Chapter Eight

Crucial Considerations in the Understanding and Treatment of Intimate Partner Violence in African American Couples

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When compared to their White and Latino/a counterparts, African Americans, whether as individuals or couples, consistently reported higher rates of overall, severe, mutual, and recurrent past year and lifetime physical IPV victimization and perpetration in general population, community, and university samples (for a review, see West, 2012). To illustrate, in a national survey, 45.1% of Black[1] women and 40.1% of Black men had been victims of sexual violence, physical aggression, and/or stalking that was committed by an intimate partner during their lifetime (Smith, Chen, Basile, Gilbert, Merrick, Patel, Walling, & Jain, 2017). Based on these prevalence rates, it is estimated that more than 6 million African American women and nearly 5 million African American men are survivors of some form of intimate partner violence (IPV) (Black, Basile, Breiding, Smith, Walters, Merrick, Chen, & Stevens, 2011).

The purpose of this chapter is to provide a brief overview of prevalence rates of IPV among African Americans, describe an ecological model, which is a more comprehensive theoretical approach to understanding the risk factors that elevate the probability that African American couples will experience intimate abuse, describe some of the challenges to understanding IPV in this population, and offer some suggestions for areas to explore when conducting a culturally sensitive assessment.

INTIMATE PARTNER VIOLENCE AMONG AFRICAN AMERICANS: AN OVERVIEW

In this section, I will define IPV, briefly discuss the prevalence rates of IPV among African Americans, highlight the patterns of relationship violence in these couples, and explain the gendered nature of partner violence. First, defining what constitutes intimate partner violence is challenging and complex; however, a comprehensive definition includes *physical aggression*, ranging from less injurious violence, such as slapping and shoving, to more lethal forms of violence, including beatings and assaults with weapons. *Rape* can take the form of completed or attempted alcohol- or drug-facilitated forced anal, oral, or digital penetration. Other forms of sexual violence include *reproductive coercion* (e.g., pressuring a woman to become pregnant against her wishes, preventing her from using birth control), *sexual coercion* (e.g., unwanted penetration obtained through nonphysical pressure), and *unwanted sexual contact* (e.g., kissing, fondling). Examples of *psychological aggression* include name-calling, insulting, or humiliating, and *coercive control* includes behaviors that are intended to monitor, control, or threaten an intimate partner. Finally, *stalking* encompasses being the recipient of unwanted communication via email or through social media; or being watched or followed at home, work, or school. These forms of violence can occur in any intimate partnership and can be perpetrated by legal or common-law spouses, boyfriends/girlfriends, cohabitating, dating, or casual sexual partners (Smith et al., 2017).

The National Intimate Partner and Sexual Violence Survey (NISVS) is an ongoing, nationally representative random digit dial telephone survey that collects information about experiences of sexual violence, intimate partner violence, and stalking among non-institutionalized English and Spanish speaking adults (9,086 women and 7,421 men) in the United States. Based on the NISVS, Black women reported a broad range of IPV victimization: 41% had been physically assaulted, 14.6% had been stalked, and 12.2% had been raped by an intimate partner during their lifetime. Too few Black men reported rape and stalking by an intimate partner to produce reliable prevalence estimates; however, 36.8% of Black men reported physical aggression that was perpetrated by an intimate partner during their lifetime (Breiding, Chen, & Black, 2014).

Ideally, both IPV victimization and perpetration should be measured in couples over time. This was accomplished in the National Longitudinal Couples Survey (NCLS) by interviewing both members of the couple in 1995 and 2000. In the 12 months before the 1995 survey, 23% of Black couples reported some form of male-to-female perpetrated partner violence (MFPV) and 30% reported some form of female-to-male perpetrated partner violence (FMPV). Most of the violence was categorized as minor or moderate (e.g.,

throwing items; pushing, shoving, grabbing; slapping) (Caetano, Cunradi, Clark, & Schafer, 2000). However, when Black couples were resurveyed in 2000, MFPV and FMPV minor physical assault (15% vs. 16%) and minor psychological aggression (53% vs. 51%) appeared to be comparable. In addition, Black couples reported similar rates of male-perpetrated and female-perpetrated severe physical assault (4% vs. 6%) and psychological aggression (28% vs. 30%) (Caetano, Field, Ramisetty-Mikler, & Lipsky, 2009).

Nevertheless, it is important to identify two patterns in relationship violence among African American couples. First, Black women were more likely to identify themselves as perpetrators than Black men were to identify themselves as victims (Caetano, Schafer, Field, & Nelson, 2002). For example, in the 1995 NCLS, Black couples more frequently reported female-perpetrated IPV than male-perpetrated IPV (30% vs. 23%, respectively). Although it was unclear if these gender differences were statistically significant, more Black women than men engaged in the following aggressive acts: threw something (22.1% vs. 5.4%); pushed, shoved, or grabbed (21.3% vs. 19.7%); slapped (9.7% vs. 7.8%); kicked, bit, hit (9.9% vs. 4.1%); and hit with something (15.8% vs. 5.1%) (Caetano et al., 2000).

