

The Primary Prevention of Sexual Violence Against Adolescents in Racine County and the Community Readiness Model

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THE PRIMARY PREVENTION OF SEXUAL VIOLENCE AGAINST
ADOLESCENTS IN RACINE COUNTY AND THE
COMMUNITY READINESS MODEL

by

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ABSTRACT
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Theresa A. DeWalt, B.A., M.A.

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Sexual violence affects tens of thousands of people annually in the United States. The majority of sexual assault victims are under the age of 18. Victims of sexual violence often experience severe, long-lasting ramifications, including post-traumatic stress disorder, depression, anxiety, interpersonal problems, suicidal ideation, self-harm behaviors, and eating disorders. As a result of these effects, it is imperative that communities provide effective primary prevention of sexual violence programs. However, it is challenging to effectively implement sexual violence primary prevention strategies for a variety of reasons. One challenge is because it is difficult to construct a prevention program that changes the social norms and cultural beliefs that both contribute to sexual violence and are reinforced on a daily basis through society's social structures and media influences. A second, and related, challenge is the difficulty of implementing effective prevention strategies that specifically address the cultural norms and belief systems of a particular community.

These challenges are addressed in this study through the Community Readiness Model (CRM). The CRM is a qualitative model of community assessment used to match a prevention strategy to the social norms and culture of a specific community. The CRM assesses a community along six Dimensions and nine Stages of Readiness. This study

was completed in rural and urban Racine County, Wisconsin. Results indicated that both the rural and urban Racine County communities were at the Vague Awareness stage of readiness to implement primary prevention strategies to reduce the incidence of sexual violence against adolescents. Implications of the study are provided including possible primary prevention implementation strategies that match the levels of readiness within the communities. Theoretical and methodological limitations of this research are presented, as well as the study's implications for future research.

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CHAPTER I: INTRODUCTION

Statement of the Problem

Sexual violence affects tens of thousands of people annually in the United States. An average of 93,514 incidents of sexual violence were reported each year to law enforcement in the United States between the years 1995 and 2003 (Office of Justice Assistance, [OJA], 2005). Perhaps even more alarmingly, the number of reported sexual assaults represents only approximately one-third of the actual incidence of sexual violence occurring in our society, as it is one of the lowest reported crimes (Department of Military Affairs and Public Safety, 2000; National Crime Victimization Survey, 1999; U.S. Department of Justice, 2002). In addition, the majority of these victims were under the age of 18. In Wisconsin, 76.8% of all victims of sexual assault in 2004 were under the age of 18, with 70% of those under the age of 15 (OJA).

Victims of sexual violence often experience severe, long-lasting ramifications. The consequences of sexual violence can include post-traumatic stress disorder, depression, anxiety, interpersonal problems, pregnancy, sexually transmitted infections, suicidal ideation, self-harm behaviors, and eating disorders (Bensley, Van Eenwyl, Spieker, & Schoder, 1999; Davis, Combs-Lane, & Jackson, 2002; Gallo-Lopez, 2000; Resnick, 1993; Tjaden & Thoennes, 2000). The emotional, psychological, and physical traumas that sexual violence victims experience can last for months, years, and for some, even a lifetime.

As a result of both the prevalence and extensive consequences of sexual violence in the U.S., governmental programs and rape crisis centers have been working to end its occurrence. Historically, these efforts have focused on changing the actions of potential

victims to reduce the likelihood that they will become a victim. These “risk reduction” efforts often involve telling potential victims (particularly women) not to walk alone at night, to take self-defense classes, to carry pepper spray, and to watch their drinks in bars. However, in recent years, prevention efforts have focused more on changing the attitudes and behaviors that allow sexual violence to occur in the first place. These efforts, labeled “primary prevention,” involve programming aimed at changing the social norms and beliefs in our culture that contribute to the occurrence of sexual violence.

Rationale for the Study

Despite increased attention on the primary prevention of sexual violence, it is still challenging to effectively implement sexual violence primary prevention strategies. One challenge arises because it is difficult to construct a prevention program that changes the social norms and cultural beliefs that both contribute to sexual violence and are reinforced on a daily basis through society’s social structures and media influences. For example, many of today’s songs, music videos, and movies perpetuate the image of women as sexual commodities. In particular, misogyny and the objectification of women are illustrated in the lyrics of many popular songs. The lyrics of these songs involve the sexual objectification of women and girls, and contribute to the perception that a woman’s value is based on what she can provide sexually. This perspective may influence one’s ability to commit an act of violence against a woman (Centers for Disease Control and Prevention [CDC], 2004). Such songs’ popularity in American culture illustrates our society’s possible acceptance of, and desensitization to, the objectification of women, and in so doing, may increase the risk that those routinely exposed to this type of media, in combination with other risk factors, may become sexual perpetrators (CDC,

2004). It is challenging to develop prevention programs that can effectively counteract the social norms and attitudes that result from these types of pervasive media messages.

A second, and related, challenge is the difficulty of implementing effective prevention strategies that specifically address the cultural norms and belief systems of a particular community. For example, an extremely effective prevention program in one city may fail in another community due to differences in knowledge, beliefs, and cultural norms. Some communities may reject public recognition of a local problem, other communities may show considerable interest in an identified problem but have little knowledge about what to do, and still other communities may have highly developed and sophisticated prevention programs (Oetting et al., 1995; Slater et al., 2005). Therefore, prevention strategies must be tailored to meet the social norms, knowledge base, and attitudes of the community members if the efforts are to be accepted and successful.

This study addressed these two challenges by assessing the knowledge, awareness, attitudes, and cultural norms of a community that speak to the community's level of readiness to accept primary prevention efforts aimed at reducing sexual violence against adolescents. The study addressed the first challenge by recommending primary prevention strategies aimed at changing the social norms that contribute to sexual violence. The second challenge was addressed through the completion of the Community Readiness Model, an assessment aimed at understanding the unique culture, attitudes and knowledge of the communities which will receive the prevention programs.

This study implemented the Community Readiness Model (CRM; Jumper-Thurman, Edwards, Plested, & Oetting, 2001; Plested, Edwards, & Jumper-Thurman, 2003), a community assessment tool used to match a prevention strategy to a specific

community. The CRM assesses a community along six “Dimensions” and nine “Stages of Readiness.” The Dimensions are specific elements within a community that describe its readiness to address a specific problem, and include Community Efforts, Community Knowledge of Efforts, Leadership, Community Climate, Knowledge about Issue, and Resources. The nine Stages of Readiness provide a framework to understand the level of community readiness in regard to those dimensions, and range from “no awareness” to a “high level of community ownership” of the problem.

The researcher will provide the results of this assessment (following completion of this dissertation) to the local rape crisis center serving the two communities that were assessed. The rape crisis center is aware that this study was completed and they have agreed to implement the study’s recommendations in their prevention strategies. The implementation of the prevention strategies will not be a part of the dissertation; rather, the results reported in the dissertation indicate appropriate prevention strategies to the center. These recommended strategies have been tailored to fit the level of readiness of the communities served by the rape crisis center, and will therefore have an increased chance of success. Overall, the hope is that these prevention efforts will work to change the communities’ acceptance of sexual violence.

Research Questions

This study was completed in rural and urban Racine County, Wisconsin. Racine County was chosen due to its high rates of sexual violence (FBI Crime Statistics, 2005, <http://www.areaconnect.com/crime/compare.htm?c1=Racine&s1=WI&c2=New+York&s2=NY> retrieved 6.12.09), the researcher’s professional association with the county as the

director of the local rape crisis center, and the researcher's proximity to the community.

The principal research questions of this study were as follows:

Question 1: What are the levels of community readiness in rural and urban Racine County regarding sexual violence primary prevention strategies within the adolescent population?

This question is important because prevention strategies are more likely to be successful when they match the level of readiness of the community in which they are to be implemented. Knowing a community's stage of readiness for a particular type of prevention initiative will allow the efforts to be tailored to match the community's belief systems and cultural norms regarding that issue, thus increasing the chance of their successful implementation.

Question 2: What, if any, are the differences in level of readiness between rural and urban Racine County?

This question was included because following completion of this dissertation, the rape crisis center will implement sexual violence prevention strategies in both rural and urban Racine County. Historically, the same prevention efforts have been implemented in both of these communities, without acknowledging the communities' potential differences. Understanding the differences between these two communities, and tailoring the efforts according to those differences, is critical to the successful implementation of the prevention initiatives.

Question 3: How do the CRM Dimensions and Stages of Readiness inform the implementation of sexual violence primary prevention strategies for the adolescent population in rural and urban Racine County?

This question is important because it addresses the end goal of this study, which is to better understand how to successfully implement sexual violence primary prevention strategies. Primary prevention can occur on multiple levels of society and in a variety of different formats. Completion of this study will provide information on what layers of society should be targeted with what types of prevention initiatives. The recommended strategies of this study will be provided to the local rape crisis program for future implementation.

CHAPTER II: REVIEW OF THE LITERATURE

Sexual Violence

Definitions

Historically, sexual violence has been inconsistently defined. Specifically, researchers have disputed which of its various components (e.g., rape, fondling, contact and non-contact sexual abuse) should be included as part of the term (Basile & Saltzman, 2002). As a result of this lack of clarification, in 2002 the Centers for Disease Control and Prevention (CDC) developed the document *Sexual violence surveillance: Uniform definitions and recommended data elements*. The purpose of this document was to present a uniform definition of sexual violence and a consistent method to collect data on its occurrence. A consistent definition of sexual violence would help to measure and identify risk and protective factors for victimization and perpetration, which would inform prevention and intervention efforts (Basile & Saltzman). The CDC's resulting definition of "sexual violence" is as follows:

Nonconsensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; nonconsensual contact between the mouth and the penis, vulva, or anus; nonconsensual penetration of the anal or genital opening of another person by a hand, finger, or other object; nonconsensual intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks; or nonconsensual non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. All of the above acts also qualify as sexual

violence if they are committed against someone who is unable to consent or refuse. (Basile & Saltzman, p. 9)

This definition of sexual violence is used for the purposes of this study.

Despite the use of the term sexual “violence,” it is important to note that violence is not used during most sexual violations. In fact, physical violence, physical assaults, battery, and/or the use of weapons are not used during the majority of all sexual violations (OJA, 2005; U.S. Department of Justice [DOJ], 2002). Sexual violence, however, does often involve manipulation, coercion, power, and control. This challenges the stereotype that sexual violence is usually a physically “violent” act, and underscores the fact that most acts of sexual violence occur in more subtle, coercive ways (Tjaden & Thoennes, 2006).

In addition, many people who work in the field of sexual violence use the word "survivor" to describe a person on whom sexual violence has been inflicted. This term is used to reflect that these individuals have endured and, in essence, “survived” a horrific life event. However, the word "victim" will be used in this document in an effort to be consistent with the language used in the prevention education field, reflecting that prevention programs work to prevent sexual “victimization.” The use of the term “victim” in this document, however, is in no way meant to imply that those who have been sexually victimized are not “survivors.”

Prevalence

Sexual violence occurs at high rates throughout the world. Research on the extent of sexual violence, both globally as well as in the United States, suggests that nearly one in four women experience sexual violence by an intimate partner, and up to one-third of

adolescent girls report that their first sexual experience was forced (Abma, Driscoll, & Moore, 1998; World Health Organization [WHO], 2002). However, these data likely underestimate the true magnitude of the problem. For example, in the United States between 1992 and 2000, only 26% of rapes, 34% of attempted rapes, and 26% of sexual assaults were reported to police (U.S. Department of Justice, 2002). This low level of reporting is common: The National Violence Against Women Survey (NVAWS) found that only 1 in 5 adult women (20%) reported their rapes to police (Tjaden & Thoennes, 2006), and an average of only one-third of sexual assaults are ever reported to authorities (Department of Military Affairs and Public Safety, 2000; National Crime Victimization Survey, 1999; U.S. Department of Justice, 2002). This rate of reporting makes sexual violence one of the most underreported crimes (National Crime Victimization Survey, 1999). The rate of non-reporting is derived from large, nation wide studies that anonymously ask individuals about whether they have been sexually victimized. The rates of sexual victimization disclosed within these samples are then compared with the numbers of sexual assaults reported to the police. This comparison reveals that significantly more people are sexually victimized than reflected by the numbers reported to the police.

Impact

Preventing sexual violence is important due to the extensive impact it has on victims and their support people. Although every victim of sexual violence experiences unique reactions, some common responses to sexual victimization are identifiable. These responses can largely be classified into two realms: impact on psychological health (including impact on self-concept), and impact on interpersonal relationships.

Sexual victimization often has a widespread impact on the psychological health of victims. This impact can range from nightmares and sleep disturbances, to eating disorders, somatic complaints, mood and anxiety disorders, dissociative responses, self-injury and suicidal ideation (Bensley, Van Eenwyl, Spieker, & Schoder, 1999; Davis, Combs-Lane, & Jackson, 2002; Gallo-Lopez, 2000). For some victims, these disturbances last for a few weeks or months, whereas for other victims, they can last considerably longer (Gallo-Lopez, 2000; Resnick, 1993).

Additionally, sexual victimization has a significant impact on how it affects an individual's self concept. Sexual victimization often affects how an individual sees her or his worth as a person. As a result, sexual violence victims often experience low self-esteem, a damaged sense of body integrity and negative body image, feelings of guilt, shame and humiliation, and learned helplessness (Bensley, Van Eenwyl, Spieker, & Schoder, 1999; Davis, Combs-Lane, & Jackson, 2002; Gallo-Lopez, 2000). This impact on self-concept influences victims' perceptions of their future goals and ability to obtain those goals (American Psychiatric Association, 2000).

The second realm of impact is how sexual victimization affects one's interpersonal relationships. Because sexual victimization is an act of violence initiated from one person onto another, it often influences an individual's ability to relate to and/or trust other people in the future. Individuals who have been sexually victimized often experience a feeling of detachment or isolation from others, a lack of understanding about appropriate interpersonal boundaries, and a reduced ability to trust others (American Psychiatric Association, 2000; Bensley, Van Eenwyl, Spieker, & Schoder, 1999; Davis, Combs-Lane, & Jackson, 2002; Gallo-Lopez, 2000).

Thus, sexual violence often affects psychological health, self-concept, as well as relationships with others. Such effects underline the importance of developing and implementing effective primary prevention strategies.

Sexual Violence Against Adolescents

Prevalence

This study focuses on sexual violence primary prevention strategies for adolescents because adolescence is a time of high risk for sexual victimization and perpetration (OJA, 2005). Lee, Guy, Perry, Sniffen, and Mixson (2007) state that “prevention work focused on adolescents is key to any comprehensive strategy to prevent sexual violence” (p. 15). Given this focus, information regarding the rates of sexual violence within this population is provided.

Approximately 1.8 million adolescents in the United States have been victims of sexual assault (Kilpatrick, et al., 1998). Statistics from the National Sexual Violence Resource Center indicate that the average age of sexual victimization for females is 15 years old and 12 years old for males (OJA, 2004). Adolescent females are particularly vulnerable to becoming victims of sexual violence, with teenagers between the age of 16 and 19 being 3½ times more likely than the general population to be victims of rape, attempted rape, or sexual assault (Bureau of Justice Statistics, National Crime Victimization Survey, U.S. Department of Justice, 1996). While the majority (82%) of all juvenile sexual assault and abuse victims are female (U.S. Department of Justice, 2000), boys are also sexually abused and assaulted. One in seven males will be the victim of sexual violence during the course of his lifetime, and males comprise one in four victims of sexual assault under the age of 12 (Office of Juvenile Justice and Delinquency

Prevention, 1999). Even more critical to sexual violence prevention efforts are the rates of underage sexual offenders. An average of 40% of all sexual offenders are under the age of 18 (OJA, 2005). These numbers clearly illustrate the need for juveniles to receive prevention and educational programming in an attempt to reduce their risk of becoming both perpetrators and victims of sexual assault.

Impact

Beyond the common responses previously discussed, sexually victimized adolescents often experience unique negative consequences because of their state of physical, social, and emotional development. Given these maturational processes, adolescents' sense of self and place in the world has not yet been fully established. As a result, if they experience sexual victimization, the trauma of this experience has an increased likelihood of affecting their developmental process, including how they see themselves, and their perception of how safe the world is. Green et al. (2005) state:

While the literature has tended to focus on childhood as a time of particular risk, more attention might usefully be directed toward adolescence, in particular to those abused during this period. Adolescence is developmentally a time when individuals are separating from their parents, developing sexually and cognitively, learning to love and socialize with their peers, and consolidating their identity ... having this process subverted by reactions to trauma may accelerate these processes, such as sexual experimentation. Assaults on physical integrity may blur distinctions between self and others and interfere with learning about boundary issues and continuity of self across time. (p. 373)

As a result of the particular vulnerabilities of this developmental stage, adolescents who are sexually assaulted are at a heightened risk for a number of other negative consequences. These include a reduced ability to reach intrapsychic and social developmental milestones, increased levels of mental health problems and risk of suicide, as well as increased risky sexual behavior.

Developmental task attainment. When adolescent growth and development are disrupted by sexual assault or abuse, such growth may be stunted. Developmental milestones may not be met, and tasks that are not achieved at the appropriate age may result in a struggle to reach social and emotional developmental milestones in the future (Crowder & Myers, 1993; Downs, 1993).

Specifically, the experience of sexual violence during adolescence affects intrapsychic and social development. When sexual violence occurs during adolescence, an individual's sense of self and basic ability to trust others is threatened. This threat then alters that individual's perception of the world and those around her or him. Sexual assault reduces adolescents' ability to feel a sense of security in the world and challenges their developing sense of right and wrong (Clements, Speck, Crane, & Faulker, 2004).

Sexual victimization at this point in life also clouds a victim's understanding of appropriate interpersonal boundaries, possibly placing them at additional risk of victimization in future relationships (Alamo Mixson, 2007; Clements, Speck, Crane, & Faulker, 2004; Downs, 1993). Thus, the experience of sexual violence during a time when adolescents are learning who they are and whether or not they can trust those around them often has long-term implications for their social development (Browne & Finkelhor, 1986; Downs; Gelinis, 1983).

Mental health problems. Sexual violence during adolescence also leads to an increase in the severity and frequency of mental health problems (particularly the development of post-traumatic stress disorder), an increased likelihood of self-harm behaviors, and the use of alcohol and other drugs. The experience of sexual violence can, in fact, result in some of the most severe emotional and traumatic reactions (Clements, Speck, Crane & Faulkner, 2004). Feelings of hopelessness and depression are common reactions to sexual assault, and subsequently, some sexual assault victims contemplate or commit suicide. In comparison to non-victimized samples, sexual assault victims experience significantly higher levels of suicidal thoughts or behaviors (Bensley, van Eenwyk, Spieker & Schoder, 1999; Brener et al., 1999; Green, et al., 2005; Kaplan et al., 1999, Rodriguez-Srednicki, 2001). Alcohol and drug use is also higher among sexually abused adolescents: In a nationally representative sample, youth who experienced sexual assault were twice as likely as their non-victimized peers to report past-year alcohol or other drug abuse or dependence (Kilpatrick et al., 2000).

Sexual behavior. In addition, adolescents who have been sexually assaulted engage in increased risky sexual behaviors as compared to those without an abuse history (Davis, Combs-Lane & Jackson, 2002; Green et al., 2005). Adolescents who have experienced sexual violence are more likely to be arrested for sex crimes and prostitution, putting them at higher risk for teen pregnancy, sexually transmitted infections, and having many sexual partners (Clements, Speck, Crane & Faulker, 2004; Wordes & Nunez, 2002). Additionally, sexual violence has been linked to increased rates of teen pregnancy. Between one-half to two-thirds of teenage mothers have been sexually

victimized prior to becoming pregnant, and between 30% and 44% have been the victims of rape or attempted rape (Department of Health and Family Services, 1998).

As the preceding data show, sexual victimization during adolescence occurs at a particularly vulnerable time. Because of the unique and significant negative effects of sexual violence on adolescents, concentrated efforts must be made to prevent sexual violence within this population.

Sexual Violence Prevention

Despite the pervasiveness of sexual violence, little is known about how to effectively prevent it. Up to this point in time, neither community-based practitioners nor academic researchers have developed prevention methods that have significantly reduced incidence rates, as demonstrated by the continued consistent rates of reported sexual victimization (Campbell & Wasco, 2005). As McCall (1993) stated, “sexual assault prevention programming remains a confused, scattered and sporadic enterprise with little scientific underpinning...” (p. 277). Prevention efforts are challenged by the many interrelated factors that contribute to sexual violence. Historically, for example, it has not been clear whether prevention efforts should be aimed at controlling crime, changing the behaviors of potential victims, or treating victims after an assault has happened. The prevention of sexual violence has thus been approached either as a matter of crime control or as a public health measure (McCall, 1993).

Some “sexual assault prevention” efforts have focused on changing the behaviors of potential victims. In fact, the majority of rape prevention programs have targeted women, and have used strategies such as self-defense classes, the inclusion of “blue lights” on college campuses, and victim advocacy programs (Hensley, 2003). Such a

focus may reduce the likelihood that particular women become victims of sexual assault, but it does not address the common perpetrators of the act itself, as men commit the majority of sexual assaults (Katz, 2006; Koss et al., 1994; OJA, 2005; Tjaden & Thoennes, 2006).

In fact, millions of dollars have been spent annually in the United States on rape prevention programs that focus on changing the behavior of potential victims. When such programming is thoughtfully considered, however, it is clear that these steps do not actually *prevent* sexual violence. Changing the behaviors of potential victims will not reduce sexual violence; such efforts simply *reduce the risk* that a specific person will be victimized. Even if the person who receives the programming is not victimized, someone else may be. Such victim-centered programming is now labeled “risk reduction,” and is losing favor with rape prevention organizations (CDC, 2004; Meyer, 2000).

Within recent years, however, there has been increased interest in developing programs that do not simply change the actions of potential victims, but rather stop perpetrators from committing offenses in the first place. This type of programming, labeled “primary prevention,” focuses on changing the attitudes and behaviors of the people who commit acts of sexual violence, as well as the surrounding community members who may support and encourage those attitudes and behaviors (CDC, 2004).

Primary Prevention

Definition of Primary Prevention

Primary prevention is based on the tenet that for true change to occur in the incidence of any type of social problem, prevention efforts must address, pre-emptively, communities and society as a whole, rather than focusing only on individuals affected by

the problem. The prevention of sexual violence requires changing existing conditions that either promote or fail to inhibit sexual violence to occur. In an effort to encompass the historical development of the field of primary prevention, Gullotta and Bloom (2003) proposed the following definition of primary prevention in the *Encyclopedia of Primary Prevention and Health Promotion*:

Primary prevention, as the promotion of health and the prevention of illness, involves actions that help participants ... 1) prevent predictable and interrelated problems, 2) protect existing states of health and healthy functioning, and 3) promote psychosocial wellness for identified populations of people. These consist of a) whole populations in which everyone requires certain basic utilities of life; b) selected groups of people at risk or with potential to be at risk; and c) indicated subgroups at very high risk. Primary prevention may be facilitated by increasing individual, group, organizations, societal, cultural and physical environmental strengths and resources, while simultaneously reducing the limitations and pressures from those same factors. (p. 13)

This strengths-based definition delineates primary prevention as efforts implemented on multiple levels within society, efforts that focus not only on the individuals who have already been affected by the problem, but also on those at risk for being affected and the population as a whole. The researcher used this definition of primary prevention in this study.

One of the central beliefs of primary prevention is that widespread diseases, disorders, and social dysfunctions cannot be reduced by efforts focused on those who have been already affected by the problem; rather, the problem must be addressed at its

source. George Albee, a psychologist central to the development of the field of primary prevention, stated that “no mass disease (disorder) in human history has ever been eliminated or significantly controlled by attempts at treating the affected individual” (1996, p. 4). In order for true change to occur, efforts must focus on the root causes of the problem.

Primary prevention has been used to address a range of such social problems. Since the establishment of the *Journal of Primary Prevention* in 1980, a significant amount of research has been published on a variety of primary prevention efforts, including adolescent substance abuse and mental health disorders. Although research has been done in the area of primary prevention, developing, implementing, and evaluating primary prevention programs is challenging for many reasons. Bloom (1981) stated, for example, that “primary prevention deals with problems that don’t exist, with people who don’t want to be bothered, with methods that probably haven’t been demonstrated to be efficacious, in problems that are multidisciplinary, multifaceted, and multigenerational, involving complex longitudinal research designs for which clear-cut results are expected immediately for political and economic reasons unrelated to the task in question” (p. 8). These challenges have contributed to a complex historical development of the field of primary prevention.

