The purpose of this study was to describe symptoms of PTSD and major depression in abused Latinas and to explore the relationships among intimate partner violence (IPV) experiences, these symptoms, and health related quality of life (HRQOL). The rate of PTSD was 69.7% and of major depressive disorder (MDD) was 57.6%. The comorbidity of PTSD and MDD was 54.5%. PTSD and MDD were not consistently correlated with IPV, although some significant relationships were found. PTSD and MDD symptoms were highly correlated with HRQOL. The impact of PTSD and MDD on psychological well-being and functioning in Latinas needs further investigation.

Victims of intimate partner violence (IPV) experience significant mental health sequelae, which manifest as symptoms of psychological and physical distress. Major depressive disorder (MDD), posttraumatic stress disorder (PTSD), and anxiety have emerged as the most frequently diagnosed mental health problems related to IPV (Roberts et al., 1998; Torres & Han, 2000; Woods, 2000). Golding (1999), who conducted a meta-analysis of the research on IPV as a risk factor for mental disorders, found that the weighted mean prevalence of PTSD was 63.8% (range 31.4%–84.4%), major depression 47.6% (range 15%–83%), and suicidality 17.7% (range 4.6%–77%).

In a subsequent review of the literature on IPV, Jones, Hughes, and Unterstaller (2001) reported that suicide is a significant risk for victims of IPV, and that PTSD may mediate the relationship between IPV and suicidal ideation. Further, data suggest that psychological symptoms continue for years post-abuse (Anderson, Saunders, Mieko, Bybee, & Sullivan, 2003; Ham-Rowbottom, Gordon, Jarvis, & Novaco, 2005; Zlotnick, Johnson, & Kohn, 2006). In one study (Woods, 2000), 44%–66% of women who had been out of an abusive relationship for a mean of 9.19 years had symptoms diagnostic for PTSD, compared to 74%–92% of currently abused women, and 6% of non-abused women.

Sheltered and help-seeking battered women have higher rates of MDD and PTSD than battered women not seeking services (Jones et al., 2001). Mechanic, Weaver, and Resick (2008) reported that in a sample of 413 severely battered, help-seeking women, the vast majority had PTSD symptoms, rated as moderate to severe (45%) and severe (31%). Seventy-one percent of this same sample reported moderate or severe symptoms of MDD. Symptoms of psychological distress in sheltered and help-seeking battered women interfere with their social functioning and impair their ability to fully utilize domestic violence agency services and personal and social resources (Gorde, Helrich, & Finlayson, 2004; Sullivan & Bybee, 1999). This population has unique needs. Further research is necessary to more fully understand this population’s mental health status and needs.

Although the Hispanic population is the fastest growing ethnic group in the US, and is projected to comprise 29% of the US population by 2050 (Pew Hispanic Center, 2008; US Bureau of the Census, 2004), few studies on the psychological impact of IPV on victims have included Latino women, either immigrant or US-born (Bauer et al., 2000; Belknap & Sayeed, 2003; Kelly, 2006; Ramos & Carlson, 2004; Rodriguez et al., 1998; Rodriguez et al., 2001; Rodriguez et al., 2008).

A few researchers have suggested that IPV-related physical and mental health symptoms are magnified for abused immigrant Latinas who face multiple stresses, higher levels of social isolation and entrapment, and exacerbating cultural factors (Kelly, 2006; Perilla, 1999; Perilla, Bakeman, & Norris, 1994; Ramos & Carlson, 2004). As a group, Latinos are disproportionately represented in socio-demographic groups with increased risk for both physical and mental health problems, creating a “double jeopardy” for abused Latino women. Additionally, overall health disparities and barriers to health care access among ethnic minority groups undoubtedly compound these health sequelae of IPV for Latinas (Centers for Disease Control,
Research is therefore greatly needed to better understand IPV-related mental health problems in Latino populations.

