

Chapter 4

Treatment Interventions for Intimate Partner Violence in the Lives of African-American Women *A Social Justice Approach*

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EDITOR'S (SG) INTRODUCTION

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MY PATH TO A SOCIAL JUSTICE APPROACH

According to a national study, 45.1% of Black¹ women experienced sexual violence, physical violence, and/or stalking by an intimate partner in their lifetimes. This prevalence rate translates into an estimated 6,349,000 survivors (Smith et al., 2017). United Methodist clergyperson, Traci West (1999), wrote: "There is no more compelling societal problem in need of redress than black women's experience of male violence" (p. 1). I agree. Accordingly, I have dedicated my personal and professional life to understanding this pervasive social and public health problem.

Three pivotal life experiences set me on the path to articulating a social justice treatment approach to addressing IPV in the lives African-American women. At age 13, I borrowed the book *Scream Quietly or the Neighbors will Hear* (Pizzey, 1974), which was one of the early academic efforts to investigate wife battering. I became passionate about using research to eradicate all forms of family violence and sexual assault. Around the same time, I discovered the "Clinical Psychologist" entry in the *World Book Encyclopedia* and intuitively knew that this would be my future career.

The second major event that shaped my professional life happened ten years later. It was February 1987, and I was a precocious, idealistic 23-year-old graduate student who was fulfilling my childhood dream of becoming a psychologist. For about three years, I experienced academic sexual harassment. After filing an Equal Employment Opportunity Complaint (EEOC) and a successful sexual harassment lawsuit against the University of Missouri, I earned my doctoral degree in Clinical Psychology in 1994. Along the way, I learned how to craft a resistance strategy using the media and the legal system, and I learned that activists of all backgrounds can collaborate and agitate to force institutional changes within universities. Equally as important, I learned that culturally aware psychologists can facilitate the healing process. With the help of these mental health professionals, loving family members, and supportive friends, as well as my teaching, writing, community activism, and strong faith, I labeled my victimization, which enabled me to evolve into an empowered survivor and activist-scholar (West, 2010).

The third important life-changing event happened during my postdoctoral research fellowship at the University of New Hampshire's Family Research Laboratory. During spirited scholarly debates and research meetings with my mentors and peers, I grew frustrated with the scarcity of literature on IPV in marginalized populations. For that reason, I made a personal promise to accomplish two career goals. One, I would become a productive scholar by conducting large systematic literature reviews, which I hoped would make the research more accessible to scholars and service providers (West, 2012, 2016b, 2016c).

The second promise: In the process of my writing, I vowed to amplify my radical voice and challenge all forms of oppression. As a self-identified Black feminist scholar living in rural New England at the time, I found solace in quotes by Audre Lorde (1982), a self-proclaimed Black feminist, poet, activist, teacher, and warrior: "For the master's tools will never dismantle the master's house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change" (p. 112). Having the "master's tools" in my toolbox meant producing rigorous scholarship, which was practical and accessible enough to be used by mental health professionals who, in turn, could make real social change. This strong desire and the sage advice of Toni Morrison, "If there is a book you want to read, but it hasn't been written yet, then you must write it," led me to collaborate with advocates and activists to edit the book *Violence in the Lives of Black Women: Battered, Black, and Blue* (West, 2003).

Today, I write, train, consult, and lecture internationally on interpersonal violence and sexual assault, with a special focus on violence among African-American women. I am deeply devoted to creating inspirational material to empower domestic violence/sexual assault survivors during their healing journey, delivering keynote addresses, conducting workshops, and customizing innovative training material to educate and equip professionals with the skills to provide culturally sensitive services. In that spirit, I will provide a brief overview of IPV in the lives of African-American women, discuss what social justice looks like in theory, and end with practical applications for treatment interventions.

