Substance Abuse and Men Who Batter : Issues in Theory and Practice

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Substance Abuse and Men Who Batter

Issues in Theory and Practice

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This article briefly reviews data supporting links between substance abuse and men's abuse of female partners, as well as several perspectives that might explain these links. Then it examines critical issues of practice with substance-abusing men who batter, including assessment, safety, and sequencing of interventions. Finally, special concerns of working with African American men who batter and abuse drugs are addressed.

Keywords: *domestic violence; substance abuse; spouse abusers*

Common sense, clinical experience, and popular wisdom suggest that the acute effects of alcohol and other drugs (intoxication) as well as the effects of chronic alcohol and drug use (substance abuse, addiction, or chemical dependency) increase the likelihood of intimate partner violence. Data tell a similar story. In the empirical literature examining substance abuse by men in batterer programs, more than 50% of the participants are evaluated as substance abusers (Gondolf, 1999; Tolman & Bennett, 1990). Although less is known about domestic violence by men in substance abuse treatment programs, when agencies bother to look, they find roughly the same proportion of batterers. Chermack, Fuller, and Blow (2000) found that 53% of 126 men in substance abuse treatment had used moderate or severe partner violence in the year prior to treatment. Over a 3-year period, a large west-side substance abuse treatment program in Chicago screened all admissions for domestic violence, and the program reported that 70% of screened men self-reported as perpetrators of domestic

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abuse (M. Feinerman, personal communication, July 18, 2000). A similar picture emerges when we study women. Among substance-abusing women, the prevalence of intimate partner violence has been estimated between 40% and 80% (Bennett & Lawson, 1994; Dansky, Byrne, & Brady, 1999; Miller, Downs, & Gondoli, 1989; Stark & Flitcraft, 1996). In this article, we will briefly review some of the data supporting links between substance abuse and domestic violence. We will also present several perspectives that might explain these links. In the second part of the article, we will examine critical issues of practice with substance-abusing men who batter, including assessment, safety, and sequencing of interventions. At this point, we will also address the special concerns of working with African American men who batter and abuse drugs. Because women's use of alcohol and drugs has a weaker association with subsequent victimization than does men's use of alcohol and drugs (Hutchison, 1999; Kantor & Straus, 1989), this article will focus exclusively on men's substance use and abuse and men's abuse of their female partners.

Several research groups have reported that empirically differentiating substance-abusing men from batterers is difficult. Stith, Crossman, and Bischof (1991) studied the frequency and severity of substance abuse by men in batterer programs and found it does not differ from the substance abuse of men in substance abuse treatment programs. Likewise, when researchers examine the frequency and severity of domestic violence by men in substance abuse treatment programs, it looks much the same as the domestic violence of men in batterer programs (Brown, Caplan, Werk, & Seraganian, 1999). It is easy to see, based on these data, why so many practitioners have come to think of batterers and substance abusers in treatment as the same men at different points of their lives, or alternately, as men who have come for help through different doors, or with different motivation. In research terms, substance abusers and batterers may be different samples from the same population; what is most different about male substance abusers in treatment and men in batterers programs may be the type of agency with which they are involved (Thomas, 2000).

Like many phenomena, however, the link between substance use and partner abuse is not as simple as it first appears. For example, in the general population, 60% to 75% of batterers are not drinking when they batter (Kantor & Straus, 1987; Pernanen,

1991). This does not contradict previous statements finding high levels of co-occurrence in clinical populations because a man may not be drinking and drugging when he batters and still be a substance abuser. In fact, for some substance abusers, the greatest potential for violence may be when they are not intoxicated, either because they are unable to procure their substance of choice or because they are abstinent during early phases of recovery. In the Center for Disease Control multisite study of batterers' treatment, one of the strongest predictors of re-offense was drunkenness during the batterer program (Gondolf, 1999). However, it was not possible for the researchers to determine the sequence of drunkenness and violence, so it is likely that a substantial proportion of the recidivate episodes occurred when men who were frequently drunk were, at that time, not drinking. This plausible scenario suggests that a substance abuser may be at greater risk for partner violence when he is not drinking or drugging because alcohol or drugs act not as a *disinhibitor* but rather as an *inhibitor* for some substance-abusing batterers under certain circumstances. Regardless of the explanation, data suggesting a minority of batterers are intoxicated when they batter suggest that intimate partner violence cannot be well explained as a simple sequela of substance use.

