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Intimate Partner Violence in Mexican-American Women with Disabilities: A Secondary Data Analysis of Cross-Language Research

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Abstract

The aim of this qualitative descriptive study, guided by Antonovosky's Salutogenic model, was to explore the manifestations of strength within the interviews of Spanish-speaking Mexican-American women aging with mobility impairments who also experienced intimate partner violence (IPV). IPV events gleaned from 26 audiotaped interviews from 7 Spanish-speaking Mexican-American women, who ranged in age from 55–75, constituted the sample for this secondary analysis. Five categories were identified: Abuse from early on that shaped sense of coherence; "Violencia tan cruel": Threatened sense of coherence; "Salutogenic" choices within the context of IPV; A quest for peace; and Strength amidst struggle.

Keywords

Intimate partner violence; women with disabilities; abuse; Spanish-speaking; Mexican-American; qualitative; mobility impairment

While the actual violence associated with intimate partner violence (IPV) may last only a brief moment, memories of it are often long-standing and inescapable. The remnants of its effects are seen in high rates of mental and physical health problems as well as permanent functional limitation in women who are its survivors. The remnants of its effects are also felt within the stories shared by individuals, families, and society. Although there is an increased awareness of IPV and its impact on health and well-being in society, only a handful of studies have focused on the experience of IPV in aging women, and fewer still have addressed this reality in aging ethnic minorities. [1,2] More specifically, how aging women construct health after the experience of IPV in the midst of multiple adversities has not been explored. Researchers need to understand and share adaptive strategies developed by women in response to severe adversity; feminist, multicultural perspectives may help foster such diverse pathways to health.

Hence, the purpose of this study is to explore ways in which aging Spanish-speaking women faced with multiple adversities including a history of IPV demonstrated their strength in overcoming adversity, using a feminist adaptation of Antonovsky's salutogenic theory. [3,4] First, we review how multiple adversities may affect health, with a focus on ethnicity, aging, functional limitation, and IPV. Next, we present findings from our secondary analysis, guided by feminist theory and Antonovsky's salutogenic theory. [3,4] Last, we discuss the

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implications of our findings and present theoretical recommendations for *salutogenesis* that may be useful to health care researchers and interdisciplinary professionals working with women aging with multiple adversities including IPV.

Theoretical Framework

This qualitative secondary analysis of strength in the midst of multiple adversities is based in a feminist interpretation of Antonovsky's salutogenic theory, which posits that some people remain healthy in the midst of adversity. [3,4] Antonovsky situates *sense of coherence (SOC)*, the central and core concept of his salutogenic theory, as the primary motivator for health in the context of adversity. Sense of coherence involves three concepts: comprehensibility, manageability, and meaningfulness. It is shaped by one's interpretation of one's life story, and it enables a person to cope and adapt, thus promoting his or her own health. Antonovsky, recognizing stressors as ubiquitous to life, explained that a person's response to stressors separates those who are healthy from those who are not. He represents health as fluctuating along a continuum of *ease* to *dis-ease*, dependent on the *resistance resources* or *deficits* shaping the individual's life experiences. Antonovsky's theory has been used extensively in studies throughout the world, with both young and old and in varying states of health, acute and chronic.[5] Although Antonovsky developed a tool to measure one's SOC, he acknowledged that there are many, potentially creative ways in which to explore the relationship between SOC and health. In particular, researchers have begun to explore aging with adversity in a "salutogenic" process, as exemplified in two recent qualitative studies: one with patients with end stage renal disease and a second with family caregivers of hospice patients. [6,7] The theory provides a unique lens to identify strength in the midst of adversity.

Background

IPV is a global crisis that affects a billion women worldwide. [8] It is a major human rights violation. [9] Over 30% of women in the US have experienced rape, physical violence, and/or stalking by an intimate partner, and IPV's estimated costs exceed $8.3 billion each year. [10] Many studies have highlighted the numerous health effects of IPV alone, including short- and long-term physical and mental health problems such as posttraumatic stress disorder, depression, chronic pain, somatization, physical disability, and chemical abuse and dependency. [1,11] Nevertheless, IPV is a preventable public health problem.

As women age, we cannot begin to understand their IPV experience without an understanding of the complexity of their world and the intersectionality of the multiple adversities they face. Not only are aging women at risk for IPV and its aftermath, they can also be vulnerable to the effects of poverty, limited access to care, language barriers, functional limitations, age discrimination, and a multitude of other adversities that can jeopardize their mental and physical health over the life course.[12] In fact, over 70% of American older adults report multiple morbidities [13, 14] with women making up the bulk of that number. The burden of impairment coupled with social disadvantage is nearing epidemic proportions for older women, and it is not surprising that "various adversities, unevenly distributed throughout society, can have an impact on an individual's health and well-being." [14](p3) It is not the purpose of this article to theorize which adversity is most significant or which adversity has preceded others. It is, however, our focus to understand how Mexican-American women manage IPV in a context of multiple adversities over time, including the experience of IPV woven within their experiences of ethnicity, functional limitation, and age. Each of these will be discussed below in relation to IPV.

