How Children Affect the Mother/Victim’s Process in Intimate Partner Violence

Therese Zink, MD, MPH; Nancy Elder, MD, MPH; Jeff Jacobson, PhD

Background: Witnessing intimate partner violence (IPV) causes physical and mental health problems for children. Children are one of multiple factors that a victim weighs as she manages the abusive relationship. Little has been written about how children affect the mother’s decisions about the abuse or what assistance a mother wants from the children’s physician in creating a nonabusive home.

Objective: To consider the role children play in their mothers’ management of abusive partners

Methods: Thirty-two mothers living in midwestern IPV shelters or participating in support groups were interviewed about their abuse stories, perceptions about the effects of the abuse on their children, and desires about IPV management in the health care setting. The interviews were audiotaped, transcribed, and analyzed by a team of researchers using thematic analysis.

Results: Children were an integral factor in the mothers’ management of their abusive relationships. For more than half of the participants, something the children did or said catalyzed their seeking help. For some, the children’s attachment to the abuser was a reason to delay seeking assistance. Based on these findings, we explored what mothers wanted from their children’s physicians regarding their abusive relationships. Mothers talked about the delicate balance between education and blame, between offering help and becoming too intrusive, and between wanting the best for their children and fearing the involvement of child protective services.

Conclusions: Children play an important role in mothers’ management of their abusive relationships. From their children’s physicians, participants wanted IPV screening and IPV resources. Some wanted the physician to educate them about how the IPV affected the children in a nonblaming manner.

From the Department of Family Medicine, University of Cincinnati, Cincinnati, Ohio.
The children played an important role in their mother’s decisions about her abusive relationship. For more than half (18 of 32), something related to the children was the reason for the mother to seek help; for some (6 of 32), the children had been a reason to delay. Despite seeking help and insights into the effects of IPV on the children, a substantial number of the participants had chosen to

### Results

Mothers juggle many factors when managing abusive relationships; their children are a critical issue. In examining mothers’ preferences about IPV screening and management by physicians, we learned that they wanted IPV screening and the telephone numbers and pamphlets of crisis agencies made available to them. Participants told us that incidents related to their children often motivated them to seek help. Given this finding, we explored how participants wanted physicians to help them understand and manage the effects of IPV on their children. The retrospective nature of the interview, in which mothers told their abuse stories after having sought and received help, gave a unique perspective on the evolution of their awareness about how the abuse affected their children and their own processes of discovery and action.

### How the Children Affected Mothers’ Processes

The children played an important role in their mother’s decisions about her abusive relationship. For more than half (18 of 32), something related to the children was the reason for the mother to seek help; for some (6 of 32), the children had been a reason to delay. Despite seeking help and insights into the effects of IPV on the children, a substantial number of the participants had chosen to

---

**Table 1. Study Subject Demographics**

<table>
<thead>
<tr>
<th>Demographic</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td>32 (18-45)</td>
</tr>
<tr>
<td>Children*</td>
<td>3 (1-7)</td>
</tr>
<tr>
<td>Currently pregnant</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>16 (50)</td>
</tr>
<tr>
<td>African American or mixed race</td>
<td>16 (50)</td>
</tr>
<tr>
<td>Households with income below the federal poverty level according to DHHS 2002 guidelines</td>
<td>24 (75)</td>
</tr>
<tr>
<td>Length of the abusive relationship, y†</td>
<td>6.7 (1-28)</td>
</tr>
<tr>
<td>Grew up in home with IPV, child abuse, or sexual abuse</td>
<td>18 (56)</td>
</tr>
</tbody>
</table>

Abbreviations: DHHS, Department of Health and Human Services; IPV, intimate partner violence.

*Thirty-one (97%) of the 32 participants reported that their children heard or saw the abuse between adults in the home.

†Nine (28%) of subjects had an ongoing relationship with an abusive partner.

**Table 2. Interview Questions**

Tell me what brought you here now (shelter or support group).

Have you ever sought medical care because of the abuse?

Has a physician or nurse asked you about the abuse? (emergency, primary care, pregnant, pediatrics)

Alone or in front of kids?

Did you disclose IPV?

Can you think of a situation when you went to the physician and when you were upset about the abuse?

What did the physician say or do that helped you?

Or what do you wish he or she had said or done to help you?*

What did your kids see/hear/know about the abuse?

How did it affect them?

Questions about screening preferences in front of children†

Probes for final 12 subjects

How would you like your physician to help you and your children?

