Intimate Partner Violence in Rural U.S. Areas: What Every Nurse Should Know

Understanding the challenges rural women face is vital to effective intervention.

OVERVIEW: Intimate partner violence is a major health care issue, affecting nearly 6% of U.S. women annually. Multiple mental and physical health problems are associated with intimate partner violence, and billions of health care dollars are spent in trying to address the consequences. Although prevalence rates of intimate partner violence are roughly the same in rural and nonrural areas, rural survivors face distinct barriers in obtaining help and services. Because rural women routinely access health care services in nonrural as well as rural settings, it's essential that all providers understand the issues specific to rural survivors. Routine screening for intimate partner violence would create opportunities for women to disclose abuse and for providers to help victims obtain assistance and support that may keep them safer. This in turn would likely decrease serious health sequelae and lower health care costs. This article describes the unique aspects of intimate partner violence in rural populations. It also describes a simple screening tool that can be used in all settings, discusses ways to approach the topic and facilitate disclosure, and addresses interventions; relevant resources are also provided.

Keywords: domestic violence, femicide, intimate partner violence, physical assault, rural population, rurality, sexual assault

Imagine for a moment that your husband or boyfriend is regularly assaulting you, and often tells you that "nobody cares." Now imagine that you live in an isolated rural community. The nearest health care services are 75 miles away—and you can't get there because he removes the car battery to keep you from driving, and there is no public transportation. You tried to call the cops once, but it took the small local force hours to respond. Your pastor is his hunting buddy; your family believes that a woman should stay with a man no matter what. One day he breaks your arm, and then he drives you to that distant hospital. Will the nurses recognize what is happening? Will there be a chance for you to tell them?

Intimate partner violence—which includes sexual assault, physical assault, and stalking by a current or former date, spouse, or cohabitating partner—is intended to dominate and control a partner, and the physical and sexual violence is almost always accompanied by psychological and emotional abuse.[1] The overall statistics are alarming. The 2010 National

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Intimate Partner and Sexual Violence Survey found that more than one in three women have experienced rape, physical assault, or stalking (or a combination thereof) by an intimate partner in their lifetime.[2] And while the same survey found that more than one in four men also reported experiencing such violence, other studies have consistently indicated that women are disproportionately the victims.[1,3,4] (This article will focus on women.)

Female victims have been found to suffer significantly more injuries than their male counterparts; many women are repeatedly assaulted.[1] Studies have shown that women who experience intimate partner violence report a significantly lower health status[5] and have higher incidences and severity of depression and anxiety, posttraumatic stress disorder, low self-esteem, and suicidal ideation[6-8] than nonabused women. They are also significantly more likely to have other long-term health problems, including chronic pain, gastrointestinal problems such as peptic ulcers and irritable bowel syndrome, headaches or migraines, sexually transmitted infections, vaginal and urinary tract infections, and drug or alcohol abuse (or both).[6,9] Intimate partner violence during pregnancy may result in delayed entry into prenatal care, fetal trauma, premature labor, low-birth-weight infants, and multiple health issues for the mother.[10,11] And exposure to violence and abuse results in higher health care utilization and costs.[12] A 2003 report by the National Center for Injury Prevention and Control estimated that nearly $4.1 billion is spent in medical and mental health care expenses each year as a result of intimate partner violence in this country.[13]

Although a significant amount of health care research and literature over the past two decades has focused on intimate partner violence, such violence in rural U.S. communities has received scant attention.[14] With an estimated 19% of the nation's population living in rural areas,[15] it's essential that nurses and other health care providers develop an understanding of the differences between urban and rural environments as they pertain to intimate partner violence.[16] It's especially important for nurses to understand the barriers survivors face in seeking help, so that they can be helped effectively.

Rural survivors sometimes seek care in nonrural settings; indeed, most providers can expect to see such patients. All nurses, not just rural nurses, need to understand the unique issues faced by women who experience intimate partner violence in rural areas. This article provides an overview of these issues and discusses the implications for practice.

