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Lubker: Socioeconomic Status and Domestic Violence
SOCIOECONOMIC STATUS AND DOMESTIC VIOLENCE

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Domestic violence is pandemic and affects women and families all over the world. It involves the “systematic use of violence and abuse to gain power over and to control a partner of ex-partner (DVIP).” Forms of domestic violence include any physical or sexual contact, aggression or violence that is unwanted and may take the form of threats, harassment, verbal abuse, hitting, kicking, etc. (DVIP). It is estimated that 20 to 50 percent of the world’s female population will be victims of domestic violence (Feminist Majority), and in the United States, it is estimated that at some point in their lives, 24 to 34 percent of all women “will be physically assaulted by an intimate partner (Weinbaum, et al, 2001: 313).” In addition, one third of female homicide victims in the U.S. are killed by their husband or partner (Kyriacou, et al, 1999), and every year two to three million women are victims of assault at the hands of male partners.

Socioeconomic status has been identified as a risk factor for domestic violence (Kyriacou, et al, 1999). The income gap is continually widening between the rich and the poor, and “the average income of the poorest fifth of the population down six percent and the average income of the top fifth up 30 percent over the past 20 years (APA).” The poverty rate in the U.S. was at 18.9 percent in 1998 and that number represents 13.5 million children (APA). Research of the rates of domestic homicide in white and black populations showed that when “stratified by rates of household crowding, the relative risk of domestic homicide in black populations was no longer significantly elevated (Centerwall, 1995).”

Identifying socioeconomic status as a risk factor for domestic violence is important for developing appropriate resources and interventions to combat the problem. Domestic violence cannot be targeted alone; risk factors such as socioeconomic status must be targeted as well in order to affect social change. While 40 to 50 percent of women who are victims of domestic violence are physically injured from an assault by a partner, it is estimated that only one in five of them seek medical treatment for their injuries (Feminist Majority). The purpose of this review was to critically examine the literature on the relationship between socioeconomic status and the occurrence of domestic violence.

The aim of a study by Centerwall (1995) was to replicate or not replicate the results of a study of domestic homicide in Atlanta, Georgia. That study found that “when black and white populations were unstratified for SES, the relative risk of intraracial domestic homicide in black populations was 5.8 compared with white populations” (Centerwall), but when the two populations were stratified by SES, the relative risk was no longer significantly elevated. Socioeconomic status was measured by household crowding. The study concluded that black people in Atlanta were no more likely than white people to commit domestic homicide when they were in comparable socioeconomic situations.

Homicide data from the New Orleans coroner’s office was analyzed and abstracted for information about the victims and offenders. There were 691 black and white victims (593 black and 98 white). Specifically, the following information was collected: race of both victim and offender, address of victim and the relationship between victim

status of that census tract was measured by rates of household crowding (the percentage of homes in the tract with more than one person living in each room). "Rates of household crowding were determined separately for blacks and whites" (Centerwall) and were not calculated for tracts with less than 400 residents. The census tracts were categorized into levels of household crowding. Researchers defined domestic homicide as "all criminal homicides committed by a relative or acquaintance, whether or not occurring in a residential setting." (Centerwall)

A relative or acquaintance had killed 405 (59 percent) of the 691 victims. Of these domestic homicides, 368 were intraracial. The relative risk of domestic homicide in the black population compared to the white population was found to be 6.1 when unstratified for socioeconomic status. When socioeconomic status was taken into account, the relative risk was 1.2. The author states that this extreme difference in relative risk is "entirely accounted for by differences in SES between the respective black and white populations." (Centerwall)

While this study was not clearly written, the importance of removing race as a confounding variable in rates of domestic violence in order to focus on socioeconomic status is recognized. The author could have used a less extremely divided population, as the inclusion of 593 black victims and only 98 white victims might alter results somewhat.

A study by Fairchild, et al (1998) attempted to find the prevalence of adult domestic violence among Native Americans and the sociodemographic factors associated with domestic violence in that community. It was conducted at an Indian Health Service (HIS) health clinic on a Navajo reservation that served a community of approximately 26,000 people. All women more than 18 years were eligible for the study if they were seeking routine care at the general medical clinic during the week of September 14, 1992, or if they were seeking care at the maternal and child health clinic during the week of October 19, 2002.

Participants gave written consent and completed a survey that asked about demographic information and about experiences of domestic abuse. The 341 participating women (92 percent of the 371 eligible women) represented 4.6 percent of the adult women in the community. The age distribution of this group of women was not significantly different from the age distribution of adult women in the community.

The prevalence of domestic violence in this Navajo community was found to be 52.5 percent, which "was similar to the cumulative violence reported by women in an urban emergency department (54.2 percent)." (Fairchild et al, 1998: 1516) Almost half (41.9 percent) of the women in this study reported a history of physical violence and the one-year prevalence of physical violence was 13.5 percent. The researchers found that living in a household that received government financial assistance was associated with higher rates of domestic violence, as was being under 40 years old.

