literature among Hispanic SV survivors, previous work has shown that poverty is associated with SV and IPV victimization in the Hispanic community (Caetano, Cunradi, Schafer, & Clark, 2000; Cunradi, Caetano, & Schafer, 2002; Kantor, Jasinski, & Aldarondo, 1994).

There are still gaps in our knowledge about the experience and circumstances of SV among Hispanic women and its association with negative health. Given the high prevalence of SV among Hispanic women as evidenced in nationally representative population studies, and the documented health impact of SV on Hispanic women from a small number of studies, as well as SV victims more broadly (Smith & Breiding, 2011), it is important to understand better the circumstances of SV victimization and its association with negative health among Hispanic women. This study uses a community sample of Hispanic women, mostly Mexican-American, to share information about the circumstances of their rape and sexual coercion victimization and its association with numerous negative mental and physical health indicators as well as health-related behaviors. Findings from this study add to the literature by providing information on the health burden associated with penetrative forms of SV victimization among Hispanic women, a group for whom little information is available on SV and negative health.

## METHODS

### Sample

For this study, 142 Hispanic women completed a face-to-face paper-and-pencil interview. Eligibility requirements for this study were that participants be female, English-speaking, of Hispanic ethnicity, and 18 years or older. Descriptive analyses were conducted using the full sample. The women's ages ranged from 18 to 78 years old, with an average age of 34. Ninety-five percent of the sample was Mexican. Approximately 40% of the sample was married, and 37% was never married. Nearly 68% completed high school or greater. The women's total household incomes varied, but tended to be low: among those who provided

income data ( $N = 124$ ), 15.3% of participants reported an annual income of less than \$5,000; 11.3% reported an annual income of \$5,000 to \$9,999; 16.1% reported \$10,000 to \$14,999; 19.4% reported \$15,000 to \$24,999; 24.2% reported \$25,000 to \$49,999; and 13.7% reported \$50,000 or greater.

## Procedures

To ensure that interview questions were clearly interpreted and the instrument was culturally appropriate, a pilot test of a Hispanic sample of women was conducted and the instrument was revised.<sup>1</sup> To locate Hispanic women to complete the main study interviews, Hispanic neighborhoods in a large urban southwestern city and addresses within those neighborhoods were randomly chosen and interviewers went to those addresses to determine whether eligible women lived there. Three different neighborhoods were utilized for recruitment. Across the 3 neighborhoods, a total of 581 women were screened for eligibility for the study, and 204 women were deemed eligible. Of the 377 who were deemed ineligible, most (254) were ineligible because they were non-English-speaking. Of the 204 deemed eligible, 49 refused participation and attempts were being made to reach the remainder of the sample when the data collection period closed. A total of 142 women were interviewed for a completion rate of 69.6%. Potential participants were initially told that the study was about women's health and well-being. As a safety precaution, interviewers were instructed to reveal the specific nature of the survey—sexual violence—only to the selected participant in a safe, private location. The location was considered *safe* as long as both respondent and interviewer felt comfortable and *private* as long as the interview could be conducted out of earshot of other household members or other people around them. Both conditions had to be met before the informed consent process could begin. Interviews were conducted in May through July 2010 in person, most often at the participant's home, and lasted from 20 minutes to 2 hours, depending on the participant's experiences with SV. All women in the study received \$20 as a token of appreciation. Interviewers read the questions and response options to participants or showed them a card with a list of the response options pertaining to the question being asked.

## Measures

Participants were asked a range of questions about their health and SV victimization, including rape and sexual coercion. For all items, responses of “don't know” were re-coded as missing.

**History and Tactics of SV**—To determine their history of SV victimization, women were asked how many times in their life they experienced a form of completed or attempted sex (vaginal, anal, or oral) that was unwanted. *Rape* items consisted of *completed or attempted sex* after a perpetrator used physical force or threats of physical harm, gave the victim drugs or alcohol, or when the sex occurred when the victim was passed out, asleep, drunk, or high (and unable to provide consent to sex). *Sexual coercion* items consisted of *completed sex* after a perpetrator did any of the following: told lies, made false promises

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<sup>1</sup>NORC at the University of Chicago performed the pilot test and the main study interviewing, including obtaining Institutional Review Board approval.

about the future, or threatened to end a relationship or spread rumors; wore down the victim by repeatedly asking for sex; or used his or her influence or authority to make the victim engage in unwanted sex.