INTIMATE PARTNER VIOLENCE AND AFRICAN-AMERICAN WOMEN: AN OVERVIEW

Despite their vulnerability, the interpersonal violence that African-American women experience in their homes, communities, and workplaces remains "hidden in plain sight." That is, their victimization is so hypervisible and pervasive that the violence against them appears to be normal and routine, which renders their violation as invisible in the larger culture. Paradoxically, Black women are perceived as *not* at risk for—and simultaneously to blame for—the violence that has been perpetrated against them (West, 2016b).

At the same time, the physical injuries (Anderson, Stockman, Sabri, Campbell, & Campbell, 2015) and mental health problems (Lacey, Sears, Matusko, & Jackson, 2015) that are associated with the IPV in their lives is very visible. Yet, when compared to survivors of other ethnic groups, Black battered women frequently underutilize traditional therapeutic mental health services, such as counselors, therapists, and support groups (Nnawulezi & Murphy,

2017). In this section I will define IPV, briefly discuss the prevalence rates and the mental and physical health consequences associated with this form of victimization, and end with a discussion of Black women's help-seeking behavior.

Defining what constitutes IPV 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 and preventing her from using birth control), *sexual coercion* (e.g., unwanted penetration obtained through nonphysical pressure), and *unwanted sexual contact* (e.g., kissing and fondling). Examples of *psychological aggression* include name-calling, insulting, and humiliating and those of *coercive control* include 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).

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 (West, 2012, 2016c). According to the National Intimate Partner and Sexual Violence Survey (NISVS), Black women reported a broad range of IPV: 41.2% had been physically abused, 9.5% had been stalked, and 8.8% had been raped by an intimate partner during their lifetime (Breiding, Chen, & Black, 2014). Moreover, between 2003 and 2014, Black women experienced the highest rates of homicides (4.4 per 100,000), which were primarily committed by former or current intimate partners (Petrosky et al., 2017).

In a national sample of Black battered women, severe physical IPV was associated with an increased risk of suicide attempts and suicidal 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 and abuse/dependence), and eating disorders (bulimia and 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 and attempts, drug problems, and eating disorders in the past year (Sabri 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 et al., 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, 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/AIDS), and gastrointestinal problems (loss of appetite, digestive problems, and abdominal problems) (Schollenberger et al., 2003). African-American women who reported more frequent partner violence, particularly if it was accompanied by PTSD symptoms (Iverson et al., 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.”

On one hand, African-American women are active help-seekers who utilized internal sources of strength, such as their spirituality and self-reliance. They physically fought back to defend themselves and their children and they terminated their abusive relationships. Moreover, they sought help from informal sources of support, such as family members and friends, and formal help sources, including the police and courts (Sabri et al., 2016; St. Vil, Sabri, Nwokolo, Alexander, & Campbell, 2017).

On the other hand, African-American women underutilized other services. For example, despite potentially lethal, severe physical victimization, which co-occurred with PTSD and depression, 66% of low-income Black battered women who lived in Baltimore and the U.S. Virgin Island did not use the services of mental health providers (counselors, therapists, and caseworkers) (Sabri et al., 2013). In fact, many survivors had limited knowledge or lacked access to these forms of help. To illustrate, 37% did not know about domestic violence services (domestic violence hotlines/advocates or shelters) and 82.8% did not have access to mental health counselors or therapists (Sabri et al., 2015).

To conclude, African-American women have high prevalence rates of IPV, experience serious mental and physical health consequences that are

associated with this form of victimization, and typically lacked the knowledge and access to mental health services to enable themselves to heal. At the same time, they are resilient survivors. In recognition of this complexity, Traci West (1999) prefers the term “victim-survivor”:

I do so to rhetorically remind us of the dual status of women who have been both victimized by violent assault and have survived it. Black women are sometimes denied an opportunity to have their victimization recognized. The strength of their coping and survival abilities is commonly emphasized at the expense of an appreciation of their injury and anguish. (p. 5)

SOCIAL JUSTICE IN THEORY

A social justice approach, I believe, requires a theoretical understanding of an ecological model of IPV, an understanding of intersectionality, which is the recognition of the multiple identities possessed by Black victim-survivors; and a fearless commitment to addressing our unconscious biases based on race and other forms of oppression.

