Sickening relationships: Gender-based violence, women's health, and the role of informal third parties

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ABSTRACT

Over the last two decades, two trends have emerged that highlight the relational and communal dimensions of health and well-being. The Ottawa Charter of 1986 proposed a model of health that encompasses personal, social, and environmental well-being and emphasizes the role of communities in creating healthy living conditions. In a parallel development, battered women's advocates identified violence against women as a major health issue, and situated effective interventions within coordinated community response strategies. Both trends point to the significance of social networks and a wide range of social and personal relationships in the promotion of women's health and well-being.

KEY WORDS: informal third parties • social networks • violence against women • women's health

In the preamble to its 1946 constitution, the World Health Organization (WHO) defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' Forty years later, the Ottawa Charter for Health Promotion identified 'peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity' as the fundamental prerequisites for health and well-being, and asserted that in order to achieve their fullest health potential people need 'a secure foundation in a supportive environment, access to

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information, life skills and opportunities for making healthy choices' (WHO, 1996).

Although these documents signify a shift, at least in spirit, away from a narrow definition of health based on the absence of physical infirmity toward a broad definition of health as physical, mental, and social well-being, they also imply that health and well-being are relational and communal achievements. In this view, individual health is contingent on a healthy social and physical environment, and is an achievement not only of individuals, but also of relationships, families, groups, neighborhoods, and societies.

The social environment invoked in these statements consists of a multitude of social and personal relationships. As Milardo and Wellman (1992) emphasized, close personal relationships between friends, spouses, and lovers are embedded in social networks that encompass a wide variety of social ties with extended family members, neighbors, coworkers, and acquaintances, as well as ties with those people who may be neither significant others nor sources of support or interference but with whom we may interact on a regular basis (Milardo, 1992).

Neighbors, coworkers, professionals, family members, friends, and acquaintances can impact women's health through the ways in which they prevent or condone gender-based violence, and facilitate or impede access to health care and safety. Social and personal relationships are the primary locations where health-promoting information, skills, and choices could be shared and modeled. However, gender-based violence is widespread and undermines the positive potential of social and personal relationships to such an extent that they cannot be assumed to be health-promoting environments. To the contrary, research over the last decades has compiled staggering evidence about the prevalence of physical, sexual, and psychological violence in intimate and family relationships, and the extent to which such violence endangers women's health and interferes with their physical, mental, and social well-being (Campbell, 2002; Heise, Pitanguy, & Germain, 1994).

After clarifying the use of key terms, this article gives an overview of the extent and health consequences of violence against women in intimate relationships, and discusses how social networks may work to intervene with and end violence against women.

Use of terms

The U.N. Declaration on the Elimination of Violence Against Women (1993) defines violence against women as 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.' Worldwide, gender-based violence extends across women's life span, beginning pre-birth with sex-selective abortion and battering during pregnancy; and continuing through infancy and childhood with differential access to food and medical care, and sexual abuse; during adolescence with dating

violence, economically coerced sex, and forced prostitution; and in adulthood with violence from an intimate partner, marital rape, dowry abuse, homicide, and sexual harassment (Heise et al., 1994).

In this article, the terms 'violence against women' and 'gender-based violence' are used interchangeably to refer to the violence many women experience from their male intimate partners or family members. The article focuses on this type of violence because of its extent worldwide, the magnitude of its health consequences and the fact that, to a degree, it is woven into 'normal' heterosexual relationships (Wood, 2001). This is not to diminish the significant amount of violence men as a group experience, mostly outside of intimate relationships and mostly from other men (WHO, 1996). Nor is it to diminish the significance of violence in same-sex relationships, or of violence that is motivated by reasons other than gender. Women and men may experience violence because they are persons of color, or disabled, or because they belong to a targeted ethnic or religious group.