The purposes of this study were to (a) describe symptoms and experiences of psychological distress in abused immigrant Latinas, including symptoms of PTSD, MDD, and health-related quality of life (HRQOL), and (b) explore the relationships among these variables and the women’s experiences and appraisals of their IPV, their history of childhood trauma, and their immigration status. This study was part of a larger cross-sectional study that examined the health status, health services utilization, and health care needs of immigrant Latino women who were seeking emergency shelter and ongoing help for IPV.

INTIMATE PARTNER VIOLENCE

Intimate partner violence is defined as psychological, physical, or sexual abuse and battering perpetrated by an intimate partner against his or her partner for the purpose of coercive control. In population-based studies in the US and globally, nearly one in four women have been physically assaulted or raped by an intimate partner in their lifetime (Krug et al., 2002; Tjaden & Thoennes, 2000). Many studies of IPV include measures of physical and sexual violence only. When psychological abuse is included, the prevalence of lifetime IPV approaches 50% (Buvinic, Morrison, & Shifter, 1999; Gonzalez-Guarda et al., 2009; Krug et al., 2002; Tjaden & Thoennes, 2000). In a recent population-based study of IPV using data from 1995 and 2002, the investigators reported equal IPV prevalence rates among blacks and Hispanics (25%) compared to 14% among whites. Hispanics had the highest recurrence rate (58%) and whites the lowest (37%) (Caetano et al., 2005). Comparative IPV rates across ethnicity and race reported in clinical literature are inconsistent. Investigators have reported roughly equal (Denham et al., 2007), higher (Lown & Vega, 2001a), and lower (Bauer, Rodriguez, & Perez-Stable, 2000) rates of IPV between Latinas and non-Latinas. Regardless, there is widespread acknowledgment that even the best estimates of IPV likely reflect the tip of the iceberg of the problem (Krug et al., 2002).

Mental Health Effects of IPV

The prevalence of lifetime MDD among Latino women living in the US has been reported as 12.3% (8.4% for immigrants and 17.5% for US-born Latinos) (Vega et al., 1998). Women were two times more likely to report MDD than men. These data are similar to those reported by Slone et al. (2006) for rates of MDD in four cities in Mexico. Data from the National Comorbidity Study showed lifetime prevalence rates for PTSD as 5% for men and 10.4% for women in the US general population (Kessler et al., 1994).

Only a few investigators of IPV-related PTSD and MDD have considered Latinas as a distinct group. In one study conducted in an immigrant primary care clinic, among Latinas who reported IPV, 45.7% had MDD and 19% had PTSD; abused Latinas were three times more likely to have PTSD than non-abused women (Fedovskiy, Higgins, & Paranjape, 2008). Caetano and Cunningham (2003) conducted a study comparing rates of IPV-related MDD among different ethnic groups in a household sample and reported that abused Hispanics had the highest rates of MDD (38%), compared to Blacks (30%), and Whites (20%). McFarlane et al. (2006) reported that Latinas experienced significantly more PTSD than African American and white women. In contrast, Torres and Han (2000) reported that, in their sample of abused women, Hispanics had less PTSD, MDD, and anxiety than whites. Though inconclusive, available data suggest that PTSD and MDD are higher among Latinas who report IPV than African American or white women.

Most reports of the comorbidity of IPV-related PTSD and MDD approach or exceed 50% (Castardi et al., 1999; Nixon, Resick, & Nishith, 2004; Stein & Kennedy, 2001). Recent discussion in the field questions the causal pathways to these two disorders following IPV (Golding, 1999; Murray & Kennedy, 2001). Given the extensive syndromal similarities, MDD detected in some studies may represent PTSD or complex PTSD (Franklin & Zimmerman, 2001). The significance of the clinical and prognostic implications of distinguishing PTSD and MDD is questionable (Stein & Kennedy, 2001). The presence, severity, and duration of symptoms of various psychological disorders in abused women are very likely more indicative of their mental health status, global functioning, and risk for chronic illnesses than the presence or absence of specific psychiatric diagnoses (Zlotnick, Franklin, & Zimmerman, 2002).

