Using Ecological Theory to Understand Intimate Partner Violence and Child Maltreatment

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This article describes the relation between intimate partner violence (IPV) and child maltreatment using an ecological model. It further clarifies the multidimensionality of IPV and child maltreatment at the individual, family, community, and societal levels. The article reviews the dynamics of IPV and the relationship issues between mother and child when IPV is present. Areas relevant to nursing, such as assessment and intervention with mothers and children, are addressed along with professional biases and understanding. This article expands the community nurses’ conceptualization of intimate violence issues and strengthens his or her nursing interventions.

Family violence and child maltreatment are major social and public health problems that cause serious injury and suffering, raise health care costs, and make demands on valuable community resources (Tomison, 2000). There is an abundance of data on the relation between intimate partner violence (IPV) and child maltreatment (Edelson, 1999; Lyon, 1998; Shepard & Raschick, 1999). It is estimated that in 30% to 60% of family violence cases, child maltreatment, and IPV co-occur (Edelson, 1999). The more violence against a partner the greater the likelihood of child physical abuse by the perpetrator (Straus & Gelles, 1990). Women who are battered by their partners are also much more likely to use corporal punishment on their children (Straus & Kaufman Kantor, 1995).

Nurses are the vanguard of professionals who address both these issues. Nurses provide assessment, prevention, and intervention for children who have been abused and women who have been battered. Nurses have been in the forefront of research that has investigated the health effects of interpersonal violence on women, intervention and as-
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substance abuse, depression, and IPV. These parental factors increase the likelihood of
For example, at the individual level, factors categorized as risk factors include parental
and battered women focus on IPV. Depending on the professional
setting, balancing the safety of a battered woman and the well being of a child at the same
time has proven a difficult job historically for health care professionals (Lyon, 1998).
The purposes of this article are twofold: first, to describe an ecological model of child
maltreatment that clarifies the multidimensionality of IPV and child maltreatment. The
second purpose is to address the dynamics of abuse using an ecological model and re-
viewing the implications for nurses.

ECOLOGICAL MODEL

Integrated, ecological models of family violence such as the one depicted in Figure 1 il-
ustrate the different levels of factors or forces that interact to cause family violence
(DePanfilis, 1998). Ecological theory has been identified by the National Research Coun-
cil as a framework best suited to address the causes, consequences, and treatment for-
mulations for abused children (U.S. Department of Health and Human Services, 1997). Un-
derstanding the contributions of the child's context is an essential feature to the model.

Research has demonstrated that child maltreatment is more likely to occur in fam-
ilies experiencing IPV, maternal distress (depression, physical symptoms), poverty,
family stress, social isolation, and parental history of physical abuse and corporal pun-
ishment as children (Mohr & Tulman, 2000). Ecological models offer a broad-based
conceptualization that take into account the complex interactions among individual,
family, community, and societal risk factors in the occurrence of child maltreatment.
For example, at the individual level, factors categorized as risk factors include parental
substance abuse, depression, and IPV. These parental factors increase the likelihood of
child maltreatment and neglect. Other factors that may be protective and reduce the
child's risk often include the child's age, developmental stage, coping abilities, intelli-
gence, and the presence of social supports or affectionate family ties (Holden & Nabo-
s, 1999). At the individual level of an ecological model, characteristics of the
child such as temperament, behavior problems, or the presence of a disability may also
be risk factors (Sullivan & Knuson, 1998).

Family factors in an ecological model of family violence refer to processes in the fam-
ily such as parenting skills, family environment, family stressors, and family interac-
tions. Family stress associated with financial difficulties and chronic poverty and
unemployment is one major area that may overwhelm a family's capacity to function and
care for its children. Higher rates of IPV are associated with the stresses and strains of so-
cioeconomic hardship (Kaufman Kantor & Straus, 1999). A lack of knowledge of normal
child development and inadequate parenting skills are also associated with IPV and may
lead to unrealistic expectations of how a child should behave (Hampton, Senatore, &

Community factors refer to the community the family lives in, the peer groups of fam-
ily members, formal and informal social supports, the existence of social isolation, job
availability, and the availability and access to community services (shelters, food stamps,
transportation, mental health services). High levels of neighborhood crime and family
poverty can impact and increase the risk and co-occurrence of IPV and child maltreat-
ment (Andrews, 1996).

