CHANGING THE WAYS COMMUNITIES SUPPORT FAMILIES TO PREVENT INTIMATE PARTNER VIOLENCE

Preventing Intimate Partner Violence: A Community Capacity Approach

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SUMMARY. Bringing together the energy, resources, creativity, and good will of citizens enhances community resilience. The shared responsibility and collective competence that emerge from community members banding together can be a powerful and ongoing positive influence on the quality of community life, including the relationships between intimate partners. We explore the importance that the community has for preventing intimate partner violence (IPV). We argue for active,

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network-oriented prevention efforts. We discuss key community principles and concepts (including a definition of the nature of community), explore a social organization perspective on communities, and present a theoretical approach to building community capacity. We posit implications for program development that include community as a place for prevention, a target for prevention, and as a force for prevention. Our implications for research include examining multiple community layers, the nexus of informal and formal social care systems, and contrasting extreme groups on pivotal social organization processes.
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Community resilience and the benefits a community provides to its residents can be enhanced by collective action, that is, by bringing together the energy, resources, creativity, and good will of citizens. The shared responsibility and collective competence that emerge from community members banding together can become a powerful and ongoing positive influence on the quality of community life, including the relationships between intimate partners. This community capacity for building an environment that supports children, youth, families, and adults can lead to the attainment of important community results, including safer neighborhoods, healthier children, and intimate partners who resolve issues without using violence.

We explore the importance that the community may have for preventing intimate partner violence (IPV). We reject reliance on passive, public-service-announcement approaches, and argue instead for active, network-oriented prevention efforts. We predicate our approach on the reality that humans are social beings and are influenced by social phenomena that include culture, norms, and community social organization. We discuss key community principles and concepts (including a definition of the nature of community), explore a social organization approach to communities, and present an approach to building community capacity. We posit implications for research and for program development.

Chaskin, Brown, Venkatesh, and Vidal (2001) raise the question, what is a community that "works"? Sampson (2001) asks, what are the

collective processes that make for a healthy neighborhood environment? We ask, more specifically, what are the community elements that promote healthy relationships and minimize IPV, and what ongoing prevention systems can be put in place to provide community elements that make positive differences?

INTIMATE PARTNER VIOLENCE TRENDS

In 2001, approximately 588,490 U.S. women reported physical or sexual assault by intimates, and men were victims of about 103,220 violent crimes committed by an intimate partner (Rennison, 2003). Rates of IPV range from 1.8% to 14% in population-based studies, and up to 44% in health care settings (Jones et al., 1999; Tjaden & Thoennes, 2000). Lifetime estimates range up to 51%, with a typical range between 25% and 35% (Tjaden & Thoennes, 2000). Women experience significantly more violence from intimate partners than men do (Bachman, 1994; Tjaden & Thoennes). More than 25% of American married couples experience one or more incidents of IPV (Feld & Straus, 1989).

PROGRAM RESPONSES TO INTIMATE PARTNER VIOLENCE

Today's response to IPV is shaped by legal reforms over the past two decades and is characterized by comprehensive and aggressive law enforcement actions focused on offender accountability and on deterring offenders' behaviors. Nevertheless, incidence and prevalence data demonstrate that legal reform alone is not sufficient, and suggest that culture and community reform are necessary (Daro, Edleson, & Pinderhughes, 2004). The prevalence of attitudes and community norms that support violence against women, excusing violence as private or as deserved by the victim, remains one of the most distressing issues in efforts to stop IPV. Community education and media campaigns directed at changing attitudes and public opinion are the dominant community-based prevention strategies, and are largely ineffective in changing behavior because they tend to be passive, stand-alone interventions rather than part of a more comprehensive strategy (Snyder, 2001). An approach with greater potential to effect change involves the activities of formal and informal community networks.

Two decades ago, the Attorney General's Task Force on Family Violence recommended coordinated community responses to IPV and specified reforms in the law and the operations of the criminal justice system (Department of Justice, 1984). Unfortunately, although community-wide responses to IPV are strongly encouraged, they are rarely obtained. Often, communities merely respond to violence, rather than proactively structuring prevention initiatives, and coordination occurs across a limited set of formal community organizations, principally those representing the criminal justice system (Pence, 1983; Shepard, 1999). Generally excluded from coordinated community response models are formal community agencies such as healthcare, faith-based, or community organizations, and informal networks such as family, friends, neighbors, or work associates.

Wolfe and Jaffe (2003) and O'Leary, Woodin, and Fritz (this volume) review IPV and sexual assault prevention programs across the age continuum, from elementary-aged children to college students and young adults. While some prevention programs target high-risk groups, most prevention efforts are psychoeducational and target a broad population. Such programs focus on clarifying attitudes and behaviors and on offering positive norms and alternatives. Wolfe and Jaffe note that schools are the ideal venues for most of these primary prevention programs. In contrast, prevention strategies targeting adults are generally limited to media or public awareness campaigns–advertisements or public service announcements providing information on community resources.

