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Beyond Urban Places: Responding to Intimate Partner Violence in Rural and Remote Areas

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ABSTRACT

Intimate partner violence is a recognized public health problem impacting the lives of women, families, and communities. Women in rural and more remote areas who experience IPV face unique barriers and challenges to accessing healthcare services to support healthy outcomes. Resources, access to services, presence of compassionate and informed healthcare providers, and environmental circumstances influence effective responses to this issue in rural and more remote areas. In a public health approach to this problem, prevention efforts, victim-centered responses, and the support of safety are imperative to improve outcomes for women. Forensic nurses play an important role in effective response by building linkages across health, human, and social systems through collaboration, partnership, activism, advocacy, and sensitivity to the issue across the rural landscape.

KEY WORDS:

Community; domestic violence; forensic nursing; health care; intimate partner violence; remote; rural; victimization

For residents of rural, frontier, and more remote areas, there are great opportunities for enjoying the outdoors, wildlife, recreation, and many of the pleasures of living space. Rural and more remote areas are often thought of as tranquil and quiet places of beautiful scenery, relaxation, and outdoor recreation that are sanctuaries from violence. The reality is that rural areas are not safe havens from violence, and intimate partner violence (IPV) is prevalent. Around the world, women, children, and communities experience the far reaching consequences of violence (World Health Organization [WHO], 2014). Violence is a term that indicates aggressive behavior of one human toward another and is one of the most important public health problems worldwide. This public health problem can take many forms and potentially result in death and disability (Fountoulakis, Leucht, & Kaprinis, 2008). Rurality has been found to be related to higher rates of intimate partner homicide, a tragic outcome of this crime (Jennings & Piquero, 2008). A social issue at the forefront, violence in areas of low population density is poorly understood, and the context in which this occurs is critical to improving response to the unique needs of victims in these areas (Lanier & Maume, 2009). Although the circumstances of violence are similar in rural areas as in urban areas, the experience of victimization and recovery can be challenged by limited provider and care access, culture, transportation, and resource availability, among other factors (Logan, Walker, Cole, Ratliff, & Leukefeld, 2003; Peek-Asa et al., 2011).

IPV "describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy" (Centers for Disease Control and Prevention, 2015, para. 1). IPV has been historically referred to as domestic violence and can take many forms, including physical, sexual, emotional, psychological, economic, and stalking. Psychological violence can include intimidation, manipulation, coercion, blame, injury, isolation, and other abusive behavior (Centers for Disease Control and Prevention, 2010; National Institute of Justice, 2007). One in four women over the age of 18 years in the United States has experienced severe violence at the hands of an intimate partner at some point in their lives (Black et al., 2011).

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Although the overall rate of IPV has declined between the years of 1994 and 2010, in the same period, four of five victims were women, with men as the primary perpetrators of this crime (Catalano, 2012).

Many women are injured and experience adverse health outcomes, which impact everyday life (Moyer, 2013). These outcomes of violence are short, intermediate, and long term with high personal and social costs. There are significant and recognizable detrimental effects on health for any type of abuse with the link between violence and poor health outcomes well established (Scott-Storey, 2011). Women will seek healthcare for past or present injuries as a result of intimate partner, sexual, or other forms of violence (Annan, 2008). Women who have been victimized may attempt to obtain services in the healthcare system in rural areas where health and social services are often fragmented (Averill, Padilla, & Clements, 2007). Although emergency departments (EDs) are often the first point of health system care for victims of IPV who seek services for injuries as a result of violence, rural EDs have significantly less IPV resources to offer (Avegno, Mills, & Mills, 2007; Choo, Newgard, Lowe, Hall, & McConnell, 2011; Olive, 2007).

Violence against women in urban, rural, and more remote areas remains a significant public health priority in society. Since the early 1990s, a shift has occurred recognizing that IPV is not primarily a criminal justice issue but a public health issue, a leading cause of injury, death, and morbidity of women (Tjaden, 2005). Violence not only impacts the victim but affects the entire family. *Healthy People 2020* has again made IPV a priority objective (U.S. Department of Health and Human Services, 2011). In a public health approach to prominent issues, an environment is fostered in which people can be healthy and safe (Schneider, 2011). In the case of IPV, health is articulated as prevention of injury, morbidity, and death, with access to effective response systems that support improved outcomes. Although healthcare is proximal to the recognition and prevention of IPV, it is not the center of treatment, and a system-wide approach with partnerships in the community is imperative to addressing IPV (Rhodes et al., 2011).