Victims of IPV experience multiple psychological health sequelae in addition to PTSD, MDD, and anxiety, including suicidal ideation, panic disorder, eating disorders, and substance abuse (Campbell & Lewandowski, 1997; Carbone-Lopez et al., 2006; El-Bassel et al., 2003; Gorde et al., 2004; McNutt et al., 2002). Physical health problems include physical injuries, many somatic and medically unexplained symptoms, chronic pain (Campbell, 2002; Coker et al., 2002; Kendall-Tackett, Marshall, & Ness, 2003; McFarlane et al., 2006), and health risk behaviors (Tomasulo & McNamara, 2007).

Health Related Quality of Life

Shetterly et al. (1996) found that Hispanics are 3.4 times more likely to report poor or fair health status than whites. More recent data from the Behavioral Risk Factor Surveillance System (BRFSS) show that 24.7% of Hispanics rated their general health as fair or poor versus 12.6 for whites (Chowdhury, Balluz, & Strine, 2008). McGee et al. (1999) found that Hispanic women who rated their health as poor or fair, versus good, very good, or excellent, had more than twice the odds of death. Abused women have significantly lower HRQOL and self-assessed health than non-abused women (Alsaker, Moen, Nortvedt, & Baste, 2006; Denham et al., 2007; Lown & Vega, 2001a, 2001b) and abused Latinas have lower HRQOL than abused women of other ethnic groups (Denham et al., 2007; Lown & Vega, 2001a).
The increased morbidity and mortality for IPV victims and their children results in increased health care costs and an economic burden on societies via lost productivity and increased use of social services (Krug et al., 2002). IPV and IPV-related trauma symptoms impair survivors’ abilities to take care of themselves, concentrate on tasks, and manage daily responsibilities, finances, and housing needs (Gorde, Helfrich, & Finlayson, 2004). Functional losses related to IPV include reduced employment (Moe & Bell, 2004), parenting impairment (Levendosky, Leahy, Bogat, Davidson, & von Eye, 2006), and increased poverty (Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003).

METHODS

Study Design

Individual interviews were conducted to obtain quantitative and qualitative data using: (a) a written survey pertaining to the women’s IPV experiences, physical and mental health, and health services utilization, and (b) semi-structured interviews pertaining to the women’s self-identified health care needs. The quantitative data on the women’s IPV experiences and physical and mental health are being used in this study.

Sample

A convenience sample was recruited from a population of women who were receiving services at a domestic violence services agency in the northeastern US. The 33 women in this study ranged in age from 19 to 74 years old ($mean = 39.7$). They originated from seven countries in Central and South America and the Caribbean, Mexico, and Puerto Rico; they had lived in the US for 8 months to 28 years. One in four of the women was an undocumented immigrant at the time of the interviews. Spanish was the primary language for all but one woman from Puerto Rico. Nearly two-thirds spoke minimal or no English. Seven had less than nine years of education ($mean = 9.18$, range 0–16). Thirteen of the women were working at the time of the interview. The number of children they had ranged from 0 to 8 ($mean = 2.64$). Of the 32 women who had children, 12 had been involved with child protective services (CPS); one as both a child and a parent (see Table 1).

Procedure

Recruitment

Institutional Review Board approval was obtained from appropriate institutions. The women were either self-referred or referred by staff. New participants in both residential and nonresidential services were informed about the study during their intake or second interview. Existing agency participants were informed about the study when they presented for services. Informational flyers were posted within the agency. Interested women were informed verbally and in writing that their participation was voluntary and that their participation decision would not impact their receipt of agency services, their health care, or their immigration status. Written informed consent was obtained; identification numbers were assigned to all participants to maintain confidentiality.

