Connecting Social Determinants of Health and Woman Abuse:
A Discussion Paper

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## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>I.  The Social Determinants of Health</td>
<td>5</td>
</tr>
<tr>
<td>II. Woman Abuse By Intimate Partners</td>
<td>9</td>
</tr>
<tr>
<td>III. Possible Links Between The Social Determinants of Health &amp; Spousal Violence</td>
<td>12</td>
</tr>
<tr>
<td>Conclusion</td>
<td>16</td>
</tr>
<tr>
<td>Bibliography</td>
<td>17</td>
</tr>
<tr>
<td>Endnotes</td>
<td>20</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

Financial support for this discussion paper came from a grant to the Atlantic Summer Institute for Healthy and Safe Communities from the National Crime Prevention Centre. The authors would like to thank the Institute Advisory Committee for the invitation to contribute to the 2nd Atlantic Summer Institute on Healthy and Safe Communities held at UPEI. We also thank our Research Assistant, Fern Paul, for her help preparing this paper during a busy summer.
INTRODUCTION

Following the recent work of researchers such as our UNB colleagues Judith Wuest and Marilyn Merritt-Gray (2004), it is increasingly recognized that woman abuse produces serious, and often long-term, effects that are costly for both the individual and the healthcare system\(^1\). This important type of research relates to what happens to women’s health and well-being after intimate partner violence has occurred. In this paper, by contrast, the issues that will be discussed are different as they relate to what happens before abuse: how some factors referred to as “social determinants of health” can be conceptualized as potential contributing causes to intimate partner violence. These issues are certainly extremely complex and we do not in this short paper pretend to properly disentangle the various causal links or paths that might exist among the variables discussed. Our aim is much more modest: to stimulate a discussion around these issues in the hope that this will be helpful, in the long run, in making Atlantic communities healthier and safer, particularly for women and their children.

In the first part of this paper, we briefly introduce the social determinants of health and some of what is known about them in plain language. In the second and third parts, we discuss woman abuse (understood here mainly as physical or sexual abuse at the hands of an intimate partner) and how it might “result” in part from (or at least be related to) the conditions of women in terms of the social determinants of health. Of course, this discussion is only a rough oversimplification of reality as Hebert Blalock would note. In conclusion, we stress that studying woman abuse through a focus on the social determinants of health leads us to understand that various social policy initiatives (in the areas of housing, income support or childcare for instance) might have the potential to reduce abuse and improve health.
I. THE SOCIAL DETERMINANTS OF HEALTH

For a long time, much of what was said and written about health was focused on the contribution of medicine and the healthcare system. To some degree, this is still the angle taken in the current media coverage of the reoccurring and never-ending “health crisis”. However, we know at least since the publication of the Lalonde Report in 1974 that the healthcare system and the health of a population are two different things and that pumping ever increasing resources into the healthcare system does not necessarily result in significant improvements in the health of the population because it is influenced by a number of other factors (or “determinants”) that are located in the environment outside the healthcare system. We therefore know that increasing the number of hospital beds in a province is no panacea for improving the health of its population.

Roughly estimated, it can be said that the healthcare system is responsible for about 25% of the health status of the population. Biological factors and genetic endowment are believed to account for about 15%, the physical environment for 10%, and social and economic factors for 50%. Hence, factors such as our education, employment, income and the physical and social environments in which we live influence our health at least as much if not more than the quality and availability of healthcare services.