Another important violent relationship pattern was the high frequency of mutual or bidirectional IPV. Specifically, 61% of Black couples reported that both partners had used physical aggression. One-third of Black couples who reported bidirectional partner violence described it as severe, defined as beat up, choked, raped, or threaten with a weapon. Five years later, 17% of Black couples continued to engage in mutual violence and 11% of those couples progressed into severe IPV. Moreover, bidirectional partner violence was reported independent of education, income, employment status, drinking, alcohol problems, and history of violence in the family of origin (Caetano, Ramisetty-Mikler, & Field, 2005).

Although not to minimize Black women's use of violence, it is important to pause here and put these findings into context. First, Black women's use of physical violence often occurs in the context of their victimization; therefore, it should not be concluded that they are the primary aggressors. Furthermore, these relationships may be better characterized as bidirectional asymmetric violence (Temple, Weston, & Marshall, 2005).[2] Alternatively stated, although the violence may appear to be mutual it does not mean that women's and men's violent acts or equivalent. When motives, frequency, and severity of violence are considered, the physical and mental health consequences associated with IPV are often greater for women (West, 2007).

To further illustrate the gendered nature of IPV, when compared to Black men and women of other ethnic groups, African American women were overrepresented among victims of certain severe forms of violence. For example, 40% of Black women have reported nonfatal strangulation (Glass, Laughon, Campbell, Block, Hanson, Sharps, & Taliaferro, 2008). Between

2003 and 2014, the rate of intimate partner homicide among Black women was 4.4 per 100,000, which was primarily committed by former or current intimate partners (Petrosky, Blair, Betz, Fowler, Jack, & Lyons, 2017). Finally, among Black couples, the overall rate of male-to-female sexual assault (MFSA) was 23.2%, which most commonly involved pressuring the partner (without the use of physical force) to engage in sexual intercourse, often without a condom. Although categorized as "minor," sexual coercion frequently occurred in conjunction with psychological abuse and physical violence (Ramisetty-Mikler, Caetano, & McGrath, 2007).

ECOLOGICAL MODEL: A COMPREHENSIVE THEORETICAL APPROACH

No single factor can explain why some people or groups are at higher risk for interpersonal violence; rather, violence is an outcome of a complex interaction among many factors. Therefore, in order to understand what accounts for the higher rates of IPV among Black Americans we need to utilize a theory that considers multiple risk factors (West, 2016c).

An ecological model, which considers risk factors at four levels, can be beneficial to help us understand IPV in the lives of African Americans (Centers for Disease Control and Prevention [CDC], 2009). At the *individual level* we should consider how a person's sociodemographic characteristics, such as social class or gender, and formative history, such as exposure to child abuse and substance use increase their risk of IPV. The *relationship level* considers the interactions between the survivor and her partner, family members, and peers. Whereas the *community level* considers the environment in which the person lives; for example, exposure to neighborhood crime. Finally, the ecological model includes larger *societal-level* factors, such as norms, policies, and structural inequalities, including racism and sexism (for a more detailed application of the ecological model to African American intimate partner violence see West, 2016c).

Below I will discuss individual-level (age, gender, income, alcohol use/abuse, and childhood victimization); relationship-level (relationship conflict); community-level (neighborhood poverty and community violence); and societal-level risk factors (experiences with racial discrimination) (see table 8.1). Although each level will be discussed separately, it is difficult to detangle the individual-, relationship-, community-, and societal-level correlates and risk factors associated with violence among African Americans because they are interrelated. For example, the combination of attitudes supporting IPV (individual-level), inadequate conflict resolution skills (relationship-level), and exposure to neighborhood violence (community-level) con-

verge to increase the risk that low-income, urban Black men will assault their intimate partners (Raiford, Seth, Braxton, & DiClemente, 2013).

INDIVIDUAL LEVEL

Age

Victimization occurs most frequently among younger individuals and couples. When compared to Black couples who were 40 years or older, the rates of severe IPV were more than three times greater among Black couples who were under age 30 (Hampton & Gelles, 1994).

Gender

Although Black couples reported a pattern of female-perpetrated (Caetano et al., 2000) and mutual IPV (Caetano et al., 2005), African American women also experienced high rates of severe gender-based violence. More specifically, when compared to Black men or women of ethnic groups, African American women reported higher rates of nonfatal strangulation (Glass et al., 2008), domestic violence homicide (femicide) (Violence Policy Center, 2016), rape/sexual assault, and stalking (Black et al., 2011).