Historical Development of Primary Prevention

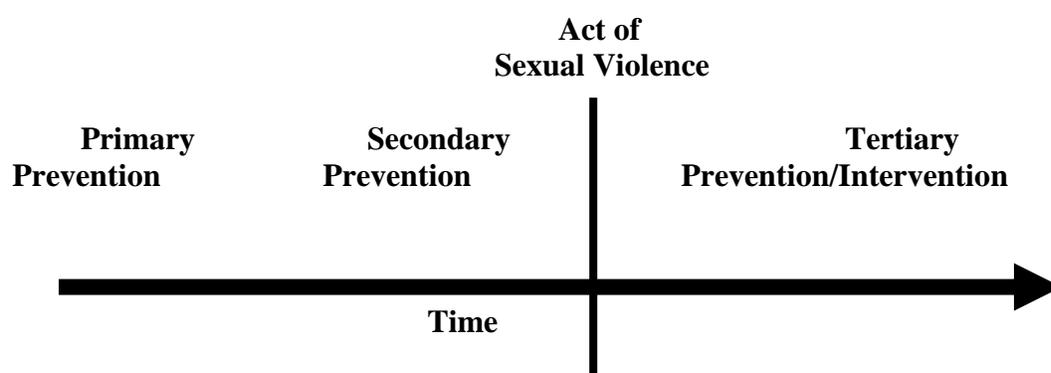
Public health and preventive medicine perspective. The field of primary prevention began in the 1950s and over time, four major advancements have emerged. Leavell and Clark provided the first major contribution, which was a basic public health definition of primary prevention. Leavell and Clark (1953) used the term “host” to refer

to a population of potential victims, “causal agents” to refer to the factors that cause the problems, and “relevant environments” to refer to the environments in which the former two interact. This perspective involved five preventive activities, including health promotion, specific protections, early recognition and prompt treatment, limiting disability, and rehabilitation (Gullotta & Bloom, 2003). Dominated by the medical model, this perspective emphasized physical illness and did not readily take into consideration social or psychological problems.

Levels of prevention. Caplan introduced the second major contribution to the field of primary prevention in his 1964 book *Principles of Preventive Psychiatry*, when he delineated primary, secondary, and tertiary levels of prevention. Since this delineation, these three levels of prevention have been consistently used as a tool to better understand the differences between prevention efforts. Caplan proposed that “primary prevention” seeks to prevent a particular behavior from occurring in the first place. Primary prevention efforts focus on reaching a whole population, and do not simply view one group of people as “high risk.” This type of prevention is least costly and most effective, as it removes the necessity of treating the effects of trauma after it has occurred (CDC, 2004). In the case of sexual violence “secondary prevention” seeks to treat someone after an act of violence has occurred, but before the ill effects have set in. In addition, this type of intervention focuses on short-term treatment of those who have been victimized or have committed acts of violence. These efforts are more costly and difficult to accomplish than primary prevention, as treatment is needed both for the victims as well as the perpetrators of sexual violence. Examples of secondary prevention include rape crisis intervention and short-term rehabilitation of sexual offenders (CDC, 2004).

“Tertiary prevention” seeks to change the behavior of perpetrators and treat victims’ long-term consequences (e.g., of having been sexually victimized). This level of prevention/intervention focuses on individuals who exhibit sexually violent behaviors and/or the victims of sexual violence. Such interventions are most costly and often the most difficult to achieve, as both offender and victim often require long-term intensive treatment (CDC, 2004). See Figure 1 below.

Figure 1: Primary, Secondary and Tertiary Levels of Prevention (Caplan, 1964)



Despite the importance of Caplan’s contribution, there is now increased awareness that secondary and tertiary prevention are not actually prevention, but rather try to minimize the ill effects of whatever problem is being discussed. In regards to sexual assault, secondary and tertiary prevention both take place after a sexual assault has occurred and therefore are not actually “preventing” the sexual offense from happening. Primary prevention, then, refers to stopping the occurrence of the problem in the first place; it is preventing the behavior that causes the ill effects that are addressed in secondary and tertiary prevention.

Strengths-based definition of primary prevention. The third wave in the history of primary prevention was a move toward a strengths-oriented definition of primary

prevention. In the 1970s, this development occurred as a reaction to the existing medical model/public health perspective. The 1975 Vermont Conferences on the Primary Prevention of Psychopathology and President Jimmy Carter's Commission on Mental Health influenced this progression. The Commission on Mental Health established the Task Force on Primary Prevention that produced a report providing a description and definition of primary prevention that differed qualitatively from the field's past dominant approaches. The report transitioned the definition of primary prevention from focusing on the reduction of deficits through therapy and rehabilitation to building on adaptive strengths, coping resources, and the healthy characteristics individuals already possess (Gullotta & Bloom, 2003). This stage in the development of primary prevention assumes that building on individual and societal strengths is the best way to ward off maladaptive problems, rather than trying to address problems that have already developed.

In addition to the work of the Taskforce on Primary Prevention, Cowen (1973) supported the progression towards a strengths-based perspective of primary prevention with his introduction of the concept of "wellness enhancement." Cowen argued that the effective enhancement of psychological wellness was as effective as disease prevention, and that each of these was preferable to the costly task of treating individuals one by one (Cowen; Gullotta & Bloom, 2003).

This wave in the historical development of primary prevention marked a movement away from a medical or disease-oriented model and toward a strengths-based perspective for change. This strengths-based definition of primary prevention differs from the earlier disease-focused, medical model of prevention in its emphasis on building on individuals' strengths and protective factors rather than trying to cope with the

aftereffects of the disorder or problem. Gullota and Bloom's definition of primary prevention used in this study reflects the strengths based perspective, as it focuses on protecting states of health, healthy functioning and promotes psychological wellness.

Social experience perspective. The fourth and final historical influence on primary prevention is the "social experience perspective." This perspective is based on Bandura's social learning theory, as well as the work of other social stress theorists, and argues that one's social environment has a significant impact on the development of a particular disorder. Albee (1982) developed the following basic equation: "the incidence of mental disorder is a function of organic factors plus social stresses plus social exploitation, reduced by the availability of personal competence, self-esteem and social support" (p. 1046). This perspective argues that disorders do not result from biological factors alone, but rather from social and environmental factors interacting with biological factors.

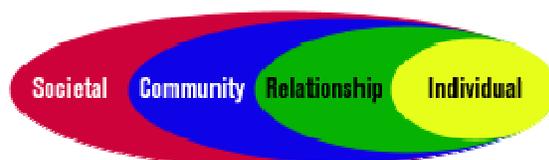
Summary. Although the roots of primary prevention were established in the 1950s, the field has progressed over time, and continues to evolve to this day. Despite the many transformations over the years, one fact that has remained stable is the idea that for prevention to be effective, efforts must focus not only on an individual level, but also on the larger social environment in which an individual is embedded.

Ecological Systems Theory

The Ecological Systems Theory likewise emphasizes that prevention must occur not only on an individual level, but also on community and societal levels. This theory, developed by Bronfenbrenner (1979), argues that it is important to examine not only the developing person, but also the person's environment and the interaction between the

person and the larger environment to best understand the cause of particular behaviors. Every individual is influenced by family, friends, and close associates, who are themselves influenced by the immediate community and society within which they reside. As stated by Bronfenbrenner, “the ecological environment is conceived as a set of nested structures, each inside the next, like a set of Russian dolls” (p. 3). Individual, relationship, community, and societal levels influence each other and do not develop independently. As a result, although sexual violence is perpetrated by an individual, violent behavior takes place in a sociocultural context (Koss et al., 1994). In this regard, social problems cannot be addressed by making changes only on an individual level. Instead, the Ecological Systems Theory asserts that the risk factors for sexual violence must be addressed on individual, relationship, community, and societal levels (see Figure 2).

Figure 2: Ecological Systems Theory (Bronfenbrenner, 1979)



Individual risk factors. Many aspects of an individual's attitudes and behaviors, personal characteristics, as well as past experiences, influence the risk of committing an act of sexual violence. Although often unstated, the most significant individual risk factor for using sexual violence is gender, as the vast majority of perpetrators are male (Koss et al., 1994; DOJ, 2006; OJA, 2004). Jackson Katz, one of America's leading anti-sexism male activists, often acknowledges that men are overwhelmingly the perpetrators of violence, although discussions of violence are often degendered. As he states in *The*

Macho Paradox, (2006), “When was the last time you heard someone, in public or private, talk about violence against women in a way that...put a sustained spotlight on men...? It is one thing to focus on the ‘against women’ part of the phrase; but someone’s responsible for doing it and (almost) everyone knows that it’s overwhelmingly men. Is it realistic to talk about preventing violence against women if no one even wants to say out loud who’s responsible for it?” (pp. 6-7). In 2004, men committed 93.3% of all sexual offenses in Wisconsin (OJA). Nationally, males also commit the majority of sexual offenses; males sexually assaulted 99.6% of the females victims and 85.2% of the male victims surveyed in the National Violence Against Women Survey (DOJ).

Beyond gender, other individual risk factors include the endorsement of rigid gender roles, hostility toward women, social isolation, depression, alcohol and drug use, violence in family of origin, coercive sexual fantasies, history of abuse as a child, and other attitudes and beliefs that are supportive of sexual violence (CDC, 2004; WHO, 2002). Compared to non-violent married men, maritally violent men are more rigid and gendered stereotyped and demonstrate greater difficulty developing intimate relationships based on mutuality and trust (Barnett & Hamberger, 1992). Other studies have found that affective dysregulation and antisocial/narcissistic tendencies are also more common among men who use violence against women (Murphy, Meyer, & O’Leary, 1991).

Relationship risk factors. Those in an individual’s closest social circle—her or his peers, partners, and family members—all shape that person’s behavior and experience, with the family playing a key role in both transmitting and perpetuating behaviors that may promote violence (Koss et al., 1994). Relationship risk factors thus include associations with people who support or tolerate gender-based violence, power and

control conflicts within relationships, patterns of poor interpersonal communication, male dominance in relationships or in the family, economic stress, emotionally unsupportive family environments, consideration of family honor as more important than the health and safety of the individual, attitudes of entitlement and male privilege, and role models for violent behavior, such as training within the military or in sports (CDC, 2004).

Witnessing domestically violent relationships between parents or caregivers during childhood is also predictive of sexually aggressive behavior among college men (Koss & Dinero, 1989; Malamuth, Sockloskie, Koss & Tanaka, 1991). In addition, research indicates that young people are much more likely to engage in negative behaviors when doing so is encouraged and approved by their friends (WHO, 2002). In support of the argument that peers influence one's propensity to use violent behavior, Gwartney-Gibbs, Stockard, and Bohmer (1983) found that men with sexually aggressive peers are much more likely to report coercive or forced intercourse in comparison to men who did not have sexually aggressive peers.

Community risk factors. Community environments such as schools, workplaces, and neighborhoods also shape an individual's behavior and beliefs. The degree to which a community is entrenched in its beliefs in male superiority and male entitlement to sex has a significant impact on the incidence of sexual violence in that community (WHO, 2002). Other factors that increase one's risk for using sexual violence include social and institutional tolerance of gender-based violence, attitudes and gender norms that support gender-based violence, gender-role socialization that promotes unequal power between men and women, lack of support from police and the judicial system, weak community sanctions against gender-based violence, poverty and economic inequality, and little or

no community engagement in prevention (CDC, 2004). In addition, other factors that contribute to high levels of violence include communities with high levels of residential mobility, a highly diverse population with little social “glue” to binds them together, and high population density (WHO, 2002).

Societal risk factors. Many societal factors also support the use of violence against women. Economic interests, social norms, cultural beliefs, laws and policies, institutional practices, and political ideologies all influence a society’s acceptance of violence against women. At the societal level, male violence against women is seen as a manifestation of gender inequality and as a mechanism for the subordination of women (Koss et al., 1994). Risk factors that contribute to gender-based violence at the societal level also include historical and societal patterns that glorify violence against women; traditional gender norms that support male superiority and sexual entitlement; economic and social policies that create or sustain gaps and tensions between groups of people; negative portrayals of women in the media; weak laws and policies related to gender-based violence, sexism, and homophobia; high levels of crime and other violence; war and militarism; and all forms of sexual exploitation (CDC, 2004). The saturation of our society with cultural norms on individual, relationship, community and societal levels that support the occurrence of sexual violence speaks to the need for the primary prevention of sexual violence.

Primary Prevention of Sexual Violence

Although researchers have used primary prevention to address many social concerns such as drug and alcohol use over the past few decades, until recently there has been minimal work on the primary prevention of sexual violence. However, that is

changing. The Rape Prevention and Education (RPE) Grant Program of the Centers for Disease Control and Prevention (CDC) provides more than \$42 million in funding to support rape prevention activities in all 50 states, 8 territories, and the District of Columbia (CDC, 2004). Until the 2006-2007 fiscal year, much of this money was used to provide “risk reduction” programming to potential victims. However, during the 2006-2007 fiscal year, the CDC mandated that all programs receiving Rape Prevention and Education Program funds begin to integrate primary prevention into their activities. This mandate requires that, rather than using risk reduction strategies, prevention efforts must focus on changing the attitudes, beliefs, and behaviors that contribute to a society that allows sexual violence to occur.

Despite this CDC mandate, there is still a great deal of confusion about how to apply primary prevention strategies to sexual violence. As previously discussed, it is challenging to develop a program that effectively changes the social norms that contribute to sexual violence when they are reinforced on a daily basis through years of socialization and familial learning. In addition, prevention efforts that are effective in one community are not necessarily effective in another community, given their different cultures and social norms. In order for any prevention effort to be successful, it must fit the social norms and belief systems of the community in which it is implemented. Out of this need to match prevention programs to specific communities arose the Community Readiness Model (CRM).

The Community Readiness Model

The Community Readiness Model (CRM) is a method of community assessment developed to ensure that prevention programs match the unique characteristics, social

norms, and belief systems of a particular community. The CRM provides a system of evaluation that assesses a community's level of readiness to adopt a particular type of prevention initiative. An assessment of community readiness is critical to the success of any primary prevention strategy because for the prevention efforts to be successful, they must match the culture and social norms of the community, as well as take into account its assets and limitations. A clear picture of the community's strengths and limitations will provide the opportunity for the prevention efforts to be built on the policies, programs, and interventions that are congruent with the goals of the prevention efforts (Jumper-Thurman, Edwards, Plested, & Oetting, 2001).

Theoretical Foundations of the CRM

A team of researchers from the Tri-Ethnic Center for Prevention Research at Colorado State University developed the CRM during the early 1990s. The theoretical model for community readiness is based on four underlying premises: First, every community is at a different stage of readiness for addressing a specific problem; second, this stage of readiness can be accurately assessed; third, communities can be moved through a series of stages to develop, implement, maintain, and improve effective programs; fourth, it is critical to identify the stage of readiness because interventions to move communities to the next stage differ for each stage of readiness (Edwards, Jumper-Thurman, Plested, Oetting & Swanson, 2000). Two research traditions: the transtheoretical model and community development models, inspired the theory of community readiness.

Transtheoretical model. The transtheoretical model, developed by Prochaska and DiClemente (1982), is a model of individual psychological readiness for change that

provided the CRM developers an example of how an individual moves through the process of implementing change. The model asserts that individual readiness is an essential component underlying the initiation of treatment, as well as the implementation and successful completion of that treatment (Prochaska & DiClemente, 1982). The model is comprised of five stages of readiness for individual psychological treatment: the pre-contemplation stage, the contemplation stage, the preparation stage, the action stage, and the final maintenance stage.

During the pre-contemplation stage, an individual has minimal awareness of the problem and as a result, has no intent to change. At contemplation, an individual is aware of the problem, is intending to make changes in the near future, and is weighing the costs and benefits of making those changes. In the preparation stage, an individual intends to take action to make changes in the immediate future. At the action stage, individuals have implemented the proposed changes and are making significant modifications to their lifestyle. During the maintenance stage, the individual is working to prevent a return to the previous behavior (Prochaska, 1999; Prochaska & DiClemente, 1982).

The Tri-Ethnic Center used the transtheoretical model as a reference point during the development of the CRM, and aspects of it were retained in the CRM. For example, the developers of the CRM translated the implementation stage of the transtheoretical model into the "initiation" stage of the CRM. In addition, the community readiness model incorporated the use of "Guttman Scales" as is present in the transtheoretical model. The Guttman Scales are a scaling technique in which each stage incorporates and retains the content of all prior stages. For example, if a community is at a "seven" on the stages of readiness, the use of Guttman Scales implies that the community has met all of the anchor

rating scales of the previous six stages, and has not met the anchored ratings of stages eight and nine.

Community development. Despite the usefulness of the transtheoretical model as a theoretical framework to understand individual processes of change, the researchers from the Tri-Ethnic Center recognized the need for a model to illustrate the change process of communities. Although some parallels exist between individual and community change, communities are obviously comprised of groups of individuals, and thus require a model that takes into account the various ways in which a community can be ready to make changes.

Two other influences on the development of the CRM, then, came from the field of community development. The first influence came from Rogers (1983), who developed what he called an “innovative decision-making process” The innovative decision-making process describes how a group decides whether to accept or reject a new concept, project, or “innovation.” This model is also comprised of five stages. The first stage consists of the initial knowledge or awareness of the concept, project, or innovation. In the second stage, the group forms an opinion or attitude about the innovation. During the third stage, the group decides whether to adopt or reject the innovation. If the group decides to adopt the innovation, the fourth stage involves the implementation of the innovation. The fifth and final stage is the decision about whether the group wants to continue or discontinue the innovation. (Rogers, 1983).

This model provided the developers of the CRM a framework to understand how groups make decisions about the adoption or rejection of a new concept, program, or innovation. However, the decision-making model does not define all of the stages of

community readiness, and it does not adequately characterize the multidimensional nature of community readiness (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000).

A second community development influence on the development of the CRM was Warren's (1978) theory of social action, which illuminates the processes groups go through as they acknowledge the need for, and choose to implement, changes in a community. The social action approach involves five stages, beginning with "stimulation of interest," in which the community recognizes the need for a new idea. The second stage, "initiation" involves the proposal and promotion of a new idea. "Legitimization," the third stage, involves the local leaders' acceptance of the need for change. The fourth stage is the "decision to act," and involves a network of community members developing specific plans to implement the new idea. The fifth and final stage, "action," involves the actual implementation of the new idea (Warren, 1978).

The theory of social action was useful in the development of the CRM in that it incorporated group characteristics and took into account the complexity of group versus individual change. In particular, the CRM incorporated the theory of social action's emphasis on the need for collective social action to enact change. This philosophy was incorporated into the CRM as evidenced by the CRM's utilization of key respondents from a variety of professional realms including law enforcement, education and the medical field.

Summary. The transtheoretical and the two community development stage models provided a framework to understand individual and community change processes. However, these models were inadequate in describing several important community

processes. Namely, they did not provide a mechanism for defining a local problem, a method of how a community decides whether or not to take action, nor a consideration of the modification or expansion of existing programs (Donnermeyer, Plested, Edwards, Oetting, & Littlethunder, 1997). The CRM was thus developed in an attempt to address the limitations of these theoretical frameworks.

Dimensions of the CRM

The heart of the Community Readiness Model (CRM) is the six dimensions that describe a community's readiness to address a specific problem. The six dimensions are Community Efforts, Community Knowledge of Efforts, Leadership, Community Climate, Knowledge about Issue, and Resources (see Appendix A).

The first of these dimensions (Community Efforts) pertains to the current efforts in the community to address the problem. This dimension addresses the strengths and weaknesses of the current efforts, whether all segments of the community are able to access these services, and what formal or informal policies, practices, and laws address the problem in the community. This dimension thus assesses whether or not a community has programs and activities that focus on addressing the particular issue, whether or not those efforts are successful, and how well those efforts meet the varying needs of the community. For example, in regard to sexual violence, some communities have well-established rape crisis programs which have been in existence since the 1970s, whereas other communities have either newly established or no such programs. The stability and longevity of these efforts affects the community's readiness to address the issue.

The second dimension, "Community Knowledge of Efforts," relates to the general community members' level of awareness of what efforts are in place to address the

problem. In addition, this dimension addresses how the community views the policies, practices, and laws that address the problem. This dimension, then, assesses the community's general awareness level of the local efforts to address the issue. For example, a community may have a well-established and well-staffed sexual assault prevention program; however, for whatever reason, the community may be largely unaware of its existence or reluctant to engage in its initiatives.

The third dimension focuses on the "Leadership" in the community. This dimension identifies the particular leaders in the community relevant to the problem, and also assesses the degree to which political and other community leaders are concerned about and involved in working on the problem. This dimension examines the degree to which leaders (mayors, judges, county executives, police chiefs, etc.) in the community are educated about, and sensitive to, an issue. In addition, it assesses the strengths of the leaders who work on the particular issue. Leaders have the power to set the official and unofficial agendas in a community and thereby to influence the community's beliefs regarding a particular issue. For example, if a judge in a community has a daughter who was sexually assaulted, he or she may be more knowledgeable about and sensitive to sexual violence. As a result, he or she may set a norm within the community that sexual violence is something that needs to be addressed and prevented. This belief will likely have a trickle-down effect on the community at large and affect its readiness to accept prevention efforts.

The fourth dimension is "Community Climate," or the community's attitude toward the problem and the obstacles that may exist in addressing the problem within the community. This dimension also addresses under what circumstances members of the

community may believe that the problem should be tolerated. This dimension thus refers to the community's general belief system and set of mores that influence understanding of, and willingness to address, the issue. For example, a small rural community may be more reluctant to accept that sexual violence occurs at high prevalence levels, and therefore may not be interested in allocating resources to its prevention. On the other hand, a large urban community that has received education on sexual violence may be more informed of its high incidence levels, and as a result, may be more ready to take steps to prevent it. This difference in community climate influences the degree to which each community sees a particular issue as a priority, and influences its readiness to prevent the issue.

The fifth dimension, "Knowledge of the Issue," focuses on how knowledgeable community members are about the problem, what local data are available regarding the extent of the problem, and how people in the community gain information about the problem. This dimension assesses a community's base level of knowledge about an issue, which in turn, influences its readiness to establish and support efforts to prevent the issue. For example, if a community has a low level of knowledge of sexual assault and underestimates the rates of its occurrence, it will be much less likely to support prevention efforts. However, if a community is widely informed about the prevalence rates of sexual violence and the severity of its impact, it may be more likely to support efforts to prevent its occurrence.

The last dimension, "Resources," describes what assets the community offers to support efforts to address the problem. Resources include services available to people affected by the problem, financial avenues to support community efforts, volunteer

involvement in supporting these efforts, and the business community's attitude about supporting these efforts. Communities differ in their degree of financial and in-kind support. Some communities may enjoy strong financial support from local, state, or federal sources to engage in prevention efforts, whereas others struggle to obtain any funding at all. In addition, communities vary in the degree to which members are willing to help prevent an issue through volunteering or other personal contributions. These differences have an important impact on a community's readiness to address an issue.

Stages of Readiness

The six dimensions of the CRM are assessed through interviews with individuals from the community who are knowledgeable about the issue. The resulting data are then assessed and placed along a continuum of readiness. The CRM defines nine stages of readiness, ranging from "no awareness" of the problem to "professionalization/high level of ownership" of the problem. (see Appendix B). The following section describes the nine stages of community readiness, and provides information about the goal of each stage and possible strategies to increase a community's readiness level at each stage.

The first stage of community readiness is "No Awareness." At this stage, the community generally does not recognize that there is a problem. In fact, at this stage the community climate may unknowingly encourage the behavior (Edwards, Jumper-Thurman, Plested, Oetting, & Swanson, 2000). If it is determined that the community is at the first stage of readiness, the initial goal is to begin to raise awareness of the problem. This can be done through one-on-one visits with community members and leaders, meeting with small groups to provide information and answer questions about

the problem, and establishing personal contact with potential supporters within the community.

The second stage of readiness is “Denial and Resistance” in which there is little to no recognition of the problem within the community. Although there may be some recognition that the problem exists elsewhere, there is a belief that the problem does not exist in that particular community. Any recognition that the problem does exist locally is often met with a sense of ambivalence about whether anything could be done about reducing its incidence. At this stage, statements are made such as “it’s not our problem, it’s just those people who do that” or “we can’t do anything about it.” The goal of this stage is to raise awareness that the problem exists locally and that it should be addressed. Strategies to increase readiness at this stage include continuing to make personal contacts with potential supporters, highlighting descriptive local examples of the problem, enlisting the help of the local newspaper to print articles that describe local circumstances relevant to the problem, preparing and submitting short articles to community newsletters, and making short presentations to local community groups.

“Vague Awareness” is the third stage of readiness. This stage is marked by a sense that there may be a problem in the community and that something should be done about it, but there is little motivation actually to do anything. Within this stage, community members do not have a clear sense as to how or why the problem is occurring, and there is little leadership to address the problem. Here, the goal is to raise awareness that the community can do something about the problem. Methods to support this effort include presenting information at local community events and to local community groups about what needs to be done to address the problem; using low-key

media such as flyers and posters with messages that address the goal of increasing motivation to do something about the problem; initiating events to present information on the problem; conducting informal surveys and preparing letters to the editor about the problem and what needs to be done to solve it.

The fourth stage of readiness is “Preplanning.” Within this stage, the community recognizes that there is a problem locally, and the community members share a belief that something should be done about it. There are usually identifiable leaders and/or a committee or group of people who are working on the problem. However, the efforts of these individuals or groups are not focused or detailed. Here, the community climate is beginning to acknowledge the necessity of dealing with the problem (Edwards et al., 2000). The goal of this stage is to raise awareness about concrete means through which the community can do something about the problem. Such methods include gaining support from community leaders, reviewing existing efforts in the community, and increasing media exposure through radio and television public service announcements and interviews.

“Preparation” is the fifth stage of readiness. At this stage, the community is planning how to address the problem. In addition, information is available regarding how the problem affects the community locally, as well as various possible prevention activities, actions, or policies to address the issue. There is active, focused, and energetic leadership regarding the issue. During this stage, the community climate offers at least modest support of efforts (Edwards et al., 2000). The goal of the fifth stage is to gather existing information to help plan strategies to address the problem. This can be done through conducting surveys regarding the prevalence of the problem, presenting

information on local statistics to community groups and leaders, determining and publicizing the costs of the problem to the community, and developing public forums to develop strategies to address the problem.

