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A Call for a Social Network-Oriented Approach to Services for Survivors of Intimate Partner Violence

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Despite the many hard-won victories of the antidomestic violence movement, it has had less success in reaching one of its own primary goals: that of making intimate partner violence a problem of the community rather than a problem between two individuals. Most mainstream domestic violence service models have not prioritized ongoing engagement of survivors' informal social support networks as a core part of their work. Yet the perpetration of domestic violence occurs within a community context that contributes to the maintenance or alleviation of the problem. Given extensive research on the centrality of social networks to the fabric of survivors' daily lives, as well as their ongoing safety and emotional well-being, it is critical to consider how domestic violence services and systems can align with these social networks more effectively. Following a review of research on the role of informal social support in survivors' lives, this article calls for a shift in mainstream domestic violence services toward a more network-oriented approach, one that highlights potential partnerships between professionals and survivors' informal social support networks. Such a shift would require a reconceptualization of the role of the domestic violence practitioner and the scope and nature of services. It would also raise a series of emergent research questions about how informal network members can best support survivors, how domestic violence services can help survivors engage with existing and new supporters, and the extent to which specific types of network-oriented practices can indeed improve survivors' safety and well-being.

Keywords: intimate partner violence, domestic violence services, social support, community, network-oriented approach

Intimate partner violence (IPV), that is, physical, psychological, or sexual abuse and control perpetrated by a current or former intimate partner, causes devastating physical, psychological, and economic damage to millions of people, primarily women, in the United States each year (Tjaden & Thoennes, 2000). Although IPV is now recognized as a widespread social problem, this was not always the case. Over the past 35 years, antidomestic violence activism has transformed public perceptions of IPV from the view that it is a private matter between two family members to the view that it is a problem requiring a formal systemic response. Our justice system has come to view IPV as a crime worthy of prosecution and victim protection, and our social service system has developed a far-reaching response. However, the antidomestic violence movement has had less success in reaching one of its own primary goals: that of making IPV a problem of the community rather than a problem between two individuals (Goodman & Epstein, 2008; Shepard, 2008). Indeed, despite extensive data on the role of informal networks in helping survivors cope with IPV, most mainstream domestic violence (DV) service models have evolved to focus on formal systems of care, without significant, ongoing engagement of survivors' networks. This article reviews existing research and conceptual evidence to support a social network-oriented approach to DV

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practice and outlines a potential template for such an approach within the DV services system.

The perpetration of DV occurs within a community context that contributes to the maintenance or alleviation of the problem (Manicini, Nelson, Bowen, & Martin, 2006). Both the partner who is abusive and the partner who is abused are embedded in relationships with family, friends, and neighbors, whether or not those relationships have become strained or disrupted. Moreover, these community members are critical to female survivors' efforts to improve their lives. Women who are battered turn to their informal social support networks before or instead of DV services, and these networks often contribute enormously to their long-term physical safety, emotional health, and overall well-being. In this article, therefore, we propose a practice and research agenda that would move the dominant social service system toward greater alignment with survivors' natural tendencies to seek support from informal network members. Although both women and men experience partner violence, we focus on violence against women because the vast majority of people who participate in DV services are women and because the bulk of research on survivors' use of informal networks is based on samples of women. We begin by grounding our proposal in a review of existing research on the role of informal social support in female survivors' lives and the extent to which this research is reflected in the practices of the DV services system.

Social Support Among IPV Survivors

Informal social support, defined here as the availability of instrumental and emotional assistance through family, neighbors, or friends (as opposed to formal support, provided through agencies or systems), is vital to DV survivors' emotional and physical well-being, as it is to everyone's. We review research showing that women who are battered are highly likely to seek help from people within their informal networks; that social networks often, although not always, improve survivors' mental health and physical safety; and at the same time, that partners who are abusive often cut off survivors from these vital sources of support. Less is known about male survivors, although evidence points to women being more willing to use informal support networks than men (Ansara & Hindin, 2010).

Seeking Help From Informal Versus Formal Sources of Support

Research in a variety of ethnically diverse samples in the United States shows that two thirds to virtually all IPV survivors access informal social support from family and friends to address the DV, whether or not they also access formal services such as health care providers or shelters (Goodman, Dutton, Weinfurt, & Cook, 2003; Hamby & Bible, 2009; analysis of archived data from Tjaden & Thoennes, 2000; Levendosky et al., 2004; Rose, Campbell, & Kub, 2000). Indeed, survivors who are marginalized by race, class, sexual orientation, nationality, or language are particularly likely to seek help exclusively from those they know (Sullivan, 2011).

