INTIMATE PARTNER VIOLENCE AMONG UNDOCUMENTED SPANISH-SPEAKING IMMIGRANTS: PREVALENCE AND HELP-SEEKING BEHAVIORS IN PHILADELPHIA

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ABSTRACT

Background: Although prior research has established intimate partner violence (IPV) as a widespread public health problem in the U.S., little is known about IPV prevalence, help seeking behaviors, and health outcomes among undocumented Spanish-speaking immigrants.

Purpose: To describe the IPV prevalence, help seeking behaviors and related health outcomes among undocumented Spanish-speaking immigrants. This study also investigates the acceptability of IPV screening and help-seeking behaviors of Spanish-speaking undocumented immigrants in Philadelphia.

Methods: Two hundred undocumented Spanish-speaking women completed a survey that assessed intimate partner violence, major depressive disorder (MDD), post-traumatic stress disorder (PTSD), and health-related quality (HRQL) of life. Pearson's chi-squared test was used to determine the association between the socio-demographic variables, IPV and the health outcomes. Logistic regression examined the multivariate association between the exposure and outcomes. Five individual interviews with Spanish-speaking undocumented immigrant IPV survivors and one focus group interview with community health workers (CHWs) were conducted to better understand help-seeking behaviors, motivations, and experiences.

Results: Sixty-nine (34.5%) of the women in the sample screened positive for lifetime IPV. Of these women, 56.6% sought help from either formal or informal sources as a

result of the violence. Of the entire sample, 41.5% endorsed major depressive disorder and 16% endorsed post-traumatic stress disorder. In fully adjusted logistic regression models, only the association between IPV and PTSD was significant (OR: 4.143, CI: 1.21-14.24). Results from the qualitative interviews indicated that screening by health care providers (HCPs) was acceptable, the primary motivation for help-seeking was severe and/or escalating violence, and unique help-seeking barriers for this population included: lack of knowledge about IPV services, language barriers, and fears of deportation (for partner or for themselves).

Discussion: Immigrants identified several help-seeking barriers unique to undocumented immigrant IPV survivors. Fears of family separation resulting from deportation and loss of child custody are unique help-seeking barriers for undocumented immigrants. Health and social service organizations serving this population should use this information to inform IPV treatment and prevention programs for women. The overall high prevalence of MDD and PTSD in the sample population was high and there was an increased risk of PTSD in IPV survivors compared with non-survivors. Our findings highlight the need for quality mental health and trauma-informed services tailored to the needs of undocumented Spanish-speaking immigrant women, including increased access to mental health services in primary healthcare settings.

ACKNOWLEDGEMENTS

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inspiration and were the motivation me to finish this dissertation and a reminder to continue to advocate for the rights of undocumented immigrants in the United States. Y finalmente, gracias a las promotoras de salud. Irma, Susana, Alma, Isabel, Fabiola, y Rosalinda, ustedes son mis amigas y compañeras. Su ayuda fue extraordinaria. Gracias por todo.

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CHAPTER 1: INTRODUCTION

Background

IPV among Latinas in the United States

Although IPV affects women from all racial/ethnic groups in the United States, historically, research has explored IPV among Caucasian women (Klevens, 2007). More recently there have been a number of studies that aim to better describe the prevalence and determinants of IPV among Latinas in the United States (Ingram, 2007; Klevens, 2007; Rodriguez et al., 2008; Zarza, Ponsoda, & Carrillo, 2009). Latinos are the largest and fastest growing minority population in the United States, compromising approximately 16% of the U.S. population. Approximately 25 million women living in the United States identify as Hispanic or Latina (Ruggles et al., 2012). The magnitude of the Latino population living in the United States underscores the importance of research and health interventions with this population.

Several studies have reported the prevalence of IPV among Hispanic populations in the United States (Black et al., 2010; Caetano, Schafer, Clark, Cunradi, & Raspberry, 2000; Hass, Dutton, & Orloff, 2000; Klevens, 2007). The most recent nationally representative data that includes Hispanics comes from the 2010 National Intimate Partner and Sexual Violence Survey. The survey found that compared to White women, Hispanic women were more likely to report experiencing IPV in their lifetime: 37.1% of Hispanic women reported rape, physical violence and/or stalking by an intimate partner during their lifetime, compared to 34.6% of Caucasian women (Black et al., 2010). This is consistent with other studies that indicate that rates of IPV among Latinas are higher than, possibly

up to double, the rates of violence experienced by Caucasian women (Adams & Campbell, 2012; Caetano, Nelson, & Cunradi, 2001; Hass et al., 2000; Hien & Ruglass, 2009). Some research has indicated that this disproportionate risk may be explained by relative differences between Hispanic and Caucasian populations with respect to income, age, alcohol consumption and geography(Klevens, 2007; Runner, Novick, & Yoshihama, 2009). While some differences by race/ethnicity can likely be explained by socio-demographic and population differences, IPV may also differ in other important ways in Hispanics, including in the form (including severity) it takes and harm it produces. Previous studies have found that Hispanic women are more likely to experience more severe physical IPV compared to Caucasian women (Straus & Smith, 1990), and to consider suicide after IPV experiences (Denham et al., 2007). Additionally, Latinas are less likely to be asked about their IPV experiences by health service professionals and are less likely to be familiar with community resources available for abused women when compared with non-Latinos . The raised prevalence of IPV among Latinas in the United States warrants further investigation.

While available data suggest that IPV may be more common in Latina populations, a major limitation of the nationally representative data is that women from diverse socio-cultural, geographic, and linguistically different regions are categorized as one homogenous group. While large areas of Latin America share linguistic similarities, distinctions exist including differences in race/ethnicity, cultural practices, and social norms.

IPV Experiences for Undocumented Immigrants in the United States

There are approximately 12 million undocumented immigrants residing in the United States, over half of whom are from Latin America and the Caribbean. Mexico is the primary country of origin for undocumented immigrants in the United States, with 52% of all unauthorized persons in the United States from Mexico (Pew Hispanic Center, 2013). As of 2014, there have been no studies that measure the population prevalence of IPV for populations of specific immigration status and country of origin. Studies with smaller and more restricted immigrant populations (e.g. a mix of documented and undocumented immigrants) report mixed results. Some have found that immigrant women (not stratified by immigration status) are more likely to experience IPV (Adams & Campbell, 2012; Raj & Silverman, 2002), more likely to be the victim of a homicide by an intimate partner (Raj & Silverman, 2002), and more likely to stay in an abusive relationship when compared to non-immigrants in the U.S (Torres, 1991). Others have reported that immigrant women experience IPV at the same rate or less frequently than non-immigrant women (Torres, 1991). These studies primarily include immigrant women from Latin American and South Asia. Similar to differences in the observed frequency of IPV among non-immigrant populations in the United States, these patterns may reflect differences in study samples as well as study design.

Undocumented immigrants face unique challenges that influence their experiences with IPV and their decision to seek help as a result. Many of the risk factors associated with IPV (discussed in detail below) disproportionately affect undocumented immigrants. For example, undocumented immigrants are almost twice as likely to have incomes below

133% of the federal poverty level compared to native-born U.S. residents. They are also more likely to be younger than the native-born population (2009). While a large literature exists on the risk and protective factors of IPV, undocumented and/or immigrant women may be more vulnerable to IPV and less likely to seek help than U.S. women because of disparities in English language proficiency, socio-economic status, social isolation, and fear related to immigration status (Runner et al., 2009). Prior research has also explored the extent to which differences in acculturation patterns between male and female Mexican immigrants may lead to increased marital distress, another risk factor for IPV (Runner et al., 2009; Sokoloff & Dupont, 2005).

Scope of Problem

IPV is one of the most common forms of violence against women globally (Watts & Zimmerman, 2002) and by definition includes acts of physical, sexual, emotional/psychological abuse, and controlling behaviors between partners in an intimate relationship (World Health Organization, 2002). Controlling behaviors include limiting or restricting access to family and friends, financial resources, work, education, and health care services (World Health Organization, 2002). Based on a review of global population-based studies, the lifetime prevalence of IPV worldwide is estimated to be as high as 70% (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Heise, Ellsberg, & Gottemoeller, 1999). In the United States approximately 25-33% of women report being physically abused and/or raped by an intimate partner (Black et al., 2010; Tjaden & Thoennes, 2000). Data from the 2010 National Intimate Partner and Sexual Violence Survey found that 35.6% of women have experienced physical violence, rape and/or

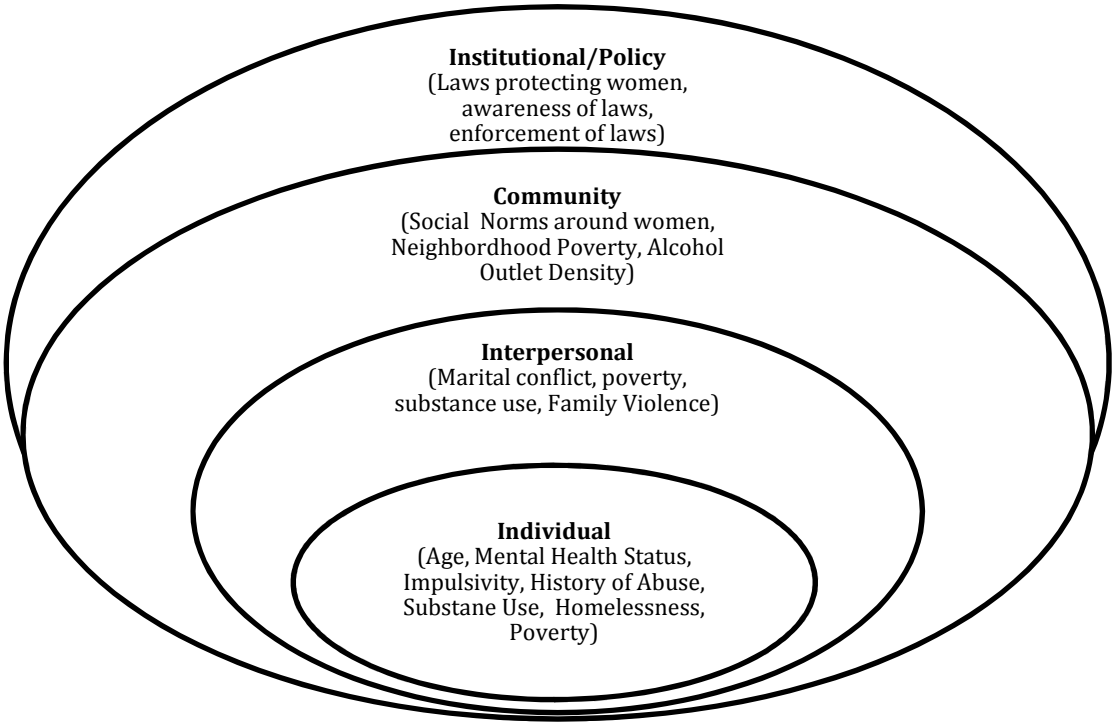
stalking by an intimate partner in their lifetime. In the same study, 5.9% of women in the United States reported experiencing rape, physical violence, and/or stalking by their partner in the previous 12 months (Black et al., 2010). Prior victimization is a risk factor for IPV, and for women who report IPV, re-victimization is common (Walton-Moss, Manganello, Frye, & Campbell, 2005). Approximately 1.5 million women are raped or physically assaulted by an intimate partner each year, resulting in approximately 4.8 million incidences of rape or abuse (Tjaden & Thoennes, 2000).

Risk Factors for IPV

Previous research has identified factors at the individual, interpersonal, community, institutional and policy levels associated with the likelihood of experiencing IPV. Individual risk factors include youth, mental illness, impulsivity, previous abuse, homelessness, heavy drinking, and poverty (Cunradi, 2010; Feder, Hutson, Ramsay, & Taket, 2006; Jewkes, 2002; Shobe & Dienemann, 2008; Walton-Moss et al., 2005). Interpersonal risk factors include marital conflicts, marital instability, financial distress, substance abuse, and family history of violence (Centers for Disease Control and Prevention, 2010; Cunradi, 2010). Examples of community-level risk factors include social norms that promote or accept violence and/or hostility toward women, high density of alcohol outlets, neighborhood poverty, and socially disorganized neighborhoods (Centers for Disease Control and Prevention, 2010). Examples of policy-level risk factors include lack of comprehensive policies that protect women, lack of clarity regarding the provisions of the policy, and/or lack of enforcement of existing policies. Figure 1 below summarizes the multiple levels of influence and provides examples of risk factors at each

level. While Figure 1 indicates that risk factor can be categorized into distinct levels of influence, each levels influences others. For example laws and policies that protect survivors of IPV are likely to influence social and community norms around the perpetration and reporting of IPV.

Figure 1. Social Ecological Model: Risk Factors for IPV

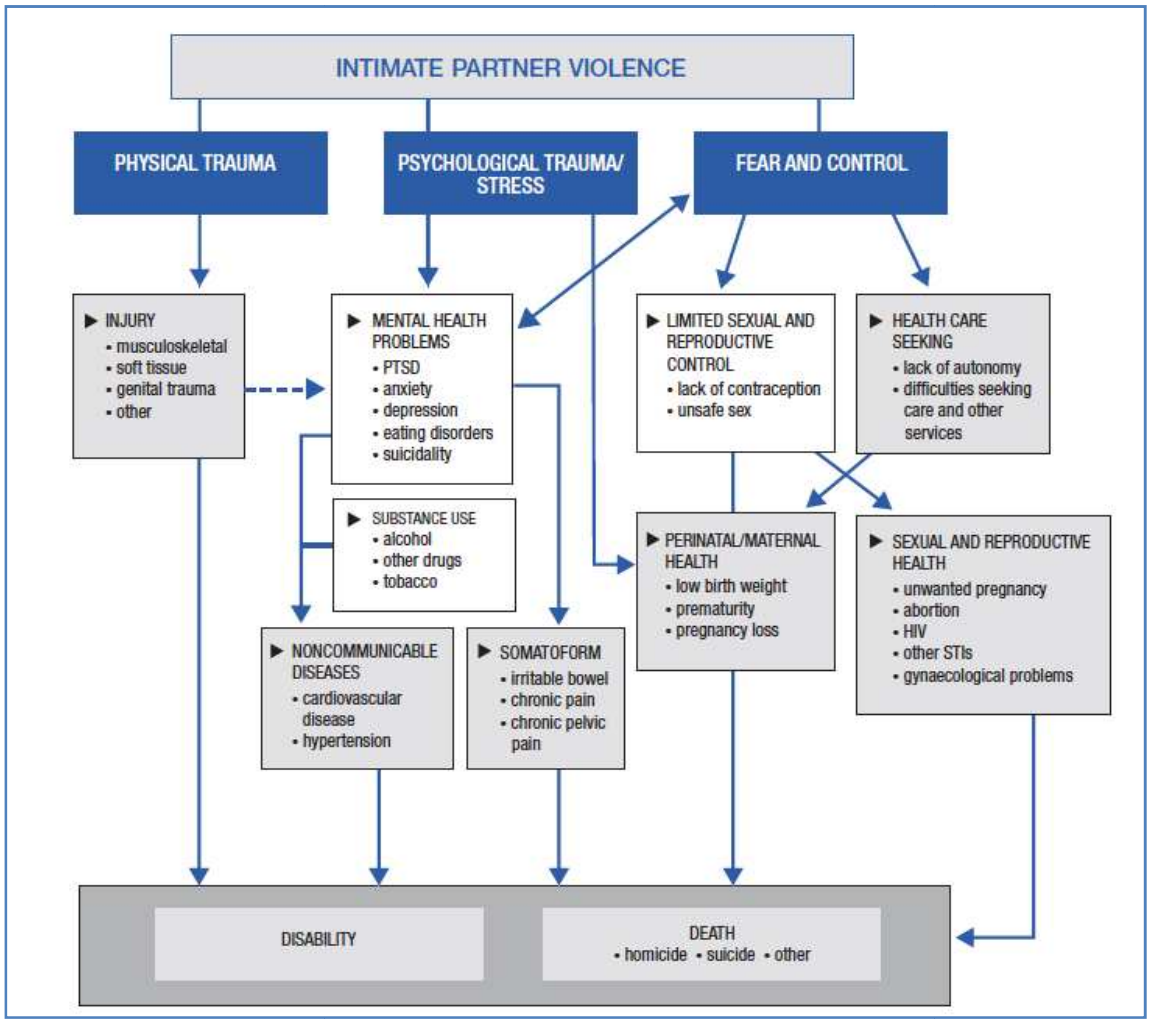


Health Consequences of IPV

The health consequences of IPV against women are severe and numerous, affecting short and long-term physical and mental health. Figure 2 is from a 2013 World Health Organization report, and outlines the negative health effects of IPV. Similar to findings from other studies, the WHO reports that in addition to a wide range of short-term physical health problems—such as bruises, cuts, welts, broken bones, and lacerations—

survivors of IPV are more likely than their non-abused counterparts to report poor long-term physical health outcomes including irritable bowel syndrome, cardiovascular disease, chronic pain, and hypertension. Additional research reports that victims of IPV are also more likely to report asthma, diabetes, headaches, contract sexually transmitted diseases, including HIV, have complications in pregnancy, and have an abortion (Black et al., 2010; Campbell, 2002; Ann Coker, 2005; World Health Organization, 2013).

Figure 2. IPV and Health Effects



(World Health Organization, 2013)

Female survivors of IPV also report worse mental health outcomes than their non-abused counterparts, including increased rates of depression, post-traumatic stress disorder (PTSD) and chronic mental illness (AL Coker et al., 2002; Fedovskiy, Higgins, & Paranjape, 2008). Severity, frequency, and type of IPV exposure predicts the severity of mental health symptoms in IPV survivors. Women who experienced IPV at a young age or who report multiple types of IPV are at increased risk for negative mental health outcomes (Carlson, McNutt, Choi, & Rose, 2002). While establishing a causal and temporal link between IPV experiences and mental health outcomes is methodologically challenging, previous research has found a strong association between major depressive disorder (MDD) and PTSD, with IPV (Fedovskiy et al., 2008; Nixon, Resick, & Nishith, 2004). Conversely, IPV survivors who receive cognitive-behavioral therapy for PTSD and/or depression have been shown to experience less IPV in the future compared to survivors not receiving therapy (Iverson et al., 2011). These and other studies indicate that the relationship between mental health and IPV experiences is complicated and that mental health is likely both a risk factor and outcome of IPV (Bell, Cattaneo, Goodman, & Dutton, 2008; Iverson et al., 2011; Perez & Johnson, 2008).

Major Depressive Disorder (MDD) is a leading cause of disability in the United States, particularly among ethnic and racial minority groups (González, Tarraf, Whitfield, & Vega, 2010). The National Institute of Mental Health's Collaborative Psychiatric Epidemiology Survey found national prevalence estimates of 8.1% for the 12-month and 18.6% lifetime prevalence of MDD in U.S. adults over 18 years old. In the same study,

Mexican Americans and foreign-born populations had lower rates of depression compared to their Caucasian counterparts (lifetime MDD: 14.5% Mexican Americans; 20.4% Whites; 12.4% foreign-born) (González et al., 2010).

Post-traumatic stress disorder (PTSD) is an anxiety disorder that is a result of experiencing or witnessing traumatic events. PTSD is often characterized by reliving the traumatizing incident through flashbacks and nightmares, the avoidance of specific thoughts or situations, and experiencing feelings that disrupt everyday life (American Psychological Association, 2013). Based on data from the U.S. National Epidemiological Survey on Alcohol and Related Conditions, the prevalence of lifetime PTSD in the United States is 6.4%, with women being more susceptible to PTSD than men (8.6% vs. 4.1%) (Pietrzak, Goldstein, Southwick, & Grant, 2011). Among women expressing PTSD symptomology, sexual assault and physical abuse from an intimate partner are two of the most common traumatic events experienced (Pietrzak et al., 2011).

Gaps in Knowledge

There is currently no consensus in the literature about whether undocumented Latina immigrants are more likely or less likely to experience IPV compared to documented persons living in the U.S. The lack of research with immigrant populations is a gap in knowledge in the field of IPV.

Within the U.S., undocumented immigrants vary from one geographic region to another; country of origin and the socio-environment likely account for these (Passel, Cohn, &

Gonzalez-Barrera, 2013). Family and community characteristics, religious beliefs, and socio-cultural norms in their country of origin may all influence IPV and help-seeking experiences. Furthermore, experiences in the United States, including community characteristics, social, cultural norms, and available programs and policies are all likely to influence the IPV prevalence and help-seeking behaviors of immigrants. More research is needed to understand the unique experiences of immigrant groups living throughout the U.S. There are currently no published studies that look exclusively at the prevalence of IPV and/or help-seeking behaviors of undocumented Spanish-speaking women in a northeastern city of the United States. In a literature review, one qualitative study was identified that investigated the help-seeking behaviors of undocumented immigrant women (Reina, Maldonado, & Lohman, 2013). The current study will add to the existing body of knowledge by investigating the IPV prevalence and help-seeking behaviors of undocumented Spanish-speaking immigrant women in Philadelphia. The specific aims and hypotheses of the study are presented in the following section.

Specific Aims

This dissertation project aims to better understand the associations between the prevalence of IPV, IPV help-seeking behaviors, and health among an urban, Spanish-speaking, undocumented female immigrant sample. The study uses a mixed methodology approach to data collection: a quantitative Women's Health Survey and data from individual and focus group interviews. Information from multiple sources and perspectives will emerge from this research, including IPV victims, healthcare

professionals, social service providers, and a review of available programs and policies that affect undocumented IPV victims.

Specific Aim 1: To describe the prevalence of intimate partner violence and help-seeking behaviors among undocumented Spanish-speaking immigrants in an urban primary care clinic.