Ethnicity

When ethnic minorities, such as first-generation Mexican-Americans, experience abuse this abuse can occur within a context of poverty, cultural isolation, and language barriers. [15] Over 27% of the Hispanic population in the U.S. lives in poverty, with 34% lacking health care coverage. [16] Addressing the complex health care needs of aging Hispanic women is challenging given the present disparities in our health care system, which include underrepresentation of Spanish-speaking health care providers. [17,18] Language barriers can often hinder disclosure of IPV, and providers who do speak Spanish have a significant advantage in performing IPV assessment.[18] The disclosure of sensitive issues such as IPV is facilitated when there is no language barrier and a relationship of trust can be more easily established.

Functional Limitations

Functional limitations may be experienced as disabling in that women may be unable to perform desired social activities, and this can add to the level of isolation and heightened risk experienced by women of Mexican-American heritage in the U.S. “Disability is an experience of the impaired body within society” [19](p86) threatening not only the health of aging women but their ability to integrate socially through health care and participation in other activities that can promote health and well-being. [20] Mexican-Americans living in the U.S. report increased numbers of functional limitations and more challenges in the activities of daily living as a result of disability than do non-Hispanic White women. [21]

Numerous studies have reported that women with functional limitations are at risk for high levels of IPV, [22,23] while others have indicated that IPV is a leading cause of functional limitations. [24] Some studies indicate that women with disabling conditions experience IPV almost twice as often as do those without a disabling condition. Lack of mobility, social isolation, and depression have been associated as risk factors for abuse in women, yet the reasons why IPV rates are higher in women with disabling conditions are often complex and not clearly understood. [23]

There is no doubt that functional limitations increase the complexity of the IPV experience, and it is often difficult to discern which adversity has appeared first, the disabling experience or the abuse, because both exist all too often side by side. The disabling effects of depression, also the leading cause of disability worldwide, [25] is one of the most prevalent consequences of IPV, [26] with some studies indicating a fourfold increase in depressive symptoms among those who report abuse. [27] Disability related to chronic pain is also more likely in women who have experienced IPV. [28] Even after the abuse has ended, long-term effects remain [26] and may be re-experienced over the life course. [29] While having a functional limitation and/or disabling condition may be a risk factor for abuse, the prolonged stress of abuse may contribute to an experience of progressive disablement, predisposing women to chronic health problems such as pelvic pain, arthritis, cardiovascular disease, and autoimmune disorders, [30] all of which are often prevalent in an aging population.

Age

Older ages are theorized to also have a heightened risk for the negative effects of IPV. The effects of adversities accumulate over the life course, and as women age with functional limitations they may be at risk for social isolation and loneliness, which increases their vulnerability to accepting negative types of interactions. The myriad problems with which an aging population is confronted are enormous, not only contributing to gradual physical decline, but often affecting overall emotional and spiritual well-being. Some women may integrate their experience of IPV and find peace, but others may remain haunted by its memories.

Two recent systematized reviews of the literature addressing IPV and older women validate IPV as a significant public health problem affecting older women. [1,31] For instance, Weeks and Leblanc [31] recognize that although physical abuse declines with aging, psychological abuse may continue; and for older women, psychological abuse is often more difficult to manage than it is for younger women. According to Weeks and Leblanc's findings, some older women expressed that the impact of nonphysical abuse was more painful than that of physical abuse.

In summary, our knowledge base surrounding IPV, including its many short- and long-term effects on health, continues to broaden. However, research is needed to highlight how older women adapt to multiple adversities including IPV; hence this study. Understanding women's multifaceted and complex lives through a feminist lens provides a novel approach to *salutogenesis*, because it provides a framework that does not lose site of the strengths that women weave throughout their life course in order to sustain their health in the midst of multiple adversities including IPV.

Methodology

From a feminist perspective, Antonovsky's views are advanced here through the writing of Monique Wittig, [32] who deconstructed the category of woman as a social construct created through oppressive categorization. As women become knowledgeable about their oppressed status, Wittig argues, they begin to oppose it. They realize that their struggles are not personal, but rather a public opposition to a sex category that situates their bodies within a society that tolerates abuse and physical destruction. She states, "Our survival demands that we contribute all our strength to the destruction of the class of women within which men appropriate women." [32(p 271)] With this combined feminist-salutogenic perspective, we began our investigation of how older women adapt to multiple adversities that include IPV. Specifically, we sought to understand both SOC and the resources that promote the ability to cope and adapt to life experiences; hence, we asked the following two research questions:

1. How do women aging with mobility impairments and a history of IPV comprehend, manage, and find meaningfulness in their life experiences?
2. What generalized resistance resources provide sources of strength, thus facilitating health for women aging with multiple adversities including IPV?

