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Rural Outreach of Little Compton

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Abstract

This idea for this project came from a semester long internship at the Women's Resource Center of Newport and Bristol Counties. It was through this internship that I found my passion for promoting awareness about domestic violence. My interest in rural intimate partner violence began when I started preliminary investigation on the barriers rural women face because of their geographic placement. Rural women face many more obstacles when suffering intimate partner violence than their urban counterparts. Isolation and distance are the major issues that plague rural women. The only rural community in Newport and Bristol counties is Little Compton, which is located about thirty to forty-five minutes from the main offices in Newport and Warren, Rhode Island.

This project, in addition to preliminary literature review, included a needs assessment. To complete this assessment, I conducted an investigation on the statistics of Little Compton and compared them to common standards in the literature. Then, I interviewed various members of the Little Compton community to better understand the unique circumstances of this community. Through interviewing, I was able to determine what the perceived notion about intimate partner violence is in various members of the community. Also, the interviews helped shape my strategies for promoting rural outreach in the most effective manner.

My goal through this project was to provide the Women's Resource Center with the knowledge they previously lacked about this community. By using this assessment,

they can implement strategies to combat intimate partner violence in this area. Domestic violence is a silent threat to rural communities because of unique challenges that simply do not exist in other environments. Through my project, I hope that programs can be put into place to secure the safety for battered women and promote education for all members of the community.

Keywords: Domestic Violence, Little Compton, Rural Outreach

Intimate Partner Violence

Intimate partner violence, "also called domestic violence, battering or spouse abuse, is violence committed by a spouse, ex-spouse, current or former girlfriend or boyfriend. It can occur among heterosexual or same-sex couples. The violence can be physical, sexual and psychological in nature and includes verbal threats of physical or sexual violence against a partner and stalking a partner" (http://studentaffairs.depaul.edu/ucs/intimatepartnerviolence.htm#definition). It has been a public health problem in the United States for decades, mostly affecting females. "The U.S. government estimates one in every four women experience domestic violence in her lifetime" (Office on Violence Against Women). "Estimates of the incidence and prevalence of IPV vary widely. National surveys report that between 1.4 to 12.1 million women are victims of physical assault in the previous 12 months" (Verhoek-Oftedahl, Pearlman, Babcock, 2000, p.308).

The gender discrepancies within intimate partner violence are reflected through the most current statistics. "Intimate partner violence – by current or former spouses, boyfriends, or girlfriends – made up 20% of all nonfatal violence against females age 12 or older in 2001, while only intimate partners committed 3% of the nonfatal violence

against men" (Renninson, 2003, p.1). Of these numbers, females comprise approximately 85% of these victimizations. For intimate partner violence, as for violent crime in general, simple assault was the most common type of crime, but more serious crimes exist. In 2000, 1,247 women and 440 men were killed by an intimate partner. An intimate killed about 33% of female murder victims and 4% of male murder victims between 1993-2001 (Rennison, 2003).

Intimate partner violence affects a greater percentage of younger women rather than older women. "The 1999 per capita rate of intimate partner violence against women was 6 victimizations per 1,000; per 1,000 females age 16-24, it was 16 victimizations, and per 1,000 females age 25-34, 9 victimizations" (Rennison, 2001, p.1). Although younger females are more prone to IPV, women in the age group between 35-49 were the most susceptible to intimate murder and "women separated from their husbands were victimized by an intimate at higher rate than married, divorced, widowed, or never married women" (Rennison, 2001, p.1). The age of females between 20 and 49 were all highly affected by homicides in 1999. "Between 1993 and 1999, an intimate was responsible for 32% homicides of women age 20-24 and almost 40% of homicides of women age 35-49" (Rennison, 2001, p.3). Through all variables it is obvious that IPV has permeating affects through society. Intimate partner violence has decreased 41% among females 12 or older from 10 to 6 victimizations in recent years (Rennison 2001). However, it is still important to improve prevention strategies.

Racial groups are almost equal affected; only the four years from 20 to 24 are African-American women affected at higher rates. For this age, there were 29 intimate partner victimizations per 1,000 black women and 20 per 1,000 white women. The levels

for Hispanic women are a bit different. The levels of intimate partner violence peak at much lower levels than that of non-Hispanic women. The major difference between victimizations occurs in the age group between 16 and 34 (Rennison, 2001). In general, there are not notable differences among various races and ethnicities. Intimate partner violence can pose a problem to any woman in America.