These approaches are passive, less intensive, and lack focus. For instance, the National Violence Against Women Prevention Research Center (2002) found that current prevention programs are limited in scope; that programs target mostly females, without acknowledging the role males play in preventing violence against women; and that few programs focus on perpetrators. Most programs are nonstandardized, in-house initiatives that lack common components and substantive evaluation efforts. These findings illustrate the need for more systematic program evaluation as well as more development and dissemination of structured prevention programs.

There are few controlled-outcome studies of interpersonal violence prevention programs (O'Leary, Woodin, & Friz, this volume), and these studies focus on adolescent dating violence rather than on young adults or on married couples. Wolfe and Jaffe (2003) also note the meager amount of existing research and its narrow focus. O'Leary et al. review substance abuse prevention research, which is substantial,

to identify potential links and lessons for intimate partner violence prevention programs. Their review shows that successful programs (a) target behavior rather than attitudes; (b) involve interactive components rather than didactic instruction; (c) include a cognitive or cognitive-behavioral orientation, especially social skills training and norms education; (d) consist of longer treatment and follow-up sessions instead of one-time programs; and (e) emphasize culturally appropriate programs.

Reviews of mass media education and awareness prevention campaigns note the paucity of research evaluating the effectiveness of such strategies (Campbell & Mangenello, this volume). Community education and media campaigns are designed to change people's behavior, either by providing new knowledge or by changing attitudes, but the findings regarding resulting behavior change are inconclusive. There is only slight support for the assumption that a tailored media campaign changes attitudes or affects behavior. In fact, when changes do occur, positive findings are fairly minimal. In a controlled study, Synder (2001) found that only 7% to 10% of those involved in a community campaign changed their behavior. Successful interventions require additional components that actually lead to behavior change (Campbell & Mangenello, 2006).

O'Leary et al. (this volume) recommend a hierarchical system of IPV prevention, depicted as a pyramid. The model's base is a universal prevention program for all individuals, consisting of psychoeducational programs that provide information about norms of behavior within romantic relationships, paired with an active or interactive learning component. Each additional level of the pyramid represents an increasingly intense level of intervention based on the level of physical aggression present. As one moves up the pyramid, interventions become more targeted and focused; different levels of intervention are provided for different levels of the problem.

EMERGING COMMUNITY-BASED APPROACHES TO PREVENTION

The increased study of community over the past decade, and the articulation of strong theoretical models of community capacity, is leading to new prevention approaches. We are moving from observing a "loss of community" to understanding the factors that are related, both positively and negatively, to building community capacity and achiev-

ing community outcomes. This understanding has led to the development of strategies and specific activities directed at impacting capacity and outcomes. For example, Bowen, Martin, and Nelson (2002) describe a large-scale community capacity initiative directed at IPV in the military–an initiative that addresses changing the social environment of a group of individuals, rather than attempting to change the individuals directly.

Though individuals perpetrate violence, IPV occurs in community and neighborhood contexts; thus, solutions must focus not only on the individual, but also on the broader environment. The boundaries of intimate relationships are permeable. Since the lives of most people involved in IPV intersect with the broader community, and therefore are subject to community influence, prevention in that larger context can potentially influence what occurs within relationships.

THE NATURE OF COMMUNITIES

Understanding the nature of community, and of a particular community, is a primary consideration in constructing community-level prevention initiatives. Such an understanding clarifies the range of prevention portals and opportunities and informs researchers and program professionals about needed research and possible prevention avenues. Community itself is a potential prevention force and not just a place where prevention activities occur.

Community as a Place: Boundaries of Interest

Boundaries are important because they help to target prevention efforts. Coulton (1995) discusses the phenomenological, interactional, statistical, and political aspects of community boundaries. Phenomenological boundaries are determined by the consensus of people who reside in contiguity; that is, people generally agree that their neighborhood covers a certain land area. An interactional view of community boundaries is concerned with patterns of contact between residents, friends, and acquaintances that occupy the same geographic area. Statistical approaches often employ census information, which provides hard data on the characteristics of occupants of particular land areas. Political boundaries include designations such as towns, districts, counties, wards, and so on.

Sampson (2001) notes the importance of focusing on a spatially oriented conceptualization of community, rather than simply defining community

in terms of solidarity among residents. He suggests the neighborhood as a concrete representation of a community. Chaskin et al. (2001) note that when community conceptualization is tied to geography, it includes natural boundaries, a recognized history, and demographic patterns, as well as industries and organizations located in it. They also note that shared social interests and characteristics (e.g., language, customs, class, or ethnicity) can be used to define community. They add that in established communities all of these community elements coalesce to form a unique geographic area inhabited by people with distinct shared characteristics.