Table 1: What Determines Health?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Income and Social Status</td>
</tr>
<tr>
<td>2.</td>
<td>Social Support Networks</td>
</tr>
<tr>
<td>3.</td>
<td>Education and Literacy</td>
</tr>
<tr>
<td>4.</td>
<td>Employment/Working Conditions</td>
</tr>
<tr>
<td>5.</td>
<td>Social Environment (norms and values)</td>
</tr>
<tr>
<td>6.</td>
<td>Physical Environment (food, shelter, clothing, and recreation)</td>
</tr>
<tr>
<td>7.</td>
<td>Personal Health Practices and Coping Skills</td>
</tr>
<tr>
<td>8.</td>
<td>Healthy Child Development</td>
</tr>
<tr>
<td>9.</td>
<td>Biology and Genetic Endowment</td>
</tr>
<tr>
<td>10.</td>
<td>Access to Quality Health Services</td>
</tr>
<tr>
<td>11.</td>
<td>Gender</td>
</tr>
<tr>
<td>12.</td>
<td>Culture</td>
</tr>
</tbody>
</table>

What does this means? Well, for instance, speaking of income and social status as determinants of health means that people with higher incomes generally enjoy better health and live longer than people with lower incomes. It appears that this is not only related to the capacity to secure safe housing, and the ability to buy sufficient high quality food, but that higher status people also enjoy a greater degree of control over their life circumstances. British researchers in fact recently found that men with low-grade jobs (with little control over daily tasks) have faster heart rates, which could explain why men with low-paying jobs have a higher risk of heart disease – a pattern that has been recognized for the last 30 years. Note that the association between higher social and economic status and better health is strong and well established scientifically, although the biological pathways explaining how this occurs are still not fully known. Moreover, not only the relationship between the socio-economic status and health status should be of concern, but also the fact that level of inequality itself (the gap between rich and poor) is associated with the overall health of societies. When larger gaps in income distribution are observed, so are increases in social problems and poorer health among the population as a whole.

Speaking of social support networks as determinants of health means that people are healthier when they feel safe, supported by and connected to others – when they can trust their family members, when they can count on friends, neighbours and members of the community in general. Social support is believed to be important because it is a key factor in helping people solve problems and survive life’s crises. Having someone to confide in, someone to count on in times of crisis, someone you can seek advice from, is good for your health. In fact, studies have associated various health outcomes – from the risk of angina pectoris to premature death rates – with the amount of social contact and emotional support. Social support is particularly important during pregnancy and has been demonstrated to influence both the baby’s birth weight and the general health of the baby. Stable, relevant and meaningful relationships with friends, relatives and neighbours are also invaluable in rearing children. Young families (and especially women) who lack such support are left unprotected to face the consequences of life
stress. That is why researchers describe social relationships as “buffers” in times of stress.

Speaking of education as a determinant of health means that health status improves with level of education (which is closely associated with income and social status). Education provides useful problem-solving skills and contributes to the feeling of control and the sense of mastery over one’s life circumstance. It provides opportunities for better jobs, income security, and satisfaction with employment. It also increases your ability to understand how you can keep yourself healthy and to act on that knowledge by choosing to avoid certain behaviours (like smoking) and engage in others (like physical activities).

Speaking of employment/working conditions as determinants of health means that having a job is generally positive for your health while unemployment has a significant adverse effect on both your physical and mental health. Similarly, it means that workers will tend to be healthier when they believe that their jobs are secure, that the work they do is important and valued, and when their workplace is not only safe but also provides opportunities to make decisions and grow as individuals.

Speaking of gender as a determinant of health is recognizing that women and men often have different, socially determined roles and responsibilities and different social realities. Women and men also have different opportunities to access and control resources, and women still, on average, earn less than men. This all means that we find disparities in health status between the genders as the health needs, health seeking behaviour, socio-economic conditions and access to health services vary substantially between women and men.

While women live longer than men, they are more likely to suffer depression, stress overload (often due to efforts to balance work and family life), chronic conditions such as arthritis and allergies, and injuries and death resulting from family violence (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999: viii).
Speaking of culture (i.e., language, ethno-racial identity, religion) as a determinant of health means that the beliefs you acquired through socialization regarding health and illness will likely affect the decisions you will make in seeking (or not) health services and about the type of services that will be sought, etc.

