

“I’m a Mother First”: The Influence of Mothering in the Decision-Making Processes of Battered Immigrant Latino Women

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Abstract: Healthcare providers (HCPs) may be perplexed by the decision-making processes of battered Latino women in situations involving intimate partner violence (IPV). In particular, decisions may appear contradictory and hazardous to the women’s children. The findings of this interpretive descriptive study reveal that the mothering role was central to battered Latina mothers’ decisions. The mothers strove to prioritize, protect, and provide for their children in every way, including managing the abuse and avoiding IPV disclosure to HCPs. Disparate understandings of the women’s decisions and mothering create a Catch-22 between battered Latina mothers and their HCPs. A trusting mother-HCP relationship is necessary for effective screening and intervention for IPV. This requires HCPs’ understanding of these mothers’ decisions and changes in clinical practice. © 2009 Wiley Periodicals, Inc. Res Nurs Health

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The decision-making processes of women who are battered by an intimate partner reflect the complexity of intimate partner violence (IPV). The decisions battered women make change as their circumstances change. Apparent contradic-

tions in their decisions often confound healthcare providers (HCPs; D’Avolio et al., 2001; Henderson, 2001). These decisions belie the adaptation required and the complicated risk-benefit analysis that guides battered women’s decisions about

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managing the abuse, staying in or leaving the abusive relationship, and disclosing the IPV to HCPs. These decision-making processes are compounded for battered women who are mothers.

Survivors of IPV who are mothers face many critical decisions in both their private and public lives. Privately, they strategize to maintain their own safety and the physical safety and emotional well-being of their children (Ulrich et al., 2006). Publicly, they make decisions about IPV disclosure and strategize to maintain custody of their children and co-parent with abusers (Hardesty & Ganong, 2006). Major influences on battered mothers' decisions are fear of the abuser and the unknown consequences of disclosing or seeking help for IPV, their children's well-being, pragmatic concerns, family ideology, and cultural values (Kelly, 2006; Rodríguez, Sheldon, Bauer, & Perez-Stable, 2001).

Mothers' decisions within the context of IPV sometimes result in the reverse of the intended outcome. For instance, decisions to leave the abuser, which are intended to ensure physical safety, may result in more danger to themselves (Fleury, Sullivan, & Bybee, 2000) and their children (Hardesty, 2002) because violence often increases after separation. Decisions to stay so their children have a father may result in physical and emotional harm to their children or the children's removal from the family because of ongoing violence (Kopels & Sheridan, 2002). Decisions to leave the abuser to protect their children may result in mothers' inability to provide financially for their children, leading to detrimental intrusion into their lives by the abuser and government and social services agencies (Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003). Decisions to allow abusers access to their children after separation often lead to escalating violence and harmful emotional effects on the children (Varcoe & Irwin, 2004).

The study reported here is part of a larger study of the healthcare experiences of battered Latino women. An important finding in the larger study was the influence of the mothering role on the women's abuse and healthcare experiences and decisions (Kelly, 2006). In this article, the IPV-related decision-making processes of battered immigrant Latina mothers are expanded upon to increase HCPs' understanding of this population's decisions, the apparently contradictory nature of these decisions, and the broader context in which they are made.

The stay/leave and disclosure decision-making processes of mothers who experience IPV are not

well understood. Even less is understood about mothers who are immigrants or U.S.-born mothers from ethnic minorities. The fastest growing ethnic minority group in the U.S., the Hispanic population accounted for one-half of the U.S. population growth between 2000 and 2006 (US Census, 2004). The Hispanic population is projected to triple between 2005 and 2050, by which time it will comprise 29% of the U.S. population (Pew Hispanic Center, 2008). Research is therefore greatly needed to better understand IPV in Hispanic populations.

The use of the ethnic categories of *Hispanic* and *Latino* are controversial and obviate differences among subgroups. The terms Hispanic and Latino refer to a culturally heterogeneous population, requiring caution when generalizing across subgroups (Malley-Morrison & Hines, 2007). In U.S. Census data, the term Hispanic is used. Latino/a is considered by many as a self-identifying term for being from a Latin American country, meaning Mexico, Central and South America, and the Caribbean. For this reason, the term Latina or Latino women was used to identify the study participants and population.