Hypothesis 1a: Undocumented Spanish-speaking immigrant women experience IPV at an equal rate as the general U.S. population of women.

Hypothesis1b: Undocumented Spanish-speaking immigrant women who have experienced IPV are more likely to seek help from informal networks (e.g. friends, family) than formal networks (e.g. police, hospitals, non-profit organizations, NGO's).

Specific Aim 2: To describe the functional and emotional health of undocumented Spanish-speaking immigrant women who have experienced IPV compared to undocumented Spanish-speaking immigrant women who have not experienced IPV.

Hypothesis 2a: Undocumented Spanish-speaking immigrant women who experience IPV are more likely to endorse major depressive disorder and post-traumatic stress disorder (PTSD) compared to their non-abused undocumented Spanish-speaking immigrant counterparts.

Hypothesis 2b: Undocumented Spanish-speaking immigrant women who experience IPV are more likely to report lower health-related quality of life compared to their non-abused undocumented Spanish-speaking immigrant women counterparts.

Specific Aim 3: To document the IPV help-seeking behaviors of undocumented Spanish-speaking immigrant women who experienced IPV while living in Philadelphia.

Theoretical Framework

To better understand how women comprehend their IPV experiences and the factors that influence their decision to seek help, a theory of help-seeking as outlined by Liang et al. (2005) was selected to guide the development of the qualitative elements of this research. This model of help-seeking behavior integrates elements of the ecological model and stages of change models.

According to Liang et al., there are three primary processes of help-seeking, each influenced by individual, interpersonal, and sociocultural factors. The authors emphasize that although the help-seeking processes are shown as three discrete mechanisms in the model, they are all inter-related and do not proceed in a linear fashion, as indicated by the double arrows in the model (Liang, Goodman, Tummala-Narra, & Weintraub, 2005). The processes of help-seeking outlined in the Liang et al. model are described briefly here. While the Liang et al. model of help-seeking was not designed specifically for IPV work

with undocumented immigrant populations, a strength of the model is that it can be easily adapted to include a range of influential factors. Examples of individual, interpersonal, and sociocultural influences that are unique to the undocumented immigrant population in this study have been integrated into the description of the model below to show how it will be adapted to fit the target population.

Problem Recognition and Definition

Women who have experienced IPV and the professionals who work with survivors of violence, including health care workers, police, and social service providers, may all define IPV differently. How a woman defines her experiences, and whether or not she considers the actions to be abusive, influences if and with whom she may seek help. Whether and how a woman recognizes and defines the problem is influenced by individual factors, such as how ready she is to make changes in her life, which incorporates stages of change theory (DiClemente et al., 1991). For example, if a woman is in a pre-contemplative stage, she is unlikely to define her experience as abuse and therefore is unlikely to be contemplating seeking help (Liang et al., 2005). Interpersonal factors, such as the constantly changing nature of the relationship with an intimate partner, and the reactions of friends and family to accounts of abuse, shape a woman's recognition and definition of abuse. Finally, larger socio-cultural influences, such as typical gender roles as well as cultural and religious norms, all influence if and how abuse is recognized and defined (Liang et al., 2005). Among undocumented immigrants from Latin America, problem recognition and definition is an important concern. Typical gender roles in which women are passive or submissive to their male partners and

observed family relationships in their country of origin may influence women to view certain forms of partner violence as normative behaviors (Fuchsel, Murphy, & Dufresne, 2012; Kyriakakis, Dawson, & Edmond, 2012; Sokoloff & Dupont, 2005).

Decision to Seek Help

Help-seeking decisions are influenced by the severity and frequency of the abuse, cultural norms, gender roles, and prior help-seeking experiences. Previous research has found that women who recognize the abuse as a problem, and believe the problem will not be resolved without the help of others, are most likely to reach out for help (Liang et al., 2005). Also drawing on a stages of change model, prior studies have found that women often first reach out to informal support networks, such as friends and family, and become more likely to draw on formal support networks, such as law enforcement and social service providers, when violence escalates (Liang et al., 2005). Prior experiences include both informal and formal experiences. If informal networks minimized the IPV experiences in the past or if formal networks were unable to provide necessary and culturally appropriate support, women will be less likely to seek help again in the future (Liang et al., 2005). In addition to the individual, interpersonal and sociocultural influences described by Liang et al., the target population in this research likely face a number of unique challenges during the help-seeking process including language barriers, fear of law enforcement linked to immigration status, and lack of social support caused by immigration (Adams & Campbell, 2012; Ammar, Orloff, Dutton, & Hass, 2012; Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Fuchsel et al., 2012).

Support Selection

Selection of the "help provider" refers to the process of deciding with whom to seek help and is typically categorized as either formal or informal help-seeking. Prior research has found that help-seeking is potentially beneficial to women, with informal help-seeking improving the mental health outcomes of women (including MDD and PTSD) (Carlson et al., 2002), and formal help-seeking making women less likely to experience serious physical IPV in the future (Goodman, Dutton, Vankos, & Weinfurt, 2005; Liang et al., 2005). In deciding to seek help, factors such as a woman's personal coping style, cost-benefit analysis of her loss of privacy, strength of social relationships, and cultural norms, may all influence her decision (Liang et al., 2005). For undocumented Spanish-speaking women in South Philadelphia, support selection may also be influenced by additional factors including language barriers, cost of service/lack of health insurance, lack of familiarity with the health, social and legal systems, and the policies and programs related to IPV in Philadelphia and nationally.

Using the theory proposed by Liang et al. and incorporating previous knowledge about factors that influence IPV specific to undocumented immigrants and Latinos, in conjunction with commonly used standardized survey instruments, this study investigates the prevalence of violence, the help-seeking behaviors of female IPV victims, and the health outcomes correlated with IPV among undocumented Spanish-speaking immigrants in South Philadelphia. The screening and referral practices of health and social service professionals are also explored.

Methods

Research Design

Data were collected to address the three specific aims of this project, and the mixed-method design included an initial quantitative survey phase, followed by a qualitative phase. The quantitative portion of the study (Specific Aims 1 & 2) collected information on the prevalence of IPV, the help-seeking behaviors of women who have experienced IPV, social support, and the mental and physical health status of women in the target population. The primary data was collected through a Women's Health Survey (Appendix 1) administered at *Puentes de Salud* (described below). Quantitative data collection was completed between August 2013 and May 2014.

Study Sample

Recruitment for this study was conducted at *Puentes de Salud*, a health clinic in South Philadelphia that serves mostly undocumented Spanish-speaking immigrants at a bi-weekly primary health clinic and at their Latina Community Health Services (LCHS) location, an obstetrics and gynecology clinic. LCHS serves women exclusively. Potential participants were recruited from the waiting room at both clinics and asked if they would be willing to participate in a Women's Health Survey, administered in a private room. Women, both patients and those accompanying patients, between 18-64 years old, were approached to complete the study questionnaire after undergoing the clinic's routine triage process. Patients determined to be in need of acute or emergency medical care, who were visibly intoxicated, or who did not speak fluent Spanish were not recruited to

participate in the study.[1] Women who were interested in participating and who met the age and medical requirements were escorted to a private room. Before completing the Women's Health Survey, the researcher assessed the immigration status and relationship history of potential participants. Only women who were undocumented and had been in an intimate relationship with a male partner during their lifetime were deemed eligible to complete the survey. Women who were currently in an abusive relationship with an intimate partner were provided with safety planning and explained their options for help-seeking, including domestic violence organizations, therapy, counseling, and legal action. Follow-up appointments and referrals were made as applicable.

To be eligible to participate in the individual interviews, participants must have completed the Women's Health Survey and reported having experienced IPV while living in Philadelphia. Women who met these requirements were asked if they were interested in participating in an individual interview at a later date to assess their knowledge of IPV resources available to them and their experiences speaking with their health care provider about IPV. Individual interviews were completed with five immigrant women and were conducted in Spanish. Interviews lasted between 30-60 minutes.

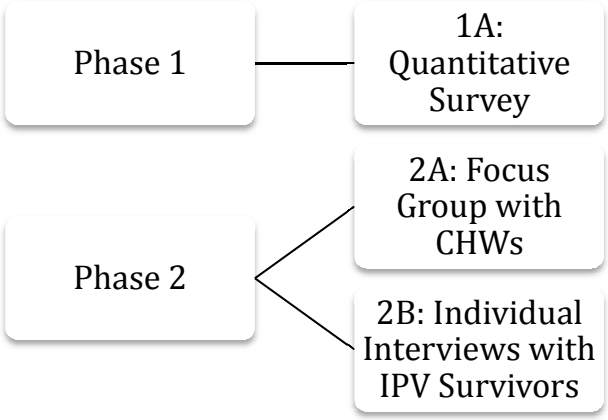
Community health workers (CHWs) were recruited from Puentes de Salud to participate in a 45-minute focus group that explored their knowledge of IPV, acceptability of IPV screening, and referral practices. All six CHWs working with *Puentes de Salud* were

[1] In the case that a women is ineligible because they are in need of immediate medical attention or are visibly intoxicated, the triage nurse was informed so that clinic staff could attend to the patient appropriately.

eligible did participate in the focus group. Example questions for the focus groups and interviews are provided in Appendix 2.

Data Collection – Women's Health Survey, Individual Interviews, and Focus Groups

Figure 3: Overview of Study Phases



Phase 1A: Women between the ages of 18 and 64 years old who visited Puentes de Salud or LCHS for health services and met the eligibility criteria were recruited to complete the Women's Health Survey. If they agreed to participate, women were escorted to a private room, received a detailed explanation of the study, and then provided oral consent in Spanish if they agreed to participate. Each survey took between 15-30 minutes to complete and included seven sections: (1) demographic information, (2) health-related quality of life, (3) depression, (4) social support, (5) IPV experiences, (6) help-seeking behaviors, and (7) PTSD. All survey questions were administered orally in Spanish by the author of this dissertation. (See English and Spanish-language versions of the survey instrument in Appendix 1.) Women were compensated $10 cash for their time.

Phase 2: The qualitative phase of this project (Specific Aim 3) includes (Phase 2A) the results from focus group interview with CHWs who work with undocumented Spanish-speaking immigrants and (Phase 2B) individual interviews with IPV survivors.

The focus group with the CHWs, who are social frontline lay persons who provide a link between their community and health and social services, explored IPV knowledge, referral practices, and acceptability of IPV screening by health care providers. A focus group was selected as the preferred methodology for the CHWs because focus groups often give rise to topics that may not have been anticipated by the researcher as a result of the group dynamic. Focus groups were also deemed advantageous over interviews in this context because they allow for the collection of data from more participants in a shorter time period, and reflected a more natural interaction in practice. CHWs were instructed not to disclose personal information or discuss individuals, limiting concerns about confidentiality.

The individual interviews (Phase 2B) with women explored IPV screening experiences and preferences and their help-seeking behaviors after experiencing IPV. Individual interview methodology ensured that women were not asked to disclose private or embarrassing information in front of their peers and created a safe environment for the individual participant to discuss. Women who completed the Women's Health Survey and reported currently experiencing IPV or having experienced IPV in a recent relationship while living in Philadelphia were invited to participate in an individual interview. Individual interviews took between 30-60 minutes to complete and women

were compensated $20 for their participation. All women who participated in individual interviews provided oral consent.

Measurement: Variables and Instruments

The Women's Health Survey collected information using multiple validated instruments. Based on feedback from members of the target population the language in some instruments was adapted slightly to improve comprehension. This section provides background information and an overview of each of the different instruments used in data collection. A complete English and Spanish language version of the Women's Health Survey is provided in Appendix 1. All surveys were administered in Spanish.

Table 1. Variables for Quantitative Analysis

Conceptual Model Area	Variable	Variable Name	Measure	Instrument
Input/Exposure Variable	IV	IPV	5-point Likert scale ranging from 0 (never) to 4 (always)	Index of Spousal Abuse to measure physical and non-physical IPV
Covariate	IV	Social support	Likert scale ranging from 1 (never/none of the time) to 5 (always/all of the time)	Medical Outcomes Study Social Support Survey to assess the social support of women
Covariates	IV	IPV risk and protective factors	Open-ended questions	Questions about: educational attainment, insurance status, marital status, alcohol and drug, age, country of origin, education status, marital status, and occupation
Outcome	DV	Help-seeking	Dichotomous and open-ended questions	Adaptation of the domestic violence module from the Demographic Health Survey. Help-seeking was categorized as none, informal, or formal
Outcome	DV	Major Depressive Disorder (MDD)	4-point Likert ranging from 0 (rarely or none of the time) to 3 (most or all the time)	Center for Epidemiologic Studies Depression Scale to assess the prevalence and severity of MDD among survey respondents
Outcome	DV	Post-traumatic Stress Disorder (PTSD)	5-point Likert scale ranging from 1 (not at all) to 5	Post-traumatic Stress Disorder CheckList-Civilian Version to assess PTSD symptomology among survey respondents

			(extremely)	
Outcome	DV	Health-related quality of life (HRQL)	12-item questionnaire with dichotomous and Likert scale questions	SF-12 survey to assess the mental and physical HRQOL among survey respondents.

Exposure variable —Index of Spouse Abuse

The Index of Spouse Abuse (ISA) is a validated (Cronbach's alpha 0.90) 30-item questionnaire that was designed to measure the prevalence and severity of physical and non-physical IPV against women (It does not measure stalking behaviors by an intimate partner). They survey was designed to be self-administered, with most women being able to complete the questions in approximately 5 minutes. Participants respond to the questions on a 5-point Likert scale ranging from 0 (never) to 4 (always). Based on the responses, individual questions are weighted and two scores are calculated: a physical ISA score (ISA-P) and a non-physical ISA score (ISA-NP) (Hudson & McIntosh, 1981).

The ISA has been validated across multiple settings. Independent evaluations by experienced therapists, considered to be the gold standard in determining if a women has experienced IPV, have been used to validate the ISA (Punukollu, 2003). The ISA has been validated with Spanish-speaking populations including populations in El Salvador, Spain, Peru, and Mexico (Monge, Iglesias, Sánchez, & de Lecea, 2011). Furthermore, Spanish-language versions have been used to measure IPV among US immigrant populations, including Mexican immigrants (Fedovskiy et al., 2008).

Mediator— Medical Outcomes Study Social Support Survey

The Medical Outcomes Study Social Support Survey (MOS SSS) is a 19-item validated scale developed to measure functional social support among patients with a chronic illness. It was originally tested on 3000 patients in three different geographic locations in the United States (Frank-Stromborg & Olsen, 2004). Items are scored on a Likert scale

ranging from 1 (never/none of the time) to 5 (always/all of the time). The instrument contains four subscales: emotional/informational, affectionate, tangible, and positive social interaction. There have been a limited number of studies that have used a Spanish-language version of the scale and only one study was identified that sought to validate the Spanish-language MOS SSS (Revilla Ahumada, Luna del Castillo, Bailón Muñoz, & Medina Moruno, 2005; Salinero-Fort et al., 2012). The authors concluded that the MOS questionnaire is valid in Spanish; however the sample for the study consisted of patients in a primary care setting in Spain, a country with significant linguistic differences as compared to Mexico (Revilla, 2005). Although this instrument has not been as widely used in Spanish compared to other scales that measure social support (e.g. Norbeck Social Support Questionnaire, Interpersonal Support Evaluation List), the MOS SSS was chosen because it is shorter and does not require participants to write the names of their social support network on paper. Writing down names of contacts is likely to be uncomfortable to the target population in this study. A Mexican community health worker and native Spanish-speaking social service provider from Puentes de Salud revised the instrument and helped adapt the language for a primarily Mexican audience. The adapted versions of all the Spanish language instruments are in Appendix 1.

Covariates —Demographic Characteristics and IPV Protective and Risk Factors

The Women's Health Survey was used to collect demographic and IPV risk/protective factor information. Examples of demographic variables collected include: age, country of origin, education status, marital status, and occupation. IPV risk/protective factor

questions include: insurance status, alcohol and drug use, and marital status. These variables were used to measure control for known risk and protective factors of IPV.

Covariate— Medical Outcomes Study Social Support Survey

The Medical Outcomes Study Social Support Survey (MOS SSS) is a 19-item validated scale developed to measure functional social support among patients with a chronic illness. It was originally tested on 3000 patients in three different geographic locations in the United States (Frank-Stromborg & Olsen, 2004; Sherbourne & Stewart, 1991). Items are scored on a Likert scale ranging from 1 (never/none of the time) to 5 (always/all of the time). The instrument contains four subscales: emotional/informational, affectionate, tangible, and positive social interaction. There have been a limited number of studies that have used a Spanish-language version of the scale and only one study was identified that sought to validate the Spanish-language MOS SSS (Revilla Ahumada et al., 2005; Salinero-Fort et al., 2012). The authors concluded that the MOS questionnaire is valid in Spanish; however the sample for the study consisted of patients in a primary care setting in Spain, a country with significant linguistic differences than Mexico (Revilla, 2005). Although this instrument has not been as widely used in Spanish compared to other scales that measure social support (e.g. Norbeck Social Support Questionnaire, Interpersonal Support Evaluation List), the MOS SSS was chosen because it is shorter and does not require participants to write the names of their social support network on paper. Writing down names of contacts is likely to be uncomfortable to the target population in this study. A Mexican community health worker and native Spanish-speaking social service

provider from Puentes de Salud revised the instrument and helped adapt the language for a primarily Mexican audience.

Outcome variable —Demographic Health Survey

The IPV help-seeking section of the Peru DHS was adapted and administered to women who reported experiencing IPV as determined by the Index of Spouse Abuse (ISA). Although the Peruvian instrument is in Spanish, linguistic differences exist between Peru and Mexico. In order to ensure that the target population understood the survey instrument, the language was reviewed and revised by two native Spanish-speakers: a Mexican community health worker and a social service provider at Puentes de Salud. Less than five minor modifications were made to the instrument.

Demographic Health Surveys (DHS) are nationally representative surveys administered in over 70 countries around the world and measure a wide range of health and social indicators, including family health, nutrition, and wealth. The complete DHS include questionnaires, biomarkers, and geographic data to collect information from participants (DHS, 2013). In some countries where the DHS is administered, the survey includes a sub-section on domestic violence, measuring the prevalence, incidence, and help-seeking behaviors of adult women. The DHS is not administered in the United States and was last administered in Mexico in 1987 (DHS, 2013). Neither of these surveys included the domestic violence section, and therefore the DHS questions related to domestic violence used in this study come from an instrument administered in Peru in 2009 (DHS, 2013).

Outcome variable —Center for Epidemiologic Studies Depression Scale

The Center for Epidemiologic Studies Depression Scale (CES-D) is a 20-item validated scale that was designed to measure depressive symptomology in epidemiological studies with the general adult population. The scale was developed in English and originally validated in the United States(Radloff, 1977). The scale is scored on a 4-point Likert scale, with responses ranging from 0 (rarely or none of the time) to 3 (most or all the time). The maximum score is 60, with higher scores indicating more depressive symptomology. A score of >15 is used to identify participants with Major Depressive Disorder (MDD)(Radloff, 1977). Participants who report a score >15 will be considered to have endorsed MDD.

The CES-D has been used with Spanish-speaking populations in the United States and has been found to be reliable. A study of the Spanish version of the CES-D with Mexican Americans found that there were no significant differences in the quality of data, including missing measures and internal consistency reliability, when compared to White Americans (Cronbach's alpha 0.88)(Roberts, 1980). The CES-D Spanish-language version has been used in an IPV study with US immigrant Mexican immigrants in the past(Fedovskiy et al., 2008).

Outcome Variable—Post-traumatic Stress Disorder CheckList-Civilian Version

The Post-traumatic Stress Disorder CheckList-Civilian Version (PCL-C) is a standardized scale for assessing post-traumatic stress disorder (PTSD). It is comprised of

17 items and designed to be self-administered. A second version of the scale is also available for participants with military experiences. The PCL-C is scored on a 5-point Likert scale and asks respondents to rate how much they have been bothered by specific problems, with responses ranging from 1 (not at all) to 5 (extremely). Scores can range from 17-85 with a higher score indicating more PTSD symptomology. Participants with a score >44 will be considered to have endorsed PTSD. Respondents using the Spanish version of this scale have been found to have substantially similar scores to those completing the English language version (Measure DHS, 2013). One identified study has utilized the PCL-C to measure PTSD symptoms among Hispanic survivors of IPV(Rodriguez et al., 2008).

Outcome Variable— Short Form Health Survey

The Short Form Health Survey (SF-12) is a 12-item self-administered survey measuring functional and mental health-related quality of life (HRQL). The domains of the SF-12 each have a standardized mean of 50 with possible scores ranging from 0-100. A higher score indicates better overall health. The SF-12 was adapted from the longer SF-36, which was originally developed to survey the health status in the Medical Outcomes Study. The SF-12 measures eight different subscales of physical and mental health over the past four-week period (Ware Jr, Kosinski, & Keller, 1996; Ware Jr & Sherbourne, 1992). Several prior studies have used a Spanish-version SF-12, although none reported information on the validity of the Spanish-language version (Hillemeier, Weisman, Chase, & Dyer, 2008; Klevens, 2007). After researching alternative instruments, the Spanish-language SF-12 was deemed to be the best instrument available for this study.

Study Strengths & Limitations

IPV impacts women of all races/ethnicities and across all social strata (Black et al., 2010; Tjaden & Thoennes, 2000). However, undocumented Spanish-speaking immigrants represent a particularly vulnerable population and are widely underrepresented in health-related research, and specifically in violence against women research. This may be because undocumented immigrants are more reluctant to participate in research due to their immigrant status, researchers are hesitant to ask about sensitive immigration information, language barriers, and/or because undocumented immigrants are treated as an invisible population in the United States.