Data Collection

Interviews were conducted in Spanish or English based on the participants’ choice. Interviews in Spanish were conducted either by bilingual study staff or with the use of an interpreter. The written survey was available in English and Spanish, and included Spanish translations of all instruments. However, the survey was read aloud and the participants’ responses recorded by the data collectors to address any illiteracy. Following completion of the written survey, audio-taped interviews pertaining to the women’s self-identified health care needs were conducted. These interviews lasted 10–20 minutes and were transcribed verbatim.

Variables and Their Measurement

Demographics

Demographic data included age, country of origin, primary language, years living in the US, immigration status, English proficiency, years of education, employment status, number of

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Sample Description ($n = 33$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>19–24</td>
<td>3</td>
</tr>
<tr>
<td>25–34</td>
<td>11</td>
</tr>
<tr>
<td>35–44</td>
<td>9</td>
</tr>
<tr>
<td>45–64</td>
<td>9</td>
</tr>
<tr>
<td>65+</td>
<td>1</td>
</tr>
<tr>
<td><strong>English proficiency</strong></td>
<td></td>
</tr>
<tr>
<td>Not at all</td>
<td>5</td>
</tr>
<tr>
<td>Minimal</td>
<td>16</td>
</tr>
<tr>
<td>Moderate</td>
<td>8</td>
</tr>
<tr>
<td>Fluent</td>
<td>4</td>
</tr>
<tr>
<td><strong>Immigration status</strong></td>
<td></td>
</tr>
<tr>
<td>US citizen</td>
<td>12</td>
</tr>
<tr>
<td>Legal resident</td>
<td>8</td>
</tr>
<tr>
<td>Temporary status</td>
<td>5</td>
</tr>
<tr>
<td>Undocumented</td>
<td>8</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
</tr>
<tr>
<td>Working: &lt; 36 hours</td>
<td>5</td>
</tr>
<tr>
<td>36+ hours</td>
<td>8</td>
</tr>
<tr>
<td>Unemployed</td>
<td>20</td>
</tr>
<tr>
<td>In school</td>
<td>5</td>
</tr>
<tr>
<td>Volunteering</td>
<td>5</td>
</tr>
<tr>
<td><strong>CPS involvement</strong></td>
<td></td>
</tr>
<tr>
<td>Ever</td>
<td>12</td>
</tr>
<tr>
<td>Current</td>
<td>6</td>
</tr>
</tbody>
</table>

CPS, Children’s Protective Services.
Intimate Partner Violence

The 46-item Severity of Violence Against Women Scale (SVAWS; Marshall, 1992) was used as an objective measure of the types, frequency, and severity of IPV. The SVAWS measures the severity of violence on two dimensions: (a) threats, which are considered psychological abuse, and (b) actual violence, which includes physical and sexual abuse (Marshall, 1992). The threat of violence subscale has four subscales: symbolic violence and threats of mild, moderate, and severe violence. The actual violence subscale has five subscales: mild, minor, moderate, and severe violence and sexual violence. For the purposes of this study, psychological abuse was defined as threats of moderate and severe violence; physical abuse included actual moderate and severe violence; and the sexual violence subscale included sexual abuse. The SVAWS has been used in several studies with diverse populations and has been correlated with other measures of the psychological effects of abuse (Haggerty et al., 2001; Vitanza et al., 1995). In this study, the alpha coefficient was .92 for both threats and actual violence.

A revised version of the 3-item Appraisal of Violent Situations (AVS; Dutton, 1992) was used to measure the women’s perceptions of abuse severity (alpha coefficient = .93) (Haggerty et al., 2001). On three visual analogue scales, the woman is asked to appraise the severity of violence, her ability to stop the violence in the future, and the likelihood that the violence could lead to serious harm or her death. Both the SVAWS and the AVS have been translated into Spanish using back translation (Pearce et al., 2003).

Childhood Sexual Assault

A single question was asked, “Were you ever sexually assaulted as a child?” For positive responses, women were asked to identify the assailant’s relationship to the woman.