Method and Design Overview

This qualitative descriptive study was a secondary analysis of data collected from an ongoing ethnographic investigation of health disparities and disablement among Mexican-American and non-Hispanic white women ages 55 to 75. [14,21] According to Sandelowski, [33] qualitative descriptive research is "a vehicle for presenting and treating research methods as living entities that resist simple classification." [33(p77)] She explains that although descriptive data are closer to the original data and much less transformed than grounded theories or phenomenology, they are "unavoidably interpretive." [33(p77)] This secondary data analysis focused on Mexican-American women who participated in the larger study and were interviewed in Spanish. Their interviews were reviewed for the presence of IPV history.

Sample and Recruitment

The sample and recruitment are described in detail elsewhere for the larger study from which this secondary analysis was generated. [14,21] The study received approval from the local institutional review board; all participants gave written informed consent before the interviews were conducted, including consent for further exploration of the data in

subsequent studies or analyses such as the present one. The entire sample for the larger study consisted of 122 women aging with mobility impairments. The women were given the option of completing the study in English or Spanish; a total of 13 elected to complete their interviews in Spanish. Data from these women were reviewed for the presence of IPV at any time during the life course. Seven of the 13 women's narratives included a discussion of the impact of IPV on the disablement experience, and their descriptions were in alignment with the CDC definitions for physical or sexual violence and for psychological or verbal abuse. [10] The 26 audiotaped interviews from these 7 Spanish-speaking women who reported IPV during their disablement interviews constituted the final sample for this secondary analysis. The sample was a piece of a much larger study that went on for over four years; therefore, the data from the 7 women are understood within a larger context. Further, as Polkinghorne explains, the number of sources is not as much of a concern as the richness of the data collected and reviewed for its ability to provide sufficient clarity to understand an experience. [34] While there were only seven women in this study sample, they had each been interviewed three to four times using a life course approach. (see Table 1 for demographic characteristics).

The 122 women aging with mobility impairments who constituted the sample for the larger study were recruited throughout the state of Texas, [14,21] where there are approximately two and a half million people over age 65 living with disabilities [35] and 38% of the population is Hispanic with heavy concentrations of Mexican-Americans along the U.S.–Mexico border. [16] The recruitment process was facilitated by community liaison s and support groups, with flyers distributed in the community. [14,21,36] The Spanish-speaking women were recruited in various regions of the state, including the Rio Grande Valley, Central Texas, and the Texas Panhandle.

Setting and Data Collection

A life course perspective captured life trajectories and transitions experienced throughout the participants' lives, and each participant was met on four different occasions with the majority of meetings being audiotaped. The data collection is described in detail elsewhere. [14,21,36] Meetings were not audio-taped if the participants asked for assistance with demographic and survey questionnaires without completing interviews ($n = 2$ meetings). In those instances, field notes were written after the questionnaires were completed. Data collection included the use of demographic sheets, questionnaires, life history calendars, and topical biographical interviews. All interviews took place in the participants' homes, with the exception of one interview that took place in a long-term care facility and were conducted in Spanish by a Spanish speaking researcher. The topical biographical interview questions focused on the participants' experiences of disablement and its effect on their lives. Participants were informed that if any abuse was ongoing and spoken of during the interviews, it would be reported to Adult Protective Services. Each participant received $50.00 per meeting. This analysis is pulled from the topical biographical interviews, field notes, and demographic profiles.

Data Management and Analysis

Translation becomes an issue of methodological significance when data has been collected in the source language and translated and published in another and translation decisions made throughout the research process can have a major impact on the quality of the research; [37] therefore, several steps were taken to foster trustworthiness. Data collection and analysis was conducted in the language of the participants and the 26 interviews used for this analysis were transcribed verbatim in Spanish. Translations were completed by professional, certified translators and checked for accuracy. The data were available in both Spanish and English; the secondary analysis began with the Spanish data. The step-by-step

process created for assuring trustworthy translations for this qualitative research was published elsewhere. [38]

The first author, fluent in Spanish, was responsible for the primary level coding of the Spanish data. Line-by-line coding was conducted by reading and re-reading the Spanish texts following a process outlined by Saldana. [39] Each interview was analyzed to identify significant statements, thoughts, descriptions, and reflections pertinent to the study. Codes were further analyzed both within and across interviews and grouped together to form categories. To increase dependability, the first and second authors met frequently to compare findings from the Spanish data with the transcribed data and the original field notes during the categorization process. During data reduction, within the context of the theoretical perspective, the data were analyzed through a hermeneutic process involving the first and third author. Insights from collecting, analyzing, and interpreting the data were pulled together to create the final draft and further increase credibility. Deep respect for the participants and their life stories and a sincere attempt to relay the meanings of their experiences was paramount throughout the process.