Although descriptions of traditional Latin cultures are often regarded as stereotypes, there is widespread agreement about gender roles and family values across Latin cultures (Kasturirangan & Williams, 2003). There is a strong emphasis on family (Raffaelli & Ontai, 2001). Cultural scripts about gender roles include *machismo* and *marianismo*. Machismo is the expectation that men be strong, dominating, in control, and providers for their families (Laganá & Gonzalez-Ramirez, 2003). Marianismo is the expectation that women be submissive and obedient. Girls are socialized to be wives and mothers, to endure suffering for the sake of their children, and to maintain the integrity of the family (Galanti, 2003). Machismo and marianismo often contribute to gender inequality and violence in Latino relationships (Cianelli, Ferrer, & McElmurry, 2008).

The cultural emphasis on family and traditional gender roles influences battered Latinas' tolerance of IPV, commitment to their abusive partners, and help-seeking decisions (Bauer, Rodríguez, Quiroga, & Flores-Ortiz, 2000; Moreno, 2007). For Latina mothers, like mothers of other cultures, their children's welfare is both a barrier and a motivator to help-seeking (Petersen, Moracco, Goldstein, & Clark, 2004; Zink, Elder, & Jacobson, 2003). Fear of immigration authorities, limited English proficiency (LEP), and low acculturation are major barriers to immigrant

Latinas who are seeking help and healthcare (Bauer et al., 2000; Lipsky, Caetano, Field, & Larkin, 2006). Experiences of immigration, racism, and marginalization also deter these women from seeking healthcare (Sorenson, 2006; Villenas, 2001).

THEORETICAL FRAMEWORK

Feminist intersectionality is a theory that is suitable to advance understanding of the experiences of battered immigrant Latino women living in the U.S. These Latino women live on the margins of society. The theory frames intersecting forms of oppression as causes of health and healthcare disparities (Collins, 1986, 2000; Crenshaw, 1991; Hurtado, 1996). The premise of feminist intersectionality is that the total effect of multiple forms of marginalization is multiplicative not additive. The societal inequities faced by battered immigrant Latinas multiply exponentially with the addition of each dimension of their subordinate differences from majority groups.

The prevailing theoretical understanding among researchers of IPV is that living with, leaving, and dealing with the aftermath of IPV are active processes influenced by several external social factors (Anderson & Saunders, 2003). The complexities and hierarchies of race, gender, class, LEP, and immigrant status deprive these women of access to essential societal resources (e.g., healthcare as well as governmental, legal, and community support and assistance; Dasgupta, 2005; Sokoloff & Dupont, 2005).

The analysis of these data was guided by feminist intersectionality theory. This choice added a theoretical complexity to the analysis that differed from the feminist theory that guided the larger study. It provided a theoretical context for understanding the decision-making processes of battered immigrant Latina mothers, who made decisions about their safety and that of their children in the context of fear, danger, and inequity in and outside of their homes.

METHODS

Study Design

Interpretive description (Thorne, Kirkham, & MacDonald-Emes, 1997) was used for the data analysis. This method produces knowledge of

common patterns in experiences that can be applied clinically at the level of the individual. Individuals' experiences are contextual and constructed (Thorne et al.). Consistent with the theory of feminist intersectionality, these experiences affect health and illness. Analysis conducted within interpretive description involves critique of existing knowledge while acknowledging the theoretical assumptions; personal, cultural, and clinical biases; and preconceptions of the researcher.

Sample

Institutional review board approval was obtained from appropriate institutions. Immigrant Latino women who had experienced past but not current IPV were recruited from a domestic violence (DV) services agency and legal services agency in an urban area in the northeastern U.S. Theoretical sampling guided recruitment of women from Mexico, Central and South America, and the Caribbean with varied levels of acculturation, immigration status, and English proficiency. These factors strongly influence the experiences and decision-making processes explored in this study. Sample adequacy was determined by redundancy in the data about common patterns and meanings in the women's experiences and decision-making processes.

The 17 women in this study were all mothers, though this was not an inclusion criterion in the original study. The women had 1–4 children. Fourteen of the women had some or all of their children living with them. One woman's children were living with her family in her native country. Two women's children were adults living independently in the U.S. Two of the women were pregnant at the time of the interviews. The women ranged in age from 19 to 53 years old; they had lived in the US for 2 to 25 years. Their most recent abusive relationships had lasted 6 months to 23 years. The women had left the abuser as recently as 3 months prior to enrolling in the study and as long ago as 4 years. Eight of the women were undocumented immigrants, three were immigrants with permanent resident status, and five were U.S. citizens from Puerto Rico, and one was a U.S. citizen originally from Guatemala. Ten of the women spoke Spanish only, six spoke Spanish and English, and one spoke English only. Their levels of education ranged from 4th grade to 2 years of college (see Table 1).