Mental Health

The PTSD Checklist-Civilian version (PCL-C; Weathers, Litz, Huska, & Keane, 1993) was used to measure the women’s perceptions of abuse severity (alpha coefficient = .906). The PCL is a 17-item self-report questionnaire that uses a ranking scale (1 = not at all to 5 = extremely) to report respondents’ level of distress related to each symptom over the past month. The total score is an indicator of symptom severity. Re-experiencing, avoidance, and hyperarousal subscales can be calculated, using a score of three or more as a symptom endorsement. Depressive symptoms were assessed using the DSM-IV criteria for major depressive episode (American Psychiatric Association [APA], 2000). The total number of MDD symptoms was based on eight of the DSM-IV MDD diagnostic symptoms, excluding suicidal ideation, which had not been asked about as a current symptom.

TABLE 2
Percent of Women Experiencing IPV by Type (n = 33)

<table>
<thead>
<tr>
<th>IPV Type</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological abuse</td>
<td>22</td>
<td>66.7</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>28</td>
<td>84.8</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>24</td>
<td>72.7</td>
</tr>
<tr>
<td>Psychological only</td>
<td>4</td>
<td>12.1</td>
</tr>
<tr>
<td>Physical only</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Sexual only</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>Psychological and physical only</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>Psychological and sexual only</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>All three types</td>
<td>20</td>
<td>60.6</td>
</tr>
</tbody>
</table>

Health Related Quality of Life

Selected items from National Health Interview Survey (NHIS; US Bureau of the Census, 1994) were used to measure HRQOL. The NHIS is available in Spanish. Self-perceived current health was assessed with the following standard question: “Compared with other people your own age, would you say that your physical and mental health is excellent, good, only fair or poor?” Respondents were also asked to rate their level of bodily pain in the previous month (1 = none to 5 = severe), the number of days in the past month their physical and mental health were not good, and the number of days in the past month that poor physical and/or mental health kept them from performing their usual activities.

Data Analysis

Data were analyzed using SPSS 17.0 for Windows. Descriptive statistics were computed for all variables. Pearson product-moment correlation coefficients were used to analyze the relationships between PTSD, MDD, and HRQOL with IPV type and severity, childhood sexual abuse, and other psychosocial variables.

RESULTS

Intimate Partner Violence

All of the women experienced some level of threatened abuse. More than two-thirds of the women experienced psychological, physical, and/or sexual abuse. Most of the women experienced at least two types of abuse and 20 women experienced all three types of abuse (Table 2). Additionally, one third (n = 11) of the women reported a history of sexual assault in childhood. The women’s self-appraisals of the severity of the abuse, their ability to stop the abuse, and the likelihood of the abuse leading to serious injury or death are described in Table 3.
PTSD and Major Depression in Abused Latinas

Table 3

<table>
<thead>
<tr>
<th>Appraisal of Violent Situations</th>
<th>Mean*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse severity</td>
<td>81.6</td>
</tr>
<tr>
<td>Ability to stop abuse in the future</td>
<td>60.0</td>
</tr>
<tr>
<td>Likelihood of serious injury or death</td>
<td>54.0</td>
</tr>
</tbody>
</table>

*Possible range 0–100.

Mental Health

PTSD and MDD

The total symptoms, diagnoses, and comorbidity of PTSD and MDD are presented in Table 4. Additionally, the severity of PTSD symptoms, which was calculated using the mean of total score of the 17 PCL-C items, had a mean of 54.82, with a possible range of 0–85. Fifteen of the women responded that they had ever “seriously considered attempting suicide,” of those, seven had attempted suicide.

HRQOL

Several questions were used to measure the women’s health status. Women were asked “Compared with other people your own age, would you say that your physical health is excellent, good, only fair, or poor?” The same question was asked about mental health. They were also asked about the extent to which their physical and mental health interfered with their functioning. For both physical and mental health, more than half of the women reported that their health was poor or only fair. These and other findings are presented in Table 5. The respondents’ past and current use of tobacco, alcohol and drugs were negligible.

