Understanding Intimate Partner Violence, Sexual Abuse, and Mental Health in Non-Indigenous Rural Chiapas: Implications for Global Mental Health Practice

UNDERSTANDING INTIMATE PARTNER VIOLENCE, SEXUAL ABUSE, AND MENTAL HEALTH IN NON-INDIGENOUS RURAL CHIAPAS: IMPLICATIONS FOR GLOBAL MENTAL HEALTH PRACTICE

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Abstract

Background: In Chiapas, over 70% of people live in poverty, and 51% of the population live in rural areas. This study emerges from three years of local experience providing mental healthcare in primary-care clinics in rural Chiapas. After rolling out mental-health services in 2014, Compañeros En Salud care-providers recognized intimate partner violence (IPV) and non-partner sexual abuse (SA) as significant contributors to women's burden of mental disorders. This paper explores the scope of IPV, partner's controlling behaviors (CB), and SA in this region, and the ways in which gender norms and roles shape experiences of violence, and emotional distress in this community.

Methods: We designed a convergent-parallel mixed-methods study in one rural community of over 1200 people. Participants were selected by random and purposeful sampling to obtain quantitative and qualitative data respectively (141 surveys of women ≥15 years, 40 individual interviews, and participatory observation with naturally-occurring groups). To measure IPV and SA, we administered an adapted version of the National Survey on the Dynamics of Relationships at Home (ENDIREH) questionnaire, and the Patient Health Questionnaire -9 (PHQ-9) to measure depressive symptoms.

Quantitative results: Lifetime prevalence of IPV was 49.7% (95% CI: 41.1–58.2%) among women 15 years and older, and 54.7% (95% CI 45.6–63.6%) among ever-partnered women.

Forty-percent (95% CI 31.3–48.9%) of ever-partnered woman have experienced moderate-severe violence with high CB (HC-IPV). In addition, 14.8% (9.2–22.2%) reported moderate-severe violence with moderate CB (MC-IPV). IPV, HC-IPV, and SA were significantly associated with moderate/severe depressive symptoms, although this was not observed for MC-IPV.

Qualitative results: Lived experiences varied significantly among three generations of participants and across five salient categories: a) parenting practices and experiences; b) inhabiting separate spheres; c) experiences of alcohol abuse and violence; d) experiences of IPV and SA; e) efforts to reduce alcohol abuse and IPV. Overall, participants framed their lived experience on the way adverse-childhood-experiences affected their current way of living, their compliance and traversing of gender roles and norms, and their experiences of violence and emotional distress.

Mixed-methods results: In the subgroup of women who were raised after the 1980s, the prevalence of physical IPV and partner alcohol abuse were significantly lower, whereas primary school completion was significantly higher. In contrast, coffee land ownership, partner controlling behaviors, and partner/non-partner sexual abuse have not changed despite women's positive change in opinions about gender norms.

Discussion: Poverty and adverse childhood experiences considerably shape experiences of IPV, alcohol abuse, and emotional distress in people who live in this region. In addition, gender norms that constrain women to the household further hinders women's access to social networks and harms their mental health. Mental health services at the primary care level need to be equipped to

address trauma, stress-related problems and depression resulting from these adverse experiences, also impacting the development of chronic health conditions, since health providers may be the only social resource for many individuals, especially for women.

Table of Contents

Figures

Graphs

Tables

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Biosocial analysis of intimate-partner violence, non-partner sexual abuse, and mental health in rural Chiapas

Preface

In this essay, I develop a biosocial analysis of mental health and violence against women in non-indigenous rural Chiapas. I write the perspective of a health care provider, and with an interest in social justice, considering historical, political, and economic forces that influence gendered experiences, and the well-being of men and women in the *Sierra Madre* of Chiapas, Mexico's poorest state. I focus on intimate partner violence (IPV) and non-partner sexual abuse (SA) for two reasons. First, they are the highest markers of gender inequality. Second, their effects on health had revealed themselves during my clinical experience and practice as a primary care physician and mental health care provider, as a tangible barrier for my female patients to maintain and restore their health.

I first became aware of inequities in healthcare between rich and poor in 2007 when I participated in medical brigades to Tolimán, a rural town in Querétaro, México, where I lived and studied medicine. But it was not until my mandatory social service year in a remote rural village in the Sierra that I became aware of gender inequities in health and health outcomes. During my social service year, I became involved with Compañeros En Salud (CES), the Mexican affiliate of Partners In Health (PIH), a non-profit organization operating in 11 countries that seeks to strengthen health systems and bring the fruits of modern medical science to those who need it most. Proposing a solution to understaffed and understocked rural clinics to guarantee the right to health for the poorest, in Chiapas CES launched a program of rehabilitation of public primary care clinics in rural villages, and offered clinical supervision and continuing medical education for physicians completing their social service year (Compañeros En Salud, 2017).

During that social service year, I was responsible of providing health services in Matasano, a highly-marginalized village with a catchment area of around 2,000 people. I understood that cash transfers, health literacy workshops, and good will were not enough to overcome the barriers to women's health—from gynecological to mental health—erected by unjust social and economic structures across and within socio-economic strata.