PREVALENCE

United States overall. While trends in the rate of intimate partner violence have shown declines in the past two decades,[3] 35.6% of U.S. women have experienced rape, physical violence, or stalking (or a combination thereof) by an intimate partner in their lifetime.[2] The 2010 National Intimate Partner and Sexual Violence Survey found that nearly 6% of U.S. women had experienced such violence during the 12 months before the survey.[2] Women are disproportionately the victims of intimate partner violence—four out of five are female.[3] In 2008, according to a U.S. Department of Justice report, 99% of intimate partner violence against women was committed by a man.[17] The same report noted that, of U.S. women murdered in 2007, roughly 70% were killed by an intimate partner; this was twice the rate for men, who were more likely to be killed by strangers. (The term *femicide*, which has been defined as "the misogynous killing of women by men"[18] is also sometimes used to describe such murders.)

Rural populations. Relatively few prevalence studies of intimate partner violence have been conducted in rural U.S. populations, and the generalizability of most of their results is limited by their use of convenience samples. This makes it difficult to estimate conclusively the scope of the problem in rural areas. One of the only population-based studies of rural U.S. women found that prevalence rates of intimate partner violence were similar in rural and nonrural areas.[19] This finding was supported by several earlier convenience sample studies, which have also reported intimate partner violence rates as high as or higher than rates in the general U.S. population.[20-25]

Most studies examining the prevalence of U.S. women murdered by an intimate partner have generally not included comparisons between rural and urban areas. However, one study did specifically examine these differences for a 20-year period, from 1980 to 1999.[26] It found that the annual rates of murder by intimate partners were higher in rural counties than in nonrural counties—and while these rates declined during this period in nonrural counties, in rural counties they increased by more than 60%. Another study in Wisconsin of women killed by an intimate partner found that the rate was higher among women in small towns than in urban areas; and a history of intimate partner violence was more often known among urban murder victims than among rural ones, although the authors acknowledged that this may be due to underreporting.[27]

ISSUES UNIQUE TO RURAL AREAS

Lack of research. There is a significant lack of research focused on the issues faced by abused women living in rural communities, even though rural women often face greater obstacles and challenges in getting help and accessing resources.[28, 29] Research in this population may not have been conducted because rural communities are geographically and physically isolated from larger communities and neighbors, so intimate partner violence appears less visible.[28] It's also possible that this lack of attention stems from false beliefs that rural areas are "idyllic, tranquil, and nonviolent"[28] with less criminal activity.[30] And rural areas are usually located fair distances from the large academic centers where most research is conducted. Urban settings tend to be more convenient for researchers to access and to more readily yield larger sample sizes.

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Factors and challenges for survivors. Compared with their nonrural counterparts, rural survivors have reported experiencing a greater variety of abuse tactics, being more likely to be currently or formerly married to the abusive partner, and being more likely to have a child with that partner.[31] Survivors in rural areas appear to need more help in obtaining services and emotional support,[32, 33] and may be less likely to request police assistance.[32] There are multiple factors that contribute to the problems and shape the options that rural survivors face.

Geographic location and isolation can put rural residents at a disadvantage with regard to obtaining services. There are a limited number of shelters, social services, and health care services available in rural areas, and the distances one must travel to reach them may be too great.[16, 30, 34-36] In general, rural survivors have reported being reluctant to seek help from formal resources in their communities.[37, 38] Social isolation, which abusers often exploit to enhance their control, is common in rural areas. The mere fact that people live too far apart to hear their neighbors makes it easier for a violent episode to go undetected. This lack of close proximity to one's neighbors may also make it harder to create a social network and

develop friendships.[30] Many abused women have reported not having any close friends in whom to confide and from whom to seek help and emotional and social support.[8, 29, 30, 33, 37-39] Strong allegiance to the land itself may also be a complicating factor.[40]

