Rates Of Domestic Violence Against Adult Women By Men Partners

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***Abstract*: This study examines the rate of domestic violence against adult women by men partners. Two hundred eighteen women at two primary care clinics responded anonymously to a questionnaire. Forty-eight percent reported verbal abuse, 44 percent minor physical abuse, and 28 percent severe physical abuse. Abuse was common (16 percent) before marriage. Respondents whose partners were reported to be chemically dependent or sexually abusive were at greater risk for verbal and physical abuse. Respondents with lower socioeconomic status were at increased risk for verbal and physical abuse, as were women whose partners had less formal education. Ages of respondents and partners were not significant factors in abuse. Boyfriends not cohabitating were the least abusive, while couples together for 4 to 6 years had more domestic violence than other couples. Because spouse abuse is common and the consequences are devastating, it is important that family physicians become astute in making this diagnosis and initiate early treatment. (J Am Bd Fam Pract 1989; 2:227-33.)**

Couples have been disagreeing since time immemorial, and as far back as 753 B.C., there were laws governing conjugal relationships. At that time, wives were considered possessions of their husbands.[1] However, American jurisprudence has established spouse abuse as assault and battery.[2] During the last 10 years, many authors have studied the psychodynamics of spouse abuse retrospectively.[3-13] However, the medical profession has not shown the same interest in spouse abuse that it has in child abuse. Consequently, the abused woman is still underdiagnosed and undertreated.

Differing patient populations and research methodologies have produced inconsistent rates of spouse abuse. Nationwide, Straus and Gelles estimate 3.8 percent and 3.9 percent in 1976 and 1986, respectively.[14,15] Helton found that 23 percent of 290 women were battered before or during their current pregnancy.[16] Spouse abuse was found in 10 percent of Canadian women in 1985[1] and less than 1 percent of couples in Britain[1] in 1975. In contrast to these low rates, counselors at Children's Inn (a local women's shelter in Sioux Falls, South Dakota) reported that spouse abuse was much more common than published reports. However, these rates do not guide family physicians in how often they should expect to diagnose significant spouse abuse in a nonselective office patient population.

The purpose of this study was to assess the rate of verbal and physical abuse and the associated demographic factors in a clinic population. Our definition of verbal abuse was similar to that used by Hoffman[4]; namely, the man said things that interfered with the woman's ability to deal with friends, family, and co-workers. Physical abuse was defined according to the wife-beating index of Straus.[14] Minor physical abuse was pushing, shoving, grabbing, slapping, and throwing objects, whereas severe physical abuse was hitting with a fist, hitting with an object, kicking, biting, beating, threatening, or using a gun or a knife. We use the terms "minor" and "severe" to refer only to the potential for physical injury and do not imply that any level of abuse is "minor."

Methods

Our survey was designed by consulting current literature and receiving feedback from family practice residents, medical staff, and other employees at two primary clinics. (Permission to conduct the survey was given by the Human Subjects Committee, University of South Da-

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kota.) Office nurses asked 222 women who came to the clinics during April to early June 1987 to complete the survey. They were aged 18 years or older and were patients in their own right or their children were patients. Because of hectic office schedules, respondents were not consecutive. Two hundred eighteen women agreed; only 4 refused. The materials consisted of an informed consent form and a survey to be filled out in the examination room before the physician saw the patient (only small children were allowed to be in the room with the respondent). The respondent enclosed the unsigned, completed survey in an envelope and placed it in a ballot-type box that was in an area not viewed by other patients. Only nurses knew that a patient had completed the survey, and it did not become a part of her medical record.

Two clinics were surveyed, the Sioux River Valley Community Health Center (CHC), a city-sponsored, federally funded clinic for low-income patients; and the Family Practice Center (FPC), a family practice residency site in Sioux Falls, South Dakota. Responses were analyzed by a statistician at the University of South Dakota School of Medicine. The chi-square test was used for all group comparisons. We defined significance at $P < 0.05$.