Survivors offer a number of reasons for this, including worry about stigmatization, concern that needing outside services represents an admission that their social networks could not help, fear that they will be pushed to leave their partners (as is often the case), worry about batterer retaliation, concerns about losing custody of their children, absence of sufficient cultural competence or diversity among agency staff, and the gap between what services can offer and what survivors want and need (Laughon, 2007; Sullivan, 2011). Many may also worry that accessing formal services could trigger a chain of events that is far less reversible than maneuvering within a social network. A decision to enter a shelter, for example, may trigger ostracism by friends and family who may perceive the survivor as stepping outside indigenous cultural norms or betraying her own community (Bograd, 1999). Such a decision may therefore mean divorcing oneself from family and from faith or giving up (sometimes permanently) identities and relationships that are sources of relief and joy (Latta & Goodman, 2005).

The Nature of Informal Network Members' Responses

Even when women who are abused seek professional help from a community agency, the legal system, or the mental health profession, most report that the long-term support that truly

helps resolve the violent relationship is more likely to come from network members or informal supporters (Mancini et al., 2006). By their very nature, friends and family members know an individual better than does a program staff person and, therefore, are often in the best position to respond to her in ways that match her needs, strengths, and contexts (Budde & Schene, 2004). Network members are also not constrained by system-mandated time limits such as those imposed by emergency shelters or health insurance policies.

Supporters can provide a wide array of instrumental assistance, driven by the survivor's needs, such as a place to stay, transportation to needed help sources, childcare, financial assistance, or resources that support the survivor's safety strategies or that enable the survivor to participate in formal services (Fleury-Steiner, Bybee, Sullivan, Belknap, & Melton, 2006; Riger, Raja, & Camacho, 2002). Network members can also provide a broad range of emotional supports, including a shoulder to cry on, ideas about how to stay safe and parent within the relationship, encouragement to take steps toward safety, and commitment to stick with the survivor no matter what (Goodman & Epstein, 2008). In each of these cases, network members can build on dimensions of a survivor's identity (e.g., informal matriarch of her neighborhood block, compassionate and competent childcare provider) that might be invisible to or discounted by the formal service system.

The Impact of Social Support on Survivors' Mental Health and Physical Safety

A large body of research documents that most women who are abused struggle with despair, distrust, hopelessness, and anger (Riger et al., 2002; Sackett & Saunders, 1999). These feelings often become deeply entrenched. Studies show that, on average, almost half of female partner violence victims suffer from depression and over 60% suffer from posttraumatic stress disorder (Golding, 1999). The psychological consequences of IPV can persist long after the relationship has ended (Adkins & Kamp Dush, 2010).

In the face of these sobering statistics, cross-sectional and longitudinal studies have indicated, again and again, that a variety of types of informal social support mitigate the harmful impact of abuse on mental health and contribute to survivors' emotional well-being. Among survivors in shelters and in the community, social support is related to lower levels of suicide risk, mental health difficulties, and general distress (Adkins & Kamp Dush, 2010; Kaslow, Thompson, Brooks, & Twomey, 2000; Thompson et al., 2000).

Several complementary theoretical models suggest how social support works to improve survivors' emotional well-being: The main effects model holds that social support contributes to survivors' psychological health regardless of the amount or severity of abuse experienced; the moderator or buffer model holds that social support functions as a protective factor, mitigating the impact of DV on survivors' well-being; and the mediator model holds that social support mediates or explains the relationship between abuse and mental health difficulties.

Evidence exists for each of these models (Beeble, Bybee, Sullivan, & Adams, 2009), and they certainly are not incompatible. Emotional support may help a woman reinterpret the abuse as not her fault; bolster her perception that she can successfully address the problem, thereby reducing her sense of helplessness; provide an experience that contradicts an abusive partner's demeaning or dehumanizing messages; and enable her to cope more effectively with the emotional and practical fallout of the violence (Carlson, McNutt, Choi, & Rose, 2002; Kocot & Goodman, 2003). Practical support may increase the resources a woman has to deal with the abuse (Coker, Watkins, Smith, & Brandt, 2003) and provide her with accurate information about her options (Rose et al., 2000), both of which may enable her to feel more empowered and capable of dealing with her situation.

Social Support and Reabuse

A robust body of research demonstrates that informal social support also contributes directly to women's physical safety. Demonstrating the link between social support and safety within the general population, Van Wyk, Benson, Fox, and DeMaris (2003) used National Survey of Families and Households and contextual neighborhood (tract) measures to determine that women with higher levels of social support are generally less likely to be victims of IPV to

begin with, irrespective of levels of neighborhood poverty or marginalization.