The links between substance (ab)use and partner violence are complex, probably more so than described by an unnamed addictionologist who suggested to the senior author that the only viable connection between substance abuse and domestic violence was in the limbic system. Such a description is not much more enlightening than that of a local bartender who, when presented with a similar opportunity, opined that the strongest link between drinking and domestic violence was in the hand. At the risk of undermining such practical theories and their applications, we will now briefly summarize what research and theory suggest about the link between partner violence and alcohol and other drugs.

PERSPECTIVES LINKING SUBSTANCE ABUSE AND PARTNER VIOLENCE

A number of theories are used to explain the way alcohol or drug use may increase the risk for domestic violence. The most

common explanations may be termed *disinhibition*, *cognitive distortion*, *learned disinhibition*, *deviancy disavowal*, and *power theory*. Readers are referred to Kantor and Straus (1987), Pernanen (1991), Leonard and Jacob (1988), and Gondolf (1995) for more detailed discussions of these perspectives.

CLASSICAL DISINHIBITION

The simplest explanation is that alcohol or drugs disinhibit our human tendency toward aggression. As discussed elsewhere (e.g., Pernanen, 1991), classical disinhibition is a psycho-physiological perspective in which psychoactive substances disengage lower brain functions (e.g., sex, aggression) from higher brain control. Drugs and alcohol are presumed to have direct chemical effects on that part of the brain that inhibits violence. However, because no such violence-inhibiting center in the brain is known, the strength of classic disinhibition as applied to drug-related violence is its popular appeal: It makes a good story. Disinhibition is further challenged by experiments suggesting the expectation of an alcohol-aggression effect may better predict aggressive behavior than alcohol itself (Lang, Goeckner, Adesso, & Marlatt, 1975), although other experiments have demonstrated a more complicated pattern between expectancy and alcohol-related aggression (Cheong, Patock-Peckham, & Nagoshi, 2001). The direct effects of alcohol and drugs on domestic violence, independent of a man's cognitive processes, beliefs, and social context, are minimal.

COGNITIVE DISTORTION

The cognitive perspective emphasizes the perception and processing of information, reacting based on cognitive appraisal, and solving problems, all of which may be altered by acute or chronic use of drugs. There is a substantial body of practice research supporting cognitive theory applied to substance abuse (see Leonard & Jacob, 1988), and feminist-informed cognitive-behavior approaches constitute the dominant model in batterer intervention programs (Ganley, 1989; Healy, Smith, & O'Sullivan, 1998). The cognitive approach offers one of the best perspectives for informing both the etiology of substance abuse and domestic

violence, as well as practical applications based on the cognitive perspective (Conner & Ackerley, 1994).

LEARNED DISINHIBITION

With enough practice, people can learn to disinhibit their aggressive behavior when they drink or drug. Such comments as "You know what happens when I drink whiskey! I go crazy!" tell a story of disinhibition in which the association between violence and drinking or drugging has been learned, even anticipated, and is not a direct behavioral outcome of drug-brain interaction. Learning occurs through observation and practice: in the family, where drinking and violence may be routine; in the written and visual media, which routinely link drinking, sex, and violence against women; and in men's peer groups, where men may learn to drink and drug with the expectation of being aggressive while they do so. Substance users often subscribe to a sociopersonal mythology of drug effects that, supposedly, mediate substance use and action. Not unlike marijuana consumers of yore detailing the relative behavioral impact of "Columbian" versus "Panama Red," alcohol consumers may maintain, for example, that beer does not affect them, whereas whisky makes them "blind-crazy and medieval," as one fellow put it.

DEVIANCY DISAVOWAL

The shared mythology of substance-related aggression incubates an opportunity for men to disavow their behavior while drunk or stoned. "That's not me. It was the booze!" and "The booze was talking" are the language of deviancy disavowal. Socially unacceptable behavior such as domestic assault can be attributed to the substance rather than to the self. MacAndrew and Edgerton (1969) proposed that cultures create a period of time-out while drinking that permits an individual to engage in deviant behavior without being viewed as a deviant. This time-out is enabled, in part, because of an assumption of alcohol malevolence in which alcohol, when found to be a part of a negative event, is assumed to be the cause of the negative event (Collins & Messerschmidt, 1993). The media handling of the tragic death of Princess Diana in 1997 offers one example of the assumption of

alcohol malevolence at work; the U.S. government's "war on drugs" is a policy variation on the same theme. Alcohol and drugs have been elevated in the public mind to powerful entities capable of killing people and being the objects of a national war.