Given that nurses represent the largest segment of the nation's healthcare workforce and on the front line of patient care (Institute of Medicine [IOM], 2010), they are often the initial contact for a victim seeking care, resources, and information. If able and/or medically necessary, victims may seek care in areas of higher population density with expanded resources. Nurses in all settings must be sensitive to the experiences of rural and remote women and provide care that addresses the unique needs of this population (Dudgeon & Evanson, 2014). In the healthcare system, nurses are expected to plan for the care of a patient who has experienced infliction of intentional and/or unintentional injury that involves violence and victimization (International Association of Forensic Nurses [IAFN], 2009). Nurses and other providers must be knowledgeable in understanding rural diversity and how different environmental circumstances and personal characteristics can influence help-seeking behavior (Eastman, Bunch, Williams, & Carawan, 2007). Forensic nurses have specialized knowledge in professional practice, "concerned primarily with the victims and perpetrators of trauma, their families, communities, and the systems that respond to them" (IAFN, 2009, p. 1). Given this specialized knowledge, forensic nurses can make a difference in prevention efforts as well as effective response to IPV in rural areas by sharing expertise, engaging with healthcare providers, participating in service to the rural community, and partnering with advocacy organizations reaching victims in underserved areas, among other actions. Forensic nurses actively involved internal and external to healthcare organizations can build awareness of the issue and serve as a collaborative partner in the continuous development of a seamless and effective response. Compassionate, victim-centered, and comprehensive responses linking criminal justice, health, social, and human service entities is imperative. Forensic nurses can be a key force in the primary prevention of this significant issue through activism, participation in research and evidence-based practice, professional consultation, volunteerism, and community outreach.

Rural and Frontier Areas

The concept of rural incorporates multiple variables creating uniqueness of place including geography, topography, population distribution, economic systems, and cultural factors (Curtin & Hargrove, 2010). According to the U.S. Census Bureau (2010), an urban area or place has been defined as having 50,000 or more people with urban clusters of at least 2500 and less than 50,000 people. By default, rural is designated as encompassing all population, housing, and territory outside these urban areas. Rural areas exist along a continuum from more to less open space, often based on factors of proximity to a central place, community size, population density, total population, and economic and socioeconomic factors. Rural areas can be defined by more than population density to reflect differences in access and resource allocation, which is critical to addressing needs of those residing there (Virgil, 2010). Rurality goes beyond a quantitative description of physical locality to include a system of accepted values, ideas, and practices that shape the social environment as they are interpreted by the people who live there (Riddell, Ford-Gilboe, & Leipert, 2009). Frontier areas are not only more remote, they have been described as the most rural settled places, are isolated, and have a population density of six or fewer people per square mile (Rural Assistance Center, 2013). These rural and remote communities struggle with low-paying jobs, less educated citizens, and a lack of healthcare. Many rural and frontier residents live in persistent poverty in the United States (Rural Poverty Persists, 2010; Virgil, 2010)

with social determinants such as unemployment; cultural, social, and gender norms; and gender inequality risk factors for violence (WHO, 2014).

Barriers to Compassionate Care and Effective Response

The experience of victimization is very different for those living in rural and frontier areas, with a push by criminologists to recognize and give more attention to rural crime (Lanier & Maume, 2009; Spano & Nagy, 2005). Rural women experience greater frequency and severity of abuse and live farther away from any type of services (Peek-Asa et al., 2011). IPV is often underreported in rural areas with heightened risk related to residence in a rural community (Bledsoe, Yankeelov, Barbee, & Antle, 2004; Cook-Craig, Lane, & Siebold, 2010). Victimization experiences may be exacerbated by economic status, presence or absence of a support system, family roles, community ties, and geographic location (Grossman, Hinkley, Kawalski, & Margrave, 2005; Logan et al., 2003). Factors such as social isolation, poverty, low educational level, and limited access to services may affect the victimization experience and subsequent outcomes in rural women. Many residents in rural communities lack awareness of services that are available, are unsure of what will happen if law enforcement is called, and fear revictimization by the system (Grama, 2000; Logan et al., 2003; Peek-Asa et al., 2011).