Several longitudinal studies have also illuminated the relationship between social support and reabuse among women who are already IPV survivors. These studies demonstrate fairly robustly that the less social support survivors have, the more likely they are to experience ongoing abuse over time (Bybee & Sullivan, 2005; Goodman, Dutton, Vankos, & Weinfurt, 2005).

Challenges of Engaging With Informal Networks

Of course, social networks are imperfect conduits of assistance for DV survivors, just as they are for those who do not have violent partners. Research exploring survivors' experiences with their informal support systems indicates that network members' unhelpful responses are as varied as their helpful responses: Family and friends may fail to understand or express sympathy, become too frightened for their own safety to provide support, push survivors to leave before they are ready or to stay to preserve the family, blame the abuse on the survivors, or deny the situation's complexity and overestimate survivors' power to change things (Goodkind, Gillum, Bybee, & Sullivan, 2003; Kocot & Goodman, 2003; Trotter & Allen, 2009).

The few studies that have examined network members' responses directly confirm these survivor impressions. In Latta and Goodman's (in press) grounded theory analysis of network members, for example, participants (family and friends of IPV survivors) were not apathetic, but few were clear on how to respond. Many relied on the survivors themselves to let them know what kind of support was needed. When survivors could not do so, some network members engaged in blaming the victim or offered solutions that did not acknowledge the complexity of the survivors' situation; others simply withdrew. It is important to note that network members who knew something about IPV either through professional or personal experience were best able to discern and respond to survivors' needs. These findings are consistent with a recent community study of residents of three low-income New York City neighborhoods, which found that a sense of self-efficacy—that is, having some sense of how to respond effectively and a feeling that it is in one's power to act on this knowledge—was a key determinant of participants' willingness to intervene to help a survivor (Frye, 2007).

Contrary to the positive benefits provided by helpful network member responses, negative responses may actually decrease survivors' well-being and increase their risk for reabuse. Regarding the former, Goodkind and colleagues (2003) found that family and friends' negative reactions were related to lower quality of life for female survivors, even after controlling for the level of physical and psychological abuse they had endured. Regarding the latter, Bybee and Sullivan's (2005) longitudinal study found that women who reported having more people in their lives who made things difficult experienced higher levels of reabuse 3 years after a shelter stay. The authors speculate that one reason for this is that "difficult" people are less likely to offer support, information, and resources. It could also be that these people are rated as "difficult" because they have encouraged the woman to reunite with the abusive partner, actively supported harassment or violence, or more subtly undercut a survivor's work to take action or reframe her thinking. Yet, despite the tremendous imperfections of social networks, it appears clear that overall, as the number of supportive people in a survivor's life increases, so too do her options for safety and well-being.

IPV's Direct and Indirect Contributions to Social Isolation

Although social support provides a clear benefit overall to women living with IPV, they have reduced access to it. Survivors in shelters and in the community report lower levels of both emotional and practical assistance than nonsurvivors (Levendosky et al., 2004; Thompson et al., 2000). This is not surprising, as many abusers take explicit steps to isolate their partners, demanding that they stop having contact with family, friends, coworkers, or anyone else with whom they have interacted in the past.

But IPV can also disrupt relationships in less direct ways. For example, women may "use up" friends' and family members' willingness to help with issues directly or indirectly related to the abuse, especially after repeated cycles of leaving and then returning to the relationship

(Goodkind et al., 2003). Survivors may be embarrassed to admit the abuse to network members whose norms and values suggest a potentially critical response or feel reluctant to lean on network members whose needs seem greater than their own (Dunham & Senn, 2000; Rose et al., 2000). Whatever the reasons, the result is often diminished access to social support, leaving a survivor with fewer resources to deal not only with the abuse itself, but also with other needs as well. For the most part, women who report more severe abuse report the highest level of social isolation (Thompson et al., 2000; for one exception, see Carlson et al., 2002).

In sum, informal social support is critical to survivors' safety and emotional well-being, and its absence significantly diminishes both, whether or not survivors are also involved in formal services. Moreover, in the end, women's ongoing connections are to their family and friends, not to DV services. It is therefore important to consider whether and how formal DV services support these connections.

Opportunities for DV Services to Help Survivors Engage With Informal Social Support

Although most female IPV survivors seek support from friends and family, a substantial portion access some formal services (e.g., 49% in a Canadian national sample; Du Mont, Forte, Cohen, Hyman, & Romans, 2005). This section describes the extent to which three mainstream service models— crisis hotlines, emergency DV shelters, and community-based services— support survivors' efforts to access informal support or support network members' efforts to provide assistance. We discuss them separately here, recognizing that, in practice, they overlap substantially and that many practices are already more network-oriented than their formal descriptions would indicate.

