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Novel Methodologies using History to Document the Effects of African American Sexual Trauma: Perspectives of Gail E. Wyatt, PhD

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Abstract

This article describes the nearly half a century career of Dr. Gail E. Wyatt, PhD, and her development of novel methodologies and measures of sexual trauma, specifically the Wyatt Sex History Questionnaire (WSHQ) and the UCLA Life Adversities Screener (LADS). These approaches broke the silence around experiences of sexual violence, particularly among African Americans, identifying their effects on sexual functioning and mental health. These novel methods are designed without assuming sexual literacy of respondents, knowledge of anatomy, or that discussing sex is easy or common; they include topics that are considered private and may evoke emotions. Trained professionals administering face-to-face interviews can serve to establish rapport and educate the participant or client while minimizing possible discomfort and shame around the disclosure of sexual practices. In this article, four topics are discussed focusing on African Americans, but may also be relevant to other racial/ethnic groups: (a) Breaking the silence about sex; (b) Sexual harassment: It's disclosure and effects in the workplace; (c) Racial discrimination: Identifying its effects as a form of trauma; and (d) The cultural relevance of promoting sexual health. Historical patterns of abuse and trauma can no longer be ignored but need to be better understood by psychologists and used to improve policy and treatment standards. Recommendations for advancing the field using novel methods are provided.

Keywords

African Americans; novel methodologies; sexual abuse; trauma

Dr. Gail E. Wyatt's parents would say that her work developing novel methodologies built on historical events in order to document the effects of African American sexual trauma is based on what they taught her almost seven decades ago. As teachers and civil rights advocates, they told her stories about the effects of slavery and oppression on African

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In this manuscript, Dr. Wyatt is referred to in the third person, and "Wyatt's team," is used throughout the paper to refer to collective contributions.

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Americans that she never read in books. The stories were based on what happened to both sides of their families and why they had European American relatives; others were retellings of friends' and neighbors' attempts to live 'The American Dream'. This article similarly provides illustrations of how a face-to-face interviewing approach and inclusion of sexual harassment and discrimination may help to document their experiences.

This article describes the novel methodologies and measures that Wyatt and her team developed, specifically the Wyatt Sex History Questionnaire (WSHQ) and the UCLA Life Adversities Scale (LADS). They counter misconceptions about the effects of sexual violence and help to explain the reticence to discuss sexuality and trauma, in general, and African Americans in particular. New approaches for psychology departments and professional schools to adopt in training students on sensitive topics such as consensual and non-consensual sexual experiences, especially in working with people of color are presented. Psychologists should also be encouraged to include culturally and contextually relevant assessments and interventions when working with people who may have suffered traumatic sexual experiences. Doing so would correctively reshape the contributions psychologists can make in understanding their research participants and clients who are people of color. These efforts will facilitate the identification, prevention, and treatment of some of the long-term and cascading deleterious effects that impact health and mental health of individuals, families, and communities.

Dr. Gail E. Wyatt: History Informs Research

Growing up in a family of educators, Wyatt was encouraged to know her history as integral to defining who she was and establishing her life's goals. As a child, she was stunned to read that human beings were the personal property of other people. In the United States, beginning in 1919 and ending in 1865, enslaved Africans and their descendants were viewed as three-fifths human and treated as property (Berry, 2017; Shah & Adolphe, 2019). The personal identities of Africans, names, native language, and knowledge of their past family or tribal affiliations were stripped from them (Gutman, 1976). Enslaved people were not allowed to speak, look at, or touch their owners, or read or write without permission (Goodell, 1853); children born to enslaved women were also enslaved property. Enslaved Black people suffered extreme physical cruelty at the hands of White people as well as sexual trauma. Sexual assaults of African American men, women, and children were legal, profitable, and systematized. For example, they were powerless to resist sexual contact ordered or perpetuated by their owners; they became accustomed to remaining silent about this cruelty and abuse in order to survive. "Breeding" of the enslaved and rape were standard practices, despite being dehumanizing and depersonalizing. While these practices severely traumatized Africans and their descendants, slavery benefitted slave owners and helped to build this country's wealth. The innumerable contributions of enslaved Black people have been widely ignored in history books despite America's tremendous prosperity as a result of slavery (National Humanities Center, 2009).

African Americans have been "free" (i.e., recognized as fully human citizens) in the U.S. for less time than they were enslaved; they are merely two- to four-generations out of slavery (Berry, 2017). Further exacerbating the historical trauma experienced during two and

one-half centuries of slavery, emancipation was followed by another 200 years of covert violence and overt oppression in the aftermath of Reconstruction during the Jim Crow era (Shah & Adolphe, 2019). These laws legalized racial segregation and discrimination until the mid-1960's. While the American Psychological Association (APA) has publicly apologized for its historical role in promoting racist practices and beliefs (APA Council of Representatives, 2021), psychology as a discipline has yet to adequately take action to address faulty notions that affect Americans today. Overdue is APA's call for research to better identify the deleterious effects of generational oppression and trauma, including their effects on the mental and emotional health (APA Council of Representatives, 2021; Mohatt et al., 2014; Wyatt, 2009) of descendants of the oppressed and oppressor.

