



Domestic violence, sexual ownership, and HIV risk in women in the American deep south

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Abstract

Domestic violence and sexual abuse are important correlates of HIV risk in women. This paper examines the links between HIV risk and domestic violence in women in a region with the highest HIV/AIDS rates in the United States. The theoretical framework incorporates Butler's Bodies that matter: On the discursive limits of "sex." New York: Routledge.(1993) Gender trouble: Feminism and the Subversion of Identity. New York: Routledge.(1990) concept of performative gender and Collins' X Troup 0.32 (2000) "controlling images" of African American women as a context for domestic violence in the Deep South. Two focus groups were convened to develop a definition of domestic violence as HIV risk; 50 in-depth individual interviews of HIV-positive women were subsequently conducted for specific information on the topic. A final focus group was conducted for verification and feedback. The interview data revealed that controlling images of women as sexualized bodies were enacted through rape, sexual coercion, and name-calling in intimate relationships. The main finding was that the women lacked the ability to control sexual activities (including condom use) in abusive relationships with HIV-positive men. The women used various strategies to escape abusive partners and to obtain treatment for HIV/AIDS. The study concludes that the links between gender inequity, domestic violence, and HIV transmission should appear in prevention materials to encourage domestic violence screening in health settings, and to provide abused women with information on the not-so-obvious risks of being infected in abusive relationships.

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Keywords: African American women; Domestic violence; HIV risk; American South; USA

Introduction

Violence towards women is an indicator of HIV risk. This violence can take the form of rape, especially during wartime (Acquaro & Landesman, 2003), childhood abuse (Cohen et al., 2000) and intimate partner violence (IPV), including domestic violence (Wyatt et al., 2002). Most studies of violence in relation to HIV risk in US women focus on a "continuum of risk" that begins with childhood abuse, followed by risk-taking through

sexual promiscuity and illicit drug use, and vulnerability to rape and other violent acts. These studies often refer to co-factors such as own or partner's drug use, trading sex for money, drugs or shelter, having multiple partners, and having sexually transmitted infections (STIs) (e.g., Eby, Campbell, Sullivan, & Davidson 1995; Coker, Smith, McKeown, & King 2000). The focus on violence as an HIV risk factor for women throughout the lifespan is a sharp reminder of how child abuse has long-term health implications (Dunne & Legosz, 2000).

Few specific explanations other than the "continuum of risk" factor exist about the link between violence and HIV risk in women and, in the related instance of domestic violence, women's inability to negotiate safe

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sex in abusive relationships (Wingood & DiClemente, 1997). Furthermore, studies of domestic violence as a major and separate risk factor for HIV/AIDS in women are rare. One exception is the focus group research of El-Bassel, Gilbert, Rajah, Foleno, and Frye (2000) who found that beatings, verbal denigration, rape, and sexual coercion of women in domestic partnerships were indicators of HIV risk through being too “worn down” to resist unsafe sex at the hands of an infected partner. Another observation was in Zierler’s (1997) chapter on HIV and violence in which she noted that most HIV-positive women have been infected by partners who threaten or use violence to control them. The consensus of these writers is that domestic violence, like other forms of violence, increases HIV risk in women. The dynamics of sexual control are important here, but are little understood in relation to the specific factors that signal a likelihood of HIV transmission in abused women. Further, the men are often omitted in these descriptions or are presented as silent partners, although their interactions with women are critical to understanding how HIV risk is engendered in abusive relationships. A review of the literature on men, domestic abuse and HIV/AIDS revealed little on the specific factors that signal HIV risk in women through violence or gender subordination.

The present study was conducted in Alabama, USA. The study examined the links between domestic violence and HIV risk by interviewing HIV-positive women who were abused and often infected by an intimate partner. The large majority of these women were African Americans from an impoverished area of the state known as the “Black Belt.” The impetus for research on this topic came from two physicians providing AIDS care in Alabama who reported that most of their women clients had experienced domestic violence and, further, that women who were abused often failed to keep appointments (Dill & Mobley, 2002). These reports suggested it was important to understand the role that domestic violence might play in women being infected, and in barriers to care. The results of this study were intended for use in educational materials on domestic violence for the workplace, colleges, shelters, drug treatment programs, churches, and social service agencies in Alabama, and to provide information to health clinics and emergency rooms on the need for domestic violence screening for intervention purposes.

The focus on HIV risk in the Deep South is particularly salient to domestic violence as a risk factor for transmission in African American women. First, HIV incidence is higher in the southeast than in other regions of the United States (The Henry J. Kaiser Family Foundation, 2002). Second, women (mostly African American) comprise over thirty percent of the HIV-positive population in some parts of the Southeast, including Alabama (Centres for Disease Control and

Prevention, 2002; Alabama Department of Public Health, 2003). In some rural counties in Alabama, especially in the Black Belt, this figure is closer to 50 percent (Dill & Mobley, 2002). The figure is higher than in the United States as a whole, and is attributed, in large part, to sexual relations with infected men. It is important to know how domestic violence fits into this overall pattern of HIV transmission, and whether or not gender constructs in this context are a contributing factor.

Theoretical framework

The theoretical framework is based upon Butler’s (1990) ideas of “performative gender,” that is, how gender is performed, enacted, and reconstituted in everyday life. Butler writes that gender as a male/female binary is not innate, but is naturalized through social repetition (the stylized repetition of acts) over time. Gender is therefore “a tacit collective agreement to perform, produce, and sustain discrete and polar genders as cultural fictions.” (140) Such performances, writes Butler, are regulated in order to sustain what she calls “the heterosexual contract.” This regulation is both punitive and reconstitutive, as evidenced in the fact that “we regularly punish those who fail to do their gender right.” (140) Butler’s framework is a challenge to gender polarity as a cultural institution in the social ordering of sexuality. The framework offers a basis for examining gendered performances in order to denaturalize and expose them as hegemonic systems of race, class, and sexual oppression.