The lack of existing or alternative shelter, service providers, delayed response by the legal system, the influence of religious teachings, and the woman's own ties to the land often inhibit the willingness of women to report and seek services for crime victimization (Bostock, Plumpton, & Pratt, 2009; Grama, 2000; Slovak & Singer, 2002). A rural victim's willingness and intent to report and/or obtain services may be further influenced by family and group loyalty, a belief that disciplinary violence is acceptable, and cultural norms. Rural women may experience more stigma associated with reporting, particularly in the case of sexual assault or IPV. Victims may experience self-blame and a feeling of lack of control if their victimization is reported to law enforcement. The fear of social rejection and lack of support from family members, neighbors, and church members create a situation that leaves the abused victim feeling isolated, alone, negated or discounted, and reluctant to seek care (Annan, 2006; Eastman et al., 2007; Logan, Evans, Stevenson, & Jordan, 2005). Family and friends of the victim often do not want to be burdened by what they may perceive as an embarrassing or awkward situation and are concerned about their own safety if they get involved (Bosch & Bergen, 2006).

The culture and structure of rural environments may conceal violence against women, and concern regarding response by law enforcement and the legal system may inhibit reporting. Existing literature suggests that rural culture is in some ways regulated by informal social controls, which influences crime reporting and utilization of services. Individuals are inherently resistant to outside help, and women in rural communities are concerned about confidentiality and may have a lack of trust in the system (Eastman & Bunch, 2007; Logan, Evans, et al., 2005; Rygh & Hjortdahl, 2007). Individuals working in service areas such as community clinics, hospitals, courts, and law enforcement offices are often known to the victim or perpetrator in rural areas, and they may even be related (Annan, 2006). Low or no income is an issue that hinders independence and a woman's attempt to leave (Averill et al., 2007; Eastman et al., 2007; Logan et al., 2003). Geographic isolation and lack of transportation to escape are two primary difficulties faced by women experiencing domestic violence in rural and remote localities (Bledsoe et al., 2004).

Important to rural women experiencing violence is the presence of supportive persons in their lives who can assist them in finding and accessing available resources, so that they can make decisions related to their personal situation for themselves and their children. Supportive individuals facilitate the connection of the woman to formal and informal resources and decrease their isolation. Negotiating safety for the victim involves collaboration among health, human, criminal justice, and social systems including friends, family, colleagues, police, health, and voluntary services (Bostock et al., 2009).

In rural areas, the recognition of the need for more and improved services is paramount to change. Although this may be needed in some urban areas as well, rural conditions and unique barriers to response related to rurality make this need more acute (Annan, 2006; Brems, Johnson, Warner, & Roberts, 2006; Cohn & Hastings, 2013). The difficulty in addressing barriers to care and response in rural and remote areas is that these areas are very diverse; one rural area can be very different from another and have varied needs (Curtin & Hargrove, 2010; Williams & Cutchin, 2002). The belief that rural areas are calm, free of violence and contributing social problems may be a significant barrier to the development and implementation of human, social, and health services, particularly mental health services (Dew, Elifson, & Dozier, 2007; Slovak & Singer, 2002).

Prevention and Screening

The U.S. Preventive Services Task Force has recently updated their recommendations for screening women of childbearing age for IPV and advocate for all women to be screened and provided with intervention services (Moyer, 2013). The IOM (2011) also endorses screening for IPV in their report, "Clinical Preventive Services for Women: Closing the Gaps." There are a number of screening tools available that can be used throughout the healthcare system, in the ED, or at a primary care visit. Current screening tools

exhibit both high specificity and sensitivity in identifying victims of IPV as well as interventions that show positive outcomes (Moyer, 2013). Regardless of the presenting complaint, women accessing healthcare services should be routinely screened for IPV (Moyer, 2013; Rhodes et al., 2011). Because many women present to the clinic with concerns unrelated to abuse, universal screening in a supportive manner, provision of information, and referrals may help to identify and serve a greater number of victims (Klevens, Sadowski, Kee, Trick, & Garcia, 2012; Rhodes et al., 2011).