Table 1. Description of the Sample

Age	Country of Origin	Immigration/Documentation Status	Language Spoken ^a	Years Living in U.S.	No. of Children	No. of Children at Home	No. Children in U.S. Not at Home	No. Children In Country Of Origin
19	Colombia	Undocumented	S/LEP	4	1	1	0	0
20	Puerto Rico	U.S. Citizen	E	15	1	1	0	0
25	Puerto Rico	U.S. Citizen	S/E	25	1	1	0	0
26	Honduras	Undocumented	S	2	2	0	0	2
26	Mexico	Undocumented	S	9	3	3	0	0
28	Honduras	Legal Resident	S/E	22	1	1	0	0
30	Mexico	Undocumented	S	11	1	1	0	0
30	Puerto Rico	U.S. Citizen	S/E	2.5	2	2	0	0
32	Puerto Rico	U.S. Citizen	S/E	19	2	1	1	0
34	Salvador	Legal Resident	S	11	3	3	0	0
35	Guatemala	U.S. Citizen	S/E	16	2	2	0	0
36	Colombia	Undocumented	S	15	3	3	0	0
36	Colombia	Undocumented	S	3	4	1	0	3
39	Colombia	Undocumented	S	15	3	3	0	0
52	Salvador	Legal Resident	S	14	3	3	0	0
53	Puerto Rico	U.S. Citizen	Spanish	19	2	0	2	0
				23	4	0	4	0

^aS, Spanish; E, English; LEP, Limited English Proficiency.

Procedure

The women were either self-referred based on information in flyers or referred by staff. They were aware their participation was voluntary. When women were hesitant, they were asked to think about whether they would like to participate and return at another time. Informed consent was obtained in writing and pseudonyms were assigned to all participants. The women were informed verbally and in writing that their participation decision would not affect their receipt of services, their healthcare, or their immigration status.

Data were obtained from November 2002 to January 2004 via individual interviews with the 17 women and two focus groups with 8 additional women. A single interview was conducted with 5 women who relocated after the first interview and could not be reached for a second interview. Eleven women were each interviewed twice. The second interviews had two purposes: to gather more information and to discuss, challenge, and refine my analysis of all data gathered to date. One woman who spoke solely about her experience of IPV and not her experience of receiving healthcare in her first interview was interviewed three times. All interviews were transcribed; those conducted in Spanish with an interpreter were transcribed in Spanish and English. Informants were given \$25 per interview; childcare and transportation were provided. Any safety concerns that surfaced in the interviews were addressed immediately with the informant's advocate or attorney.

Interviews were conducted in the language of the informants' choice; 10 chose Spanish, and 7 chose English. Although I speak Spanish with moderate fluency, bilingual and bicultural interpreters were used for interviews conducted in Spanish. The interpreters provided nuance that might otherwise have been missed. Conversely, my knowledge of Spanish allowed me to recognize and clarify meanings that were not completely conveyed by the interpreters, and to redress the occasionally missing word or idea. This approach is a strength in this study because the inevitable omissions and errors made by interpreters were minimized and appreciation of nuances was maximized. As a result, the quality of the data in both the English and Spanish interviews is consistent.

The interviews were dialogic and intentionally conversational, allowing topics of interest to the women to evolve. The original interview guide included questions about the women's healthcare experiences, their expectations, their relationships

with their HCPs, which HCP behaviors were helpful or unhelpful, and the role of culture in their abuse and healthcare experiences. The women inevitably began with the story of their abuse or of their children's healthcare. Consequently, most of the first interviews pertained to the abuse, how the women managed it and escaped it, followed by discussions about their own and their children's healthcare experiences. Subsequent interviews with the 12 women who were reachable began with having them critique and discuss the analysis of all data collected to that point. This was followed by further discussion of the informants' IPV-related decision-making processes, particularly disclosure of IPV to HCPs.