Results

The 7 women in this study, while similar in many ways, provided unique details about their lives. Two reportedly came from loving, nourishing childhood homes, but the majority experienced childhood abuse, extreme poverty and hard work. The one commonality in all of their stories was that they were abused by an intimate partner who vowed to "love them," some by more than one, and this reality left an indelible watermark on the pages of their lives. Woven within the stories of these 7 women were tremendous strength and creativity; this was illustrated by the many ways in which they managed the complexity of their lives, assuming multiple responsibilities including those of primary breadwinner and life-long caregiver. The women were not only the sole provider when their children were young, but later cared for their frail husbands as well as their grandchildren in spite of their own functional limitations. Five analytic categories were gleaned from the interviews: Abuse from early on that shaped SOC; *Violencia tan cruel*, IPV that threatened SOC; Personal choices for *salutogenesis* within the context of IPV; A quest for peace; and Strength amidst struggle. The first two categories describe life experiences that shaped SOC, including participants' comprehension of their experience. The third category, choices made within the context of IPV, describes some of the ways in which the participants managed their IPV experience. In the fourth category, participants described their lifelong quest for peace and how they sought to find meaningfulness in their lives in spite of multiple adversities. The first four categories answered our first research question. The fifth category describes the resources that fostered health; thus, it answered our second research question.

Life experiences that shaped SOC

Antonovsky [3,4] posited that life experiences were crucial in shaping one's SOC, and that inconsistent and unbalanced experiences in which one was not an active participant in the outcome could weaken one's SOC. The following two categories depict experiences that shaped and potentially weakened these women's SOC. These experiences affected not only the meaning that the women gave to themselves but also their life trajectories.

Abuse from early on that shaped sense of coherence—Five of the 7 women reported childhood physical, verbal, sexual, and/or psychological abuse. Participants recounted childhood abuse by parents, extended family members and, in one case, a teacher. Two participants described the abuse as incomprehensible. One specifically explained, "*no sé por qué me golpeaba mi mama, yo no le hacía nada…por cualquier cosita me golpeaba, y*

yo tenía miedo desde entonces es que estoy enferma de los nervios." ("I don't know why my mother would hit me, I was not doing anything to her…she would hit me for any little thing, and I was afraid, since then I have been sick with my nerves.") Her only sister "*ella no quiso aguantar ya, y ella mejor se fue*" ("didn't want to put up with it anymore and she left") at age 14 and wanted the participant to go with her, but she stayed because she was "afraid." She remained in this abusive environment for 12 more years. When she left, at age 26, her mother kept her 2-year-old child, although the reasons for this were not clear.

Another participant cried as she remembered the childhood abuse; she described the physical abuse from her father in the following way: "*Todo lo quería arreglar con golpes. Golpearnos como si fuéramos animales…Una vida muy desastrosa, muy fea.*" ("He wanted to fix everything by hitting. Hitting us as if we were animals…a very disastrous life, very ugly.") This woman reflected on how she made a conscious choice not to abuse her own children.

More than once in her interviews, another participant told of how her mother left her father early on when he attempted to hit the participant for crying when she was a 3-month-old infant. Four of the 5 participants described abuse by parents.

One participant, who lost her mother at age 5, recounted physical abuse by her teacher and uncle for not doing well in school: "*le doy gracias a Dios que cuanto menos se poner mi nombre… me pegaban mucho por las benditas letras… es que no me penetraban las letras… me dolía mucho mi vista…*" ("I give thanks to God that at least I can write my name…they (the letters) were beaten into me…I just could not retain the letters… my eyesight hurt.") Another participant recounted,

> porque me golpearon mucho, mucho que me golpearon de niña mi papa, fui mucho muy golpeada, pero el dolor de los huesos se quita, pero cuando oye uno que la humillan con palabras feas, todo eso no se olvida aunque quiera uno…que después cuando ya crecí que fui entendiendo todas esas palabras que me decían de niña.
>
> I was beaten a lot as a child…but the pain in the bones goes away, but when one hears ugly words that humiliate one, all of that can't be forgotten even if you want to, it can't be forgotten, it stays there, it stays there, it stays there, all that humiliation…when I grew up, that's when I began to understand all those words they told me when I was a little girl.

For these participants, a SOC was not established in childhood because of their perceptions of abuse. This is exemplified in their emotional reactions, their inability to "understand" the abuse, and the loss of childhood. In fact, some left their homes early to escape the childhood abuse, only to find a continuation of the abuse in an intimate partner. Three women who suffered childhood abuse spoke of marrying in their early teens; one explicitly stated that she married young to escape the abuse: "*yo me salí de la casa, me case muy chica, yo ya no aguantaba vivir asi.*" ("That's why I left the house, I married very young, but I couldn't stand living like that anymore.") Early abuse threatened the women's SOC.

"Violencia tan cruel": IPV that threatened sense of coherence—

Anotonovsky [3](p125) explained that one's SOC is "shaped and tested, reinforced and modified not only in childhood but throughout one's life". Whereas the previous category focused on abuse experienced during childhood, this category refers to the many forms of IPV manifested in the participants' lives, including physical, verbal, and psychological abuse by intimate partners. In some cases, the abuse was repeated by multiple partners throughout the life course. Participants described their IPV experience in various ways from story to story, but most of the accounts spoke of *sufrimiento*; others used terms such as *violencia tan cruel*, *un infierno*, *destrastoso*, *mortificación*, or *mi calvario* ("suffering," "such

cruel violence," "a living hell," "destructive," "mortifying," and "my calvary"). While their dignity was continually being stripped away by IPV, the women worked tirelessly to manage the stressors in their lives, engaging in an active process to find a way out of the violence and to nurture their health.

