Domestic Violence Among Family Practice Patients in Midsized and Rural Communities

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BACKGROUND. This study was designed to determine the prevalence and character of domestic violence among female patients at three family practice clinics (FPCs) in communities of varying sizes.

METHODS. Structured interviews with 127 consecutive, consenting women were conducted in three FPCs in midwestern communities with populations of 85,000, 8000, and 3000. The main outcome measures included patient self-reports of emotional, social, physical, and sexual violence, and reasons for their clinic visit.

RESULTS. Women at the clinics in the smaller communities were significantly older, reflecting their communities' demographics. Fewer women in the larger community than in the rural settings reported currently having a violent partner (12% vs 25%, P =.01). In the total sample, 46% reported violence from a previous or current partner. Emotional and social abuse were associated with moderate violence (eg, slapping and pushing), severe violence (eg, punching and kicking), and use of weapons. Sexually abused women were emotionally abused and often physically battered. Forty-six percent of currently battered women reported abuse at least once a week, and most (81%) visited their respective clinics for episodic care.

CONCLUSIONS. Domestic violence is a prevalent health problem in all family practice settings. The finding that women in the larger community were less likely to be in a current battering relationship may reflect the effectiveness of local intervention programs. Because battered women present primarily for episodic care, physicians should routinely screen for battery, provide education about violence, assess the danger, review safety plans, and refer women appropriately.

KEY WORDS. Domestic violence; spouse abuse; battered women. *(J Fam Pract 1997; 44:391-400)*

Since 1986, when the first of three surgeon generals drew national attention to domestic violence, victimization by an intimate partner has been recognized as a major public health problem.[1-4] Domestic violence, also known as partner violence or spouse abuse, occurs in all groups without regard to sex of either partner, ethnicity, age, or socioeconomic status.[5,6] National crime statistics show that 90% of all reported domestic assaults are perpetrated by men and that women are 10 times as likely as men to be injured in episodes of domestic abuse.[7,8] Among female murder victims in this country, about one third are slain by their husbands or boyfriends each year, while only 4% of all male victims are killed by their wives or girlfriends.[7,8]

The first prevalence studies of domestic violence in the medical setting, which were conducted in hospital emergency departments (EDs), demonstrated that domestic violence accounted for 22% to 35% of women seen in the ED.[9,10] Studies of patients in internal medicine,[11] obstetrics,[12] and family practice clinics[5,13,14] have been conducted to estimate the prevalence of domestic violence seen in the primary care setting. According to these studies, 12% to 28% of outpatients in these settings have reported current involvement in violent relationships. In the studies of lifetime experience with violence, between 28% and 54% of patients reported having lived with a violent partner at some previous time.[5,11,13,14]

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These rates are much higher than those of the national incidence and prevalence studies,[13,15,16] which documented that battered women are more frequent users of health care than women who are not battered. Most presentations of domestic violence involve complaints[11-15] related to the stress of abuse rather than acute injuries.[17]

In previous work, the authors investigated the prevalence and character of domestic violence in a primary care setting in Duluth, Minnesota.[13] At that family practice clinic, 12% of the women seen reported currently living with a violent partner, and almost one half (45%) reported having lived with a violent partner at some previous time. Two thirds of these women had experienced all forms of abuse: emotional, social, physical, and sexual. Approximately one third (38%) of the sample reported some form of physical abuse, 19% reported sexual abuse, and 10% reported that a weapon had been used against them. In addition, all the women currently living with a violent partner had presented to their family physician for episodic, not preventive, care.

To date, most of what is known about the prevalence of domestic violence in rural settings comes from federal incidence and prevalence statistics.[7] These statistics are based on the definition of rural as a nonmetropolitan area comprising sparsely populated areas that include cities with populations of less than 50,000. According to these statistics, women have the same risk of experiencing domestic violence regardless of where they live, although women living in central cities are more vulnerable to all types of violent crime perpetrated by strangers.