Patriarchal attitudes and traditional gender roles. Rural women may also be more vulnerable to abuse because of patriarchal ideology and traditional gender roles, which favor male domination.[30, 37] Many rural communities continue to honor conservative social beliefs and traditional values in which the man is the head of the household and the woman plays a subordinate role.[14, 30, 37] Indeed, one Canadian study found that abused women "spoke openly about male power and control in the rural setting as a barrier to their resistance. . . . Throughout their lives, they were exposed to statements such as 'The man is the man,' and 'You do as you're told.'"[37] In that context, violence between intimate partners may be seen as the norm.[14] Researchers have also found that in many rural communities, it's a common belief that whatever happens between a man and his wife is a private matter, and that such beliefs make it harder for abused women to speak about the violence that they experience.[14, 37] Tolerant attitudes toward intimate partner violence may prevail.[16, 37] These social and cultural beliefs and norms may contribute to rural survivors' feelings of self-blame and shame, which in turn can hinder help seeking.[37]

Religious beliefs may be another factor that keeps a woman entrenched in an abusive relationship. In many rural communities, churches are centers for socialization; and the people in these communities tend to have strong religious beliefs.[41] Those who ascribe to literal interpretations of religious teachings might consider it God's will that women serve men and obey their husbands at all costs.[16] Even less stringent religious beliefs can exert powerful influence; for example, a woman who believes that divorce is a sin may feel that leaving her abuser is not an option.[30, 42] Members of the clergy may be sought out for emotional, marital, and spiritual counseling. But one survey among rural clergy found that their attitudes and actions toward preventing intimate partner violence varied markedly, depending on their sex, years of experience, and level of education.[43]

Law enforcement factors. In rural communities, a survivor's safety may be compromised if she's afraid or unwilling to contact law enforcement because either she or her abuser knows the officers or their families.[30] Even if she does call, rural local police forces have fewer officers available to respond; and they may be spread out over a large area, leading to prolonged response times.[16, 30, 37] Weapons such as firearms and knives are common in rural households and increase both the risks and lethality of violent assaults on victims.[40] One small study conducted in rural Ohio found that 45% of abusive partners owned a weapon.[44] Another study of rural and urban women who were killed by their intimate partner found that more than half were killed with a firearm.[45] Moreover, of the 11% of women who had a restraining order, more than half were also killed with a firearm—even though the law prohibits anyone under a restraining order for intimate partner violence from purchasing or possessing a firearm. A higher percentage of the rural victims actually had a restraining order than did the urban victims (27% versus 11%, respectively). (*Editor's note*: The terms *restraining order* and *protective order* are often used interchangeably, although there can be subtle differences.)

Compared with urban women, rural women have reported greater barriers within the criminal justice system to obtaining protective orders, as well as to their efficacy and enforcement,[34, 35] and have reported more violations of such orders.[34] Furthermore, more rural women with protective orders have reported being married to and involved with their abusive partner for longer periods,[31, 34, 38] experiencing more severe violence during the relationship,[38] experiencing more frequent psychological and physical violence within the past year,[38] and being threatened with a weapon[34] than have nonrural women.

Resources

National Coalition Against Domestic Violence (NCADV)
www.ncadv.org
NCADV serves as a national information and referral center; supports coalitions at the local, state, regional, and national levels; and advocates policy development and innovative legislation.

National Domestic Violence Hotline
www.thehotline.org
(800) 799-SAFE
This site now also offers live help through a private online chat feature.

National Health Resource Center on Domestic Violence
www.futureswithoutviolence.org/content/features/detail/790
The center offers a wealth of culturally relevant educational materials that are appropriate for a variety of health care settings.

National Online Resource Center on Violence Against Women
www.vawnet.org
This online resource library offers thousands of materials on violence against women and related issues.