This study did not delve deeply enough into predictors of domestic violence in the Navajo community. The researchers state that the "extent the rate of poverty among the Navajo (58 percent according to the 1990 census) contributes to our results from domestic violence remains to be determined." (Fairchild et al, 1998: 1516) Looking into that aspect of poverty's effect on domestic violence would have made the study more generalizable. There could be confounding factors within this specific Navajo community that make domestic violence or poverty more extreme.

A study by Hoffman, et al (1994) examined husbands' use of physical violence against their wives in Bangkok, Thailand. The authors developed four models to guide

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their analysis: a structural model, a stress model, a family process model and an integrated model. The structural model addresses socioeconomic status as a risk factor for domestic abuse by assessing “the general propositions regarding the importance of socioeconomic status and status inconsistency.” (Hoffman and Demo, 1994: 134) Using the stress model allowed the researchers to “assess the general proposition that lower socioeconomic status and status inconsistency are associated with higher levels of stress and frustration, which in turn may lead to wife abuse.” (Hoffman and Demo, 1994: 134) These two of the four models are the ones that most directly address socioeconomic status in relation to domestic violence.

Methods for this study included secondary analysis of face-to-face interviews that were conducted by trained Thai interviewers. The questions in the interview were developed after conducting focus groups with native Thais.

With the assistance of the National Statistical Office in Bangkok, administration districts were sorted according to their population density. This explicit sorting of administration districts by population density was done to facilitate the primary focus of the original research, which concerned the effects of crowding on marital and family relations. The sample was drawn from Bangkok administration districts utilizing a two-stage, probability-proportional-to-size, cluster sample design with implicit stratification for population density. Additional stipulations placed on eligible households included having an intact marriage with at least one child, and the wife being no more than 45 years of age. The process netted a representative sample of 2,017 households, with a response rate of 87 percent. The subsample of husbands used here is 619. (p. 136)

The researchers chose to focus on husbands because much of the existing research on domestic violence is focused on women’s experiences of domestic violence and not from the perspective of the perpetrators of the abuse. Second, the level of stress of the husbands is important in terms of the models developed at the start of the study, and can only be accurately assessed when the information comes from the husband. The authors felt confident in the reports of the husbands because the rate of abuse reported by women in the larger sample was almost the same (19.5 percent for the husbands and 18 percent for the wives). Demographically, most of the men were of Thai descent, they had an average age of 37, 93 percent worked full time, and the group had an average of eight years each of formal education. The average length of time the men had been married to their wives was 11 years, 75 percent had one or two children, and more than 80 percent were in their first marriage.

During the interviews, respondents were asked about ever hitting, slapping or kicking their wives (domestic violence, the dependent variable). Regarding socioeconomic status as a predictor variable, the researchers measured income, occupational prestige and level of education. Stress and frustration were measured by scales that assessed psychological symptoms like depression, irritability, etc., as well as demands the husbands felt were put on them. Results of the study show that rates of domestic violence reported by this population of urban Thai men are approximately 20 percent. Socioeconomic status was found to be negatively correlated with domestic violence and men with fewer economic resources were more likely to abuse their wives.

The authors cited three specific factors in their methodology that could have contributed to the high rate of domestic abuse reported in this study. The sample is drawn from a very urban population and therefore cannot accurately reflect the rates of abuse for the rest of the country, especially the more rural regions. All of the couples in the study had at least one child, and studies have shown that couples with no children have slightly lower rates of domestic abuse than couples with one or more children. These

some surveys ask about acts of domestic violence committed in the previous year or month, this survey asked about acts of domestic violence ever committed.

This is an important study in that it looks at domestic abuse in a culture that strongly values the family and familial relationships. The Thai culture is also changing rapidly in terms of urbanization and industrial growth, as well as relationships between men and women, so examining domestic violence in a changing culture such as this is very worthwhile. However, the study attempted to look at so many potential influencers of domestic violence that they did not get a chance to look closely at any of them. For example, they did not look in detail at the specific effect of employment or underemployment. "Future research should examine unemployed and underemployed husbands and their work conditions to disentangle the specific aspects of lower socioeconomic status that escalate the likelihood of abuse." (Hoffman and Demo, 1994: 142)

A case-control study by Kyriacou, et al (1999) conducted at emergency rooms at eight university hospitals in the United States, had the goal of examining "socioeconomic and behavioral characteristics of women and their male partners to identify risk factors for injury to women as a result of domestic violence." (Kyriacou et al, 1999: 1892) The emergency departments served diverse populations in suburban, urban and inner-city areas. Institutional Review Boards at each site approved the study and oral consent was obtained from each participant. Populations for the study were intentionally injured women (cases) and women who had not been intentionally injured but sought medical care at the emergency room and had current or recent male partners (controls). From the eight emergency departments, 256 (90.8 percent) of the eligible cases agreed to take part in the study and 659 (88 percent) of the eligible controls agreed to take part in the study. The age and race of the controls were similar to the cases, which reduces the effects of confounding from those two factors.