Chaskin et al. (2001) and Coulton (1995) note the significance of functional elements of a community. A community attribute may be oriented on the development and delivery of goods and services. As political entities, communities can collectively mobilize around key issues, thereby having another functional element. Communities provide within their boundaries physical spaces and facilities that form the context of social interaction, which may be a visible marker of identity and belonging. Within these boundaries, regardless of how or by whom they are defined, community processes influence people's lives. How we conceptualize the community affects planning research and prevention efforts.

Community as a Prevention Force: Social Organization

Social organization is a significant element in building community capacity (Furstenberg & Hughes, 1997; Mancini, Martin, & Bowen, 2003; Sampson, 2001). Social organization pertains to how people in a community interrelate, cooperate, and provide mutual support, and includes social support norms, social controls that regulate behavior and interaction patterns, and the networks that operate in a community (Furstenberg & Hughes, 1997). Social organizational processes in the community influence individuals within intimate partner relationships. The social organization of individuals, intimate partners, and families within a community provides guidance on structuring and delivering prevention activities.

An important aspect of social organization involves people's expectations of their community life. Sampson (2001) makes an excellent point: "One of the most central of such common goals or ends is the desire of community residents to live in orderly environments free of predatory crime" (p. 8). He defines social organization as "the ability of a community structure to realize the common values of its residents and

maintain effective social controls" (p. 8). Social control is important because it is a regulatory mechanism that helps community residents achieve common goals.

Our thinking on social organization is influenced by Furstenberg and Hughes's (1997) work on neighborhood influences on children's well-being. Social relationships exercise powerful and direct influences on individual, relationship, and family well-being; furthermore, those social and intimate partner relationships mediate other community influences. Social capital is both a characteristic and a result of processes reflected in social organization (Putnam, 2000). According to Coleman (1988), the tripartite content of social capital centers on information, reciprocity, and shared norms. Social capital is a facilitating asset for people, an asset that enables them to be more successful in their communities.

Shared norms are of particular interest within the context of preventing IPV since, for instance, the belief that hitting should not be an element of a relationship is an equivocal one (Sabol, Coulton, & Korbin, 2004). For example, Silverman and Williamson (1997) report that between 10% and 25% of males in their sample felt that under certain conditions it is acceptable to abuse women. Furstenberg and Hughes (1997) note that normative support can be provided for both licit and illicit activities; activity considered unacceptable by the general population might be more tolerated among certain subgroups. These subgroups are not necessarily or solely characterized by particular demographic characteristics but also by psychographic characteristics, including attitudes about gender, about sense of self and sense of others, about risk-taking, and so on. Thus, the social organization of a community is a primary prevention portal, whether bound by physical geography, political considerations, or demographic characteristics. Community should be considered as a force in violence prevention rather than only in terms of space and place (Bowen, Gwiasda, & Brown, 2004).

COMMUNITY CAPACITY

Social organization provides an umbrella for the conceptualization of specific group processes and effects that reflect the complexity of community contexts. One such group effect, community capacity, reflects the collective dynamic of a community that comprises and surrounds families (Bowen, Martin, Mancini, & Nelson, 2000). "Building community capacity" represents a conceptual approach to adding an action

element to discussions about communities and neighborhoods. Community capacity frameworks are about change and the processes that influence change. The framework assumes that communities can take control of their own destinies, can marshal a range of resources in that regard, and can build a level of community quality and competency that has an ongoing positive influence.

