Black Women's Health: The Effect of Perceived Racism and Intimate Partner Violence
Eve Waltermaurer, Carole-Ann Watson and Louise-Anne McNutt

VIOLENCE AGAINST WOMEN 2006; 12; 1214
DOI: 10.1177/1077801206293545

The online version of this article can be found at:
http://vaw.sagepub.com/cgi/content/abstract/12/12/1214

Additional services and information for Violence Against Women can be found at:

Email Alerts: http://vaw.sagepub.com/cgi/alerts
Subscriptions: http://vaw.sagepub.com/subscriptions
Reprints: http://www.sagepub.com/journalsReprints.nav
Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations (this article cites 20 articles hosted on the SAGE Journals Online and HighWire Press platforms):
http://vaw.sagepub.com/cgi/content/refs/12/12/1214
Black Women’s Health

The Effect of Perceived Racism and Intimate Partner Violence

Eve Waltermaurer
New Paltz State University of New York
Carole-Ann Watson
New York State Department of Health, Albany
Louise-Anne McNutt
State University at Albany, NY

This study provides preliminary evidence of the relationship between perceived racial discrimination and intimate partner violence (IPV) and how these exposures interact to affect the mental and physical health of Black women. The exposures of lifetime perceived racial discrimination and IPV were found to be highly associated. Furthermore, women who reported both exposures showed a notably higher prevalence of anxiety and nonspecific physical health symptoms compared with women who reported either or neither exposure. To appropriately respond to the health needs of Black women, it is essential that women’s many stressors be considered simultaneously.

Keywords: intimate partner violence; perceived racism; women’s health

The apparent racial disparities in health outcomes have generated an extensive assessment as to what factors may exist to explain why, for so many health conditions, Blacks are worse off. Research in this matter has pointed to institutional and personal racism as a probable culprit for much of this disparity (Forman, Williams, & Jackson, 1997; Jones, 2000; Krieger & Sidney, 1996). As both racism and intimate partner violence (IPV) have only recently emerged as significant public health issues, the interest of this study was to better understand the relationships among perceived racism, IPV, and both mental and physical health.

Although there have been slow but gradual advancements toward a better understanding of the relationship between racism and IPV, most of the work on IPV and racism to date has been theoretical. Perhaps this is because of our general lack of understanding as to how racism and sexism interact in our society (Crenshaw, 1991; Kastururangan, Krishnan, & Riger, 2004). The limited consideration of how racism and sexism may interact, in regard to IPV specifically, may result from the inconsistent findings as to whether or not Black females are at higher risk than are White females.

Furthermore, even early social science research has contended that although Blacks appear to show higher risk, this information may not in fact relate to race as
much as to socioeconomic class (Cazenave & Straus, 1979). In fact, in one social science study, no racial disparity was found in the rate of IPV overall. However, when stratified by social class, Black women had a higher rate than did White women only among the middle class (46% vs. 27%, respectively). Among the upper class, the prevalence of IPV among White women was 40% higher than for Black women (30% vs. 18%, respectively), and among the lower class group, the prevalence for White women was 15% higher than for Black women (52% vs. 44%, respectively; Lockhart, 1987).

Still, it has been maintained that the impact of racism must be considered when understanding IPV victimization and offending (Hampton, Oliver, & Magarian, 2003). Hampton and colleagues (2003) argue that the existence of racism in our society results in a potential unwillingness of Black women to implicate Black men out of a perceived betrayal of their already oppressed race. Furthermore, these women may experience or perceive to experience racism from police and others in the criminal justice system that furthers their motivation to keep their abuse private. As for the Black offenders of IPV, Hampton and colleagues argue that joblessness and poor education that result from the racism in this country likely increase the propensity of these males to act violently. In terms of IPV intervention, Oliver (2000) argues that the focus of IPV interventions for Black women needs to be culturally sensitive and incorporated throughout Black popular culture.