These statistics reflect only those assaults that are reported to the police. "Studies that expand the definition of IPV to measure the multidimensional nature of violence against women generally produce higher estimates than do definitions restricted to physical and sexual assault" (Verhork-Oftedahl, et al., 2000, p. 308). There is a large range of women that are affected each year without proper reporting, due to various circumstances. Statistics are also affected by women who never receive proper medical care.

> Prevalence studies of intimate partner violence in clinical settings suggest that a significant minority of patients experience domestic violence in their lives, with some estimates as high as 20-40% of all women presenting for health care services. Clinician identification of battered women is consistently low, with at least one study suggesting clinicians misdiagnose and/or inappropriately treat almost 95% of such women in their care. Thus battered women are seeking health care services, but they are rarely identified or appropriately assisted. (Johnson, 2000, p.4)

Through a survey conducted by Violence Against Women Public Health Survey (VAWPHS), the prevalence of IPV in Rhode Island can be better understood. "In 1994, the Centers for Disease Control and Prevention funded three states-Michigan, Massachusetts, and Rhode Island-to develop surveillance systems to monitor IPV. Despite some limitations, these surveillance systems provided the first infrastructure to track and monitor IPV" (Verhoek-Oftedahl, et al., 2000, p.308). The highest rates were generally concentrated in urban areas of the state and in census tracts with seasonal

dwellings. Census tracts with the next highest rates were generally located in rural areas (Verhoek-Oftedahl et al., 2000).

Rural Challenges and Uniqueness of Rural Settings

Women living in rural jurisdictions face unique circumstances. These circumstances include geographic isolation, economic structure, strong social and cultural pressures (Office on Violence Against Women; Adler, 1996). Also poverty, "shortages of health care providers, under-insurance or lack of health insurance, and decreased access to many resources all make it difficult for rural women to escape abusive relationships" (Johnson, 2000, p. 2). Physical isolation is the most significant difference between the cultures of abuse in urban and rural societies. Abusers often combine physical isolation with social and emotional isolation (Adler, 1996; Johnson, 2000). Homes are often large distances away from one another and even further away from outside resources in general. Also, poor transportation and unpredictable road conditions provide another layer of difficulty. "Anonymity is virtually impossible in most rural communities" (Adler, 1996, p.464). The saying of "everyone knows everyone" rings true in most parts of Rhode Island, but even more specifically in small, rural communities like Little Compton.

> Strong allegiances to the land, kinship ties and traditional gender roles also increase the challenges faced by rural women when they attempt to end the abuse in their lives. The increased availability of weapons (such as firearms and knives) common in rural households also increases both the risks and lethality of domestic attacks upon rural women. (Johnson, 2000, p.2)

Distance to services and lack of transportation remains an enormous obstacle to support of women in danger (Adler, 1996; Johnson, 2000). "Very few data-based of rural battered women exist, but the already significant problems of battered women are likely exacerbated by rural factors" (Johnson, 2000, p.2). Rural communities experience the

same type of intimate partner violence as their counterparts in suburban and urban communities; however, the combination of these circumstances makes it difficult to combat.

Rural grant programs began after the passing of the Violence Against Women Act of 1994 and subsequent legislation. "The primary purpose of the Rural Program is to enhance the safety of children, youth, and adults who are victims of domestic violence, dating violence, sexual assault and stalking, and stalking by supporting projects uniquely designed to address and prevent these crimes in rural jurisdictions. It encourages collaboration to overcome the problems of domestic violence" (Office on Violence Against Women).

The DELTA project builds on the success of Rhode Island Coalition Against Domestic Violence's Rural Outreach Project which was established in 1998 as a collaboration of trained professional advocates working in partnership with local communities and residents to end family violence in RI's rural communities through prevention, education, advocacy and services. The main goals of the DELTA project are to encourage community ownership of strategies to prevent domestic violence and end domestic abuse, establish Community Partnership Teams to create specific strategies that meet the needs of the local populations, and to participate in the national DELTA program needs assessment (www.wrcnbc.org). Although the website implies that the goals have been reached, there are additional, more specific goals for individual centers that the Women Resource Center of Newport and Bristol Counties have not met. These include conducting a needs assessment, organizing collaborative events with police, health care networks, and other groups in rural areas, providing adult and child services

for victims of domestic violence, and providing violence prevention education to local schools. A more aggressive and proactive strategy needs to be applied to Little Compton.

