INTIMATE PARTNER VIOLENCE IN AFRICAN AMERICAN WOMEN

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Abstract

Violence against African American women, specifically intimate partner abuse, has a significant impact on their health and well being. Intimate partner femicide and near fatal intimate partner femicide are the major causes of premature death and disabling injuries for African American women. Yet, despite this, there is a paucity of research and interventions specific and culturally relevant for these women. This article focuses on issues relevant to intimate partner violence and abuse against African American women by examining existing empirical studies of prevalence and health outcomes of intimate partner violence against women in general, plus what limited research there is about African American women, specifically. It includes a discussion of specific recommendations for research, practice, education, and policy to reduce and prevent intimate partner violence against African American women.

Key words: violence and abuse, interpersonal violence, intimate partner violence, spouse abuse, African American women, blacks, domestic violence, ethnic groups

Intimate Partner Violence in African American Women

Straus and Gelles (1990) reported that between 1.8 and 3.6 million women in the United States are severely assaulted by their intimate partners each year. Women are more likely to be assaulted or killed by a male partner than any other type of assailant (Browne & Williams, 1993). Numerous national reports confirm these findings (Bachman & Saltzman, 1995; Greenfield, et al., 1998; Office of Justice Programs, 1998). Femicide, the killing of women, is also most often perpetrated by current or former husbands or boyfriends (Browne, 1993; Schnitzer & Runyan, 1995).

Among African American women between the ages of 15 and 44, femicide is
the leading cause of premature death (Office of Justice Programs, 1998). Near fatal femicide of African American women also contributes to long term disabling injuries and conditions. Most often the men who kill or abuse these women are their intimate partners i.e., husbands, lovers, ex-husbands or ex-lovers (Bachman & Saltzman, 1995; Bailey, et al., 1997; Mercy & Saltzman, 1989). Therefore, "The National Black Women’s Health Project" has identified the battering of women as the number one health issue for African American women (Joseph, 1997).

According to the American Medical Association (1992), one in every three women in this country can expect to be beaten by a male partner at some time during their adult life. While these general statistics are useful, violence and abuse in African American women remains a relatively understudied area, despite calls for greater inclusion of African Americans in studies of domestic violence (Asbury, 1987; Coley & Beckett, 1988; Lockhart & White 1989; Wyatt, 1994). Consequently, there is a paucity of research on how interpersonal violence affects the lives of African American women (Coley & Beckett, 1988; Gary, Campbell & Serlin, 1998; Koss, et al., 1994). There are several limitations in this small body of research, such as inappropriate comparisons of African American women with Caucasian women and lack of examination of contextual variables that increase African American women’s vulnerability to intimate partner violence and subsequent consequences (Campbell, 1993; Campbell, Masaki & Torres, 1997; Raj, Silverman, Wingood & DiClemente, 1999).

African American women’s responses to violent and abusive behavior may be influenced by the chronic experiences of racism, and the social contexts in which they live. These circumstances often provide them with different opportunities for and restrictions on their resistance to violence (Campbell, Campbell, King, Parker & Ryan, 2001). Previous racist or other negative experiences may prevent African American women from seeking help from institutional resources, which traditionally safeguard or protect Caucasian women from abuse (Harvey, 1986; Wyatt, 1994). Culture bound issues need to be studied and this may best be accomplished through within-group study of representative community samples (Koss, et al, 1994; Wyatt, 1994).

The purpose of this article is to examine current issues, relevant specifically to intimate partner violence in African Americans, a form of domestic violence or interpersonal violence, in general. The focus is on violence and abuse against African women based on empirical evidence. We include information on the incidence and prevalence of violence and abuse against women in general and African American women, specifically, based on national statistics about nonlethal and lethal violence. We briefly describe sociocultural theory as used to explain violence against women and its relevance for understanding this major health problem in African American women. Studies, which have examined a variety of contextual variables that might be associated with violence and abuse in African American women, are reported. Finally, we present recommendations for reducing the unacceptably high levels of interpersonal or intimate partner violence (IPV) in African American women with implications for nursing research, practice, education and policy.