POWER

The power to transform people attributed to alcohol and drugs has a basis in personal experience. Anyone who has ever been intoxicated on alcohol or other drugs understands how this works. In fact, the transformative capacity of substances may come to be expected by those who use them. If someone is motivated to feel more powerful, more social, more talkative, more attractive, more sexy, or more aggressive, and if they expect their substance of choice will facilitate this transformation, more often than not, the substance complies. If a man experiences a need to appear powerful or to dominate others, and if he attributes this capacity to alcohol (or to any other drug), he is far more likely to experience himself as powerful after drinking or drugging. For men who experience themselves as powerless, one motivation for drinking or drugging is to increase their experience of personal power (McClelland, 1975). A power model of alcohol and domestic violence views alcohol abuse and woman abuse as rooted in men's drive for power over others (Gondolf, 1995). One particular aspect of drinking behavior, drunkenness, may be an important means of controlling a partner's behavior by increasing her level of fear (Hutchison, 1999). The increased unpredictability of a man's behavior while drunk or stoned, observed over time, increases the chances that a woman will behave according to a man's wishes because of fear for her safety. Observing the effects of his drunkenness reinforces the alcohol-control connection, increasing the likelihood it will be repeated.

By themselves, none of these theories explain the high rate of co-occurrence or the dynamics of substance abuse and partner abuse. In time, other theories will be developed that better capture the variation in violent behavior linked to substance abuse. At present, we must be constantly seeking what facts exist in order to inform our practice and policy when these two problems do co-occur. High levels of blood alcohol increase the likelihood of cognitive distortion. A man's aggression while drinking depends on

his perceiving his target as aggressive (Leonard & Jacob, 1988). Domestic aggression is more likely at high levels of blood alcohol because the drinker, due to cognitive distortion and to beliefs about women's aggression, is more likely to misperceive his partner's behavior as aggressive, abandoning, or overwhelming (Barnett & Fagan, 1993). Alcohol is not necessary, however, for a man to misperceive his partner as aggressive; any number of conditions, historical and current, could facilitate such misperception. Through experience and acculturation, we develop expectations for the effects of alcohol use. We may believe alcohol makes us sexier, stronger, more social, or more aggressive (Goldman, Brown, & Christiansen, 1987). Lang and et al. (1975) found that male laboratory participants who believed they had drank alcohol displayed higher levels of aggression, independent of whether they were given alcohol. There are possible errors in such experiments, but within the limitations of the science, these experiments suggest that a man's belief about the effects of alcohol on his aggression is as important as the chemical effects of alcohol.

In summary, the link between substance use, substance abuse, and men's abuse of their intimate partners is far too complex to understand with simple cause-effect language. Use and abuse of chemicals are important considerations in preventing violence against women by men but no more important than the personal and cultural beliefs that support the link between substance and violence. Nor can we be sure on any but a case-by-case basis whether substance (ab)use precedes or follows men's violent behavior; overall, both sequences occur, along with situations where there is no relationship at all between substance and violence.

PRACTICE

GENERAL APPROACHES

Given that little evidence-based practice in this area has been developed, what constitutes best practice when substance abuse and intimate partner violence co-occur? To our knowledge, only two manualized approaches to these dual problems have been published to date (Center for Substance Abuse Treatment, 1996;

Illinois Department of Human Services, 2000), and neither of these manuals meet evidentiary criteria for best practice. Neither manual bases recommended approaches on empirical research because such research is, as yet, nonexistent. Both manuals are very broad in scope and proscribe certain practice and policy approaches as much as they prescribe intervention. Conner and Ackerley (1994) have argued that a cognitive-behavioral approach best unifies these seemingly disparate fields because cognitive-behavioral theorists and practitioners have developed empirically based approaches to both substance abuse treatment and interpersonal aggression. However, Gondolf (1995) proposed that the power construct may be used not only to understand the co-etiology of male substance abuse and intimate partner violence but also as a template to develop an integrated approach to intervention when substance abuse and partner abuse co-occur. An empowerment approach may be especially useful in developing an integrated approach to substance abuse and partner abuse by African American men. We now turn to several key issues of practice when substance abuse and partner abuse co-occur: (a) assumptions, (b) screening, (c) placement criteria and exclusion, (d) victim safety, and (e) sequencing interventions.