Income

Annual household income had the greatest relative influence on the probability of partner violence, with lower income being associated with higher rates of IPV. Specifically, Black couples who reported either MFPV or FMPV had significantly lower mean annual incomes than nonviolent couples (Cunradi, Caetano, & Schafer, 2002).

Alcohol Use and Abuse

When faced with extreme, persistent, economic and social inequalities, individuals are more likely to use and abuse alcohol or drugs. There is substantial evidence that alcohol-related dependence indicators (e.g., withdrawal symptoms and alcohol tolerance), alcohol-related social problems (e.g., job loss, legal problems), and greater mean male and female alcohol consumption were especially strong predictors of IPV among African American couples, independent of who in the couple reported a drinking problem (Cunradi, Caetano, Clark, & Schafer, 1999).

Table 8.1. Summary of risk factors associated with violence among African Americans by ecological level

Risk Factors	Research Findings
Individual Level	
Age	• Rates of severe IPV were more than three times greater among Black couples under age 30 (Hampton & Gelles, 1994)
Gender	• Black couples reported a pattern of bidirectional violence (Caetano et al., 2005) • Black women reported higher rates of intimate partner homicide (Violence Policy Center, 2014) • Black women reported higher rates of rape and stalking (Black et al., 2011)
Income	• Black couples who reported MFPV ($22,838) had lower mean annual incomes than those couples who did not report MFPV ($32,685) (Cunradi, Caetano, & Schafer, 2002) • Black couples who reported FMPV ($23,238) had lower mean annual incomes than those couples who did not report FMPV ($33,541) (Cunradi, Caetano, & Schafer, 2002)
Alcohol use/ abuse	• Black couples with male alcohol problems were at a sevenfold risk for MFPV compared to those without male alcohol problems (Cunradi, Caetano, Clark, & Schafer, 1999) • Black couples reporting female alcohol problems had a fivefold risk for MFPV compared to those without female alcohol problems (Cunradi, Caetano, Clark, & Schafer, 1999) • Black women in the heaviest drinking category were twice as likely to report FMPV than abstainers and infrequent drinkers (Caetano, Cunradi, Clark, & Schafer, 2000)
Childhood victimization	• Black couples in which the female reported childhood violence victimization were more likely to report MFPV than couples in which the female did not report victimization (Cunradi, Caetano, Clark, & Schafer, 1999) • Blacks who were hit as a teenager by their mother or observed parental violence had higher rates of husband-to-wife violence (Hampton & Gelles, 1994) • Blacks who were hit as a teenager by either parent were twice as likely to be in households with severe intimate partner violence (Hampton & Gelles, 1994)
Relationship Level	
Relationship Conflict	• Nearly two-thirds of non-felony related homicides (168 out of 268) involved arguments between the Black female victim and male offender (Violence Policy Center, 2016) • The rates of IPV perpetration increased as attitudes supporting IPV increased among Black men who reported high ineffective couple conflict resolution skills (Raiford, Seth, Braxton, & DiClemente, 2013)

Community Level	
Neighborhood poverty	• The risk for MFPV was threefold higher among Black couples who lived in impoverished neighborhoods compared to those not living in poor areas (Cunradi, Caetano, Clark, & Schafer, 2000) • The risk for FMPV was twofold higher among Black couples who lived in impoverished neighborhoods compared to those not living in poor areas (Cunradi, Caetano, Clark, & Schafer, 2000)
Neighborhood violence	• Community violence was correlated with emotional dating victimization among young black urban women (Stueve & O'Donnell, 2008) • Perception that neighborhood violence was frequent, personal involvement in street violence, and gang violence were associated with IPV perpetration among urban Black men (Reed et al., 2009)
Societal Level	
Racial Discrimination	• Experiencing racial discrimination was a predictor of physical and emotional IPV victimization and perpetration among young, low-income, urban African American women (Stueve & O'Donnell, 2008) • Black men who reported high rates of racial discrimination perpetrated IPV in their current relationship when compared to those who reported less discrimination (28% vs. 16%) (Reed, Silverman, Ickovics, Gupta, Welles, Santana, & Raj, 2010)

Exposure to Family Violence During Childhood

Black children who experienced serious childhood or adolescent victimization in their homes, such as beatings and threats with weapons, were more likely to engage in both male- and female-perpetrated intimate partner violence in adulthood (Caetano et al., 2000). In addition, African Americans who witnessed violence between their parents or who were hit by either parent during their teenage years reported higher rates of husband-to-wife IPV in adulthood (Hampton & Gelles, 1994).

RELATIONSHIP LEVEL

Relationship Conflict

Relationship conflict has been associated with IPV and femicide. To illustrate, in a sample of low-income African American men, perceptions of how well they and their partners resolved conflict were measured by such items as: "By the end of an argument, you and your partner have really listened to each other," "You and your partner's arguments are left hanging and unsettled," and "You and your partner go for days being mad at each other."