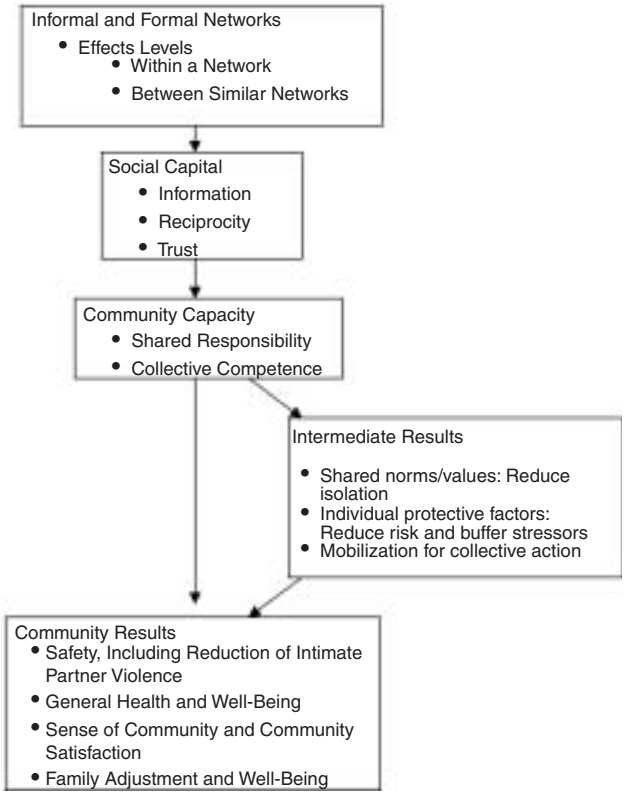
Our community capacity model (see Figure 1) contains four main concepts: (a) community capacity, (b) community results, (c) formal and informal networks, and (d) effect levels (Bowen et al., 2000; Bowen, Martin, Mancini, & Nelson, 2001; Bowen, Mancini, Martin, Ware, & Nelson, 2003; Mancini, Bowen, & Martin, 2005; Mancini et al., 2003). The figure also includes a set of intermediate results that specify the path through which community capacity operates in achieving broad-based community results. Community capacity, the central element of the model, is defined here as

> the degree to which people in a community demonstrate a sense of shared responsibility for the general welfare of the community and its individual members, and also demonstrate collective competence by taking advantage of opportunities for addressing community needs and confronting situations that threaten the safety and well-being of community members. (Bowen et al., 2000, p. 7)

This approach suggests that community capacity is evident in degrees (rather than simply being present or absent), that concern is expressed both for the community in general and for particular parts of the community, that action is taken (rather than just expressions of sentiment), that this action seizes opportunities, and that action occurs with regard to normative, everyday life situations as well as situations that are extraordinary threats.

A key term is *demonstrate* because community capacity includes taking action evidenced by observable results. Community capacity mediates between social capital accruing from formal and informal networks and the achievement of desired community results. Social capital is integral to our model and is the aggregate of resources (including information, opportunities, and instrumental support) that arise from reciprocal social networks and relationships, and that result from participation in formal and informal settings (Coleman, 1988; Putnam, 2000; Sabol et al., 2004). Social capital involves reciprocity and trust among people and is evident in civic engagement, religious groups, membership groups, and community initiatives.

FIGURE 1. Community Capacity Approach to Preventing Intimate Partner Violence



Community Results

Community capacity ultimately leads to community results because it is the demonstration of shared responsibility and of collective competence. Community results are the broad-based, shared outcomes of community members, such as health and well-being (Mancini et al., 2003), safety (Sampson, Raudenbush, & Earls, 1997), and family adaptation (Bowen et al., 2003). *Intermediate community results* identify the specific manner and mechanisms by which community capacity operates to achieve overall community results. As such, intermediate results

help structure and guide interventions and provide important markers for evaluation efforts.

Results that are recognized and endorsed by a community provide direction for the targeted use of resources to resolve issues and address concerns. Managing results rather than managing disconnected activities enables efforts to be more intentional, leads to more specific indicators of the success of community efforts, and leads toward discovery about which efforts make an important and desired difference (Orthner & Bowen, 2004). Desired community results are significant because they provide meaning for community capacity, and they are achieved because of community capacity. A focus on community results makes the model more than merely a way to describe community activities. In the current discussion, a community result is the reduction of IPV.

Networks

Formal and informal networks of social care both are vehicles for building community capacity. The former are networks associated with agencies and organizations, whereas the latter are natural networks of relationships with work colleagues, friends, neighbors, and other voluntary relationships (Budde & Schene, 2004). Within each of these networks there is interaction between individuals, but in formal networks the element of obligation is evident. The formal network is usually not the first choice of people in need, whereas people often seek support from informal associations (Beggs, Haines, & Hurlbert, 1996). When these informal systems are not available or are deemed ineffective, then attention turns to formal systems.

Our approach focuses on informal support because it seems to be the preferred source of social care and because we believe it remains a largely untapped source for building healthy communities. Communities, agencies, and organizations are not usually intentional in building informal support networks, yet formal networks can better meet their goals of supporting individuals, families, and communities by mobilizing and empowering the informal network. This approach places emphasis on people and on the community itself, thereby placing a premium on informal networks in the community.