After the data from all individual interviews were analyzed, a focus group was conducted with 4 Spanish-speaking immigrant Latinas who were not part of the original 17 women but who were receiving services at the DV agency. A second focus group was conducted with 4 bicultural advocates working at the agency. Each group lasted 90 minutes. The focus group participants were asked to critique the data analysis to that point, based on their personal and professional experiences. I believed the group setting and format were more likely to yield challenges to my interpretations than individual interviews. Field notes and reflective memos were also considered data.

Data Analysis

Data analysis and data collection were conducted concurrently and cyclically. Interview data were analyzed thematically using Van Manen's (1990) approach. Transcripts were first considered as a whole and described with a single phrase. The transcripts were then reviewed several times to identify essential phrases about the women's experiences; these phrases were described with several narrative statements that summarized the experiences. Next, the transcripts were coded line-by-line. Relationships between the phrases, narrative statements and codes were organized into themes. These themes were juxtaposed with existing literature, with particular consideration given to the intersection of the differences of this population from majority, U.S.-born mothers.

The data analysis had a phenomenological cast; the meanings the mothers ascribed to their experiences guided the interpretive process. Preliminary analyses were reviewed with informants for critique and co-creation of an interpretive description of their decision-making processes.

The use of focus groups ensured validity by interrogating my interpretive description of the mothers' decision-making processes.

Within the interpretive paradigm, rigor ensures trustworthiness and theoretical validity, the "truth value" of the findings (Thorne et al., 1997, p. 175). The influence of researcher bias on research findings is a central threat to trustworthiness and must be accounted for in the research process. Several strategies ensured trustworthiness and theoretical validity. Repeat interviews with participants and focus groups with participants and bilingual/bicultural advocates allowed the opportunity for knowledgeable Latina mothers to challenge and refine my preliminary conceptualizations and theorizing. Documentation of the analytic process, including field notes, reflective journals, and analytic memos were used to establish auditability.

Reflective journals were used to explore the intersection of my professional, personal, cultural, and socioeconomic locations with the marginalized locations of the participants, and to account for those differences in my role as researcher. For example, as an experienced HCP I was accustomed to controlling the process, method and content of data collection (i.e., conducting controlled brief patient-provider interviews, and using diagnostic reasoning to analyze data). As a researcher, I needed to relinquish control and conduct conversational interviews with participant-initiated topics and co-create my analysis with participants.

FINDINGS

The findings presented here pertain to the centrality of the mothering role in these women's lives and mothering as the primary influence on their decision-making processes about managing the abuse, staying in or leaving the abusive relationship, and disclosing the IPV to their HCPs. The women experienced and managed both the IPV and their healthcare through the lens of their mothering role. Their previous experiences of abuse, immigration travails, and for some, their undocumented immigration status, placed their decision-making in the context of fear, uncertainty, and potential danger, exacerbating the challenges they faced and magnifying their fears, worry, and suffering.

Being A Mother

Mothering was the most important aspect of these women's lives, a responsibility against which all of their decisions and actions were weighed. The

women contended with the unremitting day-to-day work and worry of being mothers, unrelated to the violence they were experiencing. They worried about their children's health and progress in school. They saw themselves as responsible for their children's happiness. They struggled with balancing the financial need to work with their desire to remain at home taking care of their children. They were disappointed in their children's fathers' lack of parental involvement. Maria endured IPV so her children would have a father, but realized "That's not a father... He never knew what a school was. He never knew what a hospital was. He never knew anything about anything."

Despite repeated assaults, beatings, threats, and intimidation, the greatest source of the women's suffering was their awareness of the effects of the IPV on their children. Sylvia, who endured years of abuse and isolation after coming to the U.S., tearfully began her description of her own experiences by describing those of her children:

To me, the worst thing about this problem was because it affected my daughters . . . my youngest one, her teeth became very loose because of her nerves from the stress, she wouldn't eat, and she was always sobbing. The older one . . . she would not sleep. My other girl . . . she became angry . . . It affected the three of them in a very hard way . . . I realized that it was the tension, how much what happened affected them.

Realizing and accepting that they would have to leave the abuser and their desire for an intact family behind to take care of their children and themselves was a process for nearly all of these mothers. It was lengthy, painful, and full of contradictions. They contended with their conflicting emotions as well as those of their children. The mothers and their children loved and feared the abuser at the same time. All the women managed to leave their abusers; all felt some guilt and regret for not getting out sooner, for the sake of both their children and themselves.