Strengths of this study include the measurement of physical health and mental health. In addition to providing knowledge to the field of IPV, it will provide information to guide the development/ improvement of programs that serve undocumented immigrant IPV survivors. An additional strength of the study is my connection and knowledge of this particular community. I have been working with Puentes de Salud for several years and have built a trusting relationship with community stakeholders as well as with health and social service providers who treat the target population. My prior work with Puentes de Salud laid the groundwork for this dissertation research. It introduced me to the target community and provided me a unique understanding of the language and socio-cultural norms of undocumented Spanish-speaking immigrants in Philadelphia. Prior to my work with Puentes de Salud I worked with Spanish-speaking undocumented immigrants in

Washington, DC and Arizona. My connection with Puentes de Salud allowed me access to a vulnerable population that is not easily accessed by researchers.

The descriptive statistics measured in this study are necessary both to inform the work of health and social service providers working with the target population and to advance future research and work with the target population. Through understanding the magnitude and severity of the problem, health and social service providers can make educated decisions on how to direct additional resources of programs. Future research, possibly examining the pathways by which IPV impacts certain physical and mental health outcomes, is dependent on first understanding the prevalence of IPV and the correlation with health outcomes. This study provides a strong base for future programmatic and research activities related to IPV among undocumented Spanish-speaking women in Philadelphia, particularly for longitudinal research with this population to measure how IPV and help-seeking behaviors change over time.

One limitation of this study is the sample. A convenience sample of women seeking primary health care services is not a representative sample of the community. The sample of women at the health centers was not selected randomly. The non-representative sample reduces the generalizability of the findings to other populations. Furthermore, the cross-sectional nature of the study does not allow for temporal associations. Future research in this area may benefit from using a random sampling design and expanding the sample population.

Dissertation Overview

The dissertation will follow a three-manuscript model, with each of the next three chapters addressing one of the three specific aims presented in this chapter[2]. In Chapter 2, I present the prevalence of IPV among the target population of female Spanish-speaking undocumented immigrant between the ages of 18-64 who were at a primary care health clinic and describes the association of IPV with demographic, risk, and protective factors. It also describes the IPV help-seeking behaviors of IPV survivors. Chapter three describes the functional and emotional health of women from the study sample, comparing those who have experienced IPV during their lifetime to those who have had no IPV experiences. Chapter four examines how CHWs understand and refer women who are experiencing IPV for additional services, as well as disclosure and help-seeking behaviors of undocumented immigrant IPV survivors.

Finally, the conclusion outlines the key findings from the three research hypothesis, discusses areas for future research and makes recommendations for primary health care clinics serving female Spanish-speaking undocumented immigrants. IPV is a serious public health problem correlated with a wide range of negative physical and mental health outcomes for victims. The research in this dissertation helps program and policy makers better understand how IPV affects the health of undocumented Spanish-speaking immigrants. Findings from these studies have the potential to provide the information

[2] Each of the specific aims outlined in the above section will make up a chapter of the dissertation and will be in the format of a stand-alone academic manuscript.

necessary to support additional culturally competent services to an underserved and under-researched population.

CHAPTER 2: THE PREVALENCE OF INTIMATE PARTNER VIOLENCE AND RELATED HELP-SEEKING BEHAVIORS IN A SPANISH-SPEAKING UNDOCUMENTED IMMIGRANT POPULATION

Abstract

Background: Although prior research has established intimate partner violence (IPV) as a widespread public health problem in the U.S., little is known about IPV prevalence and help seeking behaviors in undocumented Latina immigrants, who are understudied in the existing literature.

Purpose: This study seeks to contribute new knowledge to the study of IPV by describing the IPV prevalence and help seeking behaviors of undocumented Spanish-speaking immigrant women.

Methods: Two hundred undocumented Spanish-speaking women were recruited from urban healthcare centers to complete a survey about women's health. The Index of Spousal Abuse was used to assess lifetime IPV experiences. Pearson's chi-squared test was used to determine the association between the socio-demographic variables and the likelihood of IPV and weighted ISA scores were determined for respondents.

Results: Sixty-nine (34.5%) of the women in the sample screened positive for lifetime IPV as defined by their score on the ISA. Of these women, 56.6% sought help from either formal or informal sources as a result of the violence.

Discussion: The findings highlight several help-seeking barriers among undocumented Spanish-speaking immigrant women who are the survivors of IPV. Fears of family separation resulting from deportation and loss of child custody are unique help-seeking barriers for undocumented immigrants. Health and social service organizations serving this population should use this information to inform IPV treatment and prevention programs for women.

Introduction

Intimate partner violence (IPV) affects millions of women around the world each year, resulting in a range of negative physical and psychological health outcomes for survivors (Campbell, 2002). The most recent national IPV prevalence data collected in the United States, from the 2010 National Intimate Partner and Sexual Violence Survey, found that more than 1 in 3 women (35.6%) have experienced physical violence, rape and/or stalking by an intimate partner in their lifetime (Black et al., 2010). Both socio-demographic characteristics and the type and severity of IPV influence the help-seeking decisions and utilization of services for women (Rizo & Macy, 2011).

Although prior research has established IPV as a widespread public health problem in the U.S., less is known about IPV prevalence and help seeking behaviors for vulnerable populations – such as unauthorized immigrants and Latinas – that are often overlooked in scientific research. In general, research with undocumented immigrants is challenging because of their marginalized social status, stigma, fears of exposure, and cultural norms (Sheldin, Decena, Mangadu, & Martinez, 2011). Previous studies including undocumented immigrant populations have been small and have reported contradictory findings. Some studies concluded that immigrant women are more likely to experience IPV, be the victim of a homicide by an intimate partner (Raj & Silverman, 2002), and stay in an abusive relationship when compared to non-immigrant women (Rodriguez et al., 2008). However, other studies have found that immigrant women report IPV equal to or less frequently than non-immigrant women (Torres, 1991). Studies of IPV prevalence

among Latina/Hispanic women indicate that rates of IPV are higher for Latinas/Hispanics than for White women (Adams & Campbell, 2012; Hass et al., 2000; Hien & Ruglass, 2009). The National Intimate Partner and Sexual Violence Survey found that Hispanic women had a higher lifetime prevalence of IPV (37.1%) compared to White women (34.6%) in unadjusted analysis (Black et al., 2010). Other studies have found that the increased prevalence of IPV in Hispanics disappears once risk factors such as poverty, age, alcohol consumption, and geography are taken into account in the statistical analysis (Klevens, 2007; Runner et al., 2009). Previous research also found that Hispanic women are more likely to experience severe physical IPV (Straus & Smith, 1990) and are more likely to consider suicide after IPV experiences when compared to White women (Denham et al., 2007).

Help-Seeking Behaviors

In general, women who have experienced IPV seek help from a variety of different sources, including formal and informal sources. Examples of formal sources include social service organizations, law enforcement institutions (e.g. police, courts), and health/medical centers. Friends, family members, and colleagues are examples of informal help-seeking sources.

Little is known about help seeking among Latina immigrant populations and even less about undocumented Latina immigrants. A systematic review of help-seeking behaviors among Hispanic survivors of IPV found mixed results regarding likelihood of service utilization (Rizo & Macy, 2011). A population-based study in South Carolina found that

more than half of abused women reported using formal services as a result of IPV (Coker, Lumpkim, Aldrich & Oldendick, 2000). However, help-seeking behaviors are significantly associated with race/ethnicity; with Latinas being less likely to seek formal help compared to their non-Latina White and Black counterparts, and immigrant women being less likely to seek formal help compared to nonimmigrants (Lipsky, Caetano, Field & Larkin, 2006; Ingram, 2007).

With regards to informal help seeking, Latinas may be more likely to disclose abuse to a family member as compared to non-Latinas (Ingram, 2011). In general, low acculturation is associated with decreased service utilization (Lipsky et al, 2006; Ingram, 2007). However, to our knowledge, no quantitative studies investigating help seeking behavior have reported on immigrant documentation status. There is a need for additional research about help-seeking behaviors in undocumented immigrant Latina populations.

Prior studies indicate IPV may be of particular concern among Spanish-speaking undocumented immigrant women. This study seeks to contribute new knowledge to the study of IPV by describing the IPV prevalence and help seeking behaviors of undocumented Spanish-speaking immigrant women. Based on our review of the existing literature, we hypothesized that: (1) undocumented Spanish-speaking immigrant women experience IPV at an equal rate as the general U.S. population and (2) undocumented Spanish-speaking immigrant women who have experienced IPV are more likely to seek help from informal networks (e.g. friends, family) than formal organizations (e.g. police, hospitals, non-profit organizations, NGO's). To our knowledge, this is the first study to

describe IPV experiences and help-seeking behaviors among this vulnerable and understudied population. Results will be useful to health and social service providers designing IPV prevention and treatment interventions targeting undocumented Spanish-speaking populations.

Methods

Study Participants

Study data were collected between June 2013 and March 2014 in collaboration with a community health center in Philadelphia, PA that serves uninsured Spanish-speaking immigrants, the majority of whom are undocumented. Potential participants were recruited in the clinic waiting rooms and asked if they were interested in completing a Women's Health Survey while waiting for either their appointment or that of the person they were accompanying. Women who expressed interest were escorted to a private room, provided with an explanation of the study, and screened for eligibility. Eligibility criteria included being: between 18-64 years old, Hispanic/Latina, fluent in Spanish, an undocumented immigrant, and having had at least one intimate partner during their lifetime. Women were excluded from the study if they required urgent medical care. Eligible women provided verbal informed consent and a researcher verbally administered the Women's Health Survey in Spanish. The lead author (SJS) administered all surveys. Each survey took approximately 15-30 minutes to complete and women were compensated $10 for their participation. The Institutional Review Board at Temple

University and the Medical Director of Puentes de Salud approved this study (Protocol #22285).

Instrument Overview

The Women's Health Survey consisted of 124 questions covering the following domains: demographics, IPV exposure, major depressive disorder (MDD) and post-traumatic stress disorder (PTSD) symptoms, health-related quality of life (HRQL), social support, and help-seeking behaviors. This paper reports the results from the demographic, IPV exposure, and help-seeking subsections of the survey. All questions were orally administered in Spanish.

Socio-demographic Variables

Socio-demographic variables included age, marital status, educational attainment, number of children, employment status, and years residing in the United States. Individual immigration status was assessed with one question: "What is your immigration status?" Answer choices included: U.S. citizen, non-citizen with documentation (e.g. residency, visa), and undocumented. Only two women who were approached and interested in participating were not eligible due to their legal immigration status. Age categories were created based on U.S. census categories.

Covariates

Individual and partner's drug and alcohol use and social support were also measured. The social support variable was dichotomized based on the distribution of raw social support scores, with scores more than one standard deviation below the mean defined as low social support. Alcohol use was defined as consuming an average of five or more alcoholic beverages per week during the last year based on the CDC definition of excessive alcohol use for men (CDC, 2014). In this study, women were asked to estimate how many drinks their partner consumed per week.

Outcome Variables

The lifetime prevalence of IPV was assessed using a Spanish version the Index of Spouse Abuse (ISA), a validated (Cronbach's alpha 0.90) 30-item questionnaire designed to measure the prevalence and severity of physical and non-physical IPV against women (Torres et al, 2010). The ISA has been used as the gold standard for comparison in the development of new IPV instruments (Basile, Hertz & Back, 2007). Participants selected answers on a 5-point Likert scale ranging from 0 (never) to 4 (always). We calculated a weighted score for each question based on the methodology described by Hudson and McIntosh (Hudson & McIntosh, 1987). Two scores were calculated from each individual's responses: a physical ISA score (ISA-P) and a non-physical ISA score (ISA-NP) (Hudson & McIntosh, 1987). As recommended, scores of ≥10 for the ISA-P and ≥25 for the ISA-NP were used to distinguish women who had experienced and who had not experienced IPV in their lifetime, respectively (Hudson & McIntosh, 1987).

Help-seeking behaviors were assessed using a section from the Spanish-language version of the Demographic Health Survey (DHS). The DHS is administered in multiple countries and measures a wide range of health and social indicators, including family health, nutrition, and wealth (DHS, 2013). In select countries, the DHS includes a sub-section on domestic violence, measuring the prevalence, incidence, and help-seeking behaviors of adult women. The help-seeking section of the DHS was used in the Women's Health Survey. Questions include information about help seeking behaviors from both informal (friends and family) and formal (law enforcement, public and private institutions, etc.) sources. Women who have experienced IPV but never sought help are asked to provide a reason. Free response answers were categorized into one or more of the response choices on the DHS instrument.

Statistical Methods

The data were analyzed using SPSS statistical software version 20 for Mac (StataCorp. 2013. Descriptive statistics were calculated for socio-demographic variables, IPV type, perpetrator, and help-seeking behaviors. Pearson's chi-squared test was used to investigate the association between the socio-demographic variables and the likelihood of IPV. A p-value of < 0.05 denoted a significant relationship between the demographic variables and IPV.

Next, positive responses for each ISA question were calculated for the entire sample to identify IPV survivors. Women were considered IPV survivors if they had a score of ≥10 for the ISA-P or ≥25 for the ISA-NP. Positive responses (women answering that abuse occurred rarely, occasionally, frequently, or very frequently) for individual questions were also calculated, independent of IPV survivor status.

Finally, descriptive statistics for help-seeking behaviors among women who screened positive for physical and/or non-physical IPV were performed, including the frequency of utilization of informal and formal help seeking resources.

Results

Socio-demographic characteristics for the study population are provided in Table 2. Over half of women who participated in the survey were aged 25-34 years old and more than three quarters of respondents were married (or in a civil union), had children, and had lived in the United States for at least five years. None of the women had health insurance or identified drinking five or more alcoholic beverages per week. More than three-quarters of participants were immigrants from Mexico (80.5%), followed by Central America, South America, and the Caribbean (14.5%, 4.5%, 0.5% respectively) (data not shown).

Table 2 also shows the prevalence of IPV in the study population by covariates. Women who were divorced or separated, between 35-65 years, and/or who had a partner who drank five or more alcoholic beverages per week were significantly more likely to report lifetime IPV (IPV survivors) compared to their counterparts (χ^2 =35.5, p=.000; χ^2 =9.9, p=.007; χ^2 =16.5, p=.000 respectively).

Table 2: Socio-Demographic Characteristics of the Study Population and Prevalence of Intimate Partner Violence (IPV)

	Entire Sample N (%)	**Lifetime IPV N (%)**	**p**
Overall	200 (100%)	69 (34.5%)	
Age			.012*
18-24	31 (15.5%)	5 (7.2%)	
25-34	106 (53.0%)	34 (49.3%)	
35-44	48 (24.0%)	21 (30.4%)	
45-65	15 (7.5%)	9 (13.0%)	
Number of children			.176
0	26 (13.0%)	9 (13.0%)	
1	52 (26.0%)	14 (20.3%)	
2	59 (29.5%)	17 (24.6%)	
3	32 (16.0%)	16 (23.2%)	
4+	31 (15.5%)	13 (18.8%)	
Marital status			.000**
Married/Civil Union	168 (84.0%)	45 (65.2%)	
Divorced/Separated	22 (11.0%)	20 (29.0%)	
Never been married	10 (5.0%)	4 (5.8%)	
Years living in the U.S.			.370
≤5 years	40 (19.5%)	10 (14.5%)	
6-10 years	91 (45.5%)	35 (50.7%)	
≥11 years	70 (35.0%)	24 (34.8%)	

Educational attainment			.063
0-5 years	37 (18.5%)	17 (24.6%)	
6-12 years	139 (69.5%)	48 (69.6%)	
≥13 years	24 (12.0%)	4 (5.8%)	
Employment status			.257
Yes	102 (51.0%)	39 (56.5%)	
No	98 (49.0%)	30 (43.5%)	
Social Support			.069
High social support	153 (76.5%)	47 (70.1%)	
Low social support	44 (22.0%)	20 (29.9%)	
Missing	3 (1.5%)		
Partner's alcohol use			.000***
Yes	34 (17.0%)	47 (68.1%)	
No	166 (83.0%)	22 (31.9%)	

*P< .05; ***P< .01

IPV Experiences

Sixty-nine (34.5%) of the women in the sample screened positive for lifetime IPV as defined by their score on the ISA. Of these 69 IPV survivors, 45 (65%) had experienced both physical and non-physical IPV during their lifetime. Twelve women reported only experiencing physical IPV and twelve women reported only experiencing non-physical IPV. Furthermore, 32 (46%) of IPV survivors reported IPV from their current intimate partner and 37 (54%) reported IPV from a former intimate partner (data not shown).

The ISA questions and the frequency that women responded affirmatively to them are presented in Table 3. Responding affirmatively was defined as any answer other than "never." For the entire sample (n=200), responding positively to questions about non-physical IPV was more common than responding positively to questions about physical IPV. This was also true for IPV survivors (n=69), with having a partner who becomes angry when she disagrees with him, having a partner who screams and yells, and having a partner who is jealous and/or suspicious of friends being the most common types of non-physical IPV (87%, 87%, and 84.1% of all lifetime IPV survivors respectively). Among IPV survivors who experienced physical abuse, having a partner who punched with his fists and having a partner who becomes abusive when he drinks alcohol were the most common responses (65.2% and 62.3% respectively).

Table 3. Positive Responses[a] to IPV Screening Questions

Statement	**All participants (n=200) N (%)**	**IPV Survivors (n=69) N (%)**
1. My partner belittles me	90 (45%)	64 (92.8%)
2. My partner demands obedience to his whims	84 (42%)	55 (79.7%)
3. My partner becomes surly and angry if I tell him he is drinking too much	84 (42%)	52 (75.5%)
4. My partner makes me perform sex acts that I do not enjoy or like	39 (19.5%)	33 (47.8%)
5. My partner becomes very upset if dinner, housework, or laundry is not done when he wants	40 (20%)	31 (44.9%)
6. My partner is jealous and suspicious of my friends	114 (57%)	58 (84.1%)
7. My partner punches me with his fists	48 (34%)	45 (65.2%)
8. My partner tells me I am ugly and unattractive	45 (22.5%)	41 (59.4%)
9. My partner tells me that I really couldn't manage or take care of myself without him	38 (19%)	35 (50.7%)
10. My partner acts like I am his personal servant	60 (30%)	51 (73.9%)
11. My partner insults of shames me in front of others	57 (28.5%)	49 (71%)
12. My partner becomes very angry if I disagree with his point of view	90 (45%)	60 (87%)
13. My partner threatens me with a weapon	3 (1.5%)	3 (4.3%)
14. My partner is stingy in giving me enough money to run our home	69 (34.5%)	52 (75.4%)
15. My partner belittles me intellectually	65 (32.5%)	53 (76.8%)
16. My partner demands that I stay home to take care of the children	57 (28.5%)	37 (53.6%)
17. My partner beats me so badly that I must seek medical help	10 (5%)	10 (14.5%)
18. My partner feels that I should not work or go to school	41 (20.5%)	27 (39.1%)
19. My partner is not a kind person	61 (30.5%)	50 (72.5%)
20. My partner does not want me to socialize with my female friends	80 (40%)	48 (69.6%)

21. My partner demands sex whether I want it or not	46 (23%)	37 (53.6%)
22. My partner screams and yells at me	69 (34.5%)	60 (87%)
23. My partner slaps me around my face and head	36 (18%)	36 (52.2%)
24. My partner becomes abusive when he drinks	53 (26.5%)	43 (62.3%)
25. My partner orders me around	54 (27%)	45 (65.2%)
26. My partner has no respect for my feelings	66 (33%)	57 (82.6%)
27. My partner acts like a bully towards me	24 (12%)	24 (34.8%)
28. My partner frightens me	39 (19.5%)	37 (53.6%)
29. My partner treats me like a dunce	47 (23.5%)	46 (66.7%)
30. My partner acts like he would like to kill me	30 (15%)	30 (43.5%)

[a] Positive responses were defined as any answer other than “never.”

Help Seeking Behaviors for Women Experiencing IPV

The help-seeking behaviors of women classified as IPV survivors are presented in Table 4. Results indicated the more than half (56.5%) of IPV survivors did seek help, with informal help-seeking slightly more common than formal help-seeking. Among women who sought informal help as a result of an IPV experience, women were most likely to reach out to their siblings, followed by their parents, and then friends. Fewer women reported asking help from extended family members (e.g. cousins, aunts, uncles) or their in-laws (data not shown). The most common sources for formal help seeking were non-profit organizations (20%), such as domestic violence organizations, followed by the police (12%), or a therapist/counselor (12%). Fewer than three women reported seeking help from their church, a domestic violence shelter, or a court (data not shown). Among IPV survivors, eight (4%) sought help from both informal and formal sources (data not shown). Forty-four percent of IPV survivors did not seek help from any source. When prompted about why they did not seek help, the most common reasons were not knowing where to go (23%), believing that help was unnecessary (14.5%), embarrassment (9%), fear of deportation for herself or her partner (7%), fear of losing her children (6%), and a lack of social support from family (6%) (Table 4).

Table 4. Help-Seeking Behaviors of IPV Survivors and Reasons for Not Seeking Help (n=69)

Help Seeking	n (%)
Any help-seeking	39 (56.5%)
Informal help-seeking	25 (36%)
Parents	13
Siblings	14
Friend	7
Other family member	4
Formal help-seeking	22 (34%)
Police	8
Therapist/counselor	8
Non-governmental organization	14
Shelter	2
No help-seeking	30 (43.5%)
Didn't know where to go	16
Help wasn't necessary	10
Embarrassment	6
Lack of social support	4
Fear of losing children	4
Fear of deportation (partner or self)	5

Discussion

This study found that undocumented Spanish-speaking immigrants attending two health clinics associated with one non-profit in Philadelphia reported IPV at a rate similar to the general U.S. population (34.5% compared to 35.6% respectively), although slightly less frequently than the U.S. Latina population (37.1%). We also found that the majority of women who reported IPV did seek help, most commonly from an informal source such as a sibling, other family member, or friend. Women who did not seek help often did not know where to find it, while other women raised concerns about family separation, either through deportation or having their children taken away. This is the first study to describe IPV prevalence and help-seeking behavior among undocumented Spanish-speaking immigrants in an urban setting.