Sexual Stereotypes Perpetuated by Healthcare Professionals

Most federally funded interventions to reduce sexual practices that might promote disease transmission of HIV/AIDS and sexually transmitted infections (STIs) do not consider or assess the effects of untreated historical sexual trauma of African Americans as a contributing factor to compulsive sexual practices (Wyatt, 1997). For example, providers and policy makers of health-related interventions need to be reminded that most African Americans were denied formal medical care (Owens & Fett, 2019) and education during centuries of enslavement. The Jim Crow era yielded marginal medical services limited by segregated health care and schools (Smith, 2005), unless provided by Black doctors and teachers (Nakayama et al., 2021). Interventionists who label Black American's behavior as 'non adherent', sexual practices as 'risky,' and providers as mistrustful (Prather et al., 2018) fail to recognize their historical lack of health literacy and access to trustworthy health and reproductive care. It is erroneous for investigators to expect that most Black and White Americans have had the same histories of health care and misinterpret causes of disparities between the groups (e.g., due to a lack of information about current health care), (Wyatt, 1997; 2009). Understanding anatomy, health and reproductive selfcare, and prevention of unwanted outcomes is not routinely taught across communities (Prather et al., 2018). As such, the effects of sexual violence and coercion, and efforts to promote sustainable, culturally relevant behavior change became an area of Wyatt's great interest. She pioneered the development of a methodology that would: (a) increase rapport, comfort and decrease mistrust;(b) ask explicit questions, define sexual practices, organize questions by age and consent; (c) capture the effects of sexual abuse and trauma that results from these experiences; and (d) develop interventions that would improve symptoms of post-traumatic stress and depression (Fox-Genovese, 1988; Wyatt, 1997). The genesis of this work began while she was a young psychology major at historically Black Fisk University whose focus was to learn how to conduct research with these goals in mind.

Wyatt continued her work as an early career professional and was the first recipient of color to receive a National Institutes of Health (NIH) Research Scientist Career Development, or 'K' Award, to fund training as a sex researcher. This award was contingent upon receiving a National Institute of Mental Health (NIMH) R01 grant to describe factors affecting the sexual experiences of African American women. Wyatt was also one of the first formally trained sex therapists and investigators to examine how sexual coercion affects sexual and mental health. In 1980, she visited the Kinsey Institute, one of the first institutes devoted

to studying sexual health. She found that their practice considered middle-aged White men to be the best interviewers of men and women, regardless of race/ethnicity, age, or sexual orientation (Wyatt et al., 1988a; Wyatt et al., 1988b). It became clear that how and by whom sensitive questions about sexual experiences were asked could influence the accuracy of answers provided.

Prior to Wyatt's published work, incidents of abuse had been documented, but rarely with adequate samples using rigorous statistical methods (Gutman, 1976). Many studies compared African Americans to European Americans (Kinsey et al., 1953), despite the samples being substantially disparate (e.g., education, employment status, income, location [rural versus urban]). Wyatt discussed these issues in early publications critiquing Kinsey's work (Wyatt et al., 1988a; Wyatt et al., 1988b). When demographic characteristics of the two racial/ethnic groups were controlled using census data to recruit and interview African American and European American women with comparable ages, education, marital and work status, and geographic location, few differences in sexual practices and experiences with sexual violence were noted. These findings suggested that early nonconsensual sexual experiences that increase women's risk for early unintended pregnancies, HIV/AIDS and STI transmission were as much a product of socio-demographic characteristics, environments and lived experiences as culture or race/ethnicity (Wyatt et al., 2002).

Measures and Methods: Four Areas of Research

Many of Wyatt's NIH-funded studies were published with a core research team over the past 40 years, among which four areas of work uniquely experienced by African American men, women, and children are discussed here: (a) *Breaking the Silence about sex*; (b) *Sexual Harassment*; (c) *Racial Discrimination as Trauma;* and (d) *Cultural Relevance of Sexual Health*. Some of the research presented references two of Wyatt's books, "Stolen Women: Reclaiming our Sexuality, Taking Back our Lives," (Wyatt, 1997) and "Sexual Abuse and Consensual Sex: Women's Developmental Patterns and Outcomes" (Wyatt et al., 1993b). This research describes the measures and methods used to advance both sexual and mental health trauma research. Tools are provided for clinicians and investigators to collect more comprehensive, better documented, culturally and contextually accurate consensual and non-consensual sexual experiences that affect African American's physical and mental health.

Breaking the Silence about Sex

Given well-established histories of sexual violence for over 200 years, most African American families relied on cultural and religious teachings to encourage responsible sexual practices (Wyatt, 1997). To counter widespread stereotypes dating back to slavery (e.g., African Americans were unintelligent and promiscuous), African American families communicated to their children strict prohibitions against sexual activity before marriage. Certain sexual practices such as oral and anal sex were considered unacceptable and indicative of a promiscuous lifestyle and upbringing (Wyatt, 1997). Religious and cultural messages passed down from one generation to the next promoted 'the missionary position during sexual intercourse' were indicative of how Africans and their American descendants dictated norms of sexual expression. Any gap between cultural values and individual

behavior often generated guilt, shame, depression and anxiety and silence that could result in a repetition of risky, often coerced sexual practices and substance abuse to numb shameful feelings. The growing interest in documenting the effects of nonconsensual sexual practices yielded other research but differed in methods of studying abuse and its effects (Paolucci et al., 2001).