The term 'social network' is used to encompass networks of significant others such as close friends, parents, or spouses, as well as exchange and interactive networks, and the separate or joint networks of spouses or intimate partners (Milardo, 1992). Moreover, network members here are considered third parties in order to emphasize that they are active agents, not 'passive' structural features (Klein & Milardo, 1993). As active agents, the role of third parties in gender-based violence is influenced by their own attitudes, beliefs, and worldviews about gender, violence, and relationships, their fears for their own safety, their loyalties or split loyalties, and the pressure they may feel from members of their social networks to intervene with or ignore instances of gender-based violence.

Thus, network members as a whole are the source of 'informal' and 'formal' responses to gender-based violence. The term 'informal responses' has emerged recently to refer to the roles of friends, kin, neighbors, coworkers, and all those who are not considered 'formal' resources or support systems, such as domestic violence projects, rape crisis centers, or the criminal justice and social welfare systems (Kelly, 1996).

Extent of violence against women in intimate relationships

Women experience gender-based violence in the family, in the workplace, in the street, in trafficking, and in warfare. Among these different contexts, intimate relationships are a primary location for the victimization of women.

Worldwide

From a worldwide review of violence against women, Heise, Ellsberg, and Gottemoeller (1999) concluded that two of the most common forms of such violence are associated with intimate relationships and include physical abuse by an intimate male partner and sexual violence, such as rape and

other forms of coerced sex. This review was based on almost 50 population-based surveys from Africa, the Near East, Latin America and the Caribbean, Europe, and North America and indicated that between 10% and 50% of women report being physically or sexually harmed by an intimate male partner at some point in their lives.

Western Europe

Similar findings have been reported from Europe (Hagemann-White, 2001). They indicate that across many cultures intimate male partners (spouses, ex-spouses, partners, ex-partners) perpetrate a significant amount of violence against the women with whom they are or were involved in an intimate relationship. Reporting incidence figures, a French survey found that 9% of women had experienced violence in an intimate relationship in the previous 12 months (Jaspard et al., 2001). Lifetime prevalence figures tend to be significantly higher. Römkens (1997) found that 26.2% of Dutch women had experienced physical violence in a heterosexual relationship at some point in their lives. Among Irish women who had lived in intimate relationships, 18% had experienced sexual violence (Kelleher et al., 1995). In a Swiss survey, 20.7% of women reported being abused by their intimate partner (Gillioz, de Puy, & Ducret, 1997). Surveys in Finland (Heiskanen & Piispa, 1998) and Sweden (Lundgren & Westerstrand, 2002) report even higher estimates, suggesting that physical and sexual violence is so closely woven into intimate relationships that they pose a significant risk to almost one out of two women who enter into them.

North America

Statistics Canada (1993) reported that 25% of women surveyed in Canada indicated that a current or former male partner had physically assaulted them since age 16. For the U.S. as well, Sharp and Campbell (1999) concluded that the most common form of violence women experience occurs in intimate relationships and is physical and sexual abuse by an intimate partner. The U.S. National Crime Victimization Survey of 1992–1993 estimated that 29% of all violence against women in the U.S. was perpetrated by a current or former intimate partner (Federal Bureau of Investigation, 1993). Research sponsored by the U.S. Department of Justice estimates that for each year between 1992 and 1996 about 8 in 1,000 women (compared to 1 in 1,000 men) experienced violence by an intimate partner, male or female (Greenfield et al., 1998). The Bureau of Justice Statistics (1998) estimated that between 1976 and 1996 44% of female homicide victims were killed by a spouse, ex-spouse, or boyfriend (42.5% by a relative, stranger, acquaintance, or friend, which included an ex-boyfriend).