A few months into my social service year, I became aware that gender norms restricted women's access to capital, both economic and social, and, therefore, stood in the way of health and healing. After completing my year of social service in January 2013, I stayed at CES as the Mental Health Coordinator for two more years. During that time, it became even more evident to me that gender inequality was harming women's mental health, and significantly limiting the potential success of treatments for mental health problems, due to their experiences of IPV. Although this particular fact was prominent in women's narratives, additional negative effects were evident as a result of gender norms restrict women's capability to exercise, visit friends and family, forge social networks, or just step outside the house.

While reading about social inequality in Mexico, the following quote from Alexander Von Humboldt, a Prussian scientist and explorer, struck me:

> Mexico is the country of inequality . . . The capital and several other cities have scientific establishments, which will bear a comparison with those of Europe. The architecture of the public and private edifices, the elegance of the furniture, the equipages, the luxury and dress of the women, the tone of society, all announce a refinement to which the nakedness, ignorance, and vulgarity of the lower people form the most striking contrast (Humboldt, 1877).

Two centuries later, the gap between rich and poor persists—as does racism, classism, and sexism—and inequality obstructs 22% of the nation's human development potential (United Nations Development Program, 2015) Today, the wealthiest 20% of the population earns fourteen times more than the poorest 20% (OECD, 2016). In 2014, Mexico ranked the most unequal among countries in the Organization for Economic Cooperation and Development (OECD), with a GINI index of 0.46 (OECD, 2016), and in 2012, almost half of the population lived in moderate or extreme poverty (OECD, 2012).

Poverty, however, is not experienced equally between women and men, especially in places where men have almost exclusive economic control, or where job opportunities for women are scarce. Rather, human development is unequally distributed between women and men. Although Mexico has a high Human Development Index (HDI 0.77)—a measure that reflects life expectancy, education attainment, and per capita income—gender inequality hinders women's development. To illustrate, HDI is reduced by 7.2% for women in Mexico who experience gender-based violence (i.e., violence from an intimate partner, gender-based violence at work, sexual violence), one of the highest markers of unequal power between men and women (Sen et al., 2007). The impact of gender inequality on development vary tremendously across and within different states and municipalities. The Gender Inequality Index (GII) measures inequalities between men and women in health, empowerment, and participation in the labor market (INMUJERES, ONU México, & PNUD, 2016). Chiapas has the lowest HDI among Mexican states, and a Gender Inequality Index (GII) of 0.44 (0 meaning total equality and 1 total inequality). While the GII in Chiapas is lower than the national average, it does not mean that women in Chiapas are better off. In fact, this low GII may be due to men's low income and

secondary education attainment, as more than 70% of Chiapas' population lives under the national poverty line (CONEVAL, 2012).

Income inequality also exists within households, especially in rural areas where land is the only property available and agriculture the only job opportunity. Poverty may therefore obstruct women and/or men's access to health and healthcare to different degrees, and in different ways. In Mexico, gender norms that place men as the sole breadwinners, support men's control of economic resources, and restrict women's physical mobility and political participation, have permitted almost exclusive land tenure by men (Brunt, 1992). Consequently, many women living in rural villages are economically dependent on the men in their lives (Brunt, 1992). In 1997 the government instituted a conditional cash-transfer (CCT) program which currently provides poor families with a equivalent of $15 USD bimonthly *(Secretaria de Desarrollo Social*, 2016). Each school-age child in a household who is enrolled in school receives an additional subsidy. The subsidy is capped at $196.5 USD - $317.2 USD[1] bimonthly in households with children enrolled in high-school. The money is given to and administered by women in exchange for their fulfillment of certain obligations, such as sending children to school and participating in health promotion and prevention activities. These demands, along with gender expectations of childrearing and care giving, and the extraneous housework that comes with poverty (due to lack of tap water, and electricity), exhort them to stay at home, limit their social networks and the quality of their social relationships, which in turn increases the risk for depressive and anxiety disorders (Ehsan & Silva, 2015; Silva, Huttly, Harpham, & Kenward, 2007).

[1] Calculated at 2017 exchange rate published by OECD

Before working on this thesis, I had never considered myself a feminist. I grew up with two younger sisters, I never had a brother to compare to, and as a teenager I studied at a progressive school where I was never taught nor treated differently due to my gender. I never saw my father mistreating my mother. I have never experienced sexual abuse or assault. My romantic relationships have been mostly conflict-free and equitable. At all levels, my lived experience is very different from that of the women and girls—and boys and men—I have met, cared for, and befriended during the four years I've lived in rural Chiapas. While this fact may limit my capacity to fully understand the stakes of challenging gender norms for those who bear the triple burden of being poor, marginalized, and women, it also permits me to imagine a more gender-equitable scenario in health and health care delivery. I argue that working towards realizing gender equity in health—and addressing social determinants of health—is crucial in the struggle for social justice and in realizing the right to health in rural Chiapas, and at other global sites where Partners In Health (PIH) works. There is no social justice when half of the population is living oppressed, many times violently oppressed, within their communities.

Gender Inequality and Primary-Care: a Physician's Reflection

I heard about the feminist book *Our Body, Ourselves* during my first months as a graduate student in Boston, Massachusetts. The book, originally titled *Women and Their Bodies,* was written in 1970 by a group of feminist activists as a weapon to seize ownership of their own bodies and gain decision-making power in relation to their health, sexuality, and reproduction (Boston Women's Health Collective, 1970). When I heard those words "our body, ourselves," the faces of the many women and girls I've met in rural Mexico came to my mind.