In sum, having a safe environment, adequate income, meaningful roles in societies, secure housing, a higher level of education and some social support in the community is associated with better health and well being. Social determinants of health are therefore factors in the social environment that contribute to or detract from the health of individuals and communities. Knowing this is one thing, but genuinely taking into consideration the important contributions of the social determinants of health presents challenging public policy implications. It requires moving the emphasis from an illness-based healthcare system to a wellness-based society that focuses on the prevention of illness and chronic diseases by addressing various social and economic conditions (from poverty to housing) that affect one’s health. In Canada, while much lip service has been paid to the social determinants of health in policy discourses and publications in the last 30 years, this shift in emphasis has not fully taken place.

Because many determinants of health are outside the institutional healthcare system, the strategy for improving health requires that work be done by social actors in the public, private and non-profit sectors in areas such as income support, justice, housing, education, transportation, community-building and social services (like childcare) that were not traditionally conceptualized as health-related. In some cases, neglecting these areas might negatively impact the health status of women through the intervening effect of violence against women, as illustrated below.
II. WOMAN ABUSE BY INTIMATE PARTNERS

For several decades now, researchers have tried to understand the root causes of violence and of domestic violence in particular. Obviously this is a complex, multidimensional problem with no single factor emerging as “the” satisfactory explanation (Gill, 2005). Looking at woman abuse through a focused discussion on the social determinants of health can therefore be one of many possible avenues to contribute to the understanding of this issue.

As mentioned earlier, the links between various social determinants and the health status of individuals (we are focusing here on women) and communities have been relatively well documented and the evidence relating to the top arrow in the above figure is now impossible to ignore. More recently, it has been recognized (including by the World Health Organization) that woman abuse negatively affects health, as women who are assaulted often suffer severe physical and psychological scars. We know in fact that abused women use more health services and are more likely to have poorer social functioning than women who have not been abused (Cohen & Maclean, 2003). Women victims of spousal violence are also more likely to experience sleep problems, depression or anxiety attacks, and to use medication to help them sleep, to calm down and to help deal with depression. Few analysts would therefore doubt the existence of the link
between abuse and poor health illustrated by the arrow on the right side of the above figure 1.3.

What has been much less studied are the relationships illustrated by the arrow on the left side of the figure: the links between the social determinants of health and woman abuse. While we have some data, we are largely left in the following section to discuss some informed speculations or educated guesses on the impact of factors like education, income, housing or levels of social support on the victimization of women in intimate relationships. We must proceed with caution however here, as it is important not to convey the stereotypical image that woman abuse occurs only in lower class, poor, uneducated households in subsidised housing complexes. We know in fact that woman abuse occurs in all social strata and that no ethnic or professional group is immune from it. Yet, in Canada, rates of spousal abuse have been found to be higher in households with incomes below $30,000 than in households with incomes of $60,000 or more (Pottie Bunge, 2000). Similarly, Berger (2002) reports rates of spousal abuse of 16% for Canadians living with less than $20,000 in household income, versus 4% for those living with household income of $75,000 or more.

We also know that men can be and are victims of abuse by their intimate partners (Strauss, 1999), but a focus on woman abuse is warranted in our view given the fact that the rate of injury for women in these situations (the consequences of spousal violence) is considerably higher. According to Statistics Canada’s 2004 General Social Survey (GSS), female victims of spousal violence were more than twice as likely to be injured as male victims. Women were also three times more likely to fear for their lives, and twice as likely to be targets of multiple violent episodes. Overall, the survey found that women were more likely to experience more serious forms of spousal violence than men (who rarely report having sought medical attention following such incidents). The data on one of the most extreme forms of violence is clear as to the gender difference in outcome: in nearly all Canadian cases of homicide-suicides among families involving spouses, the female was the victim killed by a male spouse. Since 1991, only about 2% of spousal homicide-suicide victims were male spouses killed by female spouses. Overall, it is clear
that women are more likely to experience more serious forms of spousal violence than men (Tutty & Goard, 2002).