Along with screening, addressing a healthy, nurturing home environment and appropriate relationships within the household may help to prevent abuse and violence. Recognizing the opportunity to foster healthy relationships when children or parents present at any point in the healthcare system may promote positive outcomes and a change in social norms that may condone violence in the home (Black et al., 2011). Whereas laws are in place nationally that require reporting of child abuse (IOM, 2011), legislation both at the state and national levels in detecting, reporting, and prosecuting crimes of IPV can help to protect victims and deter incidents (Black et al., 2011).

Safety planning is an integral part in promoting healthy and safe choices for victims. Online safety planning tools are being implemented to help both urban and rural victims, and many national agencies have tools available on their web sites (Bloom et al., 2014; National Center on Domestic and Sexual Violence, 2013). Rural and frontier residents may not have access to the Internet, so these tools may be offered and utilized in the healthcare setting. Collaboration with victim service agencies that serve rural areas will foster effective safety planning for victims of violence.

Important to these recommendations is that nurses in all healthcare settings have knowledge regarding identification and effective response to domestic violence and appropriate interventions that support safety, be aware of and connected to advocacy organizations offering a form of shelter and other services to victims of violence, and know the full scope of community resources that are available. Nurses and other healthcare providers must be sensitive to the healthcare needs of women experiencing IPV; listen to concerns; acknowledge; support; validate; and provide a safe, nonjudgmental, and caring environment (Johnston, 2006; Tower, Rowe, & Wallis, 2012). Forensic nurses can serve as mentors and become involved in the education of nurses working in rural settings to build necessary competencies needed by health professionals for prevention; recognition; treatment; and a compassionate, patient-centered response to violence.

Promising Practices and Future Directions

Planning for prevention and intervention must go beyond individual and protective factors and explore community and regional characteristics (Dudgeon & Evanson, 2014; Lanier & Maume, 2009; Marquart, Nannini, Edwards, Stanley, & Wayman, 2007). Interprofessional applications, team-based work with appropriate flexibility of roles and responsibilities, efficient delegation of tasks, and cultural awareness and adjustments are critical to improving response to victims of violence in rural settings. Integrated care pathways, outreach programs, shared care, and telemedicine offer promising opportunities in rural and remote settings. Innovative use of technology has been found to make a positive difference in addressing rural and remote community needs of victims of violence (Cook-Craig et al., 2010). The use of technology to connect isolated and distant partners can be an effective way to support inclusion of critical stakeholders in service development and build rural capacity. Current technology can support training delivery to rural areas as well as provision of care through telehealth capabilities. Although rural and remote areas have challenges related to IPV, aggravated by the limited access to intervention services (Peek-Asa et al., 2011), advancing technology offers an increased number of tools available to both victims and providers that may help in detecting violence and implementing change in these places.

Along with the benefits of technology comes the realization and importance of the recognition of possible danger and repercussions from its use. Perpetrators of abuse may use technology against victims, through stalking, harassing messages, and invasion of their social networks. Women who are victims of IPV benefit from learning basic use of technology and how to protect themselves from their abuser if they want to access online support services, use email to communicate, or find resources to help them leave the abusive relationship (Finn & Atkinson, 2009). Community-based victim service advocacy organizations are critical partners in the systematic response to IPV in rural and remote areas. These organizations, if not located in rural and remote areas, can potentially provide outreach services from primary urban locations.

Areas of focus that will improve outcomes for victims of IPV include prevention, screening and appropriate referral, introduction of technology in the care pathway, holistic community and systems approaches, and increasing the expertise of nurses in the area of forensic nursing care. A primary goal must be to work closely with local communities to build point of care services that will meet the needs of the community and build social capital (Cook-Craig et al., 2010; Rygh & Hjortdahl, 2007). Increased collaboration across professionals and sectors facilitating a sharing of expertise, experience, perspectives, and use of existing resources will enhance the achievement of mutual goals of improving the lives of children and families (Salem & Dunford-Jackson, 2008; WHO, 2014). Increasing knowledge of the unique challenges and context of rural areas is an opportunity for forensic nurses to then be actively

involved in building capacity that supports prevention efforts and improved responses to IPV in more remote places. This is a critical need as healthcare providers from these more isolated communities are often absent from state, regional, and local levels of planning and prevention efforts related to IPV and other forms of violence (Cook-Craig et al., 2010). Forensic nurses can assist with policy development at local, regional, and state levels. Collaboration with health and community providers in rural communities will build trust and inclusion necessary to move forward in advancing the care provided to victims of violence in rural areas. Active involvement of forensic nurses across the healthcare sector is important to expand violence prevention efforts and evidence-based forensic nursing services beyond urban places. Critical to effective response to IPV will be the development of services that are evidence based, community specific, focused on partnership building, and implemented through creative and sustainable alliances (Fluharty, 2002; McCoy, 2009).