Well-documented demographic differences exist among women in communities of varying sizes. Census data indicate that rural women have their first pregnancy earlier in life than do their counterparts in larger communities.[18] Recent data also indicate that a greater percentage of rural women are married and a smaller percentage are divorced or work outside the home.[19] In two separate studies, researchers found no differences in the number of women reporting illnesses due to stress or in the amount of stress each group reported relative to the size of their respective communities.[19,20]

The purpose of this study was to compare the domestic violence experiences of female patients in rural outpatient clinics with what the authors learned from their earlier research about the prevalence and characteristics of domestic violence among women patients in the larger community setting. Based on previous clinical studies and national statistics, the authors hypothesized that differences, if any, in the prevalence of domestic violence would reflect variations in community demographics.

METHODS

Women interviewed for this study were those seen in one family practice clinic (FPC) in a city of 85,000 people and two FPCs in rural communities of less than 10,000. The clinic in the larger community, which has a metropolitan area population of 250,000, is a residency FPC approximating the size of a four-physician practice. The first rural clinic, located in a one-industry (mining) town of 3000 people, is a three-physician FPC serving an area with a 30-mile radius and a population base of 5000. The second rural clinic is an eight-physician primary care group (five family physicians, two internists, and one general surgeon) located in a town of 8000 people, with logging, paper, and tourism as its primary industries. According to the local chamber of commerce, this clinic serves an area with a 15-mile radius and a population base of approximately 15,000 (Personal communication, June 1995).

All consecutive eligible female patients coming to the clinic in the larger community for regular morning appointments during the 3-week period beginning July 26, 1993, and ending August 13, 1993, were interviewed. Interviews were conducted also with patients coming for all regularly scheduled appointments at rural clinic 1 from September 13 to September 23, 1994, and at rural clinic 2 from September 27 to September 30, 1994. Women were eligible for the interview if they were over the age of 18 years, not scheduled for a medical procedure, free of dementia, and English-speaking.

Concerns related to underreporting of violence and safety issues were addressed by the study design. To ensure privacy, women were asked by nurses to participate only after they were in an examination room and were either alone or accompanied by very small children. When a woman agreed to participate, she was asked to sign an informed consent form but, for safety reasons, was not required to take it with her. Participation was anonymous and confidential; no information regarding any woman's participation was made available to

her physician. Subjects were interviewed following their medical appointment. The average interview lasted 7 minutes, with a range of 5 to 25 minutes, and solicited information about demographics and the participant's personal experiences with partner violence. All subjects were offered information about the nearest women's coalition and its services, including a brochure and wallet-sized card listing the phone number. Two of the communities had in-town services for battered women, while in the larger rural community, the nearest battered women's shelter was 30 miles away. Any woman admitting to current battery was assessed for safety, using guidelines developed by Sassetti,[21] and further advised about the resources available to her.

Instrument

The interviewer (M.J.) was trained as an advocate by the women's coalition in the largest community. The structured interview was developed using several sources, including published guidelines for assessing domestic violence in the primary care setting,[6,22,23] insights from the literature,[21] and suggestions based on the experiences of women's advocates. Once the questionnaire was drafted, counselors at the coalition, along with a physician and the Institutional Review Board for Research with Human Subjects at the University of Minnesota, reviewed the questionnaire for appropriateness and safety. Before the study began, the questionnaire was tested with four women, two of whom were known to have been battered by their partners. As a result of this pilot questionnaire, minor changes were made in the wording of a few questions.

Abuse of various types was determined by means of responses to the questions based on the issues listed in Table 1. If a woman responded positively to at least two of the three questions addressing emotional abuse, she was considered to be emotionally abused. Positive reports to any of three items related to social abuse indicated social abuse. Violence with material things was measured using three questions. Physical abuse was measured with four categories designed to establish either "moderate battery" or "severe battery," based on the potential for physical injury. Establishing the degree of severity made these data comparable to the categories used in national studies.[24] Sexual violence was also investigated as a part of physical abuse. A woman was considered a victim of sexual abuse if her partner forced her to have intercourse as part of their relationship. Finally, threats involving weapons (eg, guns and knives) were also reviewed.

