MIGRATION, HEALTH, AND INTIMATE PARTNER VIOLENCE IN THE US AND MEXICO: A BINATIONAL STUDY

By

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TABLE OF CONTENTS

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ABSTRACT

Intimate partner violence (IPV) is a significant public health issue affecting women worldwide. Although women from all backgrounds experience IPV, Mexican migrant women have a higher predisposition to IPV when compared to non-Latina White women. As one of the fastest growing minority groups in the U.S., it is critically important to better understand the dynamics of IPV among Latina women, especially the impact on physical and mental health. Moreover, exploring these phenomena in women who migrate, either internally or transnationally, can add to our knowledge and help us develop effective prevention and intervention approaches. The purpose of this binational dissertation was to explore the relationship between IPV and health among Mexican internal migrant women in Mexico and Latina women (U.S. born & foreign-born) in Southeast Texas. The three articles that comprise this dissertation are 1) a cross-sectional survey design to examine the relationship between IPV and health among Mexican internal migrant women in Mexico City, Mexico; 2) a secondary data analysis of a subset of Latina women, using data from an ongoing study on teen dating violence and risk factors in Southeast Texas, to examine the relationship between IPV and health; and 3) a qualitative study to explore the cultural, social, and political perspectives of Mexican migrant women in Mexico City about IPV and health. Participants in study one reported high levels of experiences of IPV victimization. They also reported experiencing high levels of anxiety and depressive symptomatology, even above national rates for the U.S. and Mexico, as well as multiple unhealthy days that prevented them from functioning in the prior month. More than half (59%) of the women in study 2 scored above the cutoff scores on the anxiety screener, and 12.5% on the depression screener, indicating a high probability of meeting criteria for an anxiety or depressive disorder. These rates exceed lifetime prevalence rates for anxiety and depression in the U.S. Participants also reported high levels of experiences of IPV victimization, although the percentage of women endorsing each

type of victimization was lower for the women in the U.S. than for those in Mexico City. Study three allowed us to attain a more nuanced understanding about the cultural, social, and political factors that worsen Mexican women's experiences with violence. Women not only shared their lived experiences on IPV and other forms of violence, but also their experiences with the reactions of friends, family, law enforcement, and society more broadly. Some key findings included the fear of disclosing abuse due to possible repercussions from perpetrators and authority figures, and society's further victimization of women who experience IPV through ignoring, dismissing, blaming, or stigmatizing their experiences. Women also demanded justice to end IPV and the high rates of female homicides in Mexico due to partner violence. Results indicated that women who experience IPV have, both in the U.S. and Mexico, experienced higher symptomatology of anxiety and depression. Moreover, our qualitative findings indicated the urgent need for an end to the cycle of violence against women in Mexico. Understanding how migration may affect the health of migrant women, in both contexts (Mexico and the U.S.), can inform best practices, research, and policies that can help women break the cycle of violence.

CHAPTER 1: INTRODUCTION AND STATEMENT OF THE PROBLEM

Intimate partner violence (IPV) is a significant public health concern that transcends borders, with approximately 30% of women worldwide reporting lifetime IPV (WHO, 2017). Intimate partner violence is defined as "physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former partner" (Breiding, Basile, Smith, Black, & Mahendra, 2015, p.11). Experiencing IPV is known to result in adverse mental and physical health outcomes, including physical injuries, sexually-transmitted infections, gastrointestinal problems, depression, post-traumatic stress disorder (PTSD) (Coker, Smith, Bethea, King, & McKeown, 2000; Pico-Alfonso, Garcia-Linares, Celda-Navarro, Blasco-Ros, Echeburua, & Martinez, 2006), and alcohol and drug abuse (Reingle Gonzalez, Connell, Businelle, Jennings, & Chartier 2014). However, the risks and consequences of IPV are not equally shared by all women. Mexican women in the U.S. experience a high proportion of IPV, with barriers like cultural norms, legal status, and lack of knowledge of where to seek help, worsening their violent conditions (Reina, Lohman, & Maldonado, 2014).

Violence against women in Mexico also remains a significant public health and human rights issue. Two-thirds (66.1%) of females 15 years or older report experiencing at least one lifetime incident of violence, 43.9% report experiencing violence by a current or past partner, and 34.3% report experiencing sexual violence in a public setting (INEGI, 2017). Mexican women also experience high rates of poverty, low rates of access to healthcare, and lower educational attainment, all risk factors for IPV (Navarro, Robles, & Hernandez, 2014).

Mexico City is a sprawling metropolis of approximately 21 million people with more progressive views than Mexico's rural areas. Women make up almost half (43.2%) of the Mexican labor force (INEGI, 2017), and women who move from rural to urban areas make up a

large portion of the labor force (Soriano, 2017). Becoming "economically active" (INEGI, 2017), which means entering the labor market, may give women a new sense of autonomy and self-empowerment. This can lead to pushing back against partners who may now feel threatened by the woman's newfound sense of independence. Their partners may continue to be oppressive or abusive, increasing IPV risk or worsening IPV situations. If the woman has knowledge of IPV and access to resources, this may ultimately result in her leaving the abusive relationship (Casique, 2012; Raphael, 1997). If she does not have knowledge of IPV, access to resources, or support from other sources, she may find herself increasingly in danger.

Although there are policies that exist to protect women from violence, these laws are not always enforced. For example, in Mexico, the General Law on Women's Access to a Life Free of Violence was enacted in 2007 for the purpose of holding municipalities, states, and federal authorities responsible for protecting the safety and rights of victims of violence (U.S. Department of Justice, 2008). However, the Mexican government has been criticized for not effectively enforcing this law. For example, weaknesses that have been reported regarding the General Law on Women's Access to a Life Free of Violence include lack of coordination between local and federal authorities when documenting cases of violence against women and the lack of financial support for victim services (Comisión De Derechos Humanos Del Distrito Federal, 2017). Furthermore, female human rights activists have been known to face threats, intimidation, and attacks in their efforts to seek social justice for survivors (López & Vidal, 2015).

Mexican women who have migrated to the United States share some similar challenges with women in Mexico who migrate internally, but they also have some unique factors that put them at risk in the U.S. context. (Erez, Aldeman, & Gregory, 2009).

Approximately 50% of Latina women residing in the U.S. report experiencing some form of IPV in their lifetime (Cuevas, Sabina, & Milloshi, 2012). Moreover, for Mexican migrant women, migration experiences can significantly compound IPV situations. In the U.S context., Mexican women may feel expected to conform to traditional gender roles when residing in ethnic enclaves or with extended family, which is often the living situation in which recent migrants find themselves (Marrs Fuchsel, Murphy, & Dufresne, 2012). With these living arrangements, which provide support from family and community, may also come tremendous pressure to conform to traditional gender norms and roles, and this pressure may become magnified by the community, the extended family, the church, and/or intimate partner (Marrs Fuchsel, 2012). When Mexican migrant women start to adopt more mainstream values or behaviors, they may become the target of derision, and lose social support, further increasing IPV risks (Menjivar & Salcido, 2002). This may also be true in Mexico City, when women migrate from rural or remote locations for employment opportunities. However, this is a greatly under-studied topic in the U.S., and even more so in Mexico.

In both contexts—the U.S. and Mexico—cultural attitudes and rigid, socially-constructed gender roles may override safety concerns, making it likely that women will remain victims in their abusive relationships. For these women, IPV can also be a taboo topic that is often difficult to talk about, limiting their ability to seek help (Dubova, Pámanes-González, Billings, & Torres-Arreola, 2007). Growing financial independence through participation in the labor force, lack of knowledge of women's rights in IPV situations, lack of access to resources, and adherence to rigid cultural norms all perpetuate the cycle of violence. Cultural and systemic barriers make it difficult for Mexican migrant women to leave abusive relationships, both in the U.S. and Mexico. Further understanding the complex relationship between IPV and health in migrant

women, as this study will do, can inform best practices, policy, and research efforts. Also, it is important to recognize that a progressive city, like Mexico City, can serve as a hub/natural laboratory for enhancing existing policies and programs, as well as creating new ones, to help and support IPV survivors. Within the past decade, feminist activists, allies, political figures, and other supporters have been heavily involved in efforts to call attention to the situation of IPV in Mexico.

Recently, the murders of Ingrid Escamilla, 25, and Fátima Cecilia Aldrighett, 7, sparked a national outrage that led to protests and activism across Mexico. However, these national protests will remain in vain if they are not accompanied by national enforcement and creation of new policies to protect the well-being of IPV survivors. Given continued migration from rural to urban areas in Mexico, and between Mexico and the U.S., the rising costs of healthcare, and growing calls for gender equality in all areas, the link between migration, IPV, and health is a critical area of research. This study examines the relationship between IPV and physical and mental health, with a focus on Mexican migrant women in Mexico City and Latina women in Southeast Texas (U.S.). Study results will inform practice and policy regarding IPV prevention, screening, and treatment with migrant women, with broader applications to other groups of women (e.g., refugees and other minority women in the U.S.).

Migration is a stressful experience, and transnational migration can be particularly stressful for undocumented migrants. In the current anti-immigration climate in the U.S., all migrants—regardless of legal status—may experience heightened stigma and discrimination, which may increase isolation and fear of asking for help (Berger Cardoso, Scott, Faulkner, & Barros Lane, 2018; Roche, Vaquera, White, & Rivera, 2018). Less is known about in-country (i.e., internal) migration in Mexico, but available research suggests it is also problematic.

Mexicans who move from rural areas to larger, urban areas like Mexico City are labeled as "migrants" or "immigrants", which can stigmatize them, limit their access to resources, and lead to poor health and mental health outcomes (Soriano, 2017; Acharya & Barragán Codina, 2012). Understanding IPV and health, and doing so in a binational context, can help us better respond to the needs of migrant women.

Significance and Innovation

Intimate partner violence is a global public health concern and affects at least 30% of women worldwide (Kapoor, 2000; WHO, 2017). Globally, one in two women are killed by an intimate partner or a family member (WHO, 2013). Survivors of IPV are prone to poorer physical and mental health outcomes, negatively affecting their quality of life (Campbell, 2002). In the U.S. context, the Centers for Disease Control and Prevention (CDC) estimates that the lifetime economic cost of IPV in is approximately $3.6 trillion, which includes $2.1 trillion in medical costs, $1.3 trillion productivity loss, $73 billion in criminal justice costs, and $62 billion in costs like property loss or damage (2018). As such, our study addresses a problem of grave public health significance.

Latina women have higher rates of experiencing IPV and worse physical and mental health outcomes when compared to non-Latina White women (Lipsky & Caetano, 2007). However, less is known about the impact of IPV on Latina migrant women both in the U.S. and in Mexico. Latinos are the largest and one of the fastest growing minority groups in the U.S., and Mexican women make up the largest female subgroup (59%) in the U.S., when compared to other Latina women subgroups (Ramos, Jurkowski, Gonzalez, & Lawrence, 2010). As such, it is critical to understand the relationship between IPV and health of Latina women, both in-country and transnational.

This study is innovative because it examines these relationships in both the U.S. and Mexico, and because it uses both quantitative and qualitative approaches. The experience of migration can lead to harmful health consequences for vulnerable migrant groups (Infante, Idrovo, Sanchez-Dominguez, Vinhas, & Gonzalez-Vazquez, 2012). Conducting binational research will provide a better understanding of how intimate partner violence may affect the health outcomes of Mexican internal migrant women in Mexico and Latina women in Southeast Texas. Because often migratory flows are bidirectional, understanding IPV using a transnational lens is important to prevention efforts on both sides of the border. A binational lens can best inform practice, policy, and research to improve quality of life for these women.

Overview of Dissertation

This three-manuscript dissertation proposes the use of quantitative and qualitative methodologies to explore the relationship between IPV and health among migrant Mexican women, both in the U.S. and Mexican contexts. Binational studies are critical to attain a better understanding of migrant health and their health outcomes (Handley & Sudhinaraset, 2017), but these studies are often difficult to conduct because this research is expensive and because researchers often have challenges with participant recruitment, data collection, and adapting survey instruments to fit the cultural context (Rubinstein-Ávila, 2009). Therefore, there is a dearth of binational data that can provide insight about IPV and its relationship to help with migrant and transnational women.

The Principal Investigator (PI) recruited a sample of Mexican women who migrated from rural areas of Mexico to the capital, Mexico City, to explore their health status and factors that contribute to IPV (Paper 1). For the quantitative component of the study, a survey instrument was adapted and contextualized for Mexico, drawn from a longitudinal study being conducted in

Southeast Texas, *Dating it Safe* (Wave 8) (Temple, Paul, van den Berg, Le, McElhany, & Temple, 2012). Next, we conducted a secondary data analysis, from the sample of Latina women in Southeast Texas, both foreign born and U.S. born, who participated in *Dating it Safe* Wave 8 (paper 2), with a focus on the relationship between IPV and health. Finally, the third paper using qualitative methodology (one-on-one, semi-structured interviews) to better understand Mexican migrant women's perspectives on migration, IPV, and health (paper 3). In the qualitative data, we explore the cultural, social, and political environments that women live in and their insights.

Research Aims

The overall dissertation study seeks to identify factors associated with health (i.e., general physical health) and mental health (i.e., anxiety and depression) outcomes in Mexican migrant women in Mexico and Latina women in Southeast Texas, who may have been exposed to intimate partner violence (IPV). We will pursue three specific aims:

1. *To examine the relationship between IPV and health (i.e., general physical health) and mental health (i.e., anxiety and depression) among Mexican migrant women in Mexico City.*
2. *To examine the relationship between IPV and health (i.e., general physical health) and mental health (i.e., anxiety and depression) among Latina women in Southeast Texas.*
3. *To identify the cultural, social, and political perspectives of Mexican migrant women on migration, IPV, and health.*

Literature Review

The following literature review discusses relevant factors associated with IPV among Mexican migrant women in Mexico and the U.S. The chapter begins with a discussion of culture and cultural values of the Mexican population, before moving on to discussing the state of knowledge on migration from rural to urban Mexico and from Mexico to the United States. The chapter then delves into a discussion of IPV, risk factors for IPV, and health among Mexican migrant women in Mexico and the U.S.

Culture and Cultural Values

Mexico has a population of approximately 125 million people, making it the eleventh most populous country in the world (Central Intelligence Agency (CIA), 2018; Instituto Nacional de Estadísticas y Geografia, 2015). It is a multicultural society with a rich culture dating back hundreds of years. Pre-Hispanic and Spanish influences are still present today in every aspect of life, from the primacy of the family to the social acceptance of gender roles. Mexico also has the 11th largest economy in the world, yet it continues to have high rates of underemployment and inequitable income distribution (Central Intelligence Agency, 2018).

To attain a better understanding of Intimate Partner Violence (IPV) in a Mexican context, it is important to begin with an exploration of cultural values[1]. Often, these shared beliefs influence the context in which Mexican individuals interact and relate to one another (Schwartz, 1994; Yu, Lucero-Liu, Gamble, Taylor, Christensen, & Modry-Mandell, 2008). Traditional Mexican values such as *familismo, respeto, fatalismo,* and rigid gender roles referred to as *machismo* and *marianismo* have been studied at length and haven been found to serve as both

[1] The author notes that these cultural values are not unique to Mexicans or Latinos and may be shared by many cultures that identify as traditional (e.g., filial piety among Asian cultures). Moreover, not all Mexican individuals subscribe to these cultural values, and those who do subscribe to them may do so to different degrees. For this study, those Mexican values that have been traditionally part of the culture, will be discussed.

protective factors and risk factors for IPV (Paat, Hope, Mangadu, Núñez-Mchiri, & Chavez-Baray, 2017; Adames & Campbell, 2005; Roditti, Schultz, Gillette, & de la Rosa, 2010). A full exploration of these cultural values and their role in Mexican life is beyond the scope of this dissertation. However, those cultural values that appear to be the most relevant to IPV are briefly described below.

Familismo. A core cultural value in Mexican culture is *familismo*, which can be defined as "a multidimensional construct encompassing several dimensions, including support among family members, strong ties between family members, behavior and attitude perceptions of the family, and family honor and obligation toward the family" (Marrs Fuchsel, 2013, p. 380; Guilamo-Ramos, Bouris, Jaccard, Lesesne, & Ballan, 2009). Extended family members can be a source of support for families, especially in times of hardship (Umaña-Taylor, Updegraff, & Gonzales-Backen, 2011). Family members often play a crucial role in the decision-making process when it comes to raising children, making medical decisions, and even in the selection of romantic partners (Calzada, Fernandez, & Cortes, 2010; Muñoz-Laboy, 2008). Although this value can serve as a strength in Mexican culture, it may also negatively influence a woman's decision to disclose an abusive relationship to family members. For example, in a study conducted with migrant Mexican women, Marrs Fuchsel (2013) found that although survivors of IPV had a desire to disclose their abuse to immediate family members, they were less likely to do so due to feeling ashamed, or for fear of their families' negative reactions. The pressure to maintain the family unit intact can often override a woman's decision to disclose or leave an abusive relationship, making it more difficult for her to leave (Alcalde, 2010; Hirsch, 2003).

Respeto. Another important value in Mexican culture is *respeto.* This value sets the framework from which parents teach their children, from an early age, to obey authority, behave

in a socially acceptable way, and respect family wishes (Calzada, Fernandez, & Cortes, 2010). It is not uncommon for immediate and extended family to reside in the same household. This may include aunts, uncles, and grandparents, with each adult having the responsibility to model *respeto* for children. Although this value is intended to positively influence one's comportment toward authority figures, it may impose challenges on women experiencing IPV. For example, for these women, *respeto* may mean not questioning a male's actions, whether the male is her father or her husband, because men are viewed as having power and authority over the household (Calzada, Fernandez, & Cortes; Diaz-Guerrero, 1995). They may have been taught as young girls to show respect for authority figures, and in most cases titles of authority are held by the males in society. Furthermore, women may hesitate to disclose their abuse to family or report it to the authorities, to avoid jeopardizing their partners. This deference toward authority figures can be detrimental, especially in cases where the distinction between *respeto* and safety (or the lack thereof) is not evident for Mexican women who subscribe to traditional values.

Fatalismo. A cultural belief that may create challenges to help seeking among Latinos is fatalism (*fatalismo*), or the belief that a person's fate is inevitable (Hatcher & Whittemore, 2007). Latinos are less likely to utilize mental health services, when compared to other ethnic groups and non-Latino Whites, and often cited for low service utilization is the sense that one's fate is not within her/his control, but determined by a higher power or by destiny, that is, *fatalismo* (González et al., 2010; Alegría et al., 2008). In addition to the lack of knowledge about services or adequate resources (e.g., health insurance, transportation, availability of culturally and linguistically competent services, etc.), Latinos who adhere to *fatalismo* may remain mired in hopelessness and not get the help they need (de Los Monteros & Gallo, 2013). Although *fatalismo* is typically associated with lack of mental health utilization among the Latino

population, it can also be extrapolated as a factor in seeking services in general, including IPV service use by Latinas. There is some empirical literature to suggest that fatalism may be associated with women in IPV situations not seeking help. For example, in a qualitative study conducted with Latinas who had experienced some form of violence and who also disclosed being HIV-positive (N=32), the researchers found that for these women, negotiating safer sex did not seem like an option, making them feel like they had no control over their bodies and were destined to accept any consequences (Moreno, 2007).

Gender roles. As previously stated, the primacy of the family unity is an extremely important value in Mexican culture, and within the family, males and females play different, prescribed, and sometimes rigid roles. Traditionally, Mexican women have played a significant role in maintaining the family structure (DiGirolamo & Salgado de Snyder, 2008). They are typically seen as the nurturing caretakers of children, while men are viewed as the primary breadwinners in their families (Perilla, 1999). However, this social acceptance of rigid gender roles can place limitations on women's human, economic, and social development (Hietanen & Pick, 2015). Furthermore, it is critical to examine the impact that rigid gender roles may have on IPV. In Mexican society, gender roles are associated with the terms *machismo* and *marianismo*. These traditionally held norms can often perpetuate IPV, especially in a conventionally patriarchal society like Mexico's. Although certain states in Mexico are adopting more progressive views that recognize the detrimental effects of these rigid gender norms, these norms continue to be widely accepted within Mexican culture.

Machismo is a traditionally widespread cultural norm that portrays Mexican men as protectors of their families and as having control over their intimate relationships (Cianelli, Villegas, Lawson, Ferrer, Kaelber, Peragallo, & Yaya, 2013; Cianelli, Ferrer, & McElmurry,

2008; Marin, 2003). This norm has both positive aspects, such as male courage and responsibility, as well as negative aspects, such as domineering and aggressive behavior (Torres, Solberg, & Carlstrom, 2002). Arciniega and colleagues (2008) provide insight into this traditional Mexican male behavior by conceptualizing it in two parts, traditional *machismo*, which they describe as "aggressive, sexist, chauvinistic, and hypermasculine"—today we would refer to this as "toxic masculinity" (Connell, 2002)—and *caballerismo* (that is, chivalry or gentlemanliness), which they describe as "nurturing, family centered, and chivalrous" (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008, p.29). Although we will focus specifically on Mexico for this specific study, it is important to recognize that toxic masculinity can also be a driving force between IPV, sexism, and culture in other countries that may also subscribe to patriarchal norms. For this study, we will be specifically focusing on the Mexico context. Research has found an association between traditional *machismo* and antisocial and aggressive behavior, whereas *caballerismo* was positively associated with strong ethnic identity and good problem-solving skills (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008). Negative aspects of *machismo* are often associated antagonistic male traits that influence men's actions toward women, leading to a higher risk of intimate partner violence (Bekteshi & van Hook, 2015; Suarez- Orozco & Paez, 2002; Torres, Driscoll, & Voell, 2012).