The “stylized repetition of acts” that constitutes gender identity involves multiplicity, that is; differentiated forms of gender through styles of dress, gestures, mannerisms, speech, and other performances. An element of stylized performance is domestic violence which is usually described in feminist terms as physical, emotional, or verbal abuse of women within a context of patriarchal control. The enforcement of a gender hierarchy through domestic violence signifies what Butler describes as “efforts to preserve cultural fictions of gender polarity that are tenuously constituted in time.” (140) This temporality suggests that gender absolutes in terms of hyper-masculinity and hyper-femininity can (and will) be enforced to maintain cultural fictions as regulatory functions within a cultural status quo. It also suggests that “punitive reiterations” may also occur as a result of cultural anxiety, as in times of social or political upheaval or cultural disempowerment of marginal groups. The present paper examines the mutually constitutive relationship between race, gender and class in Alabama in relation to domestic violence and HIV risk in women within the rubric of cultural disempowerment of African Americans in the

Black Belt. This area has been described as Alabama's "underbelly" or "America's third world" because of its chronic poverty, rigid class system, and historical disenfranchisement of Blacks (Archibald, et al., 2002).

Gender performance in this sociocultural context must be viewed through the lens of historical racism and its modern-day effects on relations between African American men and women. In her book *Black Feminist Thought*, Collins (2000) writes that controlling images (cultural fictions) of Black women in white racist society have centered on "mules," "jezebels" or "mammies," and that Black men and women have internalized these images. Collins describes how historical iterations of sexual and economic servitude for Black women appear in hip hop culture in denigrations such as "hoes" "hoochies" and "bitches," and through prevailing images of Black women as "sexual aggressors" and "gold-diggers." Collins' perspective on the historicity of such denigration fits with Butler's theory of stylized repetition in that, "The more it [the cultural fictions of Black womanhood] circulates among US Blacks, the more credence it is given." (82) For Hampton, Oliver, and Magerian (2003), this credence has led to claims that domestic violence is a social equalizer for Black men who are disempowered by a racist white society. Hampton et al. (2003) and Collins (2000) counter this "justification" theory by arguing that it is men who control sociosexual relationships in African American communities, and that images of Black women as strong, inviolable and emasculating have masked this reality.

The unmasking of the "inviolable" woman image in relation to domestic violence and HIV risk among women in the study is also a task of the present paper. This goal will take account of the racial legacy of the Black Belt, in which African American men and women comprise 63 percent of the population (Institute for Rural Health Research, 2004), and in which homophily occurs due to the *de facto* segregation of the region (Archibald et al., 2002). The "gender servitude" (Collins, 2000) of women in the study therefore occurs intra-rationally, although it is located within a broader matrix of white domination in the Deep South. It will be shown how gender relations among African Americans in the Black Belt have been constituted, in part, through the struggle over such scarce resources as income from low-wage employment, illicit drug distribution, transactional sex, and welfare and social security checks, and how domestic violence is a means of exerting control over these resources. Naturalized images of Black masculinity as violent only in order to "prove" their manhood over controlling women also play a role in the narratives, if only because, "Violence against Black women and children often becomes a standard within our communities, one by which manliness can be measured." (Lorde 1984; p. 120)

The significance of domestic violence in terms of gender performance should be further explored in relation to women's agency. Following Butler, Marcus (1992; p. 388) has argued that rape is a cultural script and that "as a process it should be analyzed and undermined as it occurs" in order to reframe its fictive assumptions that women are powerless, and to craft a language of intervention. The same could be said for domestic violence, especially in view of women's narratives about rape and other forms of sexual abuse in definitions of domestic violence as HIV risk. For this task to be fulfilled, the cultural fiction that African American men are justified in using violence against "emasculating" Black women must be exposed for what it is: a controlling image that masks the interstices of power in which gender "speaks" in culturally-specific and sometimes deadly terms. Lorde (1984) has argued that not only is domestic violence presented as a social equalizer for African American men who feel marginalized by white society, but, in Collins' (2000) terms, that women who resist this cultural fiction are accused of "taking sides against the self." This embargo represents a challenge to the cultural silences surrounding domestic violence, but the women in this study wished to do so in order to clarify the links between HIV risk and domestic violence for other women. In this spirit, and in accordance with the Butler (1990, 1993) and Marcus (1992) recommendations for exposing the terrain of gender signification, the following narratives of domestic violence in Alabama's Black Belt are presented for contextual information about the links between gender performativity and HIV risk in women.

The clinic setting and sample

The study was conducted at a large public clinic in Alabama that provides medical and social support services to over 1200 HIV-positive persons in a 23 county area in south Alabama ("The Black Belt"). The client population is similar in most respects to the overall HIV-positive population in Alabama. The racial composition is African American (74%), white (24%) and Hispanic (1%) respectively. Most of the clients live below the official poverty level (61%), with more than one third (38%) not completing high school. More than half of the clients have reported a history of substance use (mostly crack cocaine and alcohol), with men outnumbering women by two to one in this respect. Over one third of clients are women, with the proportion of new clients who are women being higher. Most of the women are African American (81%). On average, the women are poorer than the men (70% versus <50%), and report fewer mental health problems. They are likely to be mothers (76%) and, unlike the men, to be exclusively heterosexual.

The participants in the study (focus groups and in-depth interviews) were representative of other women at the clinic in almost every respect. The large majority of women were African American, were unemployed or in part-time or low-paying jobs, lacked private health insurance, had children at home, and had experienced childhood and adult trauma, including domestic violence. This impoverishment, if not the violence history, is typical for many Alabama residents, especially in rural areas. For comparison purposes, demographic information was collected on all women attending the clinic. These data included age, ethnicity, income, education, employment, parental status, and marital and health insurance status. The data comparing women in the in-depth interview sample ($N = 50$) with other women at the clinic ($N = 464$) are presented in Table 1. The information for the study group includes domestic violence history and mode of HIV transmission. No such information was available for other women at the clinic or for the focus groups, which were used solely for definitions of domestic violence as HIV risk and for verification.

Most of the women in the study group had been infected during regular relationships (44/50). The women defined these relationships as marriage (12/50), cohabitation (18/50) or sole partner (14/50). Ten women had engaged in commercial sex, usually at their partners' behest but also because they were addicted to crack cocaine. Two of these addicted women had been the "shooting buddy" of a drug-injecting sexual partner. All except four of the women reported being infected by an African American man. Most women knew or suspected that these partners had also been in concurrent relationships with other women (36/50). Forty-two of the men had been in jail or prison for drug-related crimes or violence. Seventeen men were reported to have had sex with other men in addition to illicit drug use. Two men were described as being bisexual (no drug use), and six men had injected drugs with no other known risk factors. Two men did not have any known risk factors. None of the men had voluntarily disclosed their HIV-positive status to the women, and only two had used condoms on a regular basis. In these two cases, HIV transmission was described as an "accident" after condoms had burst.