The cases were women 18 to 64 years old who had experienced domestic assault and injury in the preceding two weeks by a male partner. Trained doctors or research assistants identified participants using a "standardized questionnaire administered to women with a history of trauma or signs of injury...designed for use in emergency departments to identify episodes of domestic violence."(Kyriacou et al, 1999: 1893) Women who had been sexually assaulted were excluded. The controls were women 18 to 64 years old "who were seen in the emergency department and who were selected in order to represent the distribution of study variables in the source population."(Kyriacou et al, 1999: 1893)) Participants were selected over a 15-month period, and women who did not have a current or recent male partner or who had a history of domestic violence-related injury in the year prior were excluded. Non-random sampling was chosen as the preferred method for the controls as opposed to population-based sampling because "it considered the selection factors that brought the controls to the emergency departments."(Kyriacou et al, 1999: 1893)

The researchers measured variables such as the male partner's employment status and drug and/or alcohol use. They also recorded information about the injuries received, such as type, location and severity, as well as what weapons, if any, were used. Depending on the site, data were collected for three to 15 months. The researchers did not review the women's medical charts.

Results of the study show that, in terms of the partners of intentionally injured women, alcohol abuse, drug use, intermittent employment, recent unemployment and less than a high school education were all positively associated with domestic violence.

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Race or ethnic group was not associated with the male partner inflicting injury. The researchers found that unreliable employment of the partner was a risk factor for domestic abuse, as well as low levels of attained education. Education level of the partners could be associated with other risk factors such as the unemployment or alcohol abuse, as well as with bad communication skills, which has also been associated with domestic violence.

Limitations stated by the authors include selection and misclassification biases. "Although the control women were selected from the same emergency-department populations as the intentionally injured women, factors related to injury from domestic violence may have influenced their selection." (Kyriacou et al, 1999: 1897) They attempted to limit this selection bias by selecting from all women at the emergency department so that no reason for coming to the emergency room was over-represented. In addition, they tried to limit selection bias by using the same criteria for eligibility and exclusion in both the case group and the control group. Misclassification bias was identified as more of a problem in the reporting of alcohol and drug use. The women in the case group "may have underreported their alcohol consumption to deflect any assumptions about their responsibility for the domestic violence." (Kyriacou et al, 1999: 1897) They addressed this by using a standardized, validated questionnaire and by excluding women who had a history of physical abuse from the control group.

This was a well-done study. The researchers addressed various types of bias and took measures to lower their effects, and correctly admit that the results of the study may not be easy to generalize because not all victims of domestic violence seek medical care in emergency rooms, if they need medical care at all. This study looks strictly at physical domestic abuse.

A study by Weinbaum, et al (2001) aimed to estimate the prevalence of IPP-DV in California and also to identify risk factors associated with female victims of IPP-DV. The researchers used data from the California Women's Health Survey (CWHHS), a telephone survey of randomly selected women over the age of 18. "Data are weighted by age and race/ethnicity to reflect the 1990 census of California women." (Weinbaum et al, 2001: 314) In 1998, there were 4,006 respondents to the survey and 3,408 women (85.1 percent) responded to the questions regarding domestic violence.

The researchers identified several factors associated with domestic violence: "low income; lack of higher education; unmarried status; recent enrollment in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); having children in the household; and employment status." (Weinbaum et al, 2001: 314) Poor health (physically and mentally), being pregnant in the past five years, under age 17 the first time they had sex, and having their first live birth under age 21 were also associated with higher reports of domestic violence. Victims also were more likely to smoke and to not be able to afford proper nutrition for themselves.

Study results show that in 1998, six percent of women in California experienced domestic violence (a number that is consistent with several other studies). The researchers also stated that although specific factors were indicated as risks for domestic abuse (low socioeconomic status, for example), these factors are very closely connected and hard to separate from one another. This inter-connectedness of factors points to a need for multi-dimensional interventions that target several behaviors and factors.

This was a statistically rigorous study that analyzed many factors as possible influencers of domestic violence in California. Slightly problematic is the use of a phone survey for data collection, since this does not ensure a representative sample of the population, and may not be appropriate to generalize these results to the general

The studies cited above support the fact that socioeconomic status is a factor that influences the occurrence of domestic violence. Although it may not directly cause domestic violence, there is an association between the two. However, after reviewing the literature it is apparent that there are many other factors that also affect rates of domestic violence, and they are all connected. In addition to socioeconomic status, education level, urban versus rural living situations, marital status, age, parity and health all affect one another and they also all affect domestic violence. This makes it difficult to say that socioeconomic status alone can be used as an indicator of domestic violence rates. All of these factors are confounders for one another and very hard to separate. Future research should look deeper into each factor in an attempt to find which ones are the most strongly correlated with experiencing domestic violence.

In conclusion, there does not appear to be only one answer to the problem of low socioeconomic status affecting domestic violence. Policy-level changes need to be made to improve the services offered to lower socioeconomic status populations and communities. This would help to reduce stress felt by some families. Another environmental change that should be made is making domestic violence a community issue, not just something that victims and survivors deal with. Interventions should work to mobilize communities to combat domestic violence. This would help to increase feelings of empowerment among community members and give them hope that socioeconomic status does not have to be the only determining factor on quality of life. On an individual (and community) level, working to keep people in school and from getting pregnant at an early age would help reduce some of the factors associated with domestic violence. Also, teaching communication skills and anger management would accomplish a similar goal.

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