For all SV items, response options were never, 1 time, 2–5 times, 6–10 times, and more than 10 times. Responses were re-coded into dichotomous responses to indicate whether the respondent was *ever* victimized: 0 = never; 1 = 1 or more times.

### **Lifetime Mental Health Conditions**

**Depression and suicidality:** Participants were asked to indicate whether they ever felt sad, down, or hopeless almost every day for two weeks or more; had little interest or pleasure in doing things almost every day for two weeks or more; seriously considered attempting suicide; and actually attempted suicide. Response options were coded dichotomously: 1 = yes, 0 = no.

**PTSD:** Participants were asked to indicate whether they ever had an experience that was so frightening, horrible, or upsetting that for at least one month they had nightmares about it or thought about it when they did not want to; tried hard not to think about it or went out of their way to avoid situations that reminded them of it; were constantly on guard, watchful, or easily startled; felt numb or distant from others, activities, or their surroundings. Response options were coded dichotomously: 1 = yes, 0 = no.

First unwanted sexual experience was rape or sexual coercion. Among participants who endorsed any item of rape or sexual coercion during their lifetime, we focused on those victims whose first unwanted sexual experience was rape or sexual coercion. Variables analyzed for this subset were as follows:

- *Age of victim.* Age at first rape or sexual coercion was measured using the following response options: 12 or younger, 13–17, 18–29, 30–44, 45–59, 60–64, 65 or older, and don't know.
- *Age of perpetrator.* Age of the perpetrator at the time of the victim's first rape or sexual coercion was measured using the following response options: 12 or younger, 13–17, 18–29, 30–44, 45–59, 60–64, 65 or older, and don't know.
- *Race and ethnicity of perpetrator.* Participants were asked to (1) indicate whether the perpetrator was of Hispanic origin (yes/no) and to (2) provide the race of the perpetrator using the following response options: American Indian/Alaska Native (AIAN), Asian, Black or African-American, Native Hawaiian/Pacific Islander, White or Caucasian, Other, and don't know; if multiple races were selected, they were coded as "multiracial." Responses were re-coded into one variable for race/ethnicity with the following categories: Hispanic, AIAN; Hispanic, Asian; Hispanic, Black/African-American; Hispanic, Hawaiian/Pacific Islander; Hispanic, White; Hispanic, Other; Hispanic, Multiracial; Non-Hispanic, Asian; Non-Hispanic, Black/African-American; Non-Hispanic, Native Hawaiian/Pacific Islander; Non-Hispanic, White; Non-Hispanic, Other. "Don't know" responses were coded as missing.

- *Type of perpetrator.* Participants were asked to indicate how they knew the perpetrator. Four types of perpetrators were used to categorize responses: (1) *Intimate partner:* current or former boyfriend/girlfriend/romantic partner/significant other; current or former legal spouse, including common-law; or someone they were dating but who they would not label as a boyfriend/girlfriend; (2) *Friend/acquaintance:* friend; acquaintance; someone they were on a first date with; someone in a position of power or trust (e.g., employer, teacher, clergy, police officer); or someone else they knew; (3) *Family member;* and (4) *Stranger.*

### **Physical and Reproductive Health Conditions and Services Related to Their First Unwanted Sexual Experience Which Resulted in Rape or Sexual Coercion**

**Injury:** Participants were asked to indicate whether they experienced injuries from the rape or sexual coercion that resulted from their first unwanted sexual experience. Participants were specifically asked whether they experienced the following: minor bruises or scratches; cuts, major bruises, or black eyes; broken bones or teeth; being knocked out after getting hit, slammed against something, or choked; other injuries. Response options for each type of injury were coded dichotomously: 1 = yes, 0 = no.

**STD/HIV:** In separate questions, participants were asked to indicate whether they contracted a sexually transmitted disease or whether they contracted HIV, from the rape or sexual coercion that resulted from their first unwanted sexual experience. Response options were coded dichotomously: 1 = yes, 0 = no.

