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Supporting Mothering: Service Providers' Perspectives of Mothers and Young Children Affected by Intimate Partner Violence

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Abstract: Although negative outcomes from intimate partner violence (IPV) are not inevitable, IPV is recognized to have profound negative effects on child development. We conducted a qualitative descriptive study of service providers' understandings of the impact of IPV on mothers, young children (birth to 36 months), and mother–infant/child relationships, and of the support needs of these mothers and young children. Service providers suggested that IPV negatively influenced caregiving and identified a pressing need for information and strategies to help mothers promote and protect their young children's development. Although service providers struggled to articulate ideal forms of assistance to promote maternal–infant/child relationships, they agreed that mothers and young children experiencing IPV required more support than is currently available. © 2011 Wiley Periodicals, Inc. Res Nurs Health 34:192–203, 2011

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Estimates of the percent of women with exposure to intimate partner violence (IPV) over their lifetimes by husbands, partners, or boyfriends range between 8% and 66% (Carlson, McNutt, & Choi, 2003; Huth-Bocks & Hughes, 2008; Levendosky et al., 2004). The high concentration of preschool-age children in households where women experience IPV (Fantuzzo, 2002; Fantuzzo et al., 1991) is a major concern. Research conducted over the last three decades indicate that exposure to IPV negatively affects children's emotional (Morrel, Dubowitz, Kerr, & Black, 2003; Riesen & Porath, 2004), behavioral (Hazen, Connelly, Kelleher, Barth, & Landsverk, 2006; McFarlane, Groff, O'Brien, & Watson, 2005a; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003), social, and cognitive development (Onyskiw, 2003), particularly in younger preschool-age children (Holden & Ritchie, 1991; Hughes, 1988; Hughes & Barad, 1983). Indeed, preschool-age children exposed to IPV may share many of the adjustment difficulties experienced by victims of direct physical and psychological abuse (Litrownik, Newton, Hunter, English, & Everson, 2003). The degree to which children from birth to 36 months of age are affected by IPV, however, is not well understood. Even less is known of effective services and supports that target mothers and their young children exposed to IPV. As service providers are an important source of social support for families and children affected by IPV (Health Canada, 1999), experienced service providers might offer promising suggestions for effective support interventions for these families, thus helping to fill these gaps in understanding.

Some children develop well in spite of exposure to IPV (Geffner, Igelman, & Zellner, 2003; Hughes & Luke, 2000; Kerig, 2003), suggesting that potential pathways exist for intervention to support positive outcomes in such children. Women who experience abuse often suffer lower levels of social support, including emotional and practical aid, and greater criticism from family and friends (Levendosky et al., 2004). Mothers who have experienced recent abuse and who actively seek social support from health professionals, family, and friends have a reduced risk for poor mental and physical health, anxiety, depression, post-traumatic stress disorder symptoms, and suicidal ideation and action (Coker et al., 2002). Likewise, social support from professional service providers may promote the quality of maternal–infant/child interactions and child development in families exposed to IPV.

In a randomized controlled trial, supportive professional nursing care provided to abused mothers (consisting of empathetic listening, anticipatory guidance, and referrals) was linked to better developmental outcomes in children from 18 months to 18 years (McFarlane, Groff, O'Brien, & Watson, 2005b). Children under 5 years of age showed the most improvement on standardized measures of child development. Jouriles et al. (2000) found that social support (e.g., listening, encouragement, and transportation) from a trusted adult such as a shelter counselor, combined with mother–child relationship training provided by a health professional, improved developmental outcomes in 4- to 9-year-old children of mothers exposed to IPV. Thus, social support interventions may be an effective means to promote positive maternal–infant/child relationships and young children's development (Belsky, 1984; Letourneau et al., 2001; McLoyd & Wilson, 1990).

Given that service providers' regularly support parenting by providing education and guidance, their perspectives on the role of mother–child relationships in mediating the effect of IPV exposure on child development warrant examination. In two studies of 120 mothers of 7- to 12-year olds, Levendosky and Graham-Bermann (2000, 2001) found that IPV predicted reductions in the quality of warmth, child-centeredness, and parenting effectiveness directly and indirectly via maternal psychological functioning (e.g., depressive symptoms; Levendosky & Graham-Bermann, 2001). Moreover, the negative association between IPV and children's cognitive and social–emotional functioning was mediated by parenting qualities in both school-age (Levendosky & Graham-Bermann, 2001) and preschool-age children (Levendosky, Huth-Bocks, Shapiro, & Semel, 2003). Qualities of the parent–child relationship protected children's development in families exposed to IPV. In two additional studies of mothers exposed to IPV (Levendosky et al., 2003, 2004), the lack of availability of social support predicted mothers' worsening depressive symptoms. Given that mothers' parenting qualities are affected by psychological functioning (Coker et al., 2002), social support may simultaneously promote improved maternal mental health, parenting, and child development.