Crisis Hotlines

The crisis hotline, usually housed within a shelter or other DV agency, is present in approximately 41% of counties in the United States (Tiefenthaler, Farmer, & Sambira, 2005). As a gateway into services, hotlines serve a very basic function: to increase survivors' immediate safety through the provision of information, referrals, and short-term support (Macy, Glattina, Sangster, Crosby, & Montijo, 2009).

Hotline workers by no means ignore survivors' informal networks. To our knowledge, however, most hotlines are not constructed to engage the survivor in a far-reaching and systematic discussion of who is in her network and how each might be helpful. Significantly, few are as accessible to network members as to survivors. This gap, although understandable, nonetheless represents a missed opportunity for supporting immediate as well as long-term safety, as discussed in this article's third section.

Emergency Shelters

Although only a small percentage of survivors use emergency shelters (about 4% in one national study; Hamby & Bible, 2009; analysis of archived data from Tjaden & Thoennes, 2000), shelters have nevertheless become the hallmark of the DV movement, present in 36% of United States counties (Tiefenthaler et al., 2005). Their fundamental purpose is to offer physical safety for those fleeing DV. Most also provide some level of advocacy (sometimes called "case management") to help their residents begin rebuilding areas of their lives compromised by IPV, such as health, housing, employment, mental health, and children's mental health (Sullivan, 2011).

The manner in which safety is achieved, however, may also contribute to survivors' isolation in two substantial ways. First, most DV shelters require that survivors leave their own neighborhoods and move to shelters with unpublished addresses that take significant steps to keep their locations secret (Donnelly, Cook, & Wilson, 1999; Haaken, 2010). As a result, survivors are not only forced to leave their abusers but must sever ties with their friends, family, religious groups, jobs, and children's school communities, and walk away from other grounding roles, rituals, and cultural practices (Goodman & Epstein, 2008).

Second, shelter rules, designed to support safe communal living, can have the unintended, negative consequence of furthering survivors' isolation from their existing communities (Haaken, 2010). At the most basic level, shelters with confidential locations make clear that

survivors may not divulge the shelter's location to others. Other key shelter rules often include strict curfews, which prevent survivors from traveling to visit people from their home community or participating in culturally relevant events; requirements that survivors quit their jobs; limitations on use of the telephone; or explicit prohibitions on contacting friends and family for the first few days, if not longer (Glenn, 2010). The intent of many of these rules is to enhance residents' physical safety, but for some, the result may be just the opposite, as survivors begin to find secret ways to contact family and friends, sharing less and less information with staff that might be critical to their safety (Olsen, n.d., p. 3). Certainly, these rules present enormous obstacles to any effort to help survivors reengage with family members and friends.

In the past several years, activists have begun to discuss the relative costs and benefits of these and other shelter rules and have developed recommendations for ensuring that these rules actually create short-term and longer term safety (see, e.g., Lyon, Lane, & Menard, 2008). Still, there remains a need for more systematic examination of how shelter rules explicitly and implicitly isolate residents, and how shelter practices more generally can support survivors' (re)engagement in community.

Community-Based Services

Over time, many DV shelters have added an array of services to their offerings and extended their availability to survivors living in the community. One recent national survey of 1,648 DV organizations found that on a single day in 2009, 63.3% of the adult survivors seeking their services were participating in nonresidential services and 25.5% were sheltered (National Network to End Domestic Violence, 2010). As they are currently structured, such services generally fall into one of two categories: individual advocacy/case management and peer support groups (Macy et al., 2009). These community-based services offer a variety of opportunities to enhance survivors' social networks.

In case management or advocacy, trained staff members link individuals to resources to address immediate and longer term needs and entitlements for employment, education, housing, financial, childcare, and legal services (Macy et al., 2009). It is entirely possible, however, that if trained and supported in the right way, other survivors or friends and family members could help each other find needed resources or apply for critical benefits (Smyth, in press). As the next section shows, people living in the same community may be particularly equipped to support each other not only in addressing issues directly related to DV, but also in addressing the myriad issues that are indirectly related to it, including isolation and the need for mutually enriching relationships. Because traditional advocacy is time and issue limited, it does not have the same potential for providing sustained emotional and instrumental support.

Peer support groups are designed to help survivors engage with others who have had similar experiences. By talking in groups, survivors can come to understand their experiences as part of a larger social pattern, and thereby let go of feelings of stigma, self-blame, or marginalization (Herman, 1992). Although these are critical functions, peer support groups rarely go on to help survivors develop enduring peer support networks or networks that are not focused solely on DV. Although some programs may allow for the inclusion of existing friends and family members in peer support groups, this could be done much more systematically and pervasively.

