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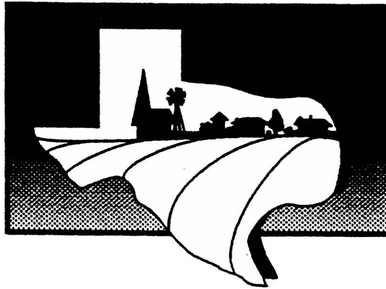

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VIOLENCE AGAINST WOMEN: STRATEGIES FOR RURAL AREAS

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ABSTRACT

The prevalence of domestic violence is greater than most people realize. Rates appear to be lower in rural areas. However, lower rates may mask under-reporting. Even if the reported rates are accurate, the prevalence of violence against women is too high. Models of prevention and intervention specific to rural health care settings are discussed.

Key words: domestic violence, race and ethnic disparities, rural health. (Texas Journal of Rural Health 2004;22(2): 39-46)

INTRODUCTION

The purpose of this report is to review the facts and literature regarding violence against women and to present some strategies that may be used by health and social service workers in rural health care settings. Health care and social service workers can and should be more proactive in identifying and addressing domestic violence. The cycle of violence will continue uninterrupted unless the normal methods of operation are changed in some way.

In a recent review of the literature on sexual assault against women in rural areas, Lewis (2003) found that crime in general, as well as rape and sexual assault specifically, is lower in rural than in urban areas. Her

conclusions were based on data from both the FBI's Uniform Crime Reports (UCR), and from the National Criminal Victimization Surveys (NCVS). The UCR database contains information only on crimes actually reported to the police while the NCVS contains self-reported victimization data from an annual national random survey of 42,000 households in the United States containing 76,000 persons.

Even though rates of family violence might be expected to be lower in rural areas, they still are higher than they should be. In this article, we review the available data on the prevalence of family violence in rural Texas and offer suggestions on how to address this problem.

METHODS

Although the FBI does not collect information on incidents of family violence, or on family violence specifically, the state of Texas collects information on domestic violence in general (Texas Department of Public Safety, 2002). The Texas Department of Public Safety reports that 53% of all reported cases of family violence involve domestic violence (Texas Department of Public Safety, 2002). In the Texas Family Code, family violence is defined as "an act by a member of a family or household against another member that is intended to result in physical harm, bodily injury, assault, or a threat that reasonably places the member in fear of imminent physical harm" (Texas Department of Public Safety, 2002).

Family members include members related by blood, marriage, and adoption or a foster relationship. Dating violence is also included as of 2002.

For this article, we combined the family violence data from the Texas Department of Public Safety for 2002 with United States Census population estimates from 2002 (The Texas State Data Center, 2003) for the 254 counties in Texas and calculated mean and median violence rates, as well as the range of rates, for each county. The counties were classified as one of four types:

1) Metropolitan, central city;
2) Metropolitan suburban;
3) Non-metropolitan, but adjacent to a metropolitan county; and
4) Non-metropolitan, non-adjacent to a metropolitan county.

FINDINGS

The descriptive data for family violence incidence within county types are presented in Table 1. Comparison of the percent of the population residing in each of the four county types in 2002 with the percent of the total number of incidents of family violence reported to the police reveals that metropolitan-central city counties had more than their share of incidents of family violence, whereas the other three types of counties had less than their share; that is, 66.22% of the state's population live in metropolitan-central city counties but these counties report 77.12% of the incidents of family violence.

Non-metropolitan counties that are adjacent to a metropolitan county have 10.50% of the state's population but report only 7.53% of the family violence incidents. The non-metropolitan counties that are not adjacent to a metropolitan county have 4.61% of the state's population but report only 3.40% of the incidents of family violence.

Mean and median numbers of incidents of family violence per 1000 population in the four types of counties reveal that the more rural

the county, the lower the rate of reported family violence. Metropolitan-central city counties having more than double the rate of reported violence compared to the non-metropolitan counties–10.50 per 1000 for metropolitan central city counties, compared to only 5.05 per 1000 for non-metropolitan-adjacent and 4.67 per 100 among the non-metropolitan-non-adjacent counties. While their overall rates are lower, the non-metropolitan counties have a wide range of means–some counties have no reported incidents of family violence, whereas nine of the non-metropolitan adjacent counties and four of the non-metropolitan nonadjacent counties have incident rates that exceed the mean rate for

Table 1. Descriptive Statistics for Family Violence Rates Per 1000 People by Metropolitan Status of the Counties for 2002