We found that IPV is a health concern among undocumented immigrant populations and prevalence of IPV against women, although our results support previous studies that concluded that immigrant women might experience IPV less frequently than native-born women (RWJ, 2009). An alternative explanation is that immigrant women, and particularly those without legal documentation, are less likely to report IPV when surveyed compared to their non-immigrant counterparts. In a systematic review of help-seeking barriers of Hispanics, limited English proficiency and tolerance of male violence were identified as barriers (Rizo & Macy, 2011). Qualitative studies with undocumented Spanish-speaking immigrants have identified fear of deportation as a barrier to help-seeking (Kelly 2009; Lewis et al., 2005; Sorenson, 1996). Future studies may consider

measuring distrust of the legal system and unfamiliarity with research studies as possible explanations for a lower reported prevalence of IPV among undocumented Spanish-speaking immigrants.

Age, marital status, and partner's alcohol use were risk factors for being an IPV survivor in this study. Although age and marital status are not modifiable risk factors for intervention, this information may help direct interventions aimed at reducing IPV. Reducing alcohol use among partners may also be a protective factor for IPV. Seventy-five percent of IPV survivors answered that their partner becomes angry when she tells him that he is drinking too much and 62% of survivors said their partner becomes abusive when he drinks. This study did not collect information on alcohol treatment programs, few Spanish language low-cost alcohol support groups (e.g. Alcoholics Anonymous) are available in this community. Alcohol use among undocumented Spanish-speaking men and its relationship with IPV is an area that warrants further research.

It is also important to note that not all women who responded affirmatively to questions on the ISA were categorized as IPV survivors. Although all women who reported physical IPV had an ISA score classifying them as survivors of IPV, other women who reported having partners who insulted them, exhibited jealous behaviors, or demanded sex regardless of her desire did not necessarily meet the threshold score for experiencing lifetime IPV. This finding suggests that additional women may benefit from IPV resources and information about health relationships.

That over half of the sample sought help as a result of IPV is encouraging. However, approximately 44% of the sample did not seek help. Research has found that help-seeking is potentially beneficial to women with informal help-seeking improving the mental health outcomes of women(Carlson et al., 2002) and formal help-seeking making women less likely to experience serious physical IPV in the future (Goodman et al., 2005; Liang et al., 2005). Among victims of IPV who did not seek help, embarrassment and not knowing where to go were the most common reasons provided explaining their decision. This suggests that future programs and policies should focus on raising awareness and strengthening the services of local institutions as places to report and seek help for IPV. Furthermore, the slight preference of women to ask for help from a relative or friend demonstrates the importance of social networks and social support among undocumented Spanish-speaking immigrant women. IPV education and resources should be widely disseminated and targeted to the general public in addition to formal institutions. Additionally, resources should be directed toward education on healthy relationships and the normalization of help-seeking behaviors in undocumented immigrant communities.

Our unique sample population is a strength of this study. Undocumented immigrants are frequently excluded from scientific research and IPV studies that have included immigrants did not ask participants to share their immigration status. In this study, fewer than ten women who were approached to complete the survey declined to participate. This study also had several limitations. No information was collected about women who declined to participate and we cannot rule out unmeasured biases or systematic differences between participants and refusals. All participants were seeking or

accompanying someone seeking health care services and there is no evidence that these patients represent the undocumented Spanish-speaking immigrant community in Philadelphia or elsewhere. But the potentially limited generalizability of our study is balanced by the strength of surveying an understudied population that may benefit from interventions to reduce IPV and promote help-seeking behavior. This work also provides a starting point for further data collection.

Conclusion

Descriptive studies are an important first step in understanding public health problems in unique populations. This study found that over a third of undocumented Spanish-speaking immigrant women seeking primary health care services in Philadelphia experienced IPV and that women identified unique barriers to help-seeking, including: lack of knowledge of available resources and fear of family separation and deportation. These findings support Liang et al.'s theoretical model that individual, interpersonal and socio-cultural factors influence IPV help-seeking behaviors (Liang et al., 2005). Finally, future studies should further investigate the pathway between partner's alcohol use and IPV and the impact of alcohol consumption reduction has on the incidence of IPV. Additional outreach from social service programs is needed in Philadelphia to better serve Spanish-speaking immigrant women who are the survivors of violence. Outreach materials and activities should be in Spanish and should clearly explain the rights and repercussions related to formal help-seeking for undocumented immigrant women.

CHAPTER 3: THE ASSOCIATION BETWEEN HEALTH AND INTIMATE PARTNER VIOLENCE IN A SAMPLE OF SPANISH-SPEAKING UNDOCUMENTED IMMIGRANT WOMEN

Abstract

Background: Little is known about health outcomes among undocumented Spanish-speaking immigrant women who are the survivors of intimate partner violence (IPV) in the United States. However, Latinas in the United States are at increased risk of IPV compared to their Caucasian counterparts.

Purpose: To investigate health outcomes associated with IPV among an undocumented Spanish-speaking immigrant population in urban Philadelphia.

Methods: Two hundred undocumented Spanish-speaking immigrant women completed a women's health survey to assess IPV, major depressive disorder (MDD), post-traumatic stress disorder (PTSD), and health-related quality (HRQL) of life. Chi-squared tests were used to assess for bivariate associations between IPV and mental health outcomes, and logistic regression was used to examine the multivariate association between the same exposure and outcomes.

Results: Of the entire sample, 41.5% endorsed major depressive disorder and 16% endorsed post-traumatic stress disorder. In the unadjusted logistic regression models, IPV survivors were more likely to endorse MDD and PTSD and report low mental health HRQL scores (OR: 2.27, 3.45, 2.19, respectively). In fully adjusted models, only the association between IPV and PTSD remained significant (OR: 4.143, CI: 1.21-14.24).

Discussion: There was an overall high prevalence of MDD and PTSD in the sample population, and an increased risk of PTSD in IPV survivors compared with non-survivors. Our findings highlight the need for quality mental health and trauma-informed services tailored to the needs of undocumented Spanish-speaking immigrant women, including increased access to mental health services in primary healthcare settings.

Introduction

Intimate partner violence (IPV) is a public health concern among all racial/ethnic and socio-economic groups in the United States. However, little is known about IPV among undocumented Latina immigrants in the United States. With approximately 12 million undocumented immigrants residing in the United States, over half of whom are from Latin America and the Caribbean, there is a lack of research with this vulnerable population (Passel, Cohn, & Gonzalez-Barrera, 2013). Furthermore, previous research indicates that Latinas are at increased risk of experiencing IPV compared to Caucasian women in the U.S. (37.1% versus 34.6% respectively) (Black et al., 2010).

Previous IPV studies of immigrant populations have reported mixed results. A study with South Asian immigrant women found that immigrant women are more likely to experience IPV and more likely to be the victim of homicide by an intimate partner (Raj & Silverman, 2002). A study with Mexican-American immigrants reported that they are more likely to stay in an abusive relationship when compared to non-immigrants in the U.S. (Torres, 1991). Other studies have reported that Latina and Asian immigrant women experience IPV at the same rate or less frequently than non-immigrant women (Runner et al., 2009). The mixed study results may be influenced by multiple factors related to study designs, methodology, populations included, and geographic location. Existing evidence on immigrants and IPV exposure is based on small samples. Based on our review of this literature, no studies have investigated the experiences of undocumented Spanish-speaking women in the United States.

Intimate partner violence can lead to a range of negative physical and mental health outcomes (Plichta, 2004; Coker et al., 2004). In addition to short-term physical health problems—such as bruises, cuts, welts, broken bones, and lacerations—victims of IPV are more likely than non-victims to report long-term physical health outcomes, including asthma, diabetes, cardiovascular disease, chronic pain, and hypertension (Black et al., 2010; Campbell, 2002; AL Coker et al., 2002; World Health Organization, 2013)

Mental health disorders are also more prevalent among women with a history of IPV than those without, including major depressive disorder (MDD), post-traumatic stress disorder (PTSD) and chronic mental illness (AL Coker et al., 2002; Fedovskiy et al., 2008). Both severity and type of IPV are predictors for the severity of mental health symptoms in women (Carlson et al., 2002). Major Depressive Disorder (MDD) is a leading cause of disability in the United States and prior research has established a correlation between IPV and depression for women. However, no studies have reported this relationship among undocumented Spanish-speaking immigrants(Filson, Ulloa, Runfola, & Hokoda, 2009; González et al., 2010; Vos et al., 2006). National studies estimate the 12-month prevalence of MDD in adults to be 8.1% and the lifetime prevalence to be 18.6%, with Mexican Americans and foreign-born populations reporting lower rates of depression compared to their white counterparts (lifetime MDD: 14.5% Mexican Americans; 20.4% Whites; 12.4% foreign-born) (González et al., 2010). A systematic review of the depression among undocumented Mexican immigrants found several reoccurring themes regarding stressors for this population including feelings of guilt, isolation, fear of deportation, and shame. The same study concluded that undocumented Mexican

immigrants have largely been ignored in mental health research, likely due to the difficult nature of asking about documentation status and recruiting this population to participate in research (Sullivan & Rehm, 2005).

Post-Traumatic Stress Disorder (PTSD) is an anxiety disorder that can result after experiencing or witnessing traumatic events, including violence. Flashbacks and nightmares, avoidance of certain thoughts or situations, and disruptive feelings are symptomatic of PTSD (American Psychological Association, 2013). The lifetime prevalence of PTSD in the United States is 6.4%, with women having significantly higher rates of PTSD than men (8.6% vs. 4.1%). Among women expressing PTSD symptomology, sexual assault and physical IPV are two of the most common traumatic experiences (Pietrzak et al., 2011)Major depressive disorder and post-traumatic stress disorder are often co-morbid conditions among IPV survivors (Fedovskiy et al., 2008; Nixon et al., 2004). However, little is known about these conditions among undocumented immigrant women who have experienced IPV.

Health-related quality of life (HRQL) is a self-reported measure of physical and mental functional status that can be used to compare and track the health of populations over time (CDC, 2011). Survivors of IPV report lower HRQL scores compared to their non-abused counterparts(Alsaker, Moen, Nortvedt, & Baste, 2006; Laffaye, Kennedy, & Stein, 2003). Although few studies have measured HRQL among undocumented Latino immigrants, those worried about deportation were more likely to report poor health related quality of life (Cavazos-Rehg, Zayas, & Spitznagel, 2007). Latino immigrants

with experiences of political violence in their country of origin and Latinos who self-report experiencing discrimination in the United States are also more likely to report lower HRQL than their counterparts (Eisenman, Gelberg, Liu, & Shapiro, 2003; Otiniano & Gee, 2012).

The purpose of this study was to examine the association between lifetime IPV exposure and physical and mental health in a sample of undocumented, Spanish-speaking immigrant women. We hypothesized that immigrants with a history of IPV are more likely to endorse symptoms of depression and post-traumatic stress disorder (PTSD) and report lower physical and mental health-related quality of life scores (SF-12) compared to undocumented immigrant women with no lifetime IPV experiences. This is the first study to investigate health outcomes of IPV among an exclusively undocumented Latina immigrant population in the United States. This work adds to the small body of literature about health outcomes correlated with IPV in undocumented immigrant populations.

Methods

Data source

Study data were collected between June 2013 and March 2014 in collaboration with a community health center in Philadelphia, PA that serves uninsured Spanish-speaking immigrants, the majority of whom are undocumented. Potential participants were recruited in the clinic waiting rooms and asked if they were interested in completing a Women's Health Survey while waiting for either their appointment or that of the person they were accompanying. Women who expressed interest were escorted to a private

room, provided with an explanation of the study, and screened for eligibility. Eligibility criteria included being: between 18-64 years old, Hispanic/Latina, fluent in Spanish, an undocumented immigrant, and having had at least one intimate partner during their lifetime. Women were excluded from the study if they required urgent medical care. Eligible women provided verbal informed consent and a researcher verbally administered the Women's Health Survey in Spanish. The lead author (SJS) administered all surveys.

Each survey took approximately 15-30 minutes to complete and women were compensated $10 for their participation. The Institutional Review Board at Temple University and the Medical Director at Puentes de Salud approved this study (Protocol: 22285).

Variables

The Women's Health Survey consisted of 124 questions covering the following domains: demographics, IPV exposure, major depressive disorder (MDD) and post-traumatic stress disorder (PTSD) symptoms, health-related quality of life (HRQL), social support, and help-seeking behaviors.

Socio-demographic Variables

Socio-demographic variables included age, marital status, educational attainment, number of children, employment status, and years residing in the United States. Individual immigration status was assessed with one question: "What is your immigration status?" Answer choices included: U.S. citizen, non-citizen with documentation (e.g.

residency, visa), and undocumented. Only two women who were approached and interested in participating were not eligible due to their legal immigration status. Age categories were created based on U.S. census categories.

Covariates

Individual and partner's drug and alcohol use and social support were also measured. The social support variable was dichotomized based on the distribution of raw social support scores, with scores more than one standard deviation below the mean defined as low social support. Alcohol use was defined as consuming an average of five or more alcoholic beverages per week during the last year based on the CDC definition of excessive alcohol use for men (CDC, 2014). In this study, women were asked to estimate how many drinks their partner consumed per week.

Exposure Variable

IPV was measured using the Index of Spouse Abuse (ISA), a validated 30-item questionnaire that measures the prevalence and severity of physical and non-physical IPV against women (Hudson & McIntosh, 1981). A physical ISA score (ISA-P) and a non-physical ISA score (ISA-NP) were calculated from the responses and an ISA-P score of ≥10 and/or an ISA-NP ≥25 indicated severe lifetime IPV.

Outcome Variables

MDD was measured using the Center for Epidemiologic Studies Depression Scale (CES-D), a validated 20-item scale designed to measure depressive symptomology among the general adult population. The maximum score is 60, the higher the score, the more indicative of depressive symptomology. A score of >15 was used to classify women with and without MDD (Radloff, 1977).

The Post-traumatic Stress Disorder CheckList-Civilian Version (PCL-C) was used to assess PTSD. This 17-item validated instrument uses a Likert scale to measure trauma symptom severity. A score of >44 indicated an endorsement of PTSD (Blanchard, Jones-Alexander, Buckley & Forners, 2006).

HRQL was assessed using the Medical Outcomes Study Short Form Health Survey (SF-12), which measures physical and mental health functioning with 12 questions. The two domains of the SF-12 each have a standardized mean of 50 with possible scores ranging from 0-100, with a higher score indicating better health functioning. For the purpose of this study, physical and mental health scores were dichotomized into normal and low scores based on the distribution of the data, with scores in the lowest 25^{th} percentile defined as low HRQL. This definition of HRQL has been used previously (Carrasco et al., 2007).

Statistical Analysis

Descriptive statistics were performed for all variables, followed by chi-squared tests to assess for bivariate associations between the independent variable (IPV) and dependent

variables (MDD, PTSD, HRQL). We used logistic regression to examine the multivariate association between lifetime IPV exposure and our three outcome measures (MDD, PTSD, and HRQL). We conducted separate logistic regression analyses for each outcome, using hierarchical models that included the following variables in sequential blocks (Model 1: unadjusted; Model 2: list variables; Model 3: list variables). The partially adjusted model included only the covariates significantly associated with the dependent variables in bivariate analysis. The fully adjusted model included all of the covariates, which may conceptually be considered confounders of the relationship between our exposure and outcomes. 95% confidence intervals (CI's) were calculated for all odds ratios (ORs), and a p-value of <0.05 was used to indicate significance. All analyses were performed using SPSS version 22 for Mac (StataCorp. 2013).

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Results

Sample Demographics

The demographic characteristics of participants and the association between the covariates and MDD, PTSD, and HRQL are presented in Table 5. A total of 200 women were included in the analysis. Over three-quarters of the participants were married (84%), had children (87%), and had been living in the United States for more than six years (81.5%). The majority had less than a high school education. None of the women reported drinking more than five alcoholic drinks per week, using drugs, or having a partner who used drugs in the last year. Regions of origin for the immigrant women were:

80.5% Mexican born, 14.5% Central American born, 4.5% South American born, and 0.5% Caribbean born (data not shown).

Prevalence of IPV Exposure and Demographics

Overall, more than one in three women (34.5%) reported experiencing physical and/or non-physical IPV during their lifetime. Bivariate analysis revealed that being older, divorced, and/or having a partner who regularly drank alcohol were more likely to report a lifetime IPV experience compared to women who were younger, married, and did not have a partner who regularly drank alcohol (Table 5).

Table 5: Socio-Demographic Characteristics of the Study Population and Association with Lifetime Intimate Partner Violence (IPV), Major Depressive Disorder (MDD), Post-traumatic Stress Disorder (PTSD), and Physical and Mental Health Related Quality of Life (HRQL)

	N (%)	**Lifetime IPV**	**p**	**MDD**	**p**	**PTSD**	**p**	**Low Physical HRQL**	**p**	**Low Mental HRQL**	**p**
Overall	200 (100%)	69 (34.5%)		81 (40.5%)		32 (16%)		49 (24.5%)		52 (26%)	
Age			.012*		.682		.047*		.007*		.802
18-25	31 (15.5%)	5 (7.2%)		14 (17.3%)		8 (25%)		7 (4.3%)		7 (13.5%)	
25-34	106 (53%)	34 (49.3%)		40 (49.4%)		15 (46.9%)		20 (40.8%)		26 (50%)	
35-44	48 (24%)	21 (30.4%)		22 (27.2%)		4 (12.5%)		13 (26.5%)		15 (28.8%)	
45-65	15 (7.5%)	9 (13%)		5 (6.2%)		5 (15.6%)		9 (18.4%)*		4 (7.7%)	
Number of children			.176		.433		.216		.243		.083
0	26 (13%)	9 (13.0%)		11 (13.6%)		5 (15.5%)		6 (12.2%)		11 (21.2%)	
1	52 (26%)	14 (20.3%)		16 (9.8%)		11 (34.4%)		13 (26.5%)		7 (13.5%)	

2	59 (29.5%)	17 (24.6%)		24 (29.6%)		4 (12.5%)		9 (18.4%)		17 (32.7%)	
3	32 (16%)	16 (23.2%)		14 (17.3%)		7 (21.9%)		11 (22.4%)		8 (15.4%)	
4+	31 (15.5%)	13 (18.8%)		16 (19.8%)		5 (15.6%)		10 (20.4%)		9 (17.3%)	
Marital status			.000*		.014*		.087		.412		.005*
Married/ Civil Union	168 (84%)	45 (65.2%)		61 (75.3%)		23 (71.9%)		41 (83.7%)		37 (71.2%)	
Divorced/ Separated	22 (11%)	20 (29.0%)*		15 (18.5%)*		7 (21.9%)		7 (14.3%)		12 (23.1%)*	
Never been married	10 (5%)	4 (5.8%)		5 (6.2%)		2 (6.3%)		1 (2.0%)		3 (5.8%)	
Years living in the U.S.			.370		.101				.720		.047*
≤5 years	40 (19.5%)	10 (14.5%)		21 (25.9%)		6 (18.8%)		11 (22.4%)		15 (28.2%)*	
6-10 years	91 (45.5%)	35 (50.7%)		37 (45.7%)		12 (37.5%)		20 (40.8%)		25 (48.1%)	
≥11 years	70 (35%)	24 (34.8%)		23 (28.4%)		14 (43.8%)		18 (36.7%)		12 (23.1%)	

Educational attainment			.063		.007*		.397		.750		.090
0-5 years	37 (18.5%)	17 (24.6%)		19 (23.5%)*		8 (25.0%)		10 (20.4%)		12 (23.1%)	
6-12 years	139 (69.5%)	48 (69.6%)		59 (72.8%)		19 (59.4%)		32 (65.3%)		38 (73.1%)	
≥13 years	24 (12%)	4 (5.8%)		2 (3.7%)		5 (15.6%)		7 (14.3%)		2 (3.8%)	
Employment status			.257		.706		.902		.997		.633
Yes	102 (51%)	39 (56.5%)		40 (49.4%)		16 (50.0%)		25 (51.0%)		28 (53.8%)	
No	98 (49%)	30 (43.5%)		41 (50.6%)		16 (50.0%)		24 (49.0%)		24 (46.2%)	
Social support			.069		.001*		.001*		.270		.000*
High social support	153 (76.5%)	47 (70.1%)		53 (65.4%)		17 (54.8%)		33 (71.7%)		29 (55.8%)	
Low social support	44 (22%)	20 (29.9%)		28 (34.6%)		14 (45.2%)		13 (28.3%)		23 (44.2%)*	
Missing	3 (1.5%)										

Partner's alcohol use			.000*		.000*		.189		.041*		.008*
Yes	34 (17%)	47 (68.1%)*		23 (28.4%)*		8 (25.0%)		13 (26.5%)*		15 (28.8%)*	
No	166 (83%)	22 (31.9%)		58 (71.6%)		24 (75%)		36 (73.5%)		37 (71.2%)	

Partner's alcohol use is defined having a partner who consumes five or more alcoholic drinks per week; Suboptimal physical and mental health quality of life (HRQL) scores are defined as participants having scores in the 25^{th} percentile. *P< .05.

Prevalence of Health Outcomes and Demographics

Eighty-one women (40.5%) in the sample were classified as having MDD based on their CES-D score. Immigrants who were divorced, had fewer than six years of formal education, and had a partner who consumed more than five alcoholic drinks per week were significantly more likely to have an MDD endorsement.