The sixth stage of readiness is “Initiation.” At this stage there is enough local information about the problem to justify significant prevention efforts. These prevention activities are underway, but they are still viewed as new efforts. At this stage there is usually no active resistance and there is often a modest involvement of community members in the efforts (Edwards et al., 2000). The goal of this stage is to provide community-specific information about the problem. This involves conducting in-service trainings for professionals and paraprofessionals, planning publicity efforts, completing a needs assessment of community resources, and researching possible community resources to support efforts to address the problem.

“Stabilization” is the seventh stage of readiness, and here a few programs or activities are being run and, overall, the programs experience support from community leaders. The individuals who address the problem are well trained, and the efforts are well established. Within this stage there may be some awareness of limitations of the prevention efforts, but formal evaluation of the efforts is not currently being conducted. At this stage, the community climate generally supports and encourages the prevention efforts. The goal of this stage of readiness is to stabilize efforts within the community by holding community events to maintain support for the efforts, providing trainings to community professionals and members, implementing a program evaluation of the efforts, reviewing progress and modifying strategies, and networking with other service providers and community systems.

At the eighth stage of readiness, that of “Confirmation/Expansion,” there are standardized efforts in place and the community leaders support expanding and improving the efforts. The original efforts have been evaluated and revised, and new efforts are being explored and planned. Data regarding the problem are regularly collected, and ongoing evaluation is occurring. At this stage the community is fundamentally supportive of the efforts, but may challenge specific efforts in a desire for improvement (Edwards et al., 2000). The goal at this point is to expand and enhance the existing services through formalizing community relationships via memoranda of understanding, preparing a community risk assessment, publishing a localized program service directory, maintaining a database of statistics on the problem in the community, developing a speaker’s bureau, attempting to initiate policy change through support of local city officials, and conducting media outreach efforts on specific data and trends related to the problem.

During the ninth and final stage of readiness, “Professionalization” or “High level of community ownership,” there is detailed knowledge regarding the prevalence, risk factors, and causes of the problem. Efforts to address the problem are strategic, and some programs aim to address specific risk factors and/or high-risk groups. The staff who work on the problem are highly trained, and the community leaders and members are involved in, and supportive of, the efforts. Thorough and effective evaluation occurs at this stage, and the results of the evaluations are used to modify and expand the programs. The community climate is fundamentally supportive at this stage; however, community members are committed enough to the issue to hold the programs accountable (Edwards et al., 2000). The goal at this stage is to maintain momentum and continue growth

through soliciting financial support from local and statewide sources, providing advanced training of professionals, continuing to assess the prevention efforts, and modifying the efforts through obtaining feedback from external evaluators.

Distinction between the dimensions and stages. One issue raised about the CRM is that the delineations between each of the dimensions and each of the stages are not fully distinct. For example, the first dimension is “Efforts,” and the second dimension is “Knowledge of Efforts.” The first dimension pertains to what efforts objectively exist in a community; the second dimension pertains to the general community members’ knowledge of those efforts. While these dimensions do assess for different information (presence of efforts versus the general community’s knowledge of those efforts), this distinction may be challenging to ascertain through the interview data, particularly when the key respondent speaks of the efforts from her/his own knowledge base rather than explicitly separating out that knowledge from the general community’s knowledge of those efforts. For example, a key respondent may be very knowledgeable of the efforts that are available in the community and speak fluently of those efforts, but may not clearly state in the interview her/his belief about whether that knowledge is shared among the general community members. In addition, it is hard to determine whether the key respondent’s knowledge of the efforts and her/his perception of the community’s knowledge of those efforts are an accurate and unbiased portrayal. For example, a key respondent may perceive that the community in general is very knowledgeable of the efforts available, but this perception may be based on biased opinions of the community and/ or anecdotal information.

In addition, the CRM's use of nine stages of readiness decreases the distinctiveness between each of the stages. For example, if the CRM only had three or four stages (No awareness, Initiation, and Professionalization, for example), the differences between those stages would likely be more distinct. For instance, if there were only three stages, the data that were intended to encompass nine stages would be collapsed into three stages. The first stage would hold all the data that were intended to fit under stages 1-3 (No Awareness, Denial and Resistance and Vague Awareness), the second stage would contain all the data that were intended to fit in stages 4-6 (Pre-planning, Preparation and Initiation), and the third stage would contain all the data that were spread over stages 7-9 (Stabilization, Confirmation and Expansion and Professionalization). This collapsing of the data from nine to three stages would create greater distinctions between the three stages. However, this collapsing of the stages would result in a corresponding loss of richness to the data. Thus, the developers of the model structured the CRM with nine stages to ensure that the stages of readiness provide as unique and specific information about the community as possible. Despite the value of the subtlety this brings, it does result in some ambiguity between the stages, as well as challenges in allocating the interview data to the appropriate stage. For example, the scorers use an anchored rating scale for each dimension to determine its appropriate stage of readiness. The differences between the anchored ratings for some of the dimensions are not as discrete as they would be if there were fewer stages. As a case in point, for Dimension B, "Community Knowledge of the Efforts," the anchored rating for stage three is: "a few members of the community have heard about the efforts, but the extent of their knowledge is limited." The anchored rating for stage four of this dimension is:

“some members of the community know about local efforts” and the anchored rating for stage five is “members of the community have basic knowledge about local efforts.”

Although these three statements cover three stages of readiness (Vague Awareness to Preparation), the potential for overlap between these stages is readily apparent. The statements speak of “a few,” “some,” and “members” of the community having knowledge of the efforts available. The differences between “a few,” “some,” and “members” are hard to quantify and are largely up to the subjective perceptions of the scorers. As a result, it is important to note the frequent fluidity and overlap between the dimensions.

Key Respondents

In the CRM, the researcher interviews “key respondents” to gain information about a community’s readiness to address a problem. Key respondents are used to gather information in two main areas. The first is to characterize the state of knowledge and attitudes of a particular community, and the second is to assess the community’s existing structural capacity to implement a particular type of prevention strategy. The key respondent method is useful in gaining information on the needs and characteristics of a particular community and has been successfully used in the area of needs assessment (Apont, 1978; Hagdorn, 1976; Warheit, Bell, & Schwab, 1977). Within the context of the CRM, a key respondent is someone from the community who is either knowledgeable about the issue being studied, or is in a position of authority within the community. A key respondent is a person who knows the community and can provide specific data about what is happening in that community (Oetting, Jumper-Thurman, Plested & Edwards, 2001). The CRM recommends that between five and seven key respondents are

interviewed within each community assessment. The CRM recommends selecting representatives from various professional systems within the community to serve as key respondents. These respondents include representatives from the school system, law enforcement, the legal system, mental health/social service systems, the medical system and the community at large.

The researcher selects possible key respondents in one of two ways. First, a key respondent may be selected simply because she or he holds a position of authority in the community. Beyond such individuals' authority via their role, the degree to which they are informed of significant social issues provides information about that community's level of readiness to address the issue. For example, the level of knowledge that the local District Attorney, who has the authority to represent sexual assault victims and prosecute sex offenders in criminal court, has about the issue of sexual violence may reflect how sexual violence is seen in the larger community. These key respondents do not necessarily need to be "experts" on the topic; rather, they simply need to be in a position that would allow them to be informed on the issue.

The second method of selecting key respondents is the reputational method of recruitment. This involves the researcher asking community members to identify people in the community who are knowledgeable or influential relative to the issue of sexual violence within the adolescent population. For example, the researcher may contact a police chief and ask that individual whom she or he would recommend within her or his department as someone who has some knowledge or experience in working on sexual assault cases and who could possibly serve as a key respondent.

Interview Process

The semi-structured interview (see Appendix C) is composed of approximately 30 questions, arranged according to the six dimensions of the CRM. The interview questions relate to the community's efforts to address the issue of sexual violence, its knowledge of those efforts, the leadership in the community to address sexual violence, the community climate in regards to sexual violence, its knowledge of the issue and the resources that are available to implement sexual violence prevention strategies.

For example, the first dimension pertains to the prevention efforts that already may exist in a community, and the second dimension involves awareness of those efforts. The next set of questions pertains to the third dimension in the model, that of "Leadership." This format continues throughout the interview, with the last set of questions comprised of questions that reflect the last dimension of the CRM, that of "Resources."

Evaluation of the CRM According to Quantitative and Qualitative Standards

The reliability and validity of the CRM have not yet been fully established, at least in part because it is a new model that it is still being developed and refined. Despite its relative early stage of development, some researchers have criticized the process of its development. Beebe et al. (2001) stated that the CRM:

Was not developed or evaluated using accepted psychometric principles. Instead, the authors relied solely on qualitatively oriented reviews. Although these are necessary components of instrument development and evaluation, they are not sufficient; the authors did not evaluate the dimensionality of domains identified through this process once the instrument was fielded...[in addition] the anchored

rating scale technique... allows interviewers a fair amount of discretion in scoring the responses. Last, there was no attempt to establish the external validity of the instrument, that is, to determine whether the instrument actually measured a community's readiness for change as assessed independently. (p.57)

To counter such criticism, the developers of the model have argued that when possible, they have taken efforts to establish its reliability and validity. In addition, they assert that given the qualitative nature of the data produced by the model, it is challenging to conduct such tests of reliability and validity (Plested, Edwards & Jumper-Thurman, 2006). The following sections report how the developers of the CRM have attempted to establish the model's reliability and validity according to a quantitative framework, and then discuss how the model compares to standards of assessment for qualitative methods.

Evaluation of the CRM According to Quantitative Standards

Although there has been some criticism about the lack of research on the reliability and validity of the model, the developers of the CRM state that it is hard to establish the reliability and validity of a measure that assesses constructs that vary with each application. For example, the CRM assesses the extent of knowledge and degree of support within a particular community to address an issue at a given point in time. The developers state that it is challenging to apply standard techniques for establishing the validity and reliability of a model when the "community" and the "issue" being examined change from application to application. The developers also argue that each application of the CRM is unique, and as a result, it is not likely that the constructs that the CRM is measuring have been assessed by other measures, making it difficult to establish the model's validity (Plested, et al., 2006). Despite these challenges, some attempts have

been made to establish the reliability and validity of the tool, both during its development and after its completion.

Inter-rater reliability. Some efforts have been taken to establish the inter-rater reliability of the CRM. As previously discussed, the transcripts of the CRM interviews are scored independently by two scorers to obtain the level of community readiness within each dimension. One attempt to establish the inter-rater reliability of the tool involved comparing the degree to which the two scorers chose the same stage of readiness for each dimension across 120 interviews pertaining to communities' stages of readiness to accept prevention initiatives. The results of this assessment indicated that the scorers selected the same stage of readiness 92% of the time across the 120 interviews (Plested, et al., 2006). This high level of agreement speaks to the inter-rater reliability of the tool.

Content validity. Efforts were taken during the development of the CRM to ensure content validity of both the anchor rating statements and the dimensions that comprise the model. The developers of the CRM asked experts (psychologists and sociologists with extensive experience working in communities) to develop a list of descriptive statements that represented community attitudes and behaviors that they believed were related to the readiness of a community to accept a new initiative. These descriptive statements were the basis of what became the anchor rating statements. The experts were asked to place each of these anchor rating statements on one of the proposed CRM dimensions. At first, the experts could not consistently place the anchor rating statements on certain dimensions, and so some of the dimensions were redefined, combined with other dimensions, or dropped. This review process continued through several rotations until the

raters could consistently place specific anchor statements on specific dimensions. The developers of the model argue that this contributes to the content validity of the tool (Edwards, et al., 2000).

Discriminant validity. The developers of the CRM stated that they evaluated the discriminant validity of the tool using a similar method as that used to assess content validity. The developers of the CRM constructed a preliminary set of stages of community readiness. The anchor statements that had been selected as reliable for a specific dimension were randomized and provided to sociologists and psychologists familiar with community development. These “experts” were asked to place the statements anywhere on the continuum of the stages. If the anchor statements could not be reliably placed at a particular stage or if they were placed on more than one dimension, the anchor statements were either revised or discarded. Following completion of this process, the raters were able to consistently place anchors at a particular stage, suggesting discriminant validity of both the stages and the anchor statements (Edwards, et al., 2000). Information on the degree of accuracy with which the experts could consistently place the anchor statements has not been provided by the developers of the model.

Construct validity. The developers of the model stated that it is challenging to establish the construct validity of the CRM, because the CRM is a broad scale theory that encompasses a large number of different phenomena (such as facts or opinions) and a very large number of possible relationships among those phenomena. The developers stated that “although it is not possible to have a single test to establish construct validity for a broad scale theory, it is possible to test hypotheses that derive from the theory, and

if the hypotheses prove to be accurate, then the underlying theory and the instrument used to assess the theory are likely to be valid” (Plested, et al., 2006, p. 65). The developers of the model asserted that this approach has been taken during the development of the model and that the “construct validity of the model has been demonstrated” (Plested, et al., p. 65). Unfortunately, the specifics as to how the construct validity of the model has been supported are not provided by the developers of the model.

Face Validity. In place of providing information on statistically supported levels of reliability and validity of the model, the developers of the model often point to the general acceptance of the model by professionals across the country, which speaks to the face validity of the CRM. Plested, Edwards and Jumper-Thurman (2006) stated, “Although it is not a scientific demonstration of validity, the widespread acceptance and the breadth of application of the model lends credence to its validity” (p. 65). The developers likewise argue that despite the model’s recency, it has been readily accepted and used as an essential element in prevention program implementation. Researchers have used model in a variety of projects, including AIDS prevention, domestic violence prevention, elimination of heart disease, and the reduction of sexually transmitted infections (Plested, et al.).

Beyond these applied uses of the CRM, researchers have used the model as a tool in a wide range of research studies. One such study examined a community’s readiness to promote Latinas’ participation in breast cancer prevention (Lawsin, Birrayo, Edwards, & Belloso, 2007). This study found that the assessed community climate did not recognize breast cancer as a health problem affecting Latinas and that leadership did not identify or allocate resources to encourage Latinas’ participation in breast cancer prevention trials.

The results of this study provide a better understanding of why there was low participation of Latinas in breast cancer clinical trials within the assessed communities.

A second research study examined the role of the CRM in a randomized group trial, testing the impact of a participatory community- media intervention on substance use (Slater, et al. 2005). The researchers used the CRM assessments as a source of data about the communities and as an evaluation tool. Results of the nested, random effects analysis indicated that the media intervention used in the communities influenced the level of community knowledge of efforts to prevention substance use and improved prevention leadership quality and community climate supportive of the substance use prevention efforts.

Beyond these examples of applied uses of and research studies on the CRM, hundreds of professionals around the country have received workshops on the model (Plested, et al., 2006). This widespread use, and acceptance of, the model again speaks to the face validity of the CRM.

Evaluation of the CRM According to Qualitative Research Standards

One of the inherent challenges with the CRM is that, while the data it produces are qualitative (i.e. interview data), its developers have attempted to establish the model's reliability and validity according to quantitative standards. Thus, as noted above, they report on its inter-rater reliability and content validity, and discuss its discriminant, construct, and face validity. However, these concepts are better suited to support the psychometric properties of a purely quantitative instrument.

The reliability of a model that produces qualitative data, such as the CRM, is more appropriately evaluated by a different set of standards, such as those outlined by

Morrow (2005) regarding the *trustworthiness* of qualitative research. Morrow discussed four concepts, which help to establish the trustworthiness of qualitative research: credibility, transferability, dependability, and confirmability. Although the developers of the CRM did not evaluate the model according to these qualitative standards, it is beneficial to do so to gain a broader perspective of the value of the model.

Credibility. Credibility is the qualitative parallel to internal validity in quantitative research, and has been defined as “how we ensure rigor in the research process and how we communicate to others that we have done so” (Gasson, 2004, p.95). Morrow (2005) asserted that credibility is established through “prolonged engagement with participants, persistent observation in the field, the use of peer debriefers or peer researchers, negative case evaluation, researcher reflexivity, and participant checks, validation or coanalysis” (p.252). Morrow (2005) also spoke of the usefulness of “thick descriptions,” which consist of rich and detailed accounts of the participants’ experiences as well as the broader contexts in which those experiences occur. Based on these criteria, the developers of the CRM only make a few provisions to establish the credibility of the model. The model does require the use of two scorers to analyze and score the data, which may be comparable to the concept of using peer researchers. Beyond this, however, the developers of the model do not include other stipulations to establish its credibility. For example, the model does not recommend that the researchers engage in prolonged exposure with the participants or engage the participants in coanalysis. Furthermore, the only source of data required by the model is interview data, and no other efforts are made to triangulate these data, such as through the use of observations,

case notes, or other outside sources. This lack of supporting data makes it difficult to render a “thick description” of each participant’s experience.

Transferability. Transferability in qualitative research has been compared to external validity or generalizability in quantitative research. Transferability refers to the degree to which a reader is able to generalize the findings of a study to other contexts and the degree to which the researcher can assert general application of her or his theory (Gasson, 2004; Morrow, 2005). Transferability is achieved when a researcher “provides sufficient information about the self (the researcher as instrument) and the research context, processes, participants, and researcher-participant relationships to enable the reader to decide how the findings may transfer” (Morrow, 2005, p. 252).

The developers of the CRM do not require researchers to provide information about themselves as researchers, nor about the researcher-participant relationships. The CRM also does not explicitly require the researchers to describe the research context or processes. However, given the structured step-by-step guidelines of the CRM handbook, the developers provide a framework for the processes of the research, with the underlying assumption that these processes are consistent across applications of the model. The inclusion of basic information about the participants (demographics, occupation, etc) is a component of the CRM procedures, and is an element of transferability in that it provides future researchers information about how their populations of interest may compare to past participants. For example, if a researcher is interested in assessing the stage of readiness of a community to accept programs aimed at reducing teenage smoking, it may be helpful for the researcher to know the basic demographics of participants in past

similar studies in an effort to gain an understanding of how those participants may compare to possible participants in their community of interest.

Taking a broader perspective on transferability, the developers of the CRM assert that every application of the model is unique (Plested, et al., 2006). This suggests, according to the developers, that the results of the CRM are not transferable across communities. However, the fact that the authors developed a model that describes stages of community change implies that they believe that every community, regardless of its unique characteristics, goes through a similar process of change. Without this theoretical assumption, there would be no basis to construct a model. Therefore, despite the fact that each community is distinct and each application of the CRM is unique, the developers of the CRM propose that the processes of change underlying each community's readiness to address a given issue are transferable across communities (Kelly et al., 2003).

Dependability. Qualitative researchers use the concept of dependability as a parallel construct to reliability, which asserts that researchers should conduct a study in a way that is “consistent across time, researchers, and analysis techniques (Gasson, 2004, p. 94). Morrow (2005) asserted that “this is accomplished through carefully tracking the emerging research design and through keeping an audit trail, that is, a detailed chronology of research activities and processes; influences on the data collection and analysis; emerging themes, categories or models; and analytic memos” (p. 252). Other researchers in the field can then review this audit trail when replicating the method to ensure that they conduct the research in a consistent manner.

The developers of the CRM provide for the model's dependability through the creation of the CRM Handbook (Plested et al., 2006). This Handbook provides

researchers step-by-step information about how to conduct a CRM assessment in their chosen communities. The Handbook helps ensure that researchers are able to consistently implement the model across communities and settings. While the Handbook contributes to the dependability of the model, the developers did not stipulate that an audit trail be a component of the CRM, and there is no required documentation of the influences on data collection and analysis. The inclusion of an audit trail and other documentation of the influences on the research process would have provided a transparency to the CRM research process that does not currently exist.

Confirmability. One can compare the concept of confirmability to “objectivity” in quantitative research. Confirmability is based on the assertion that research “findings should represent, as far as is (humanly) possible, the situation being researched rather than the beliefs, pet theories or biases of the researcher” (Gasson, 2004, p. 93). Morrow (2005) asserted that this can be done through acknowledgement of the above mentioned audit trail and the “management of subjectivity” (p. 252).

As previously mentioned, the CRM does not include an audit trail, and does not require or suggest that the researchers document any personal information which may bring bias into the research process. The developers do attempt to control for the researchers’ bias, particularly one’s bias towards a given community, by suggesting that someone external to the assessed community conduct the interviewing and scoring. The use of independent scorers institutes a safety mechanism for controlling the impact researcher bias may have on the scoring process. Beyond these steps, however, the developers of the model do not explicitly recommend methods of ways managing researcher bias.

Summary of the CRM in Comparison to Quantitative and Qualitative Standards

The above sections outlined how the CRM compares to standards of quantitative and qualitative research. As discussed, the CRM meets some of the standards set by both of these research methods, but does not fully reach either of them. In addition, rather than outwardly stating that the model is qualitative in nature and establishing its credibility according to qualitative standards, the developers of the model attempt to place it within a quantitative framework and report on how it does (and does not) reach these quantitative standards (through discussing the model's reliability and validity). Despite these challenges, the model has been used by hundreds of community prevention programs and researchers and is viewed as a valuable component of community assessment (Beebe, 2001; Kelly, et al., 2003).

Primary Prevention of Sexual Violence and the CRM

The principles of primary prevention fit well with the Community Readiness Model. Primary prevention asserts that sexual violence does not occur because of individual characteristics alone. Rather, social norms, family culture, and community climate interact with individual characteristics and influence an individual's likelihood to commit acts of sexual violence. Researchers must examine the entire social system in order for any significant reduction in sexual violence to occur. The CRM provides a mechanism to examine the larger social system and tailor the primary prevention efforts to match their level of readiness.

For true change to occur, then, researchers must examine the community to understand the particular factors that may contribute to sexual violence. Sexual violence is a societal and community problem; therefore, strategies that target individuals are

insufficient, and instead the community as a whole must address the problem (Coker, 2004). The Community Readiness Model facilitates the assessment of the community so that researchers can develop and implement primary prevention strategies that fit the community's level of readiness, and will then increase their chance of success.

CHAPTER III: METHOD

Defining the Communities

The first step to complete this assessment was to define the targeted communities by geographic and demographic characteristics. The CRM defines “community” as where residents experience their society and culture (Edwards, et al., 2000), and state that a community can be as small as an organization or as large as a city. The CRM asserts that researchers must clearly define the community to ensure that the person or organization implementing the prevention strategies can tailor them to fit the community’s unique characteristics. For the purposes of this study, the researcher completed assessments in two communities in Racine County, Wisconsin: “rural Racine County” and “urban Racine County.”

Racine County has a total population of 195,146, and is located on the shores of Lake Michigan, 30 miles south of Milwaukee and 60 miles north of Chicago. Racine County is the “6th smallest county in Wisconsin by size, the 5th largest county by population, and has the state’s 3rd highest population density at 566.9 people per square mile.” (http://www.racine.org/about_racine.html, retrieved 6.12.09). The county is comprised of two cities, seven villages, and nine towns. Interstate 94 divides the county in two parts, “eastern Racine County” and “western Racine County.” Eastern Racine County is comprised of the city of Racine and its surrounding towns and villages; Western Racine County is comprised of the city of Burlington and its surrounding towns and villages. Residents in Racine County traditionally view these two communities as distinct. For example, these two parts of the county have unique characteristics, demographics, industries, and culture. Eastern Racine County experiences higher rates of

crime and poverty, is more ethnically diverse, and has a lower median household income in comparison to western Racine County (See Table 1 below). As a result, dividing the county into eastern (urban) and western (rural) segments provides for a natural distinction as two “communities” within the CRM.

Table 1 Demographic Differences Between Rural and Urban Racine County

Demographic Variable		Rural Racine County-City of Burlington	Urban Racine County- City of Racine
Population		9,936	80,503
Race	Caucasian	95.9%	68.9%
	Hispanic/Latino	4.6	14%
	African American	.4%	20.3%
	Asian	.6%	.6%
	American Indian/ Alaskan Native	.1%	.4%
Median Household income		\$43,375	\$37,163
Poverty level for individuals		5.1%	13.9%

(<http://quickfacts.census.gov/qfd/states/55/55101.html> retrieved 6.12.09)

Rural Racine County. The researcher defined the western portion of Racine County as “rural Racine County.” Rural Racine County is composed of the city of Burlington and several surrounding small towns. Burlington has a population of approximately 9,900 people, with one public high school, one alternative high school, two middle schools, and five elementary schools. This project involved completing interviews with five key respondents who live or work in the rural portion of the county.

Urban Racine County. The researcher defined “urban Racine County” as the city of Racine, which is composed of approximately 80,503 people and its surrounding towns and villages. Racine is the main city in Racine County and is the fifth largest city in

Wisconsin. In addition, the city of Racine has one of the state's highest rates of reported sexual offenses. In fact, Racine has a higher rate of reported forcible rape per capita than New York City, Los Angeles, and Washington, DC

(<http://www.areaconnect.com/crime/compare.htm?c1=Racine&s1=WI&c2=New+York&s2=NY> retrieved 6.12.09). This high rate of reported sexual offenses is an additional reason why the researcher decided to examine the prevention of sexual violence within this community. The Community Readiness Model recommends that researchers conduct a minimum of four interviews within each community, but allows for as many interviews as is “politically” necessary. As a result, the researcher decided to conduct five interviews in the rural Racine County community and eight interviews in the urban Racine County community.