There were those who continued to be reminded of their past abuse, indicating that their SOC was affected well into adulthood in a way that was not easily repaired. For instance, the participant whose mother isolated her as a child experienced a continuation of controlling behavior from her alcoholic husband. She remembered no celebrations of special occasions: "*yo tenía mi esposo pero como si no lo tuviera*" ("I had a husband but it was as if I didn't have one.") She fled to another state to escape the abuse, yet her husband followed her. When her plans did not materialize as she had hoped, she reached the point of ultimate desperation. She explained, "*trate dos veces de matarme*" ("I tried about twice to take my life"), and as for her own children, "*ellos trataron de tambien, de hacer lo mismo que yo, de..se toman pastillas porque ya no querían vivir porque no querían ver la…por lo que estaba yo pasando, la violencia tan cruel*." ("They tried to do the same thing that I did they would take pills because they didn't want to live because they didn't want to see the, what I was going through, such a cruel violence.")

IPV affected the women's SOC. This was evident in the inability to garner social capital and economic resources, which are provided to give tangible assistance, as well as to socially confirm and authenticate our work and community service performed in earlier years. One participant described her third husband's behavior in this way:

> Dijo que él se había buscado una mujer para que lo atendiera a él, no para que uno fuera a servirle a otro. Nunca me dejo trabajar aquí en los Estados Unidos, yo por eso no tengo ninguna ayuda tampoco, porque yo no he trabajado aquí.
>
> He said he had looked for a woman to take care of him, not for her to serve someone else. He never let me work here in the United States, that's why I don't have any assistance, SS (Social Security) either, because I have not worked here.

This lack of work affected her ability to qualify for needed assistance in her later years when functional limitation and poverty left her alone and in need. Even though IPV repeatedly threatened their SOC, their strength manifested itself in their ability to find meaning in roles such as motherhood and in their desire to survive. This was evident in their attempts to leave the abuse and in the ways they struggled to provide for and protect their children, often as sole providers.

Salutogenic choices within the context of IPV—Antonovsky stressed that a person's SOC plays a significant role in choices to either remain in or change one's situation.[3,4] This category outlines the complexity of choices and arduous decisions made regarding staying in or leaving abusive relationships, sometimes decisions made over and over again. The women grappled continuously to find their way in the midst of violence. They creatively searched for ways to foster health. Through a realization of their oppression, they were able to strategize in their reactions, regardless of the outcome.

The decision to stay or leave within a relationship that included IPV was not easy. Women left abusive relationships only to find themselves in another or return to the same situation. During the course of the interviews, one woman was in the process of separating for the second time after 45 years of marriage and lifelong infidelity.

The decision to leave, however, was described as occurring in the context of a new awareness regarding their oppression. For instance, a woman described how a friend appeared in her life to validate her reality, which strengthened her SOC. She left at age 28,

after 14 years of violence. She later found out that her friend had mental health training and was someone with whom she could *desahogar* ("unleash" or "unburden"). The Spanish word *ahogar* ("drown") evokes the powerful image of a woman feeling as though she is drowning in a relationship of violence. This woman arrived at her decision to leave after reflecting on what would be best for her own children, in spite of conflicted feelings:

> me hacía mucho daño hasta que por fin decidí dejarlo…sacar a mis hijos adelante…yo quería que mis hijos tuvieran su papa, pero al mismo tiempo me puse yo a pensar ellos no tenían por que estar viendo que su papa me golpeaba…Dije yo: Estoy esclavizada y yo tengo esclavizados a mis hijos, y yo no tengo ningún respeto para mis hijos en esta forma de que ellos vieran que me golpean y yo no hago nada…
>
> he hurt me very much until I finally decided to leave him…to pull my children through… I wanted my children to have their father, but at the same time I started thinking that they didn't have to be watching as their father would beat me up…I told myself, I am enslaved and I have my children enslaved, and I am not showing any respect toward my children through this manner where they see me being beaten and I'm not doing anything…

Other decisions were contemplated in the context of faith and beliefs surrounding marriage, which resulted in a new individual interpretation of the meaning of woman. [33] One woman married in the Catholic Church at age 29, left after 10 years of physical abuse and petitioned for an annulment. Her priest reminded her that marriage was until "death do you part." She reminded the priest that her husband had hit her repeatedly for no reason even though she felt she had been a good wife. Her courage and honesty were powerful manifestations of strength and perseverance as she questioned social norms and authority and rose above societal expectations in her search for health.