Nursing Network on Violence Against Women International (NNVAWI)
http://nnvawi.org
NNVAWI's mission is "to eliminate violence by advancing nursing education, practice, research, and public policy." Membership is open to nurses and others who have an interest in ending violence against women.

Employment and economic factors. The seasonal nature of agricultural work in rural areas means that men may be home for long periods, creating more opportunities for abuse. With employment opportunities less plentiful in rural areas,[16] a woman who is being abused may be forced to stay in the relationship because she has no job[31, 33, 37] and no financial resources to make it on her own.[34] For rural women who live on farms, another complicating factor is that the farm is both their home and their place of business.[46] If they leave, they risk losing everything they've invested in this enterprise.

Lack of job opportunities for the abusive partner may be another contributing factor.[29] Unemployment among abusive men has been found to be the strongest sociodemographic risk factor for intimate partner femicide.[47] Affordable housing is also lacking in rural areas[16, 37]; a survivor who leaves might have nowhere to live. The absence of public transportation (such as trains, taxis, and buses) is another obstacle many rural survivors face.[16, 30, 35] Rural women have reported that their abusers even deny them access to the family car.[30, 37, 39]

Thus faced with cultural norms that support abuse, lack of transportation to distant services, no viable job opportunities, no affordable housing, and a limited social support network, rural survivors often must remain in the abusive relationship just to survive. All of these obstacles prevent women from acknowledging the violence in their lives, sharing their experiences with friends and family members, and seeking help from the limited resources that might be available.

Issues for rural health care providers. Rural health care providers often also face distinct barriers and challenges in providing health care services to survivors. While there has been scant research in this area, one study by Eastman and colleagues found that rural providers perceived greater difficulties in doing so than did nonrural providers because the demand for services outweighed the amount of available resources; many felt there was a lack of adequate funding and clinic staff.[16] They also perceived having a harder time obtaining relevant training than did their urban counterparts. Similarly, in a study of Oregon EDs, Choo and colleagues found that rural EDs were significantly less likely than urban EDs to provide regular clinician training on intimate partner violence.[48] The rural EDs were also less likely to have official screening policies, standardized screening instruments, and on-site advocates who could assist survivors.

Maintaining confidentiality and anonymity is another challenge. Rural providers often personally know, or are related to, the survivor or the perpetrator or both; or may provide care to both.[16, 37, 49] There is a general lack of privacy and anonymity in rural communities; nurses and other providers are well-known to community members, who might readily see them out in public and ask about certain patients.[49, 50] Survivors may fear a breach of confidentiality if they disclose abuse to a rural provider.[35, 37] In one study, rural nurses described how the blurring of boundaries between their personal and professional roles, as well as their visibility in the community, resulted in the need to be "constantly vigilant" in order to maintain confidentiality when working with families in which intimate partner violence occurred.[49] It's worth noting that these nurses also reported encountering their clients in multiple settings, which gave them more opportunities to observe for risk factors and indicators of intimate partner violence, thereby improving their ability to identify it.

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IMPLICATIONS FOR PRACTICE

Rural survivors may seek care in nonrural settings for several reasons, such as to ensure their anonymity or to seek specialized or advanced care that isn't available where they live. It's crucial that all nurses, regardless of practice setting, understand the issues that rural survivors of intimate partner violence face. A better understanding will help nurses to identify survivors and provide more appropriate interventions.

Routine screening of all women for intimate partner violence is essential in order to improve identification of and assistance to survivors. One study found that 74% of abused women had not intentionally sought health care because of the abuse.[5] Thus it's important for all nurses to be aware of health problems associated with abuse, and to screen all patients for exposure to abuse as part of standard clinical practice, regardless of the chief complaint or reason for the visit. Survivors may be reluctant to disclose abuse on their

own; nurses can create opportunities for them to do so by asking specific screening questions.