Incidence and Prevalence
Non-Lethal Violence

The Office of Justice Programs (1998) reported that rates of nonlethal intimate partner violence were higher among African American females than Caucasian females. Among women, being Black young, divorced or separated, earning lower incomes, living in rental housing, and residing in urban areas are all associated with higher rates of intimate partner victimization. Nonlethal violent victimization includes rape, sexual assault, robbery and aggravated and simple assault (Greenfield, et al., 1998). Such violence is most likely to occur at or near the home of the victim and usually during the evening and night hours.

There is a lack of ethnic group specific data on responses of women to intimate partner violence. In general, women respond to non-lethal violence by actively defending themselves during the incident (three out of four) and reporting the incident to the police. African American female victims are more likely than others to call the police, calling about two-thirds of the time compared to about 50% of Caucasian women (Greenfield, et al., 1988) and the assailant is usually arrested. When African American women call the police they call for more severe episodes of abuse.

Incidents of nonlethal violence among women in general are frequently not reported. This phenomenon is not well understood. Among this group of battered women, there is limited research about the frequency of police contacts and their reasons for not calling the police. In a sample of women who were asked about their experiences with the police, two thirds reported having had contact with the police, although most did not believe they had as much contact with the police as needed to thwart future abusive episodes. Among the reasons given by those who did not call the police were situational barriers, such as being physically prevented from using the telephone and/or being threatened with more violence. Fewer women reported that shame, embarrassment, or "love" were their sole reasons for not calling the police. Underreporting has been related to previous (negative) experiences with the police as well as to the level of violence experienced. Non-reporting victims stated that they considered the victimization a private or personal matter (Greenfield, et al., 1998) and did not consider, at that time, involving the police.

Thousands of abused female victims respond to IPV by seeking orders of protection, usually as a last resort after other sources of seeking help had failed. (Zoellner, et al., 2000). These authors found, however, that less than half of the women who initiated the restraining order process actually obtained final court orders. In this sample of whom 57% were African American, 31% Caucasian and 12% Hispanic, women’s marital status (married/living together, not married/not living together) and ethnicity (Caucasian/non-Caucasian) were not related to final restraining orders (Zoellner, et al., 2000). Wolf, Holt, Kernic and Rivara (2000) found differences among women seeking restraining orders. They reported that women who obtained protection orders were more likely than victims without protection orders to be employed full-time, be pregnant, be married, over age
24, and less likely to be involved with perpetrator at the time of the index incident. They also found that women whose families and friends are also the targets of abuse are more likely to seek a protection order.

Responding to violence and abuse by leaving the abuser may be difficult and initially unsuccessful (Campbell, 1989; Campbell, Miller, Cardwell & Belknap, 1994) with a battered woman on average, making five attempts to leave her partner before she actually ends the abusive relationship. After leaving, partner violence frequently continues in the form of stalking, threats and physical assault (Campbell, Rose, Kulb & Daphne, 1998; Kurz, 1996; Sullivan, Campbell, Angellique, Eby, & Davidson, 1994; Wilson, Johnson, & Daly, 1995). The extent to which African American women choose and are able to leave abusive relationships remains unclear and not well researched.

Nearly 170,000 female victims of violence are estimated to receive services from a victim advocacy agency during the course of a year, and this is likely an underestimate (Greenfield, et al., 1998). These data were not reported by racial or ethnic group or by ages of the women seeking services. About half report an injury of some type. The injuries usually do not involve the use of a weapon, but when a weapon is chosen, it is most likely a bat or object used to hit, or a knife or sharp object to cut or puncture. The weapon least likely to be selected is a firearm. In order of frequency, the most common injuries that women sustain are bruises followed by cuts and stab wounds with internal, musculoskeletal, concussion and head injuries, rape, sexual assault, and gunshot wounds. The relative risk of hospitalization is increased among abused women, causing a significant impact on women’s health and use of health care facilities (Kernic, Wolf & Holt, 2000). Females account for 39% of the hospital emergency department visits for violence-related injuries, but 84% of the persons treated for injuries inflicted by an intimate partner. About 20% of these women seek medical assistance resulting in health-related expenses and other costs of crime totaling about $150 million annually (Greenfield, et al., 1998). There is limited information on the use of social services agencies, the health care system and advocacy programs by African American female victims of intimate personal violence.