Among Black men who reported high ineffective couple conflict resolution skills, the rates of IPV perpetration increased as attitudes supporting IPV increased (Raiford et al., 2013). Lack of conflict resolution skills, coupled with easy access to guns, can facilitate, escalate, and amplify anger, conflicts, and arguments. According to the Violence Policy Center (2016), nearly two-thirds (168 out of 268) of Black women were murdered by a male offender, most frequently a current or former boyfriend or husband, often during the course of an argument. Fifty-two percent (88 victims) were shot with a handgun.

COMMUNITY-LEVEL

Neighborhood Poverty

Approximately one-half of the Black couples in the NCLS resided in impoverished neighborhoods. Compared to Black couples who lived in more middle-class communities, those who lived in economically distressed areas were at a threefold risk for MFPV and a twofold increase for FMPV (Cunradi, Caetano, Clark, & Schafer, 2000). Thus, it appears that individual economic distress, in the form of low household income (Cunradi et al., 2002), and residing in poor neighborhoods worked in tandem to increase the risk of inflicting and sustaining IPV.

Neighborhood Violence

Exposure to community violence in any role (witness, victim, or perpetrator) has been associated with higher rates of intimate partner abuse. For example, community violence was correlated with emotional dating victimization among young Black urban women (Stueve & O'Donnell, 2008). Black men were more likely to batter their girlfriends if they had been involved in street violence, had a history of gang involvement, or perceived that there was a "great deal" of violence in their neighborhood (Reed, Silverman, Welles, Santana, Missmer, & Raj, 2009).

Discrimination

Among young, low-income, urban African Americans, IPV perpetration and victimization have been linked to microaggressions in the form of perceived racial discrimination in their community (e.g., being unfairly stopped and frisked by police or followed by store clerks, called insulting names, or physically attacked because of skin color/race). For example, experiencing the aforementioned forms of discrimination was a predictor of physical and emotional IPV victimization and perpetration among African American

women (Stueve & O'Donnell, 2008). Black men who reported high rates of such discrimination perpetrated IPV in their current relationship when compared to those who reported less discrimination (28% vs. 16%) (Reed, Silverman, Ickovics, Gupta, Welles, Santana, & Raj, 2010).

There are several benefits of using an ecological model. Researchers have persuasively argued that when individuals live with multiple community disadvantages, which have their foundations in historical and structural racism, their frustration and anger can spill over into intimate relationships and culminate in interpersonal violence, including homicide (Cheng & Lo, 2015). Thus, an ecological model moves us beyond viewing victimization as an abnormality or personal defect that resides within the individual survivor or within the relationship. Instead, an ecological model compels us to consider the structural inequalities and the context in which the survivor and the couple exist. Thereby, the web of trauma and the barriers to help-seeking in the lives of Black victim-survivors become more visible (West, 2016c).

CHALLENGES IN UNDERSTANDING INTIMATE PARTNER VIOLENCE AMONG AFRICAN AMERICANS

Our biggest challenges to understanding the pervasive nature of IPV among African American couples has been our failure to situate contemporary Black couple's experience with relationship violence in a historical context, our reluctance to recognize the similarities and parallels between the violence that is perpetrated by intimate partners and service providers who are tasked with helping survivors, and the erasure of the intersecting and multiple identities of survivors and perpetrators.

Historical Trauma

During 250 years of slavery, followed by 90 years of de facto and de jure segregation in the form of Jim Crow laws, and the shameful incompletion of the modern civil rights movement, one thing remained constant in the lives of African-Americans: high levels of interpersonal and institutional violence in the forms of beatings, rapes, lynchings (Williams-Washington, 2010, p. 32). This is not to suggest that every destructive act, including the perpetration of interpersonal violence, is the direct result of slavery. Exposure to racism, quality of their social support system, and knowledge of these historical events can determine how contemporary African Americans experience historical trauma. Still, slavery and its aftermath have left an indelible mark on the Black psyche and consciousnesses have hindered the ability of some African Americans to develop healthy interpersonal relationships (Dixon, 2017; Williams-Washington, 2010).

As previously discussed in the ecological model, exposure to racial discrimination is a societal-level risk factor that has been associated with IPV victimization and perpetration among low-income, urban African Americans (Reed et al., 2010; Stueve & O'Donnell, 2008). Empirical research is limited in this area. Furthermore, cross-sectional research is unable to establish the temporal sequence of discrimination and IPV; therefore, we cannot conclude that experiences with racial discrimination cause IPV perpetration or victimization. Still, it is important to investigate how Black male-female relationships are negatively impacted by this form of racial trauma.