Empirically, little has been done to measure what actual impact racism and exposure to IPV may have in the lives of many Black women. One recent longitudinal study, the Family and Women Project, found a strong association between HIV and IPV among Black women; however, perceived racial discrimination was not measured (Wyatt, Axelrod, Chin, Carmona, & Loeb, 2000). A great deal of empirical research has been done looking at the impact of racism on a variety of other health outcomes, finding associations between perceived discrimination and adverse psychological and physiological health outcomes (Broman, 1996; Clark, Anderson, Clark, & Williams, 1999; Kessler, Mickelson, & Williams, 1999; Krieger & Sidney, 1996; Ren, Amick, & Williams, 1999; Williams & Collins, 1995). For example, Kessler et al. (1999) found that the risk of reporting mental illness was greater for individuals reporting discrimination. In this study, chronic or frequent experiences of discrimination were associated with a twofold increased risk of depression (odds ratio = 2.1, 95% confidence interval = 1.5-2.9) and a threefold increased risk of anxiety (odds ratio = 3.3, 95% confidence interval 1.9-5.7). Similarly, data from the 1995 National Survey of Functional Health revealed that irrespective of race, individuals who reported experiences of racial discrimination were more likely to report both poor mental and self-rated health compared to those who reported no discrimination (Ren et al., 1999).

Racial discrimination and IPV have both been associated with poorer health outcomes among Black women. However, the impact of racism and the impact of IPV rarely intersect in the literature, especially with regard to the associated health implications for Black women. This study, therefore, seeks to better understand the relationship
between perceived racial discrimination and IPV and how these experiences may affect the daily health of Black women.

Method

Sample Selection

The data for this study were drawn from a larger cross-sectional study of women’s health conducted in Albany, New York, between July and August 2001. This study included women aged 18 to 44 years old in Albany, New York, between June and August 2001. Individuals were selected through a census tract and census block random-sampling method. Interviews with participants were obtained using a street intercept method; this approach specifies that the first eligible participants encountered at a randomly selected location are invited to participate in the study (see Yates, 1960, for further information regarding moving-observer sampling methods). The census tracts sampled were predominantly in poor neighborhoods and had higher proportions of African Americans, by design. In a census comparison, the racial distribution of the sample closely resembled that of the population for these chosen areas (results not shown). The two interviewers were female and in their 20s, one Black and one Latina. Interviewers administered an 83-item questionnaire on the street at each location. As a street-conducted survey, although participation in the study could not be anonymous, the interviewers were careful to ensure that the responses of the participants were anonymous. Care was taken to ensure that no one could overhear the interview questions or answers. All participants were given $10.00 compensation and provided with a community resource list.

Of the 383 women who were encountered, 285 women (74%) allowed the researchers to describe the study and invite them to participate. Of these women, 167 completed the survey (44% overall participation rate). Of the eligible female participants in the full cross-sectional study, 88 identified themselves as Black. This study focuses solely on the experiences reported by these Black women.

Measures

Perceived racial discrimination. Lifetime experiences of perceived racial discrimination or having ever experienced racial discrimination were measured using a validated 7-item inventory developed by Forman and colleagues (1997). This scale first describes a situation in which discrimination may have been experienced. For example, it asks, “Do you think you may have been unfairly fired or denied a promotion?” If an affirmative response is given, the question is followed by ascertaining the main reason for the perceived discrimination (e.g., race, ethnicity, gender). Seven situations for discrimination are used in this scale. Racial discrimination was
defined as an affirmative response to at least one item in the 7-item scale that was attributed to race.

**IPV type.** Two measures of past-12-months prevalence of IPV were assessed: emotional-only IPV and physical or sexual IPV. Past-12-months prevalence of emotional-only abuse was measured using nine questions that include the participants’ experience of insult, property destruction, isolation, accusations of an affair, and limiting access to money by an intimate partner. This measure has been found to be associated with Straus’ Conflict Tactics Scale (CTS) Version 2, verbal aggression scale (McNutt, Carlson, Persaud, & Postmus, 2002). Responses to these questions included “not at all,” “a little bit,” “quite a bit,” and “a lot.” Women who reported no experience of any emotional, physical, or sexual abuse were considered unexposed. In addition, because of the lower level of the emotional abuse, experiences of being insulted, accused of having an affair, or partner jealousy “a little bit” with no further experiences of emotional, physical, or sexual abuse were also considered unexposed.

Past-12-months prevalence of physical IPV was measured using nine questions from the physical aggression portion of the CTS (Straus, 1979). Past-12-months prevalence of sexual IPV was measured with one question regarding frequency of forced sexual encounters by an intimate partner. Women who reported one or more experiences of either physical or sexual IPV were considered exposed. A hierarchy was then used to categorize IPV experiences. Women reporting any physical or sexual abuse were included in the physical or sexual abuse group regardless of their experiences of emotional abuse. Women reporting emotional abuse in the absence of physical violence and sexual abuse were included in the emotional abuse-only group.