Traditionally, *Marianismo* (derived from the name *Maria* or Mary, the mother of the biblical Jesus), depicts Mexican women as submissive, nurturing, and self-sacrificing (Da Silva, Verdejo, Dillon, Ertl, & De La Rosa, 2018; Castillo, Perez, Castillo, & Ghosheh, 2010). Like *machismo, marianismo* has both positive aspects, which portray women as being strong and having interpersonal harmony, and negative aspects, such as subordination and submission (Da Silva, Verdejo, Dillon, Ertl, & De La Rosa, 2018). Although not a topic widely researched, it is

possible that women who adhere to the negative aspects of *marianismo* may be more likely to experience, and less likely to disclose, IPV.

As stated earlier, these cultural values are not unique to Mexicans or Latinos and are shared by other traditional cultures. Also, not all Mexican individuals will subscribe to these cultural values, and those who do may do so to different degrees. As such, it would be a mistake to state that these values "cause" or even contribute to IPV (Sokoloff & Dupont, 2005; Frías, 2012). Like most human phenomenon, IPV can have multiple determinants. However, the fact is that these values do exist in Mexican society, to varying degrees, and their role in family dynamics and multiple outcomes has been the subject of study for decades. As such, it is important that we consider their role in IPV.

Internal and Transnational Migration and IPV

Migration has significant implications on migrant women's reproductive health, mental health, and overall well-being (Salgado de Snyder, González Vázquez, Bojorquez Chapela, & Infante Xibile, 2007). The following section provides and overview of Mexican women's internal and transnational migration, as well as its relation to health and IPV.

Internal Migration: From Rural to Urban Mexico

Mexico's internal migration has consistently been a driving force for economic growth (Perez-Campuzano, Ramirez, & Perez, 2018). Although individuals may migrate for various reasons (e.g., to reunite with family members, political reasons, seeking safety, etc.), the primary motive continues to be economic opportunity (Quintana & Salgado, 2016). Thriving markets with higher per capita GDP (Gross Domestic Product), such as those in medium-sized cities to metropolitan areas, appeal to Mexican individuals living in regions with lower per capita GDP because of the ability to be paid higher salaries (Cazzuffi & Modrego, 2017; Quintana &

Salgado, 2016). For example, the economic crises faced by poorer, rural states such as Puebla, Morelos, Tlaxcala, Veracruz, Chiapas, Oaxaca, and Tabasco (Pérez Oseguera, Coppe Gorozpe, Pérez Petrone, & Trujillo Viruega, 2008; Acharya & Barragán Codina, 2012), is one of the major factors impacting large internal migration of men and women from rural areas to Mexico City and other large cities, especially in the industrial north of the country (e.g., Monterrey). Indeed, Mexican women tend to migrate internally at higher rates, when compared to males, who typically migrate to the U.S. in larger numbers (Espinoza Damian, 2011).

The literature on Mexico's internal migration tends to focus on the economic drivers and economic impact, and less is known about health, mental health and IPV in communities that have migrated internally. To better understand and compare the dynamics of migration, especially as they relate to IPV and health, it is also important to discuss migration from Mexico to the U.S.

Transnational Migration: From Mexico to the U.S.

Women who migrate from Mexico to the U.S. may also do so in search of a better life, either alone or to reunite with a partner or spouse (Flippen & Parrado, 2015). Most of these migrant women come from poorer rural areas in Mexico, have low levels of educational attainment, and may have been exposed to both community and intimate partner violence in their communities (King, 2011). Employment in the rural areas in which they reside is often scarce, compelling these women to migrate to the U.S. for economic opportunities (King, 2011). To find sustainable solutions that address the poverty they experience in Mexico, Mexican women may find more promising employment opportunities in the U.S. For example, "pull factors" or factors that influence a Mexican woman's decision to migrate to the U.S. may include higher availability

of employment opportunities, higher wages, and more progressive views of gender norms (King, 2011).

According to the Campos & Cantor (2017), approximately 11.8 million migrant women make up 7.3% of the labor force in the U.S., with more than half being from Mexico. With the desire to provide for their families, many often take low-wage job opportunities that provide little or no benefits, such as domestic work or service area jobs (e.g., restaurant cooks, housekeepers, caregivers, etc.).

Both internal and transnational migration can result in the loss of a woman's support system, and exposure to stressors, such as residing in poorer communities with less safety, social isolation, and disconnection from community services for their health and social needs. These may in turn increase their risks for IPV and further health complications. The relationship between migration, IPV, and health, however, needs to be further examined and disentangled.

Migration and IPV

Some literature suggests that women who migrate to the U.S. may gain a greater sense of autonomy, which for some, may serve as a motivating factor to leave an abusive partner (Parrado & Flippen, 2005; Pessar & Mahler, 2003). For example, women may find more independence due to possible employment opportunities, making them less likely to remain dependent on their partners (Pessar & Mahler, 2003). In the case of IPV, survivors may become more aware of their rights and put an end to their abuse (Parrado & Flippin, 2005; Hirsch, 1999; Kibria, 1993). However, for survivors who are not able to leave their abusive relationships, a newly found sense of economic autonomy may place them at an increased risk of experiencing IPV if the partner reacts negatively to her growing sense of independence. Being in an unfamiliar environment may also make it difficult for migrant women to report their abuse to authorities. In some cases, if

they are undocumented, perpetrators may threaten to have them deported if they disclose their abuse to anyone. Understanding these risks is important to informing evidence-based approaches to help protect migrant women from IPV.

IPV in Mexico

Between 2007 and 2012, Mexico experienced significant country-wide turmoil due to the government's drug war against organized crime and drug cartels. The war on drugs resulted in a large increase in violence and deaths and impacted Mexican society as a whole. Women became especially vulnerable, with increased rates of female homicides during this time (Pan, Widner, & Enomoto, 2012). Although existing Mexican laws have been established to protect women's rights, social and cultural norms will often supersede a woman's decision to seek legal help and assert her rights (Bovarnick, 2007). Unchecked and unaddressed, IPV can lead to an ever-increasing cycle of violence that can culminate in the death of a woman.

In Mexico, approximately 66.1% of women report experiencing at least one lifetime incident of violence, 43.9% report experiencing violence by a current or past partner, and 34.3% report experiencing sexual violence in a public setting (INEGI, 2017). In 2016, Mexico experienced the highest homicide rate in its modern history: approximately 4.5 per 100,000 women died due to the country's serious femicide issue (Lettieri, 2017). Females are often murdered by their intimate partner through means such as hanging, strangulation, and drowning, to name a few (ONU Mujeres, 2011). While there are changing norms and informational campaigns, poor migrant women from rural areas who have moved to large cities often work long hours, live in isolation, have limited literacy, and may ultimately not benefit from progressive changes aimed to combat IPV. Our study will shed some light on these questions.

IPV in the U.S.

In 2017 the CDC published findings from the Center for Disease Control and Prevention's National Intimate Partner and Sexual Violence Survey (NISVS), which took place in the U.S. from 2010 to 2012. Approximately 27% of women reported experiencing sexual violence, physical violence, and/or stalking by a partner (Smith, Chen, Basile, Gilbert, Merrick, Patel, Walling, & Jain, 2017). Migrant women living in the U.S. are at even higher risk of experiencing intimate partner violence (Alvarez & Fedock, 2016). In a study conducted by Cho and colleagues on the prevalence and risk of IPV among three Latino subgroups, the researchers found that Mexican migrant women reported the highest rates of IPV, when compared to Cuban migrants and Puerto Ricans residing on the island (OR = 0.191 and 0.107) (Cho, Velez-Ortiz, & Parra Cardona, 2014). Migrating to the U.S. may mean losing a large portion of the social support they may have had in their country of origin, making it harder to navigate an unfamiliar country (Ghosh, 2009; Adams & Campbell, 2012). Being new to this country may limit their economic access and resources (Ghosh, 2009). Some will have to depend on their abusive partner financially, giving their perpetrator further control over their relationship (Cho, Velez-Ortiz, & Parra-Cardona, 2014). Due to their limited financial resources, they may find themselves residing in communities with high crime rates, increasing their risks of experiencing IPV (Cunradi, 2009). Due to these factors, Latina women remain in abusive marriages longer and return to abusive relationships more frequently, when compared to non-Latina White women (Brabeck & Guzmán, 2008; Bonilla-Santiago, 1996; Gondolf, Fisher, & McFerron, 1988; Torres, 1991).

Social structural influences, historical influences, and systematic oppression must all be considered to better understand family violence among diverse families (Malley-Morrison &

Hines, 2007; West, 2005). Research studies consistently affirm the association between poverty and intimate partner violence (Aizer, 2011; Jewkes, 2002). Although women from all economic backgrounds experience IPV, minority women living in impoverished conditions are disproportionately affected (Tjaden & Thonnes, 1998). Connecting survivors to resources that promote a health quality of life is critical to helping prevent and end the cycle of IPV.

Accepted social constructs (e.g., rigid gender norms) often normalize abusive behaviors toward women, making them more prevalent to IPV exposure (Sandoval-Jurado, Jimenez-Baez, Alcocer, Hernandez, & Espadas, 2017). IPV may be considered a private family issue and one in which Mexican society, even in the diaspora, does not deem as appropriate to intervene (Casciano & Massey, 2012). The following section will further discuss some risk factors associated with IPV experienced by Mexican migrant women. While these risk factors are often complex and interrelated, they will be discussed separately to add some clarity.

Risk Factors for IPV among Mexican Migrant Women in the U.S. and Mexico

Poverty and IPV. There are 57.5 million Latinos in the U.S. (17.8% of the U.S. population), making Latinos the largest minority group in the U.S. (U.S. Census, 2017). Latinos are also one of the fastest-growing groups in the U.S. Approximately 60.6% Latino individuals reside in the U.S., making up 18% of the total U.S. population (Pew Research Center, 2020). With this rapid growth, significant barriers continue to impact their overall well-being. As of 2017, the poverty rate for this population was approximately 15.7% (United States Census Bureau, 2020). Barriers that limit this population's quality of life include inadequate housing conditions, poor health due to lack of proper medical insurance, inability to communicate in English, and discrimination, among others (Zong & Batalova, 2016). Similarly, people living in Mexico also experience high rates of poverty. In 2016, approximately 43.6% (53.4 million) of

the Mexican population lived in poverty (Weisbrot, Merling, Watts, & Johnston, 2018). Mexican individuals who internally migrate to larger metropolitan areas are often labeled as migrants and face similar discriminatory experiences as those who migrate to the U.S. (Acharya & Barragán Codina, 2012).

There is also a well-established a link between socioeconomic status and intimate partner violence (Cunradi, Caetano, & Schafer, 2002). Although not always the case, women who are low-income may be more prone to experiencing IPV. These women often find themselves depending financially on their partners, making it difficult for them to leave their abusive relationships (Kalmuss & Straus, 1982). The desire to contribute financially to their families may encourage these women to seek employment. However, job attainment is not easy for survivors of IPV, and at times may even be hazardous to their well-being. For example, perpetrators may prohibit survivors from seeking employment, thus limiting them from self-sufficiency (Tolman & Rosen, 2001) and keeping them in poverty. Additionally, for survivors who are employed, maintaining their jobs may be difficult due to health or mental health conditions caused by their abusive experiences (Tolman & Rosen, 2001). Others may experience intimidation from their abusive partners, which may make it harder for them to maintain employment.

For Latinos, a lower annual household income is considered a strong predictor of male to female partner violence (Cunradi, Caetano, & Schaefer, 2002). This relationship also appears to hold in Mexico. In a study conducted to investigate associations between IPV and work disruptions among Mexican women in Mexico City (n=572), researchers found that among low-income women, 1 in 4 women reported employment interruptions due to their abusive relationship (Gupta et al., 2018). These disruptions often included missing work or losing their employment, further perpetuating the cycle of poverty.

Like migrant Mexican women living in the U.S., Mexican women residing in Mexico also face significant risk factors for IPV. Avila-Burgos and colleagues (2009) analyzed data from the National Survey of Violence Against Women, a study conducted in Mexico between November 2002-November 2003, to identify severity of intimate partner abuse among Mexican women (N=18,902). They found that women who were employed outside the home, had two or more children, and had a history of abuse, experienced higher rates of IPV. If their partners consumed alcohol daily, their risk of experiencing IPV significantly increased. If left unaddressed, these risk factors can exacerbate IPV.

Health and IPV. Poverty and inequality are among the major contributors to poor health conditions, and Mexican migrant women who are survivors of IPV are disproportionately impacted. There is well-established research on the association between intimate partner violence and negative health outcomes in women who experience abuse (Wong & Mellor, 2014; Ellsberg, Janse, Heise, Watts, & Garcia-Moreno, 2008). Adverse health outcomes may include reproductive health diseases, such as cervical and breast cancer, HIV, mental health disorders, and drug addiction, among others (Salgado de Snyder, González Vázquez, Bojorquez Chapela, & Infante Xibile, 2007). IPV survivors also commonly suffer from physical injuries such as concussions, lacerations, and fractures (Grisso, Schwarz, Hirschinger, Sammel, Brensinger, Santanna, & Teeple, 1999). Repeated exposure to physical injuries can lead to serious long-term health consequences, negatively affecting survivors' overall quality of life (Campbell, 2002; Tollestrup, Sklar, Frost, Olson, Weybright, Sandvig, & Larson, 1999). In a retrospective chart review of patients who had experienced head trauma as a result of intimate partner violence (N=115), 88% reported experiencing multiple injuries and 81% reported loss of consciousness (Zieman, Birdwell, & Cardenas, 2017). As a result, survivors of IPV are frequently hospitalized

because of such injuries (Wisner, Gilmer, Saltzman, & Zink, 1999). Along with chronic physical effects, survivors also suffer mentally and emotionally. Exposure to IPV can lead to mental conditions such as depression, anxiety, and PTSD (Pico-Alfonso, Garcia-Linares, Celda-Navarro, Blasco-Ros, Echeburua, & Martinez, 2006).

Latina women are more likely to experience worsened health outcomes when compared to non-Latina White women, especially as they acculturate into U.S. society (Lipsky & Caetano, 2007). This may be due to such factors such as immigration status, social isolation, economic instability, lack of resources, and other risk factors that make them more vulnerable to abuse (Campbell, & Lewandowski, 1997). In a study conducted by Lown and Vega (2001) on the relationship between health and IPV, Mexican American women (N=1,555) who had experienced physical and/or sexual IPV by a male partner within the past year reported poorer mental and physical health outcomes when compared to non-abused women. Conditions included heart attacks, high blood pressure, diabetes, and somatic symptoms (e.g., gastrointestinal problems) (Lown & Vega, 2001). Equitable access to needed physical health and mental health resources is often not possible, due again to such factors such as lack of medical insurance, inability to navigate resources, and lack of English proficiency (U.S. Department of Health and Human Services, 2001; Rastogi, Massey-Hastings, & Wieling, 2012). The conditions that are placing these women at increased risk for health and mental health conditions are also preventing them from seeking much needed resources and services.

Women who identify as undocumented may find it even more challenging to access help because of mistrust of authorities and/or for fear of disclosing their status (Furman, Negi, Iwamoto, Rowan, Shukraft, & Gragg, 2010). For women who do seek help, interventions may not be culturally tailored to effectively meet their needs. For example, Alvarez and colleagues

conducted a systematic review to identify elements of effective practice interventions for the prevention of IPV among Latina women. They found that out of the 1,274 articles screened, only 4 met their search criteria (Alvarez, Davidson, Fleming, & Glass, 2016). Coupled with a shortage of culturally competent service providers (Schwarzbaum, 2004), Latina migrant women often do not get the help they need.

Conceptual Framework: Feminist, Intersectionality, and Ecological Theories

In this section the researcher will discuss feminist, intersectionality, and ecological theoretical frameworks to conceptualize the various factors that influence migration, health, and IPV among Mexican migrant women.

Feminist Theory. Feminist theory provides a lens from which we can better understand how human behavior impacts women within their social environments (Lay & Daley, 2007). According to Lay & Daley, "a feminist lens asks us to see individuals, groups, families, and organizations, in their social, political, economic, ethnic, and cultural contexts. The intersection of these contexts produces the potential for oppression that is rooted in gendered relationships" p.50, 2007). The way in which researchers define feminist theory varies and is often influenced by the context in which it is used. Although there may be different descriptions of the theory, there are common elements across all. These common elements include a focus on critiquing the subordination of women, examining the intersecting roles of all forms of oppression (e.g., sexism, racism, and class), and envisioning resistance efforts against oppression, with power being at the center (Stanford Encyclopedia of Philosophy, 2018).

Early feminism theorized that a patriarchal society is ***the*** cause for violence against women (Tracy, 2007). Although all men within a patriarchal society are exposed to the same cultural messages, it is important to keep in mind that not all men will abuse women (Heise,

1998). This theoretical perspective—that is, that patriarchal structures ***cause*** violence against women—is still accepted today in many contexts. According to Adames & Campbell (2005), "cognitive and behavioral processes of men and women are learned socially in a patriarchal environment characterized by power inequalities that in turn serve as a basis for the continuation of IPV" (p. 1,342). More contemporary waves of feminism take a more nuanced approach and see patriarchy as one of many intersecting factors that contribute to violence against women. This contemporary wave of feminism will be the lens used for the three papers in the current proposal.

Intersectionality Theory. Researcher Kimberlé Crenshaw originally coined the term intersectionality (1989). Initially, Crenshaw developed this framework, rooted in Black feminism, to describe the intersecting roles of race and gender, and how they shape Black women's employment experiences. Furthermore, she emphasized the importance of expanding beyond feminist theory and including, for example, the intersection of identity politics, such as race, class, and gender, to better understand violence against women of color (Crenshaw, 1991). Contemporary feminist theorist Anna Carastathis states that intersectionality is an essential aspect of feminist theory (2014). Moreover, she presents four benefits to using intersectionality as a research framework, including simultaneity, complexity, irreducibility, and inclusivity, to describe contemporary feminism; therefore, providing a deeper understanding of a phenomenon, as experienced by individuals who are oppressed in society, by including the intersecting roles of social structures (Carastathis, 2014). While intersectionality can be a theoretical framework, a praxis, or an analytic strategy/tool (Bowleg, 2012; Dill & Zambrana, 2009), in the current dissertation it will be treated as a component of feminist theory.

Both feminist and intersectionality theories could also be used when describing the experiences of migrant women who are exposed to IPV. Although women from all backgrounds experience IPV at alarming rates, migrant women face unique challenges that need to be unpacked to better analyze their experiences (Sokoloff, 2008). Given the many layers of complexity and identity involved—that is, not just migrant status, but gender, ethnicity, social class, etc.—Sokoloff (2008) posits that the battery of migrant women is best examined through the lens of intersectionality and should be a social problem, not just an individual one. Migrant women must decide between separation and safety, and risk misunderstanding cultural cues when interacting with the criminal justice system and service providers. Sokoloff and Dupont state that "sexual and other violence against women in native communities and communities of color must be understood in the context of white supremacy, patriarchy, colonialism, and economic exploitation of marginalized communities, not as if such violence is inherent in the culture" (2005, p. 47). Structural factors embedded within a society must be taken into consideration to fully conceptualize experiences of IPV among migrant women.