At the societal level, the prevailing professional and legal definitions of the terms
child neglect, child maltreatment, child witnessing, and failure to protect may be incom-
plete and vague thereby increasing the chances of revictimization of various family
members. Laws and policies aimed at protecting children who are abused and maltreated
may ultimately influence the sanctioning of violence towards one or all of the victims.
For instance, battered women are increasingly being charged legally with "failure to pro-
tect" even when the partner is abusing the child and the mother (Beeman, Hagemeister,
& Edelson, 1999). Recently, some states have considered legislation that makes a child's
witnessing of domestic violence a form of criminal abuse (Schechter & Edelson, 1999)
and, therefore, reason to remove the child from the home. Battered mothers are often held
at higher standards of accountability for their children's safety than fathers are (Beeman
et. al, 1999). Perpetrator and victim may be treated as indistinguishable and battered
women can suffer the same consequences as the batterer (Lyon, 1998).

Other broader political pressures such as the narrowing of the gateway into child pro-
tective services and increasing numbers of unsubstantiated cases or early closure of cases
may impact the growing numbers of maltreated children in domestically violent homes
(English, 1998). Cutbacks of nurses in important service settings may also act as a nega-
tive force on the prevention of these problems. Consequently, staff shortages may indi-
rectly increase the risk for children. Nurses' attitudes about the futility of working with
IPV are also a problem. Seventy percent of emergency departments in the United States
do not routinely screen for IPV. Among the barriers to routine screening are the beliefs
that battered women will not disclose the truth and most of them return to their partner's
making their job seem futile (Gerard, 2000; Hastings & Kaufman Kantor, in press). How-
ever, the nursing profession has been proactive in defining and advocating for universal
screening of IPV and several nursing organizations have worked diligently to educate
nurses about screening, assessment, and appropriate interventions (Frank & Rodowski,
1999; Paluzzi, Gaffkin, & Nanda, 2000).

Individual, family, community, and societal factors substantially influence the in-
crease or decrease of the risk for child maltreatment. This ecological frame, which en-
compases multidimensional factors, challenges professionals who may make
attrition errors about the causes of child neglect and maltreatment when IPV is involved. Ecological frameworks beg certain questions about accountability for these problems and how best to intervene. The ecological model calls for nurses to use "double vision" when evaluating the circumstances of any family violence.

MULTIDIMENSIONALITY AND THE DYNAMICS OF INTERPERSONAL VIOLENCE

Professionals often have difficulties understanding the complexity and dynamics of IPV and shaping their interventions to meet the needs of mothers, children, and abusing partners, simultaneously. The risks of leaving an abusive relationship include being impoverished, homeless, beaten, stalked, harassed, or even murdered (Davies, Lyon, & Monticatania, 1998; Stark, 1995). Many battered women, if faced with a choice between the current family situation and an unknown future, including questions of where she will live, how she will support herself, or how she will cope with her children, will choose not to leave the relationship. A woman may not fear being beaten as much as she fears the possibility of being alone, unable to provide, and homeless with her children. The reality of economic issues and scarce resources has been well documented as strong deterrents to leaving (Becker, 1995; Davies et al., 1998).

Battered women often "love" their partners (Dutton & Painter, 1993). He may be charming, a great lover, and an adequate provider even though he is abusive. This is a well-documented reason for not leaving in many cases of IPV. The frequency of the abuse may also be an important influence in her decision making. Her partner may not be abusive every day, and the abuse may be infrequent and covert (Stephens, 1999). The batterer may also show affection, love, and care for his children, and the woman has to weigh the pros and cons of interfering with this (Stephens, 1999).

The perception of women as passive prisoners of abusive relationships falls short of the true reality. Women in abusive relationships do seek help and use coping strategies while in these relationships (Kaufman Kantor & Jasinski, 1998). They do not necessarily act helplessly and remain passive as posited by earlier cognitive theories of learned helplessness (Magen, 1999; Walker, 1984). Women in committed relationships, who love their partners, often work to try to end the abuse rather than end the relationship (Magen, 1999; Shepard & Raschick, 1999). The influence of religious values, such as values of commitment, forgiveness, the sanctity of marriage and doing one's best to work it out, are important (Magen, 1999; Shepard & Raschick, 1999).