Wyatt first noted in the 1980's that investigators such as John Briere, David Finkelhor, and Diana Russell wrote about the effects of child sexual abuse but used pen-and-paper self-report measures to assess incidents and the effects (Briere, 1996; Finkelhor et al., 1997; Russell, 1983). Many early studies of sexual abuse used age 14 as the cut-off for childhood. Wyatt's studies used age 18, the legal age of adulthood and sexual consent (Wyatt et al., 1993a). These early studies also relied on European American college student samples (Koss & Gidycz, 1985) and described the effects of abuse on highly educated women (Briere, 1996), while Wyatt's studies were based on community samples in ethnically diverse, lower-income areas (Wyatt et al., 1999).

Defining and Assessing Consensual and Non-Consensual Sexual Experiences—Given the variety of methods of collecting histories of sexual experiences and lack of acknowledgement that discussions about sex were infrequent in most homes, Wyatt developed the Wyatt Sexual History Questionnaire (WSHQ; Wyatt et al., 1993a).

Separating Child from Adult Incidents, Consensual Sex from Non-consensual Abuse.: The WSHQ was one of the first assessments to include separate information on child and adult incidents and to distinguish consensual sex from non-consensual abuse. Questions pertaining to consensual and non-consensual behaviors or experiences before age 18 were asked chronologically, followed by questions pertaining to experiences since age 18. In order to capture the methods described above to assess the impact of non-consensual sexual experiences and their subsequent effects on sexual functioning and mental health, the WSHQ helped to fill that gap (Wyatt et al., 1993a). The WSHQ was an improvement over extant measures; sexual socialization or how the participant learned about sex captured the sexual climate in which children grew up. Because the frequent sexual harassment experiences on working domestic workers and other service jobs (often staffed by people of color) were overlooked in research, Wyatt included it in the WSHQ (Wyatt et al., 1993b). Sexual abuse questions were asked at the end. Affirmative responses were followed by questions about each incident, including specific time frames (e.g., childhood, adolescence, and adulthood), with high internal consistency of responses ($r = .99$). A probability sample of African American and European American women were used to establish components of the WSHQ's reliability. For example, after interviewer training was complete, interrater reliability for severity of abuse averaged 0.90 (Wyatt et al., 1993b).

Asking Sensitive Questions Using Explicit Language.: Understanding that discomfort with asking and answering sensitive questions might be a barrier to obtaining accurate responses, Wyatt relied on methods used in clinical training with people of color. For example, during WSHQ training, interviewers were asked about their personal abuse histories. Those in need processed their own sexual history with a therapist before being permitted to conduct WSHQ interviews, thus avoiding re-traumatization and developing

reliable interviewers (Urquiza & Wyatt, 1997).The WSHQ's structured interview format is administered face-to-face with accompanying anatomical charts to locate body parts being discussed. This approach facilitated clarifying questions and comprehensive responses. Face-to-face interviewing has demonstrated superiority over paper-pencil self-report surveys where reading literacy, overall, and sexual literacy, specifically, have not been assessed or accommodated (Wyatt et al., 1993a). Other benefits included: (a) Establishing a common vocabulary between the interviewer and respondent: Accurate responses were obtained by a multi-step process describing and locating a body part on the anatomical chart, then referring to it by both the participant's colloquial term as well as the formal scientific name (Wyatt et al., 1993b). Some lay terms used by respondents to describe sexual anatomy personalized a body organ (e.g., for a penis: 'Mr. Johnson;' for a vagina: 'my kitty'); anatomical charts helped to clarify that the name given for a body part was indeed used during sex; (b) gender- and ethnic- matching to ensure comfort among people of color (Wyatt, 1990). Since sexual behavior has long been subjected to ethnic stereotypes (Thomas & Sillen, 1972; Wyatt, 1982), training and matching for race/ethnicity in sexual interviews, data collection, and treatment for sex-related issues decreased stereotyped assumptions and enhanced trust, especially in unfamiliar settings. Wyatt's research was informed by terms used to describe sexual activities, techniques to facilitate memory, clarifying the difference between consensual and non-consensual sex and asking how events came about thereby enhancing cultural and contextual relevance.

Defining Incidents of Sexual Abuse.: Earlier unpublished research using broader definitions eventuated to sexual abuse *incidents* being restricted to those involving body contact, including breast- or genital-fondling, and attempted or completed vaginal, anal, and/or oral intercourse. *Rape* was defined as the involuntary penetration of the vagina or anus by the penis or another object. *Attempted rape* was defined as an attempt to penetrate the vagina or anus with the penis or another object against one's will (Wyatt et al., 1993b). Child Sexual Abuse (CSA) was defined as "sexual body contact prior to age 18 with someone of any age or relationship to the respondent" (Wyatt, 1985). In order to distinguish exploitation from experimentation, additional clarifying criteria were added that included: (a) If the perpetrator was over 5 years older than the respondent; or (b) If sexual contact was with someone less than 5 years older but was not desired and/or involved coercion (Wyatt et al., 1993b). Adult Sexual Abuse (ASA) was defined as attempted and completed acts of forced and coerced penetration (Wyatt et al., 1993a).