The women prioritized their children over themselves, protected them, and provided for them as best they could under difficult and ever changing circumstances. These dimensions of mothering and the attendant actions the women took are described below. The strategies they used varied with their circumstances. The strategies were highly adaptive and were driven by what they assessed was best for their children, or would mitigate the harm when there were no alternatives. The same action could be the best choice on one day and the worst on another, depending upon the balance of risks and benefits to their children's

physical safety and emotional well-being at the moment. Staying and leaving and disclosing or not were not one-time decisions. For them the questions were not “Should I stay or should I go?” or “To tell or not to tell?” but “What is best for my children?”

Prioritizing My Children: My Children Come First

For these mothers, daily decision-making extended to concerns about basic safety, emotional and psychological well-being, and at times survival for themselves and their children. The women revealed an endless series of strategic decisions made as they lived in abusive situations, left abusers and began the process of moving forward in life with their children. Their children came first. For example, several women had sought personal obstetric care and healthcare for their children, but had not sought or received healthcare for themselves since becoming mothers or arriving in the U.S. Whatever the decision, they chose the option they thought would cause their children the least pain and suffering, even if they themselves endured more violence and hardship.

Staying for the sake of my children. Several women were caught in a complicated web of fear, threats, safety concerns, economic struggles, and conflicting emotions and values. They were threatened that if they left the abuser or told anyone about the abuse, their children would be harmed or killed by the abuser, or taken away by children’s protective services (CPS), the abuser, or his family. These mothers were threatened that they themselves would be deported or killed, leaving their children motherless in the hands of the abuser. They were told that they could not survive on their own in the U.S.; that they could not provide for their children. Their lack of knowledge about their rights, applicable laws, and available resources led the women to believe the threats. These threats held even more power over the undocumented, non-English speaking women, who were more likely to be completely isolated; some did not know a single person other than the abuser and his family. If they believed that seeking help or freedom would result in separation from their children, then they did neither. They simply avoided HCPs and remained with the abuser. Maria was trying desperately to find a way to safety for herself and her children, but had no one she could trust, so she told no one, and stayed.

He would say ‘You can’t take care of my kids [alone]’ ... I said what do I do? Do I leave? Do I turn him in? God, how will I leave if I don’t have help, if all of a sudden the police come, if all of a sudden I have nowhere to sleep, the kids are in the street and they take them away from me? Oh, I thought thousands of things!

Cultural values kept some women with the abuser, trying to be a “good wife,” striving to keep the family intact with the belief that children need a father, regardless of the costs to themselves. Others remained with or returned to the abuser under pressure from their own or the abuser’s family, or tolerated high levels of emotional or physical maltreatment without considering it abuse, based on their mother’s definitions. “[My mother] always told me that once he gets physical, not to let it get too far.” (Sheila). When Rita’s Portuguese boyfriend hit her for the first time, she broke up with him.

His mother called me crying saying ‘Please don’t do that to my son. He loves you. The reason why he hit you is because he loves you and this is the way it is in our culture and maybe because you’re Spanish it’s different for you.’ Rita’s mother also urged her to return to him, ‘because he loves you.’

Leaving for the sake of my children. For some of the women, the moment they realized that remaining with the abuser caused their children more harm than good was the moment they decided to leave. Staying for the sake of their children was no longer the best strategy. For some, that realization came in dramatic and dangerous moments, “I was like, oh my God, he really means it this time. He’s going to kill me.” For others it was more gradual, like for Rita, who realized she needed to leave when she realized she could contract HIV from her unfaithful, abusive boyfriend. If she contracted HIV, it could leave her daughter without a mother. That moment was the turning point for her.

The two oldest women in this study, ages 52 and 53, did not leave their abusers until their children were adults. Both the women and their children were irreparably “damaged” according to the women. They both described generational differences, “it was unheard of then to leave a marriage,” and lengthy trauma histories preceding and including the abusive relationships. One of the women was forced to marry her abuser after he raped her. These two women were married to their abusers for 22 and 23 years, and endured severe abuse requiring multiple hospitalizations. Both were experiencing significant mental and physical health problems as a direct result of the abuse. They also felt guilty for

staying with the abuser and failing to protect their children from him. Manuela tearfully described her unremitting guilt.