PRACTICE ASSUMPTIONS

Any practice approach should articulate how the approach addresses several critical assumptions. Here is one such critical list of assumptions: (a) The purpose of intervention (with batterers) is to increase the safety of victims and to hold offenders accountable for their behavior; substance abuse makes victims less safe and offenders less accountable. (b) The perpetrator is responsible for both his violence and his substance use; partner violence, substance use, and co-occurring substance abuse and partner abuse are always a choice or a "guided doing" (Pernanen, 1991); a man is not provoked, triggered, or stressed into being violent. (c) Violence is a vehicle chosen to establish control over a person, persons, or a situation, and substance use is often selected as one path to such control. (d) Society and culture covertly support substance abuse, woman abuse, and intoxicated woman abuse; neither substance abuse nor woman abuse may be viewed entirely at the personal level.

SCREENING AND ASSESSMENT

There are many reasons for screening and assessment, but the most important reasons are to increase intervention effectiveness, to improve victim safety, and to increase the opportunities for recovery. Assessment usually occurs at an initial interview, but it may occur during the ongoing delivery of services, at termination, or during follow up or aftercare. With co-occurrence rates on the order of 50% in populations that come to the attention of health, justice, and social service workers, identification and management of substance abusers and domestic violence victims are critical. In such settings, screening service recipients is necessary. Brief observation, testing, interviewing, or using existing records may indicate the presence of domestic violence, substance abuse, or both. More often than not, the presence of one form of abuse predicts the other form of abuse. Failure to screen batterers and victims for substance abuse in domestic violence agencies or failure to screen all clients for domestic violence in substance abuse agencies is poor practice.

PLACEMENT AND EXCLUSION

Batterers in batterer programs and substance abusers in treatment comprise a special subgroup, because, more often than not, if one problem is present, the other problem is present as well. However, the response of these two fields of practice to the cross problem has been uneven. Screening batterers for substance abuse is common; less common is screening substance abusers for domestic violence. Historically, substance abuse agencies have paid more attention to violence in the family of origin as a causal link to current dysfunction and less attention to ongoing violence in the lives of men and women in treatment. With the development of criteria for placement of substance abusers in treatment, such as those developed by the American Society of Addiction Medicine (ASAM) (2001), we now have formal mechanisms for including domestic violence intervention in a substance abuse treatment program. Domestic violence can be incorporated in substance abuse treatment plans under Dimension 5: the potential for relapse. Two other ASAM dimensions also provide convenient places for integrating domestic violence issues in substance abuse treatment plans: emotional/behavioral issues (Dimension

3) and recovery environment (Dimension 6). Based on the prevalence of domestic violence by and to substance abusers, its presence in a written treatment plan should be an issue in an agency's quality assurance process.

Although batterer programs have been more assertive in screening for and intervening with substance abuse, one question that has periodically plagued batterer programs is whether to exclude men from a batterer program if they refuse to get substance abuse treatment when such treatment is clearly indicated. In our opinion, the answer to that question in most cases is no. Unless a community has a highly coordinated response to domestic violence, which is both willing and able to hold men accountable for all episodes of noncompliance, men are more likely to slip through the cracks in the system if they are excluded from batterer programs for noncompliance with addiction referrals. They become lost, not only to the substance abuse agency but to the batterer program and, in an unfortunate number of cases, to the criminal justice system as well, and the safety of the domestic violence victim is breeched. Due to the high number of recovering men in batterers' groups, some with many years of sobriety and 12-step programs under their belt, we hypothesize that active substance abusers are more likely to "bottom out" or ask for help in a batterer group than outside of such a group. Furthermore, we assume that the longer men remain in batterer intervention systems, the greater likelihood their victim will reach safety.

Victim safety is the primary consideration in screening for violence by men in treatment for substance abuse treatment. Men screened for domestic violence in substance abuse programs (and in all programs other than domestic violence programs) must be informed that *all* men in the program are screened for domestic violence. The reason is simple: Men who batter may assume that if they are asked about domestic violence in a setting where they would not expect to be screened (e.g., substance abuse, health care, social service) they are being asked the questions because their female partner has informed the staff of the violence. Screening men without informing them that everyone will be screened is, therefore, a risk to the safety of battered women. Other "Safety 101" issues about which substance abuse agencies may need education are the following: (a) If contact with the female partner is part of screening or assessment, never document

the substance of the contact in the man's chart, and (b) once domestic violence has been identified, there should be, under all but the most conscientious conditions, no subsequent family or conjoint interviews. Our recommendations for those conscientious conditions are discussed elsewhere (Bennett & Williams, 1999).