Slightly more than half of all female victims of IPV live in households with children under age 12 who frequently witness the violence against these women (Graham-Bermann & Hughes, 1998a; Graham-Bermann & Hughes, 1998b; Langhinrichsen-Rohling & Neidig, 1995). These young children are at risk for developing a variety of physical and psychological reactions to the violence that they witness (Lehman, 1997; Lewandowski, et al., in press).

**Lethal Violence**

In 1996, just over 1,800 murders were attributable to intimate partner violence with 3 out of 4 of these having a female victim. Over the past twenty-five years there has been a decline of victims of intimate murder. The decline has been larger for spouse killings, compared to the killings of other intimates, especially for male victims (Fox & Jawitz, 2001; Greenfield, et al., 1998). However, the percentage of female murder victims killed by intimates has remained stable at about 30%.
with some declines observed since 1993. The number of Caucasian females killed by intimates rose during the mid-1980’s, declined after 1993, and in 1997 reached the lowest level recorded over the past twenty-five years. The number of intimate homicides for all other race and gender groups declined over the same period: African American females killed by intimates decreased 53%, African American males by 75%, and Caucasian males by 55%. For every age group, female murder victims are more likely than male victims to have been killed by an intimate. The decline in murder includes a sharp decrease in the rate of intimate murders of men, especially African American men, and in the number of intimate murders with guns. From 1990-1998, guns killed two thirds of the spouses and ex-spouses victims. Knives killed almost half of the boyfriend victims and intimate homicides were more likely to involve knives than nonintimate homicides (Fox & Zawitz, 2001). There is some evidence of a slight increase in the rate of Caucasian females killed by boyfriends (Greenfield, et al., 1998).

A recent study of Risk Factors for Femicide in Abusive Relationships conducted by the current authors, used a multi-city, case control design with consecutive completed femicides as cases and randomly identified abused women living in the same communities as controls. This study examined numerous variables that might be associated with risk for femicide in IPV (Campbell, et al., in review). On bivariate analysis, perpetrators and their female victims of intimate partner femicide were more likely to be African-American, unemployed and not looking for a job, and less educated compared to abused controls. However, further testing of several multivariate models revealed that unemployment was the most important perpetrator demographic risk factor and seems to underlie the apparent risk attributed to race. Other studies using multivariate models report similar findings (Centerwall, 1995; Hawkins, 1993).

Sociocultural Theories as Explanations of Violence and Abuse in the Lives of African American Women

While there are several theories that are frequently used to explain human violence, none are specific to African American women. Most theoretical frameworks used to explain domestic violence and abuse of women rely heavily on psychological models emphasizing individual characteristics. Most of these models provide an inadequate explanation of domestic violence and abuse and research based on them has failed to find any consistent pattern of psychopathology in men who batter or in women who are abused (Alexander, 1993; Hotaling & Sugarman, 1986; Ptacek, 1984).

Sociocultural theories focus on the long-term effects of adult behavior on children as well as political, economic, structural and cultural aspects of society (Barnes, 1999). Sociocultural theories may examine phenomenon from a microsocial perspective (family) or from a broader macrosocial perspective (societal influences). Sociocultural theories have also been frequently studied, and are widely accepted as explanations for domestic violence. One of the most frequently cited sociocultural theories is feminist theory, which suggests that violence against women emanates from potent socializing messages from families, peer groups, media, the law and other.
institutions of a sexist society that lead to the acceptance and normalization of gender-based violence. Feminist theory is difficult to operationalize for empirical examination and is not often used or tested in research for this reason (Raj, et al., 1999).

The theories currently used in domestic violence practice and research generally are unidimensional in nature and applied uniformly across cultural groups, ignoring ethnic-cultural differences and similarities (Barnes, 1999) or culturally specific factors that may adversely affect women’s resistance to abuse from male partners (Wyatt, 1994). Overall, the applicability of these theories for explaining the onset, course and perpetuation of intimate partner violence in ethnic people of color, especially African Americans, remains uncertain (Barnes, 1999; Hampton & Gelles, 1994; Wyatt, 1994). One promising avenue is Janette Taylor’s (1998) womanist approach, an African American specific application of feminist theory to research and scholarship on domestic violence.