	Mean (per 1000)[1]	Median (per 1000)[1]	Mean Ranges (per 1000)[1]
Total Counties[3]	5.58	4.65	0-31.62
Metropolitan Central City	10.50	9.95	5.82-21.27
Metropolitan Suburban	5.54	5.06	1.15-11.91
Non-metropolitan Adjacent to Metropolitan Co.	5.05	4.02	0-31.62
Non-metropolitan Non-adjacent to Metropolitan Co.	4.67	3.88	0-15.38

	Number of Incidents[1]	Percent of Incidents	Percent of State Population in Counties[2]	Number of Counties[3]
Total Counties[3]	184,039	100.00%	100.00%	254
Metropolitan Central City	141,932	77.12%	66.22%	27
Metropolitan Suburban	21,992	11.95%	18.67%	31
Non-metropolitan Adjacent to Metropolitan Co.	13,852	7.53%	10.50%	121
Non-metropolitan Non-adjacent to Metropolitan Co.	6,263	3.40%	4.61%	75

[1] Texas Department of Public Safety, 2002.
[2] The Texas State Data Center, 2003.
[3] Texas State Data Center and Office of the State Demographer, 2004.

the metropolitan central city counties of 10.50 incidents per 1000 population. The highest mean rate observed is in a non-metropolitan non-adjacent county in West Texas with a population of more than 15,000 people.

Thus, while the rates are lower in the non-metropolitan counties, there is considerable variability in those rates within county types. Furthermore, the total number of reported incidents is not insignificant. The residents of the non-metropolitan counties reported more than 20,000 incidents of family violence to law enforcement authorities in 2002.

Discussion

Lewis (2003) reports that rape and sexual assault in rural areas are crimes that are under-reported, as are incidents of family violence in general. Some of the factors that contribute to under-reporting of rape and sexual assault in rural areas are also likely to be factors affecting under-reporting of family violence in rural areas. The major factors that she discusses are (1) geography, (2) cultural factors, and (3) social factors. In geographic areas of low population density, medical care, social services, and law enforcement services are likely to be widely dispersed making it difficult to report incidents of family violence. These services are not likely to be as rich as in the metropolitan counties so that only minimal services may be available. Getting away from the abuser to report the violence may be problematic and getting transportation to an agency where services may be available may also be problematic. Cultural factors that may affect under-reporting include the insularity of rural communities and their distrust of outsiders. Rural residents are likely to have less experience with formal services because fewer are available in the rural areas, and they may fear intervention of agency personnel in family matters. Rural residents have strong cultural codes that value privacy and the protection of the reputation of the family at all costs. For Hispanics, additional cultural factors such as language barriers and traditional definitions of gender relations may be barriers to reporting violence.

Social factors may also adversely affect reporting of family violence. In rural areas there is a high level of acquaintance density; people are likely to know, or to know of, a high proportion of the long-time residents of the county. Both the victim and the perpetrator in incidents of family violence may have social ties with law enforcement officials, health care providers, and social service workers. These close social ties may make it difficult or impossible to preserve a victim's anonymity or confidentiality. Familiarity within a given community may increase the tolerance of deviant behavior among some social groups or families. In other words, people may think "this is just the way it is." Also, women in rural area may have fewer social and economic opportunities. Disruption of the family caused by the incarceration or absence of the breadwinner, even an abusive one, may threaten the family's economic survival. Thus, while there are fewer *reported* incidents of family violence per capita in rural areas, that does not necessarily mean that there are actually fewer incidents or that these incidents are less serious than those in more urban areas.

The differences in race and ethnic patterns of family violence are as likely to be found in rural areas as urban areas. For example, the Texas Department of Public Safety (2002) analysis of the reported incidents of family violence in Texas revealed that while Hispanics make up only 32% of the state's popula-

tion, 47% of the victims of family violence are Hispanic. Similarly, Blacks comprise only 11% of the population but 24% of family violence victims.

Domestic violence is more common than most people believe. Approximately 25% of women in a nationally representative survey of Americans report that they have been raped and/or physically assaulted by a current or former spouse or partner at some time in their lives (National Institute of Justice, 2002). African-American women are more likely to be victims of domestic violence that are Anglo women or women of other races. Living in an urban area is positively associated with being a victim of domestic violence, whereas having a lower annual household income is positively associated with victimization. African-American women are also more likely to report their victimization to the police than are white women (Rennison & Welchans, 2000). About half of the women who are victims of domestic violence report being injured. About 40% of these injuries are classified as minor, including cuts and bruises, whereas 5% are classified as serious. Most women do not seek medical attention for injuries and are treated at home or at the scene of the injury. Most injuries are not reported to health care professionals and most professionals are not comfortable asking about domestic violence (Campo & Baldwin, 1999). One study using national data on the use of emergency rooms estimates that 39% of all emergency room visits from women are for violence related injuries. Conservative estimates of the costs of medical and psychological services for victims of violence range from $1,075 to $1,633 per woman who is victimized per year (Greenfield et al., 1998).