TABLE 1

Indicators for the Categories of Abuse

Emotional abuse
Makes fun of you and/or what you believe in
Withholds approval and/or affection
Humiliates you
Social abuse
Tells you who you can see and when
Controls your access to transportation
Uses money to control you
Violence with material things
Throws things
Breaks things
Punches things
Moderate battery
Pushes you
Slaps you
Sexual abuse
Forces you to have intercourse
Severe battery
Punches you
Kicks you
Weapons
Uses a gun to threaten you
Uses a knife to threaten you

Answers to the questions and additional comments were recorded verbatim by the interviewer, and the data were coded by both authors. The few differences in the coding were resolved based on notes written in the margin of the completed questionnaires. For the purposes of analysis, Statistical Package for Social Sciences (SPSS) software (SPSS Inc, Chicago, Ill) was used to tabulate the responses (ie, to determine frequencies, means, and standard deviations), to compare experiences of abused and nonabused women in the various settings (ie, analysis of variance), and to compute Pearson product moment correlation coefficients between reported experiences with abuse.

Sample

Of the 219 women seen in all three clinics, 200 were eligible and 127 participated. The acceptance rate was approximately the same in the three clinics, as shown in Table 2. Twenty-two percent of the eligible women did not participate because they were missed owing to a busy clinic schedule (n=20) or did not have time to participate (n=23). These women

TABLE 2

Participation Rates and Demographic Characteristics of Eligible Participants, by Community

Characteristic	City Clinic (n=64)	Rural Clinic 1 (n=52)	Rural Clinic 2 (n=84)	Total (n=200)
Declined, %	13	19	15	15
Missed, %	22	15	25	22
Interviewed, %	66	67	60	64
Age, y*	34	54	41	43
No. of children†	1.4	2.5	2.5	2.1
Employed, %†	67	34	48	50
Education level				
≥ high school, %‡	100	89	86	91
Currently battered, %†	12	20	28	21
Ever battered, %	45	34	54	46

*$P \leq .001$.
†$P \leq .05$.
‡*P*</>.001.

initially agreed to be interviewed but were unable to wait for the interviewer. For instance, at one point, seven women had agreed and were waiting to be interviewed at the larger rural clinic. While the interviewer was detained in an extended interview, all but one woman left without being interviewed. Other reasons eligible women gave for not participating in the study included feeling uncomfortable talking about abuse (n=3) and having "nothing to offer" the study (n=7). Twenty women declined without comment.

Differences in demographic characteristics of the women at each clinic are also shown in Table 2. The women seen in the rural clinics were significantly older than those served by the clinic in the largest community ($P < .001$), and they had significantly more ($P < .001$) and older ($P < .05$) children. The rural women were also less likely to be employed ($P < .05$) and were more likely to have either dropped out of high school or not to have pursued education beyond high school ($P < .001$).

RESULTS

PREVALENCE

Forty-six percent of the 127 women interviewed reported some experience with violence. Twenty-one percent reported ongoing abuse by their current partner, and 28% reported violence in past relationships. Seventeen percent (22/127) of the total sample reported violence only in their current relationship, 24% (31/127) only in past relationships, while 3% (4/127) reported violence in both past and ongoing relationships. There was only one difference between women battered in the larger community compared with those battered in rural settings: involvement in an ongoing abusive relationship was significantly more common among rural women than among women in the city (25% vs 12%, respectively; $P = .01$). Further evaluation of this difference using multivariate logistic regression revealed that the difference is significant but it is not predictive of current violence.