Participants also described making choices to care for their families despite IPV. They cared for their partners until their death, with one woman explaining that she never wanted to say anything bad about her husband in front of her children. Another woman described tolerating long-term abuse for her children, and explained that her husband was "a lost cause" and a "shameless scoundrel."

Salutogenic choices were shaped by the sociocultural realities in which the women lived, as well as by their roles and perceptions of IPV. Of importance was their recognition of oppression, and their search for ways to manage their health in the midst of these multiple adversities, striving for *ease* in place of the *dis-ease* created by their past IPV.

A quest for peace—Salutogenesis compels women to search for factors that promote health *ease* instead of *dis-ease* in spite of life's stressors, which Antonovsky [3] described as omnipresent. As participants reflected on their life trajectories, they all alluded to a desire for peace. This category encompasses the participants' quest for peace throughout their lives, with some discovering it and others simply waiting for death to find it. One participant who divorced after 14 years of violence observed that "*Cuando ya me divorcie de él, ya no hubo golpes…ya viví mas en paz con mis hijos.*" ("When I divorced him there were no more beatings…I was able to live in peace with my children.") Another participant, who could not imagine remarrying, described feeling peaceful after her husband's death because his alcoholism had caused her constant worry and *mortificación*. Two women explained that their sense of independence brought peace. Four participants spoke of strong faith communities.

These women used prayer and their faith in God to obtain a sense of peace in their lives; as one said, "I never felt abandoned by God." Yet some of the women also expressed anger at God for their adversities.

> que Dios me perdone, porque yo no lo he podido perdonar a Él (Llanto). De que me perdona lo que haya hecho, que nunca me acuerdo haber hecho algo para pagar tanto de lo que he pagado toda la vida…Hay veces que ya ni quiero agarrar el Rosario. Siento que Dios no me oye y a lo mejor como estoy enojada con El, a lo mejor no me ayuda por eso.
>
> may God forgive me, because I haven't been able to forgive Him (weeping). That he forgive whatever I may have done because I don't remember having done anything to pay so dearly for what I have paid all my life…There are times when I don't even want to pick up the rosary (Catholic prayer beads) I feel like God doesn't hear me and probably because I am angry at Him, maybe that's why he doesn't help me.

This participant also described anger at herself for denying her children educational opportunities because of her life-long anxiety and anger at her husband. Her calvary began when she married, and she did not believe that she would ever be able to have peace while married to him. After 45 years, she was in the process of separating from her husband for the second time in a year. She said that she believed that it harmed her more when he was present: "*Pero yo necesito paz…*" "I need peacefulness…" She explained that she wanted nothing more than to struggle no longer and described her life as "grey," with "no good times, only less bad times" and "only a minute of happiness." She illustrated her lifelong anxiety in this way:

> como que no tengo una gota de sangre en el cuerpo, como que tengo tres meses sin comer…Yo quisiera sentirme un poquito menos tensa, menos triste, menos lastimada…¿Como sentirá la gente normal? Digo yo, que hasta cantan…
>
> it's as if I were dying, like I don't have a drop of blood in my body, as if I haven't eaten in three months…I have a hunger to know how it feels to live like a person, to know what a normal person feels…How good must they feel that some even sing? …I would like to feel less tense, less sad, less hurt…

Another participant, who sustained a hip fracture resulting in her placement in a skilled nursing facility during the course of the interviews, reflected on a life of constant suffering: "*Yo nunca he encontrado la felicidad ni el amor…todo mi vida ha sido de llanto, de dolor, de angustia, de desesperación.*" ("I was never happy, all my life has been bitter…I never had affection…all my life has been weeping, pain, anguish, desperation.") But she relied on her faith:

> aquí estoy…esperando hasta que Dios diga, pero le pido mucho a Dios que…que cuando me lleve no sufra yo, porque ya he sufrido mucho en la vida…mucho…no lo dejo yo en paz, porque yo le pido mucho por mis hijos y por el mundo entero le pido yo …
>
> here I am …until God decides, but I ask God a lot that…that when He takes me that I don't suffer, because I have suffered very much in life…very much…I don't let him rest because I pray to him so much for my children and for the entire world…What else do I have left?

Indeed, the primary strategy for finding peace was provided by their faith in God. Regardless, the loneliness and depression could become unbearable, as was evident in the story of another participant who suffered long-term abuse and lifelong anxiety, and, later in life, horrible pain. Her ruminating thoughts of the past and present prohibited peace:

> Mi cabeza es una computadora que me pasa todo lo que pase para atrás, por más de que yo trato de no recordar, se me vienen los recuerdos a la mente…Todo es muy duro… pero una como quiera Dios esta con uno…
>
> My head is a computer that brings back everything I went through in the past, no matter how hard I try not to remember, those memories come to my mind… Everything is too hard…but anyway God is with one…

She described being in this world until God would call her home.

Prayers for peace were woven throughout these women's stories. Although a few of the women described finding peace, others continued to long for it and prayed unceasingly to find it. They prayed to forget, to forgive, and to be forgiven; but mostly, they prayed for strength and an end to their suffering.