Ecological Model

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, which can occur at four levels (Centers for Disease Control and Prevention [CDC], 2009). Accordingly, an ecological model can be beneficial to help us understand IPV in the lives of African-American women. 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 factors, such as norms, policies, and structural inequalities, including racism and sexism (West, 2016c).

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, 2016). 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).

At the same time, poverty as the sole explanation for IPV is too simplistic. We risk implying that IPV is “natural” or “normal” among Black women because it occurs all too frequently. Moreover, it is perilous to attribute male-perpetrated violence to an amorphous, impersonal factor identified as “poverty” (West, 1999). From a social justice perspective, it is important to remember that “while understanding links between racism and domestic violence is an important component of any effective intervention strategy, it is also clear that women of color need not await the ultimate triumph over racism before they can expect live violence-free lives” (Crenshaw, 1994, p. 104).

Intersectionality

“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). Conwill (2010) concluded that “from a social justice perspective and in the context of the U.S. and the Americas intersectionality is an excellent tool for examining both the interpersonal and institutional dimensions of domestic violence in lower-class Black communities” (p. 36).

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). The combination of poverty and IPV can also predispose African-American women who live in economically distressed, urban communities to mental health problems, such as depression (Mugoya et al., 2017).

Unconscious Biases

Biases can be triggered based on a client’s race/ethnicity, age, gender or gender identity, sexual orientation, religious affiliation, and physical disabilities, to name a few. Our biases can be conscious (explicit) or unconscious

(implicit) (Cuellar, 2017). Honestly, what do you see when you sit with a Black victim-survivor: “An angry woman who solicited violence due to her hostile behavior, a seductive temptress who liked or enjoyed violent interactions, a stoic matriarch preferring to stay with an abusive partner or a host of other possible configurations” (Ashley, 2017). These (mis)perceptions, when acted out verbally or nonverbally, can be perceived as *racial microaggression*, subtle forms of racism that deter battered women from seeking our services (Nnawulezi & Sullivan, 2014). Even positive stereotypes, such as the super strong resilient Black woman, can present a barrier to service provision and reduce intervention effectiveness (Davis et al., 2009). It is incumbent upon mental health providers to explore the origin of these beliefs and to challenge ourselves and others to become more aware of them (Danzer, Rieger, Schubmehl, & Cort, 2016).

To conclude, using an ecological model, being aware of intersectionality, and becoming aware of our unconscious biases are a good step toward social justice. However, it is not enough. We need to move from theory to practice.

SOCIAL JUSTICE IN PRACTICE

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). In fact, if we listen carefully, Black victim-survivors have clearly and eloquently articulated the organizational policies and structures that are embraced by culturally responsive agencies and service providers. Specifically, Black victim-survivors wanted mental health providers who were welcoming to African-Americans, sensitive to the process of leaving abusive relationships, and supportive of their unique needs (Gillum, 2009). Based on a growing body of research, practicing cultural awareness is an effective way to help victim-survivors. Low-income and suicidal African-American abused women who participated in a culturally sensitive 10-week psychoeducational intervention program, which was conducted by a multiracial team of therapists, reported lower levels of depressive symptoms and general distress (Kaslow et al., 2010). Next, I will discuss how to put social justice in practice by conducting culturally responsive assessments and using a strength-based approach that honors how Black women have historically healed themselves from all forms of trauma.

Culturally Responsive Assessments

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 Black victim-survivors in our assessments, recommend a range of types violence exposure to explore with our clients, discuss respectful ways to explore mental and physical health problems, and investigate cultural barriers to help-seeking.

Intersecting Identities

A social justice approach requires us to be mindful of the intersecting identities of our clients. Focusing on the commonality of women's experience of abuse, rather than recognizing the multiple identities of women and the cultural context in which they exist, the domestic violence movement has created yet another structural barrier to equitable service delivery. For example, Sarita, an impoverished, urban-dwelling, battered Black lesbian 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 & 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, a culturally responsive comprehensive service, would welcome her to bring all aspects of her identity into treatment. It is simple; what Sarita and most of our clients 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 & Helfrich, 2014, p. 459).