Research findings determined that although widely used, the term "abuse" did not resonate with a research participant's or client's experience, particularly if they had not previously disclosed the incident to anyone (Stige et al., 2019). Consequently, Wyatt used behavioral descriptions of what occurred: "Was a penis ever inserted in your vagina against your will before age 18?" When asked about 'abuse', survivors often denied it, even though they may have provided a description that met criteria, like if the perpetrator was a trusted family member who had demonstrated affection for the survivor in the past. Intra-familial incidents of abuse are often the most painful for survivors to recall due to the betrayal of trust. The violation of trust is one of the most salient after-effects of abuse that can result in lifetime effects. A common but erroneous lay person's definition of 'abuse' was that the incident was

perpetrated by someone unknown to them. It was not until the late 1980's that date rape became understood as an acknowledged and common form of rape (Dude, 2014).

Similarly, CSA survivors often describe the initiation of sexual abuse as a 'game' like wrestling or being tickled. Only with follow-up questioning was it clear that: (a) the incident started as a game and progressed to more aggressive sexual behaviors; (b) those 'game' descriptions were used because survivors had insufficient vocabulary or comprehension for what actually happened. Once the interviews were conducted, survivors were informed that the behavior described was consistent with an abuse experience; or (c) the survivor was attempting to downplay the sexual nature of the behaviors for fear of being admonished, judged by the interviewer, or in legal violation of the survivor's rights. In some cases, the traumatic nature of the abuse experience had yet to be processed, thus avoidance of these types of discussions served as a defense against their occurrence (Fox-Genovese, 1988; Wyatt, 1997).

Anchoring and Bounding Methods to Increase Validity.: Techniques of *anchoring*, (i.e., using a key event, like going to the prom, then asking questions about sexual experiences around that event), and *bounding* (i.e., using two events, like entering and graduating from high school) to limit questions and responses to that period of time, were used to facilitate recall (Wyatt et al., 1993). Speaking openly and objectively about sex with a participant or client conveyed the message that there was no reason to be ashamed or to hide one's sexual history. Instead, this was an opportunity to ask questions about sexual health with an informed, non-judgmental professional.

Documenting the Prevalence of CSA and HIV in Community Samples.: In 1985, Wyatt's research first documented that 1 in 3 females were survivors of CSA before the age of 18 (Wyatt, 1985). This prevalence rate was obtained using the WSHQ with a multi-stage stratified probability sample of 248 African American and White women, aged 18–36 years, in Los Angeles County (Wyatt, 1985; Wyatt et al., 1993a). The psychology community's response to the high CSA rates resulted in disbelief because for some, it was unfathomable that such horrific events could be so commonly experienced by females under the age of 18. This disbelief was expressed by reviewers of manuscripts, which essentially doubted women's ability to self-report traumatic experiences and called into question the psychometrically sound and methodically rigorous research that Wyatt's team has described. Wyatt was conducting and disseminating new research findings that the research community was slow to accept.

Wyatt's team was also among the first to document that regardless of ethnic background, more severe histories of sexual and interpersonal violence were associated with increased sexual risk taking and a higher likelihood of HIV infection (Wyatt et al., 2002). This result has been replicated in other studies (El Bassel et al., 2010), but the reluctance of some HIV/AIDS researchers to ask about histories of sexual abuse of their patients persists.

A Multidimensional Approach to Trauma Measurement.: Using the WSHQ, Wyatt's team shifted from the prevalence of abuse and to developing multidimensional approaches that included characteristics (e.g., What happened? How old were you, about how old was

he/she? How many times did this happen with him/her?) associated with abuse incidents (Wyatt et al., 1999). This departure from existing research and methodologies demonstrated the vulnerability of survivors and the effects that these experiences had on mental health. These characteristics reflected the level of vulnerability of the survivor by including the severity, duration (i.e., how long incident(s) occurred), proximity (i.e., the victim's relationship to the perpetrator, such as family member, pastor, coach), and whether they reexperienced sexual abuse in adulthood. These experiences compromised survivors' ability to trust and made treatment difficult.

Next, Wyatt tested a cumulative assessment of sexual abuse that included these dimensions, using it to predict a composite measure of lifetime sexual health risks and revictimization that included: age of first consensual sex, number of sexual partners since age 18, sexually transmitted infections, unintended pregnancies, and incidents of rape/attempted rape. This produced an assessment that had significantly more predictive utility regarding the effects of sexual trauma than a standard variable that indicated the presence or absence of sexual abuse (Loeb et al., 2011). The finding provided support for the idea that multidimensional constructs could be superior reflections of the lived experiences of survivors of trauma and adversity than dichotomous variables (Loeb et al., 2011).

The Importance of the Context in which Abuse Occurs.: The dearth of women of color in community samples in sexual abuse research limited the field's understanding of the salience of sociocultural contextual factors in buffering or compounding the effects of trauma on health and mental health risks (Glover et al., 2010). Wyatt's research pivoted away from focusing exclusively on the characteristics of one specific type of abuse, to consider the co-occurrence of other common types of trauma, including family adversity and chronic stress, among diverse community samples (Sciolla et al., 2011). Wyatt's team also began to consider pre-trauma contextual factors (e.g., age, ethnicity), peri-trauma factors (e.g., severity of abuse) and post-trauma factors (e.g., self-blame, disclosure) associated with health and mental health risks (Glover et al., 2010; Sciolla et al., 2011).