Strength Amidst the Struggle—Throughout the interviews there were glimmers of resources that sustained life. This category describes some of the sources of strength that were instrumental in fostering a sense of health and well-being, including internal knowledge, family, friends, faith, pets, and nature. For example, even though she was denied formal education, a participant became self-educated and described how she loved to read because it broadened her horizons and taught new ways of being. Her aunt taught her to read and write in Spanish. "I learned how to listen to my children, not to go at them with blows like it was done to me."

Other participants found strength in social support: faith communities, family and friends to go out to eat with, and grandchildren to play with—"my children are happy, they haven't left me alone…..the best reward I have is that…" The 2 participants who did not grow up in abusive homes received continued support from their parents in their adult years, and one in particular moved closer to her parents after her divorce.

Faith or a belief in God, although occasionally creating conflicting emotions, was a strength for all 7 of the participants, and some of the most distraught participants had not given up on praying for strength. Some women continued to participate in faith communities and prayer groups, while all spoke of a personal prayer life.

Perhaps because of the connection to the '*campo'* (a word often used to describe the countryside or rural areas where many lived as children), several participants spoke of the importance of caring for plants and pets. They were saddened when their functional limitations made this more difficult. Two participants had pet birds in their homes, and one described enjoying talking to her bird; another participant, who at one time had 19 birds, spoke at length of how they brought her strength.

> Y andaba en silla de ruedas, y en la silla de ruedas yo movia a cambiarlos, a cambiarles de papel…era una cosa hermosa para mi…los demás manager eran bien, lindas personas, nunca me dijeron nada…es una terapia muy bonita para mí.
>
> I was in a wheelchair, and I would move around in the wheelchair, changing them and changing their paper…it was a beautiful thing for me…I love the sound of the small birds…that's a very nice therapy for me…. The other managers were good, fine persons, they never told me anything

This participant described sadness when her landlord cut down her plants and would not allow her to have a bird in her apartment. She experienced momentary joy when someone gave her a bird, but the bird was taken away, exacerbating her depression. She was referred for mental health services.

Ultimately, the women lived to tell of their experiences—a strong witness of strength in itself—and many continued to pray for strength even when they felt as if they could not go on: "*Mejor que me quiera mandar que me haga fuerte, porque soy fuerte porque he resistido tantos sufrimientos, pero mi corazón ya no puede*." ("It's better if He's going to send me something to make me strong. Because I am strong. Because I have endured so much suffering. But my heart can't take it any more…") Despite their pain, the women continued.

Discussion

Although the findings cannot be generalized, a number of insights into IPV can be gleaned from them. Long-term IPV, often considered a hidden phenomenon in an aging population, [2] was discussed in the interviews, with 5 of the 7 women having experienced abuse from childhood to adulthood. A life course perspective added increased understanding of violence across the life span, as other researchers have found. [29,40] The present findings, while unsettling, are not surprising given the social and cultural contexts of the participants' life stories; and they are consistent with other studies conducted with aging women, [31,41] clearly indicating that IPV is a life course phenomenon.

While the violence that these women experienced may have changed forms over the years, it is important to remember that the women were often living with long-term effects of IPV that remained unacknowledged. "Scars from mental cruelty can be as deep and long-lasting as wounds from punches or slaps but are often not as obvious" [42](p8) and can contribute to chronic pain, depression, and anxiety, as many of the women in this study experienced.

Relationships within the family of origin profoundly affect people over time. [43] This was evident in the stories of the women in this study, several of whom spoke of their vivid memories of being abused as a child. Until the late 1970s, child abuse did not receive attention in Mexico, where many of these women were born. One study from Veracruz, Mexico, reported that 97% of the women interviewed were abused as children, and over half reported being hit daily. [43]

Other studies conducted with Hispanic women have identified childhood abuse as a risk factor for IPV [44] contributing to long-term effects including, chronic pain, depression, and anxiety. [44,45] This is consistent with our findings. Wuest and colleagues [28] have explained that chronic pain in abused women often stems from a complex bio-psycho-social response to stress from physical and psychosocial trauma in childhood as well as adulthood that may result in neuropathic changes in the pathways associated with chronic pain. When pain is not managed well, the results of the childhood injuries may persist into adulthood. [28] Women who suffer with "high disability" pain often have a history of childhood abuse and IPV, depression, and PTSD. Kelly [44] has explained that depression and PTSD can continue for years post abuse. It is therefore vital to establish an "upstream," holistic approach in addressing chronic pain and depression in aging women, by inquiring about past abuse as opposed to merely treating symptoms. Such an approach might also offer an opportunity for ongoing healing of traumatic memories.