The Context of Violence in the Lives of African American Women

Among the contextual variables consistently associated with increased risk for violence and abuse in African American women are socioeconomic (poverty, low income), socioenvironmental, problem drinking and illicit drug use, especially by perpetrators, and relational factors. Not surprisingly, our research found that the most significant risk factor for intimate partner femicide or lethal violence was intimate partner violence. However, over and beyond this, we found associations with intimate partner femicide in the various models tested with each of these contextual variables (Campbell, et al., in review).

Characteristics of the socioenvironment such as neighborhood poverty are associated with the risk of partner violence, particularly among African American couples (Campbell, et al., 1997; Cunradi, Caetano, Clark & Schafer, 2000). However, Centerwall (1995), reported that a sixfold difference in African American and Caucasian rates of intraracial domestic homicide in two major cities in the South were entirely accounted for by differences in socioeconomic status between the respective African American and Caucasian populations, with no residual differences requiring cultural explanations. Our research found that the most important perpetrator demographic risk factor for femicide was partner unemployed and not seeking employment. The employment status of the victim was not a significant risk factor for femicide in any of the multivariate models tested. Higher levels of education (especially college level) were associated with lower levels of femicide (Campbell, et al., in review). Most current research employing multivariate models for analysis of variables expected to be related to both nonlethal and lethal violence have not found race or...
ethnicity to be independently associated with increased risk for violence (Campbell, et al, in review; Centerwall, 1995).

Alcohol related problems among both male and female partners were found to be important predictors of intimate partner violence across racial/ethnic groups. However, after controlling for sociodemographic and psychosocial covariates, male and female alcohol-related problems remained the strongest predictors of intimate partner violence for African American partners, but not for Caucasian and Hispanic couples (Caetano, Nelson & Cunradi, 2001; Cunradi, et al., 2000). In our femicide study, male problem drinking was associated with an eight-fold increase in partner abuse and a two-fold increased risk of femicide/attempted femicide. Male perpetrators of violence and femicide were more likely to be problem drinkers, to drink more frequently and to be binge drinkers. In our femicide/attempted femicide sample, there is an overrepresentation of African Americans males with low education, low income and perhaps restrained insight for recognizing their alcohol problems or having the resources to enroll in alcohol treatment programs (Sharps, Campbell, Campbell, Gary & Webster, 2001). Our findings are consistent with those reported by others (Campbell, 1992; Moracco, Runyan & Butts, 1998; Smith, Moracco & Butts, 1998).

Raj, et al. (1999), in a study of the relationship between social and economic power and male-perpetrated abuse among low-income African American women, reported a higher incidence of partner sexual jealousy, longer-term involvement in the relationship, receiving no income from male partner, perceptions of low empathy from partner and strong desire to have children now, to be independent predictors of relationship abuse. These relational variables accounted for 34% of the variance in abuse from male partners in this community-based sample of low-income African American women.

In our research the most significant relationship variable that was a risk factor for femicide was, first of all, a history of interpersonal violence. In addition, contributing to an increased risk for femicide were the demographic factors of the partners never living together, the victim left or asked partner to leave, and the victim had children who were stepchildren of the perpetrator (Campbell, et al., in review).

Jasinski (2001), in a recent study of physical violence among ethnically diverse groups, suggested that the same factors that might increase the initial risk for violent behavior might not affect whether or not this behavior continues. In addition, the same risk factors may be related in different ways to various patterns of violence among diverse racial/ethnic groups.

Reducing Violence and Abuse in the Lives of African American Women

Recommendations for Future Research

More systematic research is needed to generate knowledge about theoretical and causal models that enhance our understanding of the contextual variables that influence the perpetration of violence against African American women by their intimate partners. Theoretical models should be multidimensional and analytical models should be multivariate.
Community-based studies are needed that examine socioeconomic status variables such as employment, education, types of jobs/careers, and differences in status related to these variables between intimate partners. Studies should examine how socioeconomic variables and status may serve as protective or risk factors for abuse perpetration and victimization of African American women by intimate partners. Community-based studies of violence and abuse of African American women should specifically examine contextual factors such as poverty, single parenthood, and histories of previous intimate partner violence. In addition, community based studies need to further examine female and male partner’s use of alcohol and other drugs, the interaction of substance use, and the contextual factors described above. More importantly, systematic studies are needed which examine the interactions of all of the contextual factors, substance use and their influence on the perpetration of violence against African American women. Also needed are studies that systematically examine the nature of support systems that function among African American families and document the actual domains of the types of support that they provide for the victims of intimate partner violence and their children.