Ecological Theoretical Framework. The Ecological Systems Theory was originally used to explain how systems within a child's environment influence her/his development (Bronfenbrenner, 1977, 1979, & 1994). These various systems include the macrosystem, exosystem, mesosystem, & microsystem within an individual's environment. Ecological systems theory has also been widely used to explain various systemic factors that contribute to IPV (Ali & Naylor, 2013; Bronfenbrenner, 1977, 1979, & 1994). The World Health Organization has used the Ecological Theoretical Framework to look at potential IPV contributing factors at the individual, relationships, community, and societal levels (Ali & Naylor, 2013; WHO, 2010). The individual level looks at how biological and personal history may predispose a person to IPV; the

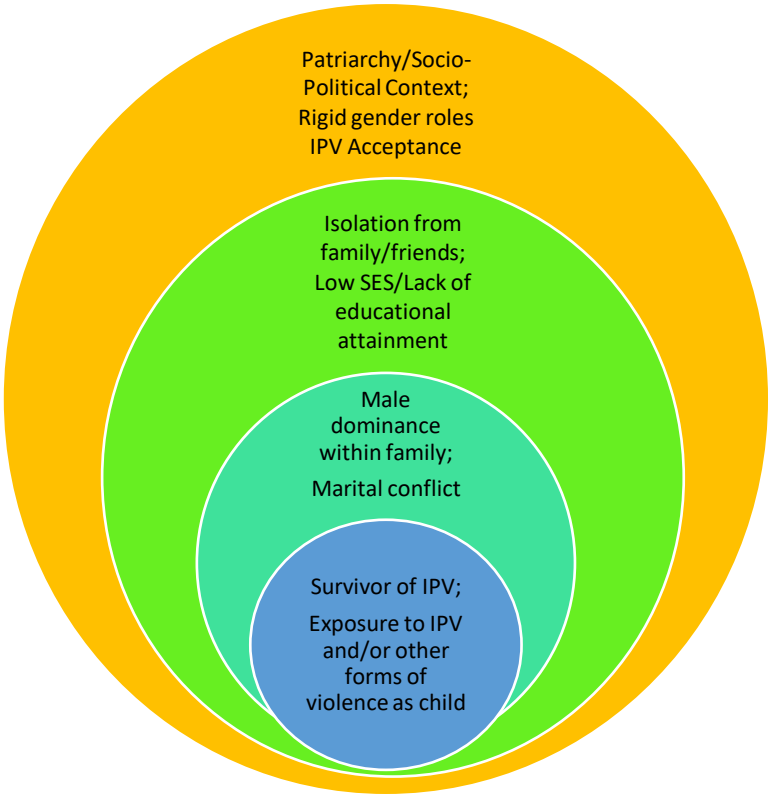
relationships level looks at how individuals' close networks may place them at risk for abuse; the community level explores how the settings in which people find themselves (e.g., neighborhood, workplace, etc.) may contribute to their experiences with IPV; and the fourth level looks at how societal factors (e.g., social and cultural norms, policies, etc.) may perpetuate the cycle of violence (WHO, 2010). **Figure 1** provides an overview of how we conceptualized IPV and potential contributing factors, among Mexican migrant women.

As informed by these theories, there are numerous systems that may contribute to the experiences of IPV of migrant women. The International Organization for Migration further conceptualizes how migration influences social determinants of health of migrants. Factors that may contribute to the physical health, mental health, and overall well-being of migrants include individual factors, lifestyle factors, living conditions, working conditions, social and community factors, and governance and socioeconomic conditions (IOM, 2019). These factors are often accompanied by legal, social, cultural, and economic barriers that predispose migrants to adverse health outcomes (IOM, 2019; WHO, 2010). For migrant women who experience IPV, there may be an increased risk for experiencing worse physical and mental health outcomes (Stockman, Hayashi, & Campbell, 2015).

For this binational dissertation, the researcher will use aspects from these three theoretical frameworks (feminist, intersectional, and ecological) and from the International Organization for Migration's social determinants of health of migrants conceptualization to examine the relationship between, migration, IPV, and health among Mexican migrant women in Mexico and Latina women, some of them migrants, in Southeast Texas. Through a feminist lens, the researcher will look at the existing patriarchal dynamics within both U.S. and Mexican societies and how these shape daily actions toward women. Moreover, the researcher will use an

intersectionality lens by examining the intersecting roles of gender, immigration status, class, sexism, racism, and how these may place women at higher risk for IPV and inhibit them from breaking the cycle of violence. By using an ecological theoretical framework, the researcher will be able to discuss how these various factors fit within a macro, mezzo, and micro context, and how each may contribute toward intimate partner violence against women. Lastly, the researcher discusses migration and social determinants of health of migration, as informed by the International Organization for Migration, to provide an overview of how migration may affect the health of migrant Mexican women, both in the U.S. and Mexico.

Figure 1. Ecological View of IPV among Mexican Migrant Women



Ethical Considerations for Overall Dissertation

It is important to keep in mind that intimate partner violence is a sensitive topic. All possible measures were taken for the protection of the migrant Mexican women, an especially vulnerable group, that were approached to participate in the studies within this dissertation; as well as for the protection of the research team. A helpful resource that helped guide the PI's approach to this study is *A Practical Guide for Researchers and Activists* (Ellsberg & Heise, 2005). Examples of ethical and safety recommendations stated in this guide are that, "The safety of respondents and the research team is paramount and should infuse all project decisions" and that "Protecting confidentiality is essential to ensure both women's safety and data quality" (Ellsberg & Heise, 2005, p.36; WHO, 1999). If participants disclosed IPV, the PI and other trained research assistants took the time to listen to and validate their concerns. During this time, the researchers also offered the number for the domestic violence hotline, as well as a list of relevant local resources created with the help of IPV experts in Mexico City, Mexico. The PI's in-country research supervisor at the Escuela Nacional de Trabajo Social of Universidad Nacional Autónoma de México (National School of Social Work, National Autonomous University of Mexico) in Mexico City helped in providing guidance throughout the research process.

Potential Implications

IPV significantly impacts survivors and their families. Migrant women, especially those who are undocumented, have limited access to IPV prevention and to healthcare. Lack of legal documentation, medical insurance, transportation, culturally tailored healthcare services, and limited bilingual providers (Hacker, Anies, Folb, & Zallman, 2015) all add to the challenges. Given the current political context in the U.S., victims of crimes may also be less likely to report

abuse to authorities due to fear of deportation (Roche, Vaquera, White, & Rivera, 2018), making it more challenging for them to receive needed help. Women in Mexico also face similar barriers to equitable health care access and resources to help them break the cycle of violence. It is crucial to attain a better understanding of the impact of IPV on health and mental health of Mexican women, both in the U.S. and Mexico, in order to best inform policies that are tailored to meet their complex needs, and to develop and disseminate evidence-based prevention and treatment interventions.

Reflexivity Statement

Research states that bias, if not addressed appropriately, can attenuate the validity of scientific studies (Sica, 2006). Although a complete elimination of bias may not be possible, it is important that researchers take all conceivable measures to minimize bias in their research efforts. This statement outlines the researcher's reflections on possible sources of bias, and the steps that will be taken to minimize the impact of any bias on study results.

For this present study, the PI does have some knowledge of the topic area (Intimate Partner Violence), the population of study (Mexican migrant women), and the country where original data collection will be done (Mexico). This knowledge comes from personal and professional experiences that have informed her research area of interest. For example, she is a first-generation, Mexican migrant female, who was raised in a rural state of Mexico (Guerrero, MX), for part of her childhood. Due to the pervasiveness of IPV across all cultures, she saw firsthand the detrimental effects of IPV within her own extended family. At the age of eight, she and her immediate family immigrated to the U.S. to permanently reside in Texas; a state with a significantly large Latino population. She pursued and attained her undergraduate and graduate degrees, both in social work, from Baylor University. During her time as a social work

practitioner, she worked in several diverse settings that allowed her to work directly with Latino migrants. As a former case manager and community educator for the Family Abuse Center, a shelter for survivors of intimate partner violence (IPV), she saw the adverse effects of IPV (physical, mental, and spiritual) on survivors and their families. As a faculty member of the Diana R. Garland Baylor School of Social Work, she obtained a deeper understanding of the importance of evidence-based practice in working with survivors of IPV and other populations who have experienced trauma.

The PI believes that sharing these experiences is important because they can provide unique insight into her research area. For example, although the quantitative instruments were not specifically created for Mexican migrant women, the PI's background can be useful in modifying/adapting the instruments. However, the PI is critically aware that, to an extent, her experiences may lead to biases and assumptions. Even if she shares some similarities (e.g., female, Mexican migrant, etc.) with the population with which she conducted her study, she is mindful that everyone has her/his unique experiences. Finally, as a woman born into a traditional Mexican family with two parents and three siblings, a sister and two brothers, all born in Mexico, the researcher is also intimately aware of family dynamics in Mexican families, including the role of patriarchal structures, the presence of strict and rigid gender roles, and the role of religion in shaping family norms and family functioning.

At the same time, the researcher acknowledges that some aspects of her family of origin dynamics were less traditional. She grew up in a home in which both of her parents were committed to providing a safe and loving environment. Her mother was a strong woman who shared fully in decision making within the family, and her father was a secure man who respected his wife and shared fully in decision making, as well. These may not be the typical

dynamics found in most traditional Mexican families impacted by IPV, as such may color the way the researcher thinks about the women who were interviewed. Therefore, she took all possible measures to minimize potential biases and assumptions throughout the whole process of her study. Some examples of these measures included continuously consulting with her dissertation committee, developing ethical and research informed study designs, providing training to the research team, collecting data from a purposive sample, interpreting results using appropriate statistical tests, and addressing any other ethical concerns that may arise. She also checked with participants, during the interviews, regarding any possible assumptions and kept a journal for personal reflections after conducting the interviews.

In addition, the researcher had co-investigators in Mexico, including a Senior Faculty Member and Researcher in the Escuela Nacional de Trabajo Social (National School of Social Work; ENTS) of the Universidad Nacional Autonoma de Mexico (UNAM), and five Mexican students completing their bachelor's in social work at ENTS/UNAM. All six are Mexican women immersed in their local culture and context and knowledgeable of Mexican cultural values, gender dynamics, and other aspects of the area of study that might represent blind spots or potential sources of biases for the PI.

The PI took two trips to Mexico City to canvass potential recruitment areas, trained the interviewers, and conducted her data collection. Having the opportunity to research IPV in the Mexican context was informative as the PI prepared to conduct her study. However, being present in the Mexico context provided a wider view of the prevalence and significance of this public health concern. Each day, after her research activities, the PI took time to journal. Journaling her everyday interactions helped her reflect and attain a better understanding of the phenomenon of IPV. It also gave her the opportunity to address any emotions she may have been

feeling as a result of seeing news stories about women dying at the hands of an intimate partner. In Mexico, these stories seem ever-present in news stations, radio stations, newspapers, and other television shows. While stories like these were hard to listen to and see, there were also stories of empowerment, survival, and social movements toward progressive change. One example is when she had the opportunity to participate in "A Day Without Women", a national strike against the rising violence toward women in Mexico, which took place while the PI was in Mexico collecting data. On this day, the PI suspended research activities and avoided public areas in solidarity with the thousands of women that die in Mexico due to violence. No research activities took place on this day. The PI also had a chance to see the largest International Women's Day march that Mexico had ever witnessed, all in efforts to bring attention to the violence that women suffer daily. While in Mexico City, her Mexico based research mentor hosted the PI. Having the opportunity to debrief after each day of research activities, gave the PI the opportunity to reflect and learn more about the phenomenon of intimate partner violence in Mexico. This experience not only informed her dissertation, but also served as a driving force for her to continue learning about and researching this area. She is grateful for all her committee members, her Mexico based mentor, research team, and the many women that took the time to share their stories. Along with completing her dissertation as a degree requirement, she hopes that it also contributes to the change that these women call for so that they can live in a just society that is free of violence.

CHAPTER 2: ARTICLE ONE

Title: Intimate Partner Violence and Health: A Survey of Mexican Migrant Women in Mexico City

Target Journal: Violence: An International Journal

Violence: An International Journal: SAGE Journals (sagepub.com)

Proposed Authorship/Co-Authorship: Flor Avellaneda et al.

Introduction

Intimate partner violence (IPV) is a pervasive public health concern affecting women worldwide. In Mexico, women's lives are increasingly endangered as a result of experiencing violence perpetrated by an intimate partner in alarming numbers. Out of the 46.5 million Mexican women in Mexico, two-thirds (66.1%) have experienced at least one lifetime incident of violence, four in ten (43.9%) have experienced violence by a current or past partner, and one-third (34.3%) have experienced sexual violence in a public setting (INEGI, 2020). The situation may be even worse in rural areas of Mexico, given the remoteness of some communities, the greater economic disadvantages, and the pervasive patriarchal views that keep women at the margins of society. Therefore, migrating internally to metropolitan areas such as Mexico City may offer better economic opportunities and perhaps some protection from IPV. Mexican women may choose internal migration because it may be less costly and less treacherous than international migration; although for some, international migration may be the next step (Curran & Rivero-Fuentes, 2003).

Mexican women from low socioeconomic backgrounds are disproportionally affected by IPV due to several factors, including lack of access to healthcare, low educational attainment, lack of adequate housing, and food insecurity (Consejo Nacional de Evaluación de la Política de

Desarrollo Social, 2017). Internally migrating from a rural area to a metropolitan area may mean losing support networks, which can make it harder to receive needed help from family and other loved ones (Agoff, Herrera, & Castro, 2007). For some, living in a city may be a first-time experience, and navigating their way through one of the largest cities in the world, such as Mexico City, may pose challenges to accessing public transportation, finding job opportunities, and accessing needed services. These factors may worsen if a woman is also experiencing IPV.

Intimate partner violence places women at higher risk for experiencing adverse physical and mental health outcomes. There is well-established research on the association between intimate partner violence and negative health outcomes in women who experience abuse (Wong & Mellor, 2014; Ellsberg, Janse, Heise, Watts, & Garcia-Moreno, 2008). IPV survivors also commonly suffer from physical injuries such as concussions, lacerations, and fractures (Grisso et al., 1999). Repeated exposure to physical injuries can lead to serious long-term health consequences, negatively affecting survivors' overall quality of life (Campbell, 2002; Tollestrup, Sklar, Frost, Olson, Weybright, Sandvig, & Larson, 1999). As a result, survivors of IPV are frequently hospitalized because of such injuries (Wisner, Gilmer, Saltzman, & Zink, 1999). Along with chronic physical effects, women who experience abuse are also prone to long-term mental health outcomes that can negatively affect their quality of life (Kumar, Jeyaseelan, Suresh, & Ahuja, 2005). One of the most common mental health conditions resulting from IPV is depression (Rodriguez, Heilemann, Fielder, Ang, Nevarez, & Mangione, 2008). Women who experience IPV are twice as likely to suffer from depression when compared to women who do not experience IPV (Guček, & Selič, 2018). Moreover, the trauma they experience from physical and psychological abuse may result in higher rates of anxiety disorders (Chandan et al., 2019).

In this paper we describe the relationship between IPV and health (general physical health, anxiety, and depression) among Mexican migrant women in Mexico City, based on a quantitative survey of 200 women.

Methodology

Research Design

A cross-sectional survey design was used for this study. Primary data collection was conducted in Mexico City, Mexico, using a subset of measures from *Dating it Safe,* a longitudinal study on teen and young adult dating risk behaviors. Institutional Review Board approval was received from the University of Houston, with additional approval from the University of Texas Medical Branch-Galveston and the Escuela Nacional de Trabajo Social (National School of Social Work) of the Universidad Nacional Autónoma de México (National Autonomous University of Mexico) (ENTS-UNAM).

Participants

A nonprobability, purposive sampling approach was used to recruit Mexican migrant women (N=200) who had migrated to Mexico City from rural Mexico. The women recruited were between the ages of 18 and 50 and had migrated to Mexico City within the previous three years, to ensure that their migration experiences were still fresh given their recency. The study focused on adult women because they have the highest risk of experiencing IPV, when compared to other age groups (Catalano, 2012). This age group is also among those more likely to migrate (Benetsky, Burd, & Rapino, 2015).

Data collection and procedures

Paper and pencil surveys were administered to participants. The team did not use laptops or tablets for data collection due to security reasons. Participants were recruited and interviewed in public spaces and laptops/tablets would have called unnecessary attention to the interviewers

and the participants. All participants received a small toiletry bag as an incentive, with a cost equivalent to approximately US$5.00 (about MEX$93) at the time of data collection. Monetary incentives were considered (e.g., a gift card to a local department store) as is often the case in the U.S. However, the Mexico-based team indicated that monetary incentives are rarely used in Mexico due to safety concerns (i.e., interviewers carrying the incentives with them) and perception issues (e.g., concerns about bribes, especially during election periods).

Five female Bachelor of Social Work (BSW) students from the ENTS-UNAM were identified by a faculty member from ENTS-UNAM who served as the lead researcher's Mexico-based mentor. Given the critical importance of training interviewers, especially when their safety and psychological well-being or that of research participants could be at-risk (WHO, 2001), the lead researcher (PI) trained the students on all study protocols, research ethics principles, and safety guidelines when interviewing women who may have been exposed to IPV. Trainings were done virtually and in person during two trips the PI made to Mexico City. The five students always worked in pairs, recruiting and interviewing participants.

The recruitment plan was done in collaboration with the Mexico-based team, and included local markets, transportation hubs, a college campus (UNAM), public parks, faith-based agencies, and other public spaces (e.g., tourist sites). Participants were directly recruited using a brief screener that queried for our five inclusion criteria (i.e., female, Mexican national, age 18 to 50, migrated from a rural area to Mexico City within the past three years, and having experienced intimate partner violence). Initially, the lead researcher had intended to distribute flyers at IPV-serving agencies. In consultation with the Mexico-based team this idea was discarded for security reasons (e.g., to avoid the risk of an abusive partner finding a flyer in a participants' possession). The team had also planned to use a variant of responded-driven

sampling, but there were concerns that women would be unwilling to identify and refer other women experiencing IPV, so this was discarded as well.

Given the sensitive nature of the topic and the fact that participating in a study about IPV and sharing details about their IPV experiences can increase risks for women in IPV situations (Ellsberg & Heise, 2005), a *Waiver of Informed Consent*, with no signatures or identifiers was approved by the University of Houston Institutional Review Board (IRB) and used to consent to participation.

Prior to initiating recruitment, the research team completed an environmental canvass of the recruitment areas to identify potential meeting venues. Interviewers approached women who appeared to be in the target age group, introduced themselves as student researchers from ENTS-UNAM conducting a study on internal migration and health in women, and asked if they had migrated to Mexico City from another region in Mexico within the past three years. If they had, the interviewers then asked if they could administer a brief screener to see if the person was eligible to participate in the study. The screener included the criteria listed above (female, Mexican national, age 18 to 50, and migrated from a rural area to Mexico City within the past three years) and a question about having experienced IPV. If the woman met the inclusion criteria, the interviewer invited her to participate in the study on the spot. Information about the study was then read to participants, to account for literacy issues, detailing the purpose of the study, procedures, risks, benefits, alternatives, privacy, confidentiality, and the voluntary nature of the study. The interviewers answered any questions or concerns that they may have had and assured the women of confidentiality and anonymity prior to conducting the survey.

The survey was then read/administered to the participants by the interviewers, question by question, and their responses were written down, with any additional comments being noted

verbatim. All members of the research team were native Spanish speakers, and they used motivational interviewing skills such as clarifying questions, probing, and/or other methods that can facilitate the process for the participants (Bowling, 2005). Only women that spoke Spanish were recruited for the study. Due to the unavailability of translators, women that spoke primarily an indigenous language were not recruited.

Measures

The PI and her mentoring team, both in the U.S. and Mexico, ensured that *Dating it Safe* measures, described briefly below, were translated/back-translated (Brislin, Lonner, & Thorndike, 1973), equivalent in meaning, and contextualized for Mexico.

Demographics. The demographics section of *Dating it Safe* Wave 8 includes questions about education, income, and marital status. These were used in Mexico, but the response categories were modified to the Mexican context (for example, "high school" is "preparatoria") (*Dating it Safe* Wave 8 Survey, Section A). Most demographic variables were categorical and contextualized for Mexico City. For example, recognizing that most individuals in Mexico who are students (university of trade) also work, the questionnaire asked, "In terms of work or study, what is your actual situation?" and the responses were "1=Only work", "2=Only study", "3=Work and Study", and "4=Neither work nor study". Also, we considered the type of educational levels by contextualizing highest level completed by asking the question, "What is the highest level of schooling you have obtained?, with response categories being "Basic education (preschool, primary, or secondary)", "Upper secondary education (high school diploma or equivalent studies, or professional technician)", "Higher education (higher technical, undergraduate, or graduate)", and "Other". Regarding gender, we acknowledge that IPV exists

across the gender spectrum. For the purpose of this study, we included only individuals that identified their gender as female.

Anxiety. The anxiety measure is the Generalized Anxiety Disorder subscale (GAD), a 9-item subscale derived from the Screen for Child Anxiety Related Emotional Disorders (SCARED, Birmaher, Khetarpal, Brent, Cully, Balach, Kaufman, & Neer, 1997). Participants were asked to report their level of anxiety on a 3-point scale from 0 (Not true, or hardly ever true) to 2 (Very true or often true). Sample questions include "people tell me that I worry too much" and "I worry about things working out for me". The scale is summative, with total scores of 0 to 18 and higher scores indicating higher levels of anxiety. Convergence and discriminant validity have been established as acceptable for this scale (Muris, Merckelbach, Ollendick, King, & Bogie, 2002).

Depression. Depression was measured using the Center for Epidemiological Studies Depression scale (CESD-10). This is a widely used, 10-item, self-report scale, used to assess participants' depressive symptoms (Bradley, Bagnell, & Brannen, 2010). Participants are asked to report the frequency with which they've experienced depressive symptoms in the last 7 days on a scale of 1 to 4, where 1=Rarely or never, 2=Some or a little of the time (1-2 days), 3=Occasionally (3-4 days), and 4= Most or all of the time (5-7 days). Sample questions included "I was bothered by things that usually don't bother me" and "I felt that everything I did was an effort". It is also a summative scale with scores from 10 to 40, with higher scores indicating higher levels of depression. The CESD-10 demonstrates good reliability and validity (Bradley, Bagnell, & Brannen, 2010).