Sioux Falls (population = 100,000) is the largest city in the area bounded by Minneapolis, Omaha, Denver, and Winnipeg. The three main industries are medical care, credit-card processing, and meat packing. Patients of the FPC and CHC are not a true cross-section of Sioux Falls residents. At the CHC, 46 percent are below the poverty level, 83 percent do not have insurance, and 87 percent are aged < 45 years. At the FPC, 40 percent do not carry insurance, 79 percent are aged < 45 years, and 23 percent do not reside within the city limits. The same family practice residents provide care at both CHC and FPC. When compared with three other private family practice clinics, where 95 percent of the patients could identify one doctor as their family doctor, only 60 percent of the FPC and 40 percent of the CHC patients identified one physician as their family doctor.[17]

Demographic questions in the survey included the respondent's age, partner's age, type of relationship (i.e., husband, live-in boyfriend, live-out boyfriend, etc.), duration of the relationship (< 1 year, 1 to 3 years, 4 to 6 years, or > 6 years), respondent's education, partner's education, household income, and race. Abuse was categorized as verbal, minor physical, or severe physical, and frequencies of abuse (daily, weekly, monthly, yearly, or never) were surveyed. Examples of survey questions are the following: Question 9 (verbal abuse), "My spouse/partner has said things that made me feel so bad that I can't deal with my family, friends and co-workers as well: Daily, Weekly, Monthly, Yearly, Never." Question 10 (minor physical abuse), "My spouse/partner has: (a) thrown things at me, (b) pushed, etc." Question 11 (severe physical abuse), "My spouse/partner has: (a) hit me with a fist, (b) hit me with an object, etc." Because of the small numbers in some frequency categories, the data on physical abuse were pooled for statistical analysis. Ages, incomes, and educational responses were also pooled for the same reasons. Other items associated with spouse abuse, such as marital rape, partner or respondent drug or alcohol use, intoxication during abuse, etc., were addressed as "Yes" or "No" questions.

In an effort to determine whether physicians at the FPC and CHC were diagnosing spouse abuse, we randomly chose and reviewed 100 women's charts, 61 at the CHC and 39 at the FPC.

Results

The results of both clinics were pooled for a total of 218 respondents (FPC = 95, CHC = 123). The majority of the respondents were young (50 percent were aged < 27 years). Forty-two percent of the men partners were aged < 27 years. Fifty-two percent of the 218 respondents were married, 8 percent were divorced, 21 percent had live-in boyfriends, and 19 percent had live-out boyfriends. Sixty-five percent of the relationships were less than 6 years in duration. The average education of the women was higher than that of their partners. Of the women, 72 percent had high-school diplomas, whereas 64 percent of the men had a high-school education or better. Household income was < $15,000 for 51 percent of the respondents. Ninety-six percent of the respondents were white, 3 percent native American, and 1 percent black. Forty-eight percent reported verbal abuse (Table 1). Forty-four percent

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Table 1. Frequency and Percent of Verbal Abuse.

Frequency*	Percent Abused
Never	51.6
Yearly	17.4
Monthly	12.2
Weekly	12.7
Daily	6.1

*Total n = 213.

noted minor physical abuse, and 28 percent severe physical abuse. These were not mutually exclusive, and there was much overlap. Of the 218 respondents, 42.2 percent reported no abuse at all, 9.4 percent had physical abuse only (minor, severe, or both), 12.2 percent verbal abuse only, and 36.2 percent reported both physical and verbal abuse. Fifteen percent of the respondents reported that they were forced to have sex against their will. When asked about chemical dependency problems, 26.3 percent of the respondents considered their partners to have an alcohol problem, 11 percent considered their partners to have a drug problem, and 2.8 percent believed that they themselves had an alcohol problem. One respondent thought she had a drug problem. Of those who were abused either verbally or physically, 52 percent thought their partners were intoxicated at the time, 16 percent reported that abuse occurred prior to their living together, 58 percent had told someone else, and 68.6 percent had fought back.