Research is needed which focuses on developing and validating culturally sensitive and relevant screening and assessment tools for African American female victims ([Bent-Goodley, 2001](http://www.nursingworld.org/ojin/topic17/tpc17_4.htm)). Many of the tools used for screening, history taking and assessment have been evaluated primarily through use with Caucasian women who may have significantly different cultural and socioeconomic backgrounds and experiences compared to African American women. For example, assessment tools might need to explore cultural differences in perceptions related to physical abuse in intimate relationships. On current tools physical abuse in IPV is only described as positive (yes) or negative (no). Assessment tools might also need to be developed to provide for a systematic examination of verbal and emotional abuse and its relationship to physical abuse. In addition, there is a need to develop and test culturally relevant intervention strategies that focus on the prevention of intimate partner violence in African American communities. Researchers, clinicians, and policy makers have a professional obligation to differentiate culture-specific thoughts and behaviors from psychopathology. Without knowledge, sophistication, and skill, one phenomena can easily be substituted for the other.

Future research is also needed that focuses on African American male perpetrators of IPV. In many urban areas African American males comprise almost half of the persons arrested for domestic violence ([Gondolf & Williams, 2001](http://www.nursingworld.org/ojin/topic17/tpc17_4.htm)). There is at least one pilot study, which provides preliminary results of the effectiveness of an intervention using culturally focused counseling for African American batterers ([Williams, 1992](http://www.nursingworld.org/ojin/topic17/tpc17_4.htm), [Williams, 1995](http://www.nursingworld.org/ojin/topic17/tpc17_4.htm)). This approach includes African American men only; an African American male therapist who uses a curriculum that emphasizes the historical, social and cultural context for male battering; and who leads the male counseling/educational sessions. Research, which evaluates the outcomes for batterers as well as their intimate relationships and perceptions of female
partners after the male partners complete the intervention, is needed. Ideally, additional culturally focused interventions for females need to be developed and tested for their effectiveness in preventing and reducing violence against African American women. It is also important that future research explore the perception that mainstream America devalues African American women and their plight as victims of family violence, and also the long-term effects of family violence on the children of mothers who are battered. For example, studies that explore the perceptions and lived experiences of the relationships among African American women and law enforcement could be useful, but are non-existant.

Recommendations for Practice

Interventions should be based on the personal qualities, as well as issues and research-based findings specific to African American women. Often African American women experience the "triple jeopardy" of increased levels of poverty, vulnerability to diseases, and mental illnesses, including substance use/abuse, and battering by an intimate partner (Gordon-Bradshaw, 1988; Sullivan & Rumpetz, 1994). Frequently these women reside in communities where resources to help them deal with these issues, as well as battering, are lacking. Clinicians need to be aware that the apparent assertiveness and resiliency that many battered African American women present with may be a style of coping that they have developed because of limited personal resources as well as a lack of trust for clinicians and other helping systems (legal, law enforcement) who could not be counted on for assistance in the past (Gondolf, 1998).

Intervention staff should include African American practitioners who recognize the strengths of these women and are sensitive to the concerns of battered African American women. It is recommended that clinicians ask all women, including African American women, who present for health care in emergency rooms, primary care, family planning, well child care, mental health and substance abuse settings about intimate partner abuse. Clinicians should inquire about conflicts, stresses, and actual and preferred methods of conflict resolution, and child rearing practices for that particular family, during the clinical visit. In the assessment phase of the clinical interview and during subsequent assessments, the nurse could further explore with the woman how crises and periods of upheavals are managed in her home and offer alternatives, literature, classes and other intervention methods that will address the specific concerns. It is important that these assessments continue beyond the first visit, with the clinician conveying concern about how individual and/or family health may be related to abuse, and at each subsequent contact focusing on the health and welfare of each family member. When children and women experience conditions such as continuous colds, weight reduction, stress, headaches, sleep disorders, and other such disorders, the nurse should be alerted to the possibility of abuse, as
well as to help the family members see how health conditions may be related to abuse. It is important to investigate injuries sustained by children and women who present at clinics and hospitals. Among intimate partner femicide victims, 69% had been abused before their death and at least 41% of these women had been seen in a health care setting before the killing. These women may have represented missed opportunities for preventing femicide (Sharps, et al., 2001). Although for these femicide victims, there may have been missed opportunities for interventions, clinicians should be aware of the potential for intervention for other abused women who will enter any health care setting in the future. Each entry point into a health care setting has the potential for initiating an intervention or referral to prevent or reduce further violence against women.