General Physical Health. Physical health was measured using the Centers for Disease Control and Prevention's Health Related Quality of Life Healthy Days core questions (CDC

HRQOL– 4) (Centers for Disease Control and Prevention, 2018). This is a 4-item measure that asks individuals about their general physical health. The first question asks participants to rate their health (e.g., "would you say that in general your health is") on a scale from 1=Excellent to 5=poor). The remaining three questions ask participants to state the number of days, in the previous 30 days, that their ***physical*** health was ***not*** good, their ***mental*** health was ***not*** good, and their poor physical or mental health kept them from doing their usual activities, such as taking care of themselves, working, or having fun/relaxing.

Dating Violence Victimization (IPV). Intimate Partner Violence (IPV) victimization (i.e., being a victim of IPV) was measured using the Conflict in Adolescent Dating Relationships Inventory (Wolfe, Scott,Reitzel-Jaffe, Grasley, Straatman, & Wekerle, 2001). The CADRI was used initially, because at *Dating it Safe* Wave 1 participants were, on average, 15 years of age. The items, as originally stated, are still appropriate for older respondents. The CADRI is a 25-item measure that assesses relational abuse (e.g., emotional abuse, physical abuse, and sexual). Each of the 25 questions are asked twice, first assessing whether the respondent is a perpetrator of relationship violence, and second assessing whether the respondent is a victim of relationship violence. Since the focus of this study is the women's experiences of victimization, only the items in the victimization category were used. Participants were asked to report experiences of relationship violence within the past year, by answering 'Yes' or 'No' to questions such as "He/She kicked, hit, or punched me" and "He/She threatened to hurt me". A follow-up, open-ended question, "If you answered "Yes" to any 1B – 25B questions, tell us about the most serious time that your partner was physical toward you", was asked at the end. The CADRI has shown good reliability and validity (Wolfe, Scott, Reitzel-Jaffe, Wekerle, Grasley, & Straatman, 2001). Reliability in our study is reported below.

Data Analyses

Analytic Approach

All computations were performed in R using the psych (Revelle, 2020) and lavaan (Rosseel, 2012) packages, along with Mplus version 8.2. Psychometric analysis of multi-item scales was performed to ensure measurement equivalency in Mexico; these analyses will be in a separate paper and are available upon request. Once final measurement models were established, estimated factor scores were estimated in a confirmatory factor analysis (CFA) framework and then subsequently used in regression models.

Intimate Partner Violence Victimization (CADRI). In the present study, the CADRI instrument consists of 25 binary items (yes/no). Because the indicators are binary, a CFA model was fit using a robust diagonally weighted least squares (DWLS, equivalent to WLSMV in M*plus*) estimator (Brown, 2006). DWLS handles missing data in a pairwise-present orientation, which was not expected to be a problem given the small amount of missingness for this scale (maximum missingness on any of the 25 indicators was seven cases). Fit of the final measurement model was adequate: $\chi^2(209) = 298.186$, $p < .001$, CFI = .979, TLI = .977, RMSEA = .047, 90% CI [.034, .059], and SRMR = .098. Reliability was estimated as $\alpha = .92$ (95% CI [.91, .94]).

Anxiety (GAD subscale of SCARED). The nine items representing generalized anxiety disorder (GAD) were taken from the Screen for Child Anxiety Related Emotional Disorders (SCARED) questionnaire, which were previously found to comprise a unidimensional subscale (Birmaher, Khetarpal, Brent, Cully, Balach, Kaufman, & Neer, 1997). Each item consists of a three-point Likert scale (0=Not True of Hardly Ever True; 1=Somewhat True or Sometimes

True; and 2=Very True or Often True). Histograms indicated some items were unimodal and generally symmetric, but some showed evidence of floor effects, with most respondents endorsing lower response categories and very few endorsing the highest category. As with the CADRI, data missingness was minimal, with no more than 10 cases exhibiting missingness on one of the items. Due to the ordinal level of measurement and minimal missing data, DWLS was once again chosen as the estimator (Yang & Xia, 2015). Fit of the final measurement model was adequate: $\chi^2(26) = 41.388$, $p = .028$, CFI = .969, TLI = .957, RMSEA = .056, 90% CI [.018, .086], and SRMR = .067. Reliability was estimated as $\alpha = .81$, 95% CI [.77, .85], and factor score determinacy ($\rho = .92$) was above the minimum recommended value of .90 (Grice, 2001).

Depression (CESD). Bradley, Bagnell, and Brannen (2010) found a two-factor structure underlying the CESD-10, with all items loading onto a single factor except items five and eight, which are reverse worded. Conversely, Mohebbi et al. (2018) posited that a one-factor solution was preferred, provided the uniqueness of the two reverse worded items were permitted to freely correlate to account for method effects. Results in the current study comported with Mohebbi et al.'s findings. The CESD-10 is comprised of four-point Likert items, which exhibited floor effects. Given this and the minimal amount of missing data (no more than 10 cases missing for each indicator), DWLS estimation was used. Fit of the final measurement model was adequate: $\chi^2(27) = 56.799$, $p = .001$, CFI = .962, TLI = .949, RMSEA = .076, 90% CI [.048, .104], and SRMR = .065. Estimated reliability was $\alpha = .86$, 95% CI [.83, .89], and factor score determinacy was excellent at .95.

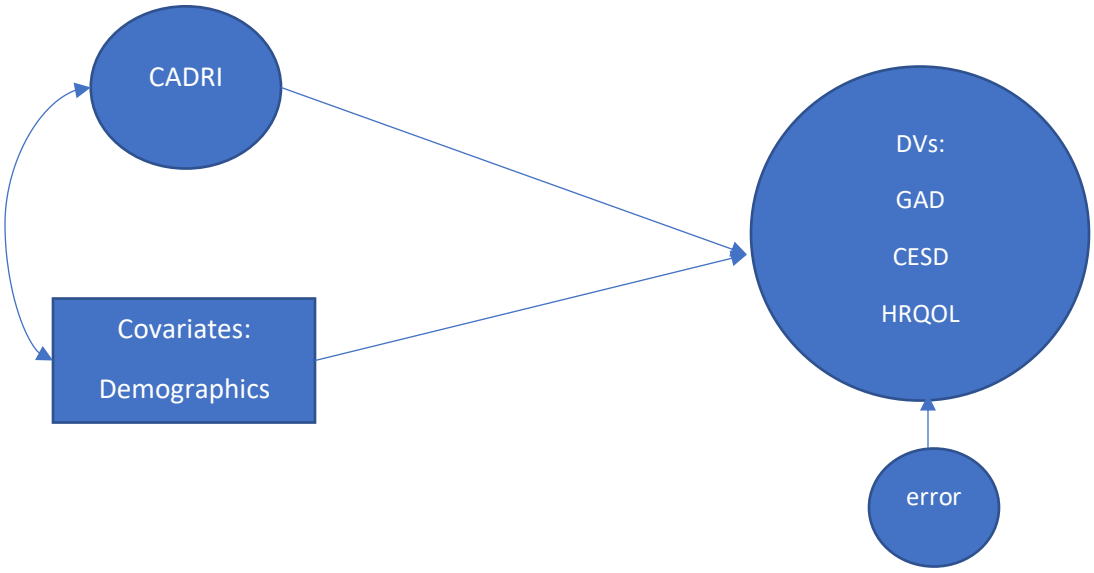
General Physical Health (HRQOL). Yin et al. (2016) determined there is a single underlying dimension to the Health Related Quality of Life Questionnaire (HRQOL), so, a one factor CFA model was fit, parameterizing the Likert item as ordinal (as with previous analyses in

this study) and the other indicators pertaining to day counts were treated as count variables. This analysis was performed using M*plus* since **lavaan** does not currently support count outcomes. Count outcomes can be modeled in several ways, and the general procedure for determining the appropriate specification is to compare results using the Bayesian information criterion (BIC), which helps identify good fitting models while respecting model parsimony (Muthén et al., 2017). In the final model, item one was treated as ordinal, items two and four as negative binomial, and item three as Poisson. The authors are not aware of any appropriate method to calculate a reliability coefficient with this mixture of indicators, but in the final model all factor loadings were statistically significant and positive. Similarly, the authors are not aware of a method to calculate factor score determinacy with count outcomes.

Results

The concept map guiding the analyses (see **Figure 2** below) depicts three identical regression models analyzing the three dependent variables of interest: anxiety (GAD), depression (CESD), and health (HRQOL). Again, a factor score regression model was chosen due to inadequate sample size for fully latent structural equation modeling given the non-normal outcomes (Kline, 2016). Prior to the analyses, basic data screening was accomplished in accordance with Tabachnick and Fidell (2013). **Table 2** presents univariate descriptive statistics for covariates as well as all substantive construct scores used in the models. **Table 3** presents intercorrelations among the dependent variables in the study. The highest dependent variable intercorrelation is .53 between the HRQOL and the CESD, but this is not close to the .85 recommended cutoff where discriminant validity is in question (Brown, 2006).

Figure 2. *Concept Map*



Note. Concept map depicting multiple regression model of the three dependent variables regressed on CADRI, controlling for demographic variables. Demographic variables include work/study status, education level, marital status, age, and income. Variables depicted with circles are latent variables, estimated using factor scores from previous confirmatory factor analyses. The error term includes any unaccounted-for measurement error and all other causes of the DVs that are not included in the model (i.e., $1 - R^2$).

As shown in **Figure 2** above, CADRI was the explanatory variable in all models, and several demographic covariates were included. No collinearity was detected when checking bivariate correlations (polychoric, polyserial, and Pearson, depending on the level of measurement) and variance inflation factor.

Data missingness was low, with about 92% of respondents having no missing values. All regression models were estimated in **lavaan** with missing data handled via missing at random maximum likelihood (so-called full-information maximum likelihood, or FIML). FIML is the generally preferred method of handling missing data; using this approach, all cases are used in the analysis (Enders, 2010). Using the VIM package, it was revealed age and income tended to vary depending on the presence or absence of data in other variables. In other words, age and

income were related to missingness on other covariates in the model. This enhances the tenability of the missing at random assumption necessary for FIML (Enders, 2010). Robust standard errors were computed, which help mitigate the influence of non-normal residuals and heteroscedasticity (Muthén et al., 2017).

Descriptive Statistics

Demographics. Our sample consisted of 200 women, with an average age of 33 (M=32.88, SD=10.05). More than half (58%, n=113) reported having a 9th grade education or lower and one third (33%, n=64) had a high school degree or equivalent. Over one third (39%, n=77) reported being single or never married, and an almost equal number reported being married (38%, n=75). The average mean annual income in U.S. dollars was just under $1,900.00 (M=$1,816.14, SD=$2,126.75). For more detailed demographics, please refer to **Table 2** (below).

Victimization (CADRI). **In Table 1** (below), we describe the response frequencies for the various examples of intimate partner victimization (CADRI). The most frequently endorsed examples of victimization by their partner were "said things just to make me angry" (63%, n=123); "spoke to me in a hostile or mean tone of voice" (58%, n=114); "blamed me for the problem" (41%, n=80)"; "did something to make me feel jealous" (38%, n=74); and "brought up something bad that I had done in the past" (35%, n=67). In terms of the most extreme forms of victimization, 23% (n=44) reported being "pushed, shoved, or shaken"; 22% (n=43) reported being "kicked, hit, or punched"; and 12% (n=23) reported that their partner forced them to have sex when they did not want to. Please refer to **Table 2** (below) for a complete list of responses in decreasing percentage of endorsement.

Table 1. CADRI Victimization

Type of Violence (In descending order)	Respondents	No	Yes	%Yes
Partner said things just to make me angry.	194	71	123	63%
Partner spoke to me in a hostile or mean tone of voice.	195	81	114	58%
Partner blamed me for the problem.	194	114	80	41%
Partner did something to make me feel jealous.	195	121	74	38%
Partner brought up something bad that I had done in the past.	194	127	67	35%
Partner insulted me with put-downs.	194	128	66	34%
Partner accused me of flirting with another girl/guy.	193	130	63	33%
Partner kept track of who I was with and where I was.	194	144	50	26%
Partner threatened to end the relationship.	192	143	49	26%
Partner ridiculed or made fun of me in front of others.	194	145	49	25%
Partner pushed, shoved, or shook me.	193	149	44	23%
Partner kicked, hit, or punched me.	194	151	43	22%
Partner deliberately tried to frighten me.	193	152	41	21%
Partner slapped me or pulled my hair.	193	154	39	20%
Partner destroyed or threatened to destroy something I valued.	195	159	36	18%
Partner threw something at me.	194	160	34	18%
Partner tried to turn my friends against me.	195	162	33	17%
Partner threatened to hit or throw something at me.	193	161	32	17%
Partner touched me sexually when I didn't want him/her to.	195	163	32	16%
Partner kissed me when I didn't want him/her to.	194	163	31	16%
Partner spread rumors about me.	193	162	31	16%
Partner said things to my friends about me to turn them against me.	193	167	26	13%
Partner forced me to have sex when I didn't want to.	195	172	23	12%
Partner threatened to hurt me.	193	170	23	12%
Partner threatened me in an attempt to have sex with me.	194	177	17	9%

Anxiety (GAD). On our measure of anxiety symptomatology, over half (57.2%, n=107) of participants scored 9 (the traditional cutoff score) or above, indicating that they are experiencing high levels of generalized anxiety symptoms, such as excessive anxiety or worry (American Psychiatric Association, 2017).

Depression (CESD). On our measure of depressive symptomatology, 16% (n=28) of respondents scored 16 or higher, the cutoff score, indicating that they are experiencing high levels of depressive symptoms and have a high likelihood of meeting criteria for a depressive disorder.

Health Related Quality of Life (HRQOL). Almost two-thirds (64%, n=121) self-reported their health as excellent, very good, or good, and 36% (n=69) self-reported their health as poor or fair. Moreover, on average, the women reported that in the last 30 days their health had been "not good" for 5 days; their mental health had been "not good" for 6 days; and that for 3 days in the prior 30 their poor health had interfered with their ability to work, study, or perform their everyday activities.

Table 2. Univariate Descriptive Statistics (with factor scores)

Covariates	Valid *n*	Mean (SD)	Median	Range
Age (In Years)	200	32.88 (10.05)	32	18-55
Annual Income (In Mexican Pesos)	196	34,305.61 (40,172.93)	24,000	0-240,000
(In U.S. Dollars)	196	1,816.14 (2, 126.75)	1,270	0-12,705.60
	Valid *n*	Count (%)		
Marital Status	197	-		
Single/Never been married		77 (39%)		
Married		75 (38%)		
Separated		19 (10%)		
Widowed		4 (2%)		
Divorced		5 (3%)		
Other (i.e., Civil Union)		17 (9%)		
	195			
Education				
9th Grade or Less		113 (58%)		
High School or Equivalent		64 (33%)		
Technical/College/Graduate		18 (9%)		
Factor Scores	Valid *n*	Mean (SD)	Median	Range
CADRI	195	0.09 (0.86)	0.03	-1.24-2.35
GAD	192	0.00 (0.86)	0.03	-2.21-2.24
CESD	191	0.03 (0.86)	-0.01	-1.40-2.43
HRQOL	194	0.00 (0.91)	0.09	-1.54-1.65

Notes. Percentages do not always sum to 100 due to rounding. Conversion rates from Mexican Pesos to U.S. Dollars at the time of data collection (February 2020) was 1 MXN = 0.05294 USD.

Table 3

Intercorrelations Among Dependent Variables

	HRQOL	GAD	CESD

HRQOL	1		
GAD	.33	1	
CESD	.53	.44	1

Note. Pearson's correlations shown since all variables were approximately normally distributed. All *r*s significant at $p < .001$.

Table 4 presents results of models regressing each of the dependent variables on CADRI and the set of demographic controls. The significance of demographic variables as a group was determined using Wald tests. In the first model (with GAD as the dependent variable), none of the demographic covariates achieved statistical significance either when evaluated individually or as a group, $\chi^2(4) = 7.541$, $p = .11$. Thus, the demographic variables did not explain a significant portion of variance in GAD. The substantive predictor, CADRI, did achieve significance, and the total model explained about 9% of the variance in the dependent variable ($R^2 = .091$). The standardized coefficient for CADRI is 0.270, which can be interpreted thusly: when comparing two people who are identical in terms of demographic covariates but who are one standard deviation unit apart on CADRI factor scores, the person with higher CADRI will report, on average, 0.270 standard deviation units higher on GAD factor scores.

For CESD, one demographic covariate did achieve significance: age. Thus, when comparing two respondents who are identical on all other demographic variables and who have the same CADRI level but are one standard deviation apart on age, the older respondent will, on average, report 0.202 standard deviation units lower on CESD. However, as a group the demographic variables explained only 1.2% of the variance in CESD, which did not achieve significance, $\chi^2(4) = 8.380$, $p = .08$. The substantive predictor CADRI was significant, with a standardized coefficient of 0.476; this coefficient is interpreted in the same manner as described in the previous paragraph: when comparing two people who are identical in terms of demographic covariates but who are one standard deviation unit apart on CADRI factor scores,

the person with higher CADRI will report, on average, 0.476 standard deviation units higher on CESD factor scores. The full model explained approximately 21.7% of the variance in CESD.

As with CESD, age was also significantly and negatively associated with HRQOL, but with a smaller effect size. All the demographic covariates as a group only explained about 3.2% of the variance in HRQOL, a figure which achieved statistical significance, $\chi^2(4) = 11.154$, $p = .02$. As with the GAD and CESD, CADRI significantly and positively predicted HRQOL, with a standardized *b* of 0.384, which is interpreted similarly as described above. Overall, the model explained approximately 16.6% of the variance in HRQOL.

Table 4. *Summary of Regression Models*

	GAD (R^2 = .091)			CESD (R^2 = .217)			HRQOL (R^2 = .166)		
Regressor	Unstd. Coeff.	Std. Coeff.†	*z*	Unstd. Coeff.	Std. Coeff. †	*z*	Unstd. Coeff.	Std. Coeff. †	*z*
Age	-0.011	-0.132	-1.514	-0.017	-0.202	-2.667*	-0.013	-0.148	-2.029*
Income	-0.000	-0.112	-1.677	-0.000	-0.008	-0.136	-0.000	-0.105	-1.866
Education (1 = HS or higher)	0.013	0.015	0.096	-0.000	-0.000	-0.000	0.079	0.087	0.617
Marital Status (1 = Married)	0.176	0.205	1.220	0.159	0.186	1.160	0.036	0.039	0.264
CADRI	0.269	0.270	3.950*	0.474	0.476	6.987*	0.409	0.384	5.704*

Notes. Dependent variables were estimated factor scores from previous CFA models.
†Standardized estimates reflect change in dependent variable (in SD units) for a one-unit change in predictor (binary predictors) or a one-SD change in predictor (continuous predictors).
*$p < .05$ (two-tailed).

Discussion

Intimate partner violence (IPV) is a significant public health concern that affects millions of women worldwide. Our study specifically focused on the relationship between IPV and health among Mexican women who had migrated from rural areas in Mexico to the capital, Mexico City, a phenomenon about which there is scarce literature. We explored the relationship between IPV and health (i.e., physical health, anxiety, and depression) in 200 Mexican women who met

our inclusion criteria: Mexican nationals 18 years of age and older who reported migrating internally from rural Mexico to the capital within the three years prior to being interviewed, and who endorsed having been victims of intimate partner violence during their lifetime.

One key finding in our study is the high rates of anxiety and depressive symptomatology in our sample. Over half (57.2%) screened positive for anxiety and 16% for depression. For comparison, the prevalence of anxiety disorders in Mexico is 14.3%, followed by mood disorders at 9.2% (Medina-Mora, Borges, Benjet, Carmen Lara, & Berglund, 2018). While we used screening tools and not diagnostic instruments, the screening tools we administered have been widely used and have solid psychometric properties across multiple populations. These findings align with other studies that have found strong associations between IPV and higher levels of mental health symptoms, including depression and anxiety, among women in several countries, whether in urban or rural settings, and regardless of documentation status (Lown & Vega, 2001; Nawaz, Nawaz, & Majeed, 2008; Furman, Negi, Iwamoto, Rowan, Shukraft, & Gragg, 2010; Hussain, Hussain, Zahra, & Hussain, 2020). In a study conducted by Lown and Vega (2001) on the relationship between health and IPV, Mexican American women (N=1,555) who had experienced physical and/or sexual IPV by a male partner within the past year reported poorer mental and physical health outcomes when compared to non-abused women. Conditions included heart attacks, high blood pressure, diabetes, and somatic symptoms (e.g., gastrointestinal problems) (Lown & Vega, 2001).Women who identify as undocumented may find it even more challenging to access help because of mistrust of authorities and/or for fear of disclosing their status (Furman, Negi, Iwamoto, Rowan, Shukraft, & Gragg, 2010).

Our study expands on previous research on IPV and health and highlights the negative outcomes of IPV among those who experience physical, psychological, and/or sexual violence.