Though the two clinics (CHC and FPC) are similar in that they have the same physicians and many of the same patients, the two clinics are different in their financial organization; i.e., one is privately subsidized, the other is federally subsidized. There were also five statistically significant differences in the two survey populations. In the FPC patient sample, there was a higher percentage of married women (64.5 percent versus 40.8 percent), and more respondents with higher than a 12th grade education (48 percent versus 37 percent). Family incomes were lower in the CHC patient sample: (49 percent had < $10,000/year versus 50 percent with > $20,000/year at FPC). There was more verbal abuse (58 percent versus 36.2 percent) in CHC patients. More respondents at CHC thought their partners had an alcohol problem (32.8 percent versus 18.1 percent). Physical abuse, however, was not significantly different in the patient samples: minor abuse was 40 percent at the FPC and 47 percent at the CHC; severe physical abuse was 24.2 percent and 31.7 percent, respectively.

Table 2. Percent of Abused Respondents by Type of Partner.

Partner	Percent Abused		
	Verbal	Minor Physical*	Severe Physical
Husband or exhusband (n = 128)	50.0	46.9	32.0
Live-in boyfriend (n = 44)	54.6	54.6	34.1
Live-out boyfriend (n = 41)	31.7	26.8	14.6

*$P = 0.026$ (Chi-square).

No statistical differences occurred when comparing the ages of the abused women with the types of abuse reported, although the trend was toward younger women reporting less verbal abuse. Similarly, no statistical differences occurred when comparing the ages of the partners with the three types of abuse.

When the type of relationship, i.e., husband, live-out boyfriend, live-in boyfriend, was compared with the three forms of abuse, live-out boyfriends were the least abusive; however, this is only statistically significant for minor physical abuse (Table 2). Duration of the relationship showed statistical differences. Couples together 4 to 6 years were more often in minor and severe physically abusive relationships (Table 3). Less well-educated women tended to receive more abuse. This was statistically significant for verbal abuse only (Table 4). Less well-educated men were statistically more abusive in all respects of abuse (Table 5). Women who had less formal education than their partners were as likely as those with the same or more education to receive verbal abuse. However, they received less minor and severe physical abuse (Table 6), but this was not statistically significant ($P = 0.056$ and $P = 0.083$, respectively). Women in the lower socioeconomic groups were involved in abusive relationships more often than women in higher income brackets

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Table 3. Percent of Abused Respondents by Duration of Relationship with Partner.

Duration	Percent Abused		
	Verbal	Minor Physical*	Severe Physical†
< 1 Year (n = 36)	36.1	30.6	13.9
1–3 Years (n = 55)	52.6	54.6	30.9
4–6 Years (n = 36)	52.8	61.1	44.4
> 6 Years (n = 70)	50.0	38.6	27.1

*$P = 0.019$ (Chi-square). †$P = 0.039$ (Chi-square).

(Table 7). This was statistically significant for verbal abuse and both forms of physical abuse. Men who forced their partners to have sex showed statistically more verbal and physical abuse ($P < 0.001$) than men who did not. Men identified as having chemical dependency problems (drugs or alcohol) were verbally and physically abusive more often than those who were not so identified ($P < 0.001$). Finally, verbal and physical abuse were usually found together ($P = 0.011$).

The respondents in each clinic were not consecutive; therefore, there could be sample bias. To assess this problem, we recorded the ages of 100 consecutive women who came to each clinic. These ages were almost identical to those in the survey sample. Thus, though the survey was not consecutive, the survey sample did approximate a consecutive sample. Because this survey was conducted during all clinic hours (morning, afternoon, and evening), and it spanned several weeks, we do not believe that the respondents are skewed to any subset of the clinic population who might be at higher risk for abuse, i.e., homemaker versus working mother. Nonetheless, the possibility exists.

Of the 100 charts that were reviewed for mention of spouse abuse, four charts showed spouse abuse in either the chronic problem list or the progress notes. Based on the progress notes, we believe that several others were abused or at high risk for abuse. Approximately one-third of the charts at the FPC did show evidence that the physician had inquired about possible stressors in the patient's life.