Prevention and Intervention Strategies

Prevention and intervention strategies are important for the response of domestic violence victims and offenders. "Prevention has largely been absent from policy and programs, which focus primarily on adult victims, crisis response and criminalizing domestic violence" (Rosewater, 2003, p.1). The Family Violence Prevention Fund created a strategy that focused on youth as the key to prevention. The fact is that children and young adults are often left out of policies which can be detrimental to their own health, but also their future, especially because the populations are affected by intimate partner violence directly and indirectly. In Little Compton, approximately 56 % of domestic violence incidents occurred with children present in 2008 (Kids Count). "Programs for youth should seek specific outcomes, including reductions in intimate partner violence, increases in positive parenting, and greater stability and success in education, training, or work" (Rosewater, 2003, p.17). These strategies are concurrent with strengthening community assets, engaging community partners and crafting social messages. It is important to identify various groups within the community interested in promoting new approaches and to create a useful message designed to change social norms among vulnerable teens in fragile communities (Rosewater, 2003).

The public health approach is emerging as a four step technique to identify and conquer intimate partner violence, while including the similar ideals of the Family Violence Prevention Fund's approach. "The overriding emphasis for public health efforts

is prevention. More specifically, we focus on primary prevention: keeping adverse health outcomes from happening in the first place" (Saltzman, Green, Marks, Thacker, 2000, p.325). The steps of the public health approach include (1) definition and measurement, (2) identifying causes of the problem for development of interventions, (3) evaluation of interventions and (4) dissemination. The first step is to define the problem and ask how big it is. The second step of the public health approach involves asking about the causes of the problem. The third focuses on identifying and evaluating interventions, using what has been learned about the underlying patterns and causes. The fourth involves taking the promising prevention and intervention strategies and putting them in place at local, state, and national levels (Saltzman, et al., 2000).

For the future implications of this approach, the CDC makes multiple suggestions. These includes a primary prevention focus which will target attitudes that result in victimization of women and teaching children better ways to handle conflict and anger, emphasizing developmental factors and studying the impact of children's exposure to violence and abuse on their subsequent perpetration and victimization (Saltzman, et al., 2000). The best practices for rural policies set out by the Federal Office of Rural Health Policy has some similarities to the CDC public health approach, but focuses more on improved surveillance and medical care.

The Federal Office of Rural Health Policy suggestions cater to the distinctiveness of rural battered women. Several key emerging public policy strategies identified include: universal screening by health care providers, appropriate training for health care providers, mandatory reporting by health care providers, documentation/coding by health care providers, employee assistance programs for health care providers experiencing

domestic violence, integration of health service into community response, and funding for expanded and improved health response (Johnson, 2000). Increased primary care is needed in order to meet the unique rural needs.

> Primary care has often been defined as the delivery of first contact medicine, and includes the assumption of longitudinal responsibility for the patient regardless of the presence or absence of disease, and the integration of physical, psychological, and social aspects of health to the limits of the capability of the health personnel. Rural areas are often disproportionately served by these providers, often in conditions of high stress and minimal resources, particularly in isolated and remote communities. (Johnson, 2000, p.4)

These goals, along with a coordinated community response and additional funds, can help improve the conditions for rural battered women. There is some uncertainty with finances, however the DELTA grant allocates funds to improved rural outreach, which makes these goals a viable solution.

Little Compton

Description of the city and its population

Today, Little Compton is an old and well-established rural-farming community. It was in Little Compton that the famous Rhode Island Red, (a breed of fowl and the State Bird), was developed. Fishing is still a major industry in the town, as one can observe with the daily departure of the fishing fleet from the Sakonnet Wharf. The town has also developed into an ideal vacation spot with the traditional atmosphere of colonial New England (www.little-compton.com). Little Compton is in southeastern Rhode Island, with a small population (about 3,500) and a large amount of land (28.9 sq mi) (U.S. Census Bureau).

Little Compton is a predominantly White community; according to the 2000 US Census Bureau, approximately 99% of the population falls into this category. There is an

extremely small minority population; African American, Asian, and American Indian, and Latino are all under 1% of the population. Males and females are virtually equally represented. About 7% of the population is under 5, 74% are 18 year and over, and 12 % are 65 years and over. Education levels are particularly high; 91% of the population graduated from high school, and about 45% have a 4-year college degree or higher. Only about 1% of children live below the poverty level, which is considerably less than the state level of 16.5%. The median household income ($55,368) is significantly higher that the state's average ($42,090), while the cost of living is slightly below the state's average (U.S. Census Bureau, 2000). "In general, the lower the annual household income, the higher the rate of intimate partner violence" (Rennison, 2001, p.6). Although Little Compton has a high income rate, almost 20% of families live on $35,000 a year or less and 10% of families with a female householder and no husband present live in poverty (U.S. Census Bureau, 2000).