Could the physician talk to you about the effects of the abuse on the children?

Abbreviation: IPV, intimate partner violence.

*Distributed by agency staff from March 28, 2000, through November 7, 2001. Locations were chosen to have variation of ethnic (African American or white), geographic (urban and small town), and socioeconomic characteristics of the participants (Table 1).

**INTERVIEW PROTOCOL**

We obtained institutional review board approval. Interviews were conducted privately, without children present, by the same female physician (T.Z.) for approximately 1 hour. After obtaining consent, the conversation was audiotaped and transcribed. Participants were asked to share their abuse stories, describe their health care experiences related to the abuse, and discuss their perceptions about the effects of the abuse on their children. During the first 20 interviews, participants often responded to “What brought you here now?” with an anecdote about their children. As a result, we added additional probes to the final 12 interviews to further understand (1) how the children had an impact on their mothers’ decisions about managing the abusive relationships and (2) how the mothers felt their children’s physicians might assist them in the management of the abuse. Interviews were conducted until we heard no new information (theoretical saturation). Interview questions are listed in Table 2.

**ANALYSIS**

Using thematic analysis, we focused our analysis on the mothers’ abuse stories, their perceptions of the effects of abuse on their children, and what they received or wanted from their children’s physicians. In the analysis of the first 20 transcripts, researchers discovered that often the children saw or did cause mothers to seek help or go to shelters or support groups. To confirm this finding, the principal investigator (T.Z.) discussed this result with staff at local IPV agencies. In 5 of 5 cases, the agencies said that this was “common knowledge.” Additional probes were added to explore this issue with the remaining 12 participants.

Four researchers with qualitative research experience (the principle investigator [T.Z.], another physician [N.E.], an anthropologist [J.J.], and a psychologist [Brenda Klostermann, PhD]) developed an initial codebook using the 4 most articulate and extensive transcripts. Using this codebook, each of the remaining 28 transcripts was coded individually by at least 2 analysts (one of whom was always T.Z.) who met to compare and consider their coding choices. In these meetings, the codebook was refined and continually updated through careful comparison of coding selections. At the end of this coding process, all team members met to reach consensus on issues of disagreement, further define the themes, and choose exemplary quotes. The major themes are presented herein.
return to the abusive relationship for a time (16 of 32) or ended up in another abusive relationship (19 of 32).

From the 18 participants who came to the shelter or joined a support group because of an event related to their children, we heard the following themes: (1) the child was hurt; (2) the child commented on the abuse; or (3) the child mimicked the abuser's behavior and assumed it was the norm. An example of each follows:

1. The reason I am here [the shelter] is because, the very last time that he abused me, he pushed me down and my son was injured. I fell on my son. He was injured enough to make him cry.
2. The reason I left that [6-year] relationship was because she [the daughter] told me one day after me and him had had a fight, “When he goes to sleep, I’m going to kill him.” [When] my 5-year-old said that, I knew it was time to leave.
3. She heard a lot of the verbal abuse and that was the main reason I did leave him when I did, because she started calling me “stupid bitch” and smacking me and stuff. . . . The biggest reason I left is because she started thinking that’s the way it was, that was normal. I knew I had to go.

Other reasons participants gave for leaving their relationships included threatened or actual severe injury to the mother, the mother entering substance abuse treatment, or the mother's arrest and mandated support group or shelter attendance.

The 6 participants who reported that their children had been a reason to continue the relationship gave the following reasons: “wanting a male figure for their male children,” acknowledging that the abuser was a “good dad,” and emphasizing the child’s attachment to the abuser. Others reported choosing to stay with the abuser while pregnant (10 of 32) because they felt safer in the abusive situation than they did with the unknowns of leaving:

I was, you know, in the seventh month of my pregnancy and so I was afraid if I said something [to the physician] . . . I didn’t know how he [abuser] would react [if I left] and I didn’t want him to hurt my unborn child . . . I was scared every day.

However, each of these participants eventually sought help with the IPV through the shelter or support group. Some reported coming and going from the shelter more than once (3 of 16); others considered the relationship ongoing (9 of 32) and were currently living with the abuser and sorting through their options or hoping to return to the abuser if he followed his treatment plan.