The U.S. National Violence Against Women Survey of 1995/1996 found that violence against women occurs primarily in intimate relationships, and that women are four times as likely to be victimized in the context of intimate relationships than are men (Tjaden & Thoennes, 2000). Prevalence estimates from the survey indicate that ‘64.0% of the women who

reported being raped, physically assaulted, or stalked since age 18 were victimized by a current or former husband, cohabitating partner, boyfriend, or date.' The corresponding estimate for men is 16.2% (p. iv). The survey focused on heterosexual relationships and assessed male-to-female and female-to-male violence. Estimates are based on data from telephone interviews with 8,000 women and 8,000 men conducted during the 1995/1996 academic year. Women suffered 2,589,071 victimizations per year from gender-based violence (on average, 7,093 per day; Tjaden & Thoennes, 2000).

The continuum of violence against women (Kelly, 1987) extends to casual dating relationships and sexual harassment. The U.S. National College Women Sexual Victimization (NCWSV) study surveyed a random sample of 4,446 women who were enrolled in 2- or 4-year institutions of higher education during fall 1996 (Fisher, Cullen, & Turner, 2000). The study assessed the incidence of 12 types of sexual victimization, including completed rape and attempted rape. About 3% of the sample had experienced either a completed rape (1.7%) or an attempted rape (1.1%), a victimization rate of 27.7 in 1,000 female students. Of the 123 rape victims in the sample, 22.8% were victimized more than once. In about 20% of the completed and attempted rape incidents, the victim was injured, citing most often either bruises, black-eyes, cuts, scratches, swelling, or chipped teeth (Fisher et al., 2000).

Health consequences

The consequences of gender-based violence include severe short- and long-term damage to women's health, significant risks for the health of their children, and staggering societal expenditures in the medical, justice, and social service systems, and the workplace (for recent reviews see Campbell, 2002; Martinez, García-Linares, & Pico-Alfonso, in press; Miller, Cohen, & Wiersema, 1996).

The most immediate physical health consequences are the consequences of injuries such as acute and chronic pain, cuts, burns, bruises, broken teeth, broken bones, muscular and skeletal injuries, and damage to eyes and ears (Grisso et al., 1991; Mullerman, Lenaghan, & Pakieser, 1996; Varvaro & Lasko, 1993). For women, the risk of injury from physical assault seems to increase when the assailant is an intimate. The U.S. National Violence Against Women Survey found that 41.5% of women reported being injured during their most recent assault by an intimate, compared to 19.9% of men. In addition, 31.5% of female rape victims reported being injured during their most recent rape, compared to 16.1% of male rape victims, and 39.0% of female physical assault victims were injured during their most recent assault, compared to 24.8% of male assault victims.

Long-term physical health consequences seem to be related, at least in part, to the chronic stress generated by violence and abuse and include symptoms and illnesses affecting the neurological, cardiovascular,

gastrointestinal, muscular, urinary, and reproductive systems (Martinez et al., in press), such as vaginal discharges, eating disorders, diarrhea or constipation, fainting or passing out, frequent or severe headaches, difficulty passing urine, problems with sleeping, shortness of breath (McCauley et al., 1996), and neurological symptoms (Cascardi, Langhinrichsen, & Vivian, 1992). The pathways linking these health outcomes to gender-based violence and morbidity may include stress-related pathologies of psychosomatic origin, as well as long-term alterations in immune and endocrine functions (Martinez et al., in press).

Acts of sexual violence have severe consequences for women's reproductive system causing nonspecific pelvic, genital, and breast pain; severe menstrual problems; urinary tract infections; pelvic inflammatory disease; vaginal and anal tearing; and sexually transmitted disease including HIV/AIDS (McFarlane, Parker, & Soeken, 1996; Plichta & Abraham, 1996).

While most of these findings pertain to the health impact of physical and sexual violence, psychological abuse alone can have devastating consequences, including depression, post-traumatic stress disorder (PTSD), anxiety, and an increase in physical health problems (Coker, Smith, McKeown, & King, 2000; Martinez et al., 2002; O'Leary, 1999).

Mental health consequences

Mental health consequences include depression, PTSD, anxiety, sleeping and eating problems, suicidal tendencies, and increased use of alcohol and other drugs (Campbell & Lewandowski, 1997; Martinez et al., in press; Plichta, 1996).