Little Compton's public education system consists of one school up to eighth grade, which is high performing. The racial diversity among the school is similar to the town overall – 97% are White, 3% are Asian, and 1% is Hispanic. About 15% of the public school population participates in general special education services, only 8% are eligible for free or reduced lunch, and no students receive ESL or bilingual services (Kids Count, 2008). Little Compton's high school students attend either Portsmouth High School or a private school (about 84% attend public schools, 13% attend private school, and 2% are home schooled). Because of this, it is difficult to estimate the drop out rate or performance level of Little Compton high school students.

Understanding Intimate Partner Violence in Little Compton

As suggested in the National Center for Injury Prevention and Control, the prevalence of IPV is hard to estimate for several reasons. First and foremost, the majority of incidents of intimate partner violence (IPV) may go unreported; it is estimated that only 20% of intimate sexual assault and 25% of intimate physical abuse are reported to the police. In addition, the definition of IPV varies depending on the collecting entity (data sources include police departments, clinical settings, nongovernmental organizations and survey research). Some definitions are limited to physical and sexual abuse, while others include verbal and psychological abuse. For these reasons, it is believed that currently available statistics greatly underestimate the actual scope of IPV (www.cdc.gov/ncipc/factsheets/ipvfacts).

According to the Bureau of Justice Statistics, IPV affects less than 1% of US households. Women are far more likely to be victims of IPV than men, accounting for 85% of IPV victimizations. Younger women, ages 16-24 years old, are more vulnerable to IPV victimization than women of other age groups. Interestingly, national data suggest that the only substantial racial difference in IPV victimization occurs between ages of 20 and 24 years old, when Black women are more likely than White women to be victimized. However, overall, IPV is experienced at similar rates across racial lines (Rennison, 2001).

According to a study published in the American Journal of Preventive Medicine (2000), the prevalence of intimate partner violence (IPV) among women in Little Compton varies from 1 to 5 per 100 women (Verhoek-Oftedahl, et al., 2000). The study, which looks at the prevalence of IPV statewide, suggests that the second highest rates of IPV were concentrated in rural areas. It also suggests that the higher rates were

concentrated in areas with seasonal dwellings. Little Compton fits into both of these categories. Through key informant interviews, the perception of occurrence of IPV in Little Compton is likely less than the actual amount of it. Consistent with national data, the rate of IPV in Rhode Island is higher among younger women and women of lower socioeconomic status (Verhoek-Oftedahl, et al., 2000).

Risk Factors Associated with Intimate Partner Violence

Risk factors for IPV, disseminated by the National Center for Injury Prevention and Control, can be directly related to characteristics of Little Compton. "It is important to note that risk factors are associated with a higher likelihood of IPV; they are not necessarily direct causes, rather identified as possible contributing factors. Therefore, not all people identified as "at risk" become victims or perpetrators" (http://www.cdc.gov/ncipc/dvp/IPV/ipv-risk_protective.htm). The factors are broken down into individual, societal, community, and relationship. The combination of any of these factors creates a higher risk for victimization of IPV.

The individual factors include low self-esteem, low income, low academic achievement, young age, aggressive or delinquent behavior as a youth, heavy alcohol and drug use, depression, anger and hostility, antisocial personality traits, borderline personality traits, prior history of being physically abusive, having few friends and being isolated from other people, unemployment, emotional dependence and insecurity, belief in strict gender roles (e.g., male dominance and aggression in relationships), desire for power and control in relationships, perpetrating psychological aggression, being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration), history of experiencing poor parenting as a child , and history of

experiencing physical discipline as a child. While it can be difficult to determine the presence of these factors within one community, they are surely exacerbated by the circumstances of rural existence.

Societal and community factors are much easier to identify. Societal factors include traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions). Community factors include poverty and associated factors (e.g., overcrowding), low social capital-lack of institutions, relationships, and norms that shape a community's social interactions, and weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence). While Little Compton, on average, has a much higher income rate that most of the country, there are pockets of rural poverty. Through a key informant interview, it was clear that rural poverty does exist in Little Compton. Also, traditional gender roles are prevalent in rural communities, with Little Compton as no exception. Since there is not a resource center within the community the only way of treating victims of domestic violence is through community members who report witnessing it or through the individuals themselves, which are both rare occurrences.