In a previous study using the Project HOW (Health Outcomes for Women) data, Keenan, Marshall, and Eve (2002) examined the effects of psychosocial characteristics on use of health care services using data from the first and second waves of the data. Having longitudinal data gives the researchers unique opportunities for data analyses that do not occur in the use of cross-sectional data. For example, using longitudinal data from the Social Security Administration's Retirement History study, Eve (1988) demonstrated that past use of health care services is highly predictive of current use of services. Patients develop different patterns of access to a system of care, and once they have need of care or determine how to access the care, those patterns continue. Thus, this study can incorporate past use of health care services into the model to examine the effect of continuity in patterns of use of care established among this vulnerable population.

CONCLUSIONS & RECOMMENDATIONS

While a large, urban medical center can afford a highly specialized treatment center for victims of domestic violence, rural providers will need a different model that is more appropriate for the geographic, cultural, and social realities of more sparsely populated areas. Lewis (2003) offers some suggestions for dealing with sexual assault cases in rural areas that are also relevant to domestic violence advocacy and intervention in general. She argues that advocacy in rural areas is more expensive than in urban areas on a per capita basis because of the great distances involved. Advocates in rural areas typically cover large geographic distances in their work as advocates. In addition, there are greater costs in terms of transporting victims to treatment facilities over greater distances in rural than urban areas. She argues that a comprehensive program in rural areas will of

necessity be more decentralized than in urban areas and suggests that two elements necessary to make a rural program more effective include 1) training for first responders and 2) increasing awareness and community outreach. Lewis argues for increased training of first responders, especially the police, nurses in hospitals and doctors' offices, and primary care physicians. She has found even relatively short, one-day training sessions with the police can be effective. McFarlane et al. (2004) recently demonstrated in a controlled clinical experiment that telephone follow-up calls over an eight-week period to discuss safety-promoting behaviors among women who are victims of domestic violence can significantly increase precautionary behaviors in at-risk women. Safety promoting behaviors include simple actions, such as having money, extra clothes, and spare house and car keys hidden in a safe accessible place; getting lethal weapons out of the home; having a secret code with friends and family to signal a need for help; and asking neighbors to call police if they become aware of violence in the home.

Physicians may often be the only providers to see victims without others present where confidentiality can be assured. Recognizing the many demands on the time and energy of physicians, especially in rural communities, Gerbert et al. (2002) recommend a simple four-step plan for physicians when dealing with suspected domestic violence. These steps include:

1) Asking the patient about the suspected abuse;
2) Providing validating statements to the victim to validate her experience;
3) Documenting the signs, symptoms, and information about the abuse in detail in the medical record; and
4) Referring the victim to appropriate domestic violence specialists for follow-up.

Furthermore, in rural areas it is important for domestic violence advocates to form alliances with community organizations and agencies, such as health care providers including both hospitals and private doctors' offices, social service agencies, law enforcement, churches, schools, libraries, and even businesses, especially those that are likely to be frequented by women, including grocery stores and fast food chains. It is important that domestic violence advocates get the word out in rural communities through frequent interaction with community groups. Being a guest speaker at a school, church or other club meeting helps to spread the word that domestic violence is not acceptable, is against the law, and that there is help available for victims. Local community agencies can also form collaborative networks with periodic programmatic meetings to share information on prevention and intervention strategies and keep the issue on the front burner. Media outreach through local television or radio spots or articles in the local newspaper are an unobtrusive way to reach victims who have not been previously identified. Posters or small cards with phone numbers of domestic violence hotlines or advocacy agencies placed in public restrooms have also been effective in reaching unidentified victims (Chamberlain, 2000).

Domestic violence advocacy within a health care setting can improve the health care response to violence through direct service and also by functioning as a resource, training, and education center for others in the community. The cycle of violence can be interrupted and health and social service professionals can and should be more effective change agents in the process. The

website sponsored by the Family Violence Prevention Fund (www.endabuse.org) is especially helpful for health care professionals who would like to follow up on these issues. Among other topics, the site has an excellent sample of model programs for health care providers, health materials that can be used for prevention and intervention with domestic violence, technical assistance including a discussion of JACHO standards for dealing with victims of abuse, and informative information on policy issues, especially related to health care.

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