Wills and Shiner (2000) describe five general informal network support functions: (a) emotional support, (b) instrumental support, (c) informational support, (d) companionship, and (e) validation. Emotional support is what we might receive from a confidant, and it often demonstrates caring and approval oriented toward reassuring self-worth; this

can motivate people to deal with difficulties they are facing and to believe they can be successful. Instrumental support is tangible and includes provision of money, household assistance, and the like. It is oriented toward solving practical, everyday life problems, and can provide respite for people experiencing stress and difficulties. Informational support is geared toward problem solving, provides information about resources and opportunities, and enhances people's knowledge about methods to resolve issues they are facing. Companionship support is time spent with others and is a socialization mechanism; it provides respite from everyday life demands in that it often includes activities involving sports, outdoor activities, movies and theatre, and trips. Companionship support can create a context for others kinds of support. Finally, validation helps a person understand her or his position in relation to other people facing similar circumstances and concerns. This is particularly important because of the despair that occurs when one feels that a situation is both unusual and insurmountable. Feedback is an important part of validation.

It is evident that the functions potentially found within the informal network of social care are not mutually exclusive; rather, they go hand-in-hand in contributing to well-being. These support functions represent how people establish and maintain intimate partner connections and they reflect the core of social organization.

Effect Levels

The final component of our model is the *effect levels* that describe the operations of formal and informal networks (Small & Supple, 2001). As formal and informal networks operate, several kinds of effects and associations occur. First-level effects occur within a homogeneous network, such as a community mental health center or a neighborhood. Efforts to address an important issue or problem are contained within the network, such as among agency staff working to address increased incidences of partner violence, or among neighbors trying to find ways to support a resident they believe to be a victim of partner violence. In the case of first-level effects, community capacity is increased because members of a single network are bonding around an important community issue (Putnam, 2000).

Second-level effects describe what happens between similar networks, such as between several community agencies dealing with partner violence. In this instance, the focus would be on how professionals from these agencies collaborate and pool their resources to meet a community

result of safety in intimate relationships. As applied to the informal network, there may be a number of contiguous neighborhoods banding together to support victims of partner violence, and to share information on improving neighborhood conditions that affect networking or interaction among neighbors.

According to Small and Supple (2001), third-level effects involve interaction between dissimilar networks. An example would be partnerships between community agencies and neighborhood groups for the purpose of providing support for violence victims and for intervening in communities that seem to present a risk of partner violence. These third-level effects are consonant with Putnam's (2000) discussion of bridging. In this case, there is intermingling of formal and informal networks–and the vitality and expertise that accompanies them–to build community capacity and to achieve desired community results (Sabol et al., 2004).

These third-level effects hold the most promise for making a difference in community life because they reflect a more comprehensive, multiple sector approach to IPV. They also elevate the informal network to a position of principal importance, which is consistent with Kretzmann and McKnight's (1993) perspective on building vital communities. For deep and enduring change to occur in communities, community members themselves must be integrally involved in the change process, and there must be a focus on the community's assets rather than solely seeing a community in terms of its problems and deficits.

Community capacity as an aspect of social organization enables researchers to capture the process of community influence on individuals and their relationships. This perspective reveals how informal networks of friends, neighbors, and associates interact; how formal networks of agencies, organizations, and civic groups interact with people and their relationships; and how the interplay of formal and informal networks shapes the relationship between intimate partners. The perspective also allows identification of the actions (reciprocity) and sentiments (trust) in intimate relationships that result from network involvement. Reciprocity and trust lead toward the action dimension (collective competence) and the sentiment dimension (sense of shared responsibility) of community capacity. Community capacity positions individuals to achieve important results for themselves and for their communities.

AIR FORCE SUICIDE PREVENTION PROGRAM: A COMMUNITY CAPACITY APPROACH

Thus far we have provided a theoretical community capacity framework. A published evaluation of a community capacity approach to the prevention of IPV could not be located. However, one recent evaluation does describe how such an approach has functioned in the prevention of a similar broad-based social problem, suicide, and generalizes to the subject of IPV prevention.

In 1996, the U.S. Air Force instituted a broad-based suicide prevention program based on eleven initiatives in three broad areas: (a) changing the policies and culture of the Air Force to encourage and support help-seeking behavior; (b) reengineering the Air Force human service system to provide better service to clients through collaboration and partnerships; and (c) providing a comprehensive, four-tiered system of suicide prevention and awareness training to all members of the community.

The overarching thrust of these initiatives was to change the norms and culture of the Air Force and in particular to remove the stigma associated with asking for help. Essentially, the Air Force focused on creating a network of social care. A fundamental objective of the program was to change overall community behavior, with the smallest work units becoming the locus for change. Specifically, work units were educated on suicide awareness and prevention within a "buddy-care" context: each member of a work unit was to note the status of his or her immediate co-worker, to pay attention to that co-worker's mood, and to provide support if needed. Thus, a key target of change was the sense of shared responsibility and collective competence among work units.