DEMOGRAPHICS

Demographic characteristics comparing women in this sample who had never been battered with those who were battered previously or currently are listed in Table 3. The groups of battered and nonbattered women did not differ significantly across communities with respect to age, educational attainment, employment status, or presence of children. Those with any history of being battered were less likely to be married ($P \leq .01$) and less likely to have medical insurance ($P \leq .01$). Women with a past history of abuse were significantly younger ($P \leq .005$) and less likely to be in a current relationship ($P \leq .001$). Compared with any other group in this study, women with a past history of abuse were much less likely to have medical insurance (47%, $P = .001$)

PATTERNS OF ABUSE

Various abusive experiences were reported by the women in this study (Table 4). Some form of physical abuse was reported by 29% (37/127) of the entire sample, sexual abuse was reported by 15% (19/127), and threats involving weapons by 14% (18/127). Every women who reported physical violence also reported emotional and social abuse. Twenty-three percent (13/57), or nearly one in four, of the women with a history of abuse, or 10% of the entire sample, reported experiencing physical abuse and threats

TABLE 3

Characteristics of Battered and Nonbattered Women

Characteristic	% of Women Never Battered (n=70)	Currently Battered (n=26)*	Past Battered (n=35)*
Age, y†	46	41	37
Currently involved in relationship, %‡	84	100	56
Married, %§	86	81	29
Duration >20 y, %‡	48	31	—
Has medical insurance, %‡	84	65	47

*Includes 4 women who reported battery in both current and past relationships.
†$P \leq .05$.
‡$P \leq .001$.
§$P \leq .01$.

with weapons in addition to emotional and social abuse. A comparable proportion, 21% (12/57), of those with any history of abuse had experienced emotional and social abuse only. For the group with a past history of abuse, 11% reported emotional and social abuse only, while 31% of those currently in an abusive relationship reported emotional and social abuse only.

When asked to detail the frequency of abusive episodes, 13 currently abused women commented. Six of these women reported that abusive events tended to occur at least once a week, and for the majority (8/13), physical violence occurred at least every 3 months. Five women reported a single episode of physical violence.

Correlations among the types of abuse indicate that women commonly experience more than one type of domestic violence (Table 5). Moderate battery and severe battery often occur together ($r = .72$, $P < .001$). Threatened or actual use of weapons does not often occur with severe battery or sexual violence, although it usually accompanies emotional and social abuse ($r = .70$, $P < .001$).

Sexual abuse also accompanies moderate battery. Of the women reporting moderate battery and sexual violence, 62% (8/13) also reported severe battery. Interestingly, sexual abuse was not correlated with social abuse ($r = -.05$, P = NS).

Clinic Visits

Subjects were asked the purpose of their medical visit on the day of the interview (Table 6). Of those who had never been battered, 38% were in the clinic for preventive care, including physical and prenatal examinations. Only one half as many of the women currently being abused were being seen for preventive visits; 81% of them had come in for episodic care with specific complaints, including neck stiffness, twisted ankles, refills of antidepressant medication, migraine headaches, injured arms, sinus infection, hip pain, and depression. The primary reasons for the clinic visit given by women who had been abused in the past included depression, leg injury, sinus infection, amenorrhea, and pelvic pain, although more of them came for preventive care than currently abused women did.

Clinical Examples

The information obtained through the interviews provided rich descriptions of the violence experienced by these women. The following examples have been selected to add clinical reality to the correlations based on the women's reports. The areas selected for further description illustrate the issues that need to be assessed in determining the risk a woman is experiencing, the implications of violence for women who live in smaller towns, and the long-term effects of living in an abusive relationship.

In determining the level of danger a woman is experiencing, the following issues reported by women in this study should be assessed: severity and

TABLE 4

Type of Reported Abuse in Current and Past Relationships

Type of Abuse	% of Women Reporting Abuse in Any Relationship (n = 57)	Current Relationship (n = 26)	Past Relationship (n = 35)
Emotional/social only	21	31	11
Moderate battery	58	38	66
Sexual abuse	33	19	40
Severe battery	39	23	46
Threats involving weapons	32	19	37

Note: Percentages may add to more than 100 because of overlap in types of abuse.