Methods

The study began with forming an advisory board consisting of the clinic director, physician, two social workers, a health department representative, two members of the Alabama Coalition against Domestic Violence, and a consumer to guide the research. The advisory board and two university institutional review boards provided approval for study procedures, includ-

ing informed consent. The women entered the study on a voluntary basis after responding to promotional materials on display at the clinic. Women currently in abusive relationships were protected by a variety of strategies that included having an "official" (medical or social support) reason for being at the clinic in order to be interviewed.

A series of focus groups and in-depth individual interviews were used to elicit information on domestic violence and HIV risk. A triangulated approach to qualitative data-gathering was taken to generate insights into domestic violence (Gorbach, 2001) as well as to obtain knowledge and understandings of dominant cultural values (Kitzinger, 1999). Two focus groups of 8 women ($N = 16$) were used to develop a working definition of domestic violence. Next, in-depth individual interviews of 50 women explored the dynamics between domestic violence and HIV risk. A final focus group of 8 women provided a further feedback loop to the author about the results, in accordance with feminist research principles (Reinharz, 1992), and served to cross-validate the findings. This verification focus group followed the Dobash and Dobash (1992) recommendation to use participatory methods for mutuality between researcher and participants.

The definitional focus groups were held in private in the clinic conference room. A focus group topic sheet was prepared by the author, and was modified by the advisory board and clinic employees before recruitment began. The focus groups were audiotaped, and lasted two hours. Each woman signed a consent form and was paid \$25 for participation. The groups began with a set of demographic questions on age, education, rural or urban residence, employment and health insurance status, and marital and parental status. The discussion centered on how women become infected, definitions of domestic violence, links between domestic violence and HIV/AIDS, and recommendations for HIV prevention in women. These a priori topics were always covered, but not exactly the same questions were asked in each group. This variability is a normal part of the focus group discussion, in which insights may be obtained when participants move into unexpected or novel terrain.

Most of the women spoke in general terms at first or spoke about how women became infected, but later focused on their own experiences of domestic violence and how they acquired HIV/AIDS. The women appeared comfortable sharing this information, perhaps because they knew one another through a support group at the clinic. The data were later analyzed on a constant comparison basis (Damico & Simmons-Mackie, 2003) for thematic commonalities about HIV transmission (e.g., forced sex, being infected with a STI, being "pimped out," infecting partner's refusal to use condoms), and, more generally, for the gender performative

Table 1
 Characteristics of interviewees compared to all women at the clinic

	Interviewees (<i>n</i> = 50)		Clinic (<i>n</i> = 464)	
	No.	(%)	No.	(%)
<i>Ethnicity</i>				
African American	42	(84)	375	(81)
White	6	(12)	79	(17)
Hispanic	2	(4)	10	(2)
<i>Age</i>				
Range	18-58		16-72	
Mean	37.1%		39.2%	
<i>Education</i>				
Graduated high school	27	(53)	121	(49)
Incomplete high school	23	(47)	343	(51)
<i>Income</i>				
< \$10,000	44	(88)	445	(96)
> \$10,000	6	(12)	19	(4)
<i>Employment</i>				
Full Time	7	(14)	60	(13)
Part Time	4	(8)	19	(4)
Unemployed	31	(62)	315	(68)
Never Employed	8	(16)	70	(15)
<i>Marital Status</i>				
Married	8	(16)	74	(16)
Single	17	(34)	148	(32)
Separated, Divorced or widowed	25	(50)	242	(52)
<i>Parental Status</i>				
Children at home, including step children	34	(68)	357	(76)
<i>Insurance Status</i>				
Private	5	(10)	9	(2)
Medicaid	25	(50)	269	(58)
None ^a	20	(40)	186	(40)
<i>Self-reported risk exposure</i>				
A. Regular partner	44	(88)	No data ^b	
B. Other/Unknown	6	(12)		
Ever engaged in commercial sex/sex for drugs (A & B)	10	(20)		
<i>Experienced domestic violence</i>				
Yes	50	(100)	No data ^b	
Physical violence, including forced sex	44	(88)		

^a For uninsured clients, medical treatment is provided by federal funds from the Ryan White fund (medical care) and the Alabama state plan (prescriptions). However, not all clients who are eligible for prescriptions are able to obtain them.

^b Screening for domestic violence (current abuse only) began at the clinic in 2000. No domestic violence information was obtained before this date.

contexts in which violence occurred. The analysis also took account of how the women conceptualized HIV risk in relation to other women. Differences by age were noted, and emerged mainly in assessments of responsi-

bility for being infected. For example, older women were likely to say that women became infected through sexual promiscuity, while younger women pointed to other factors such as drug use or “bad luck”. Cultural

differences were less clear cut because, as noted, most women had been in relationships with African American men.

The individual in-depth interviews were conducted after the definitions and delineations of domestic violence were developed from the focus groups. The author collaborated with a national expert on domestic violence and the advisory board to develop and modify a semi-structured questionnaire. The interviews took up to one-and-one half hours and were audiotaped. Each woman was paid \$50 for participation. Demographic questions were asked at the beginning of each interview, followed by open-ended questions about the woman's experience of childhood abuse, rape, dating violence and domestic violence. Information on sexually transmitted infections (STIs), mode of HIV transmission, the putative infecting partner, barriers to health care, interactions with health care providers, and family and social support were included in the inquiries.

The interview data were analyzed according to the major concerns of the study, and were organized by constructing a grid of related themes for comparative purposes as recommended by [Shedlin and Schreiber \(1995\)](#) for studies on sensitive topics. Key phrases were used to identify indicators of HIV risk in relation to lack of condom use or partners' non-disclosure of HIV-positive status. Experiences of domestic violence were analyzed within this context of HIV risk and demographic information on each woman, such as age differences between the women and their partners, helped to place these narratives in context. An interim report was written from the aggregated results of the narrative interviews and presented to the advisory board. The results were then presented to participants in a verification focus group for feedback. The conclusions contain this feedback, which include how some women felt that the analysis minimized their role in resisting the violence or, conversely, did not address the issue of being "weak-minded" in "hooking up" or staying with abusive men.