A Network-Oriented Approach to DV Practice

Despite the extensive literature on the contributions of informal social support to women's physical safety and emotional well-being, DV services do not make central the maintenance and development of survivors' connections to their informal support networks. By contrast, the network-oriented approach that we propose next views short-term safety at the cost of social support as unsustainable over the long-term and builds on research showing that survivors' engagement with others (even around issues other than the violence itself) increases their physical safety and emotional well-being.

Recognition of the key role of survivors' informal support networks has already triggered a number of innovative grassroots efforts, particularly within communities of color, to *prevent* DV through changing social norms or to

equip network members to *intervene* more effectively (Family Violence Prevention Fund, 2002, 2004). Most of these efforts have been initiated outside the bounds of mainstream domestic services in large part because social services systems do not provide avenues through which to engage community members (Kim, 2002).

We suggest, however, that if DV service models themselves aligned with and leveraged the potential of social networks directly, they could dramatically enhance their ability to support survivors in securing sustainable safety. Network-oriented practice therefore entails a realignment of services such that staff members would understand their role as partnering with community members, with each member of the partnership bringing his or her best skills, whether professional training, experiential expertise, or both, to the task of supporting survivors. Specifically, it would enable survivors to identify and engage potentially helpful friends, family, neighbors, and others; support informal network members' own efforts to assist survivors; and help survivors expand or build new support networks.

Such a shift in the way we support survivors would, in turn, require a reconceptualization of two dimensions of mainstream DV services: the role of the practitioner and the scope and nature of services. We discuss each of these next, concluding with two examples of a network-oriented approach in practice.

The Role of the DV Services Practitioner

Recognition that safety is inseparable from the web of relationships that surround a survivor leads to two major shifts in the role of the practitioner. First, although working directly with the survivor remains a priority, the network-oriented practitioner's role is also to collaborate with others in the survivor's community. Network members are seen not just as temporary supports until a space opens up in a shelter or community program, but as critical partners who can fill some short- and long-term needs as well as, if not better than, professional services. It is important to note that this does not mean simply asking network members to do for free what DV and other social services have done in the past. It means engaging them to provide the kinds of support that traditional services simply cannot provide.

This requires that the practitioner be seen as trustworthy, and that she views network members as partners. Practitioners must learn deeply about community norms and values and how the survivor understands her relationships within her social network (Kim, 2002). This may necessitate intensive diversity training, and it will also require an investment of time and a willingness of organizations to support staff in examining assumptions and beliefs about culture and social networks.

Second, the purview of the network-oriented practitioner includes engaging with the survivor's lived realities, addressing the broad spectrum of needs that may or may not be directly related to DV. To fulfill this role successfully, the practitioner needs to collaborate with professionals within the broad range of institutions with which the survivor comes into contact. For example, a network-oriented practitioner may need to work with the public housing office to help a survivor find a housing unit within driving distance of her three brothers and sisters who are key members of her support network. This kind of collaboration would require ongoing communication between the practitioner and the local public housing office and the building of a shared understanding of the importance of family to the survivor's residential stability.

Tying together these roles, the network-oriented practitioner works to *help the survivor access effective support*—through both formal systems and informal social networks—to address a variety of needs that are directly or indirectly related to the violence. Far from diminishing services' role, this approach allows for the application of relevant expertise and resources more precisely, based on the particular constellation and availability of support and knowledge within a given survivor's formal and informal network.

The Scope and Nature of DV Services

A network-oriented practice does three things: It assists survivors in engaging their own networks, it helps network members support the survivors in their lives, and it enables survivors to develop new ties to supplement their existing connections, particularly (but not only) when

their own connections become too frayed or unhelpful. Although these three goals are tightly intertwined, for the purpose of clarity, we address each separately here, highlighting where possible the distinct roles of hotline workers, shelter practitioners, and community-based services staff. Fully implementing a network-oriented approach in the context of a concealed shelter location holds particular complexities that are for the most part beyond the scope of this article (see Glenn, 2010, and Haaken, 2010, for good discussions of this topic). However, elements of the discussion below can be applied even in this situation.