Culture is central to how experiences of abuse are identified and perceived. [46] The women in these stories were born within a culture where *machismo*, the privileging of male gender roles, *familismo*, and patriarchy prevail. [47] *Machismo* and patriarchal authority dictate that males are the providers and decision makers, whereas women are often subjugated to male dominance and take on the role of the self-sacrificing woman or primary caregiver. [47] One negative aspect of machismo is the encouragement of heavy drinking, [48] which is not the root cause of violence but may have contributed to the violence described in this study. While poverty and patriarchal social norms increase a women's risk for IPV, several of these

stories portrayed elements of strength within the women. Ultimately, these women said they provided for their children when their male partners did not.

Another core cultural value present in the data was the value placed on spirituality. For centuries, "women of color have used their spirituality as a form of resistance ethics, a coping mechanism, and a method of hope so that they can survive." [49] (p94) Older women's responses to IPV are often shaped by religious beliefs about the value of marriage and by an unending trust in God that things will work out. [41] All of these women spoke of their faith; but their responses to IPV were unique, with some questioning their early religious beliefs. The women who received social support through their church communities and families reported good quality of life in spite of their adversity. While several women found solace in their faith, a few mentioned conflicting emotions, anger at God, struggles with forgiveness, and feelings of being abandoned by God. Yet they continued to hope for peace. Attaining a sense of spiritual peace and well-being has been identified as a key determinant in overall quality of life. [50]

Antonovsky [3,4] posited that a person's SOC is strengthened by generalized resistance resources such as social support, spirituality, and knowledge or weakened by the lack of these resources, and that it is shaped by one's life story as this data illustrates. The present study's life course perspective vividly depicted the many ways in which these women wrestled with their own SOC, with some achieving a greater sense of *ease* or health and others experiencing greater *dis-ease*; but all mentioned resources that were crucial to sustaining health in the midst of adversity. The model provides a unique lens for identifying aspects of aging women's lives that are important for sustaining health.

The findings not only offer much insight into ways to improve care for those aging with disabilities, especially those who have experienced lives of abuse, but also have implications for research and knowledge development. Ideally programs for an aging population with functional limitations should assume a holistic approach, not only addressing the physical aspects of well-being, but also the spiritual and emotional, given the importance of spirituality to many cultures. Such holistic interventions might serve as vehicles for bringing closure and integration to life histories that include IPV, thus nurturing peace. Perhaps a program such as Chochinov's [50] dignity therapy, aimed at bolstering dignity and personhood for those at the end of life, might be instrumental for those living with IPV and multiple adversities, and merits further research.

There is evidence here that women find ways in which to overcome adversity including IPV. Interventions that provide avenues for women to reflect on their lives and incorporate social support, faith, and nature may serve to support their quest for peace. This deserves further study.

Antonovsky's [3,4] research with menopausal women in Israel empowered him to develop his theory. He discovered that some of the women celebrated health in spite of having lived in a concentration camp in their earlier years, and he was interested in the source of their strength. Through the voice of women, from a feminist perspective, his theory has become instrumental in studies throughout the world. Antonovsky explained that some who had survived such atrocities may not have found ways to comprehend or even manage their situations, but that if they somehow continued to find meaning in their lives, this fostered a profound spirit. For the women in the present stories, the home was often the place of atrocity, not because of a dominating ethnocentric power but because of their own family members and husbands, who claimed to love and cherish them. These women too were in touch with a profound spirit that enabled them to survive in the midst of multiple adversities and even in some cases to thrive.

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Table 1

Sample Description

Characteristics	Mexican American Sample (n=60)	Spanish Speaking Only (n=13)	Spanish Speaking & Reporting Abuse (n=7)
Age	Mean=60 years SD = 4.2; (range 55 to 75)	Mean=68 years SD=5.6; (range 59 to 75)	Mean=69 years SD=5.2; (range 61 to 75)
Employment	13%	8%	0%
Income < $10K/year	43%	85%	100%
Years of Education	Mean=10 years SD=4.10; (range 1 to18)	Mean=5 SD= 2.92; (range 1 to 12)	Mean 4.43 SD=2.77; (range 1 to 8)
Both Parents U.S. Citizens	Yes=65%	Yes = 23%	Yes = 43%
Grandparents U.S. Citizens	Yes=27%	Yes = 8%	Yes=14%
Home Ownership	Yes=63%	Yes = 31%	Yes=29%
Currently Married	Yes=45%	Yes=46%	Yes=29%
Years Living in United States	Mean=59 years SD= 16; (range 3 to 75)	Mean=41 years SD=24.3; (range 3 to 75	Mean = 44.6 years SD=29.56; (range 3.5 to 75)
Number of Children	Mean=3; SD=1.88; (range 0 to 8)	Mean 3.85 SD=2.2; (range 0 to 8)	Mean 3.86 SD=2.55; (range 2 to 8)
Number of Grandchildren	Mean = 6.8; SD=4.34; (range 0 to 16)	Mean=9 SD=4.2; (range 0 to 16)	Mean = 9.2 SD=3.97; (range 5 to 16)
Country where Born	U.S. 78% Mexico 22%	U.S. = 23% Mexico= 77%	U.S. = 43% Mexico=57%