Service providers' perspectives of the needs and choices of women affected by IPV have been described (Dunn & Powell-Williams, 2007); however, to our knowledge, service providers' perspectives on social support and programs

targeted to promote optimal mother–infant/child interaction among young children and mothers exposed to IPV have not been systematically examined. Experienced service providers could assist in planning effective interventions, clarify challenges faced by both mothers and service providers, and offer support strategies to promote positive mother–infant/child relationships and child development.

METHODS

The objectives of this multi-site study conducted from 2007 to 2008 were to describe service providers' understanding of the impact and dynamics of IPV on the mother–infant/child relationship (from birth to 36 months), and the unique needs, resources, barriers, and desired supports of these mothers. Qualitative descriptive methods, including purposive sampling, individual and group interviews, and thematic content analysis, were used. Certificates of ethical approval were obtained from all appropriate agencies, including review boards of four universities and five health regions. Consistent with Canadian standards, a process of informed consent was implemented (Canadian Institutes of Health Research, 2005).

Subjects and Setting

A sample of 25 service providers was recruited for individual interviews from three Canadian Provinces of Prince Edward Island ($n = 4$), New Brunswick ($n = 11$), and Nova Scotia ($n = 10$), representing the eastern region known as the Maritimes. Eligible providers had to have experience working with mothers who left relationships involving IPV (Tuckett, 2004). Potential interviewees were invited by email or telephone to participate in the study. Interviewees were drawn from the research team members' professional networks of individuals from organizations including transition and second-stage housing, victim services, counseling services, legal education, legal aid, family and community resource centers, provincial public health, mental health, and social services departments. All participants, but one, were female. A range of disciplines was represented including nursing, social work, counseling psychology, and early childhood education. Five providers worked in women's shelters, 6 worked in counseling services, 2 were nurses working in primary health care clinics, 2 worked for the regional police in victim services, 1 worked with Aboriginal mothers, 2 worked in child protection, and the remainder worked in a variety of community outreach programs (e.g., Salvation Army outreach center, YMCA, single parents/divorcing parents support programs, government sponsored family resource centers). Nine worked with mothers, 1 worked only with children, and the rest worked with both mothers and children. Service providers worked on a daily to monthly basis with mothers and young children (birth to 36 months of age) who left abusive relationships after exposure to IPV for 2–22 years.

Data Collection

Individual interviews. Individual interviews were conducted until informational redundancy was reached (i.e., when the research team observed that interviews no longer yielded novel information; Higginbottom, 2004). The individual semi-structured interview guide consisted of 23 questions that took approximately 1.5 hours to administer (Table 1). The interviews took place in the service providers' offices or at one of the affiliated Maritime Universities.

Group interviews. Three 2-hour group interviews were completed to elaborate on the study findings from the individual interviews and uncover any additional suggestions of supports or improvements to interventions for these mothers and young children. Interviewees (Prince Edward Island, $n = 3$ participants, New Brunswick, $n = 8$ participants, and Nova Scotia $n = 5$ participants) were provided a draft summary of the study findings to date before a group interview. A purposive sample of group interviewees was selected based on identification of particularly articulate interviewees from the individual interviews. Three new interviewees (Nova Scotia, $n = 1$; New Brunswick, $n = 2$) were added to the group interview to fill gaps in group composition by service delivery type and disciplinary background.