Thirty-two (16%) women in the sample endorsed PTSD, with women in either the youngest or oldest category and with low social support being significantly more likely to report PTSD symptomology compared with women in the middle age categories and with high social support. Being in the oldest age category and having a partner who regularly consumed alcohol were associated with low physical HRQL; divorce, residing five or fewer years in the U.S., low social support, and partner's alcohol use were significantly associated with suboptimal mental HRQL (Table 5).

IPV Exposure and Health Outcomes

Compared with undocumented immigrant women with no lifetime IPV experience, women reporting lifetime IPV were more likely to endorse MDD (53.6% vs. 33.6%, p=.01), PTSD (27.5% vs. 9.9%, p=.00), and have low physical (31.9% vs. 20.6%, p=.08) and mental HRQL scores (36.2% vs. 20.6%, p=.018). The crude logistic regression models indicate that all of these were statistically significant relationships with the exception of IPV and physical HRQL (Tables 6, 7, 8). The association between IPV and PTSD remained significant in the partially adjusted (OR=2.439; 95% CI=1.06, 5.63) and fully adjusted logistic regression models (OR=4.143; 95% CI=1.21, 14.24) (Table 7).

IPV was not significantly associated with MDD or HRQL in the fully adjusted regression models.

Table 6. Crude and Adjusted Logistic Regression for Association Between Lifetime IPV and Major Depressive Disorder, MDD (n=200)

		Major Depressive Disorder (MDD) Endorsement			
		%	Crude OR (95% CI, p-value)	Partially Adjusted OR[a] (95% CI, p-value)	Adjusted OR[b] (95% CI, p-value)
Lifetime IPV	Yes	53.6%	2.27 (1.20-4.15, .01)*	1.13 (.54-2.39, .740	1.47 (.56-3.50, .43)
	No (Ref)	33.6%	1.00	1.00	1.00

Note: OR=odds ratio; CI=confidence interval, *P< .05.

[a]Adjusted for marital status, educational attainment, social support, partner's alcohol use and PTSD endorsement

[b]Adjusted for age, number of children, marital status, educational attainment, employment status, years living in the U.S., social support, partner's alcohol use, PTSD endorsement, physical HRQL, mental HRQL.

Table 7. Crude and Adjusted Logistic Regression for Association Between Lifetime IPV and PTSD (n=200)

		Post-traumatic Stress Disorder (PTSD) Endorsement			
		%	Crude OR (95% CI, p-value)	Partially Adjusted OR[a] (95% CI, p-value)	Adjusted OR[b] (95% CI, p-value)
Lifetime IPV	Yes	27.5%	3.45 (1.58-7.518, .00)*	2.439 (1.06-5.63, .04)*	4.143 (1.21-14.24, .02)*
	No (Ref)	9.9%	1.00	1.00	1.00

Note: OR=odds ratio; CI=confidence interval, *P< .05.

[a]Adjusted for social support status and MDD endorsement

[b]Adjusted for age, number of children, marital status, educational attainment, employment status, years living in the U.S., social support, partner's alcohol use, and MDD endorsement, physical HRQL, mental HRQL

Table 8. Crude and Adjusted Logistic Regression for Association Between Lifetime IPV and Mental and Physical HRQL (n=200)

					Low Physical HRQL
		%	Crude OR (95% CI, p-value)	Partially Adjusted OR[a] (95% CI, p-value)	Adjusted OR[b] (95% CI, p-value)
Lifetime IPV	Yes	31.9%	1.80 (.93-3.49, .08)	1.36 (.65-2.83, .41)	1.30 (.54-3.15, .56)
	No (Ref)	20.6%	1.00	1.00	1.00
					Low Mental HRQL
		%	Crude OR (95% CI, p-value)	Partially Adjusted OR[c] (95% CI, p-value)	Adjusted OR[d] (95% CI, p-value)
Lifetime IPV	Yes	36.2%	2.19 (1.15-4.19, .018)*	1.46 (.65- 3.29, .36)	.46 (.13-1.57, .21)
	No (Ref)	20.6%	1.00	1.00	1.00

Note: OR=odds ratio; CI=confidence interval, *P< .05.

[a]Adjusted for age and partner's alcohol use

[b]Adjusted for age, number of children, marital status, educational attainment, employment status, years living in the U.S., social support, partner's alcohol use, PTSD endorsement, MDD endorsement, and mental HRQL

[c] Adjusted for marital status, years in the U.S., social support, and partner's alcohol use

[d] Adjusted for age, number of children, marital status, educational attainment, employment status, years living in the U.S., social support, partner's alcohol use, PTSD endorsement MDD endorsement, and physical HRQL

Discussion

To our knowledge, this is the first study of IPV and health outcomes to focus exclusively on undocumented Spanish-speaking immigrants. We found the prevalence of IPV in this population (34.5%) to be slightly lower than the prevalence of IPV among Latinas in the United States (37.1%). Furthermore, our results support previous studies that have found a significant relationship between IPV and poor mental health outcomes with immigrant populations (2010).

This study of female undocumented Spanish-speaking immigrants in the United States indicates that there is a significant unadjusted association between lifetime IPV exposure and mental health outcomes including MDD, PTSD, and mental HRQL. However, once adjusting for covariates (age, number of children, marital status, educational attainment, employment status, years living in the U.S., social support, partner's alcohol use, and MDD endorsement, physical HRQL scores, and mental HRQL scores) in the partially and fully adjusted models, lifetime IPV exposure was only significantly associated with PTSD. This relationship warrants further investigation. Perhaps the relationship between IPV and MDD was not observed in adjusted analysis because of the 40% prevalence of MDD. PTSD was less common among the entire study population and it is more probably linked to a traumatic event (or set of events such as IPV) than the other measured health outcomes.

This is the first study to quantify the prevalence of MDD and PTSD in an urban population of undocumented Spanish-speaking immigrants. We found that approximately 40% of women endorsed MDD symptomology and 16% endorsed PTSD, indicating that anxiety disorders were more common in this clinic-based convenience sample than in the general U.S. population. This finding is in contrast with previous studies that have found a lower risk of anxiety disorders among Mexican born immigrants in comparison with the US-born population (Breslau, Borges, Hagar, Tancredi, & Gilman, 2009) although it has been found that Mexican immigrants are at higher risk for depression and anxiety when compared to their non-immigrant counterparts living in Mexico (Breslau et al., 2011). A

study of 554 Mexican born immigrants (immigration status unspecified) found that 11% reported any depressive disorder and 2.6% reported PTSD. While the aforementioned study used a different instrument to assess depression and PTSD, we found a much higher prevalence of MDD and PTSD, indicating that our study population may have an increased risk of anxiety disorders and depression compared to Latinos overall and the general male and female U.S. population (Breslau et al., 2011).

The association between IPV and PTSD is well-documented. In a subsample of women from the National Violence Against Women (NVAW) Survey, 24% reported moderate to severe PTSD symptomology (AL Coker, Weston, Creson, Justice, & Blakeney, 2005). Other studies have found PTSD prevalence between 31% and 84.4% among IPV survivors (Golding, 1999; Jones, Hughes, & Unterstaller, 2001). For IPV survivors in the current study, 27.5% endorsed PTSD, comparable to the sample from the NVAW Survey and lower than other studies. Our findings indicate that PTSD is the entire sample was more common than in the general U.S. population, but comparable to other IPV survivor populations. There is also a need for increased and higher quality trauma-informed and culturally competent mental health services for Spanish-speaking immigrant women.

Strengths & Limitations

Measuring prevalence and relationship of IPV and health outcomes among an exclusively undocumented immigrant population is the major strength and to our knowledge the first study to quantitatively measure IPV in this population. This is the first study to quantify the prevalence of MDD and PTSD in an urban population of undocumented Spanish-

speaking immigrants. The dearth of previous research with undocumented Spanish-speaking immigrants is likely related to their marginalized social status and difficulties in accessing this vulnerable population (Shedlin, Decena, Mangadu, & Martinez, 2011).

The small sample size (n=200) and the cross-sectional design were both limitations of this study. The cross-sectional study design is unable to distinguish the temporal relationship between the variables. It is possible that IPV experience leads to an increased prevalence of PTSD or that women with PTSD are more likely to experience IPV. All study participants were women who were either seeking or accompanying someone seeking health care services, and therefore may not be representative of all undocumented Spanish-speaking women in Philadelphia. Only one researcher was available to screen eligible women and administer the survey, limiting the number of women who could complete the survey during each clinical session. However, having the same researcher screen all 200 women reduced interviewer bias. Clinical space was also limited, making it difficult to recruit women during some clinical sessions and potentially limiting the number of eligible women being recruited to participate.

Recommendations

The high prevalence of MDD and PTSD endorsement identified in this population, coupled with findings from other studies that indicate lower mental health care service utilization among both Latinas and immigrants (compared with US-born Caucasian women), emphasize the need for increased mental health identification, outreach, and resources for undocumented Spanish-speaking women in Philadelphia (Kaltman, Hurtado

de Mendoza, Gonzales, & Serrano, 2014; Lee, Laiewski, & Choi, 2014). A recent mixed-methods study of Latina immigrants (immigration status not specified) found a preference for mental health care services delivered in primary health care settings, suggesting that primary health care centers are the appropriate venue for increased screening and treatment for mental health. In this same study, more than a third of immigrant women cited immigration-related concerns as their number one barrier to mental health treatment (Kaltman et al., 2014).

Furthermore, a lack of social support was associated with the increased prevalence of MDD, PTSD, and low mental HRQL. This finding indicates that health and social service organizations working with this population should consider creating opportunities for increased contact among undocumented Spanish-speaking immigrant women, including social support groups. Prior research indicates that the most common barrier to help-seeking in this community is not knowing where help is available. Social support groups may lead to increased resource sharing among women. Women in our sample were slightly more likely to disclose IPV to a friend or family member than to a formal source of help. Therefore, increasing social support opportunities may also promote increased IPV disclosure. Both formal and informal disclosure of IPV is beneficial to health outcomes (Carlson et al., 2002; Liang et al., 2005).

Next Steps

Future studies should explore the relationships between IPV and health outcomes with a larger and more representative undocumented Latina immigrant sample. Furthermore, it

would be helpful to explore the origins of MDD and PTSD in a systematic manner when applicable. Although many women who completed the survey shared their personal traumatic events, data about the sources of depression and/or anxiety (when applicable) were not systematically collected. This is also true for the daily life stressors of being an undocumented immigrant woman. This information could be useful for health and social service providers responsible for screening and treating mental health problems. A qualitative or a mixed-methods approach may be best suited to explore this question further. This methodology would permit a more in-depth exploration of sources of depression and anxiety. Current health and social service providers can use the results of this study to justify more routine screening for anxiety and depression disorders and advocate for increased mental health resources for their patients.

CHAPTER 4: HELP-SEEKING AMONG SPANISH-SPEAKING UNDOCUMENTED IMMIGRANT SURVIVORS OF INTIMATE PARTNER VIOLENCE: A QUALITATIVE INVESTIGATION

Abstract:

Background: There are an estimated 11.3 million undocumented immigrants residing in the United States, over half of whom are from Mexico. While intimate partner violence (IPV) is a health concern among women from all regions of the world, little is known about the help-seeking experiences of IPV among Spanish-speaking undocumented immigrants in the United States.

Purpose: To investigate the acceptability of IPV screening and help-seeking behaviors of Spanish-speaking undocumented immigrants in Philadelphia.

Methods: We conducted five individual interviews with Spanish-speaking undocumented immigrant IPV survivors and one focus group interview with six undocumented immigrant community health workers (CHWs).

Results: All participants thought that IPV screening by health care providers (HCPs) was a good idea, with one woman reporting that she disclosed for the first time to a HCP when screened. The primary motivation for help-seeking in this sample was severe and/or escalating violence. Unique help-seeking barriers for this population included: lack of knowledge about IPV services, language barriers, and fears of deportation (for partner or for themselves). All CHWs reported not feeling adequately prepared for referring IPV survivors to services.

Conclusion: Undocumented immigrants identified similar challenges in IPV help seeking as other IPV survivors. However, they also raised a number of unique barriers, including deportation concerns and concern over service availability in Spanish. CHWs are important sources of information and reported being approached by numerous women for IPV help-seeking assistance. Yet, they all reported feeling unequipped to help IPV survivors. CHWs should receive increased training to properly refer IPV survivors to services offered in Spanish and HCPs should regularly screen undocumented immigrant women receiving primary care.

Introduction

Approximately one third of the 11.3 million immigrants living in the United States are undocumented and of these three quarters are from Latin American — with six million from Mexico alone (Passel, Cohn, Krogstad, & Gonzalez-Barrera, 2014; Passel, Director, & Lopez, 2009). Although the influx of undocumented immigrants has stabilized in recent years, the undocumented immigrant population in the U.S. is not projected to change in the coming years. While the number of incoming undocumented Mexican immigrants has decreased, there has been an increase in youth from Central America crossing the US-Mexico border (Passel et al., 2014)

Intimate partner violence (IPV) affects women from all regions of the world. The worldwide lifetime prevalence ranges from 10-71%, with the U.S. prevalence for being physically abused and/or raped by an intimate partner lies between 25-33% (Black et al., 2010; García-Moreno et al., 2005; Heise et al., 1999; Tjaden & Thoennes, 2000). In one of the first quantitative studies focusing on undocumented immigrants from Latin America, the authors of this manuscript found a similar prevalence of IPV among an urban sample of undocumented Spanish-speaking Latina immigrants: of the 200 women surveyed, 35.5% reported a lifetime experience of IPV (physical and/or non-physical). In the same study, 34% and 36% of IPV survivors asked for formal (e.g. therapist, police, non-profit organization) and informal (e.g. friends and family) help (respectively) as a result of IPV (Chapter 2). However, there is a dearth of research related to IPV and help-

seeking among undocumented immigrant women in the United States (Levine & Peffer, 2012).

Although there is a large undocumented population in the United States, public health research rarely focuses on this vulnerable population. Stigma, fear, and language barriers are examples of barriers that limit the participation of undocumented immigrants in research (Shedlin et al., 2011). Additionally, language barriers, unfamiliarity with service organizations, and fear of deportation and/or authorities are all reasons why undocumented immigrants may be less likely to access health and social services in the United States (Runner et al., 2009).

Barriers to Seeking Help

Few studies have investigated the help-seeking behaviors of undocumented immigrant women. In an effort to understand how immigrant women interact with the justice system to obtain protective orders, Ammar et al. studied 153 battered immigrant women in the U.S. from around the world who had sought formal help as a result to IPV. Forty-four percent of the sample was composed of undocumented immigrants. Although results were not stratified by immigration status, the authors found that 89% of the sample had never heard of a protection order before seeking formal help (Ammar et al., 2012). This is a worrisome finding given that protection orders are one of the most common legal options available to IPV survivors. This finding suggests that IPV survivor immigrant women are not knowledgeable about legal options available to them in the United States. The authors also found that women most commonly learned about sources of help from

someone who spoke their language, indicating that services should be advertised and offered in the native language of immigrants (Ammar et al., 2012). In another study, Levine et al. estimated approximately 37,000 undocumented immigrant women were the victims of IPV in 2008 in the United States; yet only 10,000 U-visa applications (a legal help-seeking option for IPV) were available to this same population, indicating a lack of available formal resources (Levine & Peffer, 2012). Finally, another qualitative study with 17 Hispanic immigrant mothers, including undocumented immigrants, in the northeastern US identified the fear of the threat of deportation as a barrier to IPV help-seeking (Kelly, 2009).

This purpose of this study was to better understand the IPV help-seeking motivations and behaviors of undocumented immigrants. Results from this study can be used to guide IPV prevention and reduction programs for health and social service providers working with undocumented immigrant populations in this community, as well as guide policy recommendations for more systematic approaches. Furthermore, this study makes an important contribution to public health and immigrant literature, as it is one of only a handful of studies with an entirely undocumented immigrant population.

Methods

Research Design

Semi-structured individual interviews with undocumented Spanish-speaking immigrant women reporting IPV experiences in Philadelphia. We selected individual interviews as the most appropriate methodology due to the sensitive nature of IPV disclosure and help-

seeking among a vulnerable population. In addition to the individual interviews, we conducted one focus group composed of community health workers (CHWs) serving the undocumented Spanish-speaking population of Philadelphia. The first author of this manuscript (SJS) conducted the interviews and facilitated the focus group discussion.

Participants

Study participants were recruited between September 2013 and September 2014 by the lead author at a community health center in Philadelphia, PA that serves uninsured Spanish-speaking immigrants, the majority of whom are undocumented. Three women were recruited directly after completing a quantitative Women's Health Survey that included an IPV screening instrument (Index of Spouse Abuse) (Hudson & McIntosh, 1981) at a health clinic that serves uninsured Spanish-speaking patients. Women who screened positive for IPV were invited to complete a follow-up qualitative interview. Additionally, Community Health Workers (CHWs) from the same clinic alerted two women to the study. The CHWs asked women who disclosed IPV experiences if they were interested in sharing their experiences as part of a research project to better understand IPV experiences and help-seeking in their community. Interested women were contacted directly by the lead author (S.S) and met to discuss the study at the health clinic in further detail. Eligibility criteria for the interviews were as follows: female, age ≥ 18 years, fluent Spanish-speaker, undocumented immigration status, and self-reported IPV experience while residing in Philadelphia, PA. The lead author (SJS) gave a detailed

explanation of the project and the women provided verbal informed consent. Participants were compensated $20 for their participation.

Six CHWs working or volunteering for the health clinic who are also undocumented immigrants were invited to participate in a focus group exploring the prevalence and the help-seeking behaviors of women in their community. The group of six CHWs has been involved in health promotion research in the same undocumented immigrant community in the past (O'Brien, Shuman, Barrios, Alos, & Whitaker, 2014; O'Brien, Halbert, Bixby, Pimentel, & Shea, 2010). The CHWs provided informed consent and were compensated $10 for their participation. The Institutional Review Board at Temple University and the Medical Director at Puentes de Salud approved this study (Protocol: 22285).

Data Collection

Five individual interviews were conducted with undocumented Spanish-speaking immigrant women. Each interview covered three domains: (1) IPV knowledge, (2) IPV screening acceptability, and (3) IPV help-seeking behaviors. While questions in the three domains were developed in advance, the interviewer probed for additional information based on responses and the natural flow of conversation. All interviews were conducted in Spanish. Interviews lasted between approximately 30 minutes and one hour and were digitally recorded. The focus group interview with the CHWs was approximately 90 minutes, conducted in Spanish, digitally recorded, and explored the same domains as the individual interviews. See Appendix 2 for questions included in the interviews and focus group.

Data Analysis

Each recording was transcribed in Spanish by a native Spanish speaker and compared to the original recording to confirm accuracy (SJS). Atlas.ti® software (Scientific Sofware Development, 2014) was used to organize and code the transcripts and a grounded theory approach was used in data analysis. Grounded theory emphasizes an inductive, open-ended approach toward data analysis, encouraging the elimination of preconceived ideas, shifting to the generation of a list of emergent themes (Charmaz, 2008). Each interview was coded in English by the first author (S)JS with descriptive statements (e.g. influence of immigration status on help-seeking) reflecting a theme. Codes were then organized into themes across the interviews and supporting quotes were translated into English.

Results

Five undocumented Spanish-speaking females from Mexico who experienced both physical and emotional IPV while living in Philadelphia participated in one-on-one interviews. Six CHW undocumented Spanish-speaking female immigrants from Mexico participated in the focus group.

Theme 1: IPV Screening by Health Care Providers

Three of the five women reported having been screening by a healthcare provider (HCP) for IPV. However, of the three that were screened, only one disclosed IPV. One woman did not disclose because she was screened in English by her child's pediatrician and reported not immediately understanding the question and an inability to respond in English. Another women reported not disclosing because the IPV was not severe at the time of screening and she was not interested in the services that the HCP might offer. Regardless, all five interviews thought that IPV screening in health settings was a good idea and none reported a gender preference in the screening HCP.

> *"No. When I was with him, no one ever asked me this question. I think that if they had asked me, I would have told them what was happening [disclosed the IPV]…I think it is an excellent idea [health care providers screening for IPV]."*

The CHWs also agreed that IPV screening by HCPs was a good idea, commenting that if this was a routine question that would not be viewed as intrusive. Several mentioned that they had been screened in the past during an obstetric/gynecological visit. While the CHWs recognized that some women might not disclose, they felt that universal screening would help identify women in need of assistance.

> *"I think that the clinic [Puentes de Salud] should introduce this question and I don't think it would bother anyone because it is a routine question and many times it can help. Precisely because this is a clinic for prevention, the question can prevent something worse [from happening]."*

Theme 2: IPV Help-Seeking: Motivations and Challenges

Theme 2.1 IPV Help-seeking Motivated by Escalating Violence

Four of the five undocumented Latina immigrants who completed individual interviews sought formal help in the U.S. as a result of IPV. Formal help-seeking included visiting a psychologist or therapist, calling the police, attending family court, obtaining a order of protection, and/or calling a domestic violence hotline. Three women reported more than one source of formal help-seeking.

Women who sought help for IPV were asked about their motivations for help seeking. Several described scenarios of escalating violence as their prompt for help seeking. Below, a woman accompanied a new immigrant male housemate to a job interview because he not familiar with the city, described the following scene when she returned home and opened the door to her partner:

> *"He, without mincing words, was all over me. He started beating me this, he hit me very badly, practically raped me, saying: "that's what I was looking for, to be with men." He raped me, physically abused me, and grabbed knives from the kitchen. And that's when I decided I could not be there anymore, because one day he could kill me. Then he dared to say 'report me.' You are in the United States and you can report [Since you are living in the United States, you have more rights and you can report this violence to the police]."*

As a result of this violence, the woman sought formal help from the police. In the situation described below, the IPV survivor also made a 911 phone call to ask for police assistance.