Results

Definition of Domestic Violence

A preliminary definition of domestic violence was developed from the professional literature prior to the study. This definition began with, "a pattern of physical, sexual, and psychological abuse by a person with whom the victim has had an intimate relationship" ([Flitcraft, Hadley, Hendriks-Matthews, McLeer, & Warshaw, 1992](#)). Members of the advisory board then extended this American Medical Association definition to include HIV-related factors explicitly, such as forced sex, non-disclosure HIV-positive status, being deliberately in-

fectured, and refusal to use condoms. A detailed list of domestic violence factors as HIV risk was developed from the focus groups; the list is included in the Endnote.

Domestic Violence and Performative Gender

The discussions of domestic violence in the focus groups and narrative interviews identified a central theme; that of women as sexualized bodies. The women indicated that HIV risk occurred in the process of becoming a "captive body," that is, one that was beaten, raped, confined, deprived, or isolated by men who viewed women in terms of use value through sexual ownership. A chronology of events in terms of conceptualizations about risk, forming partnerships with abusive men, being abused, sexual ownership, and fighting back is discussed next in terms of the specific risk factors identified by the women. Excerpts from the focus groups and personal interviews are included for contextual information. Each excerpt from the in-depth interviews is followed by a fictitious name chosen by the participant to protect her identity. In the case of the focus groups, the participants have been assigned both a client number and a group number (e.g., Client #4, group 1). These numbers provide a link to comments made by each speaker from the focus groups as they appear in the text.

Conceptualizing Risk: The Focus Groups

Women's HIV risk was discussed in the focus groups in general terms and in relation to domestic violence. The collective experience of most women was that domestic violence had played a crucial role in becoming HIV-positive, and with few exceptions, the clients felt victimized by male partners who infected them. However, this experience did not mean that they identified with the plight of other women who had been abused. When it came to speaking about HIV risk in other women, it was assumed that "lax morals" or female promiscuity were primarily to blame. Older women, in particular, assumed that sexual promiscuity was the culprit in women's HIV risk. This belief was expressed as follows:

"It's because women today don't have the morals they did. They're just having sex with anybody and everybody." (Client # 3, group 1).

"The women of today just don't care, especially the young girls. All they want to do is get out there and have it. And that's why a lot of women are getting infected." (Client # 4, group 1).

"I have two teenage boys and I'm telling you these little girls are hot. Hot in their pants as if they're burning a hole through them. They're looking for it

more than the boys are looking for it these days. The boys used to chase the girls and now the girls are so hot and bold with it, it's unbelievable." (Client #5, group 1).

These statements about "lax morals" are indicative of the naturalizing imagery that frames women and HIV risk even if personal experience contradicts such stereotypes. Younger women also invoked images of promiscuity and risk-taking but were more likely than older women to mention "trust," "lack of knowledge," "poverty," "low self-esteem," "being naïve," "being lonely," "being from a dysfunctional family," "being on drugs," and "blind love" as contributing factors. These additional factors reflected a more nuanced understanding of HIV risk in women, even though blaming occurred in their definitions of the situation as well.

The focus groups revealed other factors in relation to women and blame. Women were often believed to be "weak-minded" when it came to men, and being a "follower" had an important role to play in relation to domestic violence and HIV risk. "Weak-mindedness" was defined in terms of personal failure such as in succumbing to drug use, prostitution, or staying with an abusive partner. One woman who had been introduced to illicit drugs by an abusive partner who had "pimped" her out for financial gain, described being weak-minded in these terms:

"The guy I was going out with introduced me to drugs. He had me out there selling my body to get all the drugs and stuff for us, you know? He got to beating on me because I didn't want to get out there no more in the streets doing it, and that's when he broke my cheekbone and everything. That's when I got infected by him because he kept forcing me to have sex. I felt bad about myself, weak-minded, you know? Because I got into drugs and prostitution and then I got myself infected." (Client #4, group 2).

Being a "follower" therefore placed women at risk of HIV/AIDS. A distinction was made between "promiscuity" and the "weak-minded women" (who were deemed followers), however, which was explained in these terms: Young, single, sexually active women were placed in the "promiscuity" category, while women who were older or who were in abusive relationships were defined as "weak-minded" after falling in with risky men. The women believed that being a "follower" also meant staying in abusive relationships or returning to them despite their own or others' better judgment. Several women were still in such relationships, indicating that notions about women and weak-mindedness were often self-referential.

Becoming Acquainted

How did HIV-positive women become "weak-minded"? According to the women, low self-esteem played an important role. However, their narratives revealed that family and economic influences were important factors, especially in partner selection. All except 47 of the 50 women in the in-depth individual interviews said they knew who had infected them. This certainty was based on having been in a long-term relationship with an HIV-positive man, or, more infrequently, obtaining a confession from an infected partner after confronting him with her own diagnosis. In most cases, the women had found out about a partner's HIV-positive status from other people or sources. For example, health workers had disclosed the partner's HIV-positive diagnosis or the woman had learned of his diagnosis through Health Department partner notification procedures. In other cases, the partner had died of AIDS-related causes, had been taken to a prison for HIV-positive inmates, or had infected other women in the area.

The men were rarely the casual partners portrayed in health warnings about HIV/AIDS. Rather, the women had met their partners through home, school or work:

"I've known him my whole life, since 4th grade—he's my step-cousin" (Amanda).

"We worked together at McDonald's, and then we got together after one of his other relationships broke up" (Doreen).

"I knew him for 14 years and we've been together for 4 or 5 years. I was always in love with him. He was a family friend and they just loved him to death" (Helen).

"He was a friend of the family. Everyone thought he'd be good to me. I've known him from the time I was 13" (Tenisha).

"He was introduced to me by my mother when I was 18. She had known him for a long time; he was her friend" (Susanna).

"I met him when I was still at school and he took me to the prom. My parents hated him, so I ran off with him. We were married for 12 years" (Olga).