BATTERED WOMEN AND THEIR CHILDREN

Nursing has contributed to much of the research on the qualitative aspects of battered women's perceptions of their experience with violence, yet little has addressed the overlap between women's perceptions of their own battering and the experiences of their children witnessing familial violence. Although little literature exists in this area, available studies suggest that battered women are vulnerable to misconceptions about their experiences. Psychological factors may be enormously difficult to overcome, and these factors are crucial considerations in nursing intervention (Stephens, 1999). For example, a central belief and barrier that is common for battered mothers is that they should stay for the sake of their children (Stephens, 1999). Another difficulty is the awareness and acknowledgment, often true, that the children love the batterer. The fact that children do bond with their abusive caretakers is real, which may make it even more difficult for a woman to leave (Stephens, 1999).

Researchers suggest that battered women may find it difficult to recognize the impact of the abuse on their children (Mills, 1998). One study found that battered women stated that if they had known earlier how their children felt, and how the witnessing had impacted them, they would have left earlier (Mills, 1998). This suggests deficits in knowledge of child development and not intentional neglect. Other studies have found that battered women may hit or spank their children to "keep them in line" to prevent further violence to themselves or their children by the batterer (Mills, 1998).
There is a significant number of women who do take steps to prevent their children from being abused or witnessing abuse once they realize their children are being negatively affected. However, battered mothers can also get stuck in their own psychological traps that contribute to their difficulties in protecting their children. Mothers may misinterpret their child’s behavior in order to minimize the impact IPV might have on the child (Stephens, 1999). A 6-year-old boy who displays bullying behavior may be told he is just like his father and have adult motives and behaviors projected onto him when he is incapable developmentally of these things. In other circumstances, a mother may be so needy that inadvertently a child may be forced to take on the role of a parent, end up having to do mother’s chores, care for siblings and give advice, or comfort her after abuse has taken place. “Parentified” children are also very common in families in which active substance abuse is a problem, and substance abuse often co-occurs in situations of IPV (Kaufman Kantor & Asdigian, 1997; Stephens, 1999).

Many battered women, as a result of their abuse, suffer from low self-esteem and view themselves as bad, guilty, inadequate, and worthless. Battered mothers may project “negative” qualities onto the child, treat the child accordingly, and fail to protect the child. Adolescent children may become accidental victims when a mother decides that the adolescent child no longer needs protection from the abuse and fails to protect (Stephens, 1999). These psychological traps and pitfalls are often a result of a lack of information and knowledge about normal child development, lack of maternal confidence, and poor self-esteem. They constitute forms of emotional maltreatment that parents may use to explain their behavior toward their child. These pitfalls must be addressed, however, with battered mothers by appropriate counseling that does not invalidate the mother’s feelings for her partner but addresses the behaviors with knowledge and information from research about its harmful affects on children.

Battered women who do abuse their children must be held accountable. However, these circumstances need to be carefully explored. Although women who are being battered are twice as likely as nonabused women to maltreat a child, male batterers are three times more likely to be identified as the perpetrator of the child abuse. Male batterers commit the vast majority of the most severe physical abuse on their children (American Humane Society, 1994; Edelson, 1999).

A battered mother may discipline her child very strictly to prevent the batterer from abusing both herself and her child and even view this as a form of protection. A batterer may use the child’s behavior as an excuse to batter his partner or the child. The mother may also be releasing her own frustration out on the child (Mills, 1998).

CHILD WITNESSING

There is a growing appreciation that child witnessing of mother assault significantly increases the risk for physical and psychological harm in children (Cummings, Pepler, & Moore, 1999). Children under 12 years of age are present in more than half the homes where violence occurs and are most at risk. The younger the child, the greater the risk. Children under the age of 9 years old are most likely to blame themselves for their mother’s anger and distress, and this guilt and self-blame can be detrimental (Tomison, 2000). Witnessing IPV can lead to the development of posttraumatic stress, behavior problems, and mental health issues such as depression or anxiety in children (Cummings et al., 1999).

A child’s exposure to IPV may vary in diversity of contexts, severity, and frequency and is usually viewed as a form of child neglect (Lyon, 1998). Fathers, stepfathers, and boyfriends, the victimized mother, siblings, or any combination of these, may victimize a child. Children who witness or overhear IPV versus situations in which a battered mother stands by while her abuser beats her child, or where she beats her child, may be approached differently in the judgment of professionals. The simple determination of whether the child witnessed or heard the violence or saw a black eye on his or her mother in the morning are important distinctions for formulating clinical judgments, filing potential charges, and assessing the impact on the child and mother. These questions and determinations are not always part of routine screening over hot lines, in shelters, emergency rooms, community health and mental health centers, or pediatrician’s offices (Gerard, 2000).