Therefore, incorporating intersectionality into our assessments and practice can help us to think differently about the multilayered intersection of identity, power, and privilege (for a visual representation of an intersectionality of cultural diversity among IPV survivors, see Lockhart & Mitchell, 2010, p. 21). For example, we should consider asking how some of the following identities influence the victim-survivor's experience with violence and her help-seeking efforts:

- *Age.* Special attention should be paid to unique forms of violence and challenges that victim-survivors 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 the ethnicity of the victim-survivor. For example, African immigrant battered women face unique challenges around language barriers, immigration status, religion, and gender roles (West, 2016a). Compared to their African-American counterparts, severely abused Black Caribbean women reported higher rates of eating disorder (Lacey et al., 2015). Consequently, mental health providers should consider ethnicity and immigration status and avoid the assumption that every phenotypically Black woman identifies as African-American and traces her roots to the transatlantic slave trade.
- *Social class.* In addition, the abuse experience can vary across social class. African-American women who live in economically distressed, urban communities are predisposed to mental health problems, such as depression (Mugoya et al., 2017). Yet, middle-class Black women face challenges as well. Revealing their victimization could jeopardize their professional status or the reputation of their partners. Moreover, their disclosure of abuse or request for services may be met with skepticism because they appear to be financially secure and successful (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 grasp how various systems of oppression (e.g., ageism, heterosexism, ableism, racism, and classism) shape their experiences as victim-survivors (Chavis & Hill, 2009). As we put intersectionality into practice, it is important that we remember that many diverse factors that 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 victim-survivor tell their stories and describe their identities.

To conclude, a social justice approach requires us to recognize and acknowledge the multiple identities of our clients. An intersectional analysis 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).

Range of Violence Exposure

After more than three decades of working as a professor, therapist, researcher, and expert witness in domestic violence homicide cases, I continue to be deeply disturbed by the range of violence and brutality in the lives of African-American women. To strive for social justice, 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 (e.g., race, social class, and sexual orientation) and varying systems of oppression (e.g., racism, classism, and heterosexism). 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 victim-survivors. They are specific types of interpersonal violence (women’s use of aggression, reproductive coercion, nonfatal strangulation, and 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, 2016b). Moreover, Black victim-survivors become victim-defendants 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,

victim-survivors also may be court mandated to participate in batterer's treatment program (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 (St. Vil et al., 2017). 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 victim-survivors is reproductive coercion, such as birth control sabotage (removing the condom during intercourse, destroying a woman's contraceptive device or birth control pills) and 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 et al., 2015). Accordingly, mental health providers should become familiar with all forms reproductive coercion and be prepared to conduct a culturally sensitive assessment with their clients (for a toolkit on reproductive coercion, see Cappelletti, Gatimu, & Shaw, 2014).

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 women of darker complexions. Immediate and lasting fear are the primary postevent reactions to strangulation (Thomas, Joshi, & Sorenson, 2014).

Domestic Homicide

When compared to victim-survivors 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. 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 et al., 2003).

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 rates of violence in the form of beatings, rapes, and lynching. Historical trauma has been defined 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” (Williams-Washington, 2010, 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 et al., 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 Black women, we need to have a discussion about *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).

Although they seem to be invisible, these forms of inequalities are very real in the lives of our clients. For example, among low-income Black women (Stueve & O'Donnell, 2008) and Black men (Reed et al., 2010), IPV perpetration and victimization have been linked to microaggressions in the form of perceived racial discrimination in the community (e.g., being unfairly stopped and frisked by police or followed by store clerks and called insulting names or physically attacked because of skin color and race). Furthermore, Black women who reported both a history of racial discrimination and IPV experienced a higher prevalence of anxiety and nonspecific physical health symptoms compared to Black women who reported either or neither of these forms of trauma (Waltermauer, Watson, & McNutt, 2006). In our efforts to use a social justice perspective, a more 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 (Bourgeois, Holmes, Sue, & Quesada, 2017).