In 2010, Wyatt's team reported that severe CSA (involving rape or attempted rape) predicted overall post-traumatic stress symptoms, avoidance/numbing, and higher levels of cortisol (an indicator of stress) among a community sample of African American and Latina women (Glover et al., 2010). These relationships were not mediated by post-trauma factors of self-blame or disclosure and no racial/ethnic differences were noted (Glover et al., 2010). In addition, Wyatt's team reported that incidents of rape or attempted rape were associated with more severe symptoms of depression; controlling for other non-sexual traumas (i.e., childhood adversity and chronic stress),(Sciolla et al., 2011). This relationship was particularly strong among Latinas who disclosed their abuse. For African American women, those that disclosed and experienced high levels of self-blame at the time of the abuse reported more severe symptoms of depression (Sciolla at el., 2011). Identifying the relationships between pre-trauma (e.g., ethnicity), peri-trauma (e.g., CSA severity) and post-trauma (e.g., disclosure and self-blame) factors, mental health symptoms, and stress while controlling for other types of trauma also laid the groundwork for Wyatt's team's future development of multidimensional trauma and adversity measurement.

Assessing specific contextual details about an abuse incident (e.g., ethnicity of victim and abuser, abuse setting, location, severity, and length of time abuse occurred; Wyatt et al., 1999) provided clinicians with information to help clients to address the origins of lasting symptoms like numbing and avoiding sex that may have occurred later in life. The disclosure and description of a participant's or client's specific conditions of their sexual trauma experience in a safe, supportive environment, aided in building the therapeutic alliance, buffered negative effects of lack of trust, and allowed clinicians to tailor treatment to the unique circumstances.

Another form of abuse, sexual harassment in the workplace, soon became the focus of national attention during the Clarence Thomas Supreme Court hearings. Questions about sexual harassment in the workplace had been included in the WSHQ (1993a).

"Me Too": The Effects of Sexual Harassment in the Workplace

Including data collected with the WSHQ, efforts to address sexual harassment in the workplace occurred before the contemporary movement known as #MeToo. The #MeToo Movement has highlighted the complex and nuanced nature of a sexualized climate in numerous settings, especially the workplace. In 2006, Tarana Burke, an African American survivor of rape and sexual assault, coined the phrase "Me Too" to inspire a social movement that has drawn attention to sexual abuse and harassment. The movement empowered victims to advocate for themselves and to report these incidents (Burke & Hinojosa, 2021). Considered sex discrimination, there are several forms of sexual harassment in the workplace, including *quid pro quo* harassment and hostile environment harassment (Browne, 2006) that may be verbal, non-verbal, and/or physical (Timmerman & Bejema, 1999). *Quid pro quo harassment* is when a worker is coerced or acquiesces to sexual requests or requirements to obtain workplace benefits (e.g., promotion) or to avoid costs (e.g., threatened demotions or dismissals). *Hostile environment harassment* involves a work setting that is sexual in a way that is unwelcome and unsettling (Hehman et al., 2022).

Predating the #MeToo movement, in 1991, during Senate confirmation hearings for Clarence Thomas, candidate for Associate Supreme Court Justice, attorney Anita Hill drew international attention to sexual harassment in the workplace. Hill testified about numerous instances where Thomas verbalized unwanted sexual comments to her as her supervisor 10 years prior at the Equal Employment Opportunity Commission. Hill did not report these incidents for fear that he or she would be fired or demoted, a common – and realistic – fear of victims of sexual harassment in the workplace. This is particularly true among African Americans: women who are often socialized to protect the image and public position of African American men.Despite the presence of several risk factors of sexual harassment (e.g., Hill's age and gender; Thomas as her male supervisor; working in a traditional, male oriented setting; polygraph test results that supported her allegations) (Ross, 1991), Hill was disbelieved, discredited, and vilified for her disclosure. Her career suffered. This outcome conveyed to women – especially African Americans – that there were punitive and long-standing emotional and financial consequences for making claims of sexual harassment in the workplace. In contrast, Thomas was confirmed and seated on the Supreme Court.

During the sensational and highly publicized Thomas-Hill hearing, Wyatt and Monika Riederle were analyzing WSHQ data on a community sample of African American and European American women's experiences with sexual harassment in the workplace (Wyatt & Riederle, 1995). They found that in this sample, the overall lifetime prevalence of sexual harassment (defined by unwanted requests, comments, and/or actions of a sexual nature) was 44%. More White women (53%) than Black women (34%) reported sexual harassment on the job (Wyatt & Riederle, 1995). Similar to other reports, Wyatt found that African American women tended to also underreport incidents of rape and CSA (Finoh & Sankofa, 2019;Wyatt,1990; 1993a). To date, there are few, if any, other studies of Black women's sexual harassment in the workplace. More research is needed.