Almost 50 years after the book was first published, I was struck that many women and girls in rural Chiapas had little, if any, voice in what happened with their bodies. As a physician, I would become frustrated when a woman with diabetes could not exercise to lower her blood sugar because her husband would not let her "loiter around as if she had no work to do at home" or because the community would stigmatize her as someone who does not care about her family. Women's halfhearted amusement at my physical activity prescriptions made me suspect that when they said they would do it, it was mostly out of pity for the naïve girl who played doctor in their town (I looked much younger than I was). Medical emergencies were equally complicated by inequitable gender norms. Take the case of a young woman with an ectopic pregnancy—a pregnancy that develops within an ovary or fallopian tube and can cause significant internal bleeding and death. This woman could not go to the hospital until a male in the family, usually hours or days away in the fields, gave her permission to go. She managed to obtain the permission of the landowner she was working for instead, and survived.

A year later, as mental health coordinator for Compañeros En Salud (CES), I became aware of the psychological consequences of women's reclusion and abuse. At our

psychoeducation group sessions in which I intended to teach patients (frequently all women) "coping skills" to deal with depression, I was discouraged by the paucity of options they had. Physical activity other than sweeping and washing clothes is practically impossible. There are no spaces to meet with friends, or no friends to meet with due to isolation in their households from an early age. Even getting permission from their husbands to visit parents and siblings in a different community is a challenge for many. Squeezing my brain for some drops of creativity, I would go as far as writing prescriptions for sun exposure so that women with depression could go out of their dark huts. I don't know if that worked. Was I witnessing a norm regarding women's lives, or was it something specific to women suffering with depression?

Women in rural Chiapas usually spend their days in dark, smoky kitchens. While the kitchen is often filled with warmth and laughter, it can be lonely and isolating if a woman doesn't have daughters or daughters-in-law sharing their time and housework. In the psychoeducation group sessions, when asked about what they liked to do the most, younger and older married women always gave the same answers: clean the house, care for the children, wash clothes, make sure food is ready. I will not argue against caring for one's family and home, and most of the women I've met do so with sincere pleasure and joy. Still, the amount of energy and strategic thinking I had to muster in order to help women remember what they liked besides housekeeping, wore me down. My fatigue somehow felt defeating.

Freedom of choice is taken away early. I remember a conversation with a 12-year-old friend, Marleni[2]. I asked her what her favorite food was. Her answer? Just food. Her favorite color? A mild shrug. I went on trying to find any preference for something with no success. Already tapered by poverty, her options were further narrowed for being a girl, whose four older

[2] Names are changed to maintain confidentiality

brothers would often decide what was best for her. I realized later that many women here do not have favorites, as they rarely have any opportunity to choose. Or was that my impression due to my experience growing up surrounded by opportunities?

Now, 16 years old, Marleni does not like to go out of the house nor visit friends, a situation lived by many women and female teenagers. Is this an authentic preference? Or could it be avoidance of negative sanctions for breaking a gender norm—a social norm expected of her because of her gender? Social norms are what people in a group believe is a typical action, an appropriate action, or both, within an important reference group. They are composed of a web of beliefs—what an individual believes she should do, what she believes others usually do, and especially, what she believes others believe she should do (social expectations). These norms are maintained by positive or negative sanctions which could be overt (i.e., jail, fines, public punishment), or covert (i.e., attitudes, reputation, gossip) (Mackie, Moneti, Shakya, & Denny, 2015).

Most health programs that target gender inequality—namely intimate-partner violence, reproductive rights, and sexual abuse—measure change in people's attitudes and behaviors, but do not measure changes in social norms (Rachel Jewkes, Flood, & Lang, 2015). Questions such as "Do you think a man has the right to hit his wife?" or "Has your husband ever hit you" can say a lot about the woman's attitudes and her husband's behaviors, but they may fail to represent women whose husbands have never hit them, but who live in fear of doing something wrong—such as going outside the house and coming back after he has arrived, or talking to friends—and being punished. They fail to represent women who temporarily leave their houses and find somewhere else to sleep with their children when they see their husband coming home drunk, even if he has never hit her. If expectations and sanctions linked to social norms are strong,

people will engage in harmful practices such as isolation, or avoid healthy behaviors such as exercising, or will stay with a violent partner, despite their personal preferences.

Negative sanctions may not be observed in a community if the threat of them is strong enough to avoid the behavior (Mackie et al., 2015). Therefore, women complying with harmful and inequitable practices do not necessarily agree with them. It is likely that social sanctions for divergence—whether overt or covert—are too strong for them to take the risk. Social norms are hard to change. Many times, it is within movements for social justice that noxious gender norms can, and should, be contested as strongly as other social structures that cause injury to people (Galtung, 1969; Hernández-Castillo, 2001b; Speed, Hernández-Castillo, & Stephen, 2006). This was the case in the 1980s in the Southern region around Motozintla, and in the 1990s in Northern Indigenous Chiapas; but it is unclear if those social movements which advanced gender equity reached the people living in the deep Sierra mountains where CES is working.