Data Analysis

After all interviews were audio-taped and transcribed verbatim, thematic content analysis was initially performed. This consisted of developing a coding framework that was created iteratively by at least two team members having read 2–4 transcripts each (Patton, 2002). After reading assigned transcripts, an open coding process

Table 1. Individual Interview Categories and Sample Questions

Category	Questions in Category	Sample Questions
A. Background	5	1. Please describe your position and how it brings you into contact with mothers and young children who have experienced IPV
B. Perceived impact of violence on mother–infant relationship and infant development	3	6. From your perspective, how does IPV affect mothers' abilities to support their infant (between birth and 3 years of age)?
C. Support needs and resources for mother–infant relationships	6	7. Are there specific policies or programs (organizational, local, regional, national) that address ways to provide support for mothers and young children experiencing IPV?
D. Barriers to support for mother–infant relationships	3	13. What barriers prevent mothers from accessing support? 14. Do you have any thoughts about how to overcome these barriers?
E. Preferences for mother–infant relationship support intervention/program	6	16. What kinds of support do you think would help mother–infant relationships affected by IPV? 21. What would be the most important issues to deal with in supporting mother–infant relationships affected by violence?

was used by individual team members to categorize the data. The team members then met and integrated their respective coding frameworks into one framework that was organized to address the research questions. The integrated coding framework was revised again after additional transcripts were read; revision occurred until the team believed the framework was sufficiently comprehensive and complete. Two trained research assistants then coded each transcript using the coding framework. When the research assistants suggested new codes, the research team met and either added them or incorporated them into existing codes.

Findings

Findings from the interviews are organized around four thematic areas including the impact of IPV on (a) women, (b) mothering, (c) young children, and (d) supports for women and mothering.

Service Providers' Understandings of the Impact of IPV on Women

Service providers characterized the women they worked with as clients having multiple overwhelming needs. They further suggested that every aspect of abused women's lives can be disrupted by IPV. Participants described how the mothers had to cope with a number of co-existing emotional and mental health issues, such as depression, self-blame, fear, low self-esteem, isolation, and withdrawal. The women were described as disempowered and lacking energy. These emotional and mental health issues were seen to interfere with the women's abilities to have their own needs met. For example, one service provider observed that many women were "just going through the motions [and] not even looking after [their] own needs, but just sort of roboting through life" (Social worker, 6 years experience).

Service providers also indicated that women's family histories significantly influenced the women's experiences of violence. Providers commented that women often had histories of IPV or another form of violence in their extended families, and that "their understanding of healthy relationships is different, or maybe there even isn't really an understanding of what a healthy relationship is" (Counselor, 16 years experience).

Service Providers' Understandings of the Impact of IPV on Mothering

Service providers also perceived women's family histories of violence to influence women's understandings of healthy mother–infant/child

relationships. As one service provider noted: ''Sometimes we have moms who, maybe their own parents weren't really good role models, so they've never had that appropriate role model and they just lack the skills because they aren't aware of them'' (Social worker, 5 years experience). Service providers described how some mothers struggled with their beliefs about what was best for the family and possibly returning to, or staying in, a relationship ''under the assumption that it's better for children to be with both of their parents'' (Social worker, 9 years experience).

Service providers noted many stressors in the mothers' lives. Three primary mechanisms were identified as affecting mothers' abilities to parent and maintain a quality mother–infant/child relationship, including demands of the violent partner, loss of self-worth, and the high energy level required to deal with the effect of IPV. Service providers explained that the violent partners expected their needs to be met before those of the child and mother and that mothers were often prevented from caring for their children as they desired. A mother was described as put in a position where ''she's always balancing the act of catering to him and maintaining a home'' (Counselor, 6 years experience). Service providers described abusive partners as being unsupportive. The lack of partner support interfered with the mothers' abilities to ''bond'' with their children. As one early childhood educator with 11 years of experience commented, ''she's so busy trying to keep him happy, how can she bond effectively with the child?'' This provider further suggested that the negative effects of violence on women's self-esteem interfered with their ability to parent as they had ''no concept that [they could] be good mom[s].''

Service providers noted that mothers' energy was drained by constantly having to manage multiple stresses, the violent partners' demands, violent incidents, every day needs for themselves and their children, and the mental and emotional after-effects of violence. The numerous demands meant that the mother had no energy left to engage with her children in her usual or intended manner. Yet, service providers suggested that even mothers' usual manner of engaging with children was not optimal. One provider stated that ''when moms are caught in violent and abusive relationships, it takes so much more for them to try to parent, because a lot of their energy is going into trying to stay alive for themselves and for their dependents'' (Counselor, 5 years experience). In other words, mothers who experienced IPV spent more energy than usual trying to meet basic safety and survival needs, limiting the available energy to cope with other events. Service providers commented that mothers who experienced IPV were ''so beaten down that they had little or nothing left for their children'' (Counselor, 9 years experience). Although mothers did their best under the circumstances of IPV, the energy demands associated with IPV made them appear emotionally detached and unaware of or minimizing of the effects of IPV on their children. As one service provider observed:

> You're not as in tune, especially with babies, you're not as in tune, and you're also. . . It takes a long time for people to recognize the damage that's really being done to the children, and they don't want to hear that, or have any part of that, because then they end up blaming themselves. (Nurse, 16 years experience)

The service providers described mothering as falling within three distinct categories, including hyper-vigilant, unresponsive or permissive, and controlling. Although service providers described the hyper-vigilant mothers as sometimes protective of their children to extremes, they also viewed this positively. A nurse with 5 years of experience commented that ''I've seen where the bond is stronger between the mother and the child because the mother takes on this ferocious protection sort of sense with the child.''