Community Violence

A form of trauma that disproportionately impacts Black women 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 Black victim-survivors, which further compromises their physical and emotional health. Therefore, our assessments should ask survivors about the communities that they call home (Stueve & O'Donnell, 2008; Violence Policy Center, 2017).

Mental and Physical Health Problems

As previously discussed, IPV has been associated with physical injuries and a broad range of mental health problems, including mood disorders, anxiety disorders, and eating disorders (Anderson et al., 2015; Lacey et al., 2015). 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, and emotional numbing). While keeping in mind that they may have experienced IPV in conjunction with multiple types of violence (structural inequalities, historical trauma, and community violence), have they adopted healthy or unhealthy coping strategies (Sullivan, Weiss, Price, Pugh, & Hansen, 2017)?

It is especially important that we include an assessment of suicidal behavior and substance abuse. A history of partner violence, more than doubles the risk of suicide attempts among African-American battered women. Negative life events, childhood maltreatment, distress and depression, feelings of hopelessness, lower levels of spiritual well-being, and substance use increased their risk of suicidal behavior (Davis et al., 2009). Black women also may self-medicate with drugs and alcohol to cope with childhood abuse and IPV. Substance using Black women wanted counselors who could “keep it real,” which meant being honest, making them feel like they mattered as a client, and allowing them to make informed decisions (Blakey & Grocher, 2017). In addition, for Black victim-survivors, particularly those who are low-income, the following techniques are helpful: mindfulness-based stress reduction (Dutton, Bermudez, Matas, Majid, & Myers, 2013), motivational interviewing (Wahab et al., 2014), and culturally sensitive psychoeducational programs focused on reducing depression (Davis et al., 2009).

Cultural Barriers to Help-Seeking

Therapists need to be attentive to structural barriers to help-seeking, for example racist policies and procedures in shelters (Nnawulezi & Sullivan,

2014) and homophobic practices that deny services to Black lesbians and transgender survivors (Simpson & Helfrich, 2014). In addition, they should attend to cultural barriers that hinder Black women's ability to get help. For instance, the "Strong Black Women" mandate is "the notion of indefatigable strength can obstruct black women's acknowledgement of the ways that they have been emotionally hurt by black male violence" (West, 1999, p. 78). More specifically, they may avoid reporting their partners' abuse or they may use physical aggression in self-defense, which can increase their risk of injury, because they perceived themselves as being resilient enough to handle the situation alone (Anyikwa, 2015).

To summarize, in order to implement a culturally competent, social justice-based intervention, mental health professional might do the following: considering multiple identities of Black victim-survivors in their assessments, ask about a broad range of violence exposure (interpersonal violence, such as women's use of aggression, reproductive coercion, nonfatal strangulation, risk of intimate partner homicide; historical trauma, structural violence, and community violence), respectfully discuss mental and physical health problems, and investigate cultural barriers to help-seeking. To conclude, "African American women's voices are a non-negotiable source for developing an ethical assessment of, and response to, violence" (West, 1999, p. 182). This requires us to listen, not in a passive way, but in a politically engaged way with active expressions of empathy.

STRENGTH-BASED APPROACH

Rather than seeing Black victim-survivors as deficient and their relationships as defective, a social justice perspective encourages us to adopt a strength-based approach that acknowledges the healing strategies that have been successfully used by African-American women. This entails encouraging internal strength and empowerment, fostering the victim-survivors' social support system, and participating in activism to combat IPV and other forms of oppression.

Encourage Internal Strength and Empowerment

Many Black victim-survivors rely on their internal strength, in the form of self-reliance, self-esteem, prayer, and spirituality to cope and heal in the aftermath of IPV (Sabri et al., 2016). Among the central characteristics of the "Strong Black Woman" image is the notion that African-American women are inherently strong, resilient, and capable of surviving significant adversity. Up to a point, this image can help mitigate some of the negative mental and physical health consequences of IPV. However, the protective effects are

reduced as the abuse becomes more severe (Iverson et al., 2013). At the same time, the image of the strong Black woman was identified as a barrier to both recognizing depression and substance abuse among battered Black women (Nicolaidis et al., 2010). Hence, as therapists we should consider discussing the psychological advantages and disadvantages of this (mis)representation and often unrealistic expectation of Black women's strength and resilience.