PARTICIPANTS’ EVOLVING AWARENESS ABOUT HOW IPV AFFECTED THEIR CHILDREN

Overall, our participants’ responses suggested that mothers’ awareness about the impact of the abuse on their children is part of a process:

As the relationship progressed, I would probably have thought, you know, “big deal” because I was very young at that time. I wouldn’t have been able to see that yes it can affect your child, you know. . . . But now I can see where it is affecting him.

Several participants expressed surprise in the developing realization of how much their children knew and understood about the abuse. According to the reports of several participants, during the time when they were unaware that their own intimate relationships were abusive, they also had little insight into the impact of the abuse on their children. In this quotation, a participant reflects back to an earlier time in the abusive relationship when, despite her daughter’s protests, she failed to recognize what was going on:

I just recently learned that he [the abuser] was molesting my daughter from the time she was 5 until she was 8 years old. She had brought it up once when she was younger, but he [the abuser] didn’t seem the type of person that would do something like that. She has stuck to her story.

As the participants began to recognize the abusive relationship as a problem, they examined their situations and became aware of how the IPV was affecting their children. This participant from a support group talked about the impact of the abuse on herself and her children, although she expresses some uncertainty about her next steps in the abusive relationship:

The verbal abuse is extreme sometimes. The mental abuse is almost constant. The physical abuse is rarely . . . I know it’s abuse . . . I don’t feel like it’s that bad . . . I mean I know it is hard on the kids . . . I know, mental abuse can be just as bad as physical abuse . . . But it’s like I said, everybody, it would be something different. I mean it’s almost gotten to the point where I just want to leave, but then, you know, I do love my husband and it’s hard to leave.

As participants began to explore altering their abusive relationships and had more insight into the impact of the abuse on their children, they took steps to protect their children. Participants talked about sending their children to stay with family or friends (11 of 32) or standing up to the abuser. The following example demonstrates both:

Participant: Things was getting really bad between me and my husband and I told her [daughter] to go to my mom’s to stay.
T.Z.: Did he ever hurt her?
Participant: Never hurt her. Never touched her. I didn’t allow him—I don’t know why—it’s like that, but when you say “Don’t touch my kids, ever, they are not yours,” they [the abusers] usually don’t . . . . They would beat the hell out of me [nervous laugh] . . . I took a whupp’n.

Struggling with the consequences of these events, participants went on with their lives. One stated, “When there are children involved, you have to put yourself aside.” Most of our participants were trying to be good parents and put the safety of their children first. Nevertheless, some of these decisions seemed contradictory: Why did she stay, but send the children away? Why did she keep one child with her, but send the others away?

WHAT PARTICIPANTS WANTED FROM PHYSICIANS

Given these initial findings and the apparent importance of child-related events to their mothers’ processes, we tried to understand what victims wanted from their children’s physicians regarding the abuse. Some participants were ambivalent about what they wanted. Most wanted resources and referrals (31 of 32), given in a non-
blaming and nonintrusive manner. Almost a third (9 of 32) expressed the fear of losing their children if they revealed the IPV. Among the 12 mothers asked directly, each wanted physicians to care, take time, explain things, and have a relationship with her child.

Regarding information about the abuse, several mothers reported wanting to know or asking their physicians about how the abuse affected the children (4 of 12), as seen in the following: “My question is how early children detect abuse. . . Is it in the womb? Is it at birth? Is it . . . when? Do they always know? Tell me the signs to look for.”

Expressing parallel concerns, the following mother regretted not having been alerted to the effects of the abuse on the children:

I never remember anybody professional taking me aside and saying, look when this [the abuse] happens, your babies feel this way. . . . I would see my children crying and stuff, but . . . I thought they’re little and they’ll get over it. I don’t know if it would have helped . . . it might have planted a seed.

However, the following participants warned about the fine line between educating and blaming: “Avoid pointing the finger, being too direct or too negative” and “I don’t like it when people say it is my fault . . . what did you do to make him [abuser] behave like that. I didn’t do anything.” In addition, the participants did not want their parenting “judged.”

The participants who asked their physicians about how IPV was affecting their children reported that the physicians did not really answer their questions. For example:

T.Z.: And did you find the pediatrician’s comments helpful?

Participant: Well . . .

T.Z.: Do you wish he would have done anything different or said anything different?

Participant: No, I mean I couldn’t. . . You know, I understand where he was coming from I mean, he didn’t really know prior to that [about my abuse] and he had never seen any signs of stress or abuse.

Some mothers reported wanting to know that there was “hope” and “help”:

T.Z.: Can you think of what you wish someone would have said to you?