Consequences for child health

Sexual and physical violence against women during pregnancy affects their children's health through later entry into prenatal care, fetal distress, preterm labors and births, low birth-weight infants, miscarriages, and stillbirths (Dye, Tollivert, Lee, & Kenney, 1995; Martinez et al., in press; McFarlane et al., 1996).

Healthy years of life lost

In its 1993 World Development Report, the World Bank tried to estimate the overall health burden of gender-based violence in terms of healthy years of life lost due to domestic violence and rape among women aged 15–44 (Heise et al., 1994). The relative impact of gender-based violence on disability-adjusted life years depends on the overall burden of disease, which is lower in more industrialized than in less industrialized countries. In industrialized countries, nearly 20% of healthy years lost are attributable to gender-based violence (5% in less industrialized countries; China, 16%). Worldwide, the threat of gender-based violence to women's health is comparable to tuberculosis, HIV, cardiovascular disease, and cancer, and about three times as big as the effect of war (Heise et al., 1994).

Societal costs

A number of studies have tried to gauge the annual societal costs of violence against women. For example, Kerr and McLean (1996) estimated that violence against women costs taxpayers in British Columbia $385 million in costs to the healthcare system, including mental health and substance abuse treatment; costs to the criminal justice system, including police, courts, and corrections; costs to social services, including welfare, housing, and child care; and costs to employers through higher absenteeism and lower productivity. The estimate does not include private costs incurred by female victims (e.g., legal costs, housing, child care), additional public sector expenditures for long-term health care or in the educational system, and lost earnings of inmates convicted of violence against women.

Because of methodological differences, annual cost estimates from different countries vary widely: $40 million for Queensland, Australia; $80 million for the Netherlands; $290 million for Switzerland; $625 million for New Zealand; and $1 billion each for Canada and New South Wales, Australia (Godenzi & Yodanis, 1999).

The impact of gender-based violence compared to other forms of personal crime is significant. Based on data from the 1970s, Straus (1986) estimated the annual costs of homicide within families as about one quarter of the total costs of homicide in the U.S. More recently, using data from 1987–1990, Miller et al. (1996) estimated the annual ‘out-of-pocket’ expenses (e.g., medical costs, lost earnings, public program costs) for rape in the U.S. at $7.5 billion, similar to the costs of burglary and approximately 1% of U.S. health expenditures in 1992 (Organization for Economic Cooperation and Development [OECD], 1993). When factors such as pain, suffering, and loss of quality of life were included in the estimate, the costs of rape soared to $127 billion annually, 28% of the $450 billion in annual costs attributable to personal crime (Miller et al., 1996), and approximately 16% of U.S. health expenditures in 1992 (OECD, 1993).

The role of social networks and third parties

Social networks are a potential source of both protection and victimization because network members can assume very different roles: as perpetrators, allies of perpetrators, or allies of victims. Whether there is room for neutrality is debatable. Doing nothing may often function as de facto support of the perpetrator.

Perpetrators

As the prevalence data suggest, the majority of perpetrators are current or former intimate partners or other members of women’s personal networks (Heise et al., 1994). Considering that much of women’s victimization occurs in the context of intimate relationships or their dissolution, and that it is

particularly severe in this context, Tjaden and Thoennes (2000) concluded that strategies to prevent violence against women needed to focus on how women can 'protect themselves from intimate partners' (p. v). Because intimate partners are the ones with whom women are supposed to be open and trusting, this recommendation confronts everyone who works towards the elimination of violence against women with a paradox: How to have one's guards up against the very people around whom one is supposed to have one's guards down? This dilemma extends beyond intimate partners to women's family relationships. For example, a Portuguese survey found that, although 14.4% of women had experienced physical violence by their husbands, of all the physical violence women reported, 68% was by family members (Lourenco, Lisboa, & Pais, 1997).