I destroyed my son because of my tolerance . . . for wanting them to be with their father, and that was my biggest error . . . He destroyed me, and I allowed him to destroy my children. I cannot forgive myself for that.

Manuela felt strongly that her HCPs did not understand her decision to stay in the relationship and were therefore dismissive of the severe ramifications of the IPV on her health.

Protecting My Children: Keeping the Secret, Keeping the Peace

Although prioritizing their children over themselves was largely an internal process for the women, protecting them involved interpersonal strategies and overt actions. They sought to protect their children physically, emotionally, and psychologically, both in moments of potential harm from the abuser's behaviors and by attempting to avoid or prevent additional harm from outside forces, both before and after leaving the abuser.

Keeping the secret. Although they thought they could mitigate the effects of the abuser's behavior on their children, the power and actions of outside entities (i.e., police, US Customs and Immigration Services [USCIS], and HCPs) seemed uncontrollable and unpredictable to the women. They did everything they could to prevent outsiders from learning about the abuse. The threats posed by HCPs lay in the direct link the women perceived between them and CPS and USCIS, both of which could separate them from their children by loss of custody or deportation, leaving their children without the love and protection of their mothers. They believed that CPS would take custody of their children based on the assumption that if a mother is being abused, so are her children, or that mothers who remain with abusers are failing to protect their children from witnessing abuse, and are therefore neglectful or abusive themselves. Many of the women viewed CPS as more dangerous to their children than the abuser. They saw themselves as better protectors of their children than CPS. Keeping the secret was, for some, the best protection they could offer their children, choosing the devil they knew over the devil they did not.

Involving outsiders, particularly by calling the police during the abuse or to enforce a restraining order, was seen by the some of the women as

protective only when they or their children were in imminent danger. They worried about the impact the resulting scene would have on their children, either scaring them or having them witness their father being arrested. They protected the abuser to spare their children emotional distress. One woman was scolded by her attorney and called hypocritical by the police when she did not enforce the restraining order against her husband.

Keeping the peace. As much as the women tried to avoid upsetting scenes involving outsiders, they also did everything they could to keep the peace at home. They placated the abusers to avoid confrontations or increased violence that would upset their children. They protected their children from seeing, hearing, and even hearing about the abuse, both for their emotional health and to preserve their children's relationships with their fathers. They put young children in another room with the door closed or sent them to a relative's house when the abuser was yelling or being violent. Magdalena admonished her father not to speak badly about the abuser in front of her son. "Don't say anything about his father. Because it's very difficult; because I don't want my son getting psychologically damaged. I want him to be a child, not an adult with those concerns and everything." Finally, they protected their children as much as they could from seeing their own suffering, both during the abuse and after getting away.

Providing for my children: Making it on our own. For all but the two oldest women, leaving the abuser made them single parents, solely responsible for young children. They struggled to make ends meet, to provide for their children's basic needs. Working was not new to them, nor was poverty, but establishing emotional and economic independence was. They struggled with the need to work more and the realization that their children now needed them more. Even after leaving the abusers, many of the women still had contact with them, either via harassment and stalking or child visitation. They allowed contact with the abusers to provide their children with a father, usually at great emotional cost to themselves, just as they had protected their children from their father's abusive behaviors.

They understood all of their decisions and efforts as their duty to "be strong" for their children. They strove to move forward, to provide their children a safe and happy future. For some of the women, relief and happiness came on the day they left the abuser, despite their concerns about managing alone. For others, that point of joy came later, when reflecting back on their "life affirming decision." Maria wanted other abused women to

know that they and their children could survive and thrive without the abuser. "I'm poor, but they have their food, they have their mom. They have support. What more does a child want in this life?"

DISCUSSION

Throughout the continuum of IPV, the battered Latina mothers in this study found themselves in unfamiliar, dangerous, and ever changing circumstances. The one constant in their lives was their children, whose well-being was paramount. The complexities of their situations required flexibility and creativity. The contradictions of being in a violent intimate relationship, both a mother and a wife, and an immigrant Latino woman in the U.S. were confounding and endlessly challenging.