TABLE 5

Correlation Matrix for Types of Abuse

	Emotional	Social	Emotional/ Social Only	Moderate Battery	Forced Sex	Social Battery	Use of Weapons
Emotional	1.00	—	—	—	—	—	—
Social	.43*	1.00	—	—	—	—	—
Emotional/ social only	.93*	.74	1.00	—	—	—	—
Moderate battery	.57*	.31†	.56*	1.00	—	—	—
Forced sex	.47*	–.05	.33†	.44*	1.00	—	—
Social battery	.47*	.27‡	.46*	.72*	.35†	1.00	—
Use of weapons	.59*	.64*	.70*	.44*	.27‡	.36†	1.00

*P <.001.
†P <.005.
‡P <.05.

frequency of physical violence and concerns about being killed. To women who reported that their partners would slam their fists through the walls, the message was clear: "Obviously that would be me." The physical violence experienced by these women was severe. Several women reported being beaten during pregnancy, and one reported that she lost a pregnancy as a result of a beating. Another woman reported an episode in which she was forcibly held in a door frame for 30 minutes. Still another woman described having her head "banged" on the sidewalk, and another told of being shoved down the steps and dragged through the hallway by her hair. Many women reported acts of physical violence that occurred at least once a week, and fear of an upcoming violent episode was a constant theme. One woman reported that if more than a week went by between abusive episodes, she "huddled around the corner waiting for what would come next." At least two of the women reported being beaten or choked as they slept.

Expressions of violence also included weapons. The husband of one woman cleaned his guns during arguments. Other men reportedly threw kitchen knives at their partners or actually held a knife blade to their throats. Some women reported that their partners threatened to kill them and then take their own lives. One man wrote suicide letters to his children during an initial separation from his wife, while another held a loaded gun to his head in front of his daughter and her friend. Despite being divorced from her husband for 4 years, another woman stated that her biggest fear was that "I'll be walking around one day and he will simply kill me." When asked how she coped with such a frightening threat to her life, still another woman explained that she never really thought of the danger of it, but that she had to "keep a sort of even tone" to her thoughts so that she would not lose her mind. Equally striking was the woman whose husband held a loaded gun to her head every day. She denied being abused because "My face isn't covered with bruises like those women in the posters."

The women also reported sexual abuse that intensified the sexual humiliation and degradation they experienced. When asked if she had been forced to have sex, one woman explained that she had not been physically forced but had been asked to do "terrible things which I went along with because I didn't know any better." For some women, sexual humiliation became public. Over the course of their marriage, one man frequently made sexually explicit and

TABLE 6

Battering Status of Women Attending Clinical Visits

	% of Women Who Were		
Reason for Visit	**Never Battered (n = 70)**	**Currently Battered* (n = 26)**	**Previously Battered (n = 35)**
Preventive care	12	8	9
Physical examination	17	8	7
Prenatal visit	9	4	5
Episodic care	62	81	79

* Percentages have been rounded.

degrading remarks about his wife in public, usually in front of their friends. Several women reported being forced to have intercourse when their partners were drunk, and another reported that if she wanted something, she had to earn it by having sex with her husband; toward the end of this pair's relationship, however, he would simply throw her on the floor and rape her.

An insidious form of abuse that accompanies physical violence is the gradual social and psychological isolation created by the batterer. Regardless of location, most of the women participating in this study reported being isolated from their friends and family. Rural women live with an additional dimension of separation: by living in a rural area, the batterer ensures geographic isolation. One woman who lived 13 miles out of town reported that no car was available to her because either she did not have her partner's permission to use it (she "knew never to take it if he didn't say I could") or he intentionally disabled the car. Several rural women also reported that they had been regularly left to care for their small children without access to vehicles until medical emergencies convinced their partners to leave a car at home "for the sake of the kids."