HEALTH, RURAL FEMINISM, AND SOCIAL MOVEMENTS IN CHIAPAS

The effects of gender inequality in health have been widely studied. Access to contraceptives and safe abortion, and violence against woman—mainly intimate-partner violence (IPV) and sexual abuse (SA)—have received special attention in clinical and public health settings, due in part to their inalienable impact on reproductive and maternal health, and HIV transmission (Akyüz, Yavan, Şahiner, & Kılıç, 2012; García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005; Sen et al., 2007). While important, the focus of this approach on civil and political rights (protecting the individual's freedom from infringement by others, including government), has dismissed rural women's demands for social rights such as food, housing, education, and comprehensive healthcare (Hernández-Castillo, 2006), all of which are strong determinants of health. Likewise, public health programs directed to improve women's health focus almost exclusively on reproductive rights and obstetric healthcare, dismissing the fact that gender affects more organs and biologic functions than simply their reproductive ones (Krieger, 2003).

Chiapas has had several movements for social justice led by rural peasants, mostly but not exclusively identified as indigenous, in which women have leveraged political and social spaces of reflection to advocate for women's rights. Hernández-Castillo is a Mexican Anthropologist who has extensively studied social movements in Chiapas with a feminist lens, and has thoroughly studied sociopolitical change in the southern frontier of the state, close to where this study takes place. What follows is in great part drawn from decades of her and her colleagues' work in this region.

In the 1990s, indigenous women in Chiapas protested hegemonic urban feminism and called for a "feminism of diversity (*feminismo de la diversidad*)" (Hernández-Castillo, 2006, p. 58) that recognizes women's rights and fights for gender equity within different cultures and

social realities. The right to health and healthcare for they and their children—beyond reproductive and obstetric care—has been central to their struggles across the decades (Speed et al., 2006). Their movement for gender equality, not without tensions and conflicts, has maintained a focus on social rights without leaving out the right to live free of violence, voluntary marriage and maternity, and political representation within and outside of their own communities. At the same time, they have fought alongside men for the right to land, to cultural self-determination, and for political autonomy of their people and communities, against exploitative economic systems such as neoliberalism as well as against hegemonic processes of modernization that dismiss traditional practices (Hernández-Castillo, 2001b; Speed et al., 2006).

Still, dominant discourse and theoretical frameworks regarding gender inequality in Mexico underrepresent rural women. With the discourse focusing either on patriarchy—women's subordination to men due to social structures that facilitate and maintain men's control over politics and decision-making—or on capitalism—economic structures and the way they determine gendered division of labor resulting in men's control of economic resources—women at the margins frequently end up represented as passive victims deprived of agency under the heavy social-political or socio-economic structures that oppress them (Speed et al., 2006).

This representation contrasts sharply with testimonies of women's participation in social movements. In this southern Mexican state, indigenous women have been politically organizing since the 1980s, with the help of priests and nuns from the Catholic Church dioceses of San Cristobal, Tapachula, and Huehuetenago, Guatemala (Hernández-Castillo, 2001b) who followed the teachings of liberation theology. The economic crisis of the 1980s that resulted in structural adjustment—the reduction of public spending on health, education, agriculture government projects, and subsidies for fertilizers and staples—left the poor hungrier and sicker in the name

of international free-market politics (Speed, 2006). These priests and nuns organized spaces of reflection on inequality and oppression and although the events focused mostly on agrarian issues, women started sharing experiences of gender exclusion and gender-based violence (Hernández-Castillo, 2001b).

A decade later, on January 1, 1994, shortly after the signing of the North-America Free-Trade Agreement (NAFTA) during Salinas de Gortari administration, a second powerful peasant movement surged in the Highlands of Chiapas: the National Zapatista Liberation Army (EZLN) "Zapatista" revolt, which reclaimed the principles of the Mexican Revolution "justice, land, and freedom." Indigenous women were active participants in the revolt as well as in the politics of the movement (Toledo-Tello & Garza-Caligaris, 2006). Challenging the academic dichotomy of individual versus community rights, and of tradition versus modernity, they created the Women's Revolutionary Law which was presented to both the EZLN and the Mexican Congress. The law included the rights of women to political participation, a life free of violence, the right to healthcare for them and their children, and the right to work and salary. In Hernandez-Castillo's words: "It is a battle on two fronts: claiming from the sate the right to cultural differences and fighting within their communities to change the traditions that they see as infringements of their rights" (Hernández-Castillo, 2006, p. 66). Maylei Blackwell (2006) suggests that women's participation in social movements, in which they have interacted with state agents and other social actors, have spurred their ability to speak out for their rights and negotiate within their communities for a better social reality.

The experience of indigenous women in Chiapas may seem similar to that of black women in the United States, who have had to fight alongside black men against racism, while fighting against sexism and male violence against women within their communities, an

experience named *political intersectionality* by Kimberly Crenshaw (1991). Crenshaw has likewise coined the terms *Intersectional Feminism*—highlighting the effects that class and race have had on the differences of gender inequalities, and protesting white feminism that fails to recognize these differences—and *structural intersectionality*—emphasizing on the gendered experience of social, political and economic structures (Crenshaw, 1991). Still, this call for *feminismos de la diversidad* has not had the same impact that Black feminism has had in the U.S.