Addressing barriers to mental health services such as supporting the requisite infrastructure for service delivery is necessary. This includes adequately funded and managed systems of care; sufficient well-trained providers who are culturally and linguistically competent, and who have access to continuous training and support to ensure knowledge of cutting-edge approaches and prevent burn out; ability for pay for services; and knowledge of where to find services (Furman, Negi, Iwamoto, Rowan, Shukraft, & Gragg, 2010; Schwarzbaum, 2004; Rastogi, Massey-Hastings, and Wieling, 2012). These are all critical to the provision of quality mental health services for women who experience IPV

Findings from our study also indicate that these women are more prone to experiencing poorer physical and mental health. In our sample, 36% of women reported their health to be fair or poor. This finding supports existing literature that indicates the adverse outcomes of IPV on health, including depression, anxiety, and chronic pain (Chandan et al., 2019; Cohen, Field, Campbell, & Hien, 2013; Wong & Mellor, 2014). Mexican migrant women are more likely to work in the informal labor sector, such as domestic work or market vendors, which often provide inadequate income and no benefits (Soriano, 2017). This places a restriction on their access to health insurance, leaving many to seek medical care in clinics that lack specialty services or the necessary infrastructure to provide quality services (Martinez, Galván, Saavedra, & Berenzon, 2017).

Mexico is one of the countries with the highest femicide rates in the world, and Mexican women who migrate internally may be more susceptible to violence due to the many complex factors they face. Some of these factors include lower socioeconomic status, lack of social support, inability to access adequate resources, and isolation, among others (Namino & Halperin, 1996; Krishman, Hilbert, McNeil, & Newman, 2004). These factors were not included in the

quantitative measures for this paper, yet many of the women spoke about them and mentioned them in the open-ended questions. Almost two-thirds (58%) of women in our study had less than a 9th grade education, and lower levels of formal education have also been linked to higher rates of IPV (Chen & Raskin White, 2004). Moreover, the stigmatization of being perceived as "immigrants" in their own country may limit them from accessing equitable resources that could contribute to their overall health and well-being (Soriano, 2017).

Our results highlight some significant implications for social work practice, both micro and macro. Despite the significant violence that women in Mexico experience, women, and especially those that are economically disadvantaged such as migrant women, lack equitable access to violence prevention services. It is critical to have health and social services in place that will help survivors break the cycle of violence. This includes service providers that are competently equipped to assess and address their health, mental health, legal, and concrete needs. Furthermore, policies that protect these women must be fully enforced and strengthened to bring justice to those that have been killed by violence and those that are living in violent conditions. Finally, there must be legal reforms that allow for true consequences to those who would inflict violence on women.

CHAPTER THREE: ARTICLE TWO

Title: Intimate Partner Violence and Health: A Survey of Foreign-born and U.S. born Latina Women in Southeast Texas

Target Journals: Violence Against Women

Violence Against Women: SAGE Journals (sagepub.com)

Proposed Authorship/Co-Authorship: Flor Avellaneda et al.

Introduction

Intimate partner violence (IPV) is a significant public health issue and the leading cause of injury to women living in the U.S. (Tjaden & Thoennes, 2000). Approximately 1 in 4 women in the United States report experiencing a form of violence, perpetrated by an intimate partner (Centers for Disease Control and Prevention, 2020). It is important to recognize that women from all backgrounds experience IPV. However, Latina women may have heightened vulnerability to IPV and its consequences due to factors such as low socioeconomic status, limited English language proficiency, and lack of health insurance (Erez, Aldeman, & Gregory, 2009). Risks for IPV may increase for undocumented women due to their fear of reporting instances of victimization because of the risk for deportation, coupled with language and lack of knowledge of where to seek services (Rajaram, Novak, Barrios, Rogers, & Leal, 2015).

Experiencing IPV may have detrimental physical and mental health outcomes. Physical injuries may include traumatic brain injury, headaches, pelvic pain, and insomnia (Lutgendorf, 2019). A World Health Organization's multi-country study found that women who reported experiencing IPV were twice as likely to report poor health, three times more likely to report emotional distress and suicidal thoughts, and four times more likely to report suicide attempts ,

relative to their non-abused counterparts (Ellsberg et al., 2008). Further, research consistently finds a robust link between IPV victimization and poor psychological health, including depression, anxiety, PTSD, and suicidality (Cohen, Field, Campbell, & Hien, 2013; Stewart & Vigod, 2017).

Cultural and systemic factors may increase susceptibility to IPV among Latinas, and especially among immigrant Latina women. These factors may include rigid gender roles that pressure Latina women to prioritize their families over their safety; economic dependence on abusive partners; immigration status; and low English proficiency (Aldarondo, Kantor, & Jasinski, 2016; Page, Chilton, Montalvo-Liendo, Matthews, & Nava, 2017). Seeking assistance may also be a challenge due to mistrust of authorities and fears of potential deportation if the woman is undocumented or lives in a mixed-status family (Coleman-Mason, 2010).

The political climate in recent years has discouraged many Latina/o immigrants from reporting crime to U.S. authorities due to fear of repercussions like undocumented status coming to light or losing their children (Berger Cardoso, Scott, Faulkner, & Barros Lane, 2018; Roche, Vaquera, White, & Rivera, 2018). Therefore, it is vitally important to better understand how Latina women's health may be affected by IPV to inform best practices and policies to better help them. This paper seeks to answer the question *what is the relationship between IPV and health (general physical health, anxiety, and depression,) among Latina Women in Southeast Texas who are emerging adults?*

Methodology

Research design

This paper focuses on Latina women in emerging adulthood. Women who are between the ages between 18-25 are considered to be in emerging adulthood. During this developmental

stage, women may experience a higher prevalence for IPV due to the complexity of shifting from adolescence into young adulthood, as well as possible experiences of instability in their romantic relationships (Arnett, 2000). We use data from Wave 8 of an ongoing longitudinal panel study (i.e., *Dating it Safe, DIS*), in which participants (N=1,042; 141 Latina respondents) were initially recruited in 2010 and have been followed annually (Temple, Paul, van den Berg, Le, McElhany, & Temple, 2012). Data were initially collected in seven public high schools throughout Southeast Texas (U.S.) and participants have continued to be followed post-high school. This study was approved by the Institutional Review Boards of the first and last author's institutions.

Participants

In *Dating it Safe* Wave 8, 141 respondents were Latina with an average age of 22. Since the focus of this paper is on emerging adulthood, only data from Wave 8 are used.

Measures

Anxiety was measured with the 9-item Generalized Anxiety Disorder subscale (GAD) derived from the Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher, Khetarpal, Brent, Cully, Balach, Kaufman, & Neer, 1997). Participants were asked to report their level of anxiety on a 3-point scale from 0 (Not true, or hardly ever true) to 2 (Very true or often true). Sample questions include "people tell me that I worry too much" and "I worry about things working out for me". The scale is summative, with total scores of 0 to 18 and higher scores indicating higher levels of anxiety. Convergence and discriminant validity have been established as acceptable for this scale (Muris, Merckelbach, Ollendick, King, & Bogie, 2002), with a Cronbach's Alpha of .92 for the current study.

Depression was measured using the Center for Epidemiological Studies Depression scale (CESD-10), which is a widely used 10-item scale to assess participants' depressive symptoms

(Bradley, Bagnell, & Brannen, 2010). Participants were asked to report the frequency with which they have experienced depressive symptoms in the last 7 days on a 4-point scale anchored by 1 (Rarely or never) and 4 (Most or all of the time (5-7 days)). Sample questions included "I was bothered by things that usually don't bother me" and "I felt that everything I did was an effort". It is also a summative scale with scores from 10 to 40, with higher scores indicating higher levels of depression. The CESD-10 demonstrates good reliability and validity (Bradley, Bagnell, & Brannen, 2010), with a Cronbach's Alpha of .79 for this study.

General Physical Health was measured with the Centers for Disease Control and Prevention's Health Related Quality of Life Healthy Days core questions (CDC HRQOL–4) (Centers for Disease Control and Prevention, 2018). This 4-item measure ask participants to rate their health (e.g., "would you say that in general your health is" on a scale anchored by 1 [Excellent] and 5 [poor]). The remaining three questions ask participants to state the number of days, in the previous 30 days, that their ***physical*** health was ***not*** good, their ***mental*** health was ***not*** good, and their poor physical or mental health kept them from doing their usual activities, such as taking care of themselves, working, or having fun/relaxing.

Intimate Partner Violence Victimization (CADRI) was measured with the Conflict in Adolescent Dating Relationships Inventory (CADRI), which is a 25-item measure of past-year relational abuse, physical abuse, and sexual abuse. Participants responded Yes/No to all questions (e.g., "He/she kicked, hit, or punched me," "He/she threatened to hurt me"). If a participant endorsed any of these items, they were asked the following open-ended question: "…tell us about the most serious time that your partner was physical toward you." The CADRI has shown good reliability and validity (Wolfe, Scott, Reitzel-Jaffe, Wekerle, Grasley, & Straatman, 2001).

Data Analyses

Analytic Approach

All analyses were performed using R 4.0.3 with specific packages as noted in the following paragraphs. Basic descriptive statistics were generated using the **psych** package (Revelle, 2020). Several demographic predictors were collapsed due to relatively small cell sizes. Education was collapsed into three categories: high school or less (24.1%), some college (45.4%), and associate degree or higher (30.5%). Income was dichotomized: up to $10,000 (48.9%) and over $10,000 (51.1%). Marital status was also dichotomized: not married (83.0%) and married (17.0%). Demographics are shown in **Table 1**.

Given the binary response option for the CADRI, tetrachoric correlations were used for analyses (Brown, 2006). Missing data are handled in a pairwise-present manner (n=3 of the current sample). Prior to analyzing the CADRI items, we noted several variables that had extreme splits in the frequency of responses. For instance, only one respondent endorsed items 9 and 10. Tabachnick and Fidell (2013) suggested deleting dichotomous variables from the analysis when they have a 90%/10% split or greater; thus, we eliminated all but the following items based on this criterion: three, five, seven, eight, 11, 15, 16, 18, 22.

The CESD scale consists of 10 items measured at the ordinal level (four-point Likert scale). Following Mohebbi et al. (2018), we expected to find the CESD to be a unidimensional measure. Thus, we fitted a single factor CFA model using **lavaan**. The diagonally weighted least squares estimator was used to account for departures from normality. After removing the reverse-worded items due to low factor loadings, model fit was good: $\chi^2_{Yuan-Bentler}(20) = 30.875$, $p = .057$, CFI = .989, TLI = .984, RMSEA = .063, 90% CI [.000, .104], SRMR = .045. Factor score determinacy was excellent ($\rho = .96$), well above the .90 cutoff recommended by

Grice (2001). Reliability was estimated as $\alpha = .87$, 95% CI [.82, .91] based on 2000 bootstrap samples.

Having established the basic psychometric properties of the CESD and CADRI scales, two ordinary least squares (OLS) regression model were fit, using the CESD factor scores estimated in the previous step as the response variable. In model one, only demographic predictors were included; in model two, the substantive predictor (CADRI) was included. This sequential regression approach permitted estimating the unique contribution of CADRI toward explaining the variability in CESD estimated factor scores. Since missingness was trivially small, listwise deletion was used, leaving 136 observations available for the analysis.

Standard diagnostic checks for multiple regression were made using the **car** package (Fox, 2002). Despite finding no evidence that model assumptions were seriously violated (Berry, 1993).

The HRQOL is measured by four items, one Likert item regarding general health quality plus three more questions related to health quality over the previous 30 days. Examination of a histogram revealed this item was approximately normally distributed, nevertheless due to the relatively small number of categories it was modeled using the structural equation modeling software **lavaan**. A robust, diagonally weighted least squares (DWLS) approach was taken since this method uses polychoric correlations. As discussed earlier, this estimator is appropriate for categorical data, such as Likert items with a relatively small number of response categories.

Anxiety (GAD Subscale of SCARED) was assessed via nine items, each utilizing a three-point Likert scale (“not true or hardly ever true,” somewhat true or sometimes true”, “Very true or often true”). There was only one case with missing data on the GAD items. Due to the ordinal nature of the data, polychoric correlations were used to analyze this scale. Fit of the final

measurement model was adequate: $\chi^2_{Yuan-Bentler}(20) = 48.490$, $p < .001$; CFI = .986; TLI = .981, RMSEA = .101, 90% CI [.065, .138], SRMR = .056. Reliability was estimated as α = .89, 95% CI [.86, .91] based on 2000 bootstrap samples. Factor score determinacy was excellent at ρ = .96.

Finally, OLS regression was then used to assess the relation of the demographic variables and CADRI estimated factor scores with the GAD estimated factor scores. As with the CESD scale described above, a sequential regression approach was taken, with only demographic variables in model one (M1), and CADRI factor scores being entered into model two (M2). Given the small amount of missing data, listwise deletion was used, leaving 136 complete cases for analysis. Regression diagnostics and residuals analysis using the **car** package did not reveal any relevant departures from the assumptions of OLS regression (Berry, 1993). M1 did not explain a significant portion of variability is estimated GAD scores: $R^2 = .038$, $F(6, 129) = 0.850$, $p = .534$. Furthermore, the increase in R^2 (from .038 to .056) due to inclusion of estimated CADRI factor scores was also not significant, $F(1, 128) = 0.850$, $p = .120$.

Results

Descriptive Statistics (Table 1). Our sample consisted of 141 women, with an average age of 22 (M=22.03, SD=.80). Almost half (n=65, 45.4%) reported having some college, while 17% (n=24) were high school graduates and 7.1% (n=10) had a primary school education. Over 82% reported never being married (n=116) while 17% (n=24) reported being married. Income was ascertained as a categorical variable, and almost half of the women reported making less than $25,000 a year while 17.3% (n=24) reported making between $25,000 and $50,000. Over three-quarters (78%, n=110) were born in the U.S., while 22% (n=31) were foreign-born. Country of origin was not asked in the DIS survey but based on the demographics of greater

Houston/Harris County, we expect between 66% and 73% of them to have been from Mexico, followed by Central America (Klineberg, Wu, Douds, & Ramirez, 2014).

Intimate Partner Violence Victimization. As shown in **Table 2**, the most frequently endorsed examples of IPV victimization were "partner said things just to make me angry" (49%, n=68), "partner spoke to me in a hostile or mean tone of voice" (46%, n=63), "partner brought up something bad that I had done in the past" (37%, n=51), "partner blamed me for the problem" (37%, n=51), and "partner kept track of who I was with and where I was" (33%, n=46). In terms of the most extreme forms of victimization, 12% (n=16) reported that their partner "pushed, shoved, or shook them", 7% (n=9) reported that their partner "kicked, hit, or punched them", and 7% (n=10) reported that their partner "touched them sexually when they didn't want to be". Please refer to **Table 2** (below) for a complete list of responses in decreasing percentage of endorsement.

General Physical Health and Mental Health (GAD, CESD, and HRQOL). With regard to our mental health screeners, over half (59.3%, n=80) of participants scored a 9 (cutoff score) or above, indicating a high likelihood of meeting criteria for an anxiety disorder. Six respondents were not calculated because they were missing at least one response. For depression, 12.5% (n= 17) scored 16 (cutoff score) or above, indicating a high likelihood of meeting criteria for a depressive disorder. Finally, with regards to general health, over three quarters (79%, n=112) of respondents in our sample reported their health as excellent, very good, or good, and 21% (n=29) reported their health as poor or fair.

As shown in **Table 3** (below), collectively the demographic variables explained approximately 6.6% of the variability in CESD estimated factor scores. Although this overall model achieved significance, only the dummy variables representing education individually

achieved significance. Once the CADRI estimated factor scores were added (model two), the R^2 increased by 5% to a total of .116, indicating about 11.6% of variability in CESD estimated factor scores was explained by the model, and this difference did achieve significance. In model two, only age achieved significance, and the dummy variables for education remained significant, as in model one. The CADRI factor score variable also predicted a statistically significant portion of variability in CESD factor scores, but income level, marital status, and nativity were not significant predictors. **Table 3** presents both standardized and unstandardized regression coefficients; the proper interpretation of these estimates is as follows. For example, the unstandardized coefficient for CADRI factor scores is 0.265, indicating that, on average, among respondents who were one unit apart on CADRI factor score but were identical on all other variables in the model, respondents with the higher CADRI factor score would, on average, report 0.265 units higher on CESD factor scores. In other words, higher levels of relationship conflict (as measured by the reduced set of CADRI items described earlier) were associated with increased depressive symptoms, controlling for other predictors in the model. Since the factor scores do not have any inherently meaningful scale, it might be easier to interpret the standardized coefficient, which is 0.244. Thus, when comparing two respondents who are one standard deviation (SD) unit different on estimated CADRI score, but are identical on all other predictors, the one with the higher CADRI score will, on average, report 0.244 SD units higher on the CESD factor scores. Similarly, when comparing respondents who were identical on all predictors except education, respondents who had at least some college reported, on average, CESD factor scores that were 0.464 SD units lower than respondents who had no education beyond high school.

Thus, when comparing two respondents who are one standard deviation (SD) unit different on estimated CADRI score, but are identical on all other predictors, the one with the higher CADRI score will, on average, report 0.244 SD units higher on the CESD factor scores. Similarly, when comparing respondents who were identical on all predictors except education, respondents who had at least some college reported, on average, CESD factor scores that were 0.464 SD units lower than respondents who had no education beyond high school. The same pattern was noted when comparing respondents with at least an associate degree versus no education beyond high school, except the effect size was even larger (0.624 SD units). We also checked whether the effect sizes for the associate degree group and some college group were different, but the test did not achieve significance. Taken together, this indicates higher education appears to be associated with lower depressive symptoms, although in this sample we are unable to definitively conclude additional education beyond some college is more beneficial, although there was a trend in that direction. Finally, age achieved statistical significance, indicating for each additional year, respondents indicated, on average, .200 SD units higher on CESD estimated factor scores. However, the effect was small.

The set of regressors used matched those in the OLS regression of CESD discussed in the previous section. The results of the HRQOL regression analysis are presented in **Table 3**. Unlike results for the CESD, only one model is shown since the R^2 change for adding CADRI factor scores as a predictor did not achieve significance. The R^2 for the overall model was .079, but this did not achieve significance, $\chi^2(7) = 11.898$, $p = .104$. None of the predictors were significant except the dummy variable indicating possession of an associate degree or higher. Controlling for other predictors in the model, when comparing a respondent with an associate degree or higher with a respondent with no more than a high school education, the one with higher

education reported, on average, 0.643 SD units lower on HRQOL item #1 (with lower scores corresponding to better health). Moreover, the difference between the associate degree group and the "some college" group was also significant, albeit with a lower effect size than the comparison with the high school only group (i.e., 0.395 SD units versus 0.643 SD units). Thus, respondents with an associate degree or higher reported, on average, better health than all other respondents.

Discussion

Our study explored the relationship between IPV victimization and health (general physical health, anxiety, and depression,) among Latina Women in Southeast Texas. Our sample consisted of 141 respondents, of which 78% (n=110) were U.S.-born and 22% (n=31) were foreign-born. While the *Dating it Safe* survey does not ask about country of origin, given the demographics of Southeast Texas—a few hours from the U.S.-Mexico border and with deep cultural, economic, and familial ties to Mexico—it is it safe to assume that most of the foreign-born Latinas were Mexican, and most of the U.S.-born Latinas were of Mexican American descent. Moreover, census data and other Houston surveys support this assertion: between 66% and 73% of Harris County Hispanics report their origins are in Mexico, followed by Central America (Klineberg, Wu, Douds, & Ramirez, 2014).

We had initially intended to examine the impact of nativity (U.S. vs. Foreign-Born) on IPV. However, the foreign-born Latinas in our sample were very similar from the U.S.-born Latinas on all our key measures. This is consistent with research showing that children and adolescents have higher levels of acculturation the longer they are in the U.S. (Costigan & Dokis, 2006; Kurtz-Costes & Pungello, 2000). The women in this sample first participated in the panel study (Wave 1) at the age of fifteen. As such, any foreign-born respondent in the sample had

already resided in the U.S. for at least seven years at the time Wave 8 data was collected. During that time, their identity, customs, and language most likely adapted to the U.S. context (Edwards, 2015).

More than half (59.3%, n=80) of participants scored a 9 or above, indicating that they have a high likelihood of meeting criteria for an anxiety condition. Findings also indicated that the Latina women in our sample who reported more victimization also experienced higher symptoms of depression. This is consistent with previous studies that examined the association between experiences of IPV and depressive symptoms (Caetano & Cunradi, 2003; Koopman, Ismailji, Holmes, Classen, Palesh, & Wales, 2005). Moreover, women with lower educational attainment were more likely to experience higher depressive symptomatology when compared to women with a higher education level. It is important to note that all survivors, regardless of socioeconomic status, may experience depressive symptoms. This is also in line with previous research that has found that economic independence, along with higher educational attainment, may serve as protective factors for women who experience IPV (Dalal, 2011).

Regarding physical health, 21% of the women reported their health as poor or fair. This is consistent with data from the Kaiser Family Foundation, which showed that in 2019 22.5% of the women in Texas reported experiencing fair or poor health (KFF, 2019). As a reminder, participants in *Dating it Safe* were recruited from the general population at Wave 1 for a longitudinal panel study and not all the women have experienced IPV. However, even in this sample from the general population, about 10% endorsed sexual violence, 9% physical violence, and between one quarter and one third reported stalking and other means of behavioral control and emotional abuse. Only education emerged as a predictor of victimization, as a protective factor

Education can facilitate survivors' access to knowledge, information, and quality resources that can help them break the cycle of violence. This includes culturally informed mental health interventions, to help address their mental health needs and equitable access to healthcare services. For women that may be undocumented, creating opportunities for services that do not limit their access due to their legal status is critical. Latinas are one of the fastest growing minority groups, and we must better understand the effects of IPV on this important group, address risk factors, and enhance protective factors.

