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Institutional Strategies to Promote the Health of Black Women Survivors of Intimate Partner Violence

Abstract

Intimate partner violence is the use of physical, sexual, and/or psychological aggression by a current or former intimate partner as a tactic to maintain control. Abuse can have devastating long-term health consequences, including physical injuries and mental health problems such as depression and anxiety disorders. Despite these challenges, Black women actively seek out support from multiple formal institutions to keep themselves and their families safe. Yet Black women face structural barriers when they seek assistance. Using a Black feminist perspective, this paper describes strategies that can be employed to improve institutional responses to Black women survivors and concludes with suggestions for future practice.

There are an estimated six million Black women survivors of intimate partner violence (IPV) in the United States (Smith et al. 2017). Black women have described bidirectional and cyclical ways in which IPV and mental and physical health intersect over time: IPV leads to adverse health effects; IPV worsens already compromised health; and Black women's illness or disability increases dependency on abusive partners, thereby potentially lengthening the duration of IPV exposure (Stockman, Hayashi, and Campbell 2015). Yet, Black women frequently underutilize traditional

therapeutic mental health services such as counselors, therapists, and support groups (Nnawulezi and Murphy 2017). Furthermore, they report negative experiences with medical care providers (West, forthcoming). Using a Black feminist approach, the aim of this paper is to identify strategies to improve institutional responses to Black women IPV survivors as a mechanism to enhance their well-being.

Intimate Partner Violence and Black Women's Health

According to the nationally representative 2010–2012 National Intimate Partner and Sexual Violence Survey, 45.1 percent of Black women respondents reported being physically assaulted, stalked, or raped by an intimate partner (Smith et al. 2017). Intimate partner violence encompasses a set of behaviors by an abusive partner to maintain control in an intimate relationship. This may include attempts to isolate survivors from their social support networks; emotional/verbal abuse in the form of name-calling or intimidation; using children to control and harass survivors; and economic/financial abuse, such as preventing survivors from working or taking their wages (West 2016).

Intimate partner violence can have a profound impact on the mental health of Black women. Black women who survive severe physical IPV have reported 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 post-traumatic stress disorder); substance disorders (alcohol or drug use, abuse, or dependence); and eating disorders (bulimia and binge eating) (Stockman, Hayashi, and Campbell 2015).

The physical health of Black women survivors also is compromised by IPV. In addition to immediate medical trauma, such as injuries that required stitches or surgeries, Black women survivors reported a range of health concerns within one year of the abuse, including problems with their central nervous system (headaches, fainting, back pain, and seizures); gynecological/reproductive health problems (abnormal vaginal bleeding, vaginal infection, pelvic pain, painful intercourse,

fibroids, urinary tract infection, and sexually transmitted infections, including HIV); and gastrointestinal problems (loss of appetite, digestive problems, and abdominal problems). Black women who reported more frequent IPV and recent violence exposure (past year compared to lifetime exposure to IPV) were more likely to self-rate their overall physical health as "fair," "poor," or "very poor" (Smith 2017; Stockman, Hayashi, and Campbell 2015).

Getting formal help for these IPV-related health concerns is not easy for Black women. Evidence suggests that Black women experience bias, incivilities, and individual and environmental microaggressions when reaching out to and receiving services from formal institutions (Nnawulezi and Sullivan 2014). The institutional investment in racialized gender stereotypes, hyper-surveillance of Black women, and experiences of discrimination make it difficult for Black women to acquire resources from institutions, further compromising their personal and familial health (West 2016).

A Black Feminist Analysis of Intimate Partner Violence

Intimate partner violence is both very similar and, at times, vastly different for Black women than the violence that is experienced by their white counterparts. Specifically, Black women report higher rates of severe violence (Smith et al. 2017) and are more likely to be murdered by an abusive partner (Violence Policy Center 2016). Black feminism is a theoretical approach that recognizes the overlapping or intersecting social identities and related systems of oppression, domination, or discrimination that exist in the lives of Black survivors. It values and centers the lived experiences of Black women and utilizes social justice praxis (Richie 2000). Given its emphasis on structural power inequities, systematic oppressions, and historical and intergenerational trauma, this framework can help its users to move from an individual, deficit-based analysis to a structural analysis that can be used to articulate the similarities across racial groups in IPV without negating the unique experiences of Black women. Black feminism can also highlight racial differences without perpetuating the stereotype that Black men are inherently more violent.