Defining the Issue

The second step the researcher took to complete the assessment was to define the issue. For the purposes of this study, the researcher defined the issue as “the primary prevention of sexual violence against adolescents.” The researcher defined the issue in this way because of the high rates of sexual violence within that age group (OJA, 2005; Tjaden & Thoennes, 2006). In addition, this population (as noted in Chapter II) faces unique vulnerabilities. Adolescents are at a developmental stage when lifelong behaviors regarding sexuality are shaped. Adolescents are learning how to perform their socially influenced gender roles, and are exploring their gender-based sexual scripts. Prevention strategies provided to community members during their adolescence may reduce the future incidence of sexual violence (Lee, Guy, Perry, Sniffen, & Alamo Mixson, 2007; Wolfe, 2003). As a result of these variables, the researcher decided to examine the

primary prevention of sexual violence against adolescents in the rural and urban Racine County communities.

Research Team

The principal research team was comprised of the primary researcher and three team members, all of whom were graduate students in an APA-accredited program in counseling psychology in the Midwest. The team included two Caucasian women, ages 31 and 45, and two Caucasian men, ages 32 and 37. The 31-year-old female was the primary researcher and was a fifth-year doctoral candidate trained in conducting CRM assessments. The 45-year-old female, a sixth-year doctoral candidate, conducted and transcribed five of the interviews. The 32-year-old male researcher, a fourth-year doctoral student, conducted five of the interviews. The 37-year old man was a ninth-year doctoral candidate who conducted three of the interviews. In addition to these team members, an additional member assisted the primary researcher with the scoring of the interviews. This member was a 55-year old Caucasian woman who had received extensive training in conducting CRM assessments.

Training procedures. The CRM dictates that the person conducting the interviews should not have a personal relationship with the key respondents, thus excluding the primary researcher as an interviewer. As a result, the primary role of the three principal members of the research team was to complete the interviews. The developers of the CRM state that those conducting the interviews do not need to be fully trained in the CRM, as their role is limited simply to the completion of the interviews; they are not involved in the scoring process. Nevertheless, the primary researcher ensured that the team members were familiar with the interview process of the CRM, by having them

complete a CRM orientation training. The training provided background information on the CRM, to explain the purpose of the project, and discussed interviewers' roles in the project and how to conduct the CRM interviews. The primary researcher familiarized the interviewers with the interview structure and questions, provided information on the recording procedures, and trained them in the process of gaining verbal informed consent from the participants.

Measures

Demographic Questionnaire

All participants completed a brief demographic form which asked identifying information including gender, age, racial/ethnic/cultural identity, occupation, and number of years involved in the Racine County community. In addition, the demographic form asked for contact information and a selection of dates and times that would be convenient to complete the interview. See Appendix D for the complete Demographic Questionnaire.

Contextual Questions

The interviewers asked the participants three opening questions to increase their comfort level with the interview process and to provide background information on their role and experiences with Racine County. The interviewers asked the participants to describe their role or position in Racine County and how long they had been a member of the community. In addition, the interviewers asked the participants to describe either the city of Racine or the city of Burlington, (depending on to which community they belonged) with regard to their population size, demographics, industries, and culture. In addition, the researcher provided some introductory information prior to the standardized questions. The introductory information included the purpose of the study, and

definitions of “sexual violence” and “community.” The researcher added the introductory information to provide a standardized definition of the terms used within the interview.

CRM Instrument

The Community Readiness Assessment involved semi-structured interviews based on open-ended questions relative to each of the six dimensions of readiness. The interview included the approximately 30 CRM questions, adapted to discuss sexual violence within the adolescent population. Examples of questions used to assess the dimensions include, “Please describe the efforts in your community to address sexual violence within the adolescent population” and “How are the leaders in your community involved in efforts regarding the reduction of sexual violence within the adolescent population?” Please see Appendix C for the complete instrument. The questions highlighted in bold are required questions of the CRM; the remaining questions are optional CRM questions which were included in this study. The researcher did not add any additional questions to the interview.

Participant Selection

The researcher selected the key respondents in one of two ways. First, the researcher selected some key respondents simply because they held a position of authority in the community. These key respondents were not necessarily “experts” on the topic; rather, they simply held a position that informed them of the issues. Secondly, the researcher asked community members to identify people in the community who were the most knowledgeable or influential relative to the issue of sexual violence within the adolescent population. The researcher used both of these participant recruitment methods to ensure adequate and diverse representation of perspectives within the key respondent

group. The researcher queried school personnel from one rural high school and one urban high school to aide in the selection of two adolescent participants (one adolescent from rural Racine County and one from urban Racine County). These two adolescents represented members of the “community at large.” The researcher obtained informed consent from all participants in the study. In addition, the researcher gained informed consent as well as parental permission for the adolescent participants in the study. See Appendices E, F, G, H and I for the Participation Request Letter (E), the Study Introduction Letter (F), the Agreement of Consent for Research Participants form (G), the Assent Form for Research Participants (H) and the Parent Permission Form (I).

Interview Protocols

The three team members individually completed all key respondent interviews via the phone. The interviewers contacted the participants within one month after the participants had signed the informed consent and demographics forms to schedule the interview. Each interview lasted between sixteen and fifty-three minutes ($M= 33.6$, $SD= 9.8$). At the end of the interview, the interviewers debriefed the participant and told her or him that the area rape crisis center, Sexual Assault Services would send her or him a copy of the final results, as was agreed upon at the onset of research study.

Participants

The research team interviewed 13 participants (key respondents) in two communities in Racine County, Wisconsin, to assess their perceptions of the primary prevention of sexual violence against adolescents. Key respondents included two medical professionals, two law enforcement professionals, two school personnel, two social service professionals, two high school students, one mental health therapist, one child

protective services worker, and one member of the Racine County District Attorney's Office. All participants identified as Caucasian. Participants ranged in age from 18 to 61 years old ($M = 43.23$, $SD = 13.15$). Seven participants identified as female, six identified as male. Length of time living and/or working in Racine County ranged from 1 year to 61 years ($M = 23.15$, $SD = 16.15$). Five participants were members of the rural community, eight were members of the urban community.

Transcription

The interviews were audiotaped and transcribed verbatim (except for minimal encouragers) by the primary researcher of this study and one of the research team members. The researcher removed all identifying information of the participants, and assigned each participant a code number to maintain confidentiality. Only the primary researcher had access to the key with the code numbers.

Procedures for Analyzing Data

After the interviews were completed and transcribed, the scoring process began. The primary researcher and the second scorer independently reviewed and scored the interviews according to the six dimensions of the CRM. The second scorer was the Rape Prevention and Education (RPE) grants administrator for the state of Wisconsin from the Department of Justice. As the administrator of the RPE grants for Wisconsin, she was very familiar with the CRM process and had completed extensive training on the background, philosophy, method, and scoring procedures of the CRM.

For the first step of the assessment process, each scorer individually read every interview's transcript in its entirety. This reading allowed the scorer to gain an overall impression of the interview, and determine whether information provided under one

dimension's questions could also be included under another dimension (Plested, et al., 2003). If there was information under a dimension's questions that pertained to another dimension, the researcher documented that information and used it to score that dimension during the scoring process.

The second step of the assessment process involved the use of anchored rating scales (see Appendix J) to assist the scorers in determining the stage of readiness for each dimension. Independently, the scorers read the anchored rating scale for each dimension and assigned a stage of readiness for that particular dimension based on the interview data. To assist the scorer in determining the correct stage of readiness, the Tri-Ethnic Center recommends that scorers highlight content in the interview which refers to the chosen anchored rating statement. The scorers examined the entire interview for each dimension, and based the dimension score on the overall interview content.

For example, the first set of interview questions involved the dimension "community efforts." When scoring this dimension, the scorers read the first anchored rating, "no awareness of the need for efforts to address the issue." The researcher assessed the entire content of the interview to determine whether the key respondent felt there was no awareness of the need to address the issue within the community. If the content of the interview reflected this statement, that dimension received a "1." However, if the interview provided information that supported the fact that the community is aware of the problem, the scorer then proceeded to the next higher anchored rating point. The scorers always started from the lowest anchored rating point and progressed upwards until the anchored statements reflected the content of the interview. This ensures that the community met all stages of readiness below the stage chosen. If the content of the

interview did not fully reflect the next higher stage of readiness, the scorers used a fraction between the lower and higher stage. For example, if some aspects of the interview contained content that supported the fact that the community had some awareness of the issue, but it did not quite reach the “Vague Awareness” level of the second stage, the scorers used “1.5.” Some questions within the CRM asked the participants to utilize a rating scale from one to ten in an effort to generate discussion from the participant. For these questions, the scorers did not use the number that the participants provided to determine the stage of readiness; rather, the scorers took into account the narrative that supported the participants’ responses in determining the stage of readiness. This scoring process continued until the scorers reached a rating that fit the community’s level of readiness for all six dimensions, and within all of the key respondents’ interviews. The unit of analysis for the scoring process was the entire interview.

The third step of the assessment process involved each scorer entering her or his independent scores for each of the dimensions in the “individual scores” table on the “Community Readiness Assessment Scoring Sheet” (see Appendix K). Each scorer determined a dimension score for each interview. During this step, the scorers also qualitatively documented the aspects of each interview that supported the determined stage of readiness for each dimension. This qualitative documentation involved identifying particular statements from the interview that reflected the stage of readiness determined for each dimension. This documentation increased the transparency of how the scorers derived the final scores, and provided a richer understanding on how the community fit the particular stage of readiness determined for each dimension.

The two scorers discussed their individual scores for the fourth step. At this stage, the goal was for the two scorers to reach consensus about the stage of readiness for each dimension of each interview. It was during this step that the two scorers compared notes and discussed what statements supported their individual decision-making process. If there was disagreement between the scorers, they reviewed the documentation that led to their decision and discussed the data that supported the stage they had chosen. The scorers did not “average” their scores; rather, they came to consensus on a score, through review of each other’s qualitative notes and a discussion of each scorer’s decision-making process. The scorers agreed initially on 56% of all possible scores. The range of disagreement on the remaining scores was .5 points to 4 points on a scale of 1 to 9 ($M=1.18$, $SD= .77$). After the scorers reached consensus, they entered the combined score in the “combined scores” table on the “Community Readiness Assessment Sheet.” An outside consultant trained in the CRM was available if there was disagreement between the two scorers on the appropriate level of readiness for a particular dimension. The scorers reached the consensual scores without needing to utilize the outside consultant.

The fifth step involved adding each dimension score for each interview to yield a total score for each dimension. The scorers then divided that score by the number of interviews to yield the “calculated score.” The CRM rounds numbers down, rather than up, so as to not overestimate a community’s level of readiness. For example, a score between 1.0 and 1.99 rounds down to the first stage of readiness, and a score of 2.0 to 2.99 rounds to the second stage of readiness.

In the sixth step, the researcher totaled the sum of all of the calculated scores, and divided that sum by the number of dimensions. As a hypothetical example, Dimension A has a score of 4.46, Dimension B has a score is 5.67. Dimension C has a score of 2.54, Dimension D is 3.29, Dimension is 6.43 and Dimension F is 4.07. These scores added together results in a sum of 26.46. The scorer divides this sum by the number of dimensions (six), to yield a final score of 4.41. This score is the overall stage of readiness for the community and corresponds to the numbered stages of readiness. In this example, a score of 4.41 rounds down to the fourth stage of readiness, “preplanning.”

The last step in the assessment process documents the researchers’ qualitative impressions of the interviews at the end of the scoring sheet. This involved including the qualifying statements that related to the level or readiness for the community which provided support for the community’s stage of readiness. For example, if the researcher determined that rural Racine County was at a “3” in its stage of readiness to accept primary prevention strategies, the scorer would document key respondents’ unique statements that support at the “vague awareness” level of readiness.

Inapplicability of Conducting Quantitative Analyses on the CRM

The Tri-Ethnic Center developed the CRM as a qualitative method of assessing a community’s level of readiness, and as a result, one should expect that the resulting data would be ordinal in nature. Nevertheless, the use of the one to nine range for the stages of readiness gives the perception that these data are interval in nature and thus should be able to be tested using parametric statistics. Despite this perception, it is not possible to test for statistical differences in the stages using parametric statistics given the ordinal nature of the data. In addition, one may assume that it may be possible to use a non-

parametric test (i.e., the Mann Whitney U) to determine if there are statistically significant differences between the stages. However, it is not possible to use non-parametric statistics on the data due to the small sample size. Because the data are ordinal, and the N of the study is so small, the data violate the assumptions required for using both parametric and non-parametric statistics and, as a result, when reviewing the results one must take the stages of readiness as purely qualitative labels.

CHAPTER IV: RESULTS

Overlap Among the Stages and Dimensions

As already discussed, the CRM has nine stages of readiness. Due to this broad range of stages, there may be some overlap between data at different stages. For example, the CRM asserts that at the Denial and Resistance stage, “there is little to no recognition of the issue as a problem within the local community,” which may present as only marginally different from data that fit within the Vague Awareness stage. The CRM asserts at this latter stage that “there is a sense that the issue may be a problem in the community, but a lack of motivation to do anything about it.” The language that separates these two stages (“little to no recognition” versus “a sense”) is not overwhelmingly clear in their differentiation. This overlap may result in some ambiguity between the stages. As a result, the reader should examine these stages with the knowledge that they exist within the context of a continuum of readiness and are not necessarily discrete stages.

In addition, similar data across two dimensions may result in a different stage because of the model’s policy of rounding down. For example, the results of this study indicated that rural Racine County is at the second stage of readiness in the Knowledge of the Issue dimension, whereas Urban Racine County is at the third stage of readiness in this dimension, despite similar interview data. This discrepancy arises from the policy of rounding down in the CRM. Urban Racine County just barely met the threshold for the third stage of readiness, with a score of 3.0, whereas Rural Racine County was rounded down to the second stage of readiness from a score of 2.6. As a result, the rural and urban data results sound very similar, yet they characterize different stages. These rounding implications should be taken into consideration when reviewing the results.

Qualitative Nature of Results

In reviewing the results, it is also important to keep in mind the qualitative nature of the data. Although the stages of readiness range from one to nine, which gives the impression that the stages are interval in nature (i.e., the difference between each of the stages is equal), the stages of readiness are actually ordinal in nature (i.e., the stages are different from each other but those differences are not necessarily equal). For example, a stage of readiness of two indicates a given level of readiness of a community to address an issue, and reflects a less developed stage of readiness than a rating of four. However, a community at the second stage of readiness is not *half* as developed as a community at the fourth stage of readiness. In other words, stage two is simply a convenient label for the characteristics of "Denial and Resistance" in a community rather than a discrete quantity of readiness.

Overall Stages of Readiness

The CRM assessed the rural Racine County and urban Racine County community's readiness to implement primary prevention of sexual violence programs within the adolescent population. The overall stage of readiness is the average of all the dimensional scores within each community. Both the rural and urban Racine County communities were at the "Vague Awareness" stage of readiness to implement primary prevention strategies to reduce the incidence of sexual violence against adolescents. At this stage there is general knowledge that sexual violence against adolescents is a problem in the community, but that knowledge is not based on sound research and statistics, and is instead based on anecdotal, stereotyped information. Those who are most knowledgeable about sexual violence are either professionals who work in the field, or

individuals who have been affected directly by sexual violence. At this stage, the leaders in the community do not view sexual violence prevention as a priority, and they are not yet motivated to actively support the prevention efforts.

Dimensional Results

This section describes the individual dimensional results of both rural and urban Racine County. The dimensional results provide a more complete picture of the varying stages of readiness within each community, and aid in the development of implementation strategies to help increase the stages of readiness within each dimension.

Calculated Scores

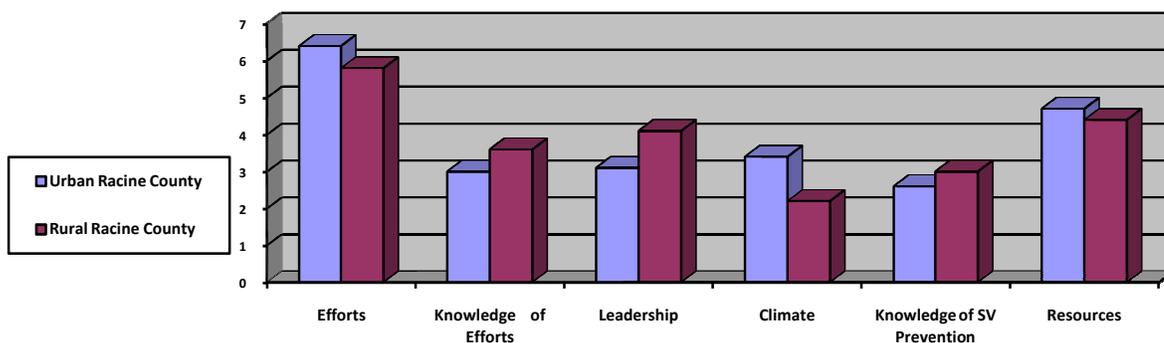
The distribution of dimensional scores across the rural and urban Racine County communities illustrated generally low levels of readiness to address sexual violence against adolescents. These scores ranged from a low stage of readiness of 2.2 (Climate within rural Racine County) to a high stage of readiness of 6.4 (Efforts within urban Racine County) on a scale of 1 to 9. The calculated scores for the six dimensions of the Community Readiness Model for both rural and urban Racine County are displayed in Table 2 below.

Table 2: Calculated Scores of Readiness in Rural and Urban Racine County

	Dimension	Rural Racine County	Urban Racine County
1	Efforts	5.8	6.4
2	Knowledge of Efforts	3.6	3
3	Leadership	4.1	3.1
4	Climate	2.2	3.4
5	Knowledge of the primary prevention of sexual violence against adolescents.	3.0	2.6
6	Community resources	4.4	4.7
Community average scores		3.8 (3)	3.9 (3)
Community Stage of Readiness		Vague Awareness	Vague Awareness

These results indicate that both rural and urban Racine County received their two highest scores in the Efforts and Resources dimensions. The two communities varied on the stages of readiness in the other dimensions. See Figure 3 below for a graphical illustration of the differences in readiness by dimension between rural and urban Racine County.

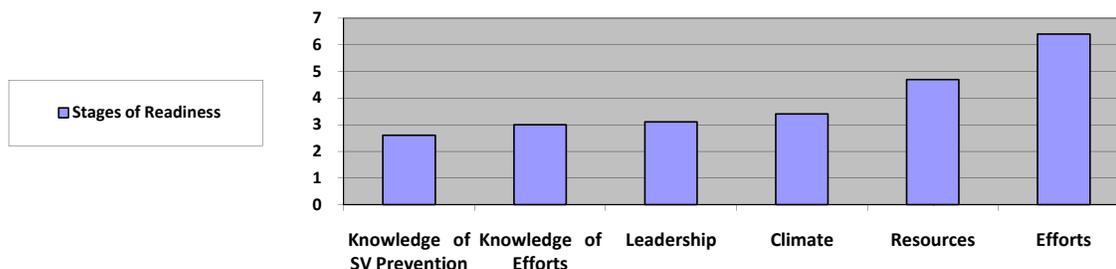
Figure 3: Comparison of Stages of Readiness Between Rural and Urban Racine County



Urban Racine County

The dimensional results for Urban Racine County in order of lowest to highest stages of readiness are Knowledge of Sexual Violence Prevention, Knowledge of Efforts, Leadership, Climate, Resources and Efforts. See Figure 4 below for an illustration of the differences in readiness by dimension in urban Racine County.

Figure 4: Stages of Readiness in Urban Racine County



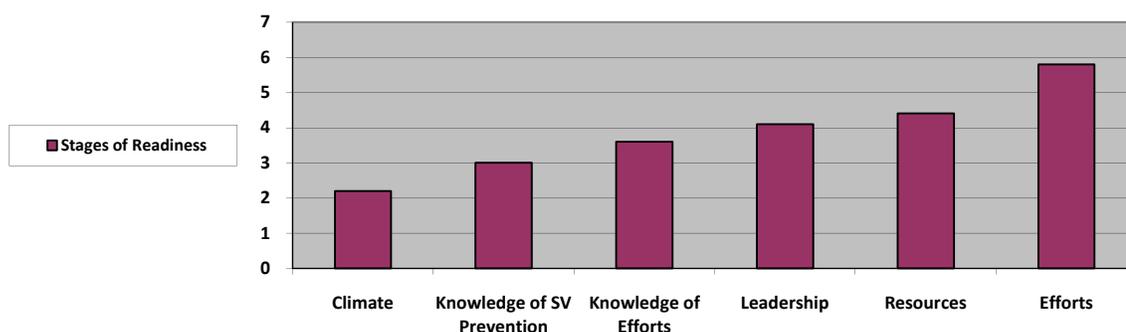
These results indicate that urban Racine County is relatively low in readiness in the

knowledge of sexual violence and knowledge of efforts dimensions, and received its highest stage of readiness scores in the efforts and resources dimensions.

Rural Racine County

Rural Racine County's dimensional results from the lowest to highest stage of readiness are Climate, Knowledge of Sexual Violence (SV) Prevention, Knowledge of Efforts, Leadership, Resources and Efforts. See Figure 5 below for an illustration of the differences in readiness by dimension in rural Racine County.

Figure 5: Stages of Readiness in Rural Racine County



Rural Racine County's lowest stage of readiness scores are in the Climate and Knowledge of the Efforts dimensions, whereas they received their highest stage scores in the Efforts and Resources dimensions.

Efforts

The "Efforts" dimension pertains to the current efforts in the community to address the problem of sexual violence against adolescents, including the strengths and weaknesses of the efforts, whether all segments of the community are able to access these services resulting from these efforts, and what formal or informal policies, practices, and laws are in place to address the problem in the community. This dimension thus assesses the degree to which the efforts are fully implemented and integrated into the community,

and how well those efforts meet the varying needs of that community. For example, some communities have long-standing sexual violence prevention programs, whereas other communities do not have these programs at all, or they are newly established.

Rural Racine County. The Efforts dimension for rural Racine County was 5.8, which is at the ‘Preparation’ stage of readiness. At the ‘Preparation’ stage of readiness, efforts in the community have been planned, and some may have been implemented, but they have only been running for a few years and may not be fully developed and established. The key respondents spoke of several efforts within the community to address the issue of sexual violence against adolescents. These efforts included the local rape crisis center, the domestic violence shelter, a program aimed at assisting teenagers involved in violent relationships, and a coalition of various community agencies and organizations working together to implement prevention and intervention programs. One key respondent stated:

There’s (sic) several programs in Racine county that do [prevention programs], Sexual Assault Services, Women’s Resource Center... I know our school resource officer over at the high school...gives the Freshman...a talk about the proper way to act in school, and what to report and what not to....There’s (sic) a lot of agencies in the county, plus the Police department focuses on that for young people, we teach a woman’s defense, which is also geared toward mothers bringing their adolescent daughters and doing it together.

A second key respondent stated:

My place of employment has a program called Safe Start and they work specifically with teens and address issues of teen dating violence ... and I know

Sexual Assault Services also provides that very thing and I think on a community wide or on a county wide effort our family violence coalitions have decided that it is time to start talking to people and talking more about prevention on how can we stop this before it starts and really looking at you know media, social and cultural things, the ideas that people have, and trying to teach people before it happens rather than after it's too late.

Another key respondent stated that these programs could be further developed:

There's always a need to expand [the prevention efforts]. I think there is a need for it, and I think its happening. There are great coalitions that get together... people that never used to get together before to discuss this type of thing are now.

The consensus of the key respondents was that there are several programs in the rural community that are addressing the issue of the prevention sexual violence against adolescents, but that they could be further developed and implemented.

Urban Racine County. Urban Racine County was at a 6.4 for the Efforts dimension. This is at the 'Initiation' stage of readiness. At this stage, there are efforts and programs in the community that have been implemented to address sexual violence against adolescents. Several key respondents were able to identify many prevention efforts, such as those provided by the local rape crisis center within the schools and community. One key respondent stated:

Well certainly, Sexual Assault Services does a wonderful job of providing both prevention and intervention services....Our agency relies heavily on them when victims come forward. And their services are stellar so... that's the first thing that pops into my mind is what a good job SAS does. I also know that Safe Start helps

to respond to that...As far as prevention is concerned, I know that the school district has done its share... allowing good prevention information to be taught to our students. The efforts of SAS and our family violence coalition really draw attention to the issues, and are helping us to create a community base for the issue.

Another stated:

Primarily through the efforts of Sexual Assault Services- they're a very big factor... They've got some good outreach... to the schools. One of the workers...does outreach to the schools and makes community presentations.

A third respondent stated:

I'm aware of the program in Racine, Sexual Assault Services, which I know that they... go out and speak with groups in the school settings and maybe there's a few times a year where there is something outside of the school where there is an activity or something to raise awareness, help people to have a better understanding- do some education.

The general consensus of the key respondents was that there are several programs in urban Racine County that provide sexual violence prevention programs, and that these programs were relatively strong.

Knowledge of Efforts

This dimension relates to community members' level of knowledge and awareness of the efforts that are in place to address the problem. It addresses to what extent the community members know about the local efforts, and assesses whether all segments of the community can access the programs. This differs from the previous

dimension in that it is not about what efforts are available and the nature of those efforts, but rather how informed the general community (not the key respondents) is of those efforts. For example, a community may have a long running sexual violence prevention program, but, for whatever reason, the community members may be largely unaware of its existence or reluctant to support its initiatives.