Relationship factors include marital conflict-fights, tension, and other struggles, marital instability-divorces or separations, dominance and control of the relationship by one partner over the other, economic stress, and unhealthy family relationships and interactions. There is an existence of divorce and separation in Little Compton (about 10% divorced). Although this number is not relatively high it is difficult to determine the existence of marital problems that go unreported. Also, a key informant interview reveled that teen pregnancy exists at an unusually high rate for the area. There were seven teen

births reported from 2003-2007, but the rate is undetermined because the teenage population is small in comparison to other Rhode Island cities and towns (Kids Count). The interviewee noted that while some of these teen mothers are in healthy relationships, others are not. These problems are likely even more unknown because of the isolated homes in Little Compton.

Protective factors for IPV are relatively unknown because of lack of research. Some factors can be reasonably extrapolated from the risk factors, but nothing concrete can be determined.

Community assets and barriers for Intimate Partner Violence Prevention

The community barriers in Little Compton are similar to those noted in other rural communities throughout the nation. Little Compton is about a forty-five minute drive from the Newport, Rhode Island office and at least a half an hour away from the Warren, Rhode Island office. Although the Women's Resource Center is well-established, Little Compton rarely reaps the benefits because of its location. The geography is like most rural areas. It is a secluded community with massive amounts of land for its relatively small population. There is no public transportation available in the area and there is only one health care provider in the area (Visiting Nurses). Resources are slim in this community.

Another barrier that may present itself is social isolation of the community. The process of performing key informant interviews was somewhat difficult. Less than half of the people contacted were willing to be interviewed. Little Compton is an exclusive community in the sense that outsiders are not warmly welcome. There is only a small

majority that is willing to discuss the sensitive subject of domestic violence. There is a sense of "that doesn't happen here" when it comes to domestic violence which makes it even more difficult to address preventative domestic violence education. A key informant believes that Little Compton lives like it was 50 years ago in a sense that there is a high disbelief that domestic violence exists.

Little Compton's assets include high levels of education and income. Intimate partner violence is known to occur more in poverty stricken communities, where these assets do not exist. Another asset is a great sense of community. One key informant noted that everybody watches out for everybody else. The town has a well-established town center and community center, in which the town's children often come together. This is the center of almost any activity that goes on in the town. This asset is also a barrier. If IPV is occurring, the victim may be reluctant to report or seek resources for fear of everybody finding out.

Future Suggestions

There is a sense that most community members know little to nothing about the Women's Resources Center's services or missions firsthand. There is a clear need for education and introduction of the services into the community. Establishing a good relationship with the Little Compton is well within the reach of the Women's Resource Center. Interviews with key informants provided insight on creating these relationships.

For one, the town has an extensive website in the making. According to a key informant, this website is rather popular with most of the community and visited regularly. It would be useful to have a link to the Women's Resource Center on this

website. This would be a neutral environment for community members to find out information or seek advice. This would also help the image of the Women's Resource Center in Little Compton. A key informant suggested that the best way to "get in" with the community members is with the endorsement of an insider.

The community center was noted through multiple key informants as a way of reaching out. One way of doing this would be through a "getting to know you" session in which the Women's Resource Center learns more about the community and visa versa. The center is well-established and respected throughout the community. The community center program director is readily available and open to helping the WRC introduce themselves into the community. Since the town's children and teens come together for various activities in the community center, an educational presentation on dating violence could be possible. This is the most viable approach to outreach.

For intervention, the WRC should schedule weekly services in Little Compton that are well known to law enforcement and social services. The best way to provide services is to get law enforcement involved. There is no health clinic located in Little Compton, so a discrete location would have to be set up to secure safety and confidentiality for battered women. Also, the WRC could offer pick up and drop off services to women who have no means of transportation. Since IPV does happen to some extent in Little Compton, it is important to have a well established intervention strategy.

In summary, IPV does affect Little Compton and the Women's Resource Center is not always there to help. Implementation of these suggested strategies would introduce the services into the community at a modest level. The Women's Resource Center needs to assign a Little Compton advocate within the office to speak for this small, rural

community. With a reasonable amount of effort, the Women's Resource Center can ensure comprehensive services to all members of the Little Compton Community, without forsaking services for any other community. Intimate Partner Violence is a serious health issue that permeates through the entire nation, with Little Compton being no exception.

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