In contrast, some service providers also described features of hyper-vigilant mothering as detrimental to the child, as expressed here:

> I think it's their way of trying to protect the child that they overprotect the child. They don't allow them out of their sight. They talk to them way too much. They just, just kind of smother them because they are so worried that they are going to see or hear something that's negative, or, if they have seen or heard something that is negative, then they are really trying to over compensate for that. (Social worker, 5 years experience)

Service providers suggested that mothers derived comfort and security from an enmeshed relationship with their children to the extent that a mother may be ''so overly involved in that baby from the very beginning that she doesn't see where she ends and the baby begins'' (Nurse, 5 years experience). Referred to as ''parentification'' (Crittenden, 2008), this enmeshed relationship may be seen as a reversal of the caregiving relationship whereby, as one service provider described it, the mother's baby is comforting her, instead of the mother ''comforting the baby'' (Early childhood educator, 11 years experience).

Service providers described unresponsive or permissive mothers as those who exerted little control over child behavior and as being ''so lenient with their children that their children just have no boundaries and that leads to a whole other set of behavior issues for children that have no boundaries and no limits'' (Counselor, 8 years experience). Service providers attributed this unresponsive or permissive behavior to the fact that mothers had so many competing demands that ''disciplining a 2-year old's behavior was just really not top of their list'' (Counselor, 5 years experience).

Service providers described the controlling behavior of young children by abused mothers as the transfer of violence and angry emotions to their child. As one provider explained: ''Because if the children misbehave, the mom gets in trouble. Then mom's at the children, 'Stop that. You pick that up. You clean that up,' you know, and she may display violent behaviors'' (Social worker, 5 years experience). Providers suggested that the higher level of child control was a response to having control taken from them by the violent partner. Furthermore, providers indicated that mothers may attempt to tailor child behavior to that desired by the violent partner, which may be inappropriate for meeting the child's developmental needs. Providers also reported that the controlling behaviors of some mothers verged on resentment and lacked empathy for their children.

Service Providers' Understandings of the Impact of IPV on Young Children

Service providers described a variety of effects of IPV on children under 36 months of age, including cognitive, language, and developmental delays (e.g., biological, physical, failure to thrive), and social–emotional regulation problems (e.g., internalizing and externalizing behaviors). Service providers attributed developmental delays to IPV and the lack of mothers' understanding of normal child behavior. One service provider attributed an 18-month-old infant's language delay to the mother's stress and need to placate the violent partner. As she explained:

> Stress plays a huge role in communication... because there's not as much talking back and forth and a lot of times it's about, you know, 'we have to be really quiet.' (Counselor, 5 years experience)

Service providers provided examples of how child social–emotional regulation was affected by the stressful caregiving environment as displayed in poor trust and bonding, self-blame, and shame. Describing ways in which mothers and infants exposed to violence presented in her office, one service provider said, ''I found with little ones...who were, let's say who might have been 2 or 3 years old, that they—I won't say were overly affectionate—but they'd gravitate to anybody who'd pay attention to them'' (Early childhood educator, 5 years experience). Service providers noted too that although the mothers loved their children to the best of their ability, even very young children displayed noticeably negative effects of IPV on their social–emotional development. As one provider said: ''The thing that always sort of stressed me and especially with little ones like babies, they need you looking at them. I watched babies come in here and they don't make eye contact. They don't coo'' (Counselor, 10 years experience).

Internalizing behaviors such as anxiety and stress are directed toward the self, and represent an over-controlled and inner-directed pattern of development (Achenbach & McConaughy, 1997; Furlong, Morrison, & Jimerson, 2004). Service providers reported that infants demonstrated fear, separation anxiety, and clinginess, and were overly tense and/or reactive as shown by more pronounced startle reflexes. Service providers described young children's behaviors as submissive and hyper-vigilant. One social worker who worked primarily with children (as opposed to mothers) explained children's internalizing behaviors in terms of their experience of the world, that a ''baby will learn not to cry when they're hungry because they might not be fed'' (Social worker, 5 years experience).