DISCUSSION

This is one of the first studies to compare women's experiences with domestic violence in family practice settings in communities of various sizes and to further define the prevalence and character of domestic violence as seen in these settings. The findings offer some insight into the range and frequency of abuse that women experience, and the types of care women seek from their family physicians.

Community Differences

In this sample, there was only one significant community-related difference between the groups of women who were battered. The women who came to their family physician in the urban setting were significantly less likely to be in a current battering relationship than those in the rural communities. In contrast to the current study's results, national surveys have documented that the same proportion of women are battered in both settings.[7] The rates of current violence in the largest community are low in comparison with previous clinical and national studies. In a previously reported study of 394 women seen in a comparable family practice residency clinic similar to the urban clinic in the current study, 22.7% of the women patients had been physically assaulted by their partners within the previous year.[5] Despite similar clinic settings, this reported rate is markedly higher than the rates reported by the women in this study. The reduced rate in this study may reflect the success of the nationally recognized domestic violence intervention program in Duluth, Minnesota,[25] combined with the relative isolation experienced in rural communities. Duluth has developed a collaborative, coordinated community response to domestic violence, with mandatory arrest since 1981, which works to hold perpetrators accountable for the violence. The regional rural communities do not have this coordinated response, which may explain why their rates of violence resemble rates reported in other studies.[5,9-14] This explanation is further supported by the finding in this study that there was no statistically significant difference in the proportion of women in all three clinics who reported experiencing previous episodes of violence.

The rural participants in this study were significantly older, less likely to be employed or educated beyond high school, and had more children. These findings are consistent with urban-rural differences previously reported.[19,20] According to regional demographics, the women interviewed represented the demographics of their respective communities.[26]

Patterns of Violence

Forty-five percent of the women interviewed in this primary care outpatient population reported some experience with domestic violence, a finding consistent with the rates reported in previous family practice studies.[5,13,14] Women who experience physical abuse are also usually emotionally and socially abused. Of the women reporting any type of abuse, 79% reported some form of physical abuse. Correlations show that when moderate battery occurs, there is also likely to be severe battery as well as a significant threat with weapons.

Women currently living with physical abuse experience it with alarming frequency. Forty-six percent of the women reporting current physical abuse described being hit once a week. This is a higher proportion than has been published in national reports,[7,8] which state that approximately one in five women reported being a victim of a

series of three or more assaults in the preceding 6 months. The higher frequency reported in this clinical study may be due to methodologic differences. The national interviews, which usually took place with both partners present, were not as likely to provide the privacy and trust afforded by the current design.

Correlations between the various types of violence demonstrated that women reportedly were living with multiple types of violence. Threats involving or use of weapons was highly correlated with emotional and social abuse. Sexual abuse, on the other hand, was positively correlated with emotional abuse but not correlated with social abuse. There seemed to be two categories of sexual abuse reported by the women in the present study. The first category was described by women who reported living with emotional and sexual abuse but denied other forms of aggression. The second category involved a larger proportion of women who reported sexual abuse that was accompanied by other forms of physical violence.

These findings are consistent with previous reports in the literature. Schwartz[27] reported that marital rape occurs in up to 10% to 14% of all marriages, and although it has been reported in relationships in which no other forms of physical abuse occur,[28,29] it seems to occur frequently in relationships involving other ongoing violent behaviors.[30] Frieze et al[31] found that sexual assault is reported by 33% to 46% of female victims who are being physically assaulted by their partners.