Table 4. Percent of Abused Respondents by Woman's Educational Level.

Education	Percent Abused		
	Verbal	Minor Physical*	Severe Physical
< High school (n = 60)	60.0	50.0	33.3
High-school graduate (n = 67)	47.8	50.8	34.3
Some college (n = 54)	46.3	38.9	24.1
College graduate (n = 36)	27.8	27.8	13.9

*$P = 0.024$ (Chi-square).

Discussion

Despite the recent higher level of public awareness, spouse abuse is still underdiagnosed. Researchers in other disciplines have contributed greatly to our understanding of the psychology of spouse abuse, but little is written in the primary medical care literature that gives the clinician practical information on how spouse abuse presents in the medical office or how frequently it occurs. This accounts for our decision to study it in this setting.

This study sample consists of predominantly lower income white women and does not repre-

Table 5. Percent of Abused Respondents by Man Partner's Educational Level.

Education	Percent Abused		
	Verbal*	Minor Physical†	Severe Physical‡
< High school (n = 76)	61.8	63.2	46.1
High-school graduate (n = 65)	41.5	41.5	24.6
Some college (n = 46)	37.0	30.4	15.2
College graduate (n = 26)	38.5	19.2	7.7

*$P = 0.018$ (Chi-square). †$P = 0.000$ (Chi-square).
‡$P = 0.000$ (Chi-square).

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Table 6. Percent of Abused Respondents by Woman's and Man Partner's Educational Level.

Education	Percent Abused		
	Verbal	Minor Physical	Severe Physical
Woman has more education (n = 73)	48.0	52.1	34.3
Partners have equal education (n = 103)	48.5	43.7	28.2
Man partner has more education (n = 36)	44.4	27.8	13.9

sent the population of Sioux Falls or the United States. However, it is representative of the two clinics. There are many reasons why the percentages mentioned here are higher than in other studies. First, this study sample is weighted to groups that we identified to be at high risk for spouse abuse; namely, low income, low education (with men less than women), and high rates of partner substance abuse. When analyzed by clinic, there was more spouse abuse at the CHC, showing the increased rate in relation to clinic demographics. Second, this study was anonymous compared with other larger studies that were conducted face-to-face or by phone.[14,15] Our respondents did not have to fear retaliation for answers that would incriminate their partners. Because of anonymity, there is less shame on the respondent's part when she admits to abuse, and this increases the possibility of higher reported rates. Third, the word "abuse" was not mentioned in this survey. Mentioning "abuse" might have biased some women (i.e., "We may fight, but he does not abuse me").

While the frequency of abuse in this study is higher than in other studies, the underlying sociopathology (i.e., education, income, and alcohol and drug use) of spouse abuse that other authors have identified is supported. We found 16 percent were abused before cohabitation, which is similar to Christiano[18] and Roy.[19] We also observed that abuse escalates with time (Table 3). We can only theorize why it decreased in the group that cohabitated for > 6 years. Possibly, abuse is a sign or cause of nonstable relationships, leading couples to separate early so that proportionately more who make it to 6 years have stable relationships. On the other hand, counselors at the Sioux Falls Children's Inn have also observed that many women who have been in abusive relationships for many years may receive less physical abuse but are still emotionally abused. Instead of a physical beating, the man may raise his hand, give her a threat, or "that look," and the fear of physical violence makes her submissive. He does not have to be violent to gain control. Both explanations may be valid and do not exclude each other. Other authors have also shown men with less formal education to be more abusive.[5,20] Like Walker,[20] we found a trend toward less abuse in more educated women. We hypothesize that more educated women may tend to marry men with higher education, better coping skills, and a better self-image. This study and Walker's[20] also found that women with more education than their partners received more abuse. In addition, our results were similar with Finkelhorn,[5] who found family income to be a significant factor in spouse abuse.