**Pregnancy and outcome of pregnancy:** Participants were asked to indicate whether (yes/no) they got pregnant from the rape or sexual coercion that resulted from their first unwanted sexual experience. If they answered yes, they were asked what happened to the pregnancy. Response options were the following: birthed and kept the baby; birthed the baby and placed him/her for adoption; had a miscarriage; had an abortion; don't know. In addition, participants were asked whether they lost an existing pregnancy as a result of their first experience of rape or sexual coercion; response options were coded dichotomously: 1 = yes, 0 = no.

**Rape kit exam:** Participants were asked to indicate whether they underwent a rape kit exam after the rape or sexual coercion that resulted from their first unwanted sexual experience: "Did a doctor or nurse take any physical evidence from you (for example, samples of bodily fluid for a 'rape kit')?" Response options were coded dichotomously: 1 = yes, 0 = no.

**Medical services, care, and hospitalization:** Participants were asked to indicate whether they needed medical care from a doctor or nurse due to the rape or sexual coercion that resulted from their first unwanted sexual experience. If they indicated yes, then they were asked if they were able to get the medical care they needed. In addition, participants were asked to indicate whether they had to stay at a hospital or get other inpatient medical care as a result of their experience of rape or sexual coercion. Response options for all questions were coded dichotomously: 1 = yes, 0 = no.

**Mental health services:** Participants were asked to indicate whether they needed mental health care from a therapist, counselor, or other mental health care provider due to the rape or sexual coercion that resulted from their first unwanted sexual experience. If they indicated yes, then they were asked if they were able to get the mental health services they needed. Response options for all questions were coded dichotomously: 1 = yes, 0 = no.

**Other services:** Participants were asked to indicate whether they needed housing services, community services, or victim's advocate services, and whether someone contacted the police due to the rape or sexual coercion that resulted from their first unwanted sexual experience. Response options were coded dichotomously: 1 = yes, 0 = no.

### **Consequences to Daily Life from the First Unwanted Sexual Experience**

**Which Was Rape or Sexual Coercion—**Participants were asked to indicate whether they felt safe in the neighborhood where they lived, whether they missed work, whether they stayed with family members or friends, and whether they relocated from the area in which they lived due to the rape or sexual coercion that resulted from their first unwanted sexual experience. Response options were coded dichotomously: 1 = yes, 0 = no.

## **Analyses**

First, we conducted analyses to determine the percentage of women from this community sample that experienced rape and/or sexual coercion in their lifetime. Next, we performed chi-square analyses to test for a relationship between mental health experiences and lifetime rape and/or sexual coercion victim status. Finally, we provide descriptive statistics regarding the characteristics and outcomes of a subset of the women for whom the first unwanted sexual experience was rape and/or sexual coercion.

## **FINDINGS**

### **Lifetime Experiences of Rape and/or Sexual Coercion in Full Sample**

In the full sample, more than one-third of participants (34.8%) indicated they were victims of rape, sexual coercion, or both at some point in their life. More specifically, 31.2% of women reported rape victimization and 22.7% reported sexual coercion in their lifetime. Nineteen percent of the full sample experienced both rape and sexual coercion in their lifetime.

**Mental Health Experiences—**Overall, 38.7% of the full sample experienced at least one symptom of PTSD, and 35.2% experienced at least one symptom of depression during their lifetime. Chi-square tests were performed which revealed statistically significant relationships between lifetime experience of rape and/or sexual coercion and individual symptoms of PTSD and depression. Among women who endorsed having experienced any PTSD symptom in their lifetime ( $N = 54$ ), 57.4% were victims of rape and/or sexual coercion ( $X^2(1) = 19.81, p = .001$ ). Among women who endorsed having experienced any symptom of depression in their lifetime ( $N = 50$ ), 54% were victims of rape and/or sexual coercion ( $X^2(1) = 12.66, p = .001$ ) (see Table 1).

In addition, 12 women (8.5%) in the full sample seriously considered suicide during their lifetime; among those, 7 women (58.3%) actually attempted suicide. Six of the seven women who both considered and attempted suicide were victims of rape and/or sexual coercion in their lifetime.