Although those residing in rural and frontier areas constitute a sizeable portion of the U.S. population, few nurse researchers have examined IPV in rural settings. Nurses and other healthcare providers must understand research and have access to the tools necessary to conduct, access, and use evidence to guide clinical practice in rural settings (McCoy, 2009). Forensic nursing research is needed to explore the victimization experience in low population areas to establish effective policies at the local, regional, and national levels and support system change for effective response (Averill et al., 2007). Research should be targeted on the discovery and understanding of the unique needs of rural victims and the outcomes of innovative programs, so that successes can be shared and adapted, with limitations identified and carefully addressed across a continuum of care services. Partnerships among academicians, forensic nursing specialists, and community agency members offer a promising opportunity for conducting research and addressing IPV.

Systems Approach and Community Response

Effective collaboration is critical to the successful response to family violence in rural areas. Collaboration aligns stakeholders who have complementary skills and capacity to facilitate effective system change, adaptation, and policy implementation (Banks, Dutch, & Wang, 2008; Davidson & Bowen, 2011). Multisector communication among agencies is paramount, with forensic nurses and other healthcare providers, public health agencies, and community-based advocacy organizations working together to develop an effective systems approach for local and surrounding population areas. Collaboration can foster research agendas in the area of violence, facilitate carefully planned interventions, and promote real-world approaches to increasing knowledge and improving response to victims. Forensic nurses can and should be at the center of these efforts. Enhancing provider-to-community linkages helps to close the research-to-practice gap, support referrals, promote volunteerism, build trust, and open the door to shared opportunities to build social capital and improve services (Davidson & Bowen, 2011; Lauder, Reel, Farmer, & Griggs, 2006).

The growing trend toward community-based intervention and response is strengthening rural communities and quality of care. Community-based policing has improved the relationship between law enforcement and local citizens in that there is cooperative work with a wide range of groups and institutions at the local level to prevent crime (Donnermeyer, n.d.). Coordinated community response efforts must expand to include informal resources, such as extended families, neighbors, friends, and social groups as well as formal organizations such as employers, to enhance the quality and quantity of resources available to rural women. Strategies to build highly individualized responses to meet the unique needs of rural women must move beyond current efforts and create a path toward community involvement in building effective responses at the local level (Pennington-Zoeller, 2009).

Implementing innovative programs for health, social, and human services and recruiting and retaining competent personnel can be challenging in rural areas with entrenched bureaucracies, limited resources, and role diffusion (Grossman et al., 2005). However, there is a national commitment to quality, effectiveness, and accessibility of care regardless of where one resides. This will require input and expertise from forensic nurses, a range of agencies, sectors, and other providers. A whole systems approach is desirable in which the roles of varied professionals and organizations are coordinated to promote access, quality of service provision, efficiency, and cost effectiveness in rural areas. This may require enhanced levels of outreach and sharing of expertise across organizations (Asthana & Halliday, 2004). Integrated databases among health, criminal justice, and social service agencies offer promise for tracking adverse outcomes as well as for identifying services being utilized (Rhodes et al., 2011).

Best practice will be further supported in rural areas through the development of a sufficient supply of motivated and skilled healthcare professionals including nurses with forensic expertise to address the unique needs of rural residents. The foundation of best practice in rural areas will be built on benchmarking; searching out the best practice, adapting it to the context of the rural environment, attempting to do better, and evaluating results and making decisions based on evidence. The future calls for multiqualified healthcare professionals who can work across current care boundaries and be more flexible in care delivery. A focus on outcome measurement will support evidence-based care approaches to all, including victims of violence, and support

the continued development of efficient and effective response sensitive to the context of the rural environment (Decker et al., 2012; Lanier & Maume, 2009).