**Mental and physical health outcomes.** Anxiety and nonspecific physical symptoms were measured using a subset of questions from the Primary Care Evaluation of Mental Disorders (PRIME-MD; Spitzer, 1994). Women could respond that they experienced the specified symptoms “not at all,” “a little,” “moderately,” or “a lot”; comparable to criteria used by the PRIME-MD, only those women reporting mental or physical health symptoms “a lot” during the past month were considered exposed. The PRIME-MD has been used in primary care settings to assess physical and mental health symptoms. Spitzer et al. (1995), using a multisite sample of 1,000 adults, found strong agreement between diagnoses made by primary care physicians using the PRIME-MD and those of mental health professionals. For example, data showed that the PRIME-MD had a sensitivity of 69%, a specificity of 90%, and a predictive value positive of 60% for anxiety disorders.

**Demographic characteristics.** Demographic characteristics included age, education, employment status, and socioeconomic status (SES). Age was categorized into three groups: 18 to 24, 25 to 34, and 35 to 44. Education was categorized as: less than a high school diploma, a high school diploma or GED, some college, and at least 4 years of
college. Employment status included unemployed, employed, student, or homemaker. To measure SES, participants were asked a commonly used measure of economic hardship, “In the past 30 days, have you been concerned about having enough food for you or your family?” Rather than a general measure of total household income to assess SES, economic hardship may more directly describe SES in that it takes into account that the sustainability of a household income varies based on the number of dependent household members.

Data Analyses

Data were entered and verified using EPIINFO 6, and statistical analyses were conducted using SAS and StatXact. Frequencies and percentages were calculated to identify general characteristics of the sample and to describe patterns of perceived racial discrimination. Trivariate analyses were used to explore the distribution of perceived racial discrimination and IPV, assessing the prevalence of the two outcomes, anxiety and nonspecific physical health symptoms. Binomial confidence intervals were calculated for prevalence estimates using the Clopper and Pearson method (Clopper & Pearson, 1934).

Results

Table 1 provides the descriptive characteristics of the sample overall and by each outcome of interest, IPV, and perceived racism. Of the 88 Black women surveyed, about one third reported IPV in the past year and about one third reported experiencing perceived racism. There were some interesting differences when this sample’s demographics were considered in light of abuse status. It appears that emotional-only IPV is more prevalent among Black women who are unemployed and who were never married. Conversely, Black women who were never married and who were unemployed showed the lowest prevalence of physical or sexual IPV. IPV did not appear to differ by educational level; however, women with lower SES tended to show a higher prevalence of IPV compared to women with higher SES.

The Black women who were employed reported a higher proportion of perceived racial discrimination compared with the Black women who were unemployed, homemakers, and students. Older women reported greater perceived racial discrimination than did the women younger than 25. Although SES appears to not affect the likelihood of a Black woman perceiving racial discrimination in our sample, women with a lower education were proportionately more likely to perceive racial discrimination than were women with a higher education.

The bivariate comparison of perceived racial discrimination and IPV status revealed a statistically significant ($p = .02$) association between these two exposures (Table 2). Of the women who reported no perceived racial discrimination, approximately
44% reported some IPV experience in the past year. Conversely, of the women who reported experiencing perceived racial discrimination, 71% reported some abuse, with most of these abused women experiencing physical or sexual IPV.

When assessing the trivariate relationship among perceived racial discrimination, IPV, and two health outcomes (see Table 3), the small sample size resulted in wide confidence intervals surrounding each estimate. As a result, it is difficult to draw any definitive conclusion about the relationships among perceived racism, IPV, and health. This analysis suggests that interactions may exist between the perceived racism and IPV, negatively affecting the health of the women studied. When both perceived racial discrimination and abuse were reported, the prevalence of anxiety may be 41% to 57% higher compared to women reporting neither. When both