Women and children should be involved in interventions that will help them to deal with their experienced interpersonal violence in the here-and-now as well as the potential for intergenerational transmission of violence. Interventions must also include solutions that identify domestic violence (DV) as a community issue, by increasing the awareness of the impact of DV on children, disruption of families, increased vulnerability to HIV infection, and on other aspects of women’s health including increased death rates for young African American women and increased numbers of African American women being incarcerated related to DV arrests. Comprehensive community-based interventions must include an early identification of abused women, perhaps by using lay African American community outreach workers, appropriate referrals to community resources, shelters or support groups. Certain intervention such as self-help or support groups may need to be Afrocentric using only African American participants and leaders. Further community-based interventions need to address poverty, access to substance abuse treatments and resources that support children and families for both female and male partners. These services need to be available in a way women can access them and find them useful. Community-based prevention strategies may include school based, church based or neighborhood violence prevention or conflict resolution programs.

**Recommendations for Education**

The education of nurses, at all levels, should include a focus on the importance of injury prevention which includes assessing for partner abuse, child abuse, and other forms of potentially destructive methods of relating between individuals and within families. Content and interventions should be specific and include culturally sensitive approaches for meeting the needs, not only of African American women and children, but also women and children of other ethnic groups and immigrant women. Nurses, at all levels, should receive instruction in the efficient use of validated and reliable assessment instruments such as the Abuse Assessment Screen (Soeken, McFarlane, Parker & Lominack, 1998), the Danger Assessment (Campbell, 2000).
or other comparable instruments that have evidence of validity and reliability specifically with African American women. Nurses and other health care providers in clinical practice, across settings, must understand that intimate partner violence and abuse can occur in a range of age, ethnic, socioeconomic, and religious groups; they need to be constantly alert for possible signs and symptoms of its occurrence.

Police and other law enforcement personnel need to have an understanding of intimate partner violence. They must also understand the roles and functions of health system personnel in preventing violence and assisting with the care of physical and mental health needs that result as a consequence of violence. Nurses must become familiar with state and national laws as they relate to abuse and violence in intimate relationships, and clearly understand the responsibilities that nurses have in assisting abused women. Equally important are the application of ethical principles as they link to helping women who are in abusive relationships. For example, regarding the safety of battered women and their children as a priority, assuring confidentiality and privacy, and respecting the integrity and authority of each battered woman over her own life choices are beginning points.

A women’s readiness to "escape" from an abusive relationship can present in various stages, and nurses should understand these stages and incorporate them effectively in aiding a woman who is in an abusive relationship (Landenberger, 1989). This level of understanding will help the nurse to realistically assist the woman, and protect the nurse against potential frustrations related to the abused woman’s readiness to leave her abusive partner. The clinician should help the woman to strengthen her coping strategies during the time that she is in the abusive relationship, and support her through the various phases of separation and withdrawal from the abusive relationship.

**Recommendations for Policy**

A coordinated community response to intimate partner violence is imperative.

Sustaining an appropriate response to domestic violence requires that nurses and other clinicians have support at the institutional level where they practice and of the communities they serve. This requires institutionalized policies coordinated by all levels of the community including health care providers, community-based domestic violence advocacy groups, child welfare and protective service agencies, and the civil and criminal justice systems.