If you think men are the victims of domestic violence, sit outside the hospital emergency room and watch who gets unloaded from the ambulances.

Steve Storie, former family violence investigator cited by Mark Sandel (2003)

Table 2: Woman Abuse Factoids

- Women experience more serious forms of violence than men.
- 16% of women experiencing violence in the last 5 years were sexually assaulted.
- 54% of women experiencing violence stated that it occurred more than once.
- 44% of women experiencing violence report injuries as a result of violence.
- 13% of women experiencing violence sought medical attention.
- 8% of injured women reported a miscarriage.
- 97% of homicide-suicide victims are wives.

Source: GSS data reported by the Canadian Centre for Justice Statistics (2005).

The 2004 GSS estimated that 7% of women (and 6% of men) in a current or previous spousal relationship encountered spousal violence during the five years up to and including 2004. In Canada, spousal violence is higher among young adults (15 to 24 years of age), those in recent relationships (3 years or less) and those living in common-law relationships. Individuals living with a heavy drinker (someone who drinks 5 or more drinks on five or more occasions in a given month) were also six times more likely to experience spousal violence than those living with non-excessive drinkers. Two victimization surveys have also revealed that pregnancy and efforts to leave a violent partner increase the risk of spousal abuse (Federal-Provincial-Territorial Ministers Responsible for the Status of Women, 2002).
III. POSSIBLE LINKS BETWEEN THE SOCIAL DETERMINANTS OF HEALTH AND SPOUSAL VIOLENCE

*Employment and Income*

A risk factor that appears to be associated with interpersonal violence at the societal level is income inequality (Gartner, 1990). We can extrapolate from this the hypothesis that intimate partner violence might be more likely to occur in relationship where a relatively large income gap exists between the partners, or where a large difference exists in the resource appropriation capacity of these partners. Hence, not having their own income might not only place women at risk of financial dependence on their partners, but might also place them at risk of being victimized by their intimate partners. Bowlus and Seitz (2005) did in fact find that husbands are more likely to abuse women who are not working. It remains that Canadian studies on domestic violence have not yet systematically investigated the potential links between intimate partner violence and income or resource differences in couples.

Interestingly, MacMillan et al. (1999) have found that while a woman’s participation in the labour force lowers her risk of spousal abuse when her male partner is also employed, it actually increases her risk when her male partner is not employed. Similarly, in the GSS, rates of violence varied according to the main activity of the victim’s spouse (Canadian Centre for Justice Statistics, 2004). Those who had spouses looking for paid employment were more likely to experience spousal violence than those whose partners were working (10% vs. 4%). As suggested by Johnson (1996), unemployment of the partner may sometimes precipitate spousal violence. Finally, the GSS found that both the accused and victim of spousal abuse were less likely to be employed than married persons in the general population (Canadian Centre for Justice Statistics, 2004).

It thus seems that employment issues and income levels probably bear some relations, albeit complex ones, with domestic violence. At the very least, it is safe to assume that low levels of employment and income may increase stress and reduce opportunities to
leave an abusive relationship. This last point is particularly important, of course, in understanding why women are often reluctant to leave abusive relationships. Because they generally have lower incomes, they are often forced by the financial realities of providing for children to stay with or return to the abuser where they remain at risk of being re-victimized.

**Network of Social Support**

It is a bit puzzling to observe that there is not more research on issues of domestic violence that focuses on networks of social support. While recently attending the 9th International Family Violence Research Conference in New Hampshire, we observed that most researchers present did not include social support in their analytic framework, many of them preferring to rely mainly on a battery of psychological instruments focusing on the individual and excluding measures of the contexts.

We do know that victims of spousal violence turn mainly to informal rather than formal sources of support in spite of the development of a number of institutionalized services. Most frequently, victims confide in someone close to them – a family member, a friend or a neighbour (Canadian Centre for Justice Statistics, 2005). Not having such a confidant at your disposal might make it much more difficult to take steps to end the abuse. Therefore, a weak network of support and a situation of relative social isolation can be considered a potential risk factor for domestic violence victimization, but much remains to be explored in this regard.