In each case, the context of family, school, work or friendship had instilled a sense of trust in the men. However, there were early signs of potential trouble, especially in relation to the difference in age between some partners. For example, Susannah's partner was twice her age, Olga and Cheryl were still at school when they had met their older partners, Tenisha's partner was 8 years older, and Doreen's partner was 20 years older. One woman had been 16 years old when she met her 56-year-old partner. In general, the women viewed these age differences with approval. The benefits of age mixing

were explained in these terms, “You want someone who can support you or your kids” (Susannah), or “The young ones do all sorts of crazy stuff. They need to calm down first before you be interested” (MaKayla). The sexual economy in the Black Belt is such that older men were the partners of choice for younger women, with this practice being encouraged by friends and family. However, age mixing has been linked to HIV risk for women in epidemiologic reports on HIV/AIDS (Joint UNAIDS Report 2002), mainly because older men are more likely to infect young women than the reverse. Age mixing has also been linked to domestic violence because of power differentials that exist between older men and young women (Wilson and Daly, 1998).

Older men initially provided young women with money, social status and a sense of being special. The women reported having been flattered by the attention of these partners, as in, “He was so respectful and dressed so nice,” or “He treated me like a lady,” or “He was considerate and kind” and “He was a perfect gentleman.” The sexualization of the women was also flattering as in, “he liked the way I moved” or “he liked my eyes” or “he liked my body.” The seduction props in gifts, money, promises, and treats that featured in courtship rituals invariably centered on the lure of financial security. Faye remarked that, “My friends encouraged me to find an older man because they were doing it. They said, “He’ll take care of you.” “This sentiment was echoed by other women who remarked, “He was working. Most of the guys I know don’t work” (Jaleesa) and, “He was real nice, different from other guys. He had a job” (Deanna). Women like Araminta were soon disillusioned with the “cake-daddy” reputation of older men, however, because, “It never happened—we just got babies, not looked after.”

From Mr. Nice Guy to Abuser

Family approval, lengthy acquaintance, or the courtesy of older men did not protect women from being abused or infected. Some men who were charming or gift-giving became abusive once the relationship progressed, and their charm and gift-giving were retrospectively viewed as seduction ploys. The transition from “ideal man” to “abuser” was described in accelerating ownership claims through sexual jealousy, verbal denigration, and in acts of violence described as “laying his hands on me.” The violence included repeated episodes of forced sex or rape as well as physical assaults. Such behavior was naturalized in that it was believed to be typical of men, particularly “ones with low self-esteem.” However, the assumption that men’s low self-esteem was a basis for domestic violence brought an angry disagreement from one focus group participant whose abusive partner had died leaving her infected, impoverished, and depressed. In her opinion,

“the men don’t take responsibility, and that’s the problem right there” (Client #3, group 3). This participant did not accept low self-esteem explanations any more than she accepted that women’s “weak-mindedness” played a role in becoming infected.

“Risky partners” were not only physically abusive, but they squandered money on gambling, alcohol, drugs, and on gifts for other sexual partners, which they lied about or kept secret. They were also often involved in violent crimes. The picture of abusive men that emerged from the interviews was a bleak and dysfunctional one. Despite their early promise, none of the men had lived up to being a responsible or loving partner. The connections between the partner’s troubled history, domestic violence, and HIV risk for women emerged in these statements:

“I was in denial about him for a long time even though I found out he was selling drugs and doing burglary. My doctor tested me for HIV after I told him about the domestic violence and about him giving me STDs, and that’s how I found out. He denied it for a long time, but then he was tested in prison in 1995. After he got out he was killed by another woman because he was abusing her too” (Evelyn).

“He infected me with syphilis but he denied it, saying “It’s your fault you got it. Your whole family got it” [her father had been a patient in the Tuskegee syphilis study]. He tried to tell me later on about being infected with HIV, but couldn’t get it out. He was a big shot in the drug scene, a very powerful man. He kept a gun under the pillow for safety but I was scared he’d use it on me” (Khadijan).

“I was diagnosed when I was pregnant. He denied infecting me until he died in prison of AIDS. I know he infected me because he infected three other women and because he lied about everything, even his name. He was a lowdown. All he did was hit me and lie to me and infect me with AIDS” (Faye).

The women were often infected with STIs in abusive relationships. In retrospect, they realized that being infected with these “lesser” infections was a sign of being at risk of HIV/AIDS. Being diagnosed with a STI was a stark reminder of the men’s sexual prerogative in having other sexual partners, of the men’s control over condom use (virtually none was reported), and over the timing and frequency of sexual intercourse in relationships (see “Sexual Ownership”). The women spoke about tolerating these arrangements which were, in fact, normative in the main woman/girlfriend paradigm of community life. For some of the women, however, this gendered arrangement meant that, “I was always getting STDs from him, one after the other. It didn’t matter to him how often I got them. I just stayed there until I got infected with the worst one there is” (Jaleesa).

The women expressed profound hurt in being deceived by men they thought they knew well or who had loved them. Part of this betrayal concerned being “tricked” out of their money or possessions. The men had been trusted with the women’s money including, in some cases, a car or apartment. Some women soon found themselves having to support their partner instead of the reverse. This was the case for Kendra, who reported that, “He gave up work after he moved in and I had to pay all the bills. When he met me, he drove a car and had a house, but then I found out they belonged to a girlfriend. It was his way of hooking up with me.” For other women, once their partner was in control, “He took my money to spend on his girlfriends” (LaTonya) or, “He kept his own money for girlfriends and then I’d have to pay the bills” (Yolanda). The practice of having girlfriends as well as “main women” (unofficial or actual wives) was resented even if it was naturalized in the local context.

Being Trapped

The interviewees agreed on a crucial point: that being trapped in violent relationships with infected men placed women at greater HIV risk than casual sex or prostitution. Wendy’s experience was instructive: she had been trapped in her partner’s semi-trailer where she had been made to have sex because, “That’s what I was there for.” Wendy’s partner would supply her with drugs (they were both “users”), beat her and remove her clothes to prevent her escape. In another example, Tenisha’s violent husband had compelled her to accompany him on trips around the United States because, “he thought he owned me and he didn’t want one of his friends to mess with me. And he forced me to have sex whether I liked it or not, even up until the time he died.” Other women who felt trapped in violent relationships related how, “He threatened to kill me, and I knew he would do it” (Cindy). In one case, Helen’s partner had not only tried to kill her but had also tried to commit suicide to prevent her from leaving. This man confessed to deliberately infecting her, saying that, “I only did it because I love you so much.”