Externalizing behaviors are aggressive behaviors directed outwardly toward the social environment and characterized by under-controlled and outer-directed patterns of development (Achenbach & McConaughy, 1997; Furlong et al., 2004). Service providers described young children's externalizing behaviors such as anger, aggression, and punitive treatment of the mother. Crying, head banging, and pulling out hair were cited examples of externalizing behaviors. In one case a service provider attributed a child's head banging to the complete absence of other self-soothing or calming strategies for the young child to cope with the tension caused by the violence in the home and long periods of time being left alone. Descriptions of these behaviors were confined to young children, not infants.

Service providers reported social learning or role modeling of violence, noting that children

often replicated either their mother's (e.g., submissive) or fathers' (e.g., aggressive) behaviors. One provider explained this modeling best when she said that "either you become very submissive or you yourself start to display violent behaviors" (Counselor, 13 years experience).

Service Providers' Understandings of Supports Needed by Women

Service providers highlighted the various types of support that mothers needed such as instrumental support to meet their basic needs, informational support including help connecting with support services, non-judgmental affirmation, and emotional support. They described the support sources mothers needed, including peers, friends, family, and professionals. They explained that mothers needed assistance to get back on their feet, find time to restore their energy, and arrange new housing, childcare, transportation, and many other needs. One provider stated that "they're [mothers who experience IPV] intelligent, and gifted, and wonderful women that are just in hugely unfortunate circumstances. And they will pull it together, with help" (Social worker, 10 years experience). The role of support persons for these women should enable them to find ways to have their needs met. The service provider added that "it's not for us to do for them but I think it's for us to provide that niche of a world that they can kind of take a breath and reconfigure" (Social worker, 10 years experience).

Instrumental and informational support. Because mothers were responsible for their children's needs, childcare help was frequently cited by service providers as a specific example of needed instrumental support. Service providers also highlighted the importance of informational support, help navigating the complex and interconnected service system, and the need to create a "road map" to resources (Nurse, 16 years experience). Mothers looked to service providers "to connect them" (Nurse, 16 years experience) and help them find what they needed. Service providers described having to deal with the challenge of providing mothers with the information they lacked while guarding against overloading mothers with too much information. "There still isn't enough information out there, but once you become involved, there's so much information that you're overwhelmed" (Counselor, 3 years experience). To optimize support and prevent information overload, providers emphasized the need for greater collaboration and coordination among different services and the need for putting a priority on strengthening and improving supports currently available.

Emotional and affirmational support. Participants emphasized that mothers affected by IPV needed emotional and affirmational support. Mothers needed someone to listen, validate their feelings, and reassure them that their decision to leave was a good one. Providers reported that mothers also needed reassurance that they were doing a good job as mothers even though this was difficult under the circumstances of IPV. As a social worker commented:

> They are just like any of us. We need to be supported when we are hurt and not given a sense of shame. That goes with the validation. Also a recognition that we cannot be expected to make the best decisions of our lives and be the most resourceful financiers and patient mothers when our lives are totally upside down. (Social worker, 8 years experience)

Emotional support from someone who would not judge mothers was thought to be especially important. Such individuals would be steady, reliable people, someone to "lean on" who helped mothers to help themselves—to enable rather than rescue. "I think they need somebody outside of their family networks, that can befriend them and be there as an anchor. And when they take one step forward, two steps back, they don't judge them" (Social worker, 22 years experience).

Support sources. Many service providers described peer support from someone who had survived a similar experience to decrease mothers' feelings of being judged. A few of the participants had delivered peer mentorship programs within their service organizations. They reported that mothers needed "other women who have gone through similar situations" (Social worker, 18 years experience) to help them through the transitional period of leaving and being on their own with their infant or young child.

Although service providers considered both friends and family as potential supports for mothers exposed to IPV, friends were described as preferable. One provider described the unique characteristic of friend support as not "as emotionally charged" (Counselor, 10 years experience). In situations of intergenerational violence, service providers expressed doubts about family members' abilities to be supportive of mothers. Service providers reported that enhancing the mother's relationship with her

young infant or child required consideration of all the stressors faced by the women and knowledge of available and needed supports. Because of the mothers' diverse needs, individuals who provided support would be required to play a range of support roles and provide different types of support. A highly experienced counselor observed:

> I think that often, the moms that I work with, I've often said they just need a mom. They need a woman in their lives that's not, that doesn't have her cell phone turned off at 5:00 or 5:30 or 6:00 when work is finished. That is able to provide some childcare when needed, that's, you know, like your mom does when you have a kid.