What is clearer is that social support is a key in predicting the behaviour of the abuser. In the criminological literature having family members and peers involved in crime in a widely recognized "risk marker" for young offenders. Regarding domestic violence, a number of studies have researched the role of patriarchal male peer support in domestic and dating violence offending, especially among young abusers (DeKeseredy, 1990; DeKeseredy and Schwartz, 1993; Lavoie, Robitaille & Hebert, 2000; Roscoe & Callahan, 1985; Williamson & Silverman, 2001; Silverman & Williamson, 1997). These studies generally suggest that abusers are more likely than non-abusers to associate with peers
that support sexist attitudes in favour of male domination over females. These men define woman abuse as a legitimate way to maintaining authority and control and serve as role models. It thus seems that associating with peers who advocate and perpetrate dating or domestic violence is strongly related to abusing one’s own female partners.

**Education**

Available data from the GSS suggest, perhaps surprisingly, no relationship between rates of spousal violence and the educational level of the victim or that of the abuser. We can reasonably postulate, however, that a higher level of education might help a woman abuse victim to identify and access appropriate services in the community and the criminal justice system once the abuse has started. Other things being equal, this could mean that an educated woman might be less likely to remain in an abusive relationship (and thus less likely to be re-abused by that same partner).

On the other hand, a study conducted at McMaster University by economist JoAnn Kingston-Riechers (1998) looked into the association between income and wife assault. She found that there is not a strong correlation between income and assault, but the link between education and assault is clear. In other words, assault is more likely to be associated with low levels of education than with either wealth or poverty.

As for a perspective on the abuser, one could think that a more educated man might be better aware of the potential social consequences of perpetrating abuse (ultimately jail) and might have more to lose in choosing this route. However, while this hypothesis seems reasonable it remains for now simply an avenue for future investigations and currently lacks any empirical support that we know of.

**Personal lifestyle and health practices**

The abuse of alcohol and other drugs is know to be related to (to co-occur with) incidence of spousal abuse. The role of alcohol (especially excessive drinking) has been well documented (Sumner & Parker, 1995). While alcohol is not the cause of intimate partner violence, it does interact with other factors to elevate risk of spousal violence (Gelles &
Straus, 1988; Gelles & Cavanaugh, 2005). In the 1993 Violence Against Women Survey, 29% of women who were violently assaulted reported that the violence usually began when their partner had been drinking. The 2004 GSS similarly indicated that in 35% of incidents the violent partner had been drinking at the time (the proportion is 44% in cases where the victim was female).

Less reliable information is available about the relationship between street drug use and spousal violence but it is likely that the patterns bear some similarities with those for alcohol. For women, being in an intimate relationship with a street drug user or using such drugs herself could place her in situations where relationship violence might occur through various circumstances.

As for some more positive personal health practices, such as regular physical activities or good life hygiene, there is no research that we know of that has attempted to connect these practices to domestic violence systematically. But, once again, we can at least postulate that these practices might convey a certain sense of mastery over one’s life and that this feeling might be useful in finding effective ways to end the abuse.

**Culture/ethnicity**

In the Canadian context, the GSS suggests that Aboriginal people were 3 times more likely to be victims of spousal violence (21% versus 7% of non-Aboriginal people). The severity of spousal violence was also greater for Aboriginal women as they were more likely to be beaten, choked, or threatened with a gun or knife. The rates of sexual assault, of injury and of those who feared for their lives were also higher among Aboriginal victims.

Let us be clear that we do not take these statistics to mean that spousal violence is inherent to the Aboriginal culture or more acceptable among them. Rather, we consider these figures as symptoms of the oppressed and underprivileged status suffered by Aboriginal people in Canada in general and of Aboriginal women in particular. Because we know that Aboriginal Canadians tend to have lower levels of income, employment
and education, and higher levels of alcohol abuse, the higher prevalence of woman abuse in their communities might actually be one of the best indications we have for the need to investigate further the links between the social determinants of health and woman victimization by intimate partners.