Using a strength-based approach, mental health professionals can strive to help African-American survivors to simultaneously express their vulnerability and celebrate their resilience. Storytelling, journal writing, creating and listening to music, and reading books and poetry produced by African-American survivors are all artistic forms of expression that can help survivors to heal themselves (Evans, Bell, Burton, & Blount, 2017).

In addition, from a social justice perspective we can conceptualize new models for empowering Black victim-survivors, and indeed all women, who have experienced IPV. For women with access to certain kinds of economic or emotional resources, such as money, housing, and social support, taking control over one's situation can be effective and energizing. In contrast, for those without means, attempting to "take control" or "solve" the problem of abuse can be met with failure and magnify existing power inequalities, resulting in further distress. Accordingly, we should reconceptualize our notion of empowerment. Cattaneo and Goodman (2015) defined empowerment as "a meaningful shift in the experience of power attained through interaction in the social world" (p. 84). Specifically, a more sensitive empowerment model

describes the process of building empowerment as an iterative one, in which a person who lacks power sets a personally meaningful goal oriented toward increasing power, takes action, and makes progress toward that goal, drawing on his or her evolving self-efficacy, knowledge, skills, and community resources, and support, and observes and reflects on the impact of his or her actions. (p. 84)

Applying this empowerment model means that we are working to understand the victim-survivor's goals, helping her to articulate her aims, acknowledging the structural barriers to achieving those objectives, and working with her to craft a strategy to overcome the challenges that she faces. Her unique circumstances and hopes for the future are moved to the forefront. This is preferable to offering her options for assistance that are based on the availability of services or the mission of a domestic violence organization.

Foster the Survivor's Social Support System

A strength-based approach might routinely include inquiries into the availability and nature of the victim-survivor's support system and service providers can incorporate women's social support networks into their programs,

policies, and practices. For example, higher levels of social support from relatives and friends were associated with better mental health status among abused Black women. Therapists can educate the victim-survivor's informal social support network about dynamics of domestic violence. Social support also can happen in the form of group therapy, which promotes healthy relationships and builds effective coping and problem-solving skills (Davis et al., 2009). When compared to women from other ethnic groups, Black victim-survivors are more likely to rely on their clergy, spirituality, and religion to cope with IPV (Nnawulezi & Murphy, 2017). Dyer (2016) recommends that social workers and mental health workers develop partnerships with clergy members. For instance, they can discuss with faith leaders how the clinical interventions and faith interventions complement, at times overlap, and possibly diverts from each other.

Finally, service providers should strive to create a broad range of services to help victim-survivors, their children, and the larger community to combat IPV:

From the standpoint of social justice, helping to empower poor black communities to develop culturally competent domestic violence shelters—prevention, neighborhood-based crisis intervention, shelters for women and children, counseling, and economic assistance—to promote families and households in their struggle against domestic violence is a salient ethical issue for counselors. (Conwill, 2010, p. 42).

CONCLUSION

In this chapter, I provided a brief overview of IPV in the lives of African-American women, discussed what social justice looks like in theory, and ended with some practical applications for treatment interventions. My personal and professional vision is simple: To educate empower, and inspire a multicultural alliance of survivors and professionals to prevent all forms of violence and to help survivors to heal themselves. From a social justice perspective, mental health professions, in collaboration with victim-survivors, should strive to commit to activism at the local, state, and national levels. As advocates for victim-survivors of abuse, it is imperative that this awareness is reinforced by deliberate engagement in efforts to reduce the impact of these oppressions within society. This will not only result in successful and individualized treatment of survivors, it will address prevention of violence in all forms.

NOTE

1. The terms *Black* and *African-American* will be used interchangeably in this chapter.

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