Witnessing IPV can have many different faces. Witnessing IPV can include multiple events: The child’s body may be used as a weapon against the spouse, or the child may be held in the arms of the perpetrator while he or she threatens or hits his partner. Some children are kidnapped or taken as a hostage by a batterer or forced to watch or participate in a beating (Stephens, 1999). Children may be told to watch their mothers or told that if their mother would stop certain behaviors there would not be any fighting (Edelson, 1999; Tomison, 2000). Child witnessing can also include watching the mother initiate violence or use violence in self-defense or seeing both parents assault each other (Stephens, 1999).

Children respond very differently to witnessing IPV depending on the frequency and severity of the exposure, their age and coping strategies, sources of affectional support, and the existence of other forms of victimization. Children who attach themselves to other families and spend little time at home, have supportive relatives and teachers, excel in school, and find an area of strength for themselves may suffer fewer negative outcomes (Sweeney, 1997).

IMPLICATIONS FOR NURSING PRACTICE

Professional Attitudes

Often clinicians evaluate children who have been physically abused or neglected and struggle with their increasing anger at the caregiver. In most cases it is a mother who is the primary caregiver. It seems that in the cases of IPV and child witnessing the ten-
dency to blame a mother for an individual failure that is viewed as intentional on her part instead of a set of circumstances that may very well be out of her control is common (Magen, 1999). One of the most entrenched views among professionals is the idea that battered women should and can leave and that women who do not are failing to protect their children. Women who return to their partners after staying at a shelter are often viewed as incompetent, weak, and masochistic (Peled, Erisiskovits, Eanes, & Winstok, 2000). These beliefs engender negative meanings and cultural stereotypes and defy the complexity and impact of IPV on women and children or acknowledge the personal strengths of the woman. They suggest the problem is not viewed from an ecological or cultural perspective and can influence a professional’s ability to help battered mothers and their children (Peled et al., 2000).

Nursing Assessment and Screening

Nursing assessment at the individual and family level must determine who is abusing the child, the frequency and forms of witnessing, and the frequency and severity of mother assault for a clear understanding of the child’s and mother’s risk. If the mother presents as the patient, nurses need to also ask about the child and his or her safety and the impact of IPV and determine the mother’s risk calculation approach (Davies et al., 1998). If a child presents as a patient, nurses need to screen the mother as well as the child and ask about IPV (see Table 1).

Assessments are enhanced when nurses first remind a suspected child or adult patient that screening of these issues is routine—that many families fight in different ways, and sometimes parents and children can get upset or hurt. Use direct questions and provide a safe context when asking these types of questions. A question such as “Have you been hit, kicked, punched, or hurt by someone in the last year?” is basic and direct (Gerard, 2000). Document findings using objective language. Use direct quotes whether it is the child or mother who is the patient (Isaac & Enos, 2000). Assess the child’s and the mother’s psychological and physical safety and previous strategies that have or have not worked.

Nurses need to develop better tools to assess family violence and the impact of witnessing. Clinical criteria for risk determination are often lacking. Even basic questions on the frequency, severity, types of violence, the child’s age and developmental status are frequently left out of assessments (Magen, 1999). Time demands may lead to only one or two basic questions. Watching a mother get beaten, kicked, and punched twice a week, versus once a month, or three times a year are important differences to determine. Emotional abuse must also be assessed. The frequency of yelling, cursing, name calling, and threatening may also be traumatic for mother and child (Ali, Oately, & Toner, 1999). Interview collaterals to verify issues (see Table 2). Ask permission to speak with relatives, friends, school personnel, or pediatricians.

A tenet of nursing philosophy is the importance of assessing parental and child strengths. It may be very important for mental health or community nurses who work with battered mothers to assess the mother–child attachment bond and the mother’s ability to nurture and protect her child in other ways when IPV is suspected. Exploring any attempts she has made to protect her child or to leave the situation would be evidence of motivation and some insight, even if a failure to protect has occurred. This is a way for nurses to validate the mother’s strengths even in the midst of an assessment or treatment.

Make screening of IPV mandatory. Nurses need to assess for multiple forms of violence and multiple perpetrators in the family. When IPV is just one of multiple types of victimization occurring in the family, the scales may be tipped against the child for remaining in the home. Lack of data and time are common problems in the clinical setting. Taking the time, however, can be life saving.