> *"He grabbed me by the hair, threw me on the bed and climbed on top of me. It did not matter to him that I was pregnant. He grabbed me by the hands and neck and did not want to let me go. I ran to grab the phone to call for help. He grabbed me again by the hair and grabbed the phone. The phone fell. I grabbed the phone and ran to the bathroom, dialed 911, and asked for someone who spoke Spanish. I asked them to send a police car to take him away"*

These quotes highlight the severe physical and sexual IPV that survivors experience.

Theme 2.2: Undocumented Immigrants Face Unique Barriers in Help-Seeking

Although formal help seeking was common among this convenience sample, participants mentioned several challenges in asking for help. These barriers included language concerns, unfamiliarity with social services, and not knowing eligibility criteria for certain services. Participants also named not wanting to be separated from children and/or have their partner deported as a barrier to asking for help.

> *"The language barrier, the barriers of not knowing where help centers are. And above all, not knowing if they will ask you for some document, for your legal status, of if you have to be of a certain race. It is a lot of misinformation."*

> *"First because I did not work at the time, and second because I said 'if they deport him, who is going to support us? And how will I explain to my children that their father hits me?'"*

These quotes demonstrate the misinformation regarding eligibility for services based on legal status and the challenges of making ends meet without financial support. While the latter often applies to IPV survivors in general, the precarious financial situation of undocumented immigrants may make this challenge especially relevant. Furthermore, wanting to leave a partner is not the same as wanting a partner deported. In addition, extended family dynamics may play a role in help-seeking decisions. One CHW shared an experience of one woman calling the police and having to deal with criticism from family in Mexico.

> *"I know a person who also had a husband who hit her, and hit her, and hit her. Until she decided one day no more — and she called the police and they took him [to jail]. Her family in Mexico was calling her and saying: "how could you do this?" They said so much until she retracted the complaint."*

Theme 3: CHWs Interactions with IPV Survivors

Theme 3.1 IPV Survivors Turn to CHWs for Help

The CHWs provided multiple examples of undocumented immigrant women turning to them for help and advice related to IPV help-seeking. These experiences varied widely, from women disclosing in casual conversations to being called in emergency situations.

> *"As community health workers, this always happens to us. I think that we always have people who are calling us looking to talk about things."*

CHWs may be one of the first points of formal help seeking contacts for undocumented IPV survivors. The fact that the undocumented IPV survivors will primarily turn to CHWs demonstrates that the CHWs have an important and trusted role in the communities they serve.

Theme 3.2 CHWs Are Not Adequately Prepared for Assisting IPV Survivors

In general, CHWs described feeling unprepared and or frustrated in advising IPV survivors asking for help. They were not aware of services that were available when they needed them. When asked how to help a women who came into the clinic and disclosed an IPV experience, they felt comfortable referring her to the on-site psychologist. However, when they were solicited for help outside of the clinic setting, they were unsure of what resources were available and/or unable to identify resources. The following situation provides an example of the lengths CHWs go to in order to help members of the community.

> *"She has two small children and has never worked. Where do you take her? In this instance, if she returns to her house, her aggressor is there. She can't go back to her house. But if you take her to an institution… there is a protocol that you have to follow and she is undocumented and can not access these services. I am telling you from experience, because this happened to me. I have to take this person with her children to my house, because her husband kicked her out. It was 6pm, I called all the institutions and all the friends that I had. They gave me numbers and numbers, where no one answered the phone or I got the*

answering machine. At 10pm I said 'let's call the police.' She said 'no! My brothers are there and if the police detain him, they are going to say things to me, assault me, I don't know what else.' So I had her living in my house for two weeks."

The case above demonstrates how CHWs use their informal networks to solicit help, but when she could not find a solution, she brought the family into her home. When probed on community resources available to IPV survivors, the CHWs identified a therapist and the church. One woman knew there might be other resources available in a more distant part of the city, but she believed that undocumented immigrants were not eligible for the services.

"Sometimes the church, they can go and talk with the sisters or the priest, but even so, apart from this I don't know any places that we can tell them [to go]. All the places are in the north [of Philadelphia] and they need papers [legal documentation]. The truth is, I don't know."

Although there was a lack of knowledge about available IPV resources, the CHWs wanted to do more.

"As community health workers, we need to know too. What can we offer? What do we have access to? Up until what point can we help?"

"We [CHWs] want to move the sky, sea, and land to help someone, but our resources are very limited. We cannot. Therefore, we have learned to listen and see what we can do. Sometimes we cannot do anything. It is sad, you want to do more, but sometimes you just cannot do anything"

Discussion

The study findings suggest that undocumented immigrant women would welcome IPV screening in their native language by primary HCPs. Both IPV survivors and CHWs agreed that the HCP gender was unimportant for screening. One woman never screened by a HCP said she would have disclosed had she been asked during a visit. Another woman who was screened but did not disclose, cited the language barrier with the HCP as the reason for non-disclosure. Providing healthcare services in the patient's language is important, not only for IPV screening, but also for high quality patient care. While there is no clear consensus on the efficacy of universal IPV screening (Moyer, 2013), research has found help-seeking to be beneficial. For example formal help-seeking may result in fewer incidents of serious physical IPV in the future (Goodman et al., 2005; Liang et al., 2005). Past research with health and social service providers identified lack of time, the behaviors of women (e.g. defending and/or not leaving the abusive partner), and lack of training as the three most common barriers preventing IPV screening (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012). We identified no studies regarding IPV screening and referral practices with HCPs serving undocumented immigrant populations. Future research with health and social service providers working with undocumented immigrants should assess their knowledge of IPV resources available to undocumented immigrants, as IPV screening alone is insufficient.

Once IPV survivors are identified, HCPs must be adequately prepared to refer women to the appropriate resources. In our interviews, one woman who disclosed IPV to her HCP was told to talk to a psychologist. However, she was not provided with a specific

psychologist or instructions on how to contact one, indicating a need for a systemic approach to improving IPV services. She said her HCP never called to follow-up to see if she received the help he recommend. She eventually disclosed her IPV experiences to her employer, who helped her contact an organization serving survivors of IPV, where she attending therapy for six months. She subsequently left her partner and indicated that she was better without her abuser.

In this study we also found that undocumented immigrant women face many of the same challenges in formal and informal help-seeking identified by non-immigrant women, such as embarrassment and shame. However, this vulnerable population also identified unique challenges related to their immigrant status including: language barriers, fear of deportation, and uncertainty about available services. These results are in line with a previous study with abused Latina immigrant women, which found Latina undocumented immigrants delayed disclosure for fear of deportation (Bauer et al., 2000). Women in this study were also worried about deportation of their partner and what that would mean for their financial stability and/or their relationship with their family. While the United States has laws in place that can provide legal immigrant status to undocumented survivors of IPV, immigrant women worried about their partner being deported have well-founded fears, as reporting an undocumented immigrant as a perpetrator of IPV may result in deportation of the agressor.

Finally, results highlighted the important role that CHWs play as a resource for IPV help-seeking in their undocumented immigrant community. Each of the CHWs had women

disclose IPV to them in the past, both in clinical and non-clinical settings. In general, they were eager to help and responses ranged from listening, making referrals to formal services, to housing IPV survivors in their homes. While inviting IPV survivors into their homes reflects their dedication to their community, it is not a recommended strategy. Furthermore, the CHWs were unsure or incorrect about the necessary legal documentation required by organizations that provide assistance to IPV survivors. The focus group with the CHWs highlighted the need for training and integrated materials about available IPV resources, eligibility requirements for services, and an ethical protocol for working with IPV survivors.

Strengths and Limitations:

One strength of this study was the inclusion of only undocumented immigrant Spanish-speaking population. A handful of studies have included undocumented Latina immigrants in their sample (Ammar et al., 2012; Bauer et al., 2000; Kelly, 2009) but this is the first to report an entirely undocumented immigrant population. Four of the five women interviewed had sought formal help as a result of IPV experiences in Philadelphia. In a previous, clinic-based quantitative study with this population, only 34% of IPV survivors reported formal IPV help seeking, suggesting that help-seeking immigrants were overrepresented in this study (Chapter 2). This over-representation of formal help-seekers allowed better exploration facilitators and challenges to help-seeking more easily.

Additionally, the fact that four out of five immigrants sought formal help limited our ability to investigate the motivations of undocumented immigrants for not seeking help. Future studies should include larger sample sizes and more diverse IPV help-seeking experiences among participants. The small sample size of this study was a limitation, but recruitment is difficult with this population and a small amount of funds were available for participant incentives. In addition to the IPV survivors who completed individual interviews for this study, an additional six women either did not keep their appointment interview (n=4) or arrived but were uncomfortable with participating in the research portion of the study (n=2). The latter group received information about safety planning sessions and formal help-seeking options.

Recommendations

We propose that HCPs working with undocumented immigrants regularly screen women for IPV in their native language. Results suggest not only that women are open to this, but also that screening may encourage disclosure and therefore improve the health outcomes of IPV survivors.

Furthermore, results indicate a lack of and incorrect knowledge about available services and eligibility requirements among undocumented immigrant IPV survivors and among CHWs. Formal organizations serving this population may consider increased outreach to undocumented immigrant communities and providing training tailored to CHWs, who often serve as the first point of formal contact for undocumented immigrants seeking help

as a result of IPV. Examples of organizations include domestic violence organizations, non-profit legal services, and health centers. Both training and services must be available in Spanish and should directly address the deportation concerns of women, as current legislation in the United States offers protections for women who have been the victims of intimate partner violence, regardless of their immigration status. Training for CHWs should include information on available resources for survivors of IPV and safety planning.

CHAPTER 5: CONCLUSION

More than one in three adult women in the United States experience IPV in their lifetime (Black et al., 2010), however less is known about IPV among vulnerable populations including undocumented immigrants. Spanish-speaking undocumented immigrants account for almost three quarters of the 11.3 million unauthorized persons in the United States in 2014 and most do not have health insurance (Passel et al., 2014).

Women who seek help as a result of IPV face a myriad of barriers including fear, shame, lack of knowledge about recourses, social stigma, and embarrassment. Undocumented immigrants likely experience the same barriers, but also may face unique challenges compared to their non-undocumented immigrant counterparts. These unique challenges may include: language barriers, fear of deportation, and unfamiliarity with health and social service systems.

The purpose of this dissertation was to understand the IPV prevalence, help-seeking behaviors, and health outcomes among an undocumented Spanish-speaking immigrant population living in Philadelphia, PA. Using primary data collection methods, two hundred undocumented immigrant women were screened for IPV, functional physical health, MDD, and PTSD in a clinical setting. In-depth interviews were conducted with five IPV survivors and one focus group was held with CHWs to learn more about disclosure and referral practices. This approach allowed for more in-depth analysis of

quantitative findings. The mixed method study provided a more in-depth look into the issue of IPV among this special population. While the quantitative survey provides a sense of the breadth of the issue, the interviews and focus groups provides a sense of the nuances and unique considerations. Across the individual papers of the dissertation, three specific aims were addressed:

> *Specific Aim 1:* Describe the prevalence of intimate partner violence and help-seeking behaviors among undocumented Spanish-speaking immigrants in an urban primary care clinic.

> *Specific Aim 2:* Describe the functional and emotional health of undocumented Spanish-speaking immigrant women who have experienced IPV compared to undocumented Spanish-speaking immigrant women who have not experienced IPV.

> *Specific Aim 3:* Document the IPV help-seeking behaviors of undocumented Spanish-speaking immigrant women who experienced IPV while living in Philadelphia.

To the author's knowledge, there are no published studies that focus on the IPV prevalence, health outcomes, or help-seeking behaviors of an exclusively undocumented Spanish-speaking immigrant population in the United States.

Summary of Findings

Chapter 2 addresses Specific Aim 1, describing the prevalence and help-seeking behaviors of undocumented Spanish-speaking women. The Index of Spousal Abuse was used to assess lifetime IPV experiences. In a sample of 200 women recruited from a health clinic serving the target population, 35.5% (n=69) of the sample screened positive for either physical or non-physical lifetime IPV (referred to as IPV survivors, confirming hypothesis 1a, that women in this population experience lifetime IPV the same amount as the U.S. general population. Sixty-five percent (n=45) of the IPV survivor population reported both physical and non-physical IPV, indicating the experiencing multiple forms of IPV was more common than experiencing one type. Having a partner who becomes angry when she disagrees with him, having a partner who screams and yells, and having a partner who is jealous and/or suspicious of friends being the most common types of non-physical IPV among survivors (87%, 87%, and 84.1% of all lifetime IPV survivors respectively). Among IPV survivors who experienced physical abuse, having a partner who punched with his fists and a partner who becomes abusive when he drinks alcohol were the most common responses to individual questions (65.2% and 62.3% respectively).

Results indicated the more than half (56.5%) of IPV survivors did seek help, with informal help-seeking slightly more common than formal help-seeking, in line with hypothesis 1b. Among women who sought informal help as a result of an IPV experience, women were most likely to reach out to their siblings, followed by their parents, and then

friends. The most common sources for formal help seeking were non-profit organizations (20%), the police (12%), and a therapist/counselor (12%). Not knowing where to seek services, embarrassment, deportation concerns, family separation, and lack of social support were the most commonly cited reasons for not seeking help as a result of IPV. These findings indicate that organizations working to provide resources for IPV have several directions to expand services. They can increase Spanish language resources, work to normalize IPV as a public health problem, and provide education on the rights of immigrants who are the survivors of abuse.

Specific Aim 2 was addressed in Chapter 3. Women from the quantitative sample were screened for MDD and PTSD and answered twelve questions related to HRQL. Logistic regression was used to examine the association between IPV and physical and mental health status. Of the entire sample (n=200) 41.5% endorsed major depressive disorder and 16% endorsed post-traumatic stress disorder. In the unadjusted logistic regression models, IPV survivors were more likely to endorse MDD and PTSD and report low mental health HRQL scores (OR: 2.27, 3.45, 2.19 respectively). In fully adjusted models, only the association between IPV and PTSD remained significant (OR: 4.143, CI: 1.21-14.24). The findings from this portion of the study indicated that there was a high prevalence of both MDD and PTSD in the study population. Health and social service providers in this community should investigate these findings further, possibly screening more women for mental health conditions and increasing or improving existing mental health services.

To better understand the help-seeking experiences and motivations of IPV survivors in this community, five in-depth individual interviews and one focus group were conducted with IPV survivors and CHWs respectively. This study is described in Chapter 3. Results from the qualitative portion demonstrated supported the findings from Chapter 2 indicating that deportation concerns may influence the IPV help-seeking decisions of undocumented women. In addition to considering the possibility of themselves or their partner being deported, at least one woman was uncertain of what services undocumented immigrants were eligible for and referenced needing legal documentation for services. Women from the interviews had sought help from a variety of sources including the police, court system, employers, therapists, and non-profit organizations. Apart from their individual experiences seeking help, all interviewees agreed that IPV screening in healthcare settings was a good idea.

Finally, results from the focus group with the CHWs provided multiple examples of undocumented immigrant women turning to CHWs for help and advice related to IPV help-seeking. While the women were eager to assist women, in general, they felt untrained and unprepared to refer women to different sources of help.

Scientific Contributions

To our knowledge, this is the first study to describe IPV experiences and help-seeking behaviors among undocumented Spanish-speaking immigrant women. The dearth of research with this vulnerable population is likely related to their marginalized social

status and difficulties related to accessing this vulnerable population . This study demonstrates that it is possible to ask immigrants about their legal status and include undocumented immigrants in social science research.

As the number of undocumented immigrants in the United States is projected to remain stable over the next several years (Passel et al., 2014), understanding their unique vulnerabilities is vital for health promotion. Results from this study indicate that IPV is a health concern in the sampled community and that currently available resources may not adequately serve undocumented immigrants and/or that service organization are not adequately advertising services to undocumented immigrants. Programs that provide linguistically and culturally (especially in terms of addressing eligibility regardless of legal immigration status) will be important in providing health and social services to IPV survivors.

This study also draws attention to the prevalence of MDD and PTSD in the sample. This convenience sample had a higher prevalence of MDD and PTSD compared to U.S. Latinos and general adult population (Breslau et al., 2011). Due to study limitations (non-random convenience sample), it is not possible to compare these different populations. However, additional research about the possibility of an increased risk of anxiety disorders and depression in undocumented immigrants may be warranted. This dissertation study provides a starting point for future research with undocumented immigrant population. Ideas for future research are discussed in more detail below.

Community Contribution

Health and social service providers currently providing IPV prevention services in Philadelphia should use results of this study, particularly about help-seeking barriers and acceptability of screening, to improve services for undocumented immigrant women by providing more culturally appropriate service in the undocumented immigrant community. Specifically, *Congreso de Latinos Unidos (Congreso),* a non-profit organization based in North Philadelphia, is working on a project to expand their Latina Domestic Violence Program to the undocumented immigrant populations in South Philadelphia. Furthermore, alcohol use and abuse was associated with the prevalence of IPV in this sample, yet only one Alcohol Anonymous group is available in South Philadlephia. *Congreso* may consider providing additional substance abuse resources for men, a service they already provide in North Philadelphia. This researcher is on the advisory board of the Latina Domestic Violence Program at *Congreso* and will continue to work on the development of this program.

Furthermore, *Puentes de Salud*, the recruitment site for this study, should consider providing additional training to CHWs, focusing on safety planning and referral resources available to Spanish-speaking undocumented immigrant. The CHWs appear to be front-line resources for IPV survivors seeking help and expressed a desire to learn more about IPV and available resources for help. The lead author (SJS) has plans to present the findings of this dissertation and specific recommendation to the staff at *Puentes de Salud.*

Limitations

The small sample size for both the quantitative and qualitative portions of this dissertation and the cross-sectional design were both limitations of this study. The cross-sectional study design is restricts any conclusions about temporal relationship and therefore reverse causality is a possibility. For example it is possible that IPV resulted in an increased likelihood of PTSD or that women with PTSD are more likely to experience IPV.

The study population was limited to women seeking or accompanying someone seeking health care services, and therefore not representative of all undocumented Spanish-speaking women in Philadelphia, including women who seek services at a different health care center and those not seeking care. Women with controlling partners may be limited or restricted from attending medical appointments.

Only one researcher was available to screen eligible women and administer the survey, limiting the number of women who could complete the survey during each clinical session. Clinical space was also limited, making it difficult to recruit during some clinical sessions and potentially limiting the number of eligible women being recruited to participate.

Finally, recruiting IPV survivors to participate in the qualitative portion of this study was a challenge. The additional time requirement and small amount of available may have contributed to the low number of successful interviews. Many women who screened

positive for IPV declined to participate in the qualitative portion of this study. In addition six women who did agree to participate either did not keep their appointment interview (n=4) or arrived but were uncomfortable with participating in the research portion of the study (n=2). The latter group received information about safety planning session and formal help-seeking options.

Future Studies

Due to the limited availability of research about IPV among undocumented immigrants, there are many opportunities for future investigation. First, future studies should explore the relationships between IPV and health outcomes with a larger and more representative undocumented Latina immigrant sample. Although this was outside the scope of this dissertation project, a larger and more representative sample would strengthen study findings.

This study found that over a third of undocumented Spanish-speaking immigrant women seeking primary health care services in Philadelphia experienced IPV and that partner's alcohol use was significantly associated with the likelihood of IPV experiences. Future studies should further investigate the pathway between partner's alcohol use and IPV and the impact of alcohol treatment programs (or alcohol reduction) on the incidence of IPV. While working with male undocumented immigrants who are the perpetrators of IPV was

outside the scope of this research, increasing knowledge about IPV from the perspectives of males is important and necessary for IPV prevention programs.

Additionally, it would be helpful to explore the origins PTSD (and possibly MDD if applicable) in a systematic manner in the future. Although many women shared their personal traumatic events unprompted, data about the sources of anxiety were not systematically collected. This is also true for the daily life stressors of being an undocumented immigrant woman. A temporal component combined with the origins of anxiety would provide further insight into the relationship between IPV and PTSD.

Finally, as a follow-up to this dissertation project, additional in-depth interviews would strengthen the results of Chapter 3 and provide more direction to health and social service agencies in Philadelphia working with undocumented immigrant IPV survivors. As discussed above, time and resource limitations proved to be a significant barrier, involving the CHWs in this process may prove helpful.

Reflection

This project provided an opportunity to design an original research study, complete primary data collection, and complete quantitative and qualitative analysis on a pressing public health issue with a marginalized population. While violence against women in its many forms is increasingly recognized as public health concern, it does not receive the same attention as equally or less prevalent health problems in the United States. As

millions of undocumented immigrants continue to reside and immigrate to this country in search of a better life, it is imperative that programs and policies exist to meet their specific needs and protect them from violence and abuse. I am committed to continuing to work with this population.

I will also use the knowledge and skills gained from this project to work on related projects. I am currently managing the qualitative component of a randomized clinical trial in Mexico City aimed at increasing help-seeking behaviors among survivors of IPV. I plan to pursue an academic career that involves both teaching and research and the skills gained in this project have provided me with a solid foundation for this path. I have given several lectures in university settings about IPV among undocumented immigrants and my research helped me gain employment as a Visiting Professor at Haverford College.

REFERENCES

Adams, M., & Campbell, J. (2012). Being Undocumented & Intimate Partner Violence (IPV): Multiple Vulnerabilities Through the Lens of Feminist Intersectionality. *Women's Health & Urban Life, 11*(1), 15-34

Alsaker, K., Moen, B. E., Nortvedt, M. W., & Baste, V. (2006). Low health-related quality of life among abused women. *Quality of life research, 15*(6), 959-965.