Service providers identified a lack of programs, training, and resources to assist mothers to strengthen relationships with their infants and young children. Few service providers identified novel resources to assist the mother–infant/child relationship. Even in response to direct questioning in individual interviews, they all voiced deep concern about the continuing need for basic and fundamental supports for maternal and child well-being, such as adequate housing and services that were accessible, respectful, validating, integrated, and collaborative. Group interview participants affirmed that the limited number of recommendations may be because service providers were so busy responding to abused mothers' needs that there was insufficient time to consider novel ways to support the mother–infant/child relationship. Nonetheless, providers affirmed that the mother who has been abused needs time for herself as a way for her to "re-find herself: the me and the baby who's attached" (Counselor, 7 years experience).

Providers were ambivalent about whether these supports should be provided by either professionals or peers. They emphasized the importance and potential of non-judgmental support from individuals who had gone through similar experiences "who can say. . .'You know, I was stuck in a situation like that'" (Counselor, 3 years experience). In contrast to peers, service providers had a professional obligation to be judgmental in reporting abuse to authorities. Thus, service providers' ambivalence may have been due to their silent acknowledgment of mothers' tremendous fear of losing their children if they disclosed ongoing abuse to professionals. Yet, as one experienced provider said:

> [To] allow women to, or teach women again, how to nurture and how to truly bond with their children. Parenting techniques [are needed] because parenting techniques, whether you're in an abusive relationship or not, are a really valuable tool that anybody can give you. (Nurse, 16 years experience)

Providers also observed that whenever possible, the support of infant/child development in these families should involve both the mother and father as "the father is always going to be the parent of the child." Not surprisingly, service providers expressed safety concerns around this recommendation.

DISCUSSION

Our findings revealed service providers' understandings of the challenges faced by mothers who experienced IPV, and the stresses on the mother, the mother–infant/child relationship, mothering quality, and child development. They recommended two main kinds of support to help mothers focus on their relationship with their children. These included the need for on-going validation as women and mothers, and for a non-judgmental coach with personal experience of IPV to build confidence.

Service providers recognized that for such supports to be most effective, a multi-faceted approach would be needed to address mothers' needs. Mothers needed to be supported to address their immediate survival needs so that they could provide the best care for themselves and their children. Women needed time to restore energy and make necessary arrangements, and they needed help to identify and connect with appropriate services. Interventions are thus warranted that incorporate peer support, are responsive to the shifting needs of women, and separately target both father- and mother–infant/child relationships, keeping in mind the safety of mothers and children.

Although our study provides information about service providers' perspectives of the impact of IPV on women and children, the findings are limited because providers were asked to comment on their experiences with mothers who left violent relationships. Yet, mothers may try to leave many times before finally leaving their violent partner permanently (Lindgren & Renck, 2008). The observations of service providers may reflect their experiences with mothers who were in various stages of the leaving process. In addition, the interview questions were intended to elicit service providers' views of services and supports needed by mothers and children (birth to 36 months of age) affected by IPV and thereby

were focused on the negative as opposed to positive aspects of these women's lives.

Consistent with findings from other studies (Holden & Ritchie, 1991; Huth-Bocks, Levendosky, & Semel, 2001; McCloskey, Figueredo, & Koss, 1995), service providers identified emotional drain, stress, and lack of partner support as key factors determining the impact of IPV on mothering. The service providers described mothering styles as falling on a continuum from hyper-vigilant to unresponsive or permissive. Both may be the result of poor emotional support (Levendosky et al., 2004; Trotter, Bogat, & Levendosky, 2004) and parenting stress (Huth-Bocks & Hughes, 2008; Owen, Kaslow, & Thompson, 2006). Women in abusive situations may view their infant or young child as vulnerable, and this perspective may contribute to hyper-vigilance (Ellis et al., 2008).