### **Characteristics of Victims Whose First Unwanted Sexual Experience Was Rape and/or Sexual Coercion**

Victims were asked a series of questions about their first unwanted sexual experience, such as their age when it happened and the person who victimized them. Here, we focus on those whose first unwanted sexual experience was rape and/or sexual coercion ( $N = 41$ ).

Of the 41 women who reported that rape or sexual coercion occurred during their first unwanted sexual experience, 73.2% ( $N = 30$ ) reported that the victimization occurred when they were under the age of 18. In Figure 1 we present the women's ages at their first unwanted sexual experience resulting in rape or sexual coercion.

**Age, Race/Ethnicity, and Type of Perpetrator**—Among the women who reported a rape or sexual coercion as their first unwanted sexual experience, perpetrators were male (100%) and known (92.7%) to the women in some capacity. The racial/ethnic identity of perpetrators was predominantly Hispanic, Other (46.3%), and Hispanic, White (43.9%). We examined the victims' age and type of perpetrator during their first unwanted sexual experience resulting in rape or sexual coercion. Among victims who were 12 and younger, perpetrators were exclusively family members (100%). Of victims who were 13 to 17 years old, perpetrators were family members (38.5%), intimate partners (30.8%), or friends/acquaintances (23.1%). Among 18- to 29-year-olds, perpetrators were mostly intimate partners (63.6%). See Table 2.

### **Consequences Experienced by Women Whose First Unwanted Sexual Experience Resulted in Rape or Sexual Coercion**

**Physical and Reproductive Health Outcomes**—Among women whose first unwanted sexual experience was rape or sexual coercion, 22% of victims suffered injuries (ranging from minor cuts to being knocked out). None of the victims contracted HIV, but 4.9% reported contracting a STD. Twelve percent of victims became pregnant as a result of the SV, and all gave birth and kept the baby (see Table 3). None of the women reported having lost an existing pregnancy after the rape or sexual coercion. Outcomes were not included in Table 3 if none of the sample endorsed them.

**Services Needed and Obtained**—Some women whose first unwanted sexual experience resulted in rape or sexual coercion reported that they needed services, including medical care, mental health care, community services, housing, victim advocacy, and police assistance. Findings revealed that 17.1% of victims needed medical care, and of them, 57.1% received those services; only 1 victim (2.4%) underwent a rape kit exam. None of the victims reported having stayed at a hospital as a result of the experience. Fifteen percent of victims stated that the police were contacted after the incident. Approximately 22% reported that they needed mental health services, and 33.3% of victims who needed them received

them. Approximately 2% to 12% needed community, housing, or victim advocacy services (see Table 3).

**Consequences to Daily Life**—Women whose first unwanted sexual experience resulted in rape or sexual coercion were asked about other consequences that impacted their daily lives after this first unwanted experience. Twelve percent of victims missed work because of the incident. In addition, 29.3% stated that they felt unsafe in their neighborhood afterward. Twenty-nine percent of victims reported that they stayed with family or friends, and 12.2% decided to relocate their residence.

## DISCUSSION

To our knowledge, this is the first study to examine the circumstances of rape and sexual coercion and the association of these types of violent victimization with numerous measures of adverse health in a dedicated sample of Hispanic women. Findings suggest that rape and sexual coercion victimization in the lives of Hispanic women in this sample tended to start early, be committed by someone known, and negatively impacted the women's health.

While few previous studies have examined age of first experience of SV among Hispanic women in particular, it is not surprising that the current study found an early age of first victimization given the consistent finding across general population samples that SV is a tragedy of youth (Black et al., 2011; Kilpatrick, Edmunds, & Seymour, 1992; Tjaden & Thoennes, 2006). Regarding the most likely perpetrator, previous work supports our findings that family members are a common perpetrator against Hispanic girls and young women (Shaw et al., 2001), and that intimate partners are more common perpetrators of rape against adult Hispanic female victims (Sorenson & Telles, 1991).