Feeling trapped in violent relationships was a common predicament. Martha was so traumatized by the repeated violence that she “just stayed there like a little dummy just looking after the kids and getting beaten to a pulp.” In another case, Evelyn’s paranoid partner would stalk or “jump” her to make sure she could not escape; he also took her car, money, food stamps and jewelry so that she had no money to leave and support her children. MaKayla’s husband had bound her with duct tape for two days, beat her with a bullwhip, and then threatened to kill her and place her in a box. Like Helen’s partner, MaKayla’s husband said, “I love you so much that I’ll kill you and then I’ll kill myself.” MaKayla managed to escape only by telling her

physician about the abuse, who then reported him to police. Other women took similar action, especially after being counseled by social workers at the clinic or at a local domestic violence shelter. More commonly, however, the relationship ended when the partner died of HIV/AIDS or other causes, was incarcerated, or the relationship finally exhausted itself.

The women’s narratives indicated that they were mostly too poor, terrorized, addicted, or isolated to leave an abusive relationship; sometimes they were still in love with their partner. These factors point to a critical issue in terms of HIV risk; that being the long-term “sexual slave” of a violent, HIV-positive man is tantamount to being injected with virus. Feelings of helplessness, having children, and being mentally or physically ill contributed to the women’s predicament. These problems were often interrelated, as was the case for Khadijan who said, “I got agoraphobia after I went to live with him and couldn’t leave the house. After the doctor put me on anti-depressants, I felt better, then I got help to leave,” and for Tenisha who said, “It didn’t seem to matter if I lived or died. So I just stayed there. I got sicker and sicker. He’s dead now, but I’m feeling much better. I just wish he’d died sooner so I didn’t have to go through all of that.”

Sexual Ownership

Sexual ownership of women was both common and culturally supported. In Butler’s (1990) terms, this ownership was enacted through the punitive regulation of delineated male/female roles, and of women as “things to be taken” (Marcus 1992). Early signs of male control occurred in statements about condom use, as in, “it was never discussed,” or “He said it didn’t feel natural” or “He just refused.” However, the lack of interest in condom use was often mutual, making the men’s refusal difficult to assess in terms of later abuse. Sexual claims to women’s bodies were a more obvious indication of domestic violence. These claims were often expressed in sexual threats, as in, “He threatened to have sex with my friend if I didn’t stop seeing her” (Aonya) or in threats to hurt children so that, “I’d promise to have sex if he left them alone” (Tamika). The following excerpts highlight how sexual ownership was exerted through threats, violence and rape:

“If I wanted to go anywhere, he’d accuse me of having sex with other men. He’d tear my clothes off and make me have sex. When I told him I had female problems, he said he’d go off and have to have sex with other women. I found out later that he had three kids with one of my cousins” (Vanessa).

“He forced me to have sex. If I didn’t want it, he’d say I was giving it to someone else. He was real jealous because he was 20 years older and thought I’d

go off with someone younger. He'd lock me up and take the keys" (Shondra).

"When he forces the sex issue on you, it's kinda like rape. You don't want it but he does, and he's sitting on top of you and then takes your clothes off, and then at the same time he's doing that, he's also slapping you around" (Ravene).

Most women felt sexually owned. These acts diminished the women's sense of selfhood and confirmed their role as non-persons in abusive relationships. Repeated sexual intercourse with an infected partner, who did not use condoms and who often demanded sex or viewed it as his prerogative, appeared to be the most important factor in HIV transmission. However, one issue concerning forcible sex and HIV risk was the problem of "being cut" (or "dry"). The vaginal tears and abrasions that occur during forcible sex are a major conduit for HIV infection, as noted in epidemiological studies on the topic (*Joint UNAIDS Report 2002*).

Sexual ownership was exerted in different ways. While forcible sex, sometimes at gun or knife point, was the worst in absolute terms, other forms of sexual ownership were psychologically damaging over the long term. This ownership was enacted through sexual jealousy (e.g., as in "He always thinks I'm flirting with someone," or "He didn't want me to talk to other men, so he'd beat me"), and in accusations of promiscuity (e.g., "It's your fault you got this STD" or "You've had an ass full of men"). Sexual control was also exerted through being labeled a whore or a slut, and being beaten in fits of "punishing" rage. This multi-layered violence served to promote men's exclusive ownership of women. Further, the violence masked the man's own sexual activities, and sometimes forced women into being "pimped out" by men for money for drugs.

Sexual ownership also involved isolating women from friends and family. This isolation was achieved through stalking or surveillance for non-resident girlfriends or confinement for resident women. Other isolating techniques involved depriving women of the ability to make contact with the outside world by blocking access to money, telephone, or transport. Lara recalled this "dog in a cage" existence in this way:

"He would take off for the weekend or a week, or whatever. I never knew where he went or what he was up to. I sat at home with the kids and never went out. We couldn't go anywhere because he'd taken the car. I always felt he was cheating on me but I couldn't prove it."

Sexual ownership for Lara and other women not only meant being confined to home but being so isolated that, "I never saw anyone except for the kids. I couldn't even see my mother. I found out later that he'd threatened her to make her stay away from me. Even his own parents

were scared of him." This sequestration had not only kept Lara at home, depressed, and away from people who might have helped her, but prevented her from knowing that her now-deceased husband had engaged in risky sexual activities and crime.