Many aspects of these mothers' IPV-related decision-making processes and the barriers to disclosure of IPV to HCPs are consistent with those reported in the literature. These include fear of the abuser and his threats, worry that disclosing the abuse might result in their children being harmed or taken by CPS, economic dependence on the abuser, social isolation, and conflicting emotions. However, the multi-dimensional context of the lives of the mothers in this study exacerbated these seemingly universal experiences. The findings of this study shed new light on the primacy of mothering as an influence on abused Latino women's decision-making processes.

The mothers in this study made decisions at the intersection of their mothering role with IPV, their immigrant status, their Latino culture, and poverty. Immigration added language barriers and magnified their isolation, economic and logistic dependence on the abuser, fear of the police, and of USCIS. Many lacked knowledge of available resources, their rights, and U.S. laws. The risks of IPV disclosure were higher for these immigrant women who had fewer resources and more vulnerabilities than U.S.-born women.

Within a Latino culture in which familism is a central component and mothering is the most important role that women have (Cianelli et al., 2008), immigrant Latina mothers who experience IPV face the difficulty of protecting and caring for their children amid increased pressure to maintain the family unit, while at the same time losing their extended family support network. The powerful dynamics of IPV and immigration, including inequality and multiple sources of vulnerability, compound these difficulties.

Although multiple barriers can keep mothers from leaving an abusive relationship, equally

compelling as reasons to stay are "double binds" to their children and their partner (Lutz, Curry, Robrecht, Libbus, & Bullock, 2006, p. 123). The immigrant Latina mothers in this study were in multiple double binds. They were bound to the abuser and their children, to their roles of wife and mother, to their idea of family and the reality of their family, and to their native country and to the U.S. The contradictions in these binds were reflected in their IPV-related decisions.

The experiences of the two women who remained with their abusers for more than 20 years suggest that the more traditional Latino socio-cultural norms of machismo and marianismo constrain battered women's options and strongly influence the decisions some make to stay in abusive relationships (Moreno, 2007). It is possible that the experiences of these mothers who had sought help and left abusive relationships differ from those of mothers still in abusive relationships. Alternatively, they may shed light on the decision-making processes of those mothers who remain with abusers.

The mothers in this study were caught in a classic Catch-22 at the intersection of their marginalized social, economic, cultural and legal positions and their conflicting emotions. Many decisions were fraught with real or potential danger. Their resilience and determination to achieve a better life for their children and themselves kept them actively managing ever-changing situations, one decision at a time.

Black and Miles (2002) described a "calculus of disclosure" (p. 691) determined by African American women with HIV in deciding to whom and when to reveal their HIV infection. This calculus involved a risk-benefit analysis that incorporated the threat of stigma, feelings of shame, and the need for support. The battered immigrant Latina mothers in this study performed a similar calculus in their decision-making processes, weighing the risks and benefits as they managed the abuse, made decisions about staying in or leaving the relationship, and disclosing the IPV to HCPs. Danger, rather than stigma, most strongly influenced their risk-benefit analyses, but their needs for support were quite similar to those described by Black and Miles. The calculus of disclosure for both populations resulted in decisions that were highly adaptive, made and remade as their circumstances and needs changed.

Some HCPs fail to understand the barriers to leaving and the double binds that compel women to stay in abusive relationships (Nicolaidis, Curry, & Gerrity, 2005; Waalen,

Goodwin, Spitz, Petersen, & Saltzman, 2000; Zink, Regan, Goldenhar, Pabst, & Rinto, 2004). For HCPs on the outside looking in, the decisions battered women make can appear inconsistent or irrational, for example, not reporting a violation of a restraining order or returning to the abuser after leaving. These decisions are often interpreted as passivity or weakness rather than strategic attempts to manage the abuser's behavior and to protect their children. These same interpretations are sometimes made by CPS workers, police officers, attorneys and judges, and even domestic violence victim advocates (Dunn & Powell-Williams, 2007). Abused mothers are often seen as bad mothers, putting their own needs before their children's, or worse yet, not taking their children into account at all (Varcoe & Irwin, 2004). They are held responsible for abusers' behaviors and they are punished rather than the abusers (Kopels & Sheridan, 2002).

The mothering role was the lens through which the women in this study viewed the IPV. For HCPs, IPV is the lens through which they view mothers (Irwin, Thorne, & Varcoe, 2002). This essential difference in perspectives lies at the heart of the misunderstandings and misinterpretations made by HCPs of abused mothers' decisions. Battered immigrant Latina mothers and their HCPs share a common goal: the protection and well-being of the children. However, their disparate understandings of how best to ensure children's well-being can create an apparent conflict of interest between HCPs and these mothers who are their patients.