Helping survivors engage their networks. A starting point for network-oriented practice is working with survivors to identify the full range of informal network members who might be helpful. Although the conversation may begin with a brainstorming session (vs. a traditional intake), this identification process occurs over time, building on three principles: First, asking the right questions in the context of a supportive inquiry (e.g., "Whom do you consider 'family'?" "Are there people you see regularly, even if you don't consider them friends?" "Is there someone who notices when you've been hurt, even when you try to hide it?") can lead to the identification of people who are generally more peripheral but nevertheless potentially helpful—a building superintendent, a child's piano teacher, or another volunteer at the food pantry.

Second, people can be helpful in some domains even when they are not in others. An abusive partner's mother could provide excellent childcare even if she does not understand why the survivor wants to leave him. A process of network exploration cannot build on the assumption that more difficult relationships can or should automatically be ignored or jettisoned.

Third, people in a social network both give and receive, although not in equal currency or amounts, and not consistently over time. Survivors may well find mastery and purpose in being able to give support even as they are receiving it. A survivor's identity is much broader and deeper than simply that of "survivor." She may also be a mother, an employee, an activist for immigrant rights, a caretaker for aging parents, or the best cook on her block. When survivors maintain these roles in others' lives, even as they struggle with IPV, they maintain a sense of self and may also develop new sources of support.

Beyond helping survivors assess their own social ecologies, network-oriented practitioners might also help survivors develop new ways of asking for help, create strategies for dealing with potentially misguided network members, or identify the relevant skills and resources that different network members possess. Of course, network practitioners might (and often should) stand in for informal network members when members of the latter group are unable or unwilling to respond.

Helping network members support survivors. As described above, research shows that some network members who want to help may fail to do so because they are unsure what to do, their attempts to help are uninformed and clumsy (and potentially harmful), or they need support to stick with the survivor because it feels too isolating to go it alone (see Latta & Goodman, in press). These network members represent untapped resources in building sustainable safety for a survivor. Network-oriented practice must therefore be equally accessible to network members as to survivors. Although some DV practitioners are already providing support to some network members some of the time, a network-oriented approach makes it a focus.

Practitioners can engage network members in a number of ways: First, at the request of, or with permission from, the survivor (which would be documented), a hotline worker could include a network member in a phone conversation with a survivor, thereby shifting the former's role from outsider to insider. Indeed, as the research discussed above makes clear, survivors are more likely to engage effectively with services if network members support their use of those services. Second, as already occurs in some settings, a hotline worker could take calls directly from network members who themselves need support and information as they attempt to support the survivors in their lives, with options discussed including, but not limited to, supporting the survivor in accessing formal systems of assistance.

Third, DV practitioners could help network members and survivors join together to support each other. Feeling as if they are part of a larger group could energize them and make them feel less alone. As one example of such an effort,

Seattle's Northwest Network of Bisexual, Transgender, and Lesbian Survivors of Abuse brings together survivors and their friends and family members in settings such as house party potlucks, picnics, or craft nights to develop strategies that discourage violence, break down isolation, and help survivors access gay-friendly services (Family Violence Prevention Fund, 2002).

Fourth, network-oriented practitioners might work directly with network members concerned for a friend or family member who is not engaging with them about the suspected abuse. For example, neighbors gathering for a barbeque may realize in the course of conversation that they have all witnessed or heard someone in the neighborhood abusing his wife, but no one has felt that calling the police was the right thing to do (although it was the only thing they could come up with). Network-oriented practitioners would be available to these barbequing neighbors, both to help them develop a plan of action and to help them stay engaged when a survivor behaves in ways that puzzle or frustrate them.

Network-oriented practitioners must be continuously aware of the real possibility that members of a network are themselves survivors of violence, are victimizing others, or know survivors other than the person they are focused on at the moment. A network-oriented approach has significant spillover beyond the "index client."

Helping survivors develop new forms of informal support. Social networks are dynamic for everyone; we continually build new relationships and adjust others. Survivors may need support in this, particularly those survivors whose networks are atrophied. A network-oriented approach actively supports survivors in developing and navigating these new relationships, perhaps based on a shared experience of violence, but also based on the range of other things about which people connect.

The peer support groups already provided by many community-based DV services are obvious initiation points, although they could be expanded in a number of ways. A simple starting place builds on the reality that whether or not they seek DV services, many survivors seek services from employment programs, health clinics, housing agencies, or substance abuse treatment programs. DV service providers could codevelop peer group opportunities in any one of these settings (Family Violence Prevention Fund, 2004). Moving beyond the social services system, a network-oriented practitioner could offer to host an informal discussion about DV during a lunch break at a small business or facilitate a group for women at a local nail salon, a gym, a YWCA, or a class for English-language learners (Kim, 2002). Indeed, creating new access points that fit the cultural and social characteristics of specific communities would create opportunities for survivors and supporters who would never seek help from traditional DV services. Such an approach begins to blur the lines between intervention and prevention, usefully extending the reach of DV services to new communities.