Women in rural Chiapas experience gender inequality very differently regarding their ethnic background, class, economic status, and degree of geographical marginalization. Contrasting with women in the Highlands of Chiapas, women in the scattered villages of the southeastern Sierra Madre bear along with their husbands and families the weight of a forgotten history, one which has limited their participation in the social movements described earlier.

Falling through the cracks of social-justice struggles in Chiapas

"No, it's not in the jungle. It's not an indigenous population. They are not Zapatistas. It's not close to Tuxtla, San Cristóbal, Comitán or Tapachula." I have learned this 10 second script for every conversation when it arrives at the uncomfortable moment in which I must say that I live and work in rural Chiapas. "Then, where are you at?" is usually what follows. "Close to anything, far from everything" is my way of closing the conversation if I don't have time, energy or hope in a conversation that will invariably include cultural ethnocide, social injustice, and neoliberalism.

Chiapas is popular for the indigenous Zapatista revolt in 1994, which was massively covered by national and international media and became an icon of anti-neoliberalist struggles. San Cristobal, the touristic capital and political hub for indigenous protests and social

movements, flooded with young and old national and international activists and non-governmental organizations (NGOs), including many healthcare and public health organizations as well as some feminists' ones. Meanwhile, in the Sierra Madre, hundreds of small scattered villages lived a different reality.

Far from Tapachula, Motozintla, and Siltepec municipalities, for women living deep in the Sierra mountains, there was no Women's Revolutionary Law, no struggle for cultural self-determination or autonomy, no space for reflection on inequality, and few opportunities for cultural and ideological exchange with other women. Instead, there is a history of constant geographical and cultural exile that has ripped them of their indigenous identity (Hernández-Castillo, 2012), possibly hampering their full participation in the peasants' movements that identify as indigenous movements, and their access to government and civil society support targeted at indigenous communities. The health sector is one that has several programs targeting indigenous populations that either do not reach this region, or are applied completely out of context. I remember being ordered to paste posters of vaccinations at our clinics in an indigenous language that is only spoken in northern Chiapas so that our clinics could fulfill "interculturality" requirements, or having to check the box of the indigenous population when reporting on my clinic's patients so that the health jurisdiction could receive more funding.

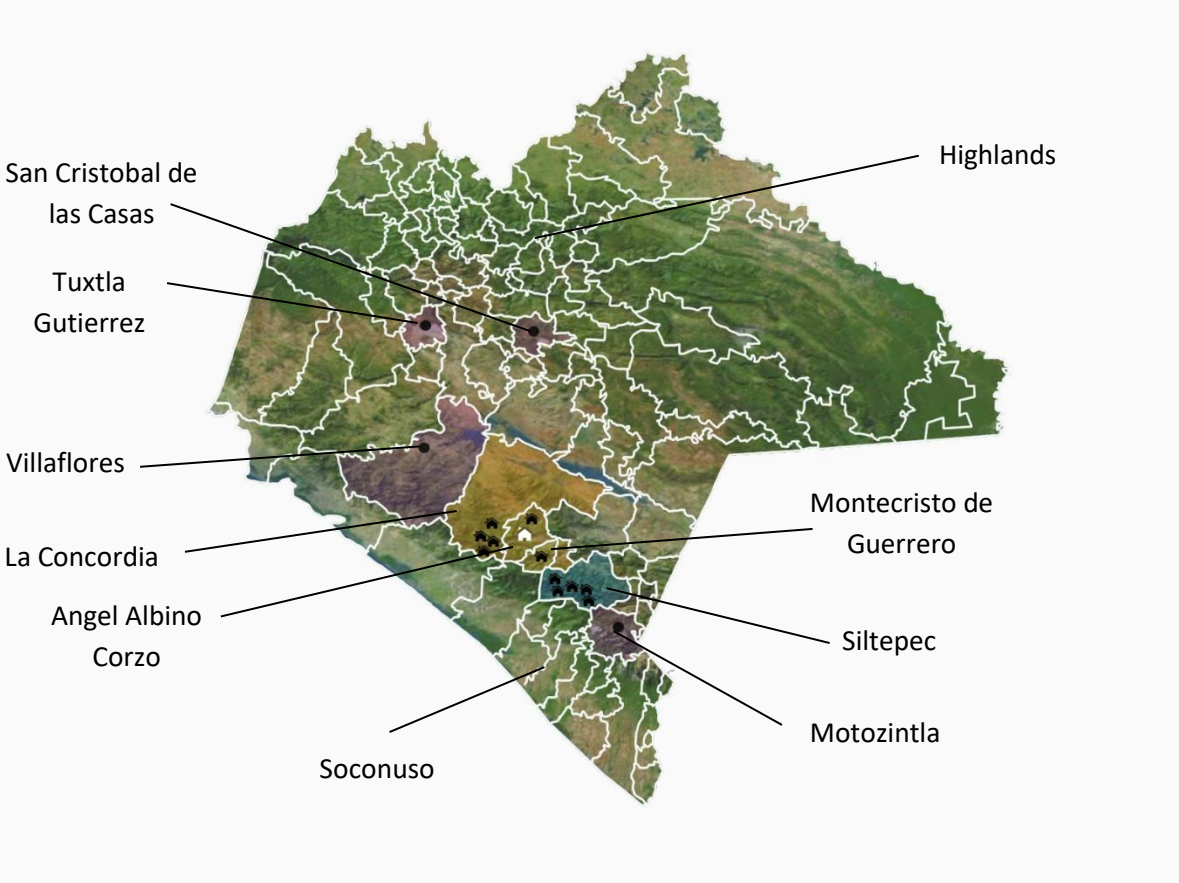

Image 1. *Municipalities where CES work (orange and blue areas), CES clinics (black houses), CES headquarters (white house), and municipalities where secondary and tertiary level care centers are located (purple areas)*