Results from this study may inform best approaches to helping Latina survivors of intimate partner violence break the cycle of violence. Due to factors such as social structural barriers and systematic oppression, Latina women may be more predisposed to experiencing IPV (Malley-Morrison & Hines, 2007; West, 2005). Moreover, they may experience economic barriers that limit them from accessing needed quality healthcare (Aizer, 2011; Jewkes, 2002; and Tjaden & Thonnes, 1998). These disparities can worsen their physical and mental health outcomes as they acculturate into U.S. society (Lipsky & Caetano, 2007). Mental health providers that are culturally prepared to work with these women are critical to best serving their needs. Equitable access to quality healthcare services, for both documented and undocumented Latinas, is crucial to ending the cycle of violence.

Table 1. Univariate Descriptive Statistics

Covariates	Valid *n*	Mean (SD)	Median	Range
Age (at start of study)	141	22.03 (0.80)	22	21-24
	Valid *n*	Count (%)		
Marital Status	141			
Never married		116 (82.3%)		
Married		24 (17%)		
Divorced		1 (0.7%)		
Education	141			
Primary school		10 (7.1%)		
HS graduate		24 (17.0%)		
Some college		64 (45.4%)		
Associate's degree		23 (16.3%)		
Bachelor's degree		19 (13.5%)		
Master's degree		1 (0.7%)		
Income	139			
$1 - $5,000		46 (33.1%)		
$5,001 -$10,000		22 (15.8%)		
$10,001 -$25,000		47 (33.8%)		
$25,001 -$50,000		24 (17.3%)		
Nativity				
Not born in US		31 (22.0%)		
Born in US		110 (78.0%)		
Factor Scores†	Valid *n*	Mean (SD)	Median	Range
CADRI	138	0.04 (0.81)	0.12	-0.94 – 1.87
GAD	140	0.00 (0.91)	-0.10	-1.98 – 1.71
CESD	140	0.05 (0.89)	-0.04	-1.35 – 2.77
HRQOL	141	2.72 (0.99)	3.00	1.00 – 5.00

Note. †Factor scores estimated using latent variable CFA approach except HRQOL; due to missing data, this construct is represented by observed values for the first item on the scale. Percentages may not sum to 100 due to rounding. With the exception of the last three items on the HRQOL instrument, data missingness was minimal, with no more than about 2% of data missing for any single variable. About one quarter of data were missing for the last three HRQOL items.

Table 2. CADRI Victimization

Type of Violence (In descending order)	Respondents	No	Yes	%Yes
Partner said things just to make me angry.	138	70	68	49%
Partner spoke to me in a hostile or mean tone of voice.	138	75	63	46%
Partner brought up something bad that I had done in the past.	138	87	51	37%
Partner blamed me for the problem.	138	87	51	37%
Partner kept track of who I was with and where I was.	138	92	46	33%
Partner insulted me with put-downs.	138	101	37	27%
Partner did something to make me feel jealous.	138	103	35	25%
Partner threatened to end the relationship.	138	108	30	22%
Partner accused me of flirting with another girl/guy.	1388	113	25	18%
Partner destroyed or threatened to destroy something I valued.	138	121	17	12%
Partner pushed, shoved, or shook me.	138	122	16	12%
Partner kissed me when I didn't want him/her to.	138	123	15	11%
Partner ridiculed or made fun of me in front of others.	138	123	15	11%
Partner threw something at me.	138	127	11	8%
Partner touched me sexually when I didn't want him/her to	138	128	10	7%
Partner tried to turn my friends against me.	138	128	10	7%
Partner kicked, hit, or punched me.	138	129	9	7%
Partner threatened to hurt me.	138	129	9	7%
Partner slapped me or pulled my hair.	138	130	8	6%
Partner threatened to hit or throw something at me.	138	130	8	6%
Partner deliberately tried to frighten me.	138	132	6	4%
Partner spread rumors about me.	138	133	5	4%
Partner said things to my friends about me to turn them against me.	138	134	4	3%
Partner forced me to have sex when I didn't want to.	138	137	1	1%
Partner threatened me in an attempt to have sex with me.	138	137	1	1%

Table 3. Regression of CESD Factor Scores on CADRI Factor Scores and Demographic Variables

Model	Parameter	Unstandardized B [95% BCa CI]	β†	*t* (Sig.)	Adj. R^2	ΔR^2	ΔR^2 *F* (Sig.)
1	Intercept	-0.205 [-1.014, 0.576]	-	-0.478, *p* = .634	.066	.066	2.581 (6, 129),
	Age	0.146 [0.001, 0.316]	0.166	1.600, *p* = .112			*p* = .021
	Education: some college	-0.424 [-0.827, -0.026]	-0.482	-2.280, *p* = .024			
	Education: associate's or higher	-0.658 [-1.112, -0.246]	-0.748	-3.231, *p* = .002			
	Income: 10K+	-0.170 [-0.469, 0.099]	-0.193	-1.146, *p* = .254			
	Marital status: married	-0.146 [-0.448, 0.301]	-0.166	-0.718, *p* = .474			
	Nativity: US-born	0.216 [-0.126, 0.553]	0.245	1.201, *p* = .232			
2	Intercept	-0.290 [-1.028, 0.439]	-	-0.695, *p* =.489	.116	.050	8.353 (1, 128),
	Age	0.176 [0.030, 0.341]	0.200	1.965, *p* =.052			*p* = .004
	Education: some college‡	-0.409 [-0.822, -0.042]	-0.464	-2.256, *p* =.026			
	Education: associate's or higher‡	-0.549 [-0.973, -0.129]	-0.624	-2.724, *p* =.007			
	Income: 10K+	-0.225 [-0.507, 0.081]	-0.255	-1.547, *p* =.124			
	Marital status: married	-0.154 [-0.509, 0.251]	-0.175	-0.777, *p* =.439			
	Nativity: US-born	0.142 [-0.208, 0.455]	0.161	0.804, *p* =.423			
	CADRI	0.265 [0.078, 0.445]	0.244	2.890 *p* = .005			

Note. BCa CI = bias-corrected and accelerated confidence interval; CIs were estimated using 2,000 bootstrapped samples. †β for CADRI is fully standardized using both *x* and *y* variables; β for all other variables standardized using only *y* variable. Thus, for continuous variables, β represents the predicted change in CESD (in standard deviation units) for a one standard deviation unit difference on the predictor; for dichotomous variables, β represents the predicted change in CESD (in standard deviation units) for a one-unit difference (i.e., 1 versus 0) on the predictor. ‡Following Hardy (1993), a test was conducted to determine if all three levels of the education variable were equal on CESD factor scores; the test achieved significance, *F* (2, 128) = 3.998, *p* = .021. Furthermore, a test was conducted to determine if mean levels of CESD were different for the some college group versus the associate's or higher group; the test did not achieve significance, *F* (1, 128) = 0.679, *p* = .41

Table 4

Regression of HRQOL Item #1 on CADRI Factor Scores and Demographic Variables

Parameter	Unstandardized B [95% CI]	β†	*z* (Sig.)
Intercept	3.296 [2.422, 4.170]	-	7.391, $p < .001$
Age	-0.063 [-0.262, 0.135]	-0.064	-0.624, $p = .533$
Education: some college‡	-0.246 [-0.668, 0.177]	-0.248	-1.139, $p = .255$
Education: associate's or higher‡	-0.637 [-1.093, -0.182]	-0.643	-2.740, $p = .006$
Income: 10K+	-0.194 [-0.503, 0.115]	-0.196	-1.228, $p = .219$
Marital status: married	-0.205 [-0.675, 0.266]	-0.207	-0.853, $p = .394$
Nativity: US-born	0.155 [-0.188, 0.497]	0.157	0.886, $p = .376$
CADRI	0.012 [-0.180, 0.204]	0.010	0.119, $p = .905$

Note. †β for CADRI is fully standardized using both *x* and *y* variables; β for all other variables standardized using only *y* variable. Thus, for continuous variables, β represents the predicted change in HRQOL item #1 (in standard deviation units) for a one standard deviation unit difference on the predictor; for dichotomous variables, β represents the predicted change in HRQOL item #1 (in standard deviation units) for a one-unit difference (i.e., 1 versus 0) on the predictor. ‡Following Hardy (1993), a Wald test was conducted to determine if all three levels of the education variable were equal on HRQOL item #1 scores; the test achieved significance, $\chi^2(2) = 8.323$, $p = .016$. Furthermore, a test was conducted to determine if mean levels of HRQOL item #1 were different for the some college group versus the associate's or higher group; this test also achieved significance $\chi^2(2) = 4.489$, p=.034.

CHAPTER 4: ARTICLE THREE

Title: "Muertas ya no podemos hacer nada" (Dead we can no longer fight back): Perspectives of Intimate Partner Violence among Migrant Women in Mexico City"

T**arget Journal:** Affilia-Journal of Women and Social Work

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Proposed Authorship/Co-Authorship: Flor Avellaneda et al.

Introduction

Intimate partner violence (IPV) is a pervasive issue affecting women all over the world, and especially in Mexico. It is a complex phenomenon that affects survivors at all levels, such as the individual, familial, and structural levels. Women who experience IPV suffer significant health and mental health consequences. Furthermore, IPV can have a detrimental impact on family functioning (English, Marshall, & Stewart, 2003). In a patriarchal society such as Mexico's, IPV can be attributed to factors that have been ingrained throughout its societal history. These factors may include rigid gender roles, economic inequality, and the normalization of violence against women. Moreover, structural violence creates inequities for Mexican women, keeping them in vicious cycles of poverty and violence (Olivera & Furio, 2006). Mexican women residing in rural areas of Mexico may be more vulnerable to inequities and this may compel them to migrate internally to find better economic opportunities for themselves and their families. Although migrating to a metropolitan area like Mexico City may bring more opportunities, violence may continue to be a fact negatively affecting their lives.

Living in a large urban center like Mexico City, a sprawling megapolis of over 21 million people, may create challenges for migrant women coming from much smaller rural communities. They may experience conditions that further place their lives at-risk every day. From working in street conditions where they face constant dangers to being harassed in public spaces such as

businesses, bars, markets, subways and other means of public transportation by men who have been socialized to see women as sexual objects (Frías & Ríos-Cázares, 2019; Fairchild & Rudman, 2008; Bowman, 1993). Women may experience lewd glances, sexual and/or verbal comments, unwanted touching, and various types of sexual coercion (Fileborn, 2013). Moreover, living in a society in which women are killed at high rates—Mexico has one of the highest femicide rates in the world (Lettieri, 2017)—and deep mistrust in a justice system that is male-dominated and seen as biased and unfair (Balmori de la Miyar, 2018), can in itself increase the risk of experiencing IPV among this population. These every day societal traumas, along with experiences of IPV, can result in adverse physical and mental health outcomes. This is a concern given that there is a lack of equitable healthcare and a dearth of mental health service providers to help these women break the cycle of violence.

To inform effective interventions with Mexican migrant women who experience IPV, it is important to explore the cultural, social, and political forces in the context in which they live. There is limited research on the experiences of IPV and its relationship to health among Mexican migrant women residing in Mexico City, Mexico. Quantitative instruments may not always capture the cultural, social, and political nuances of a phenomenon (Frías, 2012). Therefore, in-depth interviews can provide deeper insight of women's experiences with IPV (WHO, 2001), giving them the opportunity to assign meaning to their own lived experiences (Adler & Adler, 1987). The purpose of this study is to explore the cultural, social, and political perspectives of Mexican women who migrated from rural areas in Mexico to the capital, Mexico City with regards to migration, IPV, and health, through their lived experiences.

Methodology

Research Design

Our study used a phenomenological research approach to attain a greater understanding of the lived experiences of Mexican migrant women and their perspectives on migration, IPV, and health. According to Robbins and colleagues "central to a phenomenological understanding of the complexity of human experience is the idea of social, culture, and economic forces shaping us in ways that we are not aware of. It is through the process of socialization that we internalize the prevailing norms of our culture, our society, and our economic system" (2019, p. 363). Through a feminist lens, qualitative approaches are especially useful when interviewing survivors of IPV because it gives them space to lift their voices (Westmarland, 2001). Using this approach, the researcher was able to examine how women made meaning of the cultural, social, and political perspectives that have influenced their experiences of IPV

P*articipants*

A non-probability sampling technique was used to recruit Mexican migrant women (N=14) who had migrated to Mexico City from rural Mexico in the three years prior to being interviewed. Inclusion criteria consisted of being a woman between the ages of 18 and 50, Mexican national, having migrated to Mexico City within the previous three years, and having experienced intimate partner violence. If they agreed to participate in the qualitative interviews, the participant and the interviewer then moved to a smaller, quieter venue conducive to safeguarding their privacy. Information about the study was read to participants, to account for literacy issues, detailing the purpose of the study, procedures, risks, benefits, alternatives, privacy/confidentiality, and the voluntary nature of the study. Participants were then asked if they needed further clarification before starting the recorded interviews. They received a small toiletry bag as an incentive, with a cost equivalent to US$5.00 (about MEX$93), for their

participation. All but one participant agreed to be recorded. All interviews were conducted by the principal investigator/first author of this paper.

Data Collection and Procedures

The recruitment plan was done in collaboration with a Mexico-based research team, and included local markets, transportation hubs, a college campus (Universidad Nacional Autónoma de Mexico, UNAM), public parks, faith-based agencies, and other public spaces (e.g., tourist sites). Participants were directly recruited using a brief screener that queried for inclusion criteria. Given the sensitive nature of the topic and the fact that participating in a study about IPV and sharing details about their IPV experiences can increase risks for women in IPV situations (Ellsberg & Heise, 2005), a *Waiver of Informed Consent,* with no signatures or identifiers was approved by the University of Houston Institutional Review Board (IRB) and used to consent to participation.

Prior to initiating recruitment, the research team completed an environmental canvass of the recruitment areas to identify potential meeting venues. Interviewers approached women who appeared to be in the target age group, introduced themselves as student researchers from our local partner, the Escuela Nacional de Trabajo Social (National School of Social Work, ENTS) of UNAM, conducting a study on internal migration and health in women, and asked if they had migrated to Mexico City from another region in Mexico within the past three years.

After going over the consent form, the researcher then conducted an in-depth, semi-structured interview with each woman which lasted last approximately 45 minutes to 1 hour. The PI conducted all interviews in a location that was conducive to preserving the privacy and confidentiality of the participants (e.g., at a local university). Interviews were audio recorded,

except for one participant that preferred not to be recorded, so the interviewer used paper and pencil to transcribe the interview verbatim, upon receiving participant consent.

Interview Guide

To elicit rich and thick data (Creswell, 2003), a semi-structured interview guide was used to facilitate the interviews, consisting of open-ended questions relevant to the Mexico City context, their familial and cultural influences, their experiences of migration, their health concerns, and their experiences with intimate partner violence (please see appendix). Sample questions include, "What are some examples of family and cultural values that you believe may be involved in situations of IPV? For example, family and cultural values that might make it easier or harder for women to disclose IPV?" and "What would be the role of a woman's support system (e.g., family, friends, or neighbors) in situations of IPV?". Interviews proceeded in a semi-structured manner, using the questions as prompts when necessary but allowing the women to tell their stories at their own pace. While the interviews were being recorded, the researcher still collected additional notes and observations. For the one participant who did not wish to be recorded, the researcher wrote down her responses verbatim.

Data Analyses

Interviews were transcribed in the original language, Spanish, to maintain the cultural integrity of the stories shared by the women. Given the phenomenological approach, the researcher used the 7-step modified van Kaam (Moustakas, 1994) method for data analyses. A detailed description of each of the steps will be described in this section. This approach is considered fitting to phenomenology because of its reflective structural analysis that seeks to capture the essence of someone's lived experience (Moustakas, 1994). Reflexive journaling is also an important part of the qualitative research process and the modified van Kaam analysis

approach. Through journaling, researchers are able to express any personal experiences, values, and/or positions that may have influenced their research (Ortlipp, 2008; Harrison, MacGibbon, & Morton, 2001). In preparation for her research work, the researcher wrote a comprehensive reflexivity statement, available upon request, that described her perceptions, thoughts, and any potential biases that she may have had related to the topic of intimate partner violence among Mexican migrant women and experiences with IPV. As an ongoing process, she journaled daily during data collection to continue capturing thoughts, decisions, or issues during her time in Mexico.

Prior to conducting a detailed analysis, the researcher read each transcript thoroughly. Through this process she took notes, documented any thoughts, and made sure she had an overall understanding of each transcript. Also, she made sure to engage in epoche—suspension of and refraining from judgement—through the analysis process to abstain from assumptions in order to elicit bias-free findings.

Using MAXQDA© software, the researcher analyzed the data using the 7-step modified van Kaam model to conduct a detailed analysis through bracketing and imaginative variation (Moustakas, 1994; Yüksel & Yildirim, 2015). Each of the seven steps were applied to each participant's transcribed interview. The following is a brief description of the seven steps as described in Moustakas (1994).

In the initial step, horizontalization, the researcher lists every expression that is relevant to the participant's experience. In this phase all data is treated equally, and preliminary coding begins. During step two, the researcher begins to reduce and eliminate by testing each expression for two requirements: a) does it contain a moment of experience and is it necessary for understanding; and b) is the expression repetitive or vague. If the expression is repetitive or

vague it can be eliminated or described in more exact terms. In step three, clustering and thematizing begin to take place. The researcher takes the excerpts/quotes that met step 2 and begins to explore themes that describe the participants' experiences. During step four, the researcher begins to check the themes against the data to make sure they are representative of the participant's experience. In step five the researcher begins to formulate individual textural descriptions, utilizing verbatim quotes from the transcribed interviews. Next, in step six the researcher creates composite textural descriptions for each participant. This helps in the development of the prominent common themes of participants' lived experiences. In the final step, synthesis, the researcher merges both textural and composite descriptions to derive a more comprehensive understanding of the meanings and essences of the participants' lived experiences (Moustakas, 1994).

Results

Based on the data analyses, five primary themes ("essences" in the modified Van Kaam approach) were identified that capture participants' lived experiences regarding IPV and the cultural, social, and political influences present in their everyday environments. The five distinct essences are: lacking family support, fear and threats, Mexican society further victimizes women who experience IPV, lack of support from authorities, and the cry for justice. In the following section, the researcher provides more detailed descriptions of each essence and exemplary quotes for each. Each participant was assigned a pseudonym to maintain confidentiality.

Theme One. *Lacking Family Support: La Familia te da la Espalda (Family Turns their Back on You)*

Although in Mexican society family is expected to provide unconditional support, participants shared that this is not always the case when disclosing IPV, as seen in the following

quotes. Silvia's family made her feel like she would never have a relationship with another person if she left her abusive partner because she already had children. She also talked about how leaving the relationship would make her feel like she had failed:

> Well, for example, maybe not wanting to leave that relationship because you as a woman could feel like a failure. Maybe family will tell you, how you are going to leave him. Who is going to notice you, you have children? They are not going to take you seriously. So maybe you will stay in that relationship. Even if you don't like it and even if they treat you badly.

Josefina was even more explicit, stating that family completely turned their back on her when she shared that she was being abused, and that friends filled in the void left by family members:

> In my case friends, because sometimes family turns their back on you. My experience was very ugly, my family pushed me aside. Friends are more supportive than family. I was with this person (perpetrator) eight years, instead of lending their support, my family pushed me aside.

Margarita shared about the patriarchal views espoused by her father, views that include blaming the victim. Her father clearly told her that if she was being abused, it was her doing. At the same time, she shared that there were other members of the family that did encourage her to leave the abuser and believed she could make it on her own. However, the opinions of her father weighed heavily on her:

> For example, my father's way of thinking, he would say "you asked for it and you have to deal with it." And there, uhm, family tells you that. There is family that is supportive, they'll tell you "leave him, you can make it on your own", and then there's family that doesn't. Sometimes you can't count on family.

Finally, Veronica mentioned that her family did not see intimate partner violence in a way that was conducive to supporting her or helping her exit her situation. On the contrary, when they learned she was being abused they attacked her even more, as if it were her fault:

> I feel that, in the family, it (IPV) is not so well-perceived. I mean, if you suffer violence, they don't look at it very well. It's like they (family) attack you more.

These four participants expressed the lack of support from their loved ones. Ideally, family is a vital source of support. Not receiving support from loved ones may at times help perpetuate the cycle of violence.

Theme Two. El Miedo y las Amenazas (Fear and Threats)

The fear of leaving the relationship, pressing charges, or seeking justice in the face of constant threats from the abusive partner often kept women from leaving or in emotional distress even after leaving. Isabel experienced both physical and psychological abuse from her partner. Although she recognized the harm she and her children where in, she expressed the fear of leaving her abusive relationship due to the harm that her perpetrator could cause her and her children.

> Fear. Insecurity because many times we feel threatened by the person who is affecting us. It was very clear because I could not go out into the streets because if I ran into the father of my children, he would attack me. Therefore, many times that makes us afraid to file a lawsuit or report the person. Or many times because I don't want my children to suffer. Sometimes there are women who act that way, that for my children I am not going to do it, or I am going to stay with him for my children. I think that's a very silly answer, I see it that way. I never said that for the sake of my children I would stay with him, but I would return because, for the same reason that I was afraid of how this person would act.