Rural Racine County. The dimensional stage of readiness for Knowledge of Efforts was at a 3.6, Vague Awareness, for rural Racine County. At this stage, some community members have a general understanding of the efforts, but the depth and breadth of their knowledge is limited. One key respondent stated in response to the question, “Do you think the rest of the community knows about the efforts?” with:

I would say no. Even though they [the efforts] are well advertised...I would just be surprised that if you asked a lot of people that they'd know ...I think part of it is people don't want to know what's out there, you know, it's such a dirty secret sometimes: “Oh, we don't want to talk about that.”

This quote indicates that although some professionals in the community may be aware of the efforts available, there is a sense that the general community does not have a widespread knowledge of the programs available to address the issue.

Urban Racine County. Urban Racine County's Knowledge of Efforts score was also at a 3, the Vague Awareness stage of readiness. One key respondent stated:

The kids do [know about the resources], they're getting it, but you know...what I'd say is they might know about them, but they might not be paying attention to them... You know folks, folks don't pay attention to what they don't need. I mean there are people in our community that just don't think about sexual assault.

Another respondent stated:

No, I don't think they have a clue, I would even push that further... I would suggest that the people, the rest of the community, doesn't even know that it's an issue, or thinks that it's sporadic, isolated incidents. I don't think they get that this is a city-wide or county-wide issue.

These statements indicate a lack of knowledge in the general community that the efforts are available. In addition, they speak to the fact that the general community may not be open to learning about the efforts to prevent sexual violence because it is an issue that the general public does not want to think about or acknowledge.

Leadership

This dimension assesses the degree to which political and other community leaders are concerned about, and involved in, working on the problem. In addition, it assesses the strengths and limitations of the leaders who work on the particular issue.

Rural Racine County. The Leadership dimension for rural Racine County was a 4.1, which falls within the Preplanning stage of readiness. This stage implies that the leadership is supportive of efforts to address the issue, but that they are not a part of a committee or group that addresses the issue themselves. As previously mentioned, some questions within the CRM asked the participants to utilize a rating scale from one to ten in an effort to generate discussion from the participant. In these situations, the scorers did not use the number that the participants provided to determine the stage of readiness; rather, the scorers took the participants' qualitative responses into account when determining the stage of readiness. In response to the question "Using a scale from 1 to 10, how much of a problem is sexual violence against adolescents to the leadership of

your community, with one being ‘not at all’ and ten being of ‘very great concern’?” one key respondent stated: “I would say about maybe about a 5..I think our police department does what they can do.” Another key respondent stated:

Well, I think I am going to go with a seven...when I think about leadership I am thinking about the police department in both the city and the township police department and they are really quite active within the family violence coalition and they’re bought in and ... they work really hard at unraveling things and addressing things.

A third key respondent stated:

The leaders of this community take...a very good stance against any type of crime...against children. We take it very seriously.... I guess I’m thinking mostly of city council, mayor, city administrators and yeah, they would certainly be open to any ideas that would make the system better.

These key respondents perceived a general level of support from the leadership of rural Racine County. They reported that, when asked about it, the leaders would condemn sexual violence against adolescents, and would support efforts to prevent it.

Urban Racine County. The Leadership dimension score for urban Racine County was a 3.1, the Vague Awareness Stage of Readiness. At this stage, the leaders in the community recognize the need to do something regarding the issue, but they are not directly involved in addressing the issue. The general sense of the leaders is that they all think it is a problem and one that they are concerned about, but they are not actively involved in the prevention of the problem themselves.

One key respondent stated:

I mean...certainly none of our community leaders are going to stand up and say, “We don’t need any more of that [prevention efforts].” But then at the same time they don’t want to take ownership of it as a community-wide problem...So I think they would support it verbally, but I don’t know that they would support it with any kind of action, or financial resources.

Another key respondent echoed this sentiment with the statement:

I think it is almost politically correct to be concerned. And I think deep down people are concerned, but it doesn’t translate into any kind of authentic behavior that says. “Look we’re concerned and here’s the results of our concern. How does that play out?” I don’t see that. I don’t see the results of people’s concern or the dialogue around sexual violence.

The key respondents also implied that they don’t feel that the leadership has a realistic understanding of the prevalence of sexual violence against adolescents within the community. One stated: “I don’t think the leadership in our community has a firm grasp on what’s really going on as it relates to sexual violence...” A second key respondent stated:

I think individually and collectively, that they’re not aware of the scope of the issue... I think people think that these are isolated issues, isolated incidents, and don’t realize the scope of it. So, it’s probably more a question of are they aware of the scope of it and do they really know that they need to do something? Or, if nobody talks about it, it goes away. We have a lot, a lot of issues within the community that draw significantly more attention, and that are much more politically appropriate to talk about. So, unless somebody is making government

and community leaders uncomfortable, by talking about it, I don't believe, I don't think that there are going to be any changes.

As a point of interest regarding the leadership in Racine County, it may be important to note that on January 13th, 2009, the Racine Mayor was arrested on felony charges of attempted sexual assault and possession of child pornography (http://www.journaltimes.com/articles/2009/01/14/local_news/doc496deda1079ed663015381.txt retrieved 6.2.09) . If convicted of these charges, his actions (at the very least) provide poor modeling regarding the prevention of sexual violence.

Community Climate

Community climate refers to the community's general belief system about sexual violence and its set of mores, as well as the social and political obstacles that may exist in addressing the problem within the community. It also refers to the community's prevailing attitude toward the issue and whether the attitude is one of helplessness, or if it is one of responsibility and empowerment.

Rural Racine County. The Climate of rural Racine County was 2.2, and corresponds to the second stage of readiness, "Denial and Resistance." At this stage, there is a general sense in the community that there is nothing that can be done about the problem and that, in fact, it is not a widespread problem for most people. There is the sense in the community that sexual violence doesn't happen in their "quiet rural town."

One key respondent stated:

There is the belief that that once you get [into this community] the sun always shines, the birds are always singing, and nobody has any problems. When you talk with people about domestic violence or sexual assault or family violence, they

just look at you like, “That doesn’t happen in this town, it doesn’t happen in this church,” and so people want to believe that things don’t happen here.

Another key respondent echoed this sentiment with the statement:

I think they’re sort of blinded by the niceness of how it looks and how isolated they are that they don’t have the crime and stuff, but they do, they just need to open their eyes a little bit more.

A third key respondent stated that when sexual violence is brought into the public awareness in the community, the members have a hard time believing that it could happen in their small, rural community. This key respondent stated:

I think they are very appalled by it when something comes to the surface, you know, when something is reported or they read about it in the newspaper. It is very upsetting to them. They don’t like to think that that kind of thing would happen in Burlington.

There is also a general sense in the community that members should not openly discuss the issue of sexual violence: “It is one of those things that I think community members think is a horrible thing but [that they are] not necessarily willing to have that conversation. Sex may still be something that we don’t talk about.” The underlying belief in the community is that sexual violence does not happen in their community and that it is not something easily discussed.

Urban Racine County. Urban Racine County had a score of 3.4, Vague Awareness, in its Climate dimension. A score within the Vague Awareness stage of readiness implies that the community is neutral or disinterested in addressing the issue of

sexual violence against adolescents, or it believes that sexual violence does not affect the community as a whole. One key respondent stated:

I think everyone thinks it is bad, the problem is that I don't think that most people have even a little bit of a clue on how pervasive it is. So I think the biggest issue is that people don't understand how frequent it is, and everybody thinks it happens in someone else's neighborhood, but no one realizes that it is happening on their block.

There is the belief that community members would support prevention efforts, but that the community climate is not one of widespread support:

Widespread community support? I don't know that there's been that, but what I do believe is that a majority of our Racine community would nod their heads in approval if they were told about these efforts, it's definitely...a good thing. I'm glad that's happening in our community and I'm glad the kids are getting this information. They might not think about it the next day but... they'd be supportive in that way.

Despite this surface level of support in the community, key respondents also mention an underlying sense that some community members may believe that sexual violence victims do something to cause the crime to happen to them. One key respondent articulated this sentiment with:

I would say most people in our community would say, "It's an issue, it's a problem, its wrong, it shouldn't be happening," but then sometimes I hear an underlying theme saying "Yeah, but if those kids would make better choices" like it's kind of their fault. "If they wouldn't be involved sexually, if they would dress

differently, if they would listen to different music”...so it is almost like “Well, it’s kind of their fault.” In a way I hear that a little bit. But I think most people in the community would say it’s an issue that we need to be concerned about and it puts our kids at risk.

This dimension’s score indicates that the community in general is disinterested in the issue and does not believe that sexual violence affects the community as a whole. In addition, the key respondents identify a norm in the community that makes members hesitant to discuss the issue and reflects the presence of some underlying victim-blaming beliefs.

Knowledge of the Issue

This dimension focuses on how knowledgeable community members are about the problem of sexual violence as an issue in and of itself. In contrast to the earlier dimensions, this dimension does not focus on knowledge of the efforts available, but rather focuses specifically on the community members’ knowledge of the prevalence of sexual violence as well as its causes, consequences, and how it affects the community. In addition, it refers to the local data that are available regarding sexual violence, and how people in the community gain information about sexual violence.

Rural Racine County. The ‘Knowledge of the Issue’ dimension for rural Racine resulted in a score of 3.0, or the Vague Awareness Stage of Readiness. A score within this stage indicates that a few members in the community have some knowledge of the issue, but that knowledge of sexual violence is not widespread and that members do not have specific information regarding the signs and symptoms of sexual violence. One key respondent stated:

I don't think they [the community members] are very knowledgeable. There's a certain amount of people that seek information, people that come out and get it... Certain people want to become involved and certain people don't, so I would think there's not a lot of education on it out there.

Another key respondent answered the question of whether the community in general is knowledgeable of the issue with:

No, not very knowledgeable. [There are] just the same people that keep trying and trying and trying, but the other people just don't notice it. Unless something happens that hits them right in their face with their daughter or somebody, they don't notice it.

The consensus of the key respondents is that the community in general has a vague understanding about the issue of sexual violence against adolescents, but that other than professionals who work in the field and those whom sexual violence has impacted, the information is limited and incomprehensive.

Urban Racine County. Urban Racine County was at the Denial and Resistance stage of readiness with a score of 2.6 in the Knowledge of the Issue dimension. At this stage of readiness, the model asserts that, in general, the community members do not have knowledge of the issue. One key respondent stated:

Somewhere in the deep recesses of their minds they sort of know it's kind of going on. But I honestly don't think they think about it very often. And I only think they're a little knowledgeable that it's happening, I don't think they know it all.... The statistics, the effects. If you asked a regular normal adult in our community how to prevent it, I don't think that they would even be able to give

you a list of 10. It's just not something community members think about unless it's happening in their circle, a family or friend.

A second key respondent echoed this sentiment when asked how knowledgeable s/he thought the average community member was about the issue of sexual violence against adolescents:

Not very knowledgeable. I think community members know about it when it touches their lives. But everyone would like to think that it's a freak, or aberrant occurrence, so I don't think that they know about that collectively.

The prevailing belief is that limited groups of people in the community may be more knowledgeable of the issue, particularly the students who are receiving programming in the schools and their parents:

If you ask kids in the school they may be aware of it- because kids are involved in a lot of preventive kinds of things- they do a lot of skill development, so the kid in your classroom could be involved in an anti-bullying program, a peace program. I think individuals families and parents may be very aware of it, but generally speaking it's probably pretty low... I don't think the owner of the automobile dealership knows necessarily.

These statements all reflect the consensus that although some people may be knowledgeable of the issue, the general public is not.

Community Resources

The "Community Resources" dimension describes what assets the community offers to support the efforts that are in place to address the problem. This does not refer directly to the programs that are addressing the issue of sexual violence against

adolescents, but rather to the resources in the community that can support those efforts. Resources may include financial avenues to support community efforts, volunteer involvement in supporting these efforts, and the business community's support of these efforts, through financial or space donations.

Rural Racine County. The Resources dimensional score was a 4.1, 'Preplanning' for Rural Racine County. At this stage there are individuals, organizations, financial support, and/or space available to support the efforts against sexual violence. Some key respondents spoke of 'businesses' and other organizations' willingness to support the issue. One key respondent stated: "If they request it, [the community] will help in any way they need...they get a lot of help, cooperation from businesses. In Burlington we have a real good cooperation with businesses in accomplishing goals." Another key respondent echoed this sentiment with:

I think there are financial donations given. You know like with our school, I know we give the space. Some people volunteer- so some volunteering of time. I know as far as willingness to display flyers or posters, it's usually pretty good- with what I see around town- that are put up in businesses, advertising.

These results indicate that the community has resources, such as financial resources, volunteers, and space to support the efforts addressing sexual violence.

Urban Racine County. Urban Racine County was also at the 'Preplanning' Stage of Readiness for the dimension of Resources, with a score of 4.7. One key respondent reported being aware of people volunteering to support the victims of sexual violence, stating:

I think that we have some people who are volunteering as Advocates in the Sexual Assault Services program, Advocates who will talk on the hotline, who go to meet a victim at the hospital, walk them through the SANE exam. I'm not aware of whether there is financial backing going on or not. And I think that the volunteer program is always looking for more people to volunteer, so it's not like they have too many coming through.

A second key respondent spoke of some grants being written to address the issue of sexual harassment, bullying, and sexual violence. This key respondent stated:

I know that there's (sic) grants written for elementary and middle school that address the whole idea of bullying, and then maybe sexual aspects of it are pulled into that. And I know there is currently a grant being submitted for that same kind of thing, focused more on respect, and again, sexual harassment, sexual violence is going to be a part of that effort if the grant is received...The high school grant is being written for all three high schools, and so if they receive it-it is pretty much a systematic implementation-all kids will get the information, knowledge, and skills, not just a subset of some groups.

Another key respondent stated:

If asked, I think you'd see community leaders and community businesses donate money and space. I think donating somebody's time is the hardest thing to get out of people. I think, you have to find the people who have a soft spot for kids...I think you can get people to donate money, I think you can get them to donate space, but donating time is always an issue.

These dimensional results indicated that there are resources are available within the community to address the issue, ranging from people volunteering time, money, and office space, to the school district writing grants.

CHAPTER V: DISCUSSION

Overview

This chapter examines the results of the study within the context of the research questions. The section will review the study's three research questions and then respond to these questions by first presenting the overarching findings of the levels of readiness within urban and rural Racine County. Next, the discussion examines the differing levels of readiness within the six dimensions of the CRM between the two communities. A discussion follows of the implications of the study, including possible primary prevention implementation strategies that match the levels of readiness within the communities. Finally, theoretical and methodological limitations of this research are presented, as well as the study's implications for future research.

Review of Research Questions

This study sought to answer three research questions. First, what are the levels of community readiness in rural and urban Racine County regarding sexual violence primary prevention strategies within the adolescent population? Second, what, if any, are the differences in level of readiness between rural and urban Racine County? Finally, how do the CRM Dimensions and Stages of Readiness inform the implementation of sexual violence primary prevention strategies for the adolescent population in rural and urban Racine County?

Overall Stages of Readiness for Rural and Urban Racine County

Despite the demographic and geographic differences between rural and urban Racine County (<http://quickfacts.census.gov/qfd/states/55/55101.html> retrieved 6.2.09), the results of the CRM assessment indicated that overall, the two communities occupy the

same stage of readiness. Both communities fall within the “Vague Awareness” stage of readiness to implement primary prevention strategies to reduce the incidence of sexual violence against adolescents. This finding implies that, although both communities acknowledge that sexual violence against adolescents is a problem, both communities struggle with a lack of motivation to actively address it (Edwards, et al., 2000; Jumper-Thurman, et al., 2003; Plested, et al., 2006).

As discussed in the Literature Review chapter, the CRM was based theoretically, in part, on Prochaska and DiClemente’s Transtheoretical (stages of change) model (1982). The Transtheoretical model is widely used, and as a result, it may be useful to conceptualize the communities’ overall stage of readiness score within the context of the stages of change model. As stated above, both rural and urban Racine County obtained an overall stage of readiness score of Vague Awareness, indicating that the community members recognize that sexual violence is a concern locally, but that they have little motivation to do anything about it. The Vague Awareness stage may be parallel to the Precontemplation stage in the Transtheoretical model. At the Precontemplation stage, an individual has minimal awareness of a problem, or, if she or he is aware of the problem, she or he has no intention to change (Prochaska & DiClemente, 1982). DiClemente (2003) states “an individual in the Precontemplation stage is satisfied with, or at least unwilling to disrupt, a current behavior pattern” (p. 26). The parallel between the Precontemplation stage of the Transtheoretical model and the Vague Awareness stage of the CRM may be useful to keep in mind when interpreting the CRM results.

There are a variety of reasons why both the rural and urban Racine County communities may be at the Vague Awareness stage of readiness despite their differences

in population size and demographics. First, these communities are still embedded within a larger societal and geographical context that affects their overall culture and norms. Such a statement is consistent with Bronfenbrenner's Ecological Systems Theory (1979), which, as discussed in Chapter II, asserts that individual, relationship, community, and societal levels of society influence each other and do not develop independently. Therefore, although rural and urban Racine County are unique communities in and of themselves, they are still members of communities beyond the county borders. For example, the rural and urban portions of Racine County are members of the state of Wisconsin as well as the larger Midwestern community and American society. Rural and urban Racine County's membership in these larger communities affects their culture, norms, and belief systems (Rentfrow, Gosling, & Potter, 2008), and may influence their stage of readiness to address sexual violence.

The influence membership in a larger geographic community has on a communities' social norms is also consistent with research that suggests that there are variations in personality expression in the United States on a regional (i.e., Midwest, East, South, West) and statewide level (Rentfrow, et al., 2008), and that these variations in personality are related to a variety of social indicators, including "crime, social involvement, religiosity, values, occupational prevalence, health behavior and mortality" (p. 360). In addition, other research suggests that geographical differences exist in the United States among other social values and norms, such as individualism versus collectivism (Conway, Ryder, Tweed, & Sokol, 2001; Kashima et al., 2004; Vandello & Cohen, 2004), emotional expressiveness (Pennebaker, Rime, & Blankenship, 1996), and honor (Cohen, 1996, 1998, 2001; Cohen & Nisbett, 1997; Nisbett & Cohen, 1996). Given

this research, it seems reasonable to assume that, while urban and rural Racine are distinct communities, they are also embedded within, and shaped by, larger geographic and socio-political environments. Therefore, the two communities likely share similar cultural values, beliefs and social norms which may have impacted their obtainment of the Vague Awareness score in their overall stages of readiness.

An additional reason rural and urban Racine County were at the same stage of readiness may be due to the number of shared resources within the County, such as the Racine County District Attorney's Office, the Racine County Human Services Department, and a variety of other resources, including social service agencies, the county wide newspaper, and funding organizations such as the Racine Community Foundation, the United Way of Racine County, and the SC Johnson Foundation. These organizations have an impact on how the communities view sexual violence, as supported by research which asserts that community entities "can shape individuals' behavior through the transmission of values and norms" (Bracht, 1990, p. 20). For example, if the Racine County District Attorney's Office and the Racine County Human Services Department do not routinely investigate and/or prosecute sexual assault cases, this sends a message to the community that these crimes are not worthy of investigation. Likewise, if the county newspaper, the *Racine Journal Times*, consistently prints articles from the perspective of a defendant, the community may be less able to understand and empathize with the perspective of a victim. The sharing of these community resources, organizations, and media sources may influence the perception of sexual violence within both communities, and may have had an impact on the communities' overall stages of readiness.

This hypothesis is supported by a recent study which explored the factors which influence community members' attitudes about violence against women, and found that these attitudes were influenced by organizations and mass media (Flood & Pease, 2009). Flood and Pease stated that "particular institutions such as schools and workplaces shape their participants' attitudes through both formal policies and structures and informal norms; they are locations for informal peer relations that shape attitudes, and such institutions are themselves shaped in dynamic ways by wider factors such as the mass media" (p. 137). Thus, if urban and rural Racine share many of these same sources of influence, it seems reasonable to assume that they could share many of the same values and norms, which would influence their stage of readiness to prevent sexual violence.

Third, the rape crisis center in the county, Sexual Assault Services (SAS), and its corresponding sexual violence prevention program, are relatively new to Racine County. SAS was established in 1999, and the primary prevention program was not established until 2007. Prior to the establishment of SAS, there was no agency or organization dedicated to the intervention or prevention of sexual violence. Since its establishment, SAS has initiated many programs in both the rural and urban communities in an effort to increase awareness of sexual violence. These programs include annual community awareness events (a Take Back the Night, awareness booths at fairs, organizations and schools), community programming and presentations, media campaigns using the Men Can Stop Rape "Men of Strength" posters, and psychoeducational groups with adolescents. Despite the accomplishments of these programs, preventing sexual violence is complex (Campbell & Wasco, 2005; McCall, 1993), and evidence of the long-term impact of sexual violence prevention programs is elusive (Brecklin & Forde, 2001;

Breitenbecher, 2000; Lonsway, 1996; Schewe & Bennett, 2002). Given these factors, the “Vague Awareness” stage of readiness is consistent with the complexity of preventing a socially embedded construct such as sexual violence and the length of time Racine County has been involved in concerted efforts towards its prevention.

Dimensional Results

The second research question asked “what are the differences in readiness between rural and urban Racine County?” This topic is important to address because organizations often provide prevention programs in a uniform format to all communities in a county or service area. As a result, organizations often use the same prevention program to reach communities with very different sets of social norms, cultural backgrounds, demographics, and stages of readiness (Edwards, et al., 2000; Jumper-Thurman, et al., 2003). The implementation of the same program across different communities is particularly problematic given that research on effective prevention programming indicates that programming is more effective when programs are tailored to meet the needs of the community and are flexible and responsive to the cultural norms of the community (Nation et al., 2003; Stith et al., 2006). To ensure that the prevention programs implemented in Racine County best meet the varying needs of these two communities, then, this study set out to better understand the similarities and differences in stages of readiness between the rural and urban communities.

Similarities between Rural and Urban Racine County

Efforts Dimension

In addition to sharing the same overall stage of readiness, both rural and urban Racine County received their highest stage of readiness score in the “Efforts” dimension.

The fact that both communities received their highest dimensional score in Efforts implies that there are considerable efforts available to address the prevention of sexual violence against adolescents in both the rural and urban portions of Racine County. There are multiple reasons why these two communities may be at the same stage of readiness in the Efforts dimension. One reason may be the shared resources of the two communities as discussed above. In addition to the two communities sharing many community resources and media sources, the two communities also share the prevention programs. The programs that provide prevention services (e.g. Sexual Assault Services, Women’s Resource Center, Safe Start, etc.) are typically obligated by local, state, and federal grants to provide the same services in both portions of the county. Since organizations that provide the prevention programs are typically required to provide services in both the rural and urban community, it is not surprising that the Efforts dimension is at a similar stage of readiness in both portions of Racine County.

Resources Dimension

Both communities also received their second highest score in the same dimension, “Resources,” indicating that there are financial, volunteer, and space resources available in the community to support prevention efforts. This finding is also understandable considering the shared community resources and prevention programs [see above] available to address sexual violence against adolescents in Racine County. In addition, a Coordinated Community Response team (CCR) has existed for 11 years, and addresses sexual violence, domestic violence, child abuse, and elder abuse in all of Racine County. The CCR also offers space for meetings, supports grant writing, and helps recruit volunteers, factors which are a component of the Resources dimension. In addition,

Sexual Assault Services (SAS), and the other prevention programs, Safe Start and Women's Resource Center, have an impact on the recruitment of resources in both portions of the county. For example, SAS advertises the need for resources throughout the county to businesses and organizations that may be able to provide financial, volunteer, or space resources to address the prevention of sexual violence. A similar stage of readiness in the Resources dimension is therefore consistent with the shared resources and overlapping efforts to recruit resources for both urban and rural Racine County.

Differences Between Rural and Urban Racine County

Climate Dimension

As stated above, rural and urban Racine County received their highest stage of readiness scores in the Efforts and Resources dimensions. Beyond these two dimensions, however, the results differ, with the largest difference arising in the Climate dimension. The urban Racine County community obtained a score of 3.4 (Vague Awareness) in the Climate dimension, whereas the rural community obtained a score of 2.2 (Denial and Resistance). One explanation for this difference in the Climate dimension may be the unique (demographic, socio-political, religious/ spiritual, etc.) variables of the two communities. Although, as discussed above, both rural and urban Racine County are members of larger regional communities (southeast Wisconsin, Midwest, etc.), which has an impact on their overarching social and cultural norms, there is still unique variation in rates of crime, poverty, ethnic diversity and income (<http://quickfacts.census.gov/qfd/states/55/55101.html> retrieved 6.12.09) between the two areas. For example, urban Racine County experiences higher rates of crime and poverty, has a higher unemployment rate, a larger population of people from diverse ethnic/ racial

backgrounds and a lower percentage of the population attends college (<http://censtats.census.gov/data/WI/1605511200.pdf> retrieved 6.9.09; <http://quickfacts.census.gov/qfd/states/55/5566000.html> retrieved 6.9.09). Research has shown that, in addition to the impact that regional norms have on a community, communities also transmit values and norms through localized sources such as peer clusters, family groups, schools, religious organizations, and other community based structures (Bracht, 1990; Crowell & Burgess, 1996; Flood & Pease, 2009; Oetting et al., 1998). This research indicates that the unique, localized, variations in communities have an impact on community values and, considering the fact that values are an important component to the Climate dimension, may support differences in this dimension between the two communities.