Although in 2004 the U.S. Preventive Services Task Force (USPSTF) found there was insufficient evidence to recommend either for or against routine screening for intimate partner violence,[51] it has since revised this stance somewhat. Based on an updated review of the evidence, the USPSTF currently recommends that women of childbearing age be screened for intimate partner violence.[52] Furthermore, most professional organizations and experts in such violence now advocate routine screening for *all* women, at least until substantial evidence exists to support a recommendation for or against it.[53] Coker has pointed out that researchers studying the effectiveness of screening for intimate partner violence face ethical challenges, "as this work requires a comparison group who are not screened."[54] The American Medical Association and the American College of Obstetrics and Gynecologists have issued guidelines and opinions recommending that all women be routinely screened for evidence of intimate partner violence[55, 56]; the American Nurses Association has also advocated such universal screening.[57] And the Institute of Medicine now recognizes intimate partner violence screening to be a part of basic preventive health care.[58]

Screening for intimate partner violence gives women an opportunity to disclose abuse, which in turn gives nurses the opportunity to provide support, information, and referrals to appropriate community resources.[9, 59] Research has consistently shown that most survivors *want* to be asked about abuse by their health care providers. In three separate early studies with survivors, 68% to 85% reported that they would like their health care providers to ask them privately about intimate partner violence.[60-62] And in a more recent study, Kramer and colleagues found that 58% of survivors said they would disclose abuse if a nurse or physician asked.[5]

have you been hit, slapped, kicked or otherwise physically hurt by someone?" If the answer is yes, then the woman is to be asked by whom and how many times, and a body map is presented for her to mark the area of injury and score each incident according to a given scale. The next question, used only for women who are pregnant, asks the same question in relation to the pregnancy. A third question asks, "Within the last year, has anyone forced you to have sexual activities?" If she answers yes, she is to be asked by whom and how many times. Using this or a similar tool, within minutes a provider can screen for the presence of violence and, if it has occurred, assess its frequency and severity and identify the abuser. (The tool can be found in this Centers for Disease Control and Prevention report[64]: http://1.usa.gov/NGo0qv.)

Screening questions must be asked in a private environment (such as an examination room) and away from anyone accompanying the woman. This may pose a challenge if her partner is accompanying her and refuses to leave. Strategies that can be used in such situations include explaining to the couple that it's facility policy that each patient be seen alone for part of the visit, and escorting the patient to the bathroom or another diagnostic testing location away from her partner.

All screening questions should be asked after some degree of rapport and trust has been established.[59] It's best to normalize the questions as much as possible by acknowledging that abuse is a common issue in many women's lives.[5, 59] For example, the nurse might begin by saying: "Because violence is so common in many people's lives, I've begun to ask all my patients about it" or "I don't know if this is (or ever has been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I've started asking about it routinely."[9] Questions should be asked in a straightforward manner and at

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Screening for intimate partner violence can be a fairly simple routine that is integrated into the nursing process, and various effective and efficient screening tools have been created. One such tool, the Abuse Assessment Screen, has demonstrated reliability and validity.[63] It is easy to use and consists of five questions, three of which focus on events within the past 12 months. The first of these asks, "Within the last year,

multiple points of contact within the health care system.[5, 59] Among rural survivors, cultural norms may increase reluctance to talk about "private matters,"[35] so it's particularly important when screening rural women to acknowledge how difficult it must be for her to disclose such information, and to reiterate a commitment to confidentiality.[5, 59] Kramer and colleagues found that abused women disclosed abuse

more easily when they felt sure the disclosure would be kept private and when a nurse or physician asked them about it directly, genuinely wanted to know, did not ask when the abuser was present, and seemed ready to address the abuse.[5] The women were also more willing to disclose when the provider was female, did not seem rushed, did not talk down to them, and spoke their language; and when they were sure the police would be called only with their permission. Conversely, the women reported that it was harder to disclose abuse when they felt the provider wasn't listening well and when they felt "too embarrassed," were afraid the abuser would harm them, or were afraid they would lose their children.[5]

If a woman does disclose abuse, the way the nurse responds may affect her willingness to continue to seek support.