Network members as allies

Klein and Milardo (1993) argued that social network members may influence intimate relationships by taking sides and playing the role of partisan supporter or ally. In a study of third-party support and criticism among college students, partisan supporters typically came from partners' separate networks of close friends (Klein & Milardo, 2000). However, partisan support, especially from family members, cannot be taken for granted. Rather, support and interference may arise from the same individuals (Argyle & Furnham, 1983; Burger & Milardo, 1995), or from the same network sectors, such as immediate kin (including parents, children, and siblings; Wellman & Wortley, 1990) or extended kin (Bryant, 1996).

Direct allies of perpetrators

Networks of abusive peers may function as allies of perpetrators by either ignoring or actively endorsing a perpetrator's violence against his female partner (DeKeseredy, 1990; Schwartz & DeKeseredy, 1997). According to research on abusive peers, male peer groups that endorse violence against women contribute to an ideology of male domination in intimate relationships that legitimizes and encourages group members' abuse of their intimate female partners. Consistent with the abusive peer model, Silverman and Williamson (1997) found that men who received support for abuse from their abusive peers considered violence against women justified and were more likely to be physically violent to their female partner. The influence of such misogynist reference groups seems particularly strong on men with little regard for the well-being of others (Williamson & Silverman, 2001).

Indirect allies of perpetrators

Unfortunately, partisan support for perpetrators is not limited to violent men's networks of abusive peers. Interviews with battered women indicate that sometimes the perpetrators' allies come from the victims' close kin, although such responses seem to stem less from a direct endorsement of the perpetrator's violence than from a mixture of discounting the severity of such violence, blaming the victim, and subscribing to marriage ideologies

that require women to stick it out with their husbands. Romito and her collaborators (Romito, Gerin, Crisma, Scattolin, & Vascotto, 1997) interviewed 17 battered women in Italy, of whom only two reported supportive responses from family members (in one case, from the woman's father; in the other, from a sister). More likely were responses that resulted in de facto support for the battering husband. One woman, who had been married for three years, was stabbed by her drunken husband. In panic, she fled to her father's house where her father told her she should not pull him in the middle of what he defined as her problem: 'come uno si fa il letto là dorme' ('You made your bed, now lie in it', p. 332). Another woman, pregnant, tried to leave her husband who had broken her arm three times and tried to strangle her. According to the woman, her mother initially told her that, regardless of the homicide attempt, it was more important for the children that the daughter stay with her husband (p. 330). The mother eventually took her daughter and grandchild in after the husband literally kicked his wife out of the house.

Allies of victims

Despite the potential for perpetrator support, network members can and do function as effective allies of victims. Research with British women in London found that women approached family and friends, in particular mothers, about three times as often as formal systems such as the police (McGibbon, Cooper, & Kelly, 1989; Mooney, 1994). Kirkwood (1993) reports that about one third of the women in her sample of British and U.S. women relied on support from informal friends and kinship networks when leaving abusive partners. Network members provided emotional and material support, including shelter, transportation, money, and childcare.

In the U.S., Hoff (1990) interviewed nine battered women and 131 members of the women's social networks in order to shed light on the extent to which 'social network members (family, friends, neighbors, health and human service workers, clergy, police) [are] the practical avenues for expressing and reinforcing a society's values and beliefs about women, marriage, the family, and violence' (p. 11). Help from family and friends included 'emotional support, guidance, shelter and protection, money, rides, car use, baby care, and more' (p. 90). Hoff documented cases of extensive support for the victim. For example, two brothers traveled 1,500 miles to help their sister escape from her abuser. Even so, occasionally network support was mixed with criticism. One of Hoff's interviewees reported that her mother and sister rescued her from an abusive relationship but her father did not want her in his house, and after the immediate crisis was over her sister blamed her for having married the abuser in the first place (p. 91).

Thus, with regard to violence against women, the social network response remains a two-edged sword, and both weak and strong social ties may form the 'basis for many of the allies or enemies people have when things get complicated' (Milardo & Wellman, 1992, p. 341).