Second, a Black feminist analysis recognizes the vast range of violence in the lives of Black women survivors. Black women experience relationship violence in the context of historical trauma, which is the collective, intergenerational distress derived from centuries of denigrating, victimizing experiences that originated in slavery and continue in contemporary times (e.g., lynchings, rapes, and police brutality). Intimate partner violence also occurs in the context of structural violence. This can take the form of institutional and structural racism, including poverty, mass incarceration, and unfair housing policies, which contribute to residential segregation that often exposes Black women survivors to high rates of community violence (Richie 2012; West 2016).

At the same time, Black women survivors are remarkably resilient, active help-seekers who utilize internal sources of strength, such as their spirituality and self-reliance. They physically fight back to defend themselves and their children and they terminate their abusive relationships. Moreover, they seek help from informal sources of support, such as family members and friends, and formal help sources, including the police and courts (Nnawulezi and Murphy 2017, West, forthcoming).

Finally, a Black feminist analysis moves the discussion of IPV away from being an individual problem or pathology to being a structural problem that requires institutional and systemic changes. According to Beth Richie (2012):

> Analysis of the broader context is critical to an understanding of what happens to Black women who experience male violence when highly specialized institutional services are inaccessible because their experiences of male violence are inconsistent with the oversimplified classifications that result from hegemonic discourse and because of their precarious positions in a prison nation. (101)

Institutional Strategies to Promote Health Among Black Women Survivors

We identify four strategies that communities and institutions can implement to shape contexts that would best support the health needs of Black women survivors. Previous scholars have posited that an increase in representations of Black IPV service providers, implementation of cultural humility training to reduce implicit bias and stereotypical assumptions,

and use of trauma-informed and culturally specific practices are necessary strategies to improve survivor health (Nnawulezi and Sullivan, 2014; West, forthcoming). The strategies listed below complement these ongoing attempts to create more inclusive and transformative helping systems.

ERADICATE THE SAVIOR NARRATIVE WITHIN SOCIAL SERVICES

Deeply rooted in cultural imperialism and white supremacy, savior complexes are guided by the assumption that the helper is all-knowing and that the helper's target—or survivor—is deficit or defective. Many formal institutions are driven by a desire to help people. "Help" is often conceptualized within an individualistic perspective that pathologizes community members, and seeks to remove control from their lives. In a societal context where survivors are constantly blamed for their partner's abuse, efforts to "save" survivors and to teach them to "make better decisions" permeate institutions and greatly influence present-day interventions. The savior narrative can infantilize survivors and emphasize the need for outsiders—who are often white, able-bodied, middle- or upper-middle-class, and hold professional academic credentials—to fix a problem.

Instead of this savior paradigm, we need to move to a resistance paradigm for Black women survivors, where they are seen both as survivors of violence and as powerful change agents (West 1999). From a Black feminist perspective, mental health professionals and other service providers, in collaboration with survivors, should strive to commit to activism at local, state, and national levels to empower Black survivors and their communities to develop culturally relevant services and economic opportunities. This will result in successful individualized treatment of Black survivors and potentially prevent violence (West, forthcoming).

DIVEST FROM INSTITUTIONAL PRACTICES OF CONTROL THAT RELY ON HYPER-SURVEILLANCE

Some institutions create surveillance policies to ensure that survivors are not "over-using" or "taking advantage" of resources. For example, domestic violence shelters often have mandated policies such as required curfews, designated meal times, imposed limited family visitation hours, and restrictive parenting practices (Gregory, Nnawulezi and Sullivan, 2017). This level of hyper-surveillance over resources creates a legitimate hypervigilance in Black women. West (1999) described this as the

"white gaze" that Black women survivors may experience as judgmental and dismissive and that ultimately can leave them feeling stigmatized and shamed. Under this gaze, Black women must prove that they are "deserving" victims, rather than grifters who are seeking to economically exploit the system. Reducing this hyper-surveillance, which mimics the stalking and coercive control that survivors experienced in their abusive relationships, will communicate trust in the autonomy of survivors and their ability to make choices that can enhance their safety and emotional well-being (West 2016).