Incidents of CSA, rape, and harassment (namely threats, intimidation, and control) were reminiscent of slavery and the Jim Crow era. Given Black women's stereotyped sexual promiscuity (Fox-Genovese, 1988; Getman, 1984; Wyatt, 1982), they may have feared the assumption that they brought these unwanted sexual advances upon themselves and thereby only reported the most severe incidents for which they might garner support (Finoh & Sankofa, 2019). To the contrary, our research findings were consistent with Ms. Hill's descriptions of what she endured and provided insights into why she did not disclose harassment to her supervisors.

In an effort to enter the empirical findings as Congressional testimony supporting Ms. Hill's claims, Wyatt made multiple attempts to contact Congresspersons working 'on The Hill' in Washington, DC, where she had previously testified before Congress. She also attempted to send the data to Ms. Hill's attorneys to support her contention that not having reported incidents of sexual harassment was typical for Black women. Wyatt found a similar pattern in her research. However, the data were not used in Hill's defense because her legal team did not believe the results. Years later, Wyatt was invited to Brandeis University by Ms. Hill to report the findings that Wyatt tried unsuccessfully to send in defense of her testimony. This reflected a lack of respect for the presence and authority of Black women to speak about their own sexual trauma experiences, especially when contrary to the beliefs of men. Federally funded research should include questions about sexual harassment in the evaluation of African American women's traumatic experiences as unique from other racial/ethnic groups (Wyatt, 1997).

When women and men with histories of sexual harassment seek therapy, it may be useful to share research findings about these incidents to provide context for their experiences. As more cases are pursued through lawsuits to corporate entities and universities, the effects of harassment need to be documented in psychological evaluations submitted for court review. Regardless of race/ethnicity or gender, there is less pressure to be silent. Survivors of sexual harassment are being educated that it no longer needs to be tolerated as a byproduct of work.

Including Racial Discrimination as a Type of Trauma

As the field of sexual violence and trauma research evolved, it became evident that discrimination might be a factor in Black women not being believed that they had been sexually harassed in the workplace and that their promiscuity was to blame for the harassment. In 2006, when Wyatt became director of the UCLA Center for Culture,

Trauma and Mental Health Disparities, also referred to as, “The Center”, she and her team interviewed 500 multi-ethnic participants with histories of CSA and/or interpersonal violence (IPV), including 230 African Americans and 270 Latinxs in the U.S. (Myers et al., 2015). A cumulative lifetime burden of adversities and trauma was a significant predictor of psychological distress (i.e., symptoms of depression and post-traumatic stress) for the whole sample, as well as for each ethnic group, prompting questions about whether racial discrimination or other experiences of trauma better predict symptoms of PTSD and depression. Results showed that it had a significant and independent contribution to the overall burden of lifetime adversities and trauma. Furthermore, among the various dimensions of racial discrimination, race-based social rejection was associated with symptoms of post-traumatic stress and depression more strongly than other dimensions, including stereotyping, threats and physical attacks, and police maltreatment (Chin et al., 2020). These findings underscored the traumatic effects of racial discrimination even in samples with cumulative incidents of trauma. Recent efforts by other researchers have further explored the intersection between racial trauma and sexual trauma in the lives of Black men and women, such as in cultural betrayal trauma theory (Gómez & Gobin, 2019).

Wyatt and her team next used the domains of cumulative lifetime adversities and trauma identified by this research. A confirmatory factor analysis using 21 items pooled across “The Center” studies was conducted. These domains included penetrative sexual abuse, perceived discrimination, and family, interpersonal, and community violence. The research team then used item reduction to develop the UCLA Life Adversities Scale (LADS; Liu et al., 2015), a brief five-item questionnaire to assess lifetime exposure to chronic adversities and trauma, including individual, interpersonal, family and community violence. The LADS was intended for use in primary care and therapeutic practice settings, and predicted symptoms of depression, anxiety, post-traumatic stress, and somatization in “The Center” sample (Liu et al., 2015).

Distinguishing the LADS from Commonly Used Adversity Assessments

While some of the items included on the Adverse Childhood Experiences Scale (ACES) were similar to those on the LADS, the former was standardized on a mostly White, middleclass, working, and insured sample of over 17,000 men and women (Felitti et al., 1998). The LADS was standardized on 550 African American and Latino/a English and Spanish speaking men and women who were: marginally employed or unemployed; with limited or no public insurance; unmarried but with partners; from lower socio-economic backgrounds, living well below the U.S. poverty level; and with less than a high school education. Accordingly, the LADS assessed trauma and adversities disproportionately experienced by marginalized communities of color (Liu et al., 2015; Myers et al., 2015).

The results suggest that experiences of what constituted trauma should not be generalized to all populations; culture and context must be considered. Further, questions about experiences of trauma should include racial discrimination. The lived experiences of people of color are at-risk of being marginalized unless there is enhanced recognition of what is culturally and contextually relevant in assessment, treatment, prevention, and future research. The latest version of the *Diagnostic and statistical manual of mental disorders* (5th ed., text

rev.)(DSM-5-TR; American Psychiatric Association, 2022) has made advances beyond previous editions to attempt to integrate cross-cultural considerations in various syndromes and disorders. For example, it includes a cultural formulation interview guide to help identify cultural factors that may influence signs and symptoms of mental disorders. It also encourages clinicians to consider context (e.g., culture, race, ethnicity, language spoken, religion, and geographic origin) in their assessment and treatment planning. Although an important advancement, it does not go far enough. Culturally and contextually relevant mental health assessments, diagnoses, and interventions need to be adapted, developed and routinely prioritized. More in depth information about culture and how it is expressed in behaviors that may be misconstrued as severe disorders is needed. A first step would be an understanding of how oppression and trauma shape a sense of personal freedom, self-awareness and boundaries in everyday life.