In a related vein, a network-oriented approach recognizes that survivors may build more sustained, useful, and authentic relationships with each other if they are helped to form relationships around a broader range of issues than simply DV. People generally connect around neutral topics before deeper ones—a love of ice hockey or spy novels, a shared second-grade teacher, a community-service requirement to continue qualifying for food stamps. These groups could then become a natural scaffolding for more sustained relationships. For example, two survivors who discover a shared love of movies (perhaps squelched by their abusers' control of their movements and money) might attend a matinee together. Two survivors with children close in age could barter babysitting with each other to enable each to get to necessary appointments without kids in tow. Given both the stigma of DV and the deeply individual way each of us—survivors included—prioritizes needs, a flexible discussion series focused on the issues most salient to the people in the group could open the doors for attendance by survivors for whom DV may be a problem but who would need to get to that topic only after trust was established (Latta & Goodman, 2005).

Peer support groups could also be expanded or transformed to include an activist component, enabling survivors to work together to make changes in their own community. Such efforts can be enormously powerful both for the purpose of creating social change and for the purpose of connection and healing among survivors themselves (Herman, 1992; Kim, 2002). The increased mastery that comes from creating

something positive out of pain is deeply salient to many survivors and may extend to other parts of their lives.

In addition to developing informal peer support opportunities, network-oriented practitioners could look for opportunities to engage survivors in a range of informal activities that enable social ties to develop. A network-oriented approach recognizes the import of such connections and the social settings in which they occur. For many survivors whose movements were heavily controlled by their abusers, gentle encouragement to participate in community activities may be needed.

A Network-Oriented Approach in Action

Here, we provide two illustrations of some of the ways that a network-oriented approach would address the needs of a survivor and a network member, respectively.

Working with a survivor. Sheila's husband regularly mocks, berates, and beats her. She is unwilling to leave him in part because she is caring for her aging parents who live with them.

Wanda, a network-oriented practitioner, helps Sheila identify people in her network whom she had not considered originally but who might be sources of support—the guy who repairs her car and lets her stretch out payments or the VA nurse who comes to see her parents every week and with whom she went to high school years ago. Wanda is curious about whether there is a neighbor Sheila could walk or exercise with in the mornings or someone to help out with her parents while she takes a class. Wanda is interested in how these people could support Sheila not just in terms of immediate physical safety but also in terms of increasing her sense of choice, control, and stability in the broadest sense. Perhaps in time, some of those shifts could create new possibilities for safety that do not seem readily apparent.

Although talking with Wanda surfaces a number of new ideas for people who could help, Sheila remains daunted by the prospect of starting conversations with them. So next, Wanda helps Shelia develop some scripts for engaging a few potential supporters. Sheila begins to practice, for example, how she might talk to the visiting nurse about respite care for her parents if and when she needs to look into an alternative living arrangement, and how she might alert her neighbors to call or stop by if she needs them. Sheila is greatly assured when Wanda "gets" that her identity is not solely that of "survivor" and that she understands how much Sheila's role as caregiver to her parents gives her a sense of meaning, purpose, and value.

Finally, Sheila is enormously heartened when Wanda offers to support the network members who support Sheila. The two women initiate a conversation with Sheila's parents and her neighbors. Together, they create a system such that if Sheila cannot call her neighbors, her parents will. The neighbors, in turn, develop a rough schedule so that Sheila knows who will be at home when. The neighbors were afraid of involvement at first, but with Sheila's and Wanda's coaching, they figure out ways to remind the husband of their presence in small, discrete, and safe ways.

Working with a network member. Miguel hears violence occurring in the apartment immediately above his; he feels helpless and worried, both for the victim, whom he barely knows, and for himself. Because the couple is related to his landlord, he feels he cannot call the police for fear of eviction, and he is also worried about interacting with law enforcement given that he is here on an expired visa. The network-oriented practitioner he reaches when he calls the hotline discusses his concerns about law enforcement and validates his sense of vulnerability. The hotline worker helps Miguel think about others in the community who might also be concerned, perhaps others in the same building who are probably also hearing the violence. New options emerge when they come up with the idea of a phone tree: Miguel could call the acquaintance who lives in the apartment building across the street who, in turn, could call the police. The hotline worker suggests the next time he sees the survivor, he engage her gently, "I'm trying to meet people in the building—just don't know my neighbors enough!"

A Research Agenda to Support a Network-Oriented Practice

A wide range of research questions emerge from and would contribute to further consideration of a network-oriented approach. These questions fall into two broad categories: those that explore the characteristics and impact of

social network support and those that address the characteristics and impact of network-oriented approaches.