**TABLE 1**

<table>
<thead>
<tr>
<th>Assessing Child’s Experience</th>
<th>Assessing Mother’s Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take a full, comprehensive history</td>
<td>Take a full, comprehensive history</td>
</tr>
<tr>
<td>When, where, who, what, why?</td>
<td>When, where, who, what, why?</td>
</tr>
<tr>
<td>What was child’s role?</td>
<td>What was mom’s role?</td>
</tr>
<tr>
<td>(Witnesser, hearing, participant, bearing)</td>
<td>(Victim, participant, protector)</td>
</tr>
<tr>
<td>Injuries for child and parent</td>
<td>Injuries for child and parent</td>
</tr>
<tr>
<td>Psychological and physical harm (yes or no)</td>
<td>Psychological and physical harm (yes or no)</td>
</tr>
<tr>
<td>Attempts to prevent child</td>
<td>Attempts to prevent child</td>
</tr>
<tr>
<td>Frequency of IPV occurring</td>
<td>Frequency of IPV occurring</td>
</tr>
<tr>
<td>Types and severity of IPV occurring</td>
<td>Types and severity of IPV occurring</td>
</tr>
<tr>
<td>Developmental assessment</td>
<td>Age, maturity, readiness for change</td>
</tr>
<tr>
<td>(Younger, more vulnerable)</td>
<td>(Younger, more vulnerable)</td>
</tr>
<tr>
<td>Coping strategies (healthy, unhealthy)</td>
<td>Coping strategies (healthy, unhealthy)</td>
</tr>
<tr>
<td>Affectional ties to parents, adults, or peers</td>
<td>Affectional ties to child and other support</td>
</tr>
<tr>
<td>Presence of other stressors</td>
<td>Presence of other stressors</td>
</tr>
<tr>
<td>Check for other forms of abuse, disability in child, child behavior problems, parental substance abuse, mental or physical illness, economic hardship, social isolation, recent losses, arrests</td>
<td></td>
</tr>
</tbody>
</table>

Education and Counseling

Education in the form of handouts, brochures, and simple facts are invaluable. Information about the prevalence of abuse and risk, the impact on children, facts about recovery, and resources are important to share with caregivers in all clinical contexts, along with information on sources of help. Understanding that it may take several attempts for a battered woman to successfully leave makes it important that professionals continue to reach out and refuel hope in as many ways as possible. Remembering that change is a process that occurs over time should be a guiding principle of practice. When a woman decides not to leave, remember that her intuitive judgment of the costs and benefits of leaving, relative
to her or her child’s safety, may be far better than a clinician’s. Some battered women want to try to maintain the positive attributes of the relationship while trying to stop or lessen the abuse. Respecting this choice and developing strategies for empowerment and safety for her and her children may be a challenge for clinicians (Peled et al., 2000).

Table 2 illustrates an ecological approach to nursing interventions for family violence. For example, at the individual level, nurses need professional support to view the child’s, mother’s, and father’s problems ecologically and systematically and to reduce biases toward any of the members. Education on how to improve engagement strategies with difficult and resistant families is important. Knowledge of abuse dynamics is crucial (Cole, 2000). At the family level, the determination of safety by assessing factors such as severity of abuse and injury, and creation of safety plans for all family members is of key importance.

At the community level, public health nurses need to assess the availability, access, and types of services for battered mothers and their partners. There are state and national data that suggest an enormous gap in the availability of services for battered women, services that meet their special needs, and access to these services (Edelson, 1999; Lyon, 1998). This is particularly true in rural areas where there may only be one car in the family and the partner uses it every day to go to work, or the counseling center or shelter is 30 miles away.

Although services and issues related to batterers have not been the focus of this article, they too need help. Batterers need to be held accountable for their violence and included in the family evaluation if present. There is an even greater lack of services for batterers, and this too needs to be addressed (Magen, 1999).

Nurses involved with the assessment of family violence and the responsibility for reporting allegations need to be familiar with their state statutes and definitions of failure to protect, child neglect, and witnessing. In some states, for instance, if a woman has been injured, a professional has to report it to the police. Understanding and even helping to formulate legal and state policy would mean advocating at the societal level on behalf of traumatized children, battered mothers, and other victims of family violence.

Ecological models of family violence can address the causes and consequences of family violence for each family member, and provide a framework for treatment formulations. It protects against simplified explanatory short cuts, challenges professional biases, and allows for greater humanity and compassion in the assessment, prevention, and intervention on behalf of all the intended and unintended victims of family violence.

REFERENCES