During the first year following implementation of the suicide prevention program, the number of suicides in the Air Force dropped 80%. Since that time, the Air Force has maintained a significant reduction in suicide rates as well as reductions in other social problem behaviors, including IPV. An independent external evaluation (Knox, Litts, Talcott, Feig, & Caine, 2003), while cautious about attributing causality, ruled out potential confounding factors as explanations for the decline. It also identified expected changes in measurable desired intermediate outcomes, such as decreased rates of homicide, accidental death, violent offenses, and lessened severity of family violence.

What was operating here and what is its relevance, if any, to prevention of IPV? First, the state of suicide prevention research, as reflected in the literature, is very similar to the state of IPV research. There are

few empirical studies; there is a focus on individual behavior; and there is a reactive approach that favors targeting sites where individuals with suicidal ideation may appear, such as mental health crisis services, hotlines, or emergency room and other medical facilities. The only community-level intervention consists of media and public awareness campaigns.

The Air Force results have been attributed to a number of factors directly relevant and applicable to the development of community-based IPV prevention efforts. These factors include the program's framework, process, and approach, as well as its specific intervention strategies. The organizational and structural aspects of the program are key to its success. First, the Air Force adopted as its starting point the Centers for Disease Control and Prevention's (1992, 1999) consensus recommendations for population-based prevention approaches. This ensured its program would be grounded in strong science by using a rigorous data-driven prevention planning model to guide its analysis and understanding of the problem and associated issues. The program's 11 initiatives were the result of this process.

The IPV literature acknowledges the importance of community. However, coordinated community response efforts typically have been limited to a single segment of the community–the criminal justice community. In contrast, the Air Force suicide prevention program adopted a broad-based total community approach with strong leadership support. While suicide traditionally has been considered a medical issue, the Air Force program was not a traditional stovepipe response. Rather, a community-wide, cross-functional team developed it with representatives from all Air Force constituencies, including community members. Second, key intervention strategies focused on modifying community behavior and on developing collective efficacy of work units. Finally, the program adopted an absolute requirement for collaboration and partnerships among the Air Force's formal helping agencies. The Air Force model presents community as the organizing concept in its planning and development, in its prevention strategies, and in its program execution.

IMPLICATIONS FOR PROGRAM DEVELOPMENT

Current prevention practices directed at reducing the prevalence of IPV are limited predominately to media campaigns, public service announcements, and universal dating violence prevention education classes. Most

often these programs are directed at changing behaviors and social norms. These are critical outcomes, but as the research data shows, these interventions have been mostly ineffective in changing either behavior or norms, mainly due to their limited scope, individual focus, and one-time or short-term nature. Coordinated community response practices have brought about impressive changes over the past decade, including mobilizing the criminal justice system to be more responsive to victims and to hold offenders accountable. However, they have not brought about the desired changes in reduction of IPV.

Our review suggests several paths for future program development. First, it is critical to move beyond isolated program efforts and to begin designing comprehensive, multilevel, community-based strategies for the prevention of IPV. Redundancy and mutual reinforcement are critical to broad-based change.

Second, the focus on individuals and on individual-level changes in attitudes and behavior must expand to include a broad focus on the norms and social context in which the behavior occurs. Targeting social norms directly enhances the reciprocal nature between norms and individual behavior. Reflecting the widespread renewal of attention to community, Levine (1998) makes a persuasive case that an orientation on the individual is no longer sufficient for prevention planning. He argues that prevention efforts designed from an ecological perspective can change norms and result in more a positive social climate.

Third, in the language of our community capacity model, current interventions focus almost exclusively on changes within formal agencies and systems for intervening in IPV, with little or no attention given to the potential of informal networks. This represents a missed opportunity, especially in light of the knowledge that most individuals-in-need turn to informal supports rather than formal agencies. McKnight (1995) identifies the risks of relying on formal agencies, suggesting that doing so supplants the capacity of informal networks and associations. There is untapped potential capacity in individuals' informal networks, associations, and communities. Prevention programs intentionally designed to tap that capacity in the service of reduction of IPV can pay impressive dividends.

Thus, a new comprehensive approach is required in order to improve IPV prevention efforts. We recommend expanding the emerging framework described by O'Leary et al. (this volume). The O'Leary et al. model has the potential to function as an organizing framework to structure IPV prevention and intervention efforts. It provides a comprehensive, targeted, and tailored approach to resource allocation.

We propose a new base for the O'Leary et al. pyramid (this volume), one that employs community as an organizing concept. Embracing community as an organizing concept acknowledges that from a systems or ecological perspective community represents a primary focus of prevention efforts. Community as an organizing concept is operationalized in three ways: (a) community as a place for prevention, (b) community as a target of intervention, and (c) community as a force for intervention.