Implications for Clinical Forensic Nursing Practice

Nurses should be prepared to effectively respond to victims of violence across healthcare settings and must be familiar with resources in the community. Nurses working with victims must recognize that environmental circumstances may influence the help-seeking process (Eastman & Bunch, 2007; Grossman et al., 2005; Logan, Shannon, &Walker, 2005; Rygh & Hjortdahl, 2007). Nurses must be compassionate and offer individualized assistance, be knowledgeable about IPV victimization, and be familiar with resources available in the community that will support safety. Negative reactions from service providers to women experiencing violence may be associated with poorer outcomes, particularly mental health sequelae; therefore, a caring, sensitive approach to victims is important (Annan, 2006; Bosch & Bergen, 2006; Rygh & Hjortdahl, 2007).

Forensic nurses in particular can bring needed expertise to the development of victim-centered, caring responses to the unique needs of rural and more remote victims of IPV. Getting involved professionally and sharing knowledge and expertise is an opportunity to improve services in rural and remote areas. Reaching out to critical access hospitals, law enforcement agencies in rural communities, probation and parole, health department extensions, and advocacy organizations, among others, can help to create positive change for expanding services to rural and remote places.

Forensic nurses can play a key role in coordinated community responses by serving as a liaison between healthcare agencies and community-based providers. Getting involved in building effective responses to IPV in rural communities can include serving on a local task force; volunteering on a board of a nonprofit organization serving victims of violence; inviting members of victim service agencies into community clinics, hospitals, or other health system organizations to talk about community-based services available; share expertise with active participation in community-based activities addressing violence against women; and participation in violence awareness activities such as fundraisers. Forensic nurses can educate and assist healthcare providers in taking a holistic approach in the response to victims of violence by connecting with, and knowing more, about the services provided in surrounding rural communities. Forensic nurses can become active members of a state coalition or council designed to build and support services for victims of violence, be involved in funded projects, and bridge health and human services designed to address violence against women. Victim service organizations are a rich resource for informal training (often available to nurses) in supporting effective response to violence and providing important support services for victims once they leave the healthcare system. Collaboration of forensic nurses with victim service agencies is critical to effective response both internal and external to the healthcare system.

Building relationships with these key partners is important to improve whole sector system response. By getting actively involved in local, regional, and state organizations, forensic nurses can help to disseminate information on resources and support safety and improved outcomes for victims of violence. Forensic nurses can build awareness of the IAFN and the opportunities for rural nurses to obtain continuing education and certification and to build a network of support and shared expertise. Collaboration with healthcare systems and academic institutions is needed to advance awareness of forensic nursing and necessary competencies needed to effectively address exposure to violence and abuse in patient care (Ambuel et al., 2011).

Conclusion

Implementation of new approaches to the lived experience and unique issues of rural residence residency may help to facilitate a compassionate, caring, effective system response (Annan, 2008). Given that IPV is significantly related to poorer physical and mental health outcomes, building access to a caring response through linkages of the human, social, and healthcare systems is imperative to improve healthcare and quality of life in urban, rural, and more remote settings (Annan, 2008; Dudgeon & Evanson, 2014). These realities must be addressed, and services must be developed within the context of any given rural and/or remote community. Forensic nursing leaders in the community are a vital resource in working toward an improved, compassionate response to women experiencing violence from urban to rural places. Critical to effective response are nurses who are caring, supportive, and informed, and who are able to connect women to resources, help them make sense of their situation and support safety (Tower et al., 2012).

Urban models cannot unreservedly be adapted to rural areas because of the uniqueness of rurality, and further work is needed in the area of policy, practice, and research to meet the unique needs of rural residents with attention to important demographic, cultural, and economic differences across rural places (Hart, Larson, & Lishner, 2005; Slovak & Singer, 2002). Models of care for rural implementation must remain flexible to the particular needs of rural victims and involve partnerships which can provide shared resources and expertise. Forensic nurses can assist rural nursing professionals in taking an active role in a collaborative response to victims of violence and closing the gap across social, human services, and healthcare systems.

The significant public health problem of violence against women cannot be resolved by any one agency, organization,

or health professional group. Coordination among agencies, the healthcare sector, communication, and trust can foster prevention strategies and build effective services responsive to those needing and accessing them. Partnerships with urban centers and rural localities can provide opportunities for the sharing of forensic nursing expertise and other resources across the urban, rural, and more remote landscape.

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