The Characteristics and Impact of Informal Social Network Support

Despite the substantial body of research on the role of social support in promoting IPV survivors' safety and well-being, we need to understand much more about what factors, at the individual, interpersonal, cultural, community, and societal levels, contribute to network members' willingness and ability to support survivors. What forms of support (e.g., short- or long-term practical or instrumental support) contribute to what types of outcomes for what survivors, at what stage in their relationships with abusive partners? Are outcomes different for survivors who are supported by multiple individuals versus by a group of people who support each other? To what extent and under what circumstances do network members feel a sense of shared responsibility to intervene with survivors? Are there ripple effects (positive or negative) on the safety and well-being of network members who support a survivor?

The Characteristics and Impact of Network-Oriented DV Services

Although few, if any, formal service systems have made a network-oriented approach central to their work, many DV programs have instituted elements of such an approach. In New Hampshire, for example, a third of the hotline calls to which advocates respond are from secondary victims or from other concerned network members (personal communication, Grace Mattern, Executive Director of the New Hampshire Coalition Against Domestic and Sexual Violence, December 2010). We need to understand more about the extent and nature of existing network-oriented practices across hotlines, shelters, and community-based advocacy services, as well as what kinds of support, training, and resources network-oriented practitioners would need to engage in this kind of work.

Ultimately, our concern is with increasing survivors' safety and well-being. As such, it will be important to determine what works to achieve these outcomes, for whom, and under what circumstances. But as we have endeavored to show, "safety" cannot be understood as a concept discrete from social context and other factors, so research must also investigate the network-oriented services' impact on the interconnected concepts of safety, social support, emotional well-being, stability, self-efficacy, and ability to participate in useful services and supports. We also need to understand more about the extent to which network-oriented approaches contribute to changes in network members' attitudes, knowledge, and actions; the relationships between network members and survivors; and network members' sense of responsibility to survivors within their own networks.

Untangling and addressing these questions will be complicated, to be sure. Each survivor's needs and social networks are unique. As such, outcomes are highly individualized. Moreover, in some cases, the intervention could have a greater impact on a loose group of network members than on any one survivor. To answer the array of questions necessary for a meaningful determination of impact requires a mixed methods approach that is in all likelihood participatory in nature; that combines quantitative investigation with qualitative, participatory, and case study methods; and that attends to the individualized "dosing" and emergent nature of the practice.

Finally, we need to understand how the development of network-oriented practices changes systems and practitioners themselves. This will require engaging questions such as the following: How do network-oriented practices change IPV services in terms of who is being served, in what ways, and with what resources? What services are less needed (i.e., are taken up by network members) and what services are needed more? What kinds of training and support might help practitioners transition to and sustain network-oriented practice? How are DV programs' relationships with non-DV programs changed?

Clearly, the questions are legion, and answering each will probably lead to new questions, but our responsibility to survivors demands we evolve not only our practices, but our research questions as well.

Conclusion

Ultimately, a network-oriented approach recognizes that change emerges from survivors themselves, responsive formal networks, acti-

vated community members, and the collaborations that develop among them (Mancini et al., 2006). Adopting a network-oriented approach to DV would therefore help realize the original and ongoing intention of the DV movement: to frame IPV as an issue that is everyone's responsibility and within everyone's power to address.

Certainly, moving toward network-oriented practice would raise a number of conceptual and practical challenges. Most programs are already overwhelmed with the immediate needs of survivors and have little time to consider large-scale innovation. Practitioners would need to engage in systematic discussion and actions to identify and address the potential utility and drawbacks of this approach. Many practitioners would need to acquire new skills, knowledge, and tools (although many might find that they are already using some of the methods made explicit here, without having framed them quite this way); many would need to be supported in revisiting long-held assumptions about social networks and survivors. Funding streams and oversight need to be reconsidered. Important questions also remain regarding boundaries, confidentiality, and security.

But as complex as this shift might be, it is a complexity aligned with that in the lived realities of survivors. Furthermore, although our purpose is not to drive more survivors to formal services, it is possible that working directly with communities could powerfully extend the reach of the antidomestic violence movement, enabling it to embrace marginalized survivors and groups who are now unlikely to access formal institutional support (Goodman & Epstein, 2008).

The research is clear that however we design our intervention systems, victims themselves are engaging the public—their own, private public—sooner, with greater frequency and for longer periods than their episodic use of public services and systems. For our work to be truly survivor-centered, we need to join them, and those who support them, in this endeavor.

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