### Table 1

**Frequency of Intimate Partner Violence (IPV) and Perceived Racism by Select Variables Among Black Women Aged 18 to 44**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Emotional-Only IPV&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Physical or Sexual IPV&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Perceived Racial Discrimination&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>19</td>
<td>21.6</td>
<td>7</td>
<td>36.8</td>
</tr>
<tr>
<td>Employed</td>
<td>60</td>
<td>68.2</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>Homemaker</td>
<td>6</td>
<td>6.8</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td>Student</td>
<td>3</td>
<td>3.4</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>65</td>
<td>74.7</td>
<td>12</td>
<td>18.5</td>
</tr>
<tr>
<td>Beyond high school</td>
<td>132</td>
<td>36.8</td>
<td>6</td>
<td>18.7</td>
</tr>
<tr>
<td><strong>Socioeconomic status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>18</td>
<td>20.5</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Higher</td>
<td>70</td>
<td>79.6</td>
<td>13</td>
<td>18.6</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24&lt;sup&gt;e&lt;/sup&gt;</td>
<td>27</td>
<td>30.7</td>
<td>7</td>
<td>25.6</td>
</tr>
<tr>
<td>25-34</td>
<td>27</td>
<td>30.7</td>
<td>4</td>
<td>14.8</td>
</tr>
<tr>
<td>35-44</td>
<td>34</td>
<td>38.6</td>
<td>7</td>
<td>20.6</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
<td>13.6</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Formerly married</td>
<td>19</td>
<td>21.6</td>
<td>2</td>
<td>10.5</td>
</tr>
<tr>
<td>Never married</td>
<td>46</td>
<td>52.3</td>
<td>12</td>
<td>26.1</td>
</tr>
<tr>
<td>Unmarried couple</td>
<td>11</td>
<td>12.5</td>
<td>2</td>
<td>18.2</td>
</tr>
</tbody>
</table>

a. \( n = 18, \) 20.5%.

b. \( n = 29, 33.0\% \).

c. \( n = 31, 35.2\% \).

d. Percentage with outcome.

e. Relationship significant, \( \chi^2, p < .05 \) for racial discrimination outcome only.
perceived racial discrimination and abuse were experienced, the prevalence of physical symptoms may increase 28% to 43% compared to women reporting neither.

### Conclusions

This article is among the first to explore the relationship among perceived racial discrimination, IPV, and health outcomes. Even with the small sample size, there is an apparent association between perceived racial discrimination and IPV reports among the group of Black women studied. Though exploratory in nature, this study also provides supportive evidence that Black women who are experiencing racism and who are...
experiencing IPV are likely being uniquely and exceedingly burdened by mental health and physical health problems as well. Furthermore, it is unlikely this relationship is simply explained by spurious demographic characteristics as, in this study, age, education, occupation, and marital status were not similarly associated with IPV and perceived racism. Although others have argued that SES may help us understand the impact of racism on health (Cazenave & Straus, 1979; Crenshaw, 1991; Hampton et al., 2003; Lockhart, 1987; Oliver, 2000), in this sample it was interesting to find that SES, as measured, showed little difference in the prevalence of IPV or perceived racism reported.

Two important limitations to this study were the sample size and the specific sampling frame used. There is no question that the information about the true interactive effects of perceived racial discrimination and IPV are limited in this study by the small sample size. Were the sample size larger, the statistical interactions could actually be measured, a goal we hold for the future. Furthermore, this sample was derived from a low-density urban area, which may influence both exposures and outcomes differently than in other environments. It is hoped that more research will be conducted in the future using different populations.

This study may hopefully serve as a starting point toward our improved understanding of the intersectionality of racism and sexism and the health trajectories that may exist as a result. Considerations to guide this type of research have been outlined (Kastururangan et al., 2004), and theoretical arguments supporting this direction of IPV research have been well defined (Hampton et al., 2003). It is now paramount that empirical support of these contentions follows.

With regard to health, it is clear that to best understand and respond to the health needs of Black women, it is necessary to consider the multiple sources of stress they may experience. For too long, the influence of racism and the influence of IPV have remained outside of the physician’s office to the detriment of the individuals giving and receiving care. Fortunately, it is slowly being realized that experiences with sexism and racism must be considered—and considered concurrently—to best respond to the public health needs of Black women.

References


Eve Waltermaurer holds a PhD in social epidemiology and is an assistant professor at SUNY New Paltz in the Department of Sociology. She has studied violence in general and intimate partner violence (IPV) specifically for the past 8 years. Her research primarily looks at trajectories and measurement issues related to IPV, with her current research focusing on IPV risk after residential change.

Carol-Ann Watson holds an MS in epidemiology from the University at Albany, where she studied the effects of perceived discrimination on mental and physical health outcomes. In her current capacity as a research scientist for the New York State Department of Health, she focuses on behavioral characteristics among groups at high risk for transmitting or contracting the HIV virus.

Louise-Anne McNutt, PhD, is an associate professor in the Department of Epidemiology, School of Public Health, University at Albany, State University of New York. She holds degrees in both preventive medicine (epidemiology) and biostatistics. For the past 7 years, she has conducted research in the area of intimate partner violence. Building on her previous research and informed by the successes and limitations identified by her and other researchers, she works to develop and evaluate partner violence screening and intervention protocols for primary care practices.