Community as a Place for Prevention

Any prevention effort needs to account for community boundaries because these boundaries identify both resources–agencies, organizations, churches, and close-knit groups–and deficits. Accounting for a breadth of definitions of community allows for development of a roadmap of the community elements available to program professionals. An ecology of the community thus emerges that identifies the various layers of community and shows the sources of influence on people in a community, such as physical space and facilities, agency and organization locations, and so on.

Community as a Target for Prevention

In addition to directly targeting community norms, the community-capacity approach focuses directly on the development of informal social care networks to enhance capacity and to obtain positive results. Through networks of connections and social care, community capacity emerges and produces three key intermediate outcomes: (a) incorporation of shared norms and values inconsistent with interpersonal violence; (b) enhancement of individual protective factors, which reduces the probability of IPV and buffers the impact of such violence; and (c) the development of community skills, resources, and competence to engage in collective community action (i.e., to intervene in IPV). These outcomes represent the mechanisms thorough which community capacity accomplishes a reduction of IPV.

Community as a Force for Prevention

The ultimate aim of a community-capacity approach is to facilitate the mobilization of community members–to empower their direct involvement and sense of ownership–toward the articulation, development, and implementation of resident-led comprehensive strategies that

yield positive results in the face of challenges and opportunities. When this occurs, community has become a powerful force in the lives of its citizens.

Our review of the Air Force suicide prevention program suggests that at least three additional elements are necessary for a successful community-capacity approach to IPV prevention. These elements include (a) a team of leaders who share a sense of ownership and vision, (b) community engagement in the development of a strategic plan, and (c) an infrastructure to support program delivery. Notably, these elements do not include specific prevention programs.

We suggest that the range of existing programs, including media campaigns, psychoeducational programs, and coordinated community responses, should remain a part of the comprehensive set of prevention activities. What is different is that the community-capacity approach embeds these elements within a larger contextual framework that demands a comprehensive focus across multiple facets of the community, specifically centering on building connections and empowering informal networks to develop and mobilize newfound community capacity in the service of community- and resident-identified initiatives and outcomes.

IMPLICATIONS FOR RESEARCH

There appear to be relatively few studies that connect community dimensions with IPV, though research connecting community and prevention is emergent. Few studies focus on IPV and community factors, but there are studies demonstrating connections between community factors and child maltreatment (Garbarino & Kostelny, 1992) and other forms of violence (Sampson et al., 1997).

However, two recent empirical studies do address IPV issues, to a limited extent. Miles-Doan (1998) analyzed one Florida county's law enforcement data and found higher rates of IPV in neighborhoods with higher measures of social disadvantage, such as greater poverty, more unemployed males, and more female-headed households with young children. She notes that the significance of neighborhood effects for explaining IPV is less than the significance of those effects for explaining violence among other acquaintances. Nevertheless, while discussing steps to improve models of IPV, Miles-Doan points to the importance of some aspects of social organization and community capacity (e.g., com-

munity members' perceptions that violence is a problem, and residents' willingness to intervene in a intimate partner dispute).

A second relevant study is an empirical analysis of Canadian quality-of-life survey data (Dekeseredy, Schwartz, Alvi, & Tomaszewski, 2003). These researchers examine the relationship between perceived collective efficacy (i.e., a sense of shared responsibility and collective competence) and women's victimization in public housing neighborhoods. Though the statistical relationship is only weakly significant, respondents lower in collective efficacy are more likely to identify themselves as victims of IPV. Dekeseredy et al. note that their data suggest community antiviolence programs have little effect on violence against women within intimate relationships. This research is significant in that it suggests that collective efficacy, which parallels community capacity, holds promise for understanding community effects on IPV.

Community Layers

Definitions of community are important for program professionals and researchers alike, who must consider boundaries when enacting prevention initiatives. Of particular importance to the research component of IPV prevention is what definitions of community suggest about the layers of community life. Each layer is a component of the community that can be examined and that represents an intervention portal. For example, a geographic view of community attends to the juxtaposition of where people live, where they procure goods and services, and where formal network support is located. A geographic view also includes where people congregate and the density of their living arrangements. A comprehensive research approach to preventive influences and effects would account for these aspects of community geography, which may influence people's engagement in the community and in prevention activities.

A second community definition might consider statistical parameters. Census-like data may indicate pockets of greater rates of violence in general, of child maltreatment, or of IPV. If these data are available, then they should be accounted for in research planning, especially in the case of research designed to capture program effects. It can be misleading to study a phenomenon that is either over- or underrepresented within a community. Thus, depending on what researchers and program professionals want to know, it may be desirable to focus on areas where

there are greater or lesser rates of violence (or other community characteristics, for that matter).