Besides inequality, the perception of the peasant poor as ignorant and vulgar also extends from Humboldt's times to modern Mexico. As Hernández-Castillo illustrates in her ethnography *Histories and Stories from Chiapas*, the government launched a national "modernization" campaign in the 1930s intended to unite the country in one Mestizo identity, to "civilize" indigenous peoples, and integrate them in the nation's economy. The national modernization campaign was violently enforced by government officials in the Sierra region close to the border with Guatemala to, in addition, foment nationalism. There, speaking indigenous languages was considered to represent not only cultural backwardness and ignorance, but also anti-nationalism.

Children and adults were beaten and humiliated if caught speaking them (Hernández-Castillo, 2001c), and people were forced to burn their traditional clothes. Today, people living in this region do not identify as indigenous, and even the oldest ones have a difficult time remembering their elders speaking a native language. It is not surprising to find today among the people of the Sierra Madre, overt racism, and mistreatment towards indigenous people from Guatemala and the Highlands of Chiapas despite most of them sharing their ethnic backgrounds.

In fact, during the 1870s, President Porfirio Díaz published the Colonization Law, which mandated indigenous people from the Highlands and from Guatemala, to relocate on free land close the border. This strategy had two objectives: to populate and therefore protect the border with Guatemala, and to provide the region with work force for the German and U.S. investors who were starting coffee plantations in the Soconuso fertile coast lands. The fact that coffee is the backbone of the region's economy is not accidental, as it was chosen by president Porfirio Díaz as a cash crop in the late 1870s for its growing international market and value (Barta, 1996; Hernández-Castillo, 2012).

By the 1900s, nine out of then indigenous peoples lived in the steep, less fertile, and uncommunicated lands, unsuitable for productive agriculture. Few families could subsist on their land, and needed money for food, clothes, and liquor. Foreign owners of the new coffee *fincas* needed people to work the land, and contracted men, many times merchants and liquor sellers, to *enganchar* (hook) indigenous people and peasants who lived in the highlands, to come to work for them. They would offer money in advance, sell them liquor, and then trick them to accept the jobs. The initial debt would continue for generations, perpetuating a debt system used during the Spanish colony to enslave workers and their families. Between the new colonizers and the *enganchados* (hoked) the owners of the coffee fincas had enough hands to make their

productivity flourish. Since then, coffee plantations have been central to peasants' identity and economy, with alcohol consumption closely related to being payed (Barta, 1996). How did the new labor system in the region change gender and family relations among indigenous people? Would women usually stay with small children in the house, cultivating the *milpa*—traditional corn and bean crops—while men traveled long distances to do the harsh work at coffee plantations? I have heard from the elders in the Sierra that some women did go to work at the fincas, but many of their grandmothers and mothers did not.

After the 1970s, anthropologists accused the government's nationalizing strategy as "cultural ethnocide" and the official discourse for peasant inclusion changed to a movement for a "multicultural Mexico," fomenting indigenous culture and traditions. This movement facilitated a space for cultural re-creation with active participation of the Catholic priests and nuns who followed liberation theology—which promoted direct service to the poor. During this period, several organic cooperatives were born, reclaiming Mam (the original ethnicity in the region) organic practices and technologies. One of the first coffee cooperatives, ISMAM (Spanish acronym for Indigenous people from Motozintla Sierra Madre), is still very present in the communities where CES is working. Due in part to participation at the workshops organized by liberation theologists, women who lived closer to Motozintla struggled within their communities for active participation in ISMAM. Many of them were heads of households due to their husbands' migration to the city or to the United States (Hernández-Castillo, 2001b). For women in the deep Sierra, however, the long distance to ISMAM headquarters, along with gender norms that restricted their movement since colonial times (Stern, 1997), as well as child-care obligations, may have hampered their participation in these spaces of reflection in ISMAM and other similar organizations. For them, community participation was limited to sporadic Catholic

workshops and retreats with their families, which albeit endorsing women's social participation and promoting recognition of their value within their families and communities (Hernández-Castillo, 2001b), did not improve their scarce political and economic participation within either of those two social spaces. Elizabeth Schüssler Fiorenza, feminist and Christian theologian, wrote in the 1970s about how liberation theology failed to be liberating for women, since it maintained the same androcentric views that were used to justify women's submission to men, and the restriction of their roles as helpers to men and rearers of children (Schüssler-Fiorenza, 1975). In contrast, since men own land almost exclusively—with only 5 out of 85 *ejidatarios* being women in the village where this study takes place—many of them did travel the long distances to participate in this and other similar organizations, and gained organizing, political and negotiation skills (Hernández-Castillo, 2001b).