Structural Violence

Beyond the psychological consequences of historical trauma, racial discrimination has created structural inequalities, in the form of higher rates of poverty, unemployment, and residential segregation that have increased the probability that Black Americans will experience all forms of violence in their families and communities. This is a reflection of *institutional racism*, which are unfair policies and discriminatory practices of particular institutions that have a disparate impact on people of color. Relatedly, *structural racism* is the cumulative and compounding effects of an array of societal factors including the history, cultural, ideology, and interactions of institutions and policies that systematically privilege White people and disadvantage people of color (West, 2016b, 2016c).

Too often, there are similarities and parallels between various forms of coercive control utilized by the abusive intimate partner as identified by the Power and Control Wheel (Chavis & Hill, 2009) and that are utilized by agents of the state and service providers who are tasked with assisting African American victims (for a detailed discussion, see West, 2016b). For example, after they are physically abused by their intimate partner, Black women sometimes face excessive force from police officers when they report the abuse. Black women are frequently psychologically, verbally, and emotionally abused by partners and then face a similar type of psychological maltreatment when they seek services from domestic violence shelters (Nnawulezi & Sullivan, 2014). Therefore, it is crucial that we acknowledge and understand how African Americans who have experienced IPV are sometimes mistreated by the institutions that should be assisting them.

Intersectionality and Multiple Identities

Intersectionality is a term coined by Kimberle Crenshaw (1994) to describe overlapping or intersecting social identities and related systems of oppression, domination, or discrimination as well as privilege and power. The premise is simple: "It is fallacious to suppose that one experiences abuse first

as a human being, then as a woman, then as a black person, then as a lesbian, and so forth. A woman's responses cannot be correlated to aspects of her social identity on a neat flowchart" (West, 1999, p. 56).

Alternatively stated, there is rich demographic diversity among Black Americans. In order to make these subpopulations more visible, it is important to use an intersectional analyses that considers the victims' social location in terms of age, socioeconomic class, ethnicity, and sexual orientation (for a visual representation of an intersectionality of cultural diversity among IPV survivors, see Lockhart & Mitchell, 2010). To illustrate, by understanding the social location in which low-income Black women reside, intersectionality can help us to understand how and why they experience IPV in the context of high rates of poverty, mass incarceration, housing instability, and community violence, which in turn, elevates their risk for a host of physical and mental health problems—HIV, substance abuse, and anxiety (O'Leary & Frew, 2017). Intersectionality can also help us to understand how current batterer intervention programs that focus on patriarchy as a cause of IPV perpetration are ineffective when they fail to consider ways in which Black men are disempowered by social, political, and economic inequalities (Waller, 2016).

CULTURALLY SENSITIVE ASSESSMENT

Even for the most seasoned professional, assessing for possible interpersonal violence can be intimidating. However, knowing what questions to ask and when can make the difference in providing the best care for victim-survivors (for a review of assessment tools see Carney, 2015; Mortiere, 2015). In this section I will discuss how to consider intersecting identities of African American couples in our assessments, recommend a range of violence (IPV, community, and structural) to explore with our clients, and discuss respectful ways to explore mental and physical health problems (see table 8.2).

INTERSECTIONALITY AND MULTIPLE IDENTITIES

It is imperative that we recognize and acknowledge the multiple identities of our clients. An intersectional analyses is crucial because "continuing to offer fragment services, wherein issues are individually treated and not considered within the context of their intersections, is an inefficient, and ultimately *ineffective*, means of providing services" (Bent-Goodley, Chase, Circo, & Rodgers, 2010, p. 74). For example, Sarita, an impoverished, urban dwelling, battered Black lesbian with mental health problems explained the challenges of accessing services:

Table 8.2. Areas of assessment to conduct with African American victims and perpetrators of intimate partner violence

Assessment of African American Victims and Perpetrators of Intimate Partner Violence	
Areas to Assess	**Possible Themes to Explore**
Intersectionality of identities and multiple identities	• Age • Educational Level • Ethnicity (African American, Caribbean, African immigrant) • Geographic Location (urban, rural, suburban) • Religious affiliation • Sexual identity (cisgender, transgender) • Sexual orientation (gay, lesbian, bisexual) • Socioeconomic class
Range of IPV, community, and structural violence	Intimate partner violence • Women's use of violence • Reproductive coercion • Strangulation • Domestic homicide Historical trauma Structural violence Community violence
Mental Health Disorders	• Mood disorders (dysthymia, major depression disorder, and bipolar disorder) • Anxiety disorders (panic disorder, agoraphobia, generalized anxiety disorder, obsessive-compulsive disorder, and posttraumatic stress disorder) • Substance disorders (alcohol abuse/dependence, drug use/dependence) • Eating disorders • Suicidal ideation and attempts
Physical Health Disorders	• Injuries/Hospitalizations • Central nervous system (headaches, fainting, back pain, seizures) • Gynecological/reproductive health problems (abnormal vaginal bleeding, vaginal infection, pelvic pain, painful intercourse, fibroids, urinary tract infection, and sexually transmitted infections, including HIV/AIDS) • Gastrointestinal problems (loss of appetite, digestive problems, abdominal problems)