By the time the women realized their risk of HIV/AIDS, it was often too late. They were "beaten down," pregnant, isolated, or had no money or resources. Most of the women had received their HIV-positive diagnosis during pregnancy, which further bound them to abusive partners. Disclosing a diagnosis to an abusive partner often led to an escalation in violence. Ilene explained the connection between post-diagnosis trauma, disclosure, and violence in this way:

"I became so depressed that I asked him to come back and look after me. That's how desperate I was. I took to my bed and cried for three months. It just made me more dependent on him, you know? And I guess him coming back was just an open door to say, "I'll treat you anyway I want to." "

For other women, being diagnosed HIV-positive resulted in increased violence through being blamed (usually erroneously) for infecting the men. The act of being blamed repeatedly by abusive partners sometimes left the women to wonder if they had been infected through a blood transfusion or other means, and almost always increased their sense of isolation, anger, and shame. Some of the women, however, attributed this reversal of blame to men's fear of being charged with attempted murder because "he can get in big trouble with the law" or more simply, "male pride" (denial). Few men had opted to leave after being notified by their partners, but the "put-downs" and violence increased. This violence was framed in terms of control, as in "He said to me, "No one else will want you now, so you'll have to stay," (Helen) and "If I said I would leave, he'd say, "You better not go nowhere or I'll tell the world what you got" " (Jaleesa). Most of the women eventually did escape from these partners, usually through their partner's death or imprisonment, or sometimes through the help of family members, physicians, or local domestic violence networks and agencies. Disclosing an HIV-positive status to trusted friends and family members was a particularly important step in reclaiming broken lives, and the women who did so were usually able to garner support in order to regain their freedom.

Fighting Back

Despite the narratives of frank and unrelenting abuse, the issue of personal agency was a potent one in terms of self-dignity, modes of resistance, or regaining freedom. Within the rubric of being trapped and feeling

“weak-minded” were reports of assertive actions. These instances of fighting back often appeared at particularly critical or egregious moments in a violent relationship. Wendy’s case is instructive: she waited until she and her partner visited her family in Alabama and then told her five brothers about the abuse she had endured for almost a decade. The brothers hid her away and forced her partner to leave the house. Wendy was then able to enter into medical treatment at the clinic and her partner was later imprisoned on unrelated drug charges in another state.

Women who described themselves as “strong” and “not taking that sort of stuff” were generally more successful in resisting or ending the abuse even if they later regretted staying long enough to become infected. For example, Danielle explained that, “We got into an argument over him trying to make me have sex and then he kicked me. But when he did, he had to go to the hospital because I grabbed all the things below and snatched and pulled until he bled for a while, a good while.” Stella also recalled that, “He was drinking one day and he jumped on me so I took the whiskey bottle and hit him in the head with it. And then he was scared, you know, because he wasn’t too much bigger than I was. Last time he hit me I just jumped on him and got on his back and started beating him. Then he stopped.” Several other women described how they knifed or shot their abusive partners, or how they called the police to make an arrest. This reporting was sometimes inadequate however, because “he was out in 24 (or 48) hours,” or “I kept reporting him and he kept doing it,” or because “they locked us both up.”

The women who owned or rented their own homes or who were financially independent sometimes felt more empowered in finding ways to end the abuse. In one example, Denise reported that: “He wouldn’t move out of my house so I went to the police department and took out a restraining order, all that type of stuff. Two police followed me to my house and spoke to him and he had to move out after that because the house was in my name.” For Teneisha, her inheritance meant that, “I get my own money, you know? I make more money than he do on his job, so I just walked away.” In a few cases, discovering that children were also being abused prompted the women to threaten violence and to end a relationship. Roberta reasoned that, “Ain’t nobody gone to treat my kids like I wouldn’t treat my own. So I told him, if you ever come back to me or around me or around my mom’s house I’m gonna shoot you to kill you and that’s no lie. I’m not talking about shooting you in the leg just to hurt you. I’m gonna shoot to kill you dead.” However, children could also be used as buffers between women and their abusive partners. In one notable case, Yvonne avoided being abused by sleeping with her daughter in the child’s bed. She explained that, “He had to leave me alone then because he never did

anything in front of her. So I didn’t have to have to put up with his nagging after that, or him making me have sex.”

Some women engaged in what Hampton et al., (2003) have termed “reciprocal violence,” even if it meant risking an escalation of violence or arrest by the police. In one case, Sayrah had shot and severely wounded her partner who had knifed her, saying, “I done took enough. He sure never laid hands on me again.” Sayrah was not charged with attempted murder even though the incident was publicized in the media and she was later arrested for shooting someone else. Other women also engaged in reciprocal violence in the firm belief that such retaliation was both justified and necessary. This retaliation usually involved fists, knives, guns and other weapons, but household items were also used, as in, “I took that [chemical cleaner] and poured it into his eyes; he was gagging and everything, trying to catch his breath. That’s what I did to him, and I said, “Don’t you never put me outside again” ” (Heather).

Discussion

The main issue for HIV risk in this study was the women’s lack of ability to negotiate sexual activity with abusive men who infected them. This inability occurred through forcible sex and sexual ownership claims that were enacted through threats, violence, name-calling and isolation. In Butler’s (1990) terms, the gender performativity experienced and enacted by the women in this study had been naturalized in the racialized context of white ownership and Black disenfranchisement in Alabama’s Black Belt. Masculinity in this context is constructed in terms of the right to “lay hands” on women, which Collins (2000) argues is also entrenched in US Black culture through the reiterative misogyny of hip-hop and rap music. Asbury (1987) asserts that such fictions can become dangerous for those closest to them, and so it was for the women in this study who experienced repeated acts of verbal, emotional or physical abuse by male partners. The high rate of physical violence experienced by HIV-positive women in this study (88%) is disturbing, but similar rates have been reported elsewhere in relation to HIV/AIDS in the Southeast (Whetton-Goldstein & Nguyen, 2002).

Butler’s (1990) ideas on gender performativity offer an interpretative framework for the women’s experience of domestic violence and HIV risk. For Butler, gender is not only polarized in terms of a male/female binary, but also in performances that are contextual signifiers of social inequality. This interpretation suggests that the women’s lack of ability to negotiate sexual activities with HIV-positive men involved contextual signifiers of male dominance. In one example, partner-sharing arrangements in which older, wealthier men sought

(and usually gained) access to younger women were sanctioned by family and friends. Such age mixing is problematic because, as noted, age-discordant relationships create a power advantage for older men as well as a disease risk for younger women. In addition, sexual exploitation was evident in men gaining access to women's earnings, apartment, vehicle or goods in order to attract or support other women. The secrecy involved in the men's sexual acquisition placed the women at a disadvantage because they could not assess the risks of being infected with STI/HIV without full disclosure; it was also a regulating mechanism for culturally inscribed or "done to" femininity.