Assessment. When a woman discloses that she is experiencing or has experienced intimate partner violence, further assessment must be done to ascertain the level of danger she faces when returning home and to ensure her immediate safety. The Danger Assessment tool uses a calendar and a list of 20 questions to assess such danger and to determine whether the frequency and severity of violence has increased within the past year.[65] Questions include whether the survivor's partner owns a gun, if he has ever used or threatened to use a weapon against the survivor, and if he has ever threatened to kill her. These are particularly important questions because they have been found to be risk factors associated with increased risk of femicide[47]; and as we noted earlier, firearms are commonly present in rural homes. The Danger Assessment tool has demonstrated validity in predicting the risk of homicide for the survivor,[66] and can be obtained free from www.dangerassessment.org. The tool is best administered by someone trained in how to administer it and interpret the scoring; training is offered for a fee at the same Web site. The tool is available in English, Spanish, Portuguese, and French Canadian, and a revised version for use with women in same-sex relationships is also available.

A self-assessment tool that may be helpful for some women is the One Love MyPlan App (www.joinonelove.org/resources-help), developed for smart phones and other electronic devices.[67] Based on the Danger Assessment tool, One Love MyPlan is an anonymous, free application that can help the user to determine if a relationship is unsafe and to create a "best" action plan based on her characteristics and values. The application also provides access to a trained peer advocate through an embedded live chat function.

With rural survivors, it's vital for nurses to assess other aspects specific to rural populations. The patient should also be asked how far away she is from the closest neighbor, if she has access to a telephone or a means of transportation, if she has a social support system she can call upon if necessary, if she knows of shelters or other survivor services near her home, and whether she has used or would consider using those services.

Interventions. If a woman does disclose abuse, the way the nurse responds may affect her willingness to continue to seek support. It's important to let the survivor know that she is being listened to, that she is believed, that she doesn't deserve to be abused, and that the abuse is not her fault. A survivor also needs to know that she is not alone in her experience and that the information she disclosed is appreciated and essential to providers' understanding of her safety and health.[9,59] Her courage in coming forth should be acknowledged.

The next step is to help the survivor develop a safety plan. Given the complex issues faced by rural survivors, it may not be desirable or realistic for her to leave her abuser permanently. Whether she plans to do so or not, safety planning can help to minimize the potential for physical harm when a violent episode occurs. As one expert concisely explains, safety planning includes "planning an escape route, arranging in advance for a safe place to stay, and keeping some money, house and car keys, and important papers for herself and her children in a location where they can be easily retrieved."[59] The nurse should also provide the survivor with information regarding resources within the facility and help her identify what resources, if any, are available in her home community. The National Domestic Violence Hotline telephone number ([800] 799-SAFE), as well as any local hotline or crisis line numbers, should be shared with all women who disclose abuse. Hotline numbers can sometimes be written on a small piece of paper and hidden in a shoe, tampon container, lipstick case, or other small compartment where an abuser is unlikely to find it. The survivor should be asked whether it is safe for her to take relevant written materials with her. If it is not, it will be helpful to review with her some basic information, as long as this can be done in privacy, away from her partner or other family members.

Since rural survivors tend to be geographically and socially isolated, they may not receive needed help from family or friends in areas such as childcare, transportation, and advice.[29] Thus it's important to help the survivor identify whom she might turn to in her home community. Along with safety planning, seeking legal support and seeking help

from formal and informal networks are strategies that rural survivors often don't use—even though these strategies have been rated by rural women to be among the most helpful for coping with intimate partner violence.[37] This makes finding effective ways to help survivors employ these strategies all the more crucial. (For a list of resources for survivors and providers, see *Resources*.)