The Importance of the Culturally-Congruent Interventions

Broader cultural considerations also played a role in sexual risk assessment and prevention. Based on decades of her research, Wyatt identified four cultural tenants with historical roots that influence behaviors but may be used to promote sexual health among African Americans: (a) Ensure that participants or clients are encouraged to be their authentic selves in their dress, oral and body language, and avoid saying and doing what they think may be desired. Most people have an *adaptive duality that* requires knowledge about when to be less threatening and more acceptable to some Whites or people in authority (e.g., “acting White”). However, behavior change has to be rooted in self-acceptance and authenticity; (b) Interventions need to promote *personal control*: African Americans must learn to make healthy decisions for themselves by taking action to address long-term symptoms that will not improve without going to the doctor and accepting help; (c) Based on prohibitions during slavery and Jim Crow eras, long-established *indirect communication* patterns need to be replaced with direct communication and eye contact; and (d) Anticipate a *distrust of “outsiders”* (e.g., a degree of ‘healthy paranoia’ that protects against potential harm). Similar to code-switching (Salzmann & Auer, 2000), adaptive duality can be especially challenging when promoting safer sexual behaviors. For example, as there are fewer available African American men than women; women who desire an African American male partner might not insist on 100% condom use to ensure relationship stability or avoid conflict (Ickovics & Rodin, 1992; Wyatt et al., 2008). African American women may fear that their partner might believe they are promiscuous or suspect them of infidelity if they insist on condom use. Solutions include enhancing communication skills and providing sexual and reproductive health education.

Promoting Sexual Health and Understanding Resistance to Change

Building on experiences in developing culturally congruent projects, The Eban Study for Couples (El Bassel et al., 2010) and Healing our Women interventions(Chin, 2014), Wyatt proposed three content areas from a culturally-congruent Sexual Health Model for African American men and women to be incorporated in behavioral risk interventions: (a) Interconnectedness; (b) Sexual Ownership; and (c) Body Awareness (Wyatt et al., 2009).

Interconnectedness promotes behavior change by acknowledging the importance of family and social networks. It is represented by the statement, “I am because we are.” However, these values, along with economic factors, may conflict with sexual health efforts. Individuals may prefer to ‘keep the family together’ (Wyatt, 1997; 2009) and overlook sexual manipulation or abuse in a relationship. In Wyatt’s interventions, conversations about what consists of a healthy relationship were emphasized. While respecting the positive aspects of interconnectedness, strategies were discussed to assess individual risks to avoid incidents of domestic abuse or manipulation. *Sexual Ownership* acknowledges the practices during slavery where men and women did not have control over their bodies. In order to reclaim sexual decision making, individuals have a right to personal control, to change their minds at any juncture, and learn how to assume control in a safe, mutually respectful and healthy manner. Sexual and reproductive education is the key to sexual literacy. *Body Awareness* refers to a holistic view of sexuality that is aligned with skills to retain overall health and mind-body health.

National Studies on the Relationship Context-Sexual Health for Couples

While research on at-risk HIV/AIDS populations focused on individuals, Wyatt’s research team broadened the individualistic focus to include the dynamics of couples and the tenants of collectivist cultures in HIV preventive interventions. With Dr. Willo Pequegnat from NIMH as a Scientific Collaborator, Wyatt was instrumental in designing a national, multi-site intervention in cities chosen for their high HIV/STI rates. The Eban project developed and tested a culturally congruent, couples-based HIV behavioral intervention for over 500 HIV-serodiscordant African American couples (El-Bassel et al., 2010). Funded by NIMH for over a decade, this study demonstrated the Eban intervention’s efficacy in a cluster randomized trial (El-Bassel et al., 2010). It was also one of the first research collaborations funded by NIMH with people of color as principal investigators at all sites (i.e., Drs. El Bassel, Jemmott, Wingood, and Wyatt).

Heterosexual contact remains the most common method of transmission among African American women but only among 15 percent for African American men (Centers for Disease Control and Prevention [CDC], 2004, 2020). Guided by nested Ecological theory and Social Cognitive theory (NIH Center for Mental Health Research on AIDS, 2008), The Eban intervention included culturally relevant music, poetry, role-playing, men and women co-facilitators of groups, homework exercises, take home workbooks with anatomical charts and exercises, and learning to select lower-risk sexual practices (NIMH Multi-site HIV/STD Prevention Trial for African American Couples Group, 2008). The effective Eban intervention was then implemented in HIV-service organizations. Participants in the implementation trial reported basic resource challenges (e.g., housing, food, transportation instability) that created barriers to maintaining risk-reduction strategies over time. To capture real-world challenges of these resource poor couples, a *critical vulnerability* composite score was constructed. Intervention retention was higher among those with less vulnerability whereas symptoms of depression were associated with higher vulnerability (Wyatt et al., 2020). Providing culturally and contextually relevant interventions and quantifying vulnerability factors were novel methods of assessing well-being: They became hallmarks of Wyatt’s research. Examining factors that increased vulnerability helped to provide a

foundation for later implementation studies that moved the field from well-controlled clinical trials to real-world community-based preventive interventions for at-risk and underserved populations (Hamilton et al., 2015).