In addition, the difference in the Climate dimension may be related to the increased exposure to the occurrence of sexual violence in the urban community. Research has shown that increased knowledge and exposure to accurate information about sexual violence decreases one's acceptance of rape myths and increases one's empathy towards victims (Berkowitz, 2004; Foubert, 2005; Gwartney-Gibbs, Stockard, & Bohmer, 1983). The acceptance of rape myths is indicative of individuals' beliefs and attitudes regarding sexual violence (Casey & Lindhorst, 2009; Foubert, 1997), which, within the context of this study, is a defining characteristic of the Climate dimension. In 2004, 13 victims reported a sexual assault in rural Racine County in comparison to 204 victims reporting a sexual assault in urban Racine County (Office of Justice Assistance, 2005). This indicates that in 2004, more than fifteen times the number of sexual assaults were reported in urban Racine County than in rural Racine County. As a result of this increased rate of reporting

in urban Racine County, more community members are likely exposed to people who have been sexually assaulted and may therefore, as research has indicated, be more empathetic to sexual assault victims (Berkowitz, 2004; Emmers-Somer & Allen, 1999; Foubert, 2005; Gwartney-Gibbs, et al., 1983). In addition, given the significant difference in rates of reporting in the two counties, there is likely more localized media coverage within urban Racine County about sexual violence than in rural Racine County. Given this, it is possible that exposure to a heightened incidence of sexual violence in the urban portion of the county may result in community members having more sophisticated and intimate knowledge of the incidence and prevalence of sexual violence and more sensitivity to sexual violence. This difference in exposure may have impacted urban Racine County's higher stage of readiness than urban Racine County in the Climate dimension between the two portions of the County.

Differences in Dimensional Results within Rural and Urban Communities

Rural Racine County

Climate and Efforts dimensions. The results indicated that the Climate in rural Racine County was considerably lower in its readiness to address the prevention of sexual violence against adolescents than are the efforts available to address these issues. An illustration of this discrepancy in community climate and efforts available occurred when the interviewers asked the rural key respondents about the prevention efforts available, and whether the general community was aware of these efforts. Several key respondents stated that, despite the fact there are several prevention programs in the rural community, the general population is not aware of them. The reason the key respondents gave for the community's lack of knowledge of these efforts was not because the key

respondents felt the prevention programs had not done a good job advertising their services, but rather, because the community did not *want* to know about the efforts. For example, one key respondent stated “people don’t want to know what’s out there... it’s such a dirty secret sometimes: ‘Oh, we don’t want to talk about that.’” The attitude of not wanting to know what types of prevention efforts are available to address an “uncomfortable” issue like sexual violence may speak to the community’s attitudes towards sexual violence, which, within the context of this study, is a component of the Climate dimension (Edwards, et al., 2000; Jumper- Thurman, et al., 2001).

While there is not a causal relationship between these two dimensions (having a higher stage of readiness in the Efforts dimension does not cause a community to have a lower stage of readiness in the Climate dimension), the fact that rural Racine County’s highest score was in the Efforts dimension and its lowest score was in the Climate dimension does illustrate an important point. Specifically, this result indicates that SAS and other prevention programs may be implementing efforts at a stage of readiness that is above the community’s climate stage of readiness to accept them (Edwards, et al., 2000; Jumper-Thurman, et al., 2003). This mismatch of Efforts to Climate is evident when one examines some of the prevention programs SAS provides in rural Racine County. For example, SAS’s prevention programs include the provision of psycho-educational groups to adolescent boys. These groups utilize Paul Kivel’s “Making the Peace” curriculum (Kivel & Creighton, 2002), which explores the social roots of violence through intensive activities, handouts, role-plays, and discussion. These groups are designed to address and modify the prevailing social norms that contribute to, and foster, sexual violence. These groups include the necessary components for effective primary prevention

(comprehensive, varied teaching methods, grounded in theory, sufficient dosage, appropriately timed, socio-culturally relevant, etc.) as recommended by the Centers for Disease Control and Prevention (2004). In addition, these groups are consistent with the research which recommends that approaches to prevention are interactive, and presented to small all-male groups (Berkowitz, 2004; Foubert, 2005).

However, based on the community's low score in the Climate dimension, it appears that the community's social norms, attitudes, and belief systems are at a stage that is not ready to discuss the complex socio-political structures that impact the incidence of violence in our society reference. It appears that the community is in need of more basic education and awareness of sexual violence. Indeed, research has demonstrated that prevention programming is more effective when tailored to a community's specific needs and is contextually relevant (Casey & Lindhorst, 2009; Nation et al. 2003). Consequently, it may be more effective for SAS to further develop other components of their prevention program (i.e. media campaigns) as well as provide more education to the community on the prevalence, and personal and social impact of sexual violence, rather than programming which addresses social mores and norms. The latter may represent a more conceptually advanced stage of readiness, and the former may be a better "fit" for the community's needs and current Climate.

Knowledge of Issue, Knowledge of Efforts, and Efforts dimensions. Another interesting difference in readiness in rural Racine County was that the stages of readiness in the Knowledge of the Issue and Knowledge of the Efforts dimensions are relatively low, but the Efforts dimension received the highest score. The high score in the Efforts dimension is consistent with the reports of the key respondents who spoke of the

discrepancy between the efforts available to address sexual violence, and the general community's knowledge of those efforts. The key respondents indicated that they were aware of the efforts available, but they believed that the general community is not educated about them, nor about the issue of sexual violence prevention overall. Perhaps this lack of knowledge arose because some of the prevention programs SAS is implementing are at a higher stage of readiness (as discussed above) than the community is ready for. For example, if the prevention program is providing sophisticated information about how social norms influence the occurrence of sexual violence, without ensuring that the community has a basic understanding of the prevalence and incidence of sexual violence, the program may find that the audience is unable to engage in, understand, and/or relate to the programming. Indeed, Casey and Linhorst (2009) write, "contextualized prevention cannot occur without engaging community members to identify their beliefs about... sexual violence" (p. 100), which would include whether or not they perceived sexual violence to be a problem in the first place. Another reason why the Knowledge of the Issue dimension may be lower than the Knowledge of the Efforts dimension is a social norm in the community that makes it unacceptable to discuss issues like sexual violence. The low score in the Climate dimension provides supportive evidence for the social norm of not discussing sexual violence issues.

Resources and Climate dimensions. Another notable finding is the discrepancy between the Resources and Climate dimensions. The Resources dimension refers to the availability of financial, volunteer, space, and other resources, whereas the Climate dimension refers to the prevailing attitudes and social norms regarding a particular issue. Considering this, one may think that a community's climate would influence the degree

of resources available, and that the resulting stages of readiness may be similar. However, the Resources dimension in rural Racine County had the second highest readiness score, whereas the Climate dimension received the lowest stage of readiness score. One explanation for this discrepancy may be the presence of pockets of people and organizations in rural Racine County that are supportive of the efforts to prevent sexual violence and offer resources towards those efforts, but that the population overall does not recognize sexual violence as a significant problem. As a result, it is possible that these pockets of people and organizations are offering a disproportionately higher amount of resources to address sexual violence in comparison to the general community.

Urban Racine County

Efforts and Knowledge of Issue dimensions. Urban Racine County's highest score arose in the Efforts dimension, its lowest in the Knowledge of the Issue dimension. Thus, while there are significant programs and efforts in the urban community to address the prevention of sexual violence, basic knowledge of the issue among the community members appears to be low. Similar to the rural community, this discrepancy between degree of efforts and knowledge of the issue may be the result of the prevention programs not doing enough to increase the basic knowledge level in the community. The prevention programs may be provided at a stage of readiness that is not matched to that community (Oetting et al., 1995; Slater et al., 2005). This discrepancy is understandable when considering the focus on the Efforts in urban Racine County. Many of the prevention efforts in the urban portion of the county have focused on addressing the underlying social structures which allow sexual violence to thrive in our society. This focus on changing social norms was implemented, based on the understanding that it is

these underlying socio-cultural forces which support the root causes of sexual violence (Casey & Lindhorst, 2009; Centers for Disease Control and Prevention, 2004; Flood & Pease, 2009). As a result of this decision, there has been less focus on providing basic statistics and information to the community about the incidence, prevalence, and dynamics of sexual violence. The results of this study indicate that it is imperative that the prevention programs work to increase the basic knowledge and awareness of sexual violence within the community.

Efforts and Knowledge of Efforts dimensions. Another noteworthy result is the discrepancy in stage of readiness in urban Racine County between the Efforts dimension (stage six) and the Knowledge of Efforts dimension (stage three). This result occurred within rural Racine County as well, and indicates that although there are efforts available to address the prevention of sexual violence, the general community is not aware of them. An example of this discrepancy occurred when the interviewers asked the urban key respondents what types of prevention efforts were available. Some spoke of the work by law enforcement officers, the District Attorney's Office, the Sexual Assault Nurse Examiner (SANE) programs, and the services that Advocates provide to victims.

This focus on direct victim service rather than on prevention efforts may have occurred for a variety of reasons, including individuals being focused on their own job duties involving direct victim service, or as a result of a personal or political agenda to gain attention to their own particular area of professional work (Beebe, 2001). For example, if one of the systems represented by a key respondent was lacking in financial resources, it may be in that person's best interest to focus on direct victim services and not the prevention efforts in the community. One of the key respondents in this study

specifically spoke of the lack of resources within her or his system, although the intention of this focus is unknown.

In addition, direct services are a much more concrete and easily defined construct, whereas primary prevention is a relatively new concept to the field of sexual violence prevention and remains challenging to categorize and describe (Bloom, 1981; CDC, 2004; Gullotta & Bloom, 2003). Another more fundamental reason for this focus on direct victim services may be that there is simply a lack of basic knowledge of the prevention efforts available in the community. As previously mentioned, SAS only fully established the primary prevention programs in Racine County in 2007, and thus many people in the community may not be aware that these programs exist. Given the complexity of primary prevention, and the relative newness of the efforts, it is not surprising that the Efforts dimension was higher than the Knowledge of the Efforts dimension.

Leadership and Climate dimensions. Another remarkable result for urban Racine County are the low scores on both the Leadership and Climate dimensions. The leadership in a community has a direct impact on a community's climate and is also a reflection of that community's climate (Casey & Lindhorst, 2009; Fernandez et al., 2003; Kelly, 2004). For example, a community elects its leadership based on the degree to which the community members believe that the person is an accurate reflection of their values, belief systems, and principles, as well as based on the degree to which they believe these leaders will behave consistently in line with these principles (Woshinsky, 2007). Furthermore, the leadership in a community has the ability to impact the community through the decisions that person makes within the context of the leadership

role (Casey & Lindhorst, 2009; Fernandez et al., 2003; Kelly, 2004). For example, a criminal court judge decides the severity of sentences for sexual offenders. The severity of those sentences (length of incarceration, restitution requirements, etc.) may make a statement to the community about “how bad” sexual violence is. If the criminal justice system within a given community has a history of not prosecuting sexual offenders, or not sentencing them to the limits of that particular state’s statutes, that community may get the message that committing the crime of sexual violence does not have serious consequences, and therefore is not an issue about which they need to be overly concerned. Research has supported this hypothesis by demonstrating the impact leadership can have on changes in a community. For example, studies that have involved the training of “popular opinion leaders” to convey pro-social behaviors (safe sex practices, abstinence from drug use, a value of non-violence) to their respective social networks, have found that these tactics are an effective way of reducing these types of unhealthy behaviors (Casey & Lindhorst, 2009; Fernandez et al., 2003; Kelly, 2004). Within the context of this research, and given the potential symbiotic relationship between a community’s climate and its leadership it implies, it is understandable that the Leadership and Community Climate dimensions for urban Racine County received similar stage of readiness scores.

Implications: Suggested Implementation Strategies

The third research question of this study asked “How do the CRM dimensions and stages of readiness inform the implementation of sexual violence primary prevention strategies for the adolescent population in rural and urban Racine County?” Based on the results of this assessment, the researcher now better understands the current level of

awareness, knowledge, beliefs, and social norms regarding the prevention of adolescent sexual violence in these particular communities. This understanding informs the researcher about the communities' readiness to utilize primary prevention interventions and provides a framework for tailoring primary prevention strategies to the needs of each community. The researcher has tailored the suggested implementation strategies specifically to Sexual Assault Services (SAS), as SAS has agreed to implement this study's recommendations as a component of their prevention program.

Strategies to Increase the Overall Stages of Readiness

The overall stage of readiness score for both the rural and urban Racine County communities was "Vague Awareness." The CRM asserts that the goal of the implementation strategies at this stage is to "bring awareness of the problem to the level where it provides *motivation* to do something and to raise awareness that *this* community can, in fact, do something" (Oetting, et al., 2001, p. 836). This is similar to the tasks of Prochaska and DiClemente's Precontemplation stage, which is to increase the individual's awareness of the problem in an effort to increase her or his motivation to address the problem. The emphasis at the Vague Awareness stage is to help the community become motivated to address sexual violence through taking ownership of it as a problem that affects them, rather than just viewing it as a vague problem that happens to people "out there" in other communities. This researcher recommends three avenues to move these communities beyond the Vague Awareness stage of readiness: a) build meaningful relationships with community leaders who are essential to the successful implementation of sexual violence prevention programs; b) increase community members' motivation to address sexual violence by clearly demonstrating the

impact sexual violence has on their local community; and c) use media campaigns to provide community members with concrete strategies about how they, personally, can have an impact on the incidence of sexual violence in their communities. The researcher recommends these three approaches for two reasons. First, these approaches are consistent with the recommendations of the CRM for communities at the Vague Awareness stage of readiness. For example, each of the recommendations involves increasing the basic awareness and education of the community about the problem of sexual violence, with the goal of increasing the community members' motivation to address sexual violence. Secondly, these are activities that SAS either has the ability to begin (such as relationship development) or are activities that SAS is already engaged in, but could expand upon (such as the community presentations and media campaigns). Of relevance to the study's findings, it is important to note that although some of the SAS prevention program's existing activities are (as has been discussed) beyond the current stage of readiness of the communities (for example the psychoeducational groups with adolescent boys) and thus are potentially limited in their effectiveness, the activities suggested here do match Racine County's stage of readiness and therefore hold promise of improved effectiveness.

Relationship Development

The first avenue recommended by the researcher to assist Racine County in moving beyond the Vague Awareness stage of readiness is for SAS to build strong relationships with leaders in the community. The developers of the model warn that at this stage, some members of the community may be resistant to participate in, or support, prevention activities (Jumper-Thurman, et al., 2003). As previously discussed, the

leadership in a community has an impact on the norms and customs in a community and has the ability to transmit pro-social beliefs and behaviors (Casey & Lindhorst, 2009; Fernandez et al., 2003; Katz, 1995; Kelly, 2004). As a result, the researcher recommends that SAS builds relationships with those who may be important, yet resistant, to the implementation of the efforts by providing consistent and non-threatening encouragement about the need to address sexual violence against adolescents. This relationship development is preferably done by people who know these leaders and/or can appeal to their overall concern about the health of the community (Jumper-Thurman & Plested, 2000). Within the context of Racine County, it is important to involve community leaders who have an impact on the ability to provide prevention programs within the community, such as members of the school board and school administration, as well as executive directors of community organizations and agencies (such as the YMCA, the Martin Luther King Community Center, Safe Haven, etc.). This researcher recommends that SAS takes steps to systematically develop relationships with these community leaders so as to increase their awareness, knowledge, and motivation to address sexual violence. SAS can do this by first identifying the individuals in the community who are important to the implementation of the prevention programs. Second, the SAS Director should identify contacts within the SAS staff or volunteer base (or other community partners who are willing to act on the behalf of SAS) and ask them to contact these individuals and make an effort to develop an ongoing consistent and positive relationship with them. And third, those who develop the relationships with these leaders should work to gain buy-in from these leaders by discussing the problem of sexual violence in their local communities and explaining the need for their support of the prevention program. The

development of these relationships will assist in the implementation of the strategies discussed below.

Increasing Motivation Through Localized Information

The second avenue of action the researcher recommends to assist in the progression of Racine County beyond the Vague Awareness stage of readiness is increasing community member's motivation to address sexual violence by providing specific, localized information about how sexual violence affects their communities (Edwards, et al., 2000; Jumper-Thurman, et al., 2003; Oetting, et al., 2001). This can be done through two routes: first, in-person activities such as community presentations and events; and second, through the "passive" dissemination of information about localized incidents of sexual violence through media outlets (Jumper-Thurman & Plested, 2000; Oetting, et al., 2001).

Community Presentations and Events

The CRM asserts that those implementing the strategies should market community presentations and events to members of the community who have had limited exposure to sexual violence prevention (Oetting, et al., 2001). The purpose of this is to reach the segments of the population who are not in-tune with the realities of sexual violence and to help increase their motivation to address it. Providing localized information to community groups is of particular importance given the research that indicates that community group affiliation has an impact on individual attitudes towards sexual violence and that effective prevention efforts designed to change social attitudes and behaviors need to be implemented at a community-specific, local level (Flood & Pease, 2009). In addition, research suggests that prevention programming is more effective at

changing social norms when prevention efforts attempt to engage communities through existing social structures, as well as “contextualize” the information presented (i.e., tailor the information such that it reflects that community’s current and historical relationship to the issue) (Casey & Lindhorst, 2009; Nation et al., 2003). As an illustration, researchers who conducted a CRM assessment in a Native American community, and determined that it was at the Vague Awareness stage of readiness, used hog fries, pot lucks, and potlatches to increase community awareness and begin motivating action (Oetting, et al., 2001).

Within the context of Racine County, this researcher recommends increasing the public awareness component of the SAS prevention program. For example, SAS has a Volunteer and Community Education Coordinator, who is responsible for both recruiting and maintaining a volunteer base, as well as conducting community education activities. As a result of the need for volunteers to provide the basic SAS crisis intervention services, the staff person has focused more on volunteer maintenance and less on community education. This focus on volunteer recruitment has resulted in the staff person conducting fewer presentations to community groups and initiating fewer community events. The results of this study indicate that the rural and urban communities are in need of specific, localized information as a way to increase their motivation to address sexual violence, and, as a result, it is important that this position re-focus on providing more community education. The Volunteer and Community Education Coordinator can provide presentations to local community groups such as The Kiwanis Club, The Tuesday, Wednesday & Friday Optimists, Transitional Living Services, Racine Area Manufacturers and Commerce, the Rotary Clubs, the Lion’s Clubs, the Junior League and

area churches. The focus of the presentations should be on localized rural and urban Racine County sexual assault statistics. For example, the presentations can provide information about the number of victims seen at the area hospitals per year, the number of crisis line calls answered monthly, and the number of victims who access counseling services annually. In addition, de-identified demographic information can be provided to bring a personal dimension to the statistics. For example, information about the average age of the victim can be provided as well as information about the offender's relationship to the victim (acquaintance, father, sibling, etc.). These efforts may help to make the sexual violence more of a "personal" issue for the members of rural and urban Racine County, and may help to increase their motivation to address it.

Provision of Localized Information Through the Media

In addition to community presentations and events, the researcher is recommending that prevention efforts focus on raising the awareness of the local problem of sexual violence by publishing newspaper editorials, press releases, and articles related to sexual violence within the community. This provision of localized information about a problem through the media has been used with success in other communities at the Vague Awareness stage of readiness (Engstrom, Jason, Townsend, Pokorny & Curie, 2002). These articles, editorials and press releases should focus on local incidents so that the community members have a better understanding that sexual violence is happening in their communities and that sexual violence directly impacts their community members. To help ensure the success of these efforts, the researcher recommends that SAS allocates a portion of staff time of one position (Director or Coordinator of SAS) to be responsible for monitoring how the local media portrays sexual violence and sexual assault victims,

and respond accordingly through articles and letters to the editor. For example, the staff person can write articles for the local newspaper about the prevalence of sexual assault in Racine County with specific information about rates of reporting, average age of victims, relationship to offender, and number of victims served by SAS. In addition, the staff person can respond to opportunities that arise in the community concerning sexual violence by writing press releases and submitting letters to the editor. In particular, SAS should consistently respond through the media when high-profile sexual assault cases occur. For example, two high profile sexual assault cases occurred in the past year in Racine County, when (as previously mentioned) the Mayor of Racine was arrested for charges of child enticement, possession of child pornography, exposing a child to harmful materials, attempted second-degree sexual assault of a child, use of a computer to facilitate a child sex crime

(http://www.journaltimes.com/articles/2009/01/14/local_news/doc496deda1079ed663015381.txt Retrieved 6.2.09). In addition, a Racine Police Department officer was arrested for sexual assault of a child under the age of sixteen, repeated sexual assault of a child, and exposing a child to harmful material

(http://www.journaltimes.com/articles/2009/05/06/local_news/doc4a01afb0c514d628724110.txt Retrieved 6.2.09). As the primary provider of prevention efforts in Racine County, it is the responsibility of SAS to respond accordingly to such incidents. Writing newspaper articles, press releases, and letters to the editor in response to such incidents could help provide a consistent and widespread message to the community that sexual violence is a problem locally and may increase their motivation to address it.

Using Media Campaigns to Illustrate Methods for Personal Involvement

The researcher's third category of recommendations to increase motivation in the rural and urban Racine County communities involves conducting broad-based awareness building activities, specifically through the use of media campaigns. The researcher recommends a two-step process towards the implementation of this strategy. The first step is conducting focus groups to assess how the media campaigns match the norms and values of the communities, followed by using the feedback of the focus group to guide the implementation of the media campaigns. The researcher recommends that the SAS prevention program implement media campaigns that portray the message that individuals in the community can personally impact the incidence of sexual violence, specifically through the use of the "My Strength Campaign," the "Do You Ask?" program, and the "Bringing in the Bystander" program. The researcher will first discuss the value of focus groups and media campaigns, and then thoroughly explain the nature of these three media campaigns.

Focus Groups

When implementing media campaigns, it is critical to determine whether the community members will receive the campaign messages as intended. Focus groups are a useful method of gaining understanding about how community members will perceive the media campaigns and aide in assessing which images best convey the intended message (Barbour, 2005; Freeman, 2006; Potter, 2008). Within the context of Racine County, the researcher recommends conducting focus groups in both rural and urban Racine County. The purpose of these groups is twofold: first, to aid in the successful implementation of the media campaigns; and second, to build relationships with members

of the community with the goal of increasing their awareness of, and motivation to address, sexual violence. When SAS forms the focus groups, it is important that they recruit members that represent “the diversity of the media campaign’s target audience” (Potter, 2008). SAS can do this by recruiting adolescents from area high schools, middle schools, and community groups, as well as the community leaders whom SAS will ask to allow the media campaigns in their organizations (school administrators, community organization leaders, etc.) The focus group participants can discuss their impressions of the “Men of Strength,” “Do You Ask?” and the “Bringing in the Bystander” poster campaigns and explore how the images facilitate or hinder the message that individuals can impact the incidence of sexual violence in their communities. (Donovan, Francas, Patterson & Zappelli, 2000). For example, the SAS staff can ask the participants to describe the messages they think the poster campaigns are trying to convey and if they could see themselves taking the action advocated by the campaign. Potter (2008) recommends asking focus group members to “comment on the campaign language, model’s appearances, the background scenery, poster graphics and provide insight into product placement” (p. 4). The information gathered from the focus groups will provide SAS with guidance about which posters most effectively convey the intended message and provide information about how to most successfully implement the media campaigns in the communities.

Value of Media Campaigns

Media campaigns can be a relatively inexpensive way to reach an audience to introduce and promote general prevention messages, and can play a role in changing social norms, reinforcing positive behaviors, and supporting policy change (Nation et al.,

2003; Wandersman & Florin, 2003). Furthermore, for the past two decades, sexual violence advocacy organizations have used media campaigns to increase the public's knowledge about the incidence and prevalence of sexual violence (Fabiano, Perkins, Berkowitz, Linkenbach, & Stark, 2003; Kitzinger & Hunt 1993). Other communities (Edwards, et al., 2000) at the Vague Awareness stage of readiness have successfully used media campaigns, specifically using images of children and a caption stating, "Our community can change their world."

Research has found that well-crafted media campaigns can raise awareness and influence behavior (Advertising Council, 2004; Potter, 2008). One well-known and highly successful media campaign is the "Friends Don't Let Friends Drive Drunk" campaign. This message has impacted the social acceptability of drinking and driving and has rendered sayings like "one for the road" politically incorrect (Advertising Council, 2004). A 2002 Ad Council Survey showed that "90 percent of adults were aware of advertising with the tagline 'Friends Don't Let Friends Drive Drunk'" and that "62% of Americans have tried to stop someone from driving drunk" (Advertising Council, 2004, p. 18). This particular campaign is especially applicable to the sexual violence prevention field in that it was one of the first of its kind to direct the message to someone who could intervene in a situation to prevent a negative behavior from happening, (in this case, stopping someone from driving drunk). This campaign brought awareness to the "intervener strategy" (Advertising Council, 2004, p. 19), which has been successfully adapted by the sexual violence prevention field to the concept of "bystander intervention" (Banyard, Plante & Moynihan, 2004; Potter, 2008).