SEQUENCING INTERVENTION

If substance abuse and domestic violence are not delivered serially (i.e., first one then the other), are they best delivered in coordinated (concurrent by two agencies) or integrated (one agency provides both services) fashions? This is a good discussion to have, because it means that we have gotten beyond the serial mentality (i.e., get him clean and sober so he can adequately process the information delivered in a batterer program). Such a discussion requires more attention than we have in this article. There are several levels of integration. At the most basic level, *agency integration*, a single, multifaceted agency delivers both services in two different programs. For example, a large mental health center may have a substance abuse treatment unit and a separate violence intervention unit with a batterer program. Typically, these will be staffed by different professionals or paraprofessionals. At a higher level of integration, which we refer to as *staff integration*, the same staff deliver both the substance abuse program and the batterer program. The highest level of integration, rarely seen, is *theoretical integration*, in which substance abuse and partner abuse are conceptually integrated, perhaps employing cognitive-behavioral or power theory mentioned earlier. One factor looms large in making the decision to provide integrated services: Is this asking too much of mortal staff? Our experience is that the level of training demanded of staff for theoretical integration is not usually available. This leaves agency integration or coordinated approaches as the most likely models for intervention when substance abuse and domestic violence co-occur. For reasons of accountability, we favor the coordinated approach. A substance abuse treatment program and a batterer intervention program providing concurrent services, in conjunction with the assertive case management of a probation officer, all within a coordinated community response to noncompliance provides, in our opinion,

the safest feasible alternative. Coordination of services for victims requires still different approaches (Center for Substance Abuse Treatment, 1996; O'Brien & Bennett, 2002).

DOMESTIC VIOLENCE, SUBSTANCE ABUSE, AND AFRICAN AMERICAN MEN

We have presented thus far various perspectives on the causal links between substance abuse and domestic violence and a few of the critical practice issues at the confluence of these issues. These observations, theories, and practical suggestions are as important and as applicable to African American men as to men in other cultures. However, researchers and practitioners who work with African American men, in either domestic violence or substance abuse settings, suggest that social reality and social context are critically important when working with African American men. Men who batter and men who abuse substances may share common traits such as elevated need for control, poor conflict resolution skills, and low frustration tolerance. Conventional models identify these and other psychological issues when dealing with men who drug and batter. However, having such a limited focus may reduce our ability to work with men who have multiple issues, particularly issues outside the domain of psychological functioning. In batterer programs, for example, poor African American men do not fare as well in treatment as do men of other groups (Williams & Becker, 1994). Culturally incongruent treatment environments may not recognize that treatment goals, expectations, and needs differ for this group.

There are no theories that specifically address partner abuse by African American men, nor is this discussed in the literature on domestic violence (Williams, 1994). However, structural and interactional theories, although suggesting that oppressive social environments incubate and sustain violence, offer opportunities to understand the experience of young and poor African American men in oppressive social environments.

Oppressive social structures create hostile living environments that support a range of maladaptive reactions by African American men. Violence among African Americans is not discouraged by mainstream American society, as long as it was directed toward other African Americans (Hawkins, 1987). Most African

American men experience social oppression, regardless of social status, but low-income men may feel it more intensely (Gary, 1995). In many poor African American environments, violence is a behavioral imperative among male peers, and to move away from violence is a personal struggle and an evolution to self-awareness (McCall, 1994; Nicholson, 1995). Based on interviews of men in hospital emergency rooms who were victims of violence, Rich and Stone (1996) described the meaning of being a *sucker* for young African American male victims and perpetrators of violence. Respondents reported that either an unwillingness to use violence or the perception of weakness and vulnerability could result in more danger and increase the potential for abuse, more so than the actual use of violence. A tough-guy personality often develops from exposure to violent environments (Oliver, 1994). For such men, violence may result from their perception of others as a threat. Such perceptions can be triggered by verbal and nonverbal interactions with others and, as suggested earlier in this article, by alcohol and drug use and abuse. Abusive behavior toward a partner is a learned reaction to oppression within a hostile, violent community environment. Substance abuse is a means of enhancing personal power and coping with hostile environments that exacerbates perceptual distortion and, in time, paradoxically, impairs coping skills and renders a man increasingly powerless. It is essential to examine the social context of poor African American men before we develop treatment approaches that are effective and congruent with their reality and life experience (Wade, 1994). Recent approaches to the treatment of substance abuse emphasize the importance of attending to factors that contribute to substance abuse (National Institute on Drug Abuse, 1999). For African American men, these factors include unemployment, racism, discrimination, and issues pertaining to gender role and manhood.