Service providers described the negative impact of IPV on a broad range of infant and young children's outcomes (e.g., internalizing and externalizing behavior, developmental delay, and socio-emotional health) consistent with the findings of other researchers (Hazen et al., 2006; Morrel et al., 2003; Onyskiw, 2003; Wolfe et al., 2003). Although many features of social–emotional and behavioral development depend to some extent on genetic components, service providers largely attributed child outcomes to characteristics of the caregiving environment and social learning or modeling of observed violent behavior by the child. At the same time, service providers recommended that supporting infant/child development required the involvement of both parents. This is consistent with other research demonstrating the importance of fathers to children's healthy development (Lamb & Tamis-Lemonda, 2004). Their perspectives illustrate the complex effects of IPV on the mother, the child, and on relationships with both parents. Yet, little is known about the best ways of fostering such practices in both parents within a family with IPV while safeguarding women and children.

According to the service providers, mothers who experienced IPV needed emotional, affirmational, and instrumental support in order to access services. These suggestions are consistent with the research of Levendosky et al. (2004) who reported that little emotional support and practical aid were available to women in violent situations. Women's experience of high stress and limited personal support demands that service providers be particularly empathetic and non-critical in order to promote positive mental health and support-seeking behaviors among women affected by IPV (Levendosky et al.).

Support that integrates peer and professional networks may be most effective in addressing these women's needs. As Lempert (1997) indicated, however, peer support may have unintended negative consequences (e.g., being discounted or not believed) that need to be considered. Training of peer supporters may help address this risk. Moreover, examining the challenges associated with implementing effective peer support intervention programs that safely include both fathers and mothers would be useful.

Providers identified professional support strategies, such as role modeling and positive reinforcement, as key approaches to use with mothers. Instrumental, structural support (i.e., availability of child care and transportation to program sites), and attitudinal supports (i.e., a non-judgmental atmosphere) were thought to foster mother engagement with service providers and programs. These findings are consistent with the work of Jouriles et al. (2000) who reported an increase in warmth of interactions with children among mothers who received support from a trusted adult. Moreover, numerous investigators have reported the beneficial indirect effects of maternal support on child adjustment (Health Canada, 1999; Holden, Geffner, & Jouriles, 1998; Levendosky & Graham-Bermann, 2001).

Despite their emphasis on the multiple challenges faced by mothers who experienced IPV and the importance they attached to supporting these mothers in building healthy relationships with their children, service providers offered few new ideas for intervention to support mother–infant/child relationships but instead called for more basic fundamental services such as housing or caring service providers. Service providers described spending most of their time reacting to the crisis of IPV situations rather than being empowered to plan for better services and outcomes for affected mothers and young children. Moreover, the lack of resources available to service providers may make it impossible for them to address more than these crises.

Complexity theory (Gatrell, 2005) may offer an explanation for the limited number of ideas. This theory suggests that service providers may become locked into recurrent feedback loops in the presence of insufficient professional experience of different or better outcomes. Without this experience, service providers may have difficulty considering or experimenting with alternative behaviors and possibilities. In keeping with this theory, most service providers concentrated on

mothers' problems and service provision challenges and offered explanations for problems.

The paucity of research evidence available to guide development of new, proactive strategies, interventions, and programs may also limit service providers' consideration of possibilities for interventions to promote maternal–infant/child relationships affected by IPV. Indeed, according to a recent review, although a knowledge base exists showing the effect of domestic violence on children, little intervention research has been completed to inform the development of advanced practice models that take proactive and strengths-based approaches with these children (Fowler & Chanmugam, 2007). One model, the Incredible Years (Webster-Stratton, http://www.incredibleyears.com/), has shown promising evidence of reducing children's behavioral problems associated with IPV (Hughes & Gottlieb, 2004). A recent review of interventions to prevent child abuse and neglect (MacMillan et al., 2009) provides promising evidence of the effectiveness of the Nurse-Family Partnership Model (Olds et al., 2007) and Early Start (Fergusson, Grant, Horwood, & Ridder, 2005) programs. Yet, none of these programs specifically targeted the improvement of mother–infant/child relationships (MacMillan et al., 2009).

CONCLUSION

Providers were troubled that the services currently being offered to mothers experiencing IPV were not sufficient to help them cope with stress and feel supported. They suggested the need for responsive and integrated services focused specifically on mothers and their infants and young children. The role of non-professional support from friends, family members, and peers in providing support to mothers and their infants/young children was also highlighted. Services that foster the development of a positive and nurturing mother–infant/child relationship and promote healthy child emotional, social, and physical development are critically needed but sorely underfunded and not the priority in a service delivery system focused on addressing crises.

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