Recommended Media Campaigns

Three examples of media campaigns that address sexual violence prevention through encouraging personal action are the “My Strength Campaign,” the “Do You Ask?” program, and the “Bringing in the Bystander” program. These three programs are consistent with the CRM recommendations for communities at the Vague Awareness stage of readiness as they incorporate messages aimed at increasing the motivation of individuals to do something personally to reduce the incidence of sexual violence.

SAS has implemented the first two of these programs (the My Strength and Do You Ask? programs) during the 2007-2008 and 2008-2009 academic years, and based on the results of this study, are an appropriate match to the communities’ stages of readiness. This recommendation is based on the fact that the poster campaigns aim at increasing both viewers’ understanding of the dynamics of sexual violence and their motivation to take personal action to reduce the incidence of sexual violence.

For example, the My Strength posters redefine what it means for men to be “strong” by encouraging men to use their strength to listen to, and be respectful of, their partners. In addition, the Do You Ask? program encourages viewers to be personally responsible for getting active consent for sexual activity from their partners. Both of these approaches are consistent with increasing motivation of community members to address sexual violence, as recommended for communities at the Vague Awareness stage of readiness. This recommendation is also consistent with Drum’s (1984) suggestion that prevention programs go beyond informing to transforming an audience about a given issue. He argues that a prevention program must translate broad, basic information into information that individuals can use personally.

Despite SAS's past use of these poster campaigns, the implementation of the posters has been limited to certain schools and community centers and, based on the results of this study, should be more fully and systematically implemented. The third media campaign, *Bringing in the Bystander*, is new to Racine County and reflects the CRM recommendation of encouraging the members of the community to take personal action to reduce the incidence of sexual violence.

My Strength. The first media campaign, the My Strength program, was originally developed by Washington DC's Men Can Stop Rape, and is currently being administered by the California Coalition Against Sexual Assault (CALCASA). These posters focus specifically on addressing men's role in stopping sexual violence. The goal of this campaign is to "embrace men as vital allies with the will and character to make healthy choices and foster safe, equitable relationships" (<http://www.mencanstoprape.org/info-url2696/info-url.htm> Retrieved 6.12.09). The images depict males of diverse ethnic backgrounds with what is perceived to be a romantic partner (the posters include images of both male and female partners) and the tagline, "My strength is not for hurting," followed by variety of pro-social statements such as, "So when she said no, I said ok," "So when I wasn't sure how she felt, I asked," and "So when I wanted to, and he didn't, we didn't." Prevention programs have consistently praised the My Strength program and have implemented it widely around the country (Potter, 2008).

As mentioned, the My Strength program has been a component of SAS's prevention efforts during the 2007-2008 and 2008-2009 academic years. SAS has purchased 115 of these posters and implemented them in eleven schools and three community centers in the county. The use of the media campaign is consistent with the

Racine County communities' stages of readiness in that it provides the community with basic information about sexual violence dynamics, and encourages the reader to personally act in a way that impacts the incidence of sexual violence in their community. Based on the results of this study, this researcher recommends that SAS expand these efforts. As a result, this researcher recommends the investment of additional funds towards the purchasing and widespread implementation of these posters. As is consistent with the "saturation" technique recommended by the Centers for Disease Control and Prevention (2004), SAS should uniformly distribute the posters to all available community organizations, agencies, businesses and schools throughout the county.

Do You Ask? The second media campaign is the "Do You Ask?" media campaign, which is a part of the Date Safe Project and utilizes the tagline, "Respect your Partner. Get Consent. Ask First." The Date Safe Project aims to provide "strong and positive voices for discussing sexual assault awareness, healthy dating, and specifically addressing consent" (<http://www.thedatesafeproject.org/about.htm> Retrieved 6.12.09). This media campaign's message is one of men and women openly communicating about giving and requesting consent with a sexual partner. These posters complement the My Strength campaign by broadening the focus to include women as partners in preventing sexual violence, and uses images of younger models and less sexually advanced messages ("May I kiss you?" versus "When she said no, I stopped.") This diversity of age of models and messages makes this campaign adaptable to both the middle school and high school level, whereas the My Strength and Bringing in the Bystander campaigns are better suited for high school and college-aged audiences. The use of messages that fits with the language and demographics of the viewer is an important component of the

campaign, as research has stressed the importance of using language that resonates with the target audience (Lederman, Stewart, Goodhart & Laitman, 2003).

The SAS program has similarly implemented the “Do You Ask?” campaign during the 2007-2008 and 2008-2009 academic years. SAS has purchased and implemented 40 of these posters in four schools and three community centers. This researcher recommends purchasing additional Do You Ask? posters and more consistently implementing them in schools and community centers. This recommendation is based on the fact that the Do You Ask? campaign encourages viewers to take personal responsibility for their sexual actions by promoting the concept of obtaining verbal consent prior to engaging in sexual activities. This message is consistent with the recommendations that communities at the Vague Awareness stage of readiness should encourage members to be personally responsible for impacting the incidence of sexual violence in their communities.

Bringing in the Bystander. The third media campaign this researcher recommends as a result of this study, the Bringing in the Bystander program, is new to the prevention efforts in Racine County. Researchers at the University of New Hampshire developed The Bringing in the Bystander media campaign, which uses a community of responsibility model to encourage bystanders to intervene safely and effectively in cases where sexual assault may be occurring or where there may be risk (<http://www.know-your-power.org/> Retrieved 6.12.09). The Bringing in the Bystander media campaign utilizes the tagline “Know your Power. Step in. Speak up. As a bystander you can make a difference.” The posters portray actors modeling pro-social ways to intervene in situations where sexual violence is occurring or has the potential to occur (Potter,

Stapleton, & Moynihan, 2008). The campaign consists of eight posters depicting various scenarios involving the opportunity for a bystander to intervene in a situation that looks to be potentially dangerous. While several of the posters depict images that are only applicable to college campuses (due to references about contacting the “RA” or referring to on-campus resources), five of the posters convey messages that are appropriate for community use. Specifically, there are messages about how to respond to a friend who discloses a sexual assault (“Support a friend. Your support encourages victims of violence to seek help”) and how to respond to statements that encourage sexual violence (“Speak up when you hear stories that glorify sexual violence. Your responses can make a difference.”). In addition, the campaign addresses the use of alcohol as a tool to commit sexual violence with the statement: “Alcohol is the #1 date-rape drug. Don’t let anyone use it to commit sexual assault.” The campaign also includes a poster that speaks to the presence of sexual violence within the LGBTQ population, with the statement, “Speak out against intimate partner violence. It affects people who are gay, lesbian, bisexual and transgender too.”

The researcher recommends the inclusion of the “Bringing in the Bystander” media campaign in the Racine County prevention efforts for a variety of reasons. First, it is one of the few media campaigns that actively addresses the role bystanders can take in reducing the incidence of sexual violence in their communities. Furthermore, a growing number of prevention programs are utilizing bystander interventions as an effective mechanism to reduce sexual violence (Banyard, Moynihan, & Plante, 2007; Berkowitz, 2003; Foubert, 2000; Katz, 1995; Schwartz, DeKeseredy, Tait, & Alvi, 2001). In addition, research has demonstrated the efficacy of bystander intervention programs.

Banyard, Moynihan, and Plante, (2009) report “experimental and longitudinal evaluations of a prevention program to empower bystanders indicate the intervention program increased participants’ knowledge, attitudes, and behaviors regarding prosocial bystander behaviors” (p. 108).

Secondly, the Bringing in the Bystander campaign is one of the few poster campaigns that has been empirically tested and shown to have a positive influence on the pro-social behaviors of bystanders. The poster campaign was developed as a result of empirical research that finds sexual and intimate partner violence to be “rooted in larger cultural, community, and peer norms that support coercion in relationships” (Potter, Moynihan, Stapleton, & Banyard, 2009, p.108). In addition, Potter, et al., (2009) conducted a study assessing the effectiveness of the posters in changing bystanders’ potential behaviors, and reported that “participants who reported seeing the posters exhibited greater awareness of the problem...and greater willingness to participate in actions aimed at reducing sexual violence...compared to those students who did not report seeing the poster” (p.118). These findings provide positive support for the use of this campaign in Racine County.

Synthesis of the Media Campaigns

The researcher recommends the use of these three media campaigns for complementary reasons. The My Strength campaign focuses on engaging men in the ending sexual violence, the Do You Ask? posters are marketed to a younger population of both genders and encourage the open discussion about consent between partners, and the Bringing in the Bystander program is based on sound research and utilizes the bystander intervention strategy. These three campaigns are consistent with the CRM

strategy at the Vague Awareness stage of readiness that encourages community members to personally make a change in the incidence of sexual violence against adolescents locally. This researcher recommends that SAS continue to utilize and purchase more of the My Strength and Do You Ask? posters, as well as invest in the purchase of the Bringing in the Bystander posters. The researcher then recommends utilizing the feedback of the focus groups to place these posters in locations that reflect the age, ethnic diversity, and development level of the population of the setting.

Strategies to Increase the Dimensional Stages of Readiness

The CRM recommends that researchers target the dimensions with lower scores of readiness with specific approaches to increase the readiness of those dimensions (Kelly, et al., 2003; Jumper- Thurman, et al., 2001). The CRM developers assert that efforts should be taken to move all dimensions toward the same level of readiness, so that the intensity level of the interventions is consistent with the stage score for all the dimensions (Edwards et al., 2000; Jumper- Thurman, et al., 2001). The developers of the model state that “an emphasis on developmental appropriateness keeps communities from engaging in too ambitious of efforts that are likely to meet with failure because of insufficient awareness of resources to support them” (Kelly, et al., 2003, p. 417)

In this section, the researcher will discuss strategies that are appropriate for the dimensions with the lowest stages of readiness in the two communities in Racine County. However, there is only one stage of readiness difference between the overall stages of readiness and the lowest dimensional stage scores in the two communities. As a result, and due to reasons that will be discussed below, there is significant overlap between the recommendations to increase the overall stage of readiness and the dimensional stages of

readiness. In an effort to clearly delineate the reasons for this overlap, the researcher will first discuss the structural and philosophical underpinnings of the CRM strategy recommendations.

Strategy Structure of the CRM

The CRM clusters the implementation strategies for the nine stages of readiness into three categories: “lower, intermediate and advanced stages of readiness” (Kelly, et al., 2003). The focus of the recommended strategies for the lower three stages of readiness (stages 1-3: No Awareness, Denial and Resistance and Vague Awareness) is to help increase the community’s awareness that they should, and can, do something about an issue. This recommendation differs from the recommendations for communities in the three intermediate stages of readiness (stages 4-6: Pre-planning, Preparation and Initiation), where strategies prepare the community to take specific actions relevant to their goal. The CRM recommends activities focused on maintaining and evaluating the efforts for communities in the three advanced stages of readiness (stages 7-9: Stabilization, Confirmation and Expansion and Professionalization) (Kelly, et al., 2003). These categories provide a three-level framework for the recommendations of the nine stages of readiness, and results in three broad classifications of recommendations (lowest stages: awareness building; intermediate stages: planning and initiation; advanced stages: maintenance of efforts).

In addition, the CRM structures the recommended strategies in such a way that each stage’s strategies build on the previous stages. For example, the strategies the CRM recommends for stage three, Vague Awareness, include the strategies recommended for stage two, Denial and Resistance. These recommended strategies include activities aimed

at increasing the education and awareness of the local impact of sexual violence, through such activities as community presentations and articles to the media. The CRM structures this overlap of recommended strategies to ensure that the stage strategies build on one another in a logical, linear manner and that the efforts are consistent with past implementation efforts (Edwards, et al., 2000).

As a result of the above mentioned issues (the categorization of strategies and the building of one strategy on the previous stage's strategies), there is significant overlap in the recommendations for the stages within each of the three categories (low, intermediate, and advanced stages of readiness).

Denial and Resistance Stage of Readiness

The lowest dimensional score for both the rural and urban communities was Denial and Resistance, which falls in the same category of strategies as the two communities' overall stage of readiness: Vague Awareness. As a result of the reasons states above, these two stages (Denial and Resistance and Vague Awareness) share many of the same recommended intervention strategies. Therefore, in an effort to avoid redundancy, in the following sections the researcher will focus only on the specific recommendations for the Denial and Resistance stage that do not overlap with the Vague Awareness stage.

Climate Dimension in Rural Racine County

The CRM assessment indicated that the "Community Climate" dimension was at the lowest stage of readiness (Denial and Resistance) in rural Racine County. When a community's climate is at the Denial and Resistance stage, the CRM asserts that there is not generalized support to prevent sexual violence, nor understanding that sexual

violence is even a concern to people locally (Edwards, et al., 2000; Jumper-Thurman & Plested, 2000). At this stage, the prevailing attitude is that sexual violence only happens to “certain people” and that “there is nothing that we can do about it” (Jumper-Thurman & Plested, 2000). Furthermore, at this stage, it is likely that many of the community members endorse rape myths, or “prejudicial, stereotyped or false beliefs about rape, rape victims and rapists” (Burt, 1980, p.217). Common rape myths include “no doesn’t really mean no,” “women ‘ask for it’ by the way they dress or act,” and “if a person didn’t fight back, she or he wasn’t raped.” When a community believes these types of myths, they are less likely to support sexual assault victims, or to be interested in intervention and prevention programs in the community that are working to address sexual violence (Flood & Pease, 2009). Many of the strategies recommended to increase the overall stage of readiness in rural Racine County are designed to decrease the endorsement of such myths. Most specifically, the My Strength and Bringing in the Bystander media campaigns aim at reducing the endorsement of rape myths and changing bystander’s behaviors in potentially dangerous situations (Potter, 2009).

Outreach activities. As mentioned, many of the strategies recommended at the Denial and Resistance stage overlap with those of the Vague Awareness stage of readiness. However, one strategy that this researcher recommends for implementation in rural Racine County that is unique to the Denial and Resistance stage is the increased collaboration with the local health outreach programs to gain support in the distribution of flyers, posters, and brochures. This strategy has been used with success in other communities (Plested, et al., 2006), and based on the resources available in Racine County, the researcher believes it could be successfully implemented in the rural

community as well. Specifically, the researcher recommends that the SAS Rural Outreach Coordinator further strengthen her relationship with the point of contact at the Public Health Department in Burlington. This Public Health staff person is a member of the local Coordinated Community Response (CCR) team and collaborates with SAS on a number of projects within rural Racine County. Further strengthening this relationship will allow for increased opportunities for the distribution and implementation of the media campaign posters and general education flyers.

Knowledge of the Issue Dimension in Urban Racine County

The CRM assessment indicated that the “Knowledge of the Issue” dimension was at the lowest stage of readiness (Denial and Resistance) in urban Racine County. At this stage, the general community does not have basic knowledge about the issue and does not believe that sexual violence affects them locally. The goal at this stage is to increase the community’s knowledge of the incidence, prevalence, and consequences of sexual violence locally. The strategies to reach this goal are consistent with those recommended in the section on increasing the overall stages of readiness. Specifically, the SAS program should allocate additional staff time to provide education to the community about sexual violence through presentations to community groups and submitting articles about the local prevalence and effects of sexual violence to area newspapers and newsletters. The goal at this stage is to increase the sophistication of knowledge of the community members about sexual violence generally and locally.

Limitations of the Study

Theoretical

One limitation of the CRM is that the model may neglect a variety of factors that contribute to a community's ability to address the prevention of sexual violence that extend beyond the six dimensions of the model. For example, the model does not overtly assess the community's ability to provide culturally competent programming, nor does it address the barriers that individuals from diverse backgrounds face in obtaining prevention programming. Rural and urban Racine County have sizeable Hispanic/Latina/o and African American populations (<http://quickfacts.census.gov/qfd/states/55/55101.html> retrieved 6.5.09), and the CRM does not directly assess the obstacles these populations face in accessing services and prevention programs related to sexual violence. This lack is a cause for concern, particularly in light of the research which indicates disparities in access to health services by minority populations in the United States (Clark, 2009; Flores & Tomany-Korman, 2008). The developers of the CRM do emphasize the importance of providing culturally sensitive assessments. However, this researcher recommends that the developers of the CRM make their dedication to cultural sensitivity more explicit by including a dimension in the CRM that specifically assesses for cultural competency within the prevention efforts.

Another theoretical limitation of the CRM (as previously discussed) is the lack of distinction between the stages of readiness and between the dimensions. The researcher recommends either further clarifying the language of the anchored rating scales and the stages of readiness, or exploring the possibility of collapsing the model into fewer stages to increase the distinction between the stages. Furthermore, the researcher recommends clarifying the definitions of the dimensions, as well as more thoroughly exploring the

differences between some of the dimensions (e.g., Efforts and Knowledge of Efforts). It is this researcher's opinion that such changes would provide for increased clarity of the model.

Sampling

Another limitation of the CRM, as pointed out by Beebe et al. (2001), is the model's reliance on key respondents, as they may represent the vocal minority rather than the silent majority within a community. In addition, it is possible that key respondents do not provide an objective perspective of the issues and rather, may have used the opportunity to speak about this issue for political advantage, such as "minimizing problems to make a community appear more desirable or overstating problems to establish the basis for new or continued funding" (Beebe et al., 2001, p.56). Although it is not clear whether this happened within this study's sample, several of the key respondents did speak of their respective systems' (SANE program, DA's Office, Law Enforcement, etc) lack of resources and need for additional support. The sample also lacked ethnic and cultural diversity, as all thirteen participants identified as Caucasian. Although the racial makeup for rural Racine County is predominantly Caucasian (96%), the racial/ethnic make-up for urban Racine County is considerably more diverse (68.9% Caucasian, 20.3% African American, 14% Hispanic/Latino, .6% Asian, and .4% American Indian/Alaskan Native) (<http://quickfacts.census.gov/qfd/states/55/55101.html> retrieved 6.5.09). Despite the diverse population in urban Racine County, people from diverse backgrounds hold a small minority (6%) of leaderships positions within the community

(<http://quickfacts.census.gov/qfd/states/55/55101.html> retrieved 5.17.09). Given this fact, the demographics of the key respondents used in the study are largely consistent with the demographics of people in leadership positions (from which the key respondents are recruited) but not of the general population.

Instrument

The researcher could have more clearly defined the interview questions. For example, the second question of the CRM interview protocol was, “Can you describe any efforts you are aware of that address the problem of sexual violence against adolescents?” An improvement of this question would be to clarify that the interviewer is interested specifically in *prevention* efforts. As a result of this lack of clarification, it is possible that key respondents forgot that the focus of the interview was on prevention and rather, focused on intervention efforts.

In addition, the researcher should have included a uniform and guiding definition of primary prevention during the introduction of the interview process. As previously discussed, primary prevention is a complicated and challenging concept, and thus a clear definition of it during the introduction of the interview may have provided some clarity to the concept for the participants. In addition, the inclusion of a clear definition of primary prevention may have reminded the participants to focus their answers on the prevention efforts in the community. For example, several of the participants answered the interview questions by providing information about the direct victim services available in the community rather than discussing the prevention efforts. The inclusion of a definition of primary prevention during the introduction may have helped keep the concept of

prevention at the forefront of the participants' minds and thus, may have impacted their responses.

Methodological

Because this was a dissertation, the primary researcher adapted the CRM methods so that she was more involved in the study than the developers of the model recommend. The primary researcher has been an active member in the Racine County professional community for the past eight years. As a result of this community involvement, the dissertation committee decided that she should not conduct any of the interviews, so as to remove any relationship bias between the interviewer and key respondents. However, it was important that the primary researcher contribute to the completion of the study in a substantive role. Consequently, despite the fact that the CRM recommends that the scorers not be familiar with the communities assessed, the dissertation committee decided that the primary researcher would be one of the scorers, so that she could contribute to the completion of the study. This involvement of a scorer who was familiar with the communities may have affected the scoring process. Although such effects were, in part, controlled by the use of two scorers, it is still possible that having outside knowledge of the community and the key respondents affected how the researcher perceived and scored the data.

Furthermore, this study utilized three interviewers, two men and one woman, who ranged in age from 32 to 45 years old. Although the primary researcher trained the interviewers to perform the interviews in the same format and manner, it is possible that their age, gender, and personality styles influenced the manner in which they conducted the interviews. These demographic and personality differences may have affected the

amount and type of information disclosed by the key respondents, and thus may have affected the interview data.

Implications for Future Research

The present study contributes to the literature by providing an example of how the CRM can assess the primary prevention of sexual violence against adolescents, the first such contribution to the literature. Future research may include assessing the primary prevention of sexual violence within other communities to determine the stages of readiness in other parts of the state, country, or world. This would provide additional information about the progress of sexual violence prevention on a broader scale. For example, if Racine County is at the Vague Awareness stage (stage three) of readiness to prevent sexual violence, but other communities around the state or country are consistently at the Stabilization stage (stage eight), this difference would give an indication that there is something unique about Racine County and may point to particular dimensions (i.e. Leadership, Efforts, etc) that could be developed in this community to better address sexual violence prevention.

In addition, future researchers could examine other subsets of the population within Racine County. For example, this study focused on the prevention of sexual violence against adolescents. Future studies could examine the prevention of sexual violence against adults, children, or the elderly, as well as sexual violence against people from diverse ethnic or racial backgrounds or sexual orientations. Furthermore, researchers should conduct additional research to establish the reliability, validity and “trustworthiness” of the CRM, according to quantitative or qualitative standards.

Lastly, a second CRM assessment of Racine County should be conducted in the future to determine whether the communities have progressed in their stages of readiness following the implementation of the strategies recommended in this study. This reassessment may indicate whether the recommended implementation strategies are increasing the communities' stages of readiness, and may provide additional information about where SAS should focus its efforts in the future.

Summary and Conclusions

This study examined the unique characteristics of rural and urban Racine County with regard to the prevention of sexual violence against adolescents. It provided information about the overall stages of readiness to address the prevention of sexual violence against adolescents within these communities, as well as information on which dimensions of the communities are more or less ready to address these issues. Furthermore, this project has suggested implementation strategies designed to meet these communities at their unique stages of readiness. As previously stated, the rape crisis center, SAS, has agreed to implement the recommended strategies proposed within this study and to provide the key respondents a summary of the results of this study.

The overall results of this study indicated that the rural and urban communities in Racine County are at the Vague Awareness stage of readiness to address the prevention of sexual violence against adolescents. At this stage, the communities acknowledge that sexual violence is a problem and that something should be done about it, but the community members lack motivation to address it directly. As a result, the communities are in need of activities that help raise the awareness that they do, in fact, have the ability to affect the prevalence of sexual violence. This researcher recommends increasing the

communities' motivation to address sexual violence in their local communities by increasing their understanding and sensitivity to sexual violence through focusing on relationship building, conducting community presentations, disseminating information about sexual violence through local media outlets, and through the widespread implementation of media campaigns.

Sexual violence against adolescents is a crime that has devastating effects on victims, families, and communities. It affects the mental and emotional health, as well as the productivity, of our community members. It is a crime that is embedded in the social, political, and cultural structures of our society. The purpose of this study was to give the primary prevention programs instituted in Racine County the best chance of success by ensuring that they are appropriately matched to the communities' unique culture, norms and stages of readiness. It is only through the effective implementation of these types of prevention strategies that may we see a decrease in the incidence of this crime.

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Appendix A: CRM Dimensions

Dimensions of Community Readiness Model		
Dimension #	Dimension	Description of Dimension
1	Existing Prevention Efforts	What programs, activities, or policies exist to address the issue?
2	Community Knowledge of Prevention Efforts	What knowledge is there regarding the efforts being done to address the problem of sexual violence?
3	Leadership	Who are the appointed leaders or community members who are addressing the issue of sexual violence?
4	Community Climate	Prevailing attitudes in the community regarding sexual violence.
5	Knowledge about the Issue	Knowledge regarding the problem of sexual violence.
6	Resources	What financial, personnel, training resources are available to address the issue.

Appendix B: CRM Stages of Readiness

The Stages of Readiness Within The Community Readiness Model		
Stage #	Stage Name	Characteristics of Stage
1	No Awareness	The community does not recognize the issue as a problem.
2	Denial	There is little to no recognition of the issue as a problem within the local community.
3	Vague Awareness	There is a sense that the issue may be a problem in the community, a feeling that something should be done about it, but a lack of motivation to do anything about it.
4	Preplanning	There is recognition that there is a problem locally with the issue and a belief that something should be done about it.
5	Preparation	Planning is occurring in regards to how to address the issue. Information is gathered about how the issue affects the community locally as well as various possible prevention activities, actions or policies.
6	Initiation	An activity or action has been started and is underway, but it is still viewed as a new effort.
7	Stabilization	There are a few programs or activities being run and, overall they are experiencing support from community leaders. The staff are well trained and the efforts are viewed as stable.
8	Confirmation/Expansion	Standardized efforts are in place and the community leaders support expanding and improving those efforts. Original efforts have been evaluated and revised and new efforts are being explored and planned.
9	Professionalization/ High level of community ownership	The community has detailed knowledge regarding the prevalence, risk factors and causes of the problem. Efforts have become strategic and are regularly evaluated and revised.

Appendix C: Community Readiness Model Interview Questions

Opening issues/ Informed Consent:

As a reminder, this conversation will be recorded so that it can be transcribed later. Is that still okay with you?

Following your interview we'll assign a code number to the data to protect your confidentiality.

If there are pauses, it is because I am writing down notes in case something happens to the tape.

Introduction:

Thank you again for agreeing to participate in this research study.