Coffee Cooperatives are still abundant in the region and reduce harmful effects on the economy of farmers which depends on international fluctuations in the price of coffee; however, women seldom enjoy their benefits if not through the men in their families. Other than coffee cooperatives, it is hard to find civil organizations engaged in fighting for social and economic justice or providing services for the poor in this region. Not identified as indigenous, women do not participate in the National Indigenous Women's Congress or other assemblies that promote social justice and women's rights. Being "far from anything," the villages in the deep Sierra Madre are not an attractive place for tourism nor NGO headquarters, and since people do not identify as indigenous and do not have extra-ordinary religious and cultural practices—unlike the Highlands and the Jungle in Northern Chiapas—academics are not that interested either.

There are currently two non-governmental organizations at the region that focus on health and wellbeing: CES and Heifer International. While both work closely with women, employing

physicians, nurses and community health workers, and caring for women (including a birthing home)—none of them are actively struggling or advocating for gender equity, or against violence against women. Could CES act as a space for reflection in which harmful gender norms could be contested? Could CES Community Health Workers (CHW) programs, which employ and train more than a hundred women, be leveraged as a space for spurring political and negotiation skills for women in the region, or to advocate for gender equality? What role could the Catholic church and other growing Christian communities play? How could young men and women be engaged? What would be the role of community leaders? What challenges would be found, who would resist this effort, what has the community already done to address issues of intimate partner violence and sexual abuse? What are the social norms that maintain gender inequality and how are they related to women and men's mental health? This are all important questions to explore.

Violence Against Women and Mental Health: A Review of the International Evidence

While gender inequalities affect health through many different pathways, intimate-partner violence and sexual abuse are the most widely studied (García-Moreno et al., 2005, 2015). Shortly after rolling out the mental health program in 2014, it became evident that violence against women is a significant determinant of the burden of mental disorders in the region. Every year hundreds of women seeking care for depression at CES' rural health clinics report domestic abuse and sexual violence as primary contributors to their illness and suffering (Arrieta, 2015). These findings are consistent with international research that has established a bidirectional relationship between domestic and sexual abuse and mental disorders (Howard, Feder, & Agnew-Davis, 2013; Howard, Trevillion, & Agnew-Davies, 2010).

Mental disorders account for 32.4% of years lived with disability and 13% of disability adjusted life years according to recent estimates, placing them in the first position of the global burden of disease (Vigo, Thornicroft, & Atun, 2016). Mood disorders are the most common among mental disorders and have a gendered distribution cross-culturally (Kuehner, 2016; Riecher-Rossler, 2016). Women are twice as likely as men to suffer from depression (Kuehner, 2016). Researchers have sought to explain these differences through sex-related biological differences. Among those reported are differences in the stress response, differences in estrogen and progestin levels and effects (Kuehner, 2016; Parry & Haynes, 2000) —hormones found in higher concentrations among females, and used in contraceptive pills—as well as differences in concentration of serotonin, a neurotransmitter closely related to depression, and its receptors in female and male brains (Kuehner, 2016; Wizemann & Pardue, 2001). However, it has been acknowledged that a proportion of the gender gap might be attributable to gender role traditionality (Seedat et al., 2009), to unequal household labor division (Bird, 1999), and to higher exposure to adversity among females, including childhood sexual abuse and other forms of gender-based violence (Heim et al., 2000; Kuehner, 2016). Similarly, the higher prevalence of substance abuse disorders, including alcohol abuse, among males, has been linked to gender role traditionality—measured by the ratio of women to men in different elements such as participation in the labor economy, educational attainment, and age at marriage, as well as the proportion of women who used contraceptives before 25 years old (Seedat et al., 2009). Interestingly, the gap between male and female prevalence of mood disorders and substance abuse narrows in countries with more equal ratios and less adherence to gender roles (Seedat et al., 2009).

Health consequences of intimate partner violence include injury, chronic pain and gynecological syndromes, cardiovascular disease, unplanned pregnancies, and sexual dysfunction (García-Moreno et al., 2005; Howard et al., 2013). It should not come as a surprise that the World Health Organization finally recognized domestic violence as a public health concern in 1996. Violence from an intimate partner is positively associated with depression, post-traumatic stress disorder, and suicidality. This association is stronger as persistence and severity of violence increase. Generally, physical, sexual, psychological, and coercive types of violence overlap, and women who suffer more than one form of abuse also have greater risk of presenting a mental disorder than those who suffer only one form of abuse (Howard et al., 2010). Studies in high-income countries have reported that in clinical settings, women with depression have 2.7 times higher odds of suffering violence from an intimate partner, women with anxiety disorders 4 times higher odds, and women with post-traumatic stress disorder 7 times higher odds (Howard et al., 2013). Similarly, sexual abuse has been found to be among the strongest predictors of mental disorder, especially when suffered as a child, and are associated with neurobiological alterations in the stress-response system (Heim et al., 2000; Strong, 1998).These are strong reasons for making sure that mental health care services are equipped to address cases of intimate-partner violence and sexual abuse.

Violence against women is common worldwide. After several decades of feminist activism spurred by the American Women's Movement in the 1960s, the United Nations finally adopted the Declaration on the Elimination of Violence against Women in 1993, calling it a violation of human rights and an "obstacle for the achievement of equality, development and peace" (UN, 1993). Three years later, the WHO recognized the phenomenon as a significant determinant of health, calling for action from the public health community. Since then, multiple

studies have measured the epidemiology and consequences of violence against women in its various forms (García-Moreno et al., 2005; World Health Organization & London School of Hygiene and Tropical Medicine, 2010), with intimate-partner violence and sexual violence being the most widely studied.