Our data are the first to distinguish between emotional and social dimensions of violence and to note these correlations. The positive correlation between emotional and sexual abuse and lack of correlation with social abuse may be related to the emotional aspects of sexual abuse. Within the context of an intimate relationship, sexual assault is not an isolated incident but rather extends the very personal humiliation and degradation of emotional violence to a sexual level and physical dynamic. Thus, it is important for family physicians to ascertain whether a woman has been sexually assaulted in her intimate relationship. Researchers have documented that women abused sexually in the context of marriage suffer from psychological symptoms equal in severity to those experienced by women who have been raped by strangers.[27,30,32]

Clinical Care

The findings of this study also document that battered women come to their family physicians for preventive care less often than do nonbattered women. Thirty-eight percent of the women who have never been battered presented for preventive health care, compared with only one half as many of currently abused women. Interestingly, none of the currently abused women in the larger community were seen for preventive health care, while 24% of the rural women were. The authors observed, as did Rath et al,[14] that several of the women who had been in long-standing abusive relationships were currently experiencing less physical abuse. In the present study, these were the rural women who came into the clinic for preventive care.

The battered women who presented for episodic care came with complaints such as migraine headaches, neck stiffness, and depression. As occurred in other studies, [13,15,16] these women were presenting with vague somatic complaints rather than with injuries directly related to battering. Since there are no reliable indicators of which women in a given practice are likely to be experiencing domestic abuse,[15] family physicians must include questions about violence in their screening questions. When women are asked about abuse, those who are being battered but are unwilling to disclose it learn that their physician is willing to talk with them about it. The single most helpful response for a battered woman is the validation of her experience.[6,21,28]

Consequences of Battery

Another finding in this study pertains to the consequences of leaving an abusive relationship. It is well documented that domestic violence occurs among women of all socioeconomic and educational backgrounds,[5,6] and the findings of this study support these facts. For the women in this study, however, there were important consequences to leaving an abusive relationship. Those who had left their abusive relationships within the past 5 years and were in the process of reestablishing their independence were less likely to be in a current relationship and more likely to pay their medical expenses with Medicaid.

Limitations

One limitation of the current study is the relatively small sample size. One reason for the small size is

that the design of this study combined qualitative and quantitative methods that allow the correlations and other statistics to be reported along with the rich descriptions that can be elicited only through in-depth interviewing. The use of only one interviewer also affected the sample size. It was often difficult for the interviewer to keep pace with the flow of patients in the larger clinics. This lag time resulted in a long wait for some willing participants, many of whom could not wait and left without being interviewed. Despite these difficulties, the current study attempted to get in-depth interview information from as many women as possible.

A second limitation pertains to a specific area of the interview. The number of women reporting experience with sexual abuse in our study may be limited by the wording of the question asked: "Does he force you to have sex when it makes you feel uncomfortable?" Many women reacted to the word "forced." In fact, one woman said, "He doesn't force me. He strongly encourages me." The prevalence rates that are reported here are consistent with other studies in the literature, yet they may underrepresent the true prevalence rates.

CONCLUSIONS

In this study, women in the largest community were less likely to be in a battering relationship with a violent partner than were the rural women. This lower number may reflect the success of the nationally recognized domestic violence intervention program in Duluth, Minnesota.[25] The rates of violence reported by women in the rural outpatient clinics are the same as others reported in the literature.

Women in battering relationships present to family practice clinics primarily for episodic care. Therefore, if physicians ask about violence only during extended visits, such as those for preventive care, these women will be missed. The battered women in this study came to their physicians with a variety of complaints typical of women living with domestic violence, including migraine headaches, neck stiffness, and depression. A significant proportion of these women were also being sexually abused by their partners. Family physicians should ask specific questions about marital rape and sexual abuse to identify and help these women who are known to suffer from the same psychological symptoms as those of women raped by strangers.

The prevalence rates and the characteristics of violence experienced by women documented in this study indicate that physicians should routinely screen their patients for battery, educate all patients about domestic violence, assess the level of danger, review safety plans with their patients, and refer those who are living with its consequences. This screening process will help identify women in abusive relationships. To repeat: when all patients are asked about abuse, women who are battered but unwilling to disclose it will know that their physicians are ready to talk with them about it at any time.

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