The women's narratives indicated that age-discordant relationships were naturalized in the local context. Their own approval of such arrangements was evident in statements about young men being immature or "crazy" because they were prone to fighting, doing drugs, or being irresponsible, and in older men being both more respectful and financially stable. Brewer (1993) and Omolade (1994) have argued that low-income Black women frame romantic relationships in terms of financial stability because of a simple fact: they are often clustered in third tier (low-paid) service with few opportunities for advancement. Like other low-income women in the Black Belt, the women in this study were either unemployed or in low-paid, often temporary positions in the manufacturing or service sectors. The financial support of men who offered gifts and promises of love and "being looked after" therefore had considerable appeal. However, the women's reasons for seeking older men were more complex than a simple wish for emotional or financial stability. For some women, the fear of personal threat from murder, rape or burglary in violent neighborhoods fostered a reliance on older men for protection. After these men proved to be abusive, the women had realized that fears over personal safety had compromised their ability to be safe in personal relationships. Collins (2000) has noted that women's fears for safety in violent neighborhoods have served as a regulating function in fostering their dependence upon "protective" men. Several women in the study were still resigned to staying in such relationships, in large part, because of their fears or actual experiences with intruders who had raped or assaulted them.

The issue of domestic violence bears further examination in relation to partner sharing in African American communities. Sobo (1995; p. 17) refers to such partner-sharing arrangements as "man-sharing," which she defines as, "the high level of non-monogamous heterosexual intercourse culturally recommended for and often achieved by Black men." This practice, writes Sobo, can be traced to the lack of economic opportunity for black men and the related dependence on favorable peer evaluations. Man-sharing is also an outcome of what Hearn and Jackson (2002) call a "sex-ratio imbalance"

arising from the dearth of African American men (through death or imprisonment) in low-income communities. According to Fullilove, Fullilove, Haynes, & Gross (1990), the net effect of this imbalance is to increase men's power over women because men have scarcity value, so that naturalized gender constructions are reinforced in powerful ways. The imbalance of power may also help to explain the level of physical violence experienced by the low-income women in this study since being assigned a "lesser" social value might be construed giving cultural support to domestic violence.

A final point should be made about the women's description of themselves as "weak-minded." This description arose from notions of individual responsibility, such as, "I allowed it to happen," or "[promiscuous] women are to blame". Such notions have been promoted by authoritative voices in the community (e.g., in schools, church, jail, or in self-improvement and drug treatment programs) as an empowerment tool to overcome "social dangers," "bad habits" and "destroyed lives." The message assumes that being in abusive relationships is a matter of individual responsibility, a notion that tacitly supports the power structures that give rise to domestic violence, and fails to call abusive men to account. This perspective, moreover, compelled some women in the study to present their own experience as being "a special case" to the interviewer, while condemning other women for being responsible for transmitting HIV infection. However, the results also showed that some women strongly resisted the "weak-minded" descriptor by engaging in reciprocal violence. Women who fought against abusive partners with weapons or other means, those who "outed" abusive partners to family or sympathetic outsiders, those who used their home ownership or their financial independence to gain the upper hand, or those who believed they were "madder (or meaner) than he is," were the most successful in lessening or ending the abuse. In this way, they were fulfilling Marcus's (1992) challenge to women to exert will, agency and the capacity for violence in order to disrupt the grammar of violence against women as a cultural script. They were also destabilizing the view of women as the sexualized body that is always "tremulous" or "wounded" in its victimhood (Marcus, 1992). This process involved transgressing cultural rules that often prevent African American women from "taking sides against the self" (Collins 2000): It also involved reframing their identities as HIV-positive women seeking freedom in order to protect their health.

Conclusion

The women in this study gave voice to their experiences of domestic violence as performative gender

in the American Deep South. This voice arose from a cultural context in which gender relations have been defined in terms of micro-economies of power and status, and in which domestic violence is embedded within a particular discourse of gender polarity in a matrix of white domination. While it is important to acknowledge that domestic violence does not place all women at risk of HIV/AIDS, it is equally important to identify how local factors create HIV risk in abused women: in this case, in a region where women are being infected at a disproportionate rate. The task for HIV prevention campaigns for local contexts is to include both domestic violence factors (e.g., the inability to negotiate sexual activities because of abuse) and contextual perspectives on HIV risk so that prevention messages can be tailored to the specific situation. The links between gender inequity, domestic violence, and HIV transmission should appear in these prevention materials to encourage domestic violence screening in health settings, and to provide abused women with information on the not-so-obvious risk of being infected in abusive relationships.

Acknowledgements

This research was supported in the first instance by Marilyn Crain, Department of Pediatrics at The University of Alabama at Birmingham (UAB), followed by the National Institutes of Allergy and Infectious Diseases (NIAID) 5 P30 A127767-15 Supplemental Grant to the UAB Center for AIDS Research (CFAR). The methods and human protections were approved by the Institutional Review Boards at the universities of Alabama (Tuscaloosa) and Alabama at Birmingham. Thanks go to Laurie Dill, James Waid, Rhonda Hollon, Larissa Younger and other staff of the participating clinic for their collaboration and advice, to Eric Hunter and Rob McDonald of the UAB Center for AIDS Research, to Mary Ann Dutton of Georgetown University for her guidance on questionnaire development and interpretation, to Jennifer Woods and Angie Boy of the Alabama Coalition for Domestic Violence, to Stanley L. Brodsky for his technical support, to Anna Mitchell who assisted in the research, and most of all to the women who participated in the study.

Note

Definitions of domestic violence as HIV risk from the focus groups:

Not disclosing HIV-positive status to partner; infecting a partner with STI; deliberately infecting a partner with HIV/AIDS; refusing to use condoms; rape; manipulating, nagging or making her feel that she has

to have sex in order to stop the abuse to self or children; insisting on frequent and unprotected sex; non-disclosure of intravenous drug use, same sex activity, and prior criminal record of domestic violence; having sexual affairs with other women as a male prerogative; introducing her to drugs and then pimping her out for money; insisting that she “shoot” drugs with him; “cutting” her during physical or sexual violence; “keeping her down” so she becomes depressed and unable to take care of herself; instilling a sense of desperation or revenge so that she takes sexual risks with other men; evicting her so that she becomes homeless or dependent upon other men for rescue; preventing her from having contact with family and other support systems; being secretive; being a chronic liar; stealing her money and other possessions.

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