Few scholars have sought to understand different kinds of violence from an intimate partner beyond its categorization as physical, sexual, emotional and economic. Michael Johnson (2008) , sociologist specialist on the subject, identifies three main typologies that can include all of the previous categories: *intimate terrorism,* in which the perpetrator controls his female partner (9 out of 10 perpetrators of intimate terrorism are men according to his studies), using violence as a mean to exert this control; *violent resistance,* in which is usually the response of a female victim to severe and chronic violence from her partner; and *situational couple violence,* in which one or both partners resort to violence in the context of conflict, but violence is not exercised to control the other. In cases of situational couple violence where female partners are also violent, men's violent events are often considerably more frequent and more severe, although variations may exist in different settings (Johnson, 2008). Although intimate partner violence can also be perpetrated by female partners and is not exclusive of heterosexual couples, for this work, I focus on intimate partner violence perpetrated by men against their female partners.

The importance of identifying different types of intimate partner violence in research and in practice lies in the fact that different typologies have different associated factors and would require different interventions. Cases of intimate terrorism are mostly found in shelters, justice agencies, emergency rooms, and mental health services, and often highly associated with depression, anxiety, and PTSD. Research studies from these places mostly illustrate intimate

terrorism. In contrast, cases of situational couple violence are the bulk of cases reported at demographic household surveys (DHS) and thus, analysis of DHS data that does not try to differentiate between these two types of violence from an intimate partner usually depicts characteristics of situational couple violence. Still, situational couple violence should not be underestimated since it can be as severe and frightening as intimate terrorism despite not including controlling tactics. Similarly, situational couple violence is associated with a high risk of mental health problems among those who suffer from it (Johnson, 2008).

According to Johnson, risk factors for these different types of violence can also vary. Life situations that increase conflict and stress, such as poverty, unemployment, disagreements about childrearing, and alcohol and drug abuse, increase the risk of situational couple violence. On the other hand, the number of children—possibly a proxy for family traditionalism, and the conception that the man should be the head of the family—low male education attainment, and having witnessed his father attacking his mother, are the main factors associated with being an intimate terrorist.

An intimate terrorist employs several controlling techniques such as stating that "his word is law . . . and she doesn't talk back" (Johnson, 2008, pg. 8), isolating his partner by restricting her movements and interaction with others, convincing her that she can't live without him, surveilling, and policing her behavior, minimizing his abuse, and legitimizing it by blaming the woman for not behaving as expected. After an event of physical and sexual violence, control tactics take on a new meaning as they announce the possibility of recurrence of such violent acts. For women who experience intimate terrorism, "[o]ne of the most important resources is other people—people who might help [her] understand what is happening . . . encourage her to resist or leave, or even offer financial and logistical support" (Johnson, 2008, pg.28). Sadly, men's

control over their female partner is supported by the same social norms that restricts women's access to social networks and social capital: norms that restrict their freedom of movement and community and political participation, and place childrearing responsibility solely on them; and norms that endorse that men have to be the providers and the authority at home (Rachel Jewkes et al., 2015; Rachel Jewkes, Morrell, Sikweyiya, Dunkle, & Penn-Kekana, 2012; Johnson, 2008; Roberts, 2009). For the many women in this situation, the primary care provider may be their only social resource.

It has been shown around the world that patriarchal beliefs—male power over women and acceptability of violence against women for transgressing their assigned roles—are significantly related with wife battering. Physical abuse is usually a sign of a less visible persistent psychological and coercive violence. Coercive control—through abusive emotional intimidation, threats, and withholding social and resources—predicts physical and sexual violence from an intimate partner (Stuckless, Toner, & Butt, 2015; Terrazas-Carrillo, McWhirter, & Martel, 2016; Woodin & O'Leary, 2010). Power and control—whether social, political, in decision-making, or economic—is the pathway that links patriarchy to violence against women. Studies in Mexico and in developed countries have found that women who suffer coercive violence frequently present depression, anxiety, sleep problems, and chronic headache (Terrazas-Carrillo et al., 2016).

The role of alcohol abuse as a causal or facilitating factor of violence against women is still debated in the academic field with some stating that its biochemical effects on cognitive functions affect impulsive behavior control and alters judgement of perceived social threats (Klostermann & Fals-Stewart, 2006), facilitating aggressive responses. Furthermore, being drunk may be socially accepted as a "time out behavior" in which men are condoned of not behaving

properly (Kaufman Kantor & Straus, 1987). Others suggest that the social norms that endorse alcohol abuse among men, could be the same that facilitate violence against women, as well as other predisposing factors (Kaufman Kantor & Straus, 1987; Klostermann & Fals-Stewart, 2006). In the words of Kaufman-Kantor and Straus, "[m]en who are concerned about demonstrating their masculinity may try to accomplish this symbolically by drunkenness, by dominance over women, and by the exertion of physical force on others" (Kaufman Kantor & Straus, 1987, pg. 224). Still, although high alcohol abuse and binge drinking are strongly associated with intimate partner violence, several studies indicate that less than half of violent actions are preceded by alcohol consumption (Johnson, 2008; Kaufman Kantor & Straus, 1987). There are no studies comparing the