Conclusions and Future Directions

Sexual violence is part of American history. Silence about its effects on health and mental health fueled Wyatt's commitment to develop innovative methods and measures that would comprehensively describe incidents of consensual and non-consensual sexual experiences of African Americans and other understudied populations. A secondary goal was to develop therapeutic treatment strategies for trauma symptoms of post-traumatic stress and depression. The ability to prevent health problems such as disease transmission is dependent on national organizations like the American Psychological Association prioritizing sexual health as a historically ignored but important component of health and well-being. The reluctance to provide formal and informal education and discussions that promote sexual health has resulted in an avoidable epidemic of sexually transmitted illnesses and sexual violence, COVID-19 infections, and HIV/STIs and trauma, to name a few (Andersson, 2006). If untreated, they can cause premature death and/or a host of chronic physical and mental illnesses (U.S. Department of Health and Human Services, 2019). Consistent reports over time indicate that patterns of abuse and intergenerational trauma can no longer be ignored (Asare, 2022). Psychologists can and should be at the forefront to improve policy and treatment standards. To advance the field:

Psychology Training Programs

I. With cooperation from DSM-5-TR (American Psychiatric Association, 2022), organizations such as the National Institutes of Health should endorse standardized definitions, methods, and treatment strategies to obtain data from diverse populations. The chronicity of adverse experiences is important because cumulative effects may impact long-term health and mental health. It is disconcerting that the rates of sexual abuse have not significantly decreased in the almost 50 years that Wyatt has been conducting research. The DSM-5-TR (American Psychiatric Association, 2022) and its future editions need to integrate the impact that personal and historical sexual violence has on mental health treatment.

ll. Teaching institutions should provide frameworks that help to understand sexual health disparities comprehensively and objectively among African Americans and other underrepresented people of color (e.g., Mthembu et al., 2020). As part of their training and re-licensure, psychologists and mental health professionals should be required to take courses that challenge their biases and stereotypes of African American men and women.

lll. Institutions must prioritize increasing the number of African American psychologists by addressing affordability of graduate education. Black students incur disproportionately higher college debt than White students (Hanson, 2022). Historical debt makes graduate or professional schools less accessible (Scott-Clayton & Li, 2017). As such, funding specifically targeted for African American psychology graduate students should be a priority.

Clinical Implications

Overlooking cumulative traumatogenic experiences of people of color may result in under-diagnoses of PTSD and over-diagnosis of severe mental illness (e.g., schizophrenia, bipolar disorder), critically affecting treatment (Novacek et al., 2020; Sibrava et al., 2019).

Accuracy of Historical Accounts

An accurate, comprehensive, and detailed *recounting of American history* that begins with a focus on slavery (e.g., *The 1619 Project*; Hannah-Jones & New York Times Magazine, 2021) is needed to advance knowledge of how to heal from centuries-old sexual violence (Grills et al., 2016). As other groups have received national apologies and compensation for legalized horrific traumas inflicted upon them (e.g., Native people who were indigenous to the Americas, and interned Japanese Americans during World War II), effortful and significant recompense for descendants of enslaved African Americans is overdue (Cohen, 2020).

Although there is a movement to discount it (CRT; Kendi, 2021), Critical Race Theory needs to be examined to help understand the totality of America's history, painful or not (Crenshaw et al., 1996; George, 2021). Psychologists are aware that we cannot heal from experiences we avoid. My alma mater, Fisk University (an HBCU), taught its students the truth about who built this country, and the price that people of color have paid with their lives for being major, yet discounted, contributors to that history. With this knowledge, Dr. Henry Tomes gave Wyatt the confidence to develop her own research agenda and methods that yielded achievements reported here. Institutions like HBCUs that promote historical accuracy, instill courage, and inspire excellence must be recognized and supported so that the entire field of psychology benefits from these advances.

Doing the Right Thing

A recurring purpose throughout Wyatt's career has been to "do the right thing." This research has focused on marginalized people to broaden our understanding of sexual abuse and trauma based on people with a range of experiences. Going forward, the dynamic interdisciplinary research team and emerging academics from the U.S and in South Africa who interface with Wyatt's Center for Culture, Trauma, and Mental Health Disparities at UCLA will continue this work. Through NIH domestic and international training and mentoring programs, scholars and faculty have contributed to the presentations, grants and special issues generated from continuous federal funding since 1980. There are countless others, like Drs. Cheryl Grills and Thema Bryant Davis, who continue to make significant contributions as well. Numerous literary contributions like "Killing the Black Body" by Dorothy Roberts (1999), Patricia Hill Collins' "Black Sexual Politics" (2004) and "Hunger" by Roxane Gay (2017) provide historical and political perspectives to understanding sexual violence. The next generation of psychologists will begin careers with an understanding of how history can empower us to seek truth, promote advocacy, and advance healing.

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Public Significance Statement:

Understanding of historical patterns of sexual trauma and abuse experienced by African Americans will better inform psychologists so that they may provide culturally congruent assessments, diagnosis, treatment, and training.