HCPs practice under several standards of care and mandates pertinent to the care of abused immigrant mothers: (a) routine screening and intervention for IPV (American Medical Association, 1992; American Nurses Association, 1991; Joint Commission on the Accreditation of Healthcare Organizations, 1995), (b) culturally competent healthcare for all patients (US Department of Health and Human Services Office of Minority Health, 2001), and (c) mandated reporting to CPS of suspected or known child abuse or neglect. Collectively, these standards and mandates create a Catch-22 for HCPs who are often unable to meet them simultaneously.

HCPs face personal and systemic barriers to effective screening and intervention for IPV, cultural and linguistic disparities between themselves and their patients, uncertainty about what constitutes child abuse and neglect in the context of IPV, and concerns about the outcome of contacting CPS. As with the abused mothers who are their patients, HCPs make decisions that

may appear contradictory, and that can result in unintended consequences. For example, a decision to file a CPS report may result in the placement of children in foster care where they are in more danger, and in an irreparably fractured relationship with the mother, ending all possibilities for successful intervention.

There is a fine line between the education and blaming that abused mothers experience in their encounters with HCPs (Zink et al., 2003). The challenge for HCPs is finding that line, particularly as mandated reporters of known or suspected child abuse or neglect. HCPs have an incentive not to ask about IPV when they believe that a mandated report of suspected child abuse may cause more harm than good; abused women have an incentive not to disclose IPV for fear of CPS involvement. "Don't ask, don't tell" is often the result. There is no obvious solution to this Catch-22, which creates missed opportunities for support, patient education, and effective intervention for battered immigrant Latina mothers and their children.

CLINICAL IMPLICATIONS

A trusting and respectful relationship between battered immigrant Latina mothers and their HCPs is necessary for effective screening and intervention for IPV (Kelly, 2006). This requires that HCPs understand the influence of mothering in the mothers' decision-making processes, despite the seemingly contradictory and inconsistent nature of these decisions. Further, it is essential that HCPs understand the marginalized locations from which these mothers seek healthcare, and the influence of culture on their relationships with HCPs.

Many Latino women need to feel recognized as individuals, "not just a number," to trust their HCPs (Kelly, 2006). Toward this end, HCPs can begin a healthcare encounter with a brief social conversation, asking about these women's lives, particularly their children (e.g., "How are you? How are the kids?") rather than the standard initial greeting of "What brings you in today?" Although this requires an upfront investment of time by HCPs, it will likely yield a return of trust and rapport, creating opportunities for identification and intervention for IPV, as well as other health concerns.

For battered immigrant Latina mothers who fear the unknown consequences of IPV disclosure, standard screening questions like "Do you feel safe at home?" are not effective. Protocols for IPV

screening have not been tailored to ethnic groups or immigrants. For Latinas, an indirect and individualized approach may be more appropriate. This requires creativity and attention to nuances in communication and clues provided by the women. Battered mothers need to know the consequences of IPV disclosure prior to being screened for IPV by HCPs.

Currently recommended responses to disclosures of IPV, such as “No one deserves to be hit,” are based on women’s rights to freedom from violence. For battered immigrant Latina mothers who prioritize their children over themselves, responses that acknowledge their mothering role and address their children’s well-being may be more effective. Education about the harmful effects of IPV on children provided in a nonjudgmental manner can facilitate earlier IPV disclosure and create opportunities for intervention.

HCPs cannot guarantee that the ramifications of disclosure feared by battered immigrant Latina mothers will not occur. As mandated reporters, HCPs cannot guarantee that CPS will not become involved. They cannot guarantee that seeking help from the police or court system will not result in reports to USCIS of undocumented women or their abusers. Close collaboration between HCPs and CPS could provide abused mothers and their children safety and support, rather than punitive action. Healthcare providers are called upon to advocate for changes in CPS and USCIS policies to consider the abuser rather than the abused mother as the offender and threat to children’s well-being. In the meantime, a shift in basic assumptions about the motives and behaviors of battered immigrant Latina mothers, an understanding of their multiple vulnerabilities, and attention by HCPs to nuances in communication can facilitate effective identification of and intervention for IPV.

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