Ammar, N. H., Orloff, L. E., Dutton, M. A., & Hass, G. A. (2012). Battered Immigrant Women in the United States and Protection Orders: An Exploratory Research. *Criminal Justice Review, 37*(3), 337-359. doi: 10.1177/0734016812454660

Bauer, H. M., Rodriguez, M. A., Quiroga, S. S., & Flores-Ortiz, Y. G. (2000). Barriers to health care for abused Latina and Asian immigrant women. *Journal of health care for the poor and underserved, 11*(1), 33-44.

Bell, M. E., Cattaneo, L. B., Goodman, L. A., & Dutton, M. A. (2008). Assessing the risk of future psychological abuse: Predicting the accuracy of battered women's predictions. *Journal of Family Violence, 23*(2), 69-80.

Beynon, C. E., Gutmanis, I. A., Tutty, L. M., Wathen, C. N., & MacMillan, H. L. (2012). Why physicians and nurses ask (or don't) about partner violence: a qualitative analysis. *BMC public health, 12*(1), 473.

Black, M., Basile, K., Breiding, M., Smith, S., Walters, M., Merrick, M., & Stevens, M. (2010). National Intimate Partner and Sexual Violence Survey 2010 Summary Report: Executive Summary: Centers for Disease Control and Prevention.[Online] Available: http://www. cdc. gov/violenceprevention/nisvs.

Breslau, J., Borges, G., Hagar, Y., Tancredi, D., & Gilman, S. (2009). Immigration to the USA and risk for mood and anxiety disorders: variation by origin and age at immigration. *Psychological medicine, 39*(07), 1117-1127.

Breslau, J., Borges, G., Tancredi, D., Saito, N., Kravitz, R., Hinton, L., . . . Aguilar-Gaxiola, S. (2011). Migration from Mexico to the United States and subsequent

risk for depressive and anxiety disorders: a cross-national study. *Archives of general psychiatry, 68*(4), 428-433.

Caetano, R., Nelson, S., & Cunradi, C. (2001). Intimate partner violence, dependence symptoms and social consequences from drinking among white, black and Hispanic couples in the United States. *The American Journal on Addictions, 10*(s1), s60-s69.

Caetano, R., Schafer, J., Clark, C. L., Cunradi, C. B., & Raspberry, K. (2000). Intimate partner violence, acculturation, and alcohol consumption among Hispanic couples in the United States. *J Interpers Violence, 15*(1), 30-45.

Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet, 359*(9314), 1331-1336.

Carlson, B. E., McNutt, L.-A., Choi, D. Y., & Rose, I. M. (2002). Intimate Partner Abuse and Mental Health The Role of Social Support and Other Protective Factors. *Violence Against Women, 8*(6), 720-745.

Carrasco, J. M., Pérez-Gómez, B., García-Mendizábal, M. J., Lope, V., Aragonés, N., Forjaz, M. J., . . . Pollán, M. (2007). Health-related quality of life and mental health in the medium-term aftermath of the Prestige oil spill in Galiza (Spain): a cross-sectional study. *BMC public health, 7*(1), 245.

Cavazos-Rehg, P. A., Zayas, L. H., & Spitznagel, E. L. (2007). Legal status, emotional well-being and subjective health status of Latino immigrants. *Journal of the National Medical Association, 99*(10), 1126.

Centers for Disease Control and Prevention. (2010). Intimate Partner Violence: Risk and Protective Factors. Retrieved November 4, 2012, from http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/riskprotectivefactors.html

Charmaz, K. (2008). Constructionism and the grounded theory method. *Handbook of constructionist research*, 397-412.

Coker, A. (2005). Opportunities for prevention: addressing IPV in the health care setting. *Family Violence Prevention and Health Practice, 1*(1), 7-9.

Coker, A., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). Physical and mental health effects of intimate partner violence for men and women. *Am J Prev Med, 23*(4), 260-268.

Coker, A., Weston, R., Creson, D., Justice, B., & Blakeney, P. (2005). PTSD symptoms among men and women survivors of intimate partner violence: The role of risk and protective factors. *Violence and Victims, 20*(6), 625-643.

Cunradi, C. (2010). Neighborhoods, alcohol outlets and intimate partner violence: Addressing research gaps in explanatory mechanisms. *International journal of environmental research and public health, 7*(3), 799-813.

Denham, A. C., Frasier, P. Y., Hooten, E. G., Belton, L., Newton, W., Gonzalez, P., Campbell, M. K. (2007). Intimate partner violence among Latinas in eastern North Carolina. *Violence Against Women, 13*(2), 123-140.

DHS, M. (2013). Demographic Health Survey Overview. Retrieved February 23, 2013, from http://www.measuredhs.com/What-We-Do/Survey-Types/DHS.cfm

DiClemente, C. C., Prochaska, J. O., Fairhurst, S. K., Velicer, W. F., Velasquez, M. M., & Rossi, J. S. (1991). The process of smoking cessation: an analysis of precontemplation, contemplation, and preparation stages of change. *J Consult Clin Psychol, 59*(2), 295.

Eisenman, D. P., Gelberg, L., Liu, H., & Shapiro, M. F. (2003). Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence. *JAMA, 290*(5), 627-634.

Feder, G. S., Hutson, M., Ramsay, J., & Taket, A. R. (2006). Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Archives of internal medicine, 166*(1), 22-37.

Fedovskiy, K., Higgins, S., & Paranjape, A. (2008). Intimate partner violence: how does it impact major depressive disorder and post traumatic stress disorder among immigrant Latinas? *Journal of Immigrant and Minority Health, 10*(1), 45-51.

Filson, J., Ulloa, E., Runfola, C., & Hokoda, A. (2009). Does powerlessness explain the relationship between intimate partner violence and depression? *J Interpers Violence*.

Frank-Stromborg, M., & Olsen, S. J. (2004). *Instruments for clinical health-care research*: Jones & Bartlett Learning.

Fuchsel, C. L. M., Murphy, S. B., & Dufresne, R. (2012). Domestic Violence, Culture, and Relationship Dynamics Among Immigrant Mexican Women. *Affilia, 27*(3), 263-274. doi: 10.1177/0886109912452403

García-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. (2005). *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*: World Health Organization.

Golding, J. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence, 14*(2), 99-132.

González, H. M., Tarraf, W., Whitfield, K. E., & Vega, W. A. (2010). The epidemiology of major depression and ethnicity in the United States. *Journal of psychiatric research, 44*(15), 1043-1051.

Goodman, L., Dutton, M. A., Vankos, N., & Weinfurt, K. (2005). Women's resources and use of strategies as risk and protective factors for reabuse over time. *Violence Against Women, 11*(3), 311-336.

Hass, G. A., Dutton, M. A., & Orloff, L. E. (2000). Lifetime prevalence of violence against Latina immigrants: Legal and policy implications. *International Review of Victimology, 7*(1-3), 93-113.

Heise, L., Ellsberg, M., & Gottemoeller, M. (1999). Ending violence against women. *Population Reports. Series L: Issues in World Health*(11), 1-43.

Hien, D., & Ruglass, L. (2009). Interpersonal partner violence and women in the United States: an overview of prevalence rates, psychiatric correlates and consequences and barriers to help seeking. *Int J Law Psychiatry, 32*(1), 48-55. doi: 10.1016/j.ijlp.2008.11.003

Hillemeier, M. M., Weisman, C. S., Chase, G. A., & Dyer, A.-M. (2008). Mental health status among rural women of reproductive age: Findings from the Central Pennsylvania Women's Health Study. *Am J Public Health, 98*(7), 1271.

Hudson, W. W., & McIntosh, S. R. (1981). The assessment of spouse abuse: Two quantifiable dimensions. *Journal of Marriage and the Family*, 873-888.

Ingram, E. M. (2007). A comparison of help seeking between Latino and non-Latino victims of intimate partner violence. *Violence Against Women, 13*(2), 159-171. doi: 10.1177/1077801206296981

Iverson, K. M., Gradus, J. L., Resick, P. A., Suvak, M. K., Smith, K. F., & Monson, C. M. (2011). Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. *J Consult Clin Psychol, 79*(2), 193-202. doi: 10.1037/a0022512

Jewkes, R. (2002). Intimate partner violence: causes and prevention. *The Lancet, 359*(9315), 1423-1429.

Jones, L., Hughes, M., & Unterstaller, U. (2001). Post-Traumatic Stress Disorder (PTSD) in Victims of Domestic Violence A Review of the Research. *Trauma, Violence, & Abuse, 2*(2), 99-119.

Kaltman, S., Hurtado de Mendoza, A., Gonzales, F. A., & Serrano, A. (2014). Preferences for trauma-related mental health services among Latina immigrants from Central America, South America, and Mexico. *Psychological Trauma: Theory, Research, Practice, and Policy, 6*(1), 83.

Kelly, U. A. (2009). "I'm a mother first": The influence of mothering in the decision‐making processes of battered immigrant Latino women. *Research in nursing & health, 32*(3), 286-297.

Klevens, J. (2007). An overview of intimate partner violence among Latinos. *Violence Against Women, 13*(2), 111-122.

Kyriakakis, S., Dawson, B. A., & Edmond, T. (2012). Mexican Immigrant Survivors of Intimate Partner Violence: Conceptualization and Descriptions of Abuse. *Violence and Victims, 27*(4), 548-562. doi: 10.1891/0886-6708.27.4.548

Laffaye, C., Kennedy, C., & Stein, M. B. (2003). Post-traumatic stress disorder and health-related quality of life in female victims of intimate partner violence. *Violence and Victims, 18*(2), 227-238.

Lee, S., Laiewski, L., & Choi, S. (2014). Racial-Ethnic Variation in US Mental Health Service Use Among Latino and Asian Non-US Citizens. *Psychiatric Services, 65*(1), 68-74.

Levine, H., & Peffer, S. (2012). Quiet Casualties: An Analysis of U Non-Immigrant Status of Undocumented Immigrant Victims of Intimate Partner Violence. *International Journal of Public Administration, 35*(9), 634-642. doi: 10.1080/01900692.2012.661191

Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence. *Am J Community Psychol, 36*(1-2), 71-84. doi: 10.1007/s10464-005-6233-6

Monge, F. S., Iglesias, P. S., Sánchez, M. P. B., & de Lecea, J. M. S. M. (2011). Validation of a reduced Spanish version of the Index of Spouse Abuse. *International Journal of Clinical and Health Psychology, 11*(2), 363-383.

Moyer, V. A. (2013). Screening for intimate partner violence and abuse of elderly and vulnerable adults: US Preventive Services Task Force recommendation statement. *Annals of internal medicine, 158*(6), 478-486.

Nixon, R. D., Resick, P. A., & Nishith, P. (2004). An exploration of comorbid depression among female victims of intimate partner violence with posttraumatic stress disorder. *Journal of affective disorders, 82*(2), 315-320.

O'Brien, M. J., Shuman, S. J., Barrios, D. M., Alos, V. A., & Whitaker, R. C. (2014). A qualitative study of acculturation and diabetes risk among urban immigrant latinas: implications for diabetes prevention efforts. *Diabetes Educ, 40*(5), 616-625. doi: 10.1177/0145721714535992

O'Brien, M. J., Halbert, C. H., Bixby, R., Pimentel, S., & Shea, J. A. (2010). Community health worker intervention to decrease cervical cancer disparities in Hispanic women. *Journal of general internal medicine, 25*(11), 1186-1192.

Otiniano, A. D., & Gee, G. C. (2012). Self-reported discrimination and health-related quality of life among Whites, Blacks, Mexicans and Central Americans. *Journal of Immigrant and Minority Health, 14*(2), 189-197.

Passel, J. S., Cohn, D., & Gonzalez-Barrera, A. (2013). Population decline of unauthorized immigrants stalls, may have reversed. *Washington, DC: Pew Hispanic Center.* http://www. *pewhispanic. org/files/2013/09/Unauthorized-Sept-2013-FINAL. pdf.*

Passel, J. S., Cohn, D., Krogstad, J. M., & Gonzalez-Barrera, A. (2014). As Growth Stalls, Unauthorized Immigrant Population Becomes More Settled: Pew Research Center.

Passel, J. S., Director, P. T., & Lopez, M. H. (2009). A portrait of unauthorized immigrants in the United States.

Perez, S., & Johnson, D. M. (2008). PTSD compromises battered women's future safety. *J Interpers Violence*.

Pietrzak, R. H., Goldstein, R. B., Southwick, S. M., & Grant, B. F. (2011). Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of anxiety disorders, 25*(3), 456-465.

Punukollu, M. (2003). Domestic violence: Screening made practical. *Journal of Family Practice, 52*(7), 537-543.

Radloff, L. S. (1977). The CES-D scale a self-report depression scale for research in the general population. *Applied psychological measurement, 1*(3), 385-401.

Raj, A., & Silverman, J. (2002). Violence Against Immigrant Women The Roles of Culture, Context, and Legal Immigrant Status on Intimate Partner Violence. *Violence Against Women, 8*(3), 367-398.

Reina, A. S., Maldonado, M. M., & Lohman, B. J. (2013). Undocumented Latina Networks and Responses to Domestic Violence in a New Immigrant Gateway Toward a Place-Specific Analysis. *Violence Against Women, 19*(12), 1472-1497.

Revilla Ahumada, L. d. l., Luna del Castillo, J., Bailón Muñoz, E., & Medina Moruno, I. (2005). Validación del cuestionario MOS de apoyo social en Atención Primaria. *Medicina de Familia, 6*, 10-18.

Roberts, R. E. (1980). Reliability of the CES-D scale in different ethnic contexts. *Psychiatry research, 2*(2), 125-134.

Rodriguez, M. A., Heilemann, M. V., Fielder, E., Ang, A., Nevarez, F., & Mangione, C. M. (2008). Intimate partner violence, depression, and PTSD among pregnant Latina women. *The Annals of Family Medicine, 6*(1), 44-52.

Runner, M., Novick, S., & Yoshihama, M. (2009). Intimate partner violence in immigrant and refugee communities: Challenges, promising practices and recommendations.

Salinero-Fort, M. Á., Jiménez-García, R., del Otero-Sanz, L., de Burgos-Lunar, C., Chico-Moraleja, R. M., Martín-Madrazo, C., Group, I. (2012). Self-reported health status in primary health care: the influence of immigration and other associated factors. *PloS one, 7*(6), e38462.

Shedlin, M. G., Decena, C. U., Mangadu, T., & Martinez, A. (2011). Research participant recruitment in Hispanic communities: lessons learned. *J Immigr Minor Health, 13*(2), 352-360. doi: 10.1007/s10903-009-9292-1

Sherbourne, C. D., & Stewart, A. L. (1991). The MOS social support survey. *Social science & medicine, 32*(6), 705-714.

Shobe, M. A., & Dienemann, J. (2008). Intimate partner violence in the United States: An ecological approach to prevention and treatment. *Social Policy and Society, 7*(02), 185-195.

Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women, 11*(1), 38-64. doi: 10.1177/1077801204271476

Straus, M. A., & Smith, C. (1990). Violence in Hispanic families in the United States: Incidence rates and structural interpretations. *Physical violence in American families: Risk factors and adaptations to violence in, 8*(145), 341-367.

Tjaden, P. G., & Thoennes, N. (2000). *Extent, nature, and consequences of intimate partner violence*: US Department of Justice, Office of Justice Programs, National Institute of Justice Washington, DC.

Torres, S. (1991). A comparison of wife abuse between two cultures: Perceptions, attitudes, nature, and extent. *Issues in mental health nursing, 12*(1), 113-131.

Vos, T., Astbury, J., Piers, L., Magnus, A., Heenan, M., Stanley, L., Webster, K. (2006). Measuring the impact of intimate partner violence on the health of women in Victoria, Australia. *Bulletin of the World Health Organization, 84*(9), 739-744.

Walton-Moss, B. J., Manganello, J., Frye, V., & Campbell, J. C. (2005). Risk factors for intimate partner violence and associated injury among urban women. *Journal of community health, 30*(5), 377-389.

Ware Jr, J. E., Kosinski, M., & Keller, S. D. (1996). A 12-Item Short-Form Health Survey: construction of scales and preliminary tests of reliability and validity. *Medical care, 34*(3), 220-233.

Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical care*, 473-483.

Watts, C., & Zimmerman, C. (2002). Violence against women: global scope and magnitude. *The Lancet, 359*(9313), 1232-1237.

World Health Organization. (2002). Intimate Partner Violence. Geneva: World Health Organization.

World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*: World Health Organization.

Zarza, M. J., Ponsoda, V., & Carrillo, R. (2009). Predictors of Violence and Lethality Among Latina Immigrants: Implications for Assessment and Treatment. *Journal of Aggression, Maltreatment & Trauma*, *18*(1), 1-16. doi: 10.1080/10926770802616423

APPENDIX A: WOMEN'S HEALTH SURVEY (ENGLISH/SPANISH)

Date:	
Initials:	
Informed Consent?	☐ Yes ☐ No

DEMOGRAPHIC INFORMATION

Immigration Status: ☐ Documented, citizen ☐ Documented, resident or visa ☐ Undocumented	Spanish Fluency: ☐ Yes ☐ No
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	DOB: _____/_____/_____ (mo/day/yr)
Eligible?	☐ Yes ☐ No
Country of Origin: _____	Years residing in U.S.: _____
Years of education: _____(years)	Health Insurance Status: ☐ Yes, has insurance ☐ No insurance
Employed: ☐ Yes ☐ No	Occupation:
Ever intimate partner: ☐ Yes ☐ No (If no, skip ISA & Help-seeking sections)	Current intimate partner: ☐ Yes ☐ No
Marital Status:	Parity:
# of children: _____	# of children living in household: _____
Do you drink alcohol? ☐ Yes ☐ No	How often do you get drunk (circle): often, only sometimes, or never?
Does/Did your husband/partner drink alcohol? ☐ Yes ☐ No	How often does (did) he get drunk (circle one): often, only sometimes, or never?

HEALTH-RELATED QUALITY OF LIFE ASSESSMENT

1. In general, would you say your health is:
   _____ Excellent (1)
   _____ Very Good (2)
   _____ Good (3)
   _____ Fair (4)
   _____ Poor (5)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:
_____ Yes, Limited a Lot (1)
_____ Yes, Limited a Little (2)
_____ No, Not Limited at All (3)

3. Climbing SEVERAL flights of stairs:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

5. Were limited in the KIND of work or other activities:
_____ Yes (1)
_____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A
RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

7. Didn't do work or other activities as CAREFULLY as usual:
_____ Yes (1)
_____ No (2)

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?
   _____ Not At All (1)
   _____ A Little Bit (2)

_____ Moderately (3)
_____ Quite A Bit (4)
_____ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

10. Did you have a lot of energy?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

11. Have you felt downhearted and blue?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL
PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?
_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

DEPRESSION SCALE

During the past week…	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I did not feel like eating; my appetite was poor	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family	0	1	2	3
4. I felt that I was just as good as other people	0	1	2	3
5. I had trouble keeping my mind on what I was doing	0	1	2	3
6. I felt depressed	0	1	2	3
7. I felt that everything I did was an effort	0	1	2	3
8. I felt hopeful about the future	0	1	2	3
9. I thought my life had been a failure	0	1	2	3
10. I felt fearful	0	1	2	3
11. My sleep was restless	0	1	2	3
12. I was happy	0	1	2	3
13. I talked less than usual	0	1	2	3
14. I felt lonely	0	1	2	3
15. People were unfriendly	0	1	2	3
16. I enjoyed life	0	1	2	3
17. I had crying spells	0	1	2	3
18. I felt sad	0	1	2	3
19. I felt that people disliked me	0	1	2	3
20. I could not "get going"	0	1	2	3

SOCIAL SUPPORT SCALE

1. About how many close friends and close relatives do you have (people you feel at ease with and can talk to about what is on your mind)?
Write in number of close friends and close relatives: #

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to YOU if you need it?

	None of the Time	A Little of the Time	Some of the Time	Most of the Time	All of the Time
2. Someone to help you if you were confined to bed	1	2	3	4	5
3. Someone you can count *on* to listen to you when you need to talk	1	2	3	4	5
4. Someone to give you good advice about a crisis	1	2	3	4	5
5. Someone to take you to the doctor if you needed it	1	2	3	4	5
6. Someone who shows you love and affection	1	2	3	4	5
7. Someone to have a good time with	1	2	3	4	5
8. Someone to give you information to help you understand a situation	1	2	3	4	5
9. Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
10. Someone who hugs you	1	2	3	4	5
Il. Someone to get together with for relaxation	1	2	3	4	5
12. Someone to prepare your meals if you were unable to do it yourself..	1	2	3	4	5
13. Someone whose advice you really want..	1	2	3	4	5
14. Someone to do things with to help you get your mind off things	1	2	3	4	5
15. Someone to help with daily chores if you were sick	1	2	3	4	5
16. Someone to share your most private worries and fears with	1	2	3	4	5

17. Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
18. Someone to do something enjoyable with	1	2	3	4	5
19. Someone who understands your problems	1	2	3	4	5
20. Someone to love and make you feel wanted	1	2	3	4	5

IPV SCREENING

This questionnaire was designed to measure certain negative aspects of the treatment of you in your relationship with your partner. It is not an exam and there are no right or wrong answers.

Please answer each statement carefully by placing an "X" in the chosen answer.

	Never	Rarely	Occasionally	Frequently	Very Frequently	Current Partner?	Past Partner?
1. My partner belittles me.							
2. My partner demands obedience to his whims.							
3. My partner becomes surly and angry if I tell him he is drinking too much.							
4. My partner makes me perform sex acts that I do not enjoy or like							
5. My partner becomes very upset if dinner, housework or laundry is not done when he thinks it should be.							
6. My partner is jealous and suspicious of my friends							
7. My partner punches me with his fists.							
8. My partner tells me I am ugly and unattractive.							
9. My partner tells me I really couldn't manage or take care of myself without him.							
10. My partner acts like I am his personal servant.							
11. My partner insults or shames me in front of others							
12. My partner becomes very angry if I disagree with his point of view.							
13. My partner threatens me with a weapon.							