Participant: That there was a way for me to get help for my kids.

Participants wanted to know about resources—“if someone would have said something about counseling”—but wanted physicians to avoid being too intrusive or pushy about what they should do. Sample responses included “Being assured that what I tell them is confidential and they are going to give me some resources . . . and that I can do what I want . . . from there it is up to me” and “I feel like a lot of times when people start to pry the other person shuts down and doesn’t want to talk . . . you get scared . . . all these ideas running through your head.”

For some mothers (9 of 32), one of the biggest fears was that in revealing the IPV they might lose their children, as stated in the following: “I think the number one thing would be being afraid that other things would come into play with my kids. My kids might be at risk of being taken away.”

In summary, some mothers felt a need to know more about how IPV affected their children, and they saw health care providers as sources of this information. Most wanted to know about resources. They wanted this information to be shared in a nonblaming and nonintrusive manner by a physician who “showed interest,” “was sincere,” “took time,” “explained stuff,” and “had a relationship with the kids.”

In interviews with mothers seeking care for their children in the emergency department, Dowd et al27 and Zink et al28 learned that, like our IPV participants, the mothers thought IPV screening and resource sharing was appropriate. In addition, our participants gave us insight into the importance of their children in making decisions about how to manage IPV. Studies show that victims weigh the effects on their children and other factors when deciding when and how to end the abuse. These other factors include attachment to the perpetrator, fear of the perpetrator, financial and educational realities, the support or lack of support from family and friends, and the help received or not received from professionals and community agencies.19 Given our finding about the priority of the children, the children’s physician might help the mother make the link between living in an abusive home and the health and mental health issues for her and her children. This is a role beyond the current recommendations of screening for IPV and sharing of IPV resources.15,18

When we explored what assistance mothers wanted from their children’s physicians in managing IPV, we received a range of answers. Among those who sought information about the effects of IPV on their children, most reported unsatisfactory answers from their physicians. Physicians may not have responded because they did not know what guidance to give. This is not surprising, because current IPV guidelines provide little help in this area.15,16,18 In fact, guidelines for diagnoses that are frequently associated with witnessing IPV do not mention screening for IPV. Examples of these diagnoses include attention-deficit/hyperactivity disorder28,29 and depressive disorders.30 It is clear that IPV is not yet on physicians’ radar screens as part of the differential diagnosis for behavioral problems, mental health problems, and chronic somatic complaints in children—conditions commonly associated with witnessing IPV.1

Our participants stressed the fine line physicians must walk, ie, educating without blaming and giving help without being too pushy or intrusive. This is a delicate issue that highlights the long-term tension between the battered women’s movement and child protective services.31 Both seek to end family violence, but the former is focused on honoring the victim’s time line and the latter on the welfare of the children. Pediatricians must be careful not to revictimize the victim/mother by overwhelming her with facts about the effects of IPV on the
Witnessing IPV causes physical and mental health problems for children. Given these findings, professionals recommend screening for IPV when mothers bring their children for well-child visits or if there is a suspicion of IPV. However, current protocols give little guidance on the effect of witnessing IPV on the children and management of these effects. This study presents the retrospective reflections of mothers/victims of IPV on the critical role their children played in their decisions to seek help. In addition to providing IPV screening and resources about IPV, some mothers/victims wanted pediatricians to educate them about the effects of IPV on their children in an empathetic, nonblaming, and nonintrusive manner.

CONCLUSIONS

In exploratory interviews with 32 mothers with IPV experience who sought help in IPV shelters or support groups, we learned that participants wanted IPV screening from physicians even if they chose not to disclose the IPV. In addition, they wanted IPV crisis telephone numbers and resources made available. A smaller group had sought information or wished that their children’s physician had educated them about how witnessing IPV had affected their children. Participants stressed that physicians should communicate in an empathetic and nonblaming manner. In addition, some mothers feared the involvement of child protective services if they disclosed IPV. Pediatricians have an opportunity to screen for IPV and intervene when it has an impact on a mother and her children.

Accepted for publication February 3, 2003.

This study was supported in part by the Robert Wood Johnson Generalist Faculty Scholars Program, The Robert Wood Johnson Foundation, Princeton, NJ.

Corresponding author and reprints: Therese Zink, MD, MPH, Department of Family Medicine, University of Cincinnati, PO Box 670582, Cincinnati, OH 45267 (e-mail: zinktm@fammed.uc.edu).

REFERENCES