One model for treating substance abusers is described as a paradigm for socialization: empowering African American male substance abusers to maximize their human potential through a continuum of care (Ormand, 1992). This model focuses on criminality and substance use, and anxiety and depression. It also explores education/functional literacy, vocational development, therapeutic recreation, family and community psychosocial

functioning, nutrition, and spirituality. Not to be overlooked in this approach is the availability and importation of alcohol and other drugs in the African American community and the impact of criminal sanctions and incarceration. The "war on drugs" is described by some observers as a war on young African American men (Wilson, 1992). The war on drugs has many fronts. Repeat victims of violence to emergency rooms are most likely to be poor African American males who have substance abuse and mental health problems and who live in neighborhoods where violence is pervasive (Rasheed & Rasheed, 1999). Despite this, there are many treatment programs targeting African American men that do not discuss the impact of the 1980s cocaine epidemic for African Americans, the resulting psychiatric co-morbidity, and the fallout of the war on drugs (Pena & Koss-Chioino, 1992).

Cultural competence and social reality competence are important in treating both substance abuse and domestic violence in African American men and, indeed, in all men. In those programs that avoid these contexts, attrition rates are likely to be higher. What would programs include if they wanted to address cultural and social context competence among their practitioners and within their program. We suggest the following elements as critical in helping African American men change their behavior:

Confront and take ownership of the problem and associated negative behaviors. Men must develop the capacity to admit how their behavior destroys the lives of women, children, families, and the community. To arrest the roots of this problem, they must be able to conduct an honest self-assessment about how the violence and abuse has negatively affected them and those close to them.

Challenge current methods of addressing problems in their lives. Because both domestic violence and substance abuse are seen as an approach to address a situation, problem, or conflict, they must explore how the use of violence or the use of drugs has not worked for them.

Identify other models for life and problem solving. It is important for men to identify or be taught to handle problems or challenges in more positive ways without the use of violence or drugs.

Develop alternative life codes of conduct. Because many of these men have disorganized lives, it is imperative to get them to develop principles for living and treating others as well as themselves.

Build the capacity to problem solve in challenging situations. With poor African American men, the topic of life context and challenges is a

recurrent theme. Men who speak of such things must develop the capacity to appropriately address their problems within these challenging circumstances.

SUMMARY

In this article, we have argued that substance abuse and domestic violence have multiple paths of risk and reinforcement. Simplistic perspectives that suggest that drugs disinhibit men to be violent, that violence and chemicals have common pathways in the brain, or that substance abuse and domestic violence are alternate forms of male power motivation all have their utility. However, simple perspectives should not be a basis for either practice approaches or social policies. Perspectives that account for complex, multiple determined relationships between drinking, drugging, and male partner violence are preferred. In our experience, a single man who batters often has experienced the following: both violence and substance abuse in the family of origin, a strong need to be in control, grown up in oppressive environments, few social skills, clinical depression, high levels of narcissism, underemployment, high levels of hostility, a very small stake in conformity to the dominant culture, and substance abuse. To isolate and treat any of these psychosocial characteristics as the etiology of his violence toward women is misdirected.

This misdirection is often compounded, however, by our tendency to regard substance abuse and partner violence as strictly personal problems, as if the community and societal reactions to them were uninvolved in their occurrence. We have argued that the war on drugs is barking up the wrong tree, and a particularly racist tree at that. We would also suggest that violence against women can never be seen or treated as a personal problem, distinct from a society that has long tolerated such violence, both through our failure to enforce laws and through our celebration of male dominance in popular culture. Finally, we suggest that intervention with men who abuse both substances and their partners must be linked to the aforementioned culture as well as to the healing properties of communities and cultures that bear and sustain African American men.

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