Network Types and Their Nexus

From a practice perspective, knowing which aspects of community influence IPV levels enables more informed program development and evaluation. The community capacity literature discusses informal and formal networks and their nexus. What is not known is the relative influence of these networks on quality of life–whether that quality is measured by how well people like where they live or is measured by the use of violence as a way to resolve problems and vent frustrations. Consequently, a primary research question has to focus on teasing apart elements of community life and examining their role in either mitigating or exacerbating IPV.

More particularly, and of great significance in the community capacity model, is the necessity for a close examination of the relationships between informal and formal networks of social care (Budde & Schene, 2004). Important research issues include how formal networks engage informal networks in prevention activities, how the informal network supports formal networks and contributes to their viability, and whether each of these networks of social care is functioning in the most appropriate, efficient, and successful ways. We subscribe to the opinion that formal networks should not replace informal networks; that is, formal networks should not deny informal systems their rightful and preferred place of influence in people's lives. However, we also believe that formal networks play an important role in communities: to support well-functioning informal networks, and in the case of IPV, to provide support that informal networks may be unprepared to provide.

Explanatory Models of IPV

Another primary research question is how community elements compare with other factors in explaining, understanding, and predicting IPV (Guterman, 2004). Because so little research has been conducted in this area, it is difficult to know if the findings are artifacts of conceptualization and measurement or if they truly reflect the relevance of community factors. There certainly may be individual or family factors that act as the primary determinants of IPV; however, community factors including social disadvantage may influence those individual and family factors (Sabol et al., 2004). Even if community elements are relatively

less significant for explaining the incidence of IPV, it may still be important from a prevention perspective to understand how they might be used to promote more positive relationships within communities.

Need for Comparative Studies

The community capacity model defines community capacity as sense of shared responsibility and collective competence, and suggests that when these elements are stronger there are positive results for communities. However, we assume that people within informal networks also possess these characteristics and that they will act in certain ways because they are high in capacity. But does this hold with regard to a severe social problem such as IPV? To what degree is there community capacity among friends and neighbors when IPV is the issue? Do they feel a sense of shared responsibility in the case of IPV, and do they exhibit that tendency to collectively make a positive difference? In a broader sense, what indications are there that a community will address tough social problems such as IPV? These are primary questions for research, which in turn will have important implications for program development.

One research approach that may have merit in understanding how community connections permeate couples' lives, and the positive or negative influence of these connections, is to examine extreme groups. For example, what is the nature of community connections among couples that are violence-free? In contrast, what is the nature of the informal network of social care among those who are violent? There may be marked differences in the two groups' friend and neighbor networks, in their associations with confidants outside of the couple relationship, or in the value placed on these connections. There may also be differences in the values, qualities, and behaviors of the two groups, or in the people who comprise the informal network of friends, neighbors, and other associates.

The content of what transpires within the informal network may also differ. For example, our earlier discussion of types of social support demonstrates that support is far-ranging, includes instrumental and affective elements, and can function in identity formation. An interesting research question is, what kind of social support exercises more relative impact on a person's behavior and values? A related applied research question is, which aspects of social support can be mobilized to prevent IPV? An underlying assumption is that informal networks do have an impact on adult behaviors, attitudes, and values.

Evaluation Research

As community-capacity-oriented prevention programs are developed and implemented, an equally important corollary is evaluation (Guterman, 2004; Mancini, Huebner, McCollum, & Marek, 2005). Overall, IPV preventions are not known for rigorous evaluation of program effects, either formative or summative. But unless programs are systematically evaluated and accordingly adjusted, they remain intentions-based rather than science-based. A particular research avenue is to examine how coordinated community responses affect IPV. The community capacity model places importance on collaboration and partnerships (see Figure 1, Effects Levels), yet there is little empirical evidence about how such collaborations would enhance IPV prevention. There is a more nuanced question as well: What combination of formal network members (agencies and organizations) provides the more effective approach to IPV prevention? A primary evaluation science question is *what* works for *whom*, and *when* does it work? In order to demonstrate how a community capacity approach influences reduction in IPV, researchers need to be specific about measuring their desired results (this involves identifying a reasonable target rate), clearly defining and measuring community components (an example being elements of informal networks), monitoring the intensity of a community-oriented prevention effort (this raises the issue of dosage and exposure), and determining an informed timeline on when results should be evident (this requires a strong formative and summative evaluation approach).

CONCLUSION

We assume that the prevention of IPV largely depends on both informal and formal network connections within communities. Community capacity ultimately resides with people in the community because it is their sense of shared responsibility and collective competence, marshaled to bring about the conditions they desire, that make positive differences in their lives. How intimate partners interact and how they solve disagreements and problems are amenable to influence by community networks, if those networks are wise to the problems and are equally wise to the solutions. A community capacity approach is multilayered and recognizes that change emerges from resilient community members and from viable institutions in the community, and from the partnerships they develop to prevent IPV.

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