Correlates of Mental Health

Pearson correlation coefficients were analyzed for the relationships of PTSD diagnosis, PTSD symptom severity, MDD diagnosis, MDD symptom total, and co-morbid PTSD/MDD to IPV experiences, IPV appraisals, a history of childhood sexual assault, and immigration status (Table 6). There were significant correlations among psychological abuse and MDD diagnosis, MDD symptom total and comorbid PTSD/MDD. Physical abuse was correlated with MDD diagnosis; sexual abuse was not. PTSD diagnosis was not correlated with any type of abuse. The strongest associations were found between a history of childhood sexual assault and PTSD, MDD, and comorbid PTSD and MDD.

Correlates of HRQOL

PTSD and MDD were highly correlated with measures of HRQOL (Table 6). Several HRQOL indicators were also significantly correlated with a history of childhood sexual assault, with sexual IPV, undocumented immigration status, and appraisals of the IPV (Table 7). Bodily pain was very significantly correlated with other HRQOL indicators.

Limitations

This study addresses a gap in the literature regarding the mental health sequelae of IPV in Latinas. Although the
participants represent a number of countries, the sample is small, and this makes generalizations difficult. This sample of Latino women who have sought help for IPV may vary from other Latinas, or from abused women who do not seek services in several ways, including experiences of IPV and of psychological distress. Given the sample size, the Pearson correlation analyses should be considered exploratory.

**DISCUSSION**

The rates of PTSD (69.7%) and MDD (57.6%) in this study sample were higher than population based rates among Latinas (Vega et al., 1998) and most published results of abused women (Caetano & Cunradi, 2003; Golding, 1999; Jones et al., 2001; Stein & Kennedy, 2001; Torres & Han, 2000), but they were similar to the severely battered help-seeking women in Mechanic et al.’s study (2008). The findings indicate that abused Latinas, specifically those seeking shelter or help, experience significant psychological effects of IPV that are likely more severe than white or African American women, and those not seeking shelter or IPV services. Though individually, PTSD and MDD rates were significantly higher in this study than in others, the comorbidity of PTSD and MDD in this study is consistent with the findings in several other studies.

**TABLE 7**

<table>
<thead>
<tr>
<th>HRQOL</th>
<th>Childhood Sexual Assault</th>
<th>IPV-Related Sexual Abuse</th>
<th>Undocumented Immigration Status</th>
<th>Bodily Pain</th>
<th>Abuse Severity Appraisal</th>
<th>Ability to Stop Abuse in the Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health appraisal</td>
<td>.544***</td>
<td>.420*</td>
<td>.404*</td>
<td>.497**</td>
<td>.421*</td>
<td>−.228</td>
</tr>
<tr>
<td>Mental health appraisal</td>
<td>.503**</td>
<td>.270</td>
<td>.346</td>
<td>.512**</td>
<td>.308</td>
<td>−.136</td>
</tr>
<tr>
<td>Bodily pain</td>
<td>.499**</td>
<td>.021</td>
<td>.394*</td>
<td>—</td>
<td>.054</td>
<td>−.271</td>
</tr>
<tr>
<td>Days physical health not good</td>
<td>.443*</td>
<td>.410*</td>
<td>.494**</td>
<td>.601***</td>
<td>.444*</td>
<td>−.563**</td>
</tr>
<tr>
<td>Days mental health not good</td>
<td>.305</td>
<td>.341</td>
<td>.291</td>
<td>.480**</td>
<td>.332</td>
<td>−.448*</td>
</tr>
<tr>
<td>Impaired daily activity</td>
<td>.343</td>
<td>.529**</td>
<td>.306</td>
<td>.318</td>
<td>.383*</td>
<td>−.506**</td>
</tr>
</tbody>
</table>

*p ≤ .05, **p ≤ .01, ***p ≤ .001.
The analyses of the relationships among types of IPV and PTSD and MDD in this study showed some surprising results. Experiences of IPV were not closely associated with psychological and physical abuse, PTSD diagnosis and symptom severity were not. These results are inconsistent with most reports, in which the relationships between IPV and mental health are firmly established. One possible explanation is that cumulative lifetime trauma is more strongly associated with psychological distress than IPV alone. In this study, a single item identifier of childhood sexual assault was strongly correlated with PTSD, MDD, PTSD/MDD comorbidity, and HRQOL.