When intimate partner violence is suspected but not disclosed, the woman's choice must be honored. Only she can know when it is safe for her, physically and emotionally, to disclose the abuse. In such cases, the woman should still be offered educational information and information about available resources and services, including local hotline and crisis line numbers. It's helpful to present the information in a way that respects her decision not to disclose, yet equips her with vital resources. For example, the nurse might say, "I am really glad to hear that violence isn't part of your relationship. Because we know that it happens in so many relationships and because no one ever deserves to be abused, I'd like to offer you some information and resources so that you can help a friend, a sister, or any other women whom you care about, if need be." Again, the woman should be allowed to determine whether or not she wants to take any information with her.

CREATING SYSTEMS-LEVEL CHANGES

Nurses who live and work in rural settings should be involved in community health assessments to help discern the local prevalence of and raise awareness about intimate partner violence.[37] Rural nurses can facilitate communication and advocacy efforts among health care and social services providers, religious organizations, employers, educators, legislators, law enforcement, and the media, in order to address the barriers that rural survivors face. Educational public health campaigns targeting rural communities have been shown to be effective at significantly changing attitudes and beliefs about intimate partner violence.[68] Rural survivors have suggested mass mailings to rural homes, advertisements and articles in rural newspapers, and radio and television ads as useful mechanisms both for disseminating information to survivors and for changing community attitudes and beliefs.[37]

All nurses can work to educate lawmakers about the needs of survivors and to advocate laws and policies that provide more resources, as well as the funding to create and maintain them. Nurses with experience in working with survivors of intimate partner violence can provide valuable testimony. The need for advocacy in policy development is especially important, given that rural populations tend to have less representation at state and national levels. Research has found that previous arrest of the abuser is associated with decreased risk of femicide.[47] More stringent laws against intimate partner violence might help to lessen the likelihood of repeated offenses. And it's essential that rural police forces are adequately staffed and trained in how to respond effectively to intimate partner violence. We believe such training should be mandatory. Nurses can also advocate that more shelters be established in rural communities, with enough funding to ensure adequate staffing 24 hours a day.

At their own health care institutions, nurses can advocate the creation of policies that make screening all patients for intimate partner violence mandatory and ensure that all clinicians are properly trained in such screening, as well as in assessment and interventions. Such training *must* include the issues that rural survivors face. Education of rural providers is particularly important, as Riddell and colleagues have noted, given that they are also members of rural communities and "may subscribe to patriarchal beliefs and attitudes that reinforce women's dependence and make breaking free from an abusive partner difficult."[37] Nurses should strive to ensure that their own facilities convey the message that intimate partner violence is unacceptable and that help is available. Space for confidential interviewing; informative posters that are multicultural and multilingual; and educational materials placed in examination rooms, women's bathrooms, and other private areas are effective ways to create such an environment. And if need be, nurses should demand that their employer's human resource policies include supportive measures for nurses and other employees who are themselves survivors of intimate partner violence.

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Lastly, in rural health care settings where on-site survivor advocates and mental health professionals who can offer immediate assistance are lacking, innovative collaborations should be considered. Advocacy and counseling services through telehealth mechanisms have shown promise as possible solutions in rural areas.[69, 70]

CONCLUSION

All nurses need to understand the unique factors that influence whether rural survivors leave or stay with their abuser and their ability to obtain assistance and services. Nurses should know how to identify these

survivors, advocate on their behalf, and provide them with interventions that may keep them safer. If all patients were screened for intimate partner violence at every health care visit, in an environment that fostered trust and disclosure, more survivors could be identified and given the help and resources they need. This, in turn, would likely reduce the incidence of injury, illness, and death caused by intimate partner violence, as well as decrease the associated high health care costs.[12]

It's worth noting that nurses continue to outrank all other professionals in Gallup's annual poll, which asks the public to rate the honesty and ethical standards of members of various professions.[71, 72] With such trust comes the responsibility to address conditions, such as intimate partner violence, that put the public's health at great risk. The importance of nurses' efforts in their own institutions and communities to create social and systemic change cannot be underestimated. ▼

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