14. My partner is stingy in giving me enough money to run our home.							
15. My partner belittles me intellectually.							
16. My partner demands that I stay home to take care of the children							
17. My partner beats me so badly that I must seek medical help							
18. My partner feels that I should not work or go to school.							
19. My partner is not a kind person.							
20. My partner does not want me to socialize with my female friends.							
21. My partner demands sex whether I want it or not.							
22. My partner screams and yells at me.							
23. My partner slaps me around my face and head.							
24. My partner becomes abusive when he drinks.							
25. My partner orders me around.							
26. My partner has no respect for my feelings.							
27. My partner acts like a bully towards me.							
28. My partner frightens me							
29. My partner treats me like a dunce.							
30. My partner acts like he would like to kill me.							

HELP-SEEKING BEHAVIORS

1. Thinking about what you yourself have experienced among the different things we have been talking about, have you ever tried to seek help to stop (the/these) person(s) from doing this to you again?	☐ Yes ☐ No (if no, skip to #3)
2. From whom have you sought help? Anyone else? RECORD ALL MENTIONED	OWN FAMILY ☐ HUSBAND/PARTNER'S FAMILY ☐ CURRENT/LAST/LATE - HUSBAND/PARTNER ☐ CURRENT/FORMER BOYFRIEND ☐ FRIEND ☐ NEIGHBOR ☐ RELIGIOUS LEADER ☐ DOCTOR/MEDICAL PERSONNEL ☐ POLICE ☐ LAWYER ☐ SOCIAL SERVICE ORGANIZATION ☐ OTHER: _____
3. What is the main reason that you never sought help?	DID NOT KNOW WHERE TO GO/UNAWARE OF SERVICES ☐ NOT NECESSARY ☐ ASKING FOR HELP ISN'T BENEFICIAL ☐ IT IS PART OF LIFE ☐ AFRAID OF DIVORCE/SEPERATION ☐ AFRAID THAT SHE WOULD BE ABUSED OR OF CHILDREN ☐ BEING ABUSED ☐ AFRAID IT WILL CAUSE PROBLEMS FOR THE ABUSER ☐ EMBARRASSMENT ☐ IT WAS HER FAULT ☐ OTHER:_____

POST-TRAUMATIC STRESS

Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
2. Repeated, disturbing dreams of a stressful experience from the past?					
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?					
4. Feeling very upset when something reminded you of a stressful experience from the past?					
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?					
6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					
7. Avoid activities or situations because they remind you of a stressful experience from the past?					
8. Trouble remembering important parts of a stressful experience from the past?					
9. Loss of interest in things that you used to enjoy?					
10. Feeling distant or cut off from other people?					
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12. Feeling as if your future will somehow be cut short?					
13. Trouble falling or staying asleep?					
14. Feeling irritable or having angry outbursts?					
15. Having difficulty concentrating?					
16. Being “super alert” or watchful on guard?					

17. Feeling jumpy or easily startled?					

ENCUESTA DE SALUD DE LA MUJER (ESPANOL)

Date:	
Initials:	
Informed Consent?	☐ Yes ☐ No

DEMOGRAPHIC INFORMATION

Immigration Status: ☐ Documented, citizen ☐ Documented, resident or visa ☐ Undocumented	Spanish Fluency ☐ Yes ☐ No
Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	DOB: _____/_____/_____ (mo/day/yr)
Eligible?	☐ Yes ☐ No
Country of Origin: _____	Years residing in U.S.: _____
Years of education: _____(years)	Health Insurance Status: ☐ Yes, has insurance ☐ No insurance
Employed: ☐ Yes ☐ No	Occupation:
Ever intimate partner: ☐ Yes ☐ No (If no, skip ISA & Help-seeking sections)	Current intimate partner: ☐ Yes ☐ No
Marital Status:	Parity:
# of children: _____	# of children living in household: _____
Do you drink alcohol? ☐ Yes ☐ No	How often do you get drunk (circle): often, only sometimes, or never?
Does/Did your husband/partner drink alcohol? ☐ Yes ☐ No	How often does (did) he get drunk (circle one): often, only sometimes, or never?

INSTRUCCIONES: Las preguntas que siguen se refieren a lo que usted piensa sobre su salud. Sus respuestas permitirán saber cómo se encuentra usted y hasta qué punto es capaz de hacer sus actividades habituales.

Por favor, conteste cada pregunta marcando una casilla. Si no está seguro/a de cómo responder a una pregunta, por favor conteste lo que le parezca más cierto.

1. En general, usted diría que su salud es:

☐	☐	☐	☐	☐
Excelente	**Muy buena**	**Buena**	**Regular**	**Mala**

Las siguientes preguntas se refieren a actividades o cosas que usted podría hacer en un día normal. Su salud actual, ¿le limita para hacer esas actividades o cosas? Si es así, ¿cuánto?

	Sí, me limita mucho	**Sí, me limita un poco**	**No, no me limita mucho**
2. **Esfuerzos moderados**, como mover una mesa, pasar la aspiradora, jugar a los bolos o caminar más de 1 hora	☐	☐	☐
3. Subir **varios** pisos por la escalera	☐	☐	☐

Durante las 4 últimas semanas, ¿ha tenido alguno de los siguientes problemas en su trabajo o en sus actividades cotidianas, a causa de su salud física?

	Sí	**No**
4. ¿**Hizo menos** de lo que hubiera querido hacer?	☐	☐
5. ¿Tuvo que **dejar de hacer algunas tareas** en su trabajo o en sus actividades cotidianas?	☐	☐

Durante las 4 últimas semanas, ¿ha tenido alguno de los siguientes problemas en su trabajo o en sus actividades cotidianas, a causa de algún problema emocional (como estar triste, deprimido, o nervioso)?

	Sí	No
6. ¿**Hizo menos** de lo que hubiera querido hacer, por algún problema emocional?	☐	☐
7. ¿No hizo su trabajo o sus actividades cotidianas tan **cuidadosamente** como de costumbre**, por algún problema emocional**?	☐	☐

8. Durante las 4 últimas semanas, ¿hasta qué punto el dolor le ha dificultado su trabajo habitual (incluido el trabajo fuera de casa y las tareas domésticas)?

☐ **Nada** ☐ **Un poco** ☐ **Regular** ☐ **Bastante** ☐ **Mucho**

Las preguntas que siguen se refieren a cómo se ha sentido y cómo le han ido las cosas durante las 4 últimas semanas. En cada pregunta responda lo que se parezca más a cómo se ha sentido usted. Durante las últimas 4 semanas ¿cuánto tiempo…

	Siempre	Casi siempre	Muchas veces	Algunas veces	Sólo alguna vez	Nunca
9. se sintió calmado y tranquilo?	☐	☐	☐	☐	☐	☐
10. tuvo mucha energía?	☐	☐	☐	☐	☐	☐
11. se sintió desanimado y triste?	☐	☐	☐	☐	☐	☐

12. Durante las 4 últimas semanas, ¿con qué frecuencia la salud física o los problemas emocionales le han dificultado sus actividades sociales (como visitar a los amigos o familiares)?

☐ **Siempre** ☐ **Casi Siempre** ☐ **Algunas veces** ☐ **Sólo alguna vez** ☐ **Nunca**

DEPRESSION SCALE (CES-D)

Le voy a leer unas frases que describen como usted podría haber sentido. Por favor dígame con que frecuencia se ha sentido de esta manera durante la semana pasada: raramente o ninguna vez; alguna o poca vez; ocasionalmente o una cantidad de tiempo moderada; o la mayor parte o todo el tiempo.

Durante la semana pasada, eso es desde (fecha) hasta el presente:	Raremente o ninguna vez. (Menos de un día)	Alguna o poca vez (1-2 días)	Ocasionalmente o una cantidad moderado (3-4 días)	La mayor parte o todo le tiempo (5-7 días)
1. Me molestaron cosas que usualmente no me molestan.				
2. No me sentía con ganas de comer; tenía mal apetito.				
3. Me sentía que no podía quitarme de encima la tristeza aún con la ayuda de mí familia o amigos.				
4. Sentía que yo era tan bueno como cualquiera otra persona.				
5. Tenía dificultad en mantener mi mente en lo que estaba haciendo.				
6. Me sentía deprimido.				
7. Sentía que todo lo que hacía era un esfuerzo.				
8. Me sentía optimista sobre el futuro.				
9. Pensé que mi vida había sido un fracaso.				
10. Me sentía con miedo.				
11. Mi sueño era inquieto.				
12. Estaba contento.				
13. Hablé menos de lo usual.				
14. Me sentí solo.				
15. La gente no era amistosa.				
16. Disfruté de la vida.				
17. Pasé ratos llorando.				
18. Me sentí triste.				
19. Sentía que no le caía bien a				

la gente.				
20. No tenía ganas de hacer nada.				

SOCIAL SUPPORT SCALE

Tabla 1. Cuestionario de apoyo social MOS
Las siguientes preguntas se refieren al apoyo o ayuda de que Ud. dispone

1. Aproximadamente , ¿cuántos amigos íntimos o familiares cercanos tiene Ud? (personas con las que se encuentra a gusto y puede hablar acerca de todo lo que se le ocurre)

   Escriba el n.º de amigos íntimos y familiares cercanos | | |

La gente busca a otras personas para encontrar compañía, asistencia, u otros tipos de ayuda. ¿ Con qué frecuencia dispone Ud. de cada uno de los siguientes tipos de apoyo cuando lo necesita?)

Marque con un círculo uno de los números de cada fila

	Nunca	Pocas veces	Algunas veces	La mayoría de veces	Siempre
2. Alguien que le ayude cuando tenga que estar en la cama	1	2	3	4	5
3. Alguien con quien pueda contar cuando necesita hablar	1	2	3	4	5
4. Alguien que le aconseje cuando tenga problemas	1	2	3	4	5
5. Alguien que le lleve al médico cuando lo necesita	1	2	3	4	5
6. Alguien que le muestre amor y afecto	1	2	3	4	5
7. Alguien con quién pasar un buen rato	1	2	3	4	5
8. Alguien que le informe y le ayude a entender una situación	1	2	3	4	5
9. Alguien en quien confiar o con quien hablar de sí mismo y sus preocupaciones	1	2	3	4	5
10. Alguien que le abrace	1	2	3	4	5
11. Alguien con quien pueda relajarse	1	2	3	4	5
12. Alguien que le prepare la comida si no puede hacerlo	1	2	3	4	5
13. Alguien cuyo consejo realmente desee	1	2	3	4	5
14. Alguien con quien hacer cosas que le sirvan para olvidar sus problemas	1	2	3	4	5
15. Alguien que le ayude en sus tareas domésticas si está enfermo	1	2	3	4	5
16. Alguien con quien compartir sus temores y problemas más íntimos	1	2	3	4	5
17. Alguien que le aconseje cómo resolver sus problemas personales	1	2	3	4	5
18. Alguien con quién divertirse	1	2	3	4	5
19. Alguien que comprenda sus problemas	1	2	3	4	5
20. Alguien a quién amar y hacerle sentirse querido	1	2	3	4	5

IPV SCREENING

Mi pareja:		Nunca	Raras Veces	De vez en cuando	Frecuentemente	Muy Frecuentemente
1.	Me menosprecia					
2.	Exige obediencia a sus caprichos					
3.	Se pone de mal humor y se enfada si le digo que ha bebido demasiado					
4.	Me obliga a tener relaciones sexuales que me desagradan					
5.	Se enfada mucho si no tiene la comida, las tareas domésticas o la ropa lista cuando él quiere					
6.	Es celoso y desconfía de mis amigo					
7.	Me da puñetazos					
8.	Me dice que soy fea y					

Este cuestionario ha sido diseñado para valorar aspectos negativos en el trato que usted, recibe en su relación de pareja. No se trata de un examen, no hay respuestas verdaderas o falsas.

	poco atractiva					
9.	Me dice que no puedo apañarme o arreglarme sin él					
10.	Se comporta como si yo fuera su sirvienta					
11.	Me insulta y me avergüenza delante de los demás					
12.	Se enfada mucho si no le doy la razón					
13.	Me amenaza con un arma					
14.	Es tacaño en darme dinero para la casa					
15.	Me subestima intelectualmente					
16.	Quiere que me quede en casa para cuidar a los hijos					
17.	Me pega tan fuerte que tengo que ir a Urgencias					
18.	Piensa que no debo trabajar o estudiar					
19.	Es una persona poco amable					
20.	Pone pegas a que me relacione con mis amigas					
21.	Exige sexo sin importarle mi consentimiento					
22.	Me grita y me insulta					
23.	Me golpea en la cara y en la cabeza					
24.	Se vuelve agresivo					

	cuando bebe					
25.	Siempre está mandándome					
26.	Desprecia mis sentimientos					
27.	Se comporta conmigo como un matón					
28.	Me amenaza					
29.	Me trata como si fuese una burra o imbécil					
30.	Se comporta como si quisiera matarme					

HELP-SEEKING BEHAVIOR

Cuando la han maltratado ¿usted le ha pedido ayuda a personas cercanas a usted?	SI ..... 1 NO ..... 2 —
¿A quién le ha pedido ayuda? ¿Alguien más? ANOTE TODAS LAS PERSONAS QUE MENCIONE	MADRE ..... A PADRE ..... B HERMANA ..... C HERMANO ..... D ACTUAL (ÚLTIMO) ESPOSO (COMPAÑERO) ..... E SUEGRA ..... F SUEGRO ..... G OTRO FAMILIAR FEMENINO DEL ESPOSO ..... H OTRO FAMILIAR MASCULINO DEL ESPOSO ..... I OTRO PARIENTE FEMENINO ..... J OTRO PARIENTE MASCULINO ..... K AMIGO(A) ..... L VECINO(A) ..... M OTRA _____ X (ESPECIFIQUE)
Cuando fue maltratada, ¿Ud. ha acudido a alguna institución para buscar ayuda? SI HA ASISTIDO ¿a cuál institución ha acudido? ¿Alguna otra institución?	COMISARÍA ..... A JUZGADO ..... B FISCALIA ..... C DEFENSORIA MUNICIPAL (DEMUNA) ..... D MINISTERIO DE LA MUJER (MIMDES) ..... E DEFENSORIA DEL PUEBLO ..... F ESTABLECIMIENTO DE SALUD ..... G ORGANIZACIÓN PRIVADA ..... H OTRA: _____ X (ESPECIFIQUE) NO / NUNCA HA BUSCADO AYUDA ..... Z
¿Cuál es la principal razón por la cual usted nunca buscó ayuda?	NO SABIA DONDE IR / NO CONOCE SERVICIOS ..... 01 NO ERA NECESARIO ..... 02 DE NADA SIRVE ..... 03 COSAS DE LA VIDA ..... 04 MIEDO AL DIVORCIO/SEPARACIÓN ..... 05 MIEDO A QUE LE PEGARA DE NUEVO A ELLA O A SUS HIJOS ..... 06 MIEDO DE CAUSARLE UN PROBLEMA A LA PERSONA QUE LE PEGO ..... 07 VERGUENZA ..... 08 ELLA TENÍA LA CULPA ..... 09 OTRA _____ 96 (ESPECIFIQUE)

POST-TRAUMATIC STRESS SCALE

Ahora voy a leer una lista de problemas y síntomas que a veces tiene la gente después de una lesión (herida). Dígame cuánto le ha molestado cada una de estas cosas desde que ocurrió la lesión (herida).

Desde la lesión (herida), ¿cuánto le ha molestado _____?

	Para nada	**Un poco**	**Más o menos**	**Bastante**	**Extremadamente**
1. tener recuerdos, pensamientos perturbadores o imágenes que se repiten de la lesión?	1	2	3	4	5
2. tener sueños perturbadores y que se repiten de la lesión?	1	2	3	4	5
3. Actuar o sentir de repente como si la lesión ocurriera otra vez (como si lo a vivir)?	1	2	3	4	5
4. sentirse muy disgustado (preocupado o afligido) cuando algo le recuerda la lesión (herida)?	1	2	3	4	5
5. tener reacciones físicas (como latidos fuertes del corazón, le cuesta respirar, suda mucho) cuando algo le recuerda la lesión (herida)?	1	2	3	4	5
6. evitar pensar o hablar sobre la lesión (herida) o evitar sentir algo que ver con eso?	1	2	3	4	5
7. evitar actividades o situaciones porque le recuerdan cuando estaba siendo (herido)?	1	2	3	4	5
8. tener dificultad para recordar lo que pasó durante el accidente (sin contar lo que no podría recordar por estar inconsciente)?	1	2	3	4	5
9. perder interés en las actividades que antes disfrutaba?	1	2	3	4	5
10. sentirse distante o aislado (alejado) de otras personas?	1	2	3	4	5
11. sentir insensibilidad emocional o incapacidad de sentir amor por sus seres queridos?	1	2	3	4	5
12. sentir como si su futuro será más corto [o interrumpido] de alguna manera?	1	2	3	4	5
13. tener dificultad para quedarse dormido o seguir durmiendo?	1	2	3	4	5
14. sentirse irritado o tener arrebatos de coraje?	1	2	3	4	5
15. tener mucha dificultad para concentrarse?	1	2	3	4	5
16. estar siempre muy “alerta”, vigilante o en guardia?	1	2	3	4	5
17. sentirse sobresaltado o asustado por	1	2	3	4	5

	Para nada	**Un poco**	**Más o menos**	**Bastante**	**Extremadamente**
cualquier cosa?					

APPENDIX B: QUALITIATIVE INTERVIEW GUIDES

FOCUS GROUP GUIDE

Thank you for being here today and agreeing to participate in a focus group about domestic violence experienced by Spanish-speaking immigrants in Philadelphia.
You each were asked to participate in this group because you provide services to or work with immigrant women in Philadelphia.

I am going to start with a few general questions about domestic violence and screening for intimate partner violence. After talking about domestic violence more broadly, I will ask you to tell me more about how you interact with immigrant women and the services available to immigrant women who have experienced domestic violence.

This focus group will last between 60 and 90 minutes.
Thank you again for your participation.

IPV Knowledge:

How common do you think domestic violence is in the United States? Do you think it is more or less common in immigrant populations than the general non-immigrant population?

What do you think are risk factors for violence? In other words, do you think there are certain characteristics that make women more likely to experience domestic violence in their relationships? What might be additional risk factors for undocumented and immigrant women?

How do you think intimate partner violence impacts the health of women? How might past partner violence experiences continue to contribute to poor health?

Do you think that most women who have experienced IPV seek help? Where/with whom do you think they are most likely to ask for help? What might be barriers to seeking help? Specifically for undocumented immigrant women?

Screening Practices:

Do you think it is the role of health care providers to screen women for domestic violence? Why or why not? If not, whose responsibility is it? What are some of the barriers to asking women about violence in their intimate relationships?

Do you think universal screening would be beneficial for Spanish-speaking immigrant women in Philadelphia in particular? Why or why not? If not, what is an effective way to screen women?

Who/Where do you think undocumented Spanish-speaking immigrants most commonly turn to for help? (Probe: formal versus informal help-seeking behaviors)

Referral Practices:

If a women reports currently experiencing domestic violence in her relationship, what do/would you do? (Probe for how referral services are presented to women.

Do you think this action(s) (insert answer from above) is helpful to women?

What programs are available in Philadelphia to undocumented immigrant women experiencing partner violence? Would you feel comfortable referring an undocumented Spanish-speaking immigrant to these agencies? Why or why not?

INDIVIDUAL INTERVIEW GUIDE

Target population: Spanish-speaking undocumented immigrant women who currently experience or have experienced IPV while living in Philadelphia. All participants will be between the ages of 18-64 years old and individual interviews will be conducted in Spanish.

Thank you so much for agreeing to speak with me today. I am going to ask you questions about your experience with domestic violence and what kinds of services are available to help women like you who are Spanish-speaking immigrants living in Philadelphia. I am asking these questions because I am working on a project to better understand partner violence in Philadelphia. Your answers are confidential and I won't share your name or personal experiences. I want to remind you that you can stop this interview at any time. If there are any questions you don't want to answer, let me know and we can skip them.

IPV Knowledge:

Do you think intimate partner violence is common in your community? Why?

Screening Acceptability:

Do you think that doctors/nurses should ask women about domestic violence? Why or why not?

Has your doctor/nurse ever asked you if you experience/ have experienced domestic violence? If yes, how did they ask?

Have you ever told your doctor about your experience with violence? What prompted you to disclose/not disclose your experience? Why? (Probe: Would you have told your doctor if they asked you about it? Why or why not? Does it matter if your doctor is a male or female?)

How do you think doctors/nurses can best ask immigrant women about violence?

Help-Seeking & IPV Policy:

Do you know of any people or organizations that are available to help you or other women who have experienced domestic violence in Philadelphia?

What are some of the barriers to accessing these sources of help?

Have you ever asked anyone for help?

If yes, tell me about your experience. (Probe: Who? How did you select this person/agency? What did this person say? What happened next? Did it help? How?)

If no, why have you never asked for help?

Do you want help? Why or why not?

Thinking about yourself or other women you know, what are some of the things you have to consider before asking for help from an institution or agency (clarify if necessary: institutions include the police, doctor/nurse, social service/non-profit?

Did/Would your documentation status influence your decision? Do you think you can you be deported for reporting violence to the police?

What do you think would happen to your partner if you reported the violence? How do you feel about this?

What kind of help would be most useful to you?

End of interview: Inform all women about their formal help-seeking options and encourage them to seek assistance if they are currently experiencing domestic violence or are suffering as a result of past IPV exposure. Offer to assist in setting up an appointment/referral if they want (contacting the police, a social service organization, a doctor/nurse, a psychologist). Provide Spanish language domestic violence hotline card to all women regardless of IPV experiences.