The weak relationships among IPV and PTSD and MDD are similar to the findings of Torres and Han (2000). They suggested that the significant life changes that IPV causes, such as needing to relocate, and changing employment and financial status, may be the cause of psychological distress. Logically, this is particularly true for women who have sought services for IPV, which is often the first step in a series of life changes. The sample in this study and the Hispanic sample of Torres and Han (2000) are similar in size and were recruited from similar settings. The small sample size of this study precludes regression analysis to determine the contribution of these many factors to symptoms of psychological distress. The lack of consistent correlations may also be attributable to sampling error, given the sample size in this study. One finding that supports the hypothesis that abused immigrant Latino women may experience compounded influences on their mental well-being is the strong correlation between undocumented immigration status and several HRQOL indicators.

PTSD has been shown to strongly mediate the relationship between trauma and health status and functioning (Green & Kimberling, 2004). In this study, the relationships among childhood sexual assault and IPV-related sexual abuse, PTSD, MDD, and HRQOL demonstrate these links. IPV-related trauma symptoms have been linked to several dimensions of health status and functioning, and were strongly related in this study. PTSD symptom severity and MDD symptom totals were more strongly correlated with HRQOL than with PTSD and MDD diagnoses. This supports the argument that the clinical implications of PTSD and MDD have more to do with symptom severity than with diagnoses. The strength of the correlations between HRQOL indicators and PTSD and MDD diagnoses and symptoms also support this argument.

Nurius et al. (2003) found that psychological vulnerability, which is based on a woman’s perception of the abuser, his potential for harm, and her degree of powerlessness and entrapment, was more strongly correlated with both depression and physical functioning than both physical and psychological abuse. In this study, appraisals of abuse severity and ability to stop the abuse in the future were more strongly correlated with HRQOL than were types of abuse experienced, lending credence to Nurius et al.’s findings. Just as IPV is understood as an issue of control by the abuser, women’s psychological responses to the violence, particularly PTSD severity, have been demonstrated to relate to a sense of powerlessness and lack of control.

**IMPLICATIONS**

Latino women who survive IPV, particularly immigrants who face additional stressors and challenges, experience high levels of psychological distress, which in turn negatively influence their health status, quality of life, and functioning. Cumulative trauma undoubtedly compounds these effects. Further research is needed to describe more fully the manifestations and severity of psychological distress in this population, as well as the impact of this distress on daily functioning, including the ability to access needed services and resources. The influences of the process of immigration, immigration status, acculturation, cultural factors, literacy, and English-proficiency all warrant further investigation.

Though not addressed in this study, resilience in this population should be considered along with symptoms of psychological distress. Resilience is defined in various ways, though always with three essential components: (1) the ability to change or adapt to harsh or negative life circumstances; (2) the capacity to “bounce back” and succeed in the face of negative outcome expectancies; and (3) the capacity for determined engagement with the risk factor in question, rather than avoidance (Greene, 2002). According to Hobfoll’s (1998) theory of conservation of resources, the loss of abused women’s personal, interpersonal, and material resources causes increased symptoms of PTSD, leading to further resource loss creating a downward spiral of increasing symptoms and further loss of resources and decreased functioning. Resilience can be eroded by IPV, but can also serve to mitigate its harmful psychological effects. Improved understanding of the effect of resilience on the relationships among IPV, PTSD, MDD, and health status and functioning will help to guide social and clinical interventions for this population.

*Declaration of interest:* The author reports no conflicts of interest. The author alone is responsible for the content and writing of this paper.

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