Findings of this study are consistent with other research indicating a combination of numerous negative health-related experiences in the histories of SV victims. For example, our findings about the association of SV victimization with suicidality are consistent with previous work (Cuellar & Curry, 2007; McFarlane, Malecha, Gist, et al., 2005; McFarlane, Malecha, Watson, et al., 2005). Other work supports this study's findings that victims were more likely than non-victims to report PTSD and depression symptoms (Gonzalez-Guarda et al., 2009; Temple et al., 2007). Little is known about acquiring STDs from or the pregnancy impact of rape and other sexual victimization among Hispanic women, and findings from this sample remind us that the impact of these outcomes are critically underexplored in the literature. Furthermore, 22% of women were injured as a result of their first unwanted experience of SV, and nearly one-third of victims reported feeling unsafe in their neighborhood post-victimization, which is further support for the traumatic physical and mental health impact of experiences of SV on the lives of Hispanic women.

A particularly remarkable finding, the women in this study did not report a great level of need of services as a result of their victimization experiences. While approximately 17% of victims reported needing services post-assault, only a little more than half (57%) of them received services. Only 15% reported that the police were contacted post-victimization, which is consistent with some previous work (Sabina et al., 2012). It is important to consider

that there may be a variety of structural and socio-cultural factors that contribute to the context in which Hispanic women experience SV and seek or do not seek post-victimization help. These factors may be especially relevant in the family and support infrastructure, accessibility to medical care, availability of culturally competent services, and immigration status, all of which could have a unique impact on the health outcomes of this population.

This study is a contribution to the dearth of literature focused on the circumstances and health impact of SV victimization of Hispanic women. Findings provide a more detailed picture of the SV experience among an urban southwestern sample of Hispanic (mostly Mexican) women. Another strength of this study is the measurement of SV victimization used, which was very detailed, including numerous tactics and using behaviorally specific questions, which likely improved disclosure. Furthermore, this study highlights the importance of understanding victims' needs for services. The study findings warrant future formative, qualitative exploration to determine how groups of Hispanic and other Spanish-speaking women SV victims define and perceive their post-victimization needs.

This study also has some limitations. First, the sample is from an urban neighborhood in a southwestern city, so the findings may not be generalizable to all Hispanic women. Second, the sample is relatively small, which limited our ability to conduct more complex statistical testing. In addition, due to space limitations, many of the measures (e.g., PTSD, depression) were adapted or created for this study instead of using longer preexisting validated measures. Also, the study only included one ethnic group of women so it did not enable comparisons to other racial/ethnic groups. Although the sample in this study is predominantly Mexican, future research with Hispanic and other Spanish-speaking groups is warranted to understand differences related to victimization and perpetration. In addition, the analyses conducted in this study only focused on rape and sexual coercion, and other types of SV such as unwanted sexual contact are not represented. The main SV variable used in this study combined rape and/or sexual coercion. Ideally, we would have examined rape experiences and sexual coercion victimization experiences separately so that we could determine if there were differences in the health associations linked to these two forms of SV. However, the experiences of the women in our sample did not enable us to examine rape and sexual coercion separately because a relatively large subset of the women in our sample experienced both rape and sexual coercion.

## CONCLUSION

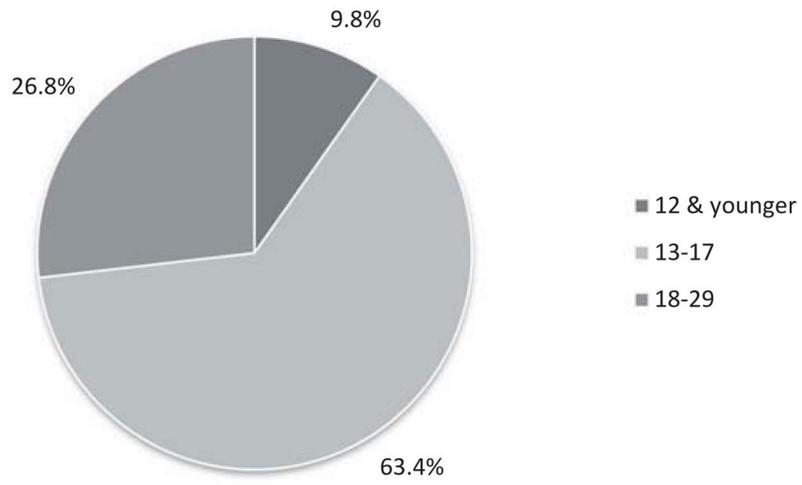
More research is needed about the experience of SV victimization among Hispanic women. Given the early age of first victimization and relatives as perpetrators reported in this sample, attention is needed in prevention research and program efforts for Hispanic girls and their families as an at-risk group. Practitioners and researchers must accurately assess the impact of SV victimization for Hispanic and Spanish-speaking women. Learning more about Hispanic victims' post-assault needs and the consequences they experience could inform the development of strategies for effectively serving them and mitigating the negative consequences of assault. For example, bilingual service providers may help eliminate barriers for disclosure and reporting for some Hispanic survivors. Understanding such cultural and preferred ways of help-seeking and service utilization is important for