Health care systems should institutionalize policies that support programs known to reduce intimate partner violence among African American women and other economically less advantaged women. Health system policies should direct clinical protocols for screening of women for abuse during health-related visits as a routine component of the overall health assessment and treatment process. Programs for the treatment of sexually transmitted diseases, HIV/AIDS and alcohol, and substance abuse should recognize the
disparate impact of these social and health problems on the issues of intimate personal violence (Cohen, et al., 2000) and routinely screen for violence and abuse in these settings as well as in others. Within health care settings, culturally relevant, language appropriate, easy to read and understand posters, brochures, and other types of media should be readily accessible to women.

Rates of intimate partner homicide have decreased substantially over the past 25 years. During the same period there has also been an increase in public awareness, and an expansion of domestic violence policies, services and programs. There is a need to examine relationships between these concurrent trends to document the impact of social responses and types of resources available to victims of domestic violence on these trends. Policies aimed at reducing community poverty may contribute to effective partner violence prevention strategies (Campbell, et al., 1997; Cunradi, et al., 2000). A re-examination of legal, health and material resources for poor women and women of color could be a first step. There is evidence that some recent policies may have resulted in a backlash effect for women at highest risk, particularly African American women, with the resulting interventions aimed at reducing violence actually increasing its likelihood. (e.g. restraining orders, mandatory arrests, shelter protection). Such policies may anger or threaten the abusive partner without effectively reducing contact with the victim. For example, negative consequences of cutting AFDC payment levels appear to have increased homicides of black married men, black unmarried partners, and white unmarried females (Dugan, Naggin & Rosenfeld, 2000).

Little is known about which welfare to work policies are effective for battered women, or which strategies women on welfare who are battered can use to become economically self-sufficient. Many of these women cannot sustain employment over time, even though they desire to do so, unless the violence stops. Raphael & Tolman (1997) suggest that recent changes in welfare law, with rigid requirements for employment and time limits for welfare receipt, will place some battered women and their children at greater risk for continued abuse and increased risk for long-term poverty. State welfare departments should critically evaluate these policies and programs for their impact on domestic violence. There is a need to assure that discrepancies in implementation of policy or services do not effectively limit the reduction in exposure to violence. Poor women of color may be quite vulnerable to increased violence if they do not have equal access to the types of protection mandated by law and policy.

Policies directed at understanding and intervening with abusers are also essential. In the context of current policies, some men who are uneducated, unemployed, or underemployed may feel abandoned by both governmental and private helping systems, increasing their need to control and dominate their partners. The seeds of constructive interventions with batterers lie in a better understanding of the dynamics of these abusive relationships (Raphael & Tolman, 1997). Policies that increase strain on relationships without reducing contact may increase risk for homicides that vary by marital status, race and gender...
Coker argues firmly that in every area of anti-domestic violence law and policy, priority should be given to those laws and policies which improve women’s access to material resources whether it be determining funding priorities, analyzing appropriate criminal law or arrest policies, developing city ordinances, or drafting administrative rules.

**Conclusion**

There has been limited attention to the availability and effectiveness of supportive community agencies, including health systems, in addressing the needs of African American and other women of color who experience violence and victimization. Although many types of community services exist, the accessibility, sensitivity, and usefulness to women of color are not known (Wyatt, 1994). High priority by public policy and both public and private funding agencies should be given to research-based interventions that are sensitive to cultural differences among various populations.

In the final analysis, diligent, serious and coordinated efforts of groups with an interdisciplinary focus must shape policies that include the best practices of public policy advocates, health care and legal systems, law enforcement, and the religious communities. From such efforts, substantial progress can be made in specifically addressing the needs of all women for whom intimate partner violence is a vivid and continuing reality.

Intimate partner violence against African American women is a complex problem. Consequences include increased disparities in both physical and mental health. Efforts to decrease vulnerability of African American women to intimate partner violence requires a better understanding of the underlying causes of such violence and the contexts within which it occurs. Efforts to reduce violence in the lives of African American women must focus on decreasing vulnerability and health consequences through more and better research, improved practice, education and policy. Such efforts require coordinated community responses including nursing and other health care professions, law enforcement and legal systems, policy makers, the religious community and community based agencies.

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References


Dugan, L., Nagin, D. & Rosenfeld, R. (2000). Exposure reduction or backlash? The effects of domestic violence resources on intimate partner homicide. A Final Report to the National Institutes of Justice, (Grant #97WTX0004).


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