As a reminder, the study is on the prevention of sexual violence against adolescents in Racine County. You were selected as a participant because you are seen as a leader in *the community/ in your school*. However, you may not know the answer to all of the questions, and that is okay. In addition, some of the questions may make more sense to you than others, and that is also okay. Just answer them as best as you can.

For the purposes of this study, sexual violence is defined as any act that is sexual in nature and without the full consent of both individuals. This can include physical acts that are sexual in nature such as fondling, incest, sexual assault and rape, as well as non-contact acts that are sexual in nature such as voyeurism and verbal or behavioral sexual harassment.

For the purposes of this interview, the term "community" refers to the community in which you live (the city of Racine/ city of Burlington) and surrounding areas.

Do you have any questions before we begin?

Interview Questions:

Opening/ warm up questions

1. *For adults:* Can you describe your role or position in the community?
For adolescents: Can you tell me what grade you are in and what school you attend?
2. How long have you been a member of the Racine County community?
3. Can you describe the *city of Racine/ city of Burlington* to me? (population size, demographics, industries, culture, etc.) (D)

Great. Now we are going to move into the questions about sexual violence within Racine County.

Dimensions A & B: Community Efforts and Knowledge of Community Efforts

4. **Using a scale from 1-10, how much of a problem do you think sexual violence against adolescents is in *Racine/ Burlington*?** (with 1 being "not at all" and 10 being a "very great concern") Please explain.

5. **Can you describe any efforts you are aware of that address the problem of sexual violence against adolescents? (A)**
 - a. **How long have those efforts been going on in your community? (A)**
 - b. **What are the strengths of these prevention efforts? (B)**
 - c. **What are the weaknesses of these prevention efforts? (B)**
 - d. Do you feel there is a need to expand those efforts? Why or why not?
 - e. **Do you think rest of the community knows about these efforts? (B)**
6. What formal or informal policies, practices, and laws address the issue of sexual violence against adolescents in your *community/ school*?
 - a. Do you feel there is a need to expand these policies, practices and laws?
 - i. If so, do you know if there are any plans to expand them? Please explain. (A)

Dimension C: Leadership

7. **Using a scale from 1 to 10, how much of a concern is sexual violence against adolescents to the leadership in your community?** (with 1 being “not at all” and 10 being a “very great concern”) Please explain.
8. **How are community leaders involved in efforts to prevent sexual violence against adolescents?** Please explain.
9. **Do you think the leadership would support additional efforts to address sexual violence against adolescents? Please explain.**
10. Who are the people in *Racine/ Burlington* who are “leaders” in addressing the issue of sexual violence against adolescents?

Dimension D: Community Climate

11. What do you think is the overall opinion of community members regarding the issue of sexual violence against adolescents?
12. **How does the community support the efforts to address sexual violence against adolescents?**
13. **What are the primary obstacles to efforts addressing sexual violence against adolescents in your community?**

Dimension E: Knowledge about the issue

- 14. How knowledgeable are community members about the issue of sexual violence against adolescents? Please explain.**
- 15. What local data are available on sexual violence within the adolescent population in your community?**
- a. How do people in your community obtain this information?**

Dimension F: Resources for Prevention Efforts

- 16. Where would an adolescent affected by sexual violence turn first to for help in your community? Why?**
- 17. What are the community's and/or local business' attitudes about supporting efforts to address sexual violence within the adolescent population? (Do people volunteer time, make financial donations and/or provide space?).**
- 18. Are you aware of any proposals or action plans that have been submitted for funding that address sexual violence within the adolescent population in your community?**
- a. If yes, please explain.**
- 19. Do you know if there is any evaluation of efforts that are in place to address sexual violence within the adolescent population?**
- a. If yes:**
- i. On a scale of 1 to 10, how sophisticated is the evaluation effort (with 1 being "not at all" and 10 being "very sophisticated")?**
- ii. Are the evaluation results being used to make changes in programs, activities or policies or to start new ones?**
- 20. That is the end of our questions. Is there anything else you would like to add that you think we did not cover regarding the issue of sexual violence against adolescents?**

Code Number: _____ (to be filled in by researcher)

Appendix D: Demographic Questionnaire

Your Current Age: _____

Your Sex: Female _____ Male _____

Your Race/Ethnicity: _____

Your Occupation (your current profession or student status):

Number of Years involved in the Racine County community: _____

Your Name: _____

The phone number we should call you at to conduct the interview: _____

Your email: _____

- *Convenient times you can be reached by phone during the next few weeks (please indicate if you plan to be away in the next few weeks):*

Days/Evenings

Time

Appendix E: Participation Request Letter

Terri DeWalt, MA, LPC
 Doctoral Candidate
 Marquette University
 (262) 619-1634
 theresa.dewalt@mu.edu

.....

Date
 Name
 Address

Dear Community Professional,

I am writing to request your participation in a research study I am conducting as a doctoral student in counseling psychology at Marquette University. You were selected as a potential participant in the study due to your role as a professional in the community who potentially has experience working with sexual assault victims. The study is about the prevention of sexual violence against adolescents in Racine County. The purpose of the study is to better understand the Racine County community's awareness and knowledge of sexual violence against adolescents and the degree to which the Racine County community is ready to support primary prevention efforts that work to reduce the incidence of sexual violence against adolescents.

Participation in this study is completely voluntary, and not participating will not affect you negatively in any way. Participation in the study will not result in direct, tangible benefits to you. However, this study will provide recommendations about what types of prevention efforts may be effective in reducing sexual violence against adolescents in Racine County. This, in turn, may have an impact in the incidence of sexual violence in our community, which has clear and significant benefits.

If you agree to participate in the study, you will be one of approximately fifteen participants, and you will be interviewed via the phone on questions involving sexual violence against adolescents in Racine County. The interview will last approximately one hour, and will be audio taped to ensure accuracy in transcription. Your responses will be kept confidential, and your interview data will be kept confidential through the use of a code number.

This study has been officially approved by the Marquette University Institutional Review Board. If you have any questions about the study, or would like official verification of Marquette University's approval of the study, please feel free to call them at (414) 288-7570 or me at (262) 619-1634.

Your potential participation with this study is valued and very much appreciated. Thank you!

Sincerely,

Theresa (Terri) DeWalt, MA

Appendix F: Study Introduction Letter

Terri DeWalt, MA, LPC
 Doctoral Candidate
 Marquette University
 (262) 619-1634
 theresa.dewalt@mu.edu

.....
 Date
 Name
 Address

Dear Community Professional,

Thank you so much for agreeing to participate in the study I am conducting as a doctoral student in counseling psychology at Marquette University. As you know, the study is about the prevention of sexual violence against adolescents in Racine County, and its purpose is to better understand our community's beliefs about sexual violence so that we can work to reduce its incidence.

The study will involve one telephone interview that will be conducted by one my fellow researchers. The interview should take approximately one hour and will be scheduled at a time that is convenient for you. With your permission, the interview will be tape recorded for accuracy in transcription. Your confidentiality is important to me. Your interview will be assigned an arbitrary code number rather than using your name, and when the results of the study are published, you will not be identified by name.

Enclosed is a packet of information for you regarding the process of the study. There is referral information of community resources, a demographic form, an informed consent form and a stamped, addressed envelope. The listing of community resources is enclosed so that you are aware of resources available to you in case you would like to talk with someone about any feelings that arose as a result of the interview. Please know that I am available to talk with you as well.

Prior to completion of your interview, I request that you read and sign the enclosed informed consent form. If you have any questions or concerns about the study or anything in the informed consent, please contact me at (262) 619-1634. Additionally, please complete the demographics form, and include days and times that would be good for you to complete the interview. Please then place these two forms in the stamped and addressed envelope and return it to me at Sexual Assault Services.

After I receive your informed consent and demographics forms, your interviewer will call you at the phone number you provided and will schedule a time with you to complete the interview.

As a reminder, participation in this study is completely voluntary, and not participating will not affect you negatively in any way. Participation in the study will not result in direct, tangible benefits to you. However, this study will provide recommendations about what types of prevention efforts may be effective in reducing sexual violence against adolescents in Racine County. This, in turn, may have an impact in the incidence of sexual violence in our community, which has clear and significant benefits.

This study has been officially approved by the Marquette University Institutional Review Board. If you have any questions about the study, or would like official verification of Marquette University's approval of the study, please feel free to call them at (414) 288-7570 or me at (262) 619-1634. Your participation with this study is valued and very much appreciated. Thank you!

Sincerely, Terri DeWalt, MA, LPC

Appendix G: Agreement of Consent for Research Participants

MARQUETTE UNIVERSITY
AGREEMENT OF CONSENT FOR RESEARCH PARTICIPANTS
Primary Prevention of Sexual Violence Against Adolescents and
The Community Readiness Model
Theresa A. DeWalt
Counseling and Educational Psychology



You have been invited to participate in this research study. Before you agree to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please feel free to ask the researcher any questions about anything you do not understand before deciding whether or not to participate.

PURPOSE: I understand the purpose of this research study is to better understand the Racine County community's awareness and knowledge of sexual violence against adolescents and the degree to which the Racine County community is ready to support primary prevention efforts to reduce the incidence of sexual violence against adolescents. I understand that I will be one of approximately fifteen participants in this research study.

PROCEDURES:

I will be interviewed via the phone on questions involving sexual violence against adolescents in Racine County. The interview will last approximately one hour. I understand that I will be audio taped during the interview portion of the study to ensure accuracy. The tapes will be transcribed and after five years both the tapes and the transcriptions will be destroyed. For confidentiality purposes, my name will not be recorded.

DURATION: I understand that my participation will consist of one telephone interview lasting approximately one hour.

RISKS: I understand that the risks associated with participation in this study are minimal. However, I also understand that the interview topic (sexual violence against adolescents) may cause some emotional and psychological discomfort. I understand that the effects of this risk will be minimized by the interviewer providing time for me to debrief following the interview. In addition, I understand that I will be provided with community referral information of professionals who specialize in the area of sexual violence, in case I would like to discuss any additional issues that may have arisen as a result of the interview.

It is possible that during the course of the interview I may disclose information that the researcher is required to report under mandatory reporting requirements. I understand that the researcher is required to report any of the following information:

1. children under the age of 18 being physically, sexually, or emotionally abused or neglected.
2. Elder abuse
3. Intent to harm self or others

BENEFITS: I understand that participation in this study does not have direct, tangible benefits to me. However, this study will provide recommendations about what types of prevention efforts may be effective in reducing sexual violence against adolescents in Racine County. I understand that this, in turn, may have an impact in the incidence of sexual violence in that community, which has clear and significant benefits to society in general.

Page 1 of 2

 Initials and Date

CONFIDENTIALITY: I understand that all information I reveal in this study will be kept confidential. All my data will be assigned an arbitrary code number rather than using my name or other information that could identify me as an individual. When the results of the study are published, I will not be identified by name. I understand that these consent forms will be kept in a locked file cabinet in the researcher's place of employment: Sexual Assault Services of Lutheran Social Services at 1220 Mound Ave. Suite 304, Racine, WI 53404. I understand that the research records will be stored in a locked file cabinet at the researcher's place of employment for a minimum of 5 years. I understand that the data will be destroyed by shredding paper documents and deleting electronic files five years after the completion of the study. I understand that the information I reveal will be kept confidential unless I disclose information pertaining to child or elder physical, sexual, or emotional abuse or neglect, or suicidal or homicidal intention. Your research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

INJURY OR ILLNESS: I understand that Marquette University will not provide medical treatment or financial compensation if I am injured or become ill as a result of participating in this research project. This does not waive any of my legal rights nor release any claim I might have based on negligence.

VOLUNTARY NATURE OF PARTICIPATION: I understand that participating in this study is completely voluntary and that I may withdraw from the study and stop participating at any time without penalty or loss of benefits to which I am otherwise entitled. I understand that if I choose to withdraw my data I will simply need to pose this request to Terri DeWalt by contacting her at (262) 488-0011 or theresa.dewalt@mu.edu. I understand that if I chose to withdraw my data, the audiotape and transcript of the interview data will be destroyed.

CONTACT INFORMATION: If I have any questions about this research project, I can contact Terri DeWalt at (262) 488-0011. If I have questions or concerns about my rights as a research participant, I can contact Marquette University's Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND AM PREPARED TO PARTICIPATE IN THIS PROJECT.

Participant's Signature

Date

Participant's Name

Researcher's Signature

Date



Appendix H: Assent Form for Research Participants

Protocol Number: _____

MARQUETTE UNIVERSITY
ASSENT FORM FOR RESEARCH PARTICIPANTS
Primary Prevention of Sexual Violence Against Adolescents and
The Community Readiness Model
Theresa A. DeWalt
Counseling and Educational Psychology

Investigator(s): Theresa A. DeWalt, MA, Chris Daood, MA, Walter Drymalski, MA, JoEllen Kozlowski, MA, Sarah Knox, Ph.D.

We are doing a research study to find out how to best prevent sexual violence against adolescents, and we are inviting you to be in this study. If you take part in this study, you will be interviewed over the phone for about an hour.

We want to tell you about some things you might experience if you are in this study. The interview topic (sexual violence against adolescents) may be uncomfortable, but the researcher will try to make the interview as comfortable as possible by talking with you about how you are feeling after the interview. The researcher will also give you the names of other people you can call if you want to discuss any thoughts or feelings you may have after being interviewed.

There are no direct benefits to you for being in the study. However, we might find out things that will help other children some day.

When the study is finished, we will write a report about what we found. We won't use your name in the report, and all of the information you provide will be kept private. No one except the research team will know that you are in the study unless you and your parents decide to tell them. The only time that we would break this rule would be if you tell us information that we think your parents need to know to be able to keep you or other people safe. For example, if you have been having serious thoughts about hurting yourself, or someone else, or if you told us that you know about any kids who are being abused, we would inform your parents.

Your parents have agreed to let you take part in this study, but it is your decision whether or not to be in the study. You do not have to be in this study if you don't want to. You can say "no" and nothing bad will happen. If you say "yes" now, but you want to stop later, that's okay too. If something about the study bothers you, you can stop being in the study. All you have to do is tell the researcher you want to stop.

If you have any questions about the study, you can ask the researcher, who will try to explain everything that is being done and why. Please ask us about anything you want to know.

If you want to be in this study, please sign and print your name.

I, _____, want to be in this research study.
(write your name here)

Sign your name here

(Date)

Investigator signature

(Date)



Appendix I: Parent Permission Form

MARQUETTE UNIVERSITY
 PARENT PERMISSION FORM
 Primary Prevention of Sexual Violence Against Adolescents and
 The Community Readiness Model
 Theresa A. DeWalt
 Counseling and Educational Psychology



Your child has been invited to participate in this research study. Before you agree to allow your child to participate, it is important that you read and understand the following information. Participation is completely voluntary. Please feel free to ask the researcher questions about anything you do not understand before deciding whether or not to give permission for your child to participate.

PURPOSE: I understand the purpose of this research study is to better understand the Racine County community's awareness and knowledge of sexual violence against adolescents and the degree to which the Racine County community is ready to support primary prevention efforts to reduce the incidence of sexual violence against adolescents. I understand that my child will be one of approximately fifteen participants in this research study.

PROCEDURES: I understand that my child will be interviewed via the phone on questions involving sexual violence against adolescents in Racine County. The interview will last approximately one hour. I understand that my child will be audio taped during the interview portion of the study to ensure accuracy. The tapes will be transcribed and after five years both the tapes and transcriptions will be destroyed. For confidentiality purposes, my child's name will not be recorded.

DURATION: I understand that my child's participation will consist of one telephone interview lasting approximately one hour.

RISKS: I understand that the risks associated with participation in this study are minimal. However, I also understand that the interview topic (sexual violence against adolescents) may cause some emotional and psychological discomfort for my child. I understand that the effects of this risk will be minimized by the interviewer providing time for my child to debrief following the interview. In addition, I understand that my child will be provided with community referral information of professionals who specialize in the area of sexual violence, in case she or he would like to discuss any additional issues that may have arisen as a result of the interview.

It is possible that during the course of the interview my child may disclose information that the researcher is required to report under mandatory reporting requirements. I understand that the researcher is required to report any of the following information:

1. Children under the age of 18 being physically, sexually, or emotionally abused or neglected.
2. Elder abuse
3. Intent to harm self or others

BENEFITS: I understand that participation in this study does not have direct, tangible benefits to my child. However, this study will provide recommendations about what types of prevention efforts may be effective in reducing sexual violence against adolescents in Racine County. I understand that this,

in turn, may have an impact in the incidence of sexual violence in that community, which has clear and significant benefits to society in general.

CONFIDENTIALITY: I understand that all information my child reveals in this study will be kept confidential. All of my child's data will be assigned an arbitrary code number rather than using my child's name or other information that could identify my child as an individual. When the results of the study are published, my child will not be identified by name. I understand that these consent forms will be kept in a locked file cabinet in the researcher's place of employment: Sexual Assault Services of Lutheran Social Services at 1220 Mound Ave. Suite 304, Racine, WI 53404. I understand that the research records will be stored in a locked file cabinet at the researcher's place of employment for a minimum of 5 years. I understand that the data will be destroyed by shredding paper documents and deleting electronic files five years after the completion of the study. I understand that the information my child reveals will be kept confidential unless s/he discloses information pertaining to child or elder physical, sexual, or emotional abuse or neglect, or suicidal or homicidal intention. I understand that the research records may be inspected by the Marquette University Institutional Review Board or its designees, and (as allowable by law) state and federal agencies.

INJURY OR ILLNESS: I understand that Marquette University will not provide medical treatment or financial compensation if my child is injured or becomes ill as a result of participating in this research project. This does not waive any legal rights nor release any claim based on negligence.

VOLUNTARY NATURE OF PARTICIPATION: I understand that participating in this study is completely voluntary and that my child may withdraw from the study and stop participating at any time without penalty or loss of benefits to which my child is otherwise entitled. I understand that if I choose to withdraw my child's data, I will simply need to pose this request to Terri DeWalt by contacting her at (262) 488-0011 or Theresa.dewalt@mu.edu. I understand that if I choose to withdraw my child's data, the audiotape and transcript of the interview data will be destroyed.

CONTACT INFORMATION: If I have any questions about this research project, I can contact Terri DeWalt at (262) 488-0011. If I have questions or concerns about my child's rights as a research participant, I can contact Marquette University's Office of Research Compliance at (414) 288-7570.

I HAVE HAD THE OPPORTUNITY TO READ THIS PARENT PERMISSION FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT, AND AM PREPARED TO GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN THIS PROJECT.

Parent's Signature(s)

Date

Parent's Name(s)

Researcher's Signature

Date



Appendix J: Anchored Rating Scales by Dimension

Anchored Rating Scale for Dimension A: Existing Community Efforts

- 1 No awareness of the need for efforts to address the issue in any capacity.
-
-
- 2 No efforts addressing the issue.
-
-
- 3 A few individuals recognize the need to initiate some type of effort, but there is no immediate motivation to do anything.
-
-
- 4 Some community members have met and have begun a discussion of developing community efforts.
-
-
- 5 Efforts (programs/activities) are being planned.
-
-
- 6 Efforts (programs/activities) have been implemented.
-
-
- 7 Efforts (programs/activities) have been running for several years.
-
-
- 8 Several different programs, activities and policies are in place, covering different age groups and reaching a wide range of people. New efforts are being developed based on evaluation data.
-
-
- 9 Evaluation plans are routinely used to test effectiveness of many different efforts, and the results are being used to make changes and improvements.

Anchored Rating Scale for Dimension D: Community Knowledge of the Efforts

- 1 Community has no knowledge of the need for efforts addressing the issue.
-
-
- 2 Community has no knowledge about efforts addressing the issue.
-
-
- 3 A few members of the community have heard about efforts, but the extent of their knowledge is limited.
-
-
- 4 Some members of the community know about local efforts.
-
-
- 5 Members of the community have basic knowledge about local efforts (e.g., purpose).
-
-
- 6 An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.
-
-
- 7 There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.
-
-
- 8 There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.
-
-
- 9 Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.

Anchored Rating Scale for Dimension C: Leadership

- 1 Leadership has no recognition of the issue.
-
-
- 2 Leadership believes that the issue is not a concern in their community.
-
-
- 3 Leader(s) recognize(s) the need to do something regarding the issue.
-
-
- 4 Leader(s) is/are trying to get something started.
-
-
- 5 Leaders are part of a committee or group that addresses the issue.
-
-
- 6 Leaders are active and supportive of the implementation of efforts.
-
-
- 7 Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.
-
-
- 8 Leaders are supportive of expanding/improving efforts through active participation in the expansion/improvement.
-
-
- 9 Leaders are continually reviewing evaluation results of the efforts and are modifying support accordingly.

Anchored Rating Scale for Dimension D: Community Climate

- 1 The prevailing attitude is that the issue is not considered, unnoticed or overlooked within the community. "It's just not our concern."
-
-
-
- 2 The prevailing attitude is "There's nothing we can do," or "Only 'those' people do that," or "Only 'those people' have that."
-
-
-
- 3 Community climate is neutral, disinterested, or believes that the issue does not affect the community as a whole.
-
-
-
- 4 The attitude in the community is now beginning to reflect interest in the issue. "We have to do something, but we don't know what to do."
-
-
-
- 5 The attitude in the community is "We are concerned about this," and community members are beginning to reflect modest support for efforts.
-
-
-
- 6 The attitude in the community is "This is our responsibility" and is now beginning to reflect modest involvement in efforts.
-
-
-
- 7 The majority of the community generally supports programs, activities, or policies. "We have taken responsibility."
-
-
-
- 8 Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high. "We need to keep up on this issue and make sure what we are doing is effective."
-
-
-
- 9 All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

Anchored Rating Scale for Dimension E: Community Knowledge about the Issue

- 1 The issue is not viewed as an issue that we need to know about.
-
-
- 2 No knowledge about the issue.
-
-
- 3 A few in the community have basic knowledge of the issue, and recognize that some people here may be affected by the issue.
-
-
- 4 Some community members have basic knowledge and recognize that the issue occurs locally, but information and/or access to information is lacking.
-
-
- 5 Some community members have basic knowledge of the issue, including local statistics, signs, etc. General information on the issue is available
-
-
- 6 A majority of community members have basic knowledge of the issue, laws, local statistics, signs, etc. Understanding high-risk behaviors, and that it occurs locally. There are specific local data on the issue available.
-
-
- 7 Community members have knowledge of, and access to, detailed information about local prevalence, laws, etc.
-
-
- 8 Community members have knowledge about prevalence, statistics, laws, and related concerns.
-
-
- 9 Community members have detailed information about the issue and related concerns as well as information about the effectiveness of local programs.

Anchored Rating Scale for Dimension F: Resources Related to the Issue

- 1 There is no awareness of the need for resources to deal with the issue.
-
-
- 2 There are no resources available for dealing with the issue.
-
-
- 3 The community is not sure what it would take, (or where the resources would come from), to initiate efforts.
-
-
- 4 The community has individuals, organizations, and/or space available that could be used as resources.
-
-
- 5 Some members of the community are looking into the available resources.
-
-
- 6 Resources have been obtained and/or allocated for the issue.
-
-
- 7 A considerable part of support of on-going efforts are from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.
-
-
- 8 Diversified resources and funds are secured and efforts are expected to be ongoing. There is additional support for further efforts.
-
-
- 9 There is continuous and secure support for programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.

Appendix K: CRM Scoring Sheet

Community Readiness Assessment Scoring Sheet

Scorer: _____

Date: _____

INDIVIDUAL SCORES: Record each scorer's independent results for each interview for each dimension. The table provides spaces for up to six interviews.

Interviews	#1	#2	#3	#4	#5	#6
Dimension A						
Dimension B						
Dimension C						
Dimension D						
Dimension E						
Dimension F						

COMBINED SCORES: For each interview, the two scorers should discuss their individual scores and then agree on a single score. This is the COMBINED SCORE. Record it below and repeat for each interview in each dimension. Then *add across each row* and find the total for each dimension. Use the total to find the calculated score below.

Interviews	#1	#2	#3	#4	#5	#6	TOTAL
Dimension A							
Dimension B							
Dimension C							
Dimension D							
Dimension E							
Dimension F							

CALCULATED SCORES: Use the combined score TOTAL in the table and divide by the number of interviews conducted. Add the calculated scores together and enter it under total.

	Stage Score
TOTAL Dimension A _____ / # of interviews _____ = _____	_____
TOTAL Dimension B _____ / # of interviews _____ = _____	_____
TOTAL Dimension C _____ / # of interviews _____ = _____	_____
TOTAL Dimension D _____ / # of interviews _____ = _____	_____
TOTAL Dimension E _____ / # of interviews _____ = _____	_____
TOTAL Dimension F _____ / # of interviews _____ = _____	_____

Average Overall Community Readiness Score: _____

Community Readiness Assessment Scoring Sheet, cont'd.

OVERALL STAGE OF READINESS: Take the TOTAL calculated score and divide by 6 (the number of dimensions). Use the list of stages below to match the result with a stage of readiness. *Remember, round down instead of up.*

TOTAL Calculated Score _____ / 6 = _____

Score	Stage of Readiness
1	No Awareness
2	Denial/ Resistance
3	Vague Awareness
4	Preplanning
5	Preparation
6	Initiation
7	Stabilization
8	Confirmation/ Expansion
9	High Level of Community Readiness

COMMENTS, IMPRESSIONS, and QUALIFYING STATEMENTS about the community.