prevention programs to be effective. Overall, these study findings have implications for the development and improvement of SV prevention and intervention with Hispanic women as an underserved and under-examined population.

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**FIGURE 1.** Age at victim's first unwanted sexual experience: Victims of rape or sexual coercion ( $N = 41$ ).

**TABLE 1**  
 Lifetime Mental Health Experiences by Lifetime Victim of Rape and/or Sexual Coercion

Participant Has Experienced	Victim		Non-Victim		Total		Chi-square
	%	N	%	N	%	N	
<i>PTSD symptoms (any)</i>	57.4%	31	42.6%	23	54	54	19.81*
Nightmares	62.9%	22	37.1%	13	35	35	16.22*
Avoided situations that reminded her of the experience	61.9%	26	38.1%	16	42	42	19.45*
Constantly on guard or easily startled	82.6%	19	17.4%	4	23	23	27.76*
Felt numb or distant from others or activities	55.3%	21	44.7%	17	38	38	9.65**
<i>Depression symptoms (any)</i>	54.0%	27	46.0%	23	50	50	12.66*
Felt sad, down, or hopeless for 2 weeks or more	64.1%	25	35.9%	14	39	39	20.48*
Little interest or pleasure in doing things for 2 weeks or more	59.0%	23	41.0%	16	39	39	13.95*

Note. Percentages represent proportion of victims or non-victims of rape or sexual coercion who endorsed the mental health experience.

\*  $p < .001$ .

\*\*  $p < .01$ .

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Victim Age and Perpetrator Type among Those Whose First Unwanted Sexual Experience Was Rape and/or Sexual Coercion (N = 41)

**TABLE 2**

	<u>Intimate partner</u>		<u>Family</u>		<u>Friend/ Acquaintance</u>		<u>Stranger</u>		<u>Total N</u>
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	
12 & younger	0	0.0	4	100%	0	0.0	0	0.0	4
13-17	8	30.8	10	38.4	6	23.1	2	7.7	26
18-29	7	63.6	2	18.2	1	9.1	1	9.1	11

TABLE 3

## Consequences of First Unwanted Sexual Experience (Rape and/or Sexual Coercion)

Consequences	Yes		No	
	%	N	%	N
<i>Physical</i>				
Injured	22.0%	9	78.0%	32
Minor bruises or scratches	100%	9	0%	0
Cuts, major bruises or black eyes, knocked out	66.7%	6	33.3%	3
<i>Reproductive Health</i>				
Contracted an STD	4.9%	2	95.1%	39
Became pregnant	12.0%	3	88.0%	22
Birthed and kept the baby	100%	3	0%	0
<i>Services</i>				
Needed medical services	17.1%	7	82.9%	34
Able to get medical services	57.1%	4	42.9%	3
Rape kit exam was performed	2.4%	1	97.6%	40
Needed mental health services	22.0%	9	78.0%	32
Able to get mental health services	33.3%	3	66.7%	6
Needed community services	2.4%	1	97.6%	40
Needed housing services	7.3%	3	92.7%	38
Needed victim advocacy services	12.2%	5	87.8%	36
Police were contacted	15.0%	6	85.0%	34
<i>Daily Life</i>				
Stayed with family or friends afterward	29.3%	12	70.7%	29
Relocated or changed residence afterward	12.2%	5	87.8%	36
Missed work afterward	12.2%	5	87.8%	36
Felt unsafe in neighborhood afterward	29.3%	12	70.7%	29