Third-party capacity to end violence against women

Based on a review of network responses to gender-based violence in non-industrial societies, Baumgartner (1993) concluded 'domestic violence, then, is bred of many interactions, not just the one that transpires between the person who inflicts injury and the one who sustains it' (p. 228). Considering the range of third-party responses to violence against women, how helpful can social networks be in deterring or preventing violence against women? On the one hand, Kelly (1996) argued that in the long run 'women's kinship and friendship networks, their neighborhoods and work-places . . . may prove to be a key resource not only in establishing safety for women and children, but also in beginning to decrease the prevalence' of violence against women (p. 67). On the other hand, the evidence on abusive peers and collusion with perpetrators suggests that network members can directly or indirectly endanger women and contribute to the continuation of gender-based violence. If all third parties cannot be trusted, then the communal task of creating a healthy environment becomes more challenging because victims and those who are striving to build safety need to 'create *substitute* sources of social support' when support is not forth-coming (Hoff, 1990, p. 83, emphasis in the original).

Towards this effort, Cavanagh (1978) proposed that women who have been victims of gender-based violence first look to informal networks for help, and to formal support systems second, and only when informal networks are not effective in deterring the offender or helping the victim to escape. Although battered women have been shown to be very resource-ful in dealing with abusive partners (Bowker, 1993), the success of their help-seeking strategies will depend on the effectiveness of the third parties approached for help. To make women's help-seeking strategies more effec-tive, social networks need to increase the number of victim allies and decrease the influence of beliefs and ideologies that weaken the ties between potential allies and victims (Baumgartner, 1993).

Broaden the base of potential allies

From a network perspective, potential allies could be located in a wide spectrum of women's social and personal relationships, including their networks of significant others, their exchange networks, and their inter-active networks, which overlap only to some extent (Milardo, 1992).

Significant others are important sources of validation and emotional support. Members of women's exchange networks are also potential sources of emotional and tangible support, but, as the research has docu-mented, they may also be sources of criticism or they may withhold support. Potential allies are also located in women's interactive networks of people 'with whom interactions typically occur' (Milardo, 1992, p. 447), including neighbors, coworkers, and professionals in the healthcare and social services systems.

Healthcare professionals are particularly likely to encounter women who have been physically or sexually assaulted. According to some estimates,

as many as 35% of women seen in hospital emergency rooms are there as the result of gender-based violence (AMA, 1991; Dearwater et al., 1998; Plichta, 1996). Koss et al. (1994) estimated that 21% of all women in the U.S. seeking emergency surgical procedures needed them as a result of abuse by an intimate partner. Over their lifetime, abused women use the healthcare system more than nonabused women (Sharp & Campbell, 1999).

It is important not to prejudge whether some network sectors or relationships are more significant sources of support than others, in particular with regard to cultural differences in the ways in which communities are organized and informal and formal third parties are perceived. Whereas a Canadian national study reported that women who had been attacked by a known man sought out help from family and friends (Kaukinen, 2002), a survey of African-American women found that over 70% of those who had experienced physical, sexual, or emotional violence from an intimate partner indicated feeling comfortable seeking support from a wider range of social ties, including friends, spiritual leaders, Black community members, family members close in age to the help-seeker, and physicians (Fraser, McNutt, Clark, Williams-Muhammed, & Lee, 2002).

Structurally, women's separate networks remain a significant source of potential allies, whereas the lack of such networks contributes to the social isolation that abusive partners exploit and actively promote. This predicament reaches a new level of complexity when abusive peer groups have ties to formal third-party systems such as 'old-boy' networks among rural law enforcement officers (Websdale, 1998). Here, the representative of the criminal justice system, who could confront and arrest the perpetrator, may turn out to be his drinking buddy.

Obstacles to being an effective ally for victims

Much like the responses of formal systems (Romito, 2000), informal responses vary greatly in their appropriateness, and they vary in the ways in which the supportive may occur in close proximity to the destructive.