Rosario, who shared that it took her 16 years to recognize that she was in a domestically abusive relationship, adds the fear of not knowing what the future may hold for victims of violence.

> Even the fear of not knowing what will happen to you later. Because there are women who are afraid of running out of money, of being homeless, of being without their children. The main weapon that a person who is an aggressor has is the fear that the other person already has, apart from misinformation, obviously not all women know that they can ask for help. Not all women know that there are institutions, and as women we have that same fear of retaliation from an institution.

Teresa shed light on the impact of daily reports, via television, radio, social media, and other news outlets, of women being killed by an intimate partner at alarming rates in Mexico. The threats they receive from violent partners, and the actual violent actions of some partners, may be so significant that they can lead to a woman's death:

> Threats. The threats, the fear. On the part of the person who experiences the violence. Threats and fear. Because I have seen cases in the news that "they killed her because she did not report out of fear or that they beat her, they beat her to death because of fear, because of threats".

Similarly, Josefina expressed the gravity of not reporting due to fear. The reality that many abused women face daily may lead to extreme situations, which can result in the death of a woman.

> Women do not report out of fear, out of fear. Everything can be undone except death. If we are dead, we will no longer be able to do anything.

Fear is a component of intimately abusive relationships that keeps women from leaving and seeking assistance. The repercussions that they may face often outweigh their physical and emotional well-being. Based on these findings, women had an imminent fear of leaving an abusive relationship due to further harm from an abuser, uncertainty about their futures, and even fear of death.

Theme Three. Society's Violence: Mexican Society further victimizes women who experience IPV (La sociedad es violenta con la mujer cuando sufre violencia)

Violence against women may be related to cultural norms that make it challenging for women to survive IPV. The stigma and blame that society places on women who are abused further oppresses and limits their voices when trying to end the violence. In the following quotes, respondents describe Mexican society's perception of women who experience IPV.

Veronica shared how women in Mexico are oppressed, which she believes is a contributing factor to women's silence when it comes to IPV, whether it's dating violence or violence while married.

> I feel that women here in Mexico are super oppressed with this situation of gender violence, obviously in dating or marriage. We are super oppressed, we are afraid to speak.

Additionally, Silvia speaks to the normalization and acceptance of violence against women in Mexico. Women are to be subjected to men and the desire to seek their freedom is perceived as being disrespectful toward their partners.

> I think they see it (gender violence) as something very normal. As it is something very normal that they have us subjugated. That you as a woman do not have that freedom, maybe to be late or to have friends. If you already have, I don't know, maybe a husband, they think you are disrespecting him if you have other friends or if you talk to other people.

For Elena, personally hearing mixed messages that women are told about what they should do in situations of abuse, not only shames women for not meeting gender role expectations, but also places the responsibility on them. This, in her opinion, further victimizes women.

> That they (women) let this happen. As if. It is strange, because I have seen from "don't let it happen to you", but still, "stay at home". I don't know. Society is violent towards women when they suffer violence. Well, you got married, you chose him, te friegas ("you're screwed"), stay there. There is no support. Leave, let's see other solutions. It is exercising more violence toward women.

Ana expresses frustration about society's lack of empathy and understanding of women's experiences with abuse. She believes that survivors are blamed too often for their violent situations, when more attention should be paid to the influence of Mexico's rigid, male-dominated, "machista" gender roles on violence.

> I think it would be a way to dismiss them because the first thing they tell you about violence is, how silly. You're letting this happen to you, why do you let this happen to you? Why don't you put a stop to it? But why do people not see beyond that? The problem is not only that. Within Mexican culture and society, if you let this happen to you, you are a fool. Because they think it's very easy to stop, but it's not. The culture here, it is very machista.

These participants expressed how disclosing IPV may be difficult for survivors. Moreover, they expressed that it becomes even more challenging because they are living in a society that has historically normalized violence against women and commits further violence toward women when they experience IPV.

Theme Four. Lack of Support from Authorities: La Autoridad no Mueve ni un Dedo (The Authorities Don't Lift a Finger)

Intimate partner violence is a common phenomenon affecting women in Mexico. Reporting their abuse may sometimes worsen their situation if their abuser threatens their life or well-being. When women do report, they may be revictimized by authorities, most of whom are men. In the following quote, Martha discusses her mistrust in law enforcement. As a woman who has experienced IPV and daily harassment from other men while working in Mexico City, she believes that authorities should do everything in their power to listen to women who experience violence and to recognize that any woman is susceptible to violence, including their (the authorities') own daughters.

> When are the authorities going to open their eyes that this woman suffered violence, family abuse? That "my daughter" can suffer it at any time, they can hit my daughter at any time". Any time, we do not know when. Today or tomorrow, the authorities don't lift a finger.

Margarita believes that it is law enforcement's duty to serve and protect women. That women who report should be taken seriously, so that no more lives are lost:

> Well, their obligation, I suppose is that if you are reporting it is for a reason. Because, for example here in Mexico, I sometimes watch the news and it makes me sick because there is more violence against women. In other words, if I reported it and they ignored me, until they see me dead, then they will listen to me.

Juana experienced abuse from a partner who controlled her every step, but never reported him to authorities because she believed it never got physically violent, and that reporting would cause more problems with her abusive partner. Although she did not report her abuse, she shared how police often revictimize victims.

> And this, well, what gets in the way sometimes is these stereotypes that police officers have, and I have seen things like "Ah, well, it's that you're out walking at night", "Oh it's you, because of how do you dress." That would be it, biases.

Rosario talked about her negative experience in seeking help for her abuse. She felt that there was a lack of attention from authorities and other institutions she sought help from. That if only they paid attention to women in the moment, that women wouldn't be discouraged from returning to seek help.

> And if you go at that moment, in crisis or something similar, they do not take care of you. Seeing it as relevant, having time to attend to cases in the moment because they do not realize that a woman who arrives and reports, or wants psychological help, to at least to get out of a violent situation of any kind. But as a woman you go to an institution to ask for that support, and they tell you, come back a week later, and that gives you seven days to change your mind about what you did, and then you tell yourself "no, I better not". If they did it in the moment and there really was the capacity to deal with these types of situations, I believe that there would be fewer, or rather there would be more cases already as legally attended to.

As shared by these participants, women who experience IPV do not feel protected by law enforcement. When there is mistrust in entities that are meant to protect women from violence, women cannot safely leave an abusive relationship.

Theme Five. A Cry for Justice: Deberían de Poner más Atención (They Should Pay more Attention)

The participation of law enforcement and policy makers is critical to ending violence against women. In Mexico, a country in which there is widespread public insecurity due to mistrust

of the justice system and corruption, women are often the victims of violence due to lack of enforcement of laws that are written to protect them. In the following quote, Ana shares her thoughts on what law enforcement should be ideally doing to end the cycle of violence.

> I think they (law enforcement) should really not dismiss any case because I think that all cases are important. If they (women) are raising their voices, then there is a reason behind that. I think they should pay more attention to those little details, whether it's two, three days, months. And then follow through with the investigation. Because what's the use if they do not give it any importance and if you are going to repeat. What you want is to break that cycle.

Maria has seen police officers that also mistreat women. She urges law enforcement to treat women as equally as men because women too have rights.

> Well, helping people, more than anything helping women. Not men, because there are police officers who help men more than women. Policemen give more rights to men. I have seen that there are policemen who grab women and mistreat them much the same. They'd rather help a man, than a woman.

Patricia believes that laws to protect victims of violence should not only be enforced but should be stricter. This, in her opinion, can prevent future acts of violence by perpetrators.

> I suppose creating stricter laws. Creating laws that really take action on the matter so that cases of violence do not continue to happen. But through justice, that is, they need to make more severe laws so that the aggressor thinks twice before committing it (IPV) again.

Finally, Josefina believes that violence against women should be taken seriously. That women should be believed and supported, so that no woman has to suffer violence like she did.

> That the government listen to us, support us as women. That they listen more when we file a complaint, that we were mistreated, that they pay attention to us. They take us here and there; they treat us like a puppet. From experience, I can say I did not feel supported. That they take us seriously. Because we're women, they push us aside.

These participants expressed the urgent need for a just and fair legal system that is invested in helping women break the cycle of violence. Their voices are a cry for women's rights to be recognized and respected so that they can live in a safe society, free of violence.

Discussion

A core cultural value in Mexican culture is *familismo,* a broadly held belief that influences interpersonal connections among Latino families (Marín & Marín, 1991). Family is seen as the primary source of support and care, and the unity of the family is at the core of all efforts and experiences. Although family cohesion can serve as a protective factor (Smokowski, Rose, & Bacallao 2008), this may not be the case for women who experience IPV. If they disclose their abuse, family members may pressure them to "keep the family together", and/or may blame or shame survivors for their violent circumstances (Reina, Lohman, & Maldonado, 2014). This is seen clearly in the first theme/essence discussed, L*acking family support: La familia te da la espalda (Family turns their back on you),* in which participants expressed lacking the needed support from their loved ones. This finding reiterates previous research that discusses how family may often pressure survivors to remain in their abusive relationships for the sake of keeping the family together, which may cause women to override concerns for their own safety (Goldberg Edelson, Hokoda, & Ramos-Lira, 2007; Galanti, 2003).

As seen in theme/essence two, *El Miedo y las Amenazas (Fear and Threats)*, leaving an abusive relationship may be a difficult choice to make for women who experience IPV. Although survivors may desire to leave, doing so may put their lives in grave danger. The fear that comes from threats coupled with potentially escalating abuse from their abusers may outweigh their decision to leave, especially since the most dangerous time for a woman in an IPV situation is when she decides to exit a relationship. Women may also experience stalking, further physical and

psychological harm, and even death (Palarea, Zona, Lane, & Langhinrichsen-Rohling, 1999). Moreover, living in a society in which news reports of female homicides is a daily occurrence does not engender confidence in a safe environment. Mexico has been experiencing one of the highest rates of female homicides in its history, and many of these deaths can be attributed to IPV (Lettieri, 2017). Women may live in constant fear, knowing that they could very possibly become just another statistic.

In theme/essence three, *Society's violence: Mexican society further victimizes women who experience IPV (La sociedad es violenta con la mujer cuando sufre violencia),* participants shared how they are often stigmatized by Mexican society. Women are made to feel that they're invisible and that their voices are meaningless. This societal perception of women is harmful to survivors' emotional and physical well-being and keeps them in vicious cycles of violence.

In theme/essence four*, lack of support from authorities: La autoridad no mueve ni un dedo (The authorities don't lift a finger*), participants brought attention to the failure of the justice system to protect them. The Mexican legal system has been criticized for not offering adequate protection and often dismissing women's pleas for help (Castañeda Salgado et al., 2013; Frías & Agoff, 2015). Women may find that their IPV cases are not always initiated or thoroughly investigated; the legal system's failure to serve and protect women who experience IPV may contribute to the high rates of female deaths (Frías, 2020).

Violence against women is a significant public health issue and a violation of Mexican women's rights. In a historically patriarchal society like Mexico's, misogynistic perceptions of women may filter into law enforcement agencies, which are typically run by men. These gendered biased perceptions can result in ignoring women's cries for help and further victimizing them (Gillis et al, 2006; & Mirchandani, 2006). As seen in theme/essence five, *A cry for justice:*

Deberían de poner más atención (They Should Pay more Attention), participants are calling on law enforcement and other public security entities to end the pervasiveness of gender violence in Mexico. It should be acknowledged that Mexico is advancing in that there is growing participation of women in the economic, social, and political sectors of Mexican society, especially in urban cities, like Mexico City (Moctezuma Navarro, Narro Robles, & Orozco Hernandez, 2014). However, gender inequality remains a pervasive issue that negates women their fundamental rights (Cerva Cerna, 2014).

Recently, Mexican female activists have taken to the streets to demand justice for women's rights and for an end to the alarming rates of female homicides. Regardless of pushback from the patriarchy, their unceasing efforts call for sustainable changes that promote the safety and well-being of all women. It is evident that women are angry and fearful of the number of lives that will continue to be lost if nothing is done. However, they cannot do this work alone. Local, state, and national governments must do their part to enforce viable actions and policies to eliminate IPV.

CHAPTER 5: CONCLUSION

This three-article dissertation explored the relationship between Intimate Partner Violence (IPV), physical health, and mental health in Mexican migrant women Mexico and Latina women in Southeast Texas. Past research has examined the physical and mental health effects of IPV on women who have experienced partner violence, including mental health outcomes such as depression, anxiety, and post-traumatic stress disorder (Coker, Smith, Bethea, King, & McKeown, 2000; Pico-Alfonso, Garcia-Linares, Celda-Navarro, Blasco-Ros, Echeburua, & Martinez, 2006). Women who experience IPV are likely to experience physical health consequences such as physical injury, gynecological problems, and traumatic brain injury, which can lead to poor health outcomes in the short and long-term (Lutgendorf, 2019). For Mexican migrant women, structural barriers may worsen their IPV experiences. Barriers such as

lack of health insurance, not knowing how or where to seek help, patriarchal societal structures, and health and safety systems that are built by and for men and seem insensitive to the needs of women, may all predispose women to IPV situations, prevent them from seeking help by accessing services, and further victimize them when they do seek help. For women who are in the U.S. without documentation and who have limited English proficiency, and for Indigenous women who migrate internally in Mexico, speak limited Spanish, and are labeled, "immigrants" within their own country, the situation may be even worse.

Extant research has documented the vast array of barriers and limitations Mexican migrant women face in breaking the cycle of violence. However, to attain a greater understanding of the effects of IPV on Mexican migrant women, it is necessary to look at this pervasive issue on both sides of the border. The goal for this binational dissertation study was to attain a greater understanding of the relationship between IPV and health on Mexican migrant women, including factors related to their personal, cultural, and sociopolitical perspectives.

In paper one, we explored the relationship between IPV and health (general physical health, anxiety, and depression) among Mexican migrant women (N=200) in Mexico City through a quantitative survey. The women in the sample were all Mexican nationals, had migrated from rural areas in Mexico to the capital, Mexico City, within the preceding three years, were 18 years of age and older, and reported having experienced intimate partner violence during their lifetime. Participants reported high levels of experiences of IPV victimization. They also reported experiencing high levels of anxiety and depressive symptomatology, even above national rates for the U.S. and Mexico, as well as multiple unhealthy days that prevented them from functioning in the prior month.

Paper two explores the relation between IPV and health (general physical health, anxiety, and depression), through secondary data analyses, among Latina women (N=141) in Southeast Texas. These women were part of Wave 8 of *Dating it Safe*, a longitudinal study on teen dating, risk, and protective factors. Paper two focuses exclusively on Latina women in the U.S., in Southeast Texas. Initially, study two intended to look at the influence of nativity (i.e., U.S. vs. foreign-born) on the relationship between IPV and health. However, the 20% of the sample that were foreign-born Latinas were indistinguishable on all key measures from the 80% US-born Latinas. In hindsight, this was to be expected. Given that these participants were recruited for Wave 1 of *Dating it Safe* when they were still in high school (Mean age=15), they had already resided in the U.S. for at least seven years or more at Wave 8 (Mean age= 22). It is well established that children and adolescents are quicker to acculturate then adults (Costigan & Dokis, 2006; Kurtz-Costes & Pungello; Cortez, 2008). Acculturation has transformed their language, identity, and customs (Edwards, 2015). As such, we should have anticipated that nativity in this sample might not be a significant predictor of differences, and that was in fact the case. More than half (59%) or women who participated in Study 2 scored above the cutoff scores on the anxiety screener, and 12.5% on the depression screener, indicating a high probability of meeting criteria for an anxiety or depressive disorder. These rates exceed lifetime prevalence rates for anxiety and depression in the U.S. Participants also reported high levels of experiences of IPV victimization, although the percentage of women endorsing each type of victimization was lower for the women in the U.S. than for those in Mexico City (discussed later).

Finally, in paper three, we explored the cultural, social, and political perspectives of Mexican migrant women in Mexico City (N=14) on IPV and health, through in-depth qualitative interviews. Themes/essences that emerged from our study included lacking family support,

living with fear and threats, the sense that Mexican society further victimizes women who experience IPV, lacking support from authorities, and women's cry for justice when it comes to IPV: to be heard, taken seriously, and helped; for the abusers to be punished; and for stronger laws to protect women in general. Study three allowed us to attain a more nuanced understanding about the cultural, social, and political factors that worsen Mexican women's experiences with violence. Women not only shared their lived experiences on IPV and other forms of violence, but also their experiences with the reactions of friends, family, law enforcement, and society more broadly. Some key findings included the fear of disclosing abuse due to possible repercussions from perpetrators and authority figures, and society's further victimization of women who experience IPV through ignoring, dismissing, blaming, or stigmatizing their experiences. Women also demanded justice to end IPV and the high rates of female homicides in Mexico due to partner violence.

Although this was not an integrated mixed-methods study, we will weave the three studies and talk about them in a parallel way. Papers 1 and 2 were quantitative studies that looked at the relationships between IPV and physical and mental health among Mexican migrant women in Mexico (paper 1) and Latina women in Southeast Texas (paper 2). Although *Dating it Safe* (*DIS*) did not ask about country of origin, considering the demographics of South Texas it is safe to assume that most of the women in the U.S. were Mexican American or of Mexican.

More than half (57.2%) of the women surveyed in Mexico City scored above the cutoff score for anxiety and 16% scored above the cutoff score for depression. In the U.S., 59.3% of the women surveyed by DIS scored above the cutoff score for anxiety and 12.5% scored above the cutoff score for depression. For comparison, anxiety disorders are the most common psychiatric disorder in Mexico (14.3%), followed by mood disorders (9.2%) (Medina-Mora, Borges, Benjet,

Carmen Lara, & Berglund, 2018). In a nationally representative study in Mexico, anxiety and mood disorders were more likely among females, who had 1.7 times the odds of developing an anxiety disorder and 1.6 times the odds of developing a mood disorder, compared to men (Medina-Mora, Borges, Benjet, Carmen Lara, & Berglund, 2018). To our knowledge, no data exists examining prevalence rates of anxiety and depression in Mexico for women who migrate internally and are exposed to IPV. As such, our study represents an initial examination of this phenomenon.

In the meantime, in the U.S anxiety affects more than 40 million individuals each year, or 18.1% of the population; women are twice as likely than men to experience Generalized Anxiety Disorder (Anxiety & Depression Association of America, 2021). In our sample, 59.3% of women scored above the cutoff score for anxiety on the GAD, indicating a high probability of meeting criteria for an anxiety disorder. As for depression, approximately 17.3 million U.S. adults have experienced at least one major depressive episode, with prevalence being higher among women (8.7%) than men (5.3%) (National Institute of Mental Health, 2019). In our sample approximately 12.5% of participants scored above the cutoff score on the CESD, indicating a high likelihood of meeting criteria for a depressive disorder. While we did not use a diagnostic instrument and instead used a screener, both the GAD and the CESD have shown excellent psychometric properties as screeners for anxiety and depressive disorder. With regards to self-reported quality of life, 36% of women in Mexico self-reported their health as poor or fair, while 21% of the women in the U.S. self-reported their health as poor or fair.

Our results suggest that Mexican women migrating internally to the capital, and Latina women in Southeast Texas, are experiencing high levels of anxiety and depressive symptoms in the context of IPV. Additionally, while Latina women in our U.S. sample seem to be

experiencing anxiety and depression at higher rates than women in the U.S. generally, they also seem to be doing better than the women in Mexico. This may be due to the women in the U.S. having more availability of mental health and IPV resources than the women in Mexico, greater sensitization to mental health issues in the U.S., and perhaps even less stigma about mental health than in Mexico. However, it is important to note that while we purposely recruited women who had experienced IPV in Mexico, our U.S. sample consisted of a panel of Latina women (foreign-born and US-born), that were recruited as teens for a longitudinal study on teen dating, and not all participants have experienced IPV.

We also noted that the women in Mexico and the women in the U.S. endorsed similar types of IPV victimization. The most reported IPV victimization behaviors in both countries included "partner said things just to make me angry", "partner spoke to me in a hostile or mean tone of voice", "partner brought up something bad that I had done in the past", and "partner blamed me for the problem". Examples of extreme forms of violence in both groups of women included, "pushed, shoved, or shaken", "kicked, hit, or punched", and partner had touched them or forced them to have sex without their consent (two separate items). This finding may indicate that experiences of IPV may look similar across populations and that the women are equally unsafe across two countries with very different laws, approaches, and resources related to IPV. IPV among Mexican migrant women and Latina women in both countries continues to exacerbate the disparities faced by women.

With regards to papers 1 and 3, our qualitative study (paper 3) helped us delve deeper into the factors that may be contributing to IPV among Mexican migrant women in Mexico (paper 1). In addition, paper 3 helps us document the lived experiences of the women in Mexico City with IPV. Attaining a better understanding of the cultural, social, and political perspectives

of IPV among Mexican women in Mexico City can help us capture data that we would not have been able to gather using only quantitative measures. This includes women's perspectives on IPV and family support, societal stigma, rigid gender norms, and the inadequacy of law enforcement when it comes to women seeking justice. In paper one, we found that women in Mexico reported higher rates of depression and anxiety symptomatology, when compared to national rates, as well as poorer health. Our qualitative data may help inform these findings given the lived experiences that contribute to the negative physical and mental health outcomes of women who experience IPV. For example, women expressed lacking family support and being pushed aside, leaving them feeling alone with their IPV experiences. The same feeling was echoed when being dismissed and further victimized by society and law enforcement. The despair these women experienced could lead to symptoms of anxiety and depression, that are worsened by the everyday factors that shame and isolate them in their experiences.