> You offer me this place over here for mental illness. Then I go to this domestic violence shelter . . . that's not helping me with my mental illness . . . So, I go back over here [mental health agency] so at least they can monitor my meds. (Simpson & Helfrich, 2014, p. 455)

We should avoid asking our clients to fragment themselves and to present one identity when they seek help, while neglecting other important parts of themselves. Instead, a social justice–based, culturally responsive comprehensive service would welcome her to bring all aspects of her identity into treatment. What Sarita and most of our clients want is simple: "the opportunity to define for themselves who they are and what aspects of their identities are most important or relevant to their situations at a particular point in time" (Simpson & Helfrich, 2014, p. 459).

Therefore, we should consider asking how some of the following identities influence the victim's or perpetrator's experiences with violence and help-seeking efforts (for a more detailed discussion, see West, in press).

Age

Special attention should be paid to unique forms of violence and challenges that victims and perpetrators experience across the age-spectrum. Black adolescents, particularly those who are poor, are at risk for dating violence in their intimate relationships, family violence in their homes, and sexual harassment in their neighborhoods and schools (Miller, 2008). At the other end of the age continuum, older African American women may be financially abused by their adult children and physically and emotionally abused by their spouses. In addition, older victims often lack resources for independent living, including stable housing, personal income, and good physical health (Lichtenstein & Johnson, 2009).

Ethnicity

The abuse experience can vary based on ethnicity of the couple. For example, African immigrant couples may face unique challenges around language barriers, immigration status, and gender roles (West, 2016a). Likewise, the demographic risk factors and mental health consequences that are associated with IPV between African American and Caribbean battered women may vary (Lacey, Sears, Matusko, & Jackson, 2015). Consequently, mental health providers should consider ethnicity and immigration status and avoid the assumption that every phenotypically Black person identifies as African American and traces his or her roots to the transatlantic slave trade.

Geographic Location

Although the research is limited, it appears that the types of abuse, location of the assault, and response to intimate partner violence varies between urban and rural African American couples. For example, rural woman were more likely to be attacked by kitchen knives and pieces of furniture; whereas urban women were assaulted with guns. Urban women reported that their abuse

occurred in public places, such as shopping malls and gas station and, in contrast, rural women were beaten in private settings, including houses and apartments. Furthermore, the way the abusers controlled the lives of women in the two settings differed. Urban abusers told the victim how to wear her hair and/or how to dress, while rural abusers battered their partners for failing to perform domestic duties, such as cooking and cleaning (Bhandari, Bullock, Richardson, Kimeto, Campbell, & Sharps, 2015).

Social Class

Much of the research in this area has focus on impoverished African Americans (O'Leary & Frew, 2017); yet their middle-class peers also face challenges. Revealing that they were victims of IPV could jeopardize the status and reputation of professional Black women and their partners. Moreover, their disclosure of abuse or request for services may be met with skepticism because they appear to be financially secure (West, 2016b).

Sexual Orientation/Gender Identity

Transgender Black women and Black lesbians face barriers that prevent them from freely and safely accessing services, such as heterosexism, discrimination, and stigma. They also encounter institutional and agency-specific barriers, homophobia, and transphobia in the Black community, and racism in the LGBTQ community (Simpson & Helfrich, 2014).

Mental health providers can use the Multicultural Power and Control Wheel as a visual representation to help themselves and their clients, both victims and perpetrators, to grasp how various systems of oppression (e.g., ageism, heterosexism, ableism, racism, classism) shape their experiences with IPV (Chavis & Hill, 2009). As we put intersectionality into practice, it is important that we remember that many diverse factors correlate with privilege (such as sex, race, and socioeconomic status) are based on visible traits or observable characteristics. However, numerous identity factors, including gender identity, immigration status, dis/ability challenges, religion, sexual orientation, and education are sometimes ambiguous or invisible. Therefore, we have to listen to the victims and perpetrators tell their stories and describe their identities.

RANGE OF VIOLENCE

To strive for social justice and cultural sensitivity, we should make all forms of violence more visible, both to ourselves as mental health professionals and our clients. Again, the Multicultural Power and Control Wheel can be used to illustrate how perpetrators' coercive control tactics are shaped by intersecting

identities and varying systems of oppression. These forms of abuse include isolation, emotional abuse, sexual abuse, using children to control and harass the victim, intimidation, and physical violence (Chavis & Hill, 2009). However, service professionals need to be aware of several neglected forms of violence that disproportionately impact Black victims. They are specific types of IPV (women's use of aggression, reproductive coercion, nonfatal strangulation, intimate partner homicide) as well as historical trauma, structural violence and inequalities, and community violence.

Women's Use of Aggression

African American women sometimes use aggression as a form of self-defense, in retaliation for past abuse, or to preempt future abuse. However, the use of aggression may not serve them well. Direct confrontation may not stop the primary aggressor over the long term; in fact, the violence may escalate. Black women who used this strategy seldom felt a sense of control, independence, or power within their relationships; rather, they reported symptoms of depression, anxiety, and PTSD (West, 2007; West, 2016b). Moreover, when they are arrested, the social and legal consequences can be devastating and include the problems that are associated with a felony conviction: unemployment or possible eviction from public housing. Although they are not the primary perpetrator, Black women victim-defendants also may be court mandated to participate in batterer's treatment programs (West, 2007).

Mental health providers can discuss the advantages and disadvantages of using aggression and strategize about more appropriate tactics to end the violence. They may also educate clients about arrest policies and the legal consequences associated with their use of violence. Remembering that their use of aggression often occurs in the context of their victimization can help us to avoid the unconscious bias and stereotype of the inherently angry and hyper-violent Black woman (West, 2007).

Reproductive Coercion

A frequently overlooked form of sexual violence that impacts Black victims is reproductive coercion, such as birth control sabotage (removing the condom during intercourse, destroying a woman's contraceptive device or birth control pills) or pregnancy pressure (verbal or emotional pressure to get pregnant or to terminate a pregnancy). This form of victimization has often resulted in high rates of unintended pregnancies among African American women (Nikolajski, Miller, McCauley, Akers, Schwarz, Freedman, et al., 2015). Accordingly, mental health providers should become familiar with all forms reproductive coercion and be prepare to conduct a culturally sensitive

assessment with their clients (for a toolkit on reproductive coercion see Cappelletti, Gatimu, & Shaw, 2014).

Strangulation

When compared to battered women of other ethnic backgrounds, African American women are at elevated risk for strangulation. It is important to ask our clients about strangulation, a unique form of physical aggression, which can be used, sometimes just once, to immobilize and terrorize the victim. It is a potentially lethal, but invisible form of violence, in that there is seldom immediate external evidence. Bruising and swelling may not appear until days later, especially on darker complexions. Immediate and lasting fear are the primary post-event reactions to strangulation (Glass et al., 2008).

Domestic Homicide

When compared to victims of other ethnic backgrounds, Black women are murdered at higher rates by their intimate partners, often with a handgun during the course of an argument (Violence Policy Center, 2016). Therefore, it is imperative that mental health providers use a lethality screening tool, such as the Danger Assessment, which considers nonfatal strangulation, to determine a client's risk for intimate partner homicide (Campbell, Webster, Koziol-McLain, Block, Campbell, Curry, et al., 2003).

Historical Trauma

Williams-Washington (2010) has defined *historical trauma*, as "the collective spiritual, psychological, emotional and cognitive distress perpetuated intergenerationally deriving from multiple denigrating experiences originating with slavery and continuing with patterns forms of racism and discrimination to the present day" (p. 32). Marriage and family therapists and other mental health professionals should strive to educate themselves about the impact that historical trauma of slavery has had on African Americans and the clinical implications of this trauma (Danzer, Rieger, Schubmehl, & Cort, 2016; Dixon, 2017; Wilkins, Whiting, Watson, Russon, & Moncrief, 2013).

Structural Violence and Inequalities

In order to capture the full range of violence that is experienced by African Americans, we need to have a discussion about institutional racism and structural violence. Although they seem to be invisible, these forms of inequalities are very real in the lives of our clients. A comprehensive medical and mental health assessment could include a measure of "structural vulnerability" to help providers to think more clearly, critically, and practically about the

ways in which social structures and inequalities result in health disparities (Bourgois, Holmes, Sue, & Quesada, 2017).

Community Violence

A form of trauma that disproportionately impacts African Americans is community violence. It may involve experiencing or witnessing homicide, gun violence, assaults, robberies, or exposure to drug markets. The combination of interpersonal violence within the home and violence in the neighborhood means that safety is illusive for many Blacks, which further compromises their physical and emotional health and elevate their risk for IPV. Therefore, our assessments should ask survivors about the communities that they call home (Stueve & O'Donnell, 2008; Violence Policy Center, 2017).

ASSESS FOR PHYSICAL AND MENTAL HEALTH PROBLEMS

In a national sample of Black battered women, severe physical IPV was associated with an increased risk of suicide attempts and ideation as well as lifetime mental health problems, including mood disorders (dysthymia, major depression disorder, and bipolar disorder); anxiety disorders (panic disorder, agoraphobia, generalized disorder, obsessive disorder, and posttraumatic stress disorder [PTSD]); substance disorders (alcohol or drug use, abuse/dependence); and eating disorders (bulimia, binge eating) (Lacey et al., 2015). In addition, when compared to survivors who had experienced one or two forms of victimization, Black women who sustained cumulative violence (physical, sexual, and emotional abuse) reported higher rates of clinically significant depressive symptoms, PTSD, self-mutilation, suicidal thoughts/attempts, drug problems, and eating disorders in the past year (Sabri, Holliday, Alexander, Huerta, Cimino, Callwood, et al., 2016).

The physical health of African American battered women also is compromised by IPV. When compared to their nonvictimized counterparts, survivors of recent assaults sustained bruises and facial, dental, and head injuries, which often required stitches and surgeries; broken bones and dislocated jaws, and a loss of consciousness. Furthermore, in the year prior to the study, recent victims were hospitalized or sought treatment in the emergency room more frequently (Anderson, Stockman, Sabri, Campbell, & Campbell, 2015). In addition to their immediate medical trauma, Black victims reported a range of health concerns in the past year, including problems with their central nervous system (headaches, fainting, back pain, seizures); gynecological/reproductive health problems (abnormal vaginal bleeding, vaginal infection, pelvic pain, painful intercourse, fibroids, urinary tract infection, and sexually transmitted infections, including HIV/AIDS); and gastrointestinal problems (loss of appetite, digestive problems, abdominal problems) (Schol-

lenberger, Campbell, Sharps, O'Campo, Gielen, Dinemann, et al., 2003). African American women who reported more frequent partner violence, particularly if it was accompanied by PTSD symptoms (Iverson, Bauer, Shipherd, Pineles, Harrington, & Resick, 2013), cumulative violence exposure (Sabri et al., 2016), and recent violence exposure (past year compared to lifetime exposure to IPV) (Schollenberger et al., 2003), were more likely to self-rate their overall physical health as "fair," "poor," or "very poor."

We can assess for mental health problems without seeing our clients as personifying a diagnosis. Instead, we can ask them how they cope with symptoms of depression or PTSD (e.g., intrusive recollections, distressing dreams, flashbacks, emotional numbing). While keeping in mind that they may have experienced IPV in conjunction with multiple types of violence (structural inequalities, historical trauma, community violence), have they adopted healthy or unhealthy coping strategies? (Sullivan, Weiss, Price, Pugh, & Hansen, 2017).

To conclude, in order to practice cultural competency, mental health providers should strive to become more culturally sensitive and aware, which "is more than being politically correct or tolerating diversity, it is a sincere commitment, active engagement in, and dedication to a lifelong learning process to enrich the delivery of services to domestic violence survivors and other persons seeking the services of helping professionals" (Lockhart & Mitchell, 2010, p. 6). Although it is challenging, considering intersecting identities of African Americans, exploring a range of violence in their lives, and gathering information about mental health and physical health problems that are related to IPV is an important step in the process of cultural awareness.

CONCLUSION

In this chapter, I provided a brief overview of the prevalence rates of IPV among African Americans, described an ecological model, which is a more comprehensive theoretical approach to understanding the risk factors that elevate the probability that African American couples will experience intimate abuse, described some of the challenges to understanding IPV in this population, and offered some suggestions for areas to explore when conducting a culturally sensitive assessment. Mental health professionals, in collaboration with those impacted by abuse, should strive to commit to activism at the local, state, and national levels. It is imperative that a greater awareness of racism and other forms of oppression in the lives of African Americans is reinforced by deliberate engagement in efforts to reduce the impact of these forms of oppression within society. This will not only result in successful and

culturally sensitive treatment of survivors, it will address prevention in violence in all forms.

DISCUSSION QUESTIONS

1. What historical and cultural factors do you think account for higher rates of female-perpetrated and mutual violence among African American couples?
2. In what ways can individual-, relationship-, community-, and societal-level correlates and risk factors converge to elevate the risk of intimate partner violence among African American couples?
3. In what ways has historical trauma contributed to the elevated rates of intimate partner violence in contemporary African American couples?
4. Can you identify similarities and parallels between various forms of coercive control utilized by abusive intimate partners and by agents of the state (e.g., police officers, judges) and service providers (e.g., shelter workers, mental health professionals) who are tasked with assisting African American victims?
5. How can we use the concept of intersectionality and multiple identities of clients to improve service provision?
6. Can you identify some sources of resilience among African American victims and perpetrators of intimate partner violence?

NOTES

1. The term *Black* and *African American* are used interchangeably in this chapter.
2. To illustrate, Janay Palmer and her fiancé, now husband, Ray Rice, a former running back for the NFL's Baltimore Ravens, was described as having "little more than a very minor physical altercation." However, in later video footage he could be seen dragging her limp body from an Atlantic City casino elevator after he had allegedly knocked her unconscious. Although both partners use violence, at least in this case, the woman sustained more serious injuries (Christensen, Gill, & Perez, 2016).

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and William G. Herron

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