CONCLUSION
The aim of this short paper was to help stimulate discussion on the social determinants of health and their potential impacts on domestic violence (against women) as one common form or type of victimization. It is by now clear that the social determinants of health have a considerable influence on the health status of individuals. It is also fairly well-established that being victims of domestic violence can result in negative consequences for women and that these scars can sometimes be long-lasting. What is still sorely needed is extensive further research on the relationships between many social determinants of health and victimization of women by intimate partners. It is likely that many of these relationships are complex and not simply linear nor unidirectional.

If we think about inadequate and unsafe housing for instance, we can postulate reasonably that substandard and unsafe housing conditions can be both a consequence of and a contributor to domestic violence as illustrated in figure 2 below.

Figure 2: Housing and Woman Abuse

Clearly, domestic violence can be a contributor to inadequate housing arrangements or even homelessness among women (Neal, 2004). We may think also that certain housing arrangements (like multiple families living in the same dwelling, as is not uncommon among Aboriginals facing housing issues) might generate stress that can ignite domestic
violence incidents. Researchers (DeKeseredy and Schwartz, 2002; DeKeseredy et al., 1999) in fact found in both the U.S. and Canada that women living in urban public housing estates report high rates of such victimization. The social policy implications of this are that by working to make safe housing more affordable for low income Canadians we could contribute to preventing domestic violence in many ways, including by making it financially easier for women to find adequate housing options upon leaving an abusive relationship.

In similar fashion, creating a universal network of childcare centres could also be a social policy initiative that would indirectly contribute to the reduction of re-victimization of women by making it easier for them to balance work and child rearing upon leaving abusive partners. Community development initiatives might help strengthen local social networks and decrease the isolation experienced by certain women at risk of, or suffering from, abuse. Other social policy initiatives aimed at addressing the income needs of women, and more generally at decreasing income inequalities in society, are not only likely (based on what we now know) to work toward better health for the population as a whole (Vaillancourt et al. 2004) but might also contribute to the prevention and reduction of various forms of violence, including woman abuse by intimate partners.

As seen in this paper, we have to acknowledge the complexity of the issues surrounding woman abuse. By being aware of potential links between social determinants of health and the victimization of women by their intimate partners we can be better positioned to propose and support research and social policy initiatives that could contribute to reducing the incidence of domestic violence and create a generally healthier and safer Atlantic Canada.

BIBLIOGRAPHY


Endnotes:

1 In Canada, Greaves, Hankivsky and Kingston-Riechers (1995) have conservatively estimated the annual cost of intimate partner violence to be more than $408 million.

2 As noted by a reviewer of this paper, the issue is not just knowledge but also the resources to act on that knowledge – so you need money or extended health care coverage for many smoking cessation strategies and you may also need money or other resources to find the time, childcare and facilities to exercise.

3 Note that domestic abuse can have serious implications for children witnessing the abuse. By comparing respondents who reported growing up in abusive homes with those not from abusive homes, Berger (2002) found that respondents from abusive homes were more likely to report their health to be only fair or poor, compared to other Canadians. In his semi-annual telephone survey, Berger also found evidence that domestic abuse can be transmitted from generation to generation as respondents who reported growing up in abusive homes are more likely to report that they have suffered spousal/partner abuse as adults.

4 The Population Health Monitor survey of Berger (2002) found that 9% of Canadians 19 and older report suffering some degree of spousal or partner abuse. Among women 13% reported spousal/partner abuse versus 5% among men.

5 For more information on this conference, see: http://www.unh.edu/fri/conferences/2005/

6 On this, see DeKeseredy, W. S. & M. D. Schwartz (2003).

7 A reviewer of this paper mentioned the possibility that constructive physical exercise might defuse violence for abusers. This interesting point is in need of further research!