Drug and alcohol dependence have been linked with abuse in other studies as well.[6,19,21,22] While our study confirms this association, this does not necessarily prove that drugs or alcohol are the etiology of abuse. It is known that alcohol and drug abuses are found in people with poor impulse control. Abuse often occurs when the man cannot control his anger.[15] Thus, chemical abuse and spouse abuse may be symptoms of an under-

Table 7. Percent of Abused Respondents by Household Income.

Household Income	Percent Abused		
	Verbal*	Minor Physical†	Severe Physical‡
< $15,000 (n = 105)	57.1	54.3	39.1
$15–24,999 (n = 48)	43.8	45.8	31.1
$25–34,999 (n = 33)	39.4	30.3	6.1
$35,000 or more (n = 21)	23.8	14.3	9.5

*$P = 0.021$ (Chi-square).
†$P = 0.002$ (Chi-square).
‡$P = 0.001$ (Chi-square).

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Table 8. Tips for Treating Abused Women.

1. Treatment must be safe for her.
2. Do not be judgmental or accusatory.
3. Be supportive, listen, and believe her.
4. Have practical advice, i.e., local shelter, counseling agencies, where to seek legal aid. The National Coalition Against Domestic Violence (P.O. Box 15127, Washington, D.C. 20003-0127) has a hot line, 1-800-333-SAFE.
5. Try to improve her self esteem. Encourage jobs, support groups; get her involved in something at which she excels.
6. If possible, take pictures of injuries. These may be helpful for future litigation, if she chooses. Pictures should be kept in a sealed envelope in her chart.
7. Arrange counseling for partner; this is often difficult. (Abuse is the abuser's fault!)
8. If abuse is new in a previously nonabusive relationship, rule out organic pathology in the abuser, i.e., brain metastasis, subdural hematoma, drug reaction.
9. Rule out psychopathology in both partners. A borderline or antisocial personality will be very difficult to treat.
10. She may not trust men. Have women in your office who are willing to help or talk with her.

lying psychological problem; namely, poor impulse control.

It is not our purpose to present a detailed discussion of the diagnosis and treatment of spouse abuse. Other authors[18,23-27] have addressed the issues. It will suffice to recommend a high level of suspicion. Concerning treatment, Table 8 lists several key points. The first and foremost is the patient's safety. Is it safe for her to go home? Should she go to the hospital or shelter? Second, one office visit will not cure spouse abuse; follow-up visits are needed. Physicians can alienate abused women by being judgmental or accusatory. It is important to believe her. For instance, a question like, "Why don't you leave?" or a statement such as, "I can't believe that Romeo beats you," will place blame on her or lower her self esteem, and she may not come back to her physician or anyone else. Third, practical advice about shelter and counseling organizations is important, because the family physician may be the first person the abused woman will tell.

Several issues are not addressed by this study. First is the issue of violence from woman to man. Straus and Galles[15] have shown that this type of abuse is more common (4.3 percent versus 3 percent). However, much of it is in self-defense, and the smaller woman will sustain more physical injury during an abusive episode. Second, there may be overreporting on the respondent's part. Jouriles and O'Leary[28] found a difference between what the woman and the man partner will report as abuse. Also, our study does not address when abuse becomes clinically significant, when or how the physician should make the diagnosis, or when abuse is the "hidden agenda" for an office visit. These are areas for further research.

Conclusion

Spouse abuse is often a cyclic phenomenon that escalates in frequency and severity, and, thus, with time, morbidity and mortality are high. Consequently, it is important to make the diagnosis and begin treatment early. Making this diagnosis can be difficult because initial symptoms are often vague, and there may be a great deal of denial. Family physicians are in a prime position to diagnose spouse abuse and, therefore, should always have a high level of suspicion.

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Editorial Comment

This article is intended to raise the level of awareness of family physicians about a serious and frequently unrecognized health and social problem. Most of the studies on spouse abuse have been conducted in emergency room settings. This paper strongly suggests that its prevalence is significant also in a primary care setting. Family physicians should become more aware of the likelihood of spousal abuse in their patient population and develop appropriate plans, utilizing available community sources, to manage this important health problem.

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