Although we did not pursue an integrated mixed-methods approach for this dissertation, the data analyzed from all three papers helps us attain a greater understanding about IPV and health among Mexican migrant women in Mexico and Latina women in the U.S. As one of the fastest growing populations in the U.S., the health of Mexican migrant and Mexican American women is a shared responsibility among providers, researchers, advocates, policy makers, social workers, and survivors in both countries. Given the global inequities caused by political instability, engrained discriminatory social structures, trickledown economics, and weak and/or inadequately enforced policies, it is critical that we address the disparities caused by IPV among migrant women in Mexico and both U.S. and foreign-born Latinas in the U.S.

Limitations of our research

This dissertation allowed us to explore a few of the many elements of IPV at the micro, mezzo, and macro levels. While our study makes an important contribution to our understanding of IPV in vulnerable populations—immigrant women in Mexico and Latinas in Southeast Texas—like all research, it is not without limitations.

Almost 500 women were screened by the research team to arrive at the sample of 200, for the data collected in Mexico City; many other women endorsed IPV but did not want to participate in the study because they did not feel comfortable speaking about their experiences of IPV. Moreover, participants may have responded to questions of IPV in a manner that they perceived as socially desirable, as a way to avoid feeling shame and stigma (Visschers, Jaspaert, & Vervaeke, 2017; Beck, McNiff, Clapp, Olsen, Avery, & Hagewood, 2011). Secondary data analyses limit the researcher to the data that was originally collected. For example, the Latina sample in the U.S. was small and the foreign-born Latina subset even smaller, limiting variability on our measures as well as the types of analyses we were able to conduct. Also, although we had nativity, we were unable to determine the country of origin of the foreign-born Latinas in the U.S. We assume that most are Mexican/Mexican American because of the location of DIS (i.e., Southeast Texas), but some may have been from Central America, the Caribbean, or South America.

Originally, we planned to take an integrated, mixed-methods approach for this dissertation. However, conducting cross-national research may be challenging if researchers do not have comparable theoretical approaches and measurement tools that allow for appropriate comparisons of data (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). Since the U.S. portion was based on secondary data that had already been collected, we could not simply merge

this data with the Mexico quantitative data given the disparate nature of the samples, the timeframes, and the location. Moreover, the *Dating it Safe* longitudinal study in the U.S. does not have qualitative data. Overall, despite our limitations, our study is an initial approach to better understanding IPV and health among women, binationally.

Recommendations for Future Research and Implications for Social Work Practice and Policy

Future research should explore an integrated mixed-methods approach to further explore IPV and health among Mexican migrant women, binationally. Such an approach would use a comparable research design and procedures, including collecting data at the same time in both countries. Doing this can allow for data comparisons that can further enrich our understanding of IPV and health for women, both in the U.S. and Mexico. Future research can also explore the experiences of service providers, policy makers, and law enforcement personnel serving women who experience IPV in Mexico and Latina women in the U.S., to better understand potential gaps in supporting survivors.

In Mexico and in the U.S., Mexican migrant women, and Latina women in the U.S., are disproportionately affected by IPV. While Mexican migrant women, in both countries, may face similar barriers to equitable access to IPV resources, such as discrimination, social isolation, economic instability, and educational inequality, there are some distinctions based on the context in which they reside. For example, Mexican migrant women residing in the U.S. may hesitate to call the police for help due to fear of potential deportation, while Mexican migrant women residing in Mexico may fear calling the police in Mexico for fear of further victimization from law enforcement. This fear is justified in that gender prejudices, blaming, and derogatory attitudes toward IPV survivors may often be present in law enforcement agencies (Gracia,

García, & Lila, 2014; Capezza & Arriaga, 2008). Law enforcement plays a critical role in combating intimate partner violence. Along with bringing legal justice for survivors, they must also work to create safe environments in which women are not further victimized. Furthermore, intentional police trainings and education that challenge male sexist views, so that officers, particularly male officers, are aware of the harm gender stereotypes can cause in survivors (Gracia, García, & Lila, 2014) are necessary to sensitize to the pain these women experience and motivate them to action. As one of our participants in study three stated: "When are the authorities going to open their eyes that this woman suffered violence, family abuse? That "my daughter" can suffer it at any time, they can hit my daughter at any time". Understanding, believing, and doing everything in the best-interest of survivors is vital to ending intimate partner violence.

Social Workers are often on the front lines helping survivors navigate a path to safety and healing. Therefore, it is important for social workers to understand the compounding factors that may contribute to trauma experienced by women victimized by IPV, and that trauma may manifest differently for each person (Anyikwa, 2016). Creating environments in which services are trauma-informed is essential to serving survivors holistically. For example, giving survivors the opportunity to shape the social worker and client work, promoting agency policies that help increase survivors' sense of safety and control, and creating inclusive environments in which survivors of all backgrounds feel welcomed and supported (Wilson, Fauci, & Goodman, 2015) can promote safety and trauma-informed approaches.

From a policy perspective, social workers are called to seek social change for oppressed populations. Efforts from social workers in both the U.S. and Mexico should encompass the voices of women who experience IPV. Latinas/os are the largest and still one of the fastest

growing minority groups the U.S. In Mexico, women are over half of the population. Therefore, understanding Latina and Mexican women's experiences with IPV, both in the U.S. and Mexico, can help us inform practices and policies that improve their quality of life and that allow for all women to live a life free of violence.

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APPENDICES

Dating it Safe Spanish Survey

UNIVERSITY of HOUSTON
GRADUATE COLLEGE of SOCIAL WORK

INSTRUCCIONES

Le leeremos cada pregunta cuidadosamente. No hay respuesta correcta o incorrecta, por lo que no dedicaremos demasiado tiempo a una sola pregunta—simplemente marcaremos su mejor respuesta y seguiremos adelante. Marcaremos una sola respuesta a menos que usted indique lo contrario.

Algunas de las preguntas pueden parecer personales. Recuerde que su honestidad es muy importante para nosotras y que sus respuestas se mantendrán en privado. No escribiremos su nombre en la encuesta. Otras personas no sabrán cómo respondió y su nombre no estará conectado a sus respuestas.

Esperamos que pueda responder todas las preguntas, pero si hay una pregunta que no quiere responder o no sabe cómo responder, simplemente continuaremos con la siguiente pregunta.

¡¡¡¡MUCHAS GRACIAS!!!!

Encuestadora de la encuesta, ingrese lo siguiente:

Número de folio: _____

Fecha: _____

Aprobado por el Comité de Ética de la Universidad de Houston
Numero de Protocolo: STUDY00001885

SECCIÓN A

Instrucciones: Por favor díganos su mejor respuesta.

1. ¿Qué edad tiene? _____

2. En términos de estudio o trabajo ¿cuál es su situación actual?

□ Solo trabajo
□ Solo estudio
□ Trabajo y estudio
□ No trabajo y no estudio

2a. Si asiste la Universidad/Educación superior ¿a qué tipo asiste?

□ Técnico superior universitario o profesional asociado
□ Licenciatura
□ Posgrado (especialización, maestría, o doctorado)
□ Otro_____

3. ¿Cuál es el nivel de escolaridad más alto que ha obtenido?

□ Educación básica (preescolar, primaria, o secundaria)
□ Educación media superior (bachillerato o estudios equivalentes, o técnico profesional)
□ Educación superior (técnico superior, licenciatura, o posgrado)
□ Otro

4. En los últimos 30 días, ¿cuánto ingreso recibió por todas fuentes de trabajo? _____

4b. ¿Cuántos meses de este último año trabajó? _____

4c. ¿Cuál fue su ingreso anual para el 2019? _____

5. ¿Con quién vive?

□ Sola
□ Amigo (as) / Compañero (as)
□ Pareja/Esposo(a)
□ Familia (padres, padrastros, abuelos, hermanos)
□ Otro (refugio, institución, etc.) _____

6. ¿Cuál es su estado civil?

□ Soltera/Nunca me he casado
□ Casada
□ Separada
□ Viuda
□ Divorciada

SECCIÓN B & C

LAS SIGUIENTES PREGUNTAS SON SOBRE SUS EXPERIENCIAS DE RELACIÓN DE PAREJA.

7. ¿Cuántas parejas románticas ha tenido en los últimos 12 meses, incluyendo la persona con la que está actualmente?

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 o más

LA PRÓXIMA SECCIÓN INCLUYE ALGUNAS PREGUNTAS SOBRE SU RELACIÓN DE PAREJA ACTUAL O MAS RECIENTE.

- **SI ESTÁ PENSANDO EN SU PAREJA ACTUAL POR FAVOR CONTESTE LAS PREGUNTAS DE 9-15:**

- **SI ESTÁ PENSANDO EN SU EX-PAREJA MÁS RECIENTE POR FAVOR CONTESTE LAS PREGUNTAS DE 16-22:**

8. Primero por favor indique en quien está pensando cuando responde a estas preguntas:

□ Estoy pensando en alguien que es mi pareja actual. [Entrevistador/a: 9-15]
□ Actualmente no tengo pareja, por lo tanto, estaré pensando en mi ex-pareja más reciente. [Entrevistador/a: 16-22]

PENSANDO EN SU PAREJA ACTUAL…

9. ¿Cuánto tiempo llevan juntos?

□ Menos de un mes
□ 1 a 3 meses
□ 3 a 6 meses
□ 6 meses a un año
□ Más de un año (Si más de un año, ¿cuántos años han estado juntos? ____)

10. Su pareja es: □ Hombre □ Mujer

11. ¿Viven juntos? □ Sí □ No

11a.Si no viven juntos ¿cuán a menudo se ven por semana?

□ Un día por semana o menos
□ 2-3 días por semana
□ 4-5 días por semana
□ 6-7 días por semana

12. ¿Su pareja toma alcohol a su alrededor? □ Sí □ No

13. ¿Su pareja usa drogas a su alrededor? □ Sí □ No

14. ¿Cuán a menudo discuten o no están de acuerdo?

□ Nunca □ Raramente □ A veces □ Siempre

15. ¿Qué tan importante es esta relación para usted?

□ No muy importante □ Algo importante □ Importante □ Muy importante

PENSANDO EN SU EX-PAREJA MAS RECIENTE…

16. ¿Cuánto tiempo estuvieron juntos?

□ Menos de un mes
□ 1 a 3 meses
□ 3 a 6 meses
□ 6 meses a un año
□ Más de un año (si más de un año, ¿cuántos años estuvieron juntos? ____)

17a. ¿Cuánto tiempo llevan separados?

□ Hace menos de un mes
□ Hace 1 a 3 meses
□ Hace 3 a 6 meses
□ Hace 6 meses a un año
□ Hace más de 1 año

17b. ¿Cuál fue la razón por la separación? _____

17c. ¿Aún se ven? Si es así, ¿cuán a menudo? _____

18. ¿Su ex-pareja es? □ Hombre □ Mujer

19. ¿Cuando eran pareja, cuán a menudo se veían por semana?

□ Un día por semana o menos □ 2-3 días por semana □ 4-5 días por semana □ 6-7 días por semana

20. ¿Alguna vez su pareja bebió alcohol a su alrededor? □ Sí □ No

21. ¿Alguna vez su pareja usó drogas a su alrededor? □ Sí □ No

22. ¿Cuán a menudo discutían o estaban en desacuerdo?

□ Nunca □ Raramente □ A veces □ Siempre

23. ¿Cuán importante fue esta relación para usted?

□ No muy importante □ Algo importante □ Importante □ Muy importante

SECCIÓN D

Las siguientes preguntas se refieren a cosas que pueden haberle ocurrido a usted con su pareja en el último año. Si tiene pareja actual piense en su pareja actual. Si no tiene pareja actual piense en su expareja más reciente.

Durante un conflicto o discusión con mi pareja o ex-pareja más reciente:	**Sí**	**No**
1. Mi pareja me tocó sexualmente cuando no quería que lo hiciera.		
2. Mi pareja trató de poner a mis amigo/as en mi contra.		
3. Mi pareja hizo algo para ponerme celosa.		
4. Mi pareja destrozó o amenazó con destrozar algo que yo valoraba.		
5. Mi pareja sacó a relucir algo malo que yo había hecho en el pasado.		
6. Mi pareja me lanzó algún objeto.		
7. Mi pareja dijo cosas sólo para hacerme enojar.		
8. Mi pareja me habló en un tono de voz hostil u ofensivo.		
9. Mi pareja me forzó a practicar alguna actividad sexual cuando yo no quería.		
10. Mi pareja me amenazó en un intento de tener sexo conmigo.		
11. Mi pareja me insultó con humillaciones.		
12. Mi pareja me besó cuando yo no quería.		
13. Mi pareja dijo cosas a mis amigos/as sobre mi para ponerlos/as en mi contra.		
14. Mi pareja me ridiculizó o se burló de mi delante de otros.		
15. Mi pareja me siguió para saber con quién y dónde estaba yo.		
16. Mi pareja me culpó por el problema.		
17. Mi pareja me dio una patada, me golpeó o me dio un puñetazo.		
18. Mi pareja me acusó de coquetear con otro/a persona		
19. Mi pareja trató deliberadamente (al propósito) de asustarme.		
20. Mi pareja me abofeteó o me jalo del pelo.		
21. Mi pareja amenazó con herirme.		
22. Mi pareja me amenazó con dejar la relación.		
23. Mi pareja me amenazó con golpearme o con lanzarme algo.		
24. Mi pareja me empujó o sacudió.		
25. Mi pareja difundió rumores sobre mí.		

26. Si respondió “Sí” a cualquier pregunta de 1 - 25, cuéntenos sobre el momento más serio en que su pareja la agredió:

_____

_____

_____

_____

SECCIÓN E

Los siguientes grupos de preguntas son sobre el uso de alcohol y drogas. Cuando decimos alcohol nos referimos a cualquier bebida alcohólica como mezcal, cerveza, vino, licor, ron, o varias bebidas alcohólicas mezcladas. Por favor, también tenga en cuenta que un trago de alcohol se refiere a una cerveza, un trago de mezcal, o a una copa de vino, etc.

En el último año, ¿usó usted alguno de los siguientes?	**Sí**	**No**
1. Alcohol (más que unos pocos tragos de mezcal, cerveza, tequila, etc.)		
2. Cigarrillos		
3. Cigarrillos electrónicos (e-cigs, vapores).		
4. Marihuana (Cannabis)		
5. Marihuana sintética (kush, k2, especia)		
6. Cocaína (polvo, crack o freebase)		
7. Anfetaminas (speed, cristal, manivela, hielo)		
8. Inhalantes (pegamento inhalado, resoplido, etc.)		
9. Alucinógenos (LSD / ácido, PCP, hongos / hongos)		
10. Medicamentos de venta libre para el resfriado o la tos con la intención de drogarse (DXM, Triple Cs, Skittles, drank)		
11. El éxtasis (MDMA, X, XTC, E)		
12. Medicamentos que no fueron recetados para usted por un profesional de la salud. Por favor díganos cuales son:		
13. Medicamentos que fueron recetados para usted por un profesional de la salud, pero que usted uso más de lo indicado. Por favor díganos cuales son:		

14. ¿Alguna vez sintió que debería reducir su consumo de alcohol o drogas?
____SI _____NO

15. ¿Le ha molestado la gente criticando su consumo de alcohol o drogas?
____SI _____NO

16. ¿Se ha sentido mal o culpable por su consumo de alcohol o drogas?
____SI _____NO

17. ¿Alguna vez ha tomado una bebida o usado drogas a primera hora de la mañana para calmar sus nervios o deshacerse de una resaca/cruda?
___SI _____NO

SECCIÓN F

Las siguientes preguntas son sobre preocupaciones que a veces tenemos.

En general, ¿qué tan ciertas son las siguientes afirmaciones sobre usted?:	**Casi nunca o nunca es cierto**	**Algunas veces es cierto**	**Casi siempre o siempre es cierto**
1. Me preocupa caerle bien a la gente.			
2. Soy una persona nerviosa.			
3. Me preocupa ser tan buena como otras personas.			
2. Me preocupo de que las cosas me salgan bien.			
5. Me preocupo demasiado.			
6. Las personas me dicen que yo me preocupo demasiado.			
7. Me preocupo de que me pasará en el futuro.			
8. Me preocupo de que tan bien hago las cosas.			
9. Me preocupo de las cosas que ya han pasado.			

A continuación, hay una lista de las formas en que usted podría haberse sentido o comportado. Por favor dígame cuán a menudo se ha sentido así durante la SEMANA PASADA/ ULTIMOS 7 DIAS:

DURANTE LA SEMANA PASADA…	Raramente o nunca (menos de 1 día)	Algún o un poco de tiempo (1-2 días)	Ocasionalmente (3-4 días)	La mayoría o todo el tiempo (5-7 días)
1. Me molestaron cosas que usualmente no me molestan.				
2. Tenía dificultad para mantener mi mente en lo que estaba haciendo.				
3. Me sentía deprimida.				
4. Sentía que todo lo que hacía era un esfuerzo.				
5. Me sentía optimista sobre el futuro.				
6. Me sentía con miedo.				
7. Mi sueño era inquieto (no puedo dormir bien).				
8. Estaba contenta.				
9. Me sentí sola.				
10. No tenía ganas de hacer nada.				

Las próximas preguntas son sobre su salud o cosas que le puedan molestar.

11. Diría usted que su salud general es:

□ Excelente
□ Muy buena

□ Buena
□ Mas o menos
□ Mala

12. Pensando ahora en su salud física, incluyendo enfermedades y lesiones físicas, ¿cuántos días durante los últimos 30 días diría usted que su salud física NO fue buena? ____ días

13. Ahora piense en su salud mental/nervios, incluyendo estrés, depresión y problemas con las emociones, ¿cuántos días durante los últimos 30 días diría usted que su salud mental/salud de nervios NO fue buena? ____ días

14. Durante los últimos 30 días, ¿por cuántos días la mala salud física o mental/salud de los nervios le impidió realizar sus actividades habituales, como cuidarse, trabajar o divertirse/relajarse? ____ días

15. En general, su salud física es:

□ Mejor que la mayoría de las personas de su edad
□ Casi igual que la mayoría las personas de su edad
□ Peor que la mayoría de las personas de su edad

16a. ¿Ha recibido tratamiento/consejería de salud mental/salud de los nervios EN EL ULTIMO AÑO por parte de un psicólogo(a), psiquiatra, trabajador(a) social o consejero(a)?

□ Sí □ No

16b. En caso afirmativo, ¿a qué tipo de especialista acudió? _____

17. ¿ACTUALMENTE está tomando algún medicamento recetado por un(a) profesional de la salud utilizado para tratar la depresión, la ansiedad, o cualquier otro problema psicológico o de salud mental/salud de los nervios?

□ Sí □ No □ No actualmente, pero si en el pasado

18. Ha recibido tratamiento/consejería de salud mental/salud de los nervios EN EL ULTIMO AÑO por parte de un curandero(a), yerbero(a), sobador(a), etc.?

□ Sí □ No □ No actualmente, pero si en el pasado

¡Gracias por su participación! La encuesta se ha completado.

Qualitative Interview Guide

Mexican Immigrant women: Perspectives on migration, health, and Intimate Partner Violence (IPV)

Hello! Thank you for your time today. You have been invited to participate in a one-on-one interview about health and intimate partner violence in Mexican immigrant women. Remember: I am interested in your thoughts and ideas; there are no right or wrong answers. We will meet for about 45 minutes to an hour, and I will ask you a few questions. You can participate as much or as little as you feel comfortable doing. Remember, this is just a conversation and I am interested in your thoughts and experiences about the topic, health and intimate partner violence in Mexican immigrant women. Do you have any questions and/or need for clarification before we start?

Internal Migration Experience

1. Please tell me about your migration experience? What brought you to Mexico City?

2. Please tell me how you define intimate partner violence. Please feel free to give me more than one definition if you would like.

3. In what ways are the experiences of IPV related to physical health? Mental health?

IPV and Cultural and Social Environments

4. How do you believe women who experience IPV are perceived by Mexican society? By their family and friends? How do you think family members (both immediate and extended) might react if a woman experiencing IPV disclosed the situation to her family?

5. What are some examples of family and cultural values that you believe may be involved in situations of IPV? For example, family and cultural values that might make it easier or harder for women to disclose IPV?

6. What would be the role of a woman's support system (e.g., family, friends, or neighbors) in situations of IPV?

IPV and Political Environment

7. If someone was experiencing IPV, where might they go to ask for help? What might get in the way of asking for help?

8. How would someone experiencing IPV report it, and to whom?

9. What do you think is the role of legal authorities (for example, the police or the courts system) in intimate partner violence?

10. What do you think service providers, legal authorities, and policymakers can do to better help victims of IPV?

11. Is there anything else you would like to share about IPV and health in Mexican immigrant women?