Victim blaming is common (Hoff, 1990; Romito et al., 1997). Third parties may not understand the dynamics of abusive relationships or become exasperated at the time and effort it takes to overcome them (Choice & Lamke, 1999; Römkens & Mastenbroek, 1998; Rosen, 1996). Third parties may be reluctant to name violence and talk about it, resist unlearning the ways in which gender-based violence has been normalized and trivialized in everyday language (West, 2001), or refuse to acknowledge their own role in the emotional and moral constraints that keep women in abusive relationships (Johnson, 1998). Third parties may fear for their own safety or be reluctant to meddle in other people's private lives.

Many third parties subscribe to family and relationship ideals that include the triple notion of keeping relationships and families together at all cost; holding women responsible for keeping relationships and families together at all cost; and denouncing women who, for whatever reason, do not keep their families or relationships together as having 'failed' and

bringing shame on the family (e.g., Non-consensual Sex in Marriage Programme, 1999). These notions occur in different cultures. For example, moral pressure to keep the family together and to make relationships work was reported by women in Italy (Romito et al., 1997), Greece (Chatzifotiou & Dobash, 2001), and South Australia (Bagshaw, Chung, Couch, Lilburn, & Wadham, 1999). For some network members who side with the perpetrator, it may be difficult to imagine that the nice son-in-law or respectable community member beats his wife at home.

Becoming an effective ally means cultural change

Anthropological studies have identified numerous factors related to low rates of gender-based violence, including women's economic independence and mobility, their right to divorce, female workgroups, and cultural beliefs that reject violence and support egalitarian relationships between women and men (Baumgartner, 1993; Counts, Brown, & Campbell, 1999; Lepowsky, 1993; Levinson, 1989; Ross, 1993; Rozée, 1993; Sanday, 1981).

Although such conclusions may be difficult to translate into social change practices in industrialized countries, there are promising examples that utilize the potential of social networks to confront gender-based violence and thus promote women's health. During the 1990s, battered women's advocates worldwide began to organize police departments, prosecutors, courts, hospitals, and other agencies into what has become known as a 'coordinated community response' to violence against women (Shepard & Pence, 1999). While coordinated community response efforts focus primarily on improving the helpfulness of responses from formal systems such as the criminal justice system, healthcare providers, child protective services, and housing and welfare offices, more recently work is emerging on 'informal responses' from women's networks of family, friends, neighbors, and coworkers (Kelly, 1996).

Aimee Thompson's Close to Home Domestic Violence Prevention Initiative in Boston (www.waittfoundation.org/CommunityBuild/close-home.asp) works to develop the capacity of informal neighborhood networks to prevent violence against women. Groups such as Men Can Stop Rape use the concept of the 'visible ally' to end complicity with perpetrators and develop strategies that encourage men to publicly question misogynist forms of masculinity and to speak out against gender-based violence. In Canberra, Australia, Partners for Prevention aims at generating a 'sense' of community participation in responding to domestic violence by investigating how family and friends recognize violence in intimate and family relationships and respond to requests for help (ACT Domestic Violence and Prevention Council, 1999, p. 3).

Although these projects differ in focus, scope, and location, they have in common the resolve to shift responsibility for intervention with gender-based violence toward collective, communal efforts and away from approaches that either blame the victim or focus on perpetrators without taking into account the social and relational contexts of either. Lyons and her collaborators formalized this commitment to 'shared action

orientation' in their communal coping model (Lyons, Mickelson, Sullivan, & Coyne, 1998). From a communal coping perspective, violence against women is neither just the woman's problem nor merely a matter of punishing the perpetrator, but rather an issue that concerns the collective of those social and personal relationships in which victim and perpetrator are embedded. This perspective takes into account that every 'relationship between two people is conditioned by their separate and mutual relationships with others' (Milardo & Wellman, 1992, p. 341).

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