INVEST IN THE USE OF MULTIPLE HEALING MODALITIES AND NONTRADITIONAL HELPING PROFESSIONALS

Rather than seeing Black women survivors as deficient and their relationships as defective, a Black feminist perspective encourages us to adopt a strength-based approach that acknowledges the healing strategies that have been successfully implemented by Black women. Using a strength-based approach, mental health professionals can strive to help Black women survivors to simultaneously express their vulnerability and celebrate their resilience. Storytelling, journal writing, creating, listening to music, and reading books and poetry produced by Black women survivors are all artistic forms of expression that can help survivors to heal themselves (West, forthcoming). A strength-based approach might routinely include inquiries into the availability and nature of survivors' support systems. Service providers can incorporate women's social support networks into their programs, policies, and practices. For example, therapists can educate survivors' informal social support networks about dynamics of intimate partner violence (West, forthcoming).

DEVELOP FLEXIBLE, LONG-TERM STRUCTURAL SUPPORTS THAT ARE ROOTED IN SURVIVORS' NEEDS

Institutions typically focus on short, static supportive structures rather than long-term flexible mechanisms that provide on-going support. For instance, police often respond to immediate individual episodes of violence. Shelters use crisis intervention models. Therapists (depending on the type of insurance) focus on serving people within a predetermined number of sessions. The assumption is that once people get their initial needs met, then they must terminate therapy or other services so that other

clients can benefit from the services. Long-term options for survivors are often unavailable, regardless of the need or the sufficient empirical evidence that suggests that the negative mental and physical health impacts of IPV persist over time (Stockman, Hayashi, and Campbell 2015).

Black feminists seek to create an empowerment model that works to understand survivors' goals, helps them to articulate their aims, acknowledges the structural barriers to achieving those objectives, and works with them to craft a strategy to overcome the challenges that they face. A survivor's unique circumstances and hopes for the future are moved to the forefront. This is preferable to offering options for assistance that are based on the availability of services or the mission of an organization (West, forthcoming).

Moreover, providers should avoid asking clients to fragment themselves and to present one identity when they seek help while neglecting other important parts of themselves. Instead, a Black feminist, culturally responsive, comprehensive service would welcome a Black woman survivor to bring all aspects of herself into treatment. For example, Sarita[1], a poor, urban-dwelling, Black lesbian survivor with mental health problems, explained the challenges of accessing services:

> 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 and Helfrich, 2014, 455)

It is simple: What Sarita and most women want is "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 and Helfrich, 2014, 459).

Practice Implications

Black women's health is intimately connected to the health of the whole community. Culturally specific services that focus on all aspects of community life must be supported and maintained. Since all fights for liberation are mutually interconnected, community-based actions that focus

on obtaining distributive justice for all people (e.g., fair housing, minimum wage increases, etc.) and adopt an intersectional approach should be actively engaged. Organizing around fair and accessible health care, reproductive rights, and affordable childcare systems are key components of this work. There are also a multitude of groups who are organizing outside of formal helping systems (see the Audre Lorde Project's [n.d.] Safe Outside the System Collective, for an example). Supporting these efforts are a way to ensure that survivors who are otherwise unsafe accessing formal support systems have localized supports available to help them when needed.

Conclusion

Intimate partner violence directly compromises the health of individual survivors and their families, as well as indirectly influencing the neighborhoods and communities in which they are situated. Therefore, when survivors seek out support, it is important that communities are well-equipped to best support them, to increase the odds that they will survive and be healthy. Cultural bias and structural oppressions can serve as impediments for Black women survivors receiving the care they need and getting the resources that will promote their well-being. Providing research and organizing resources that focus on institutional change and provide better services to Black women survivors are critical ways to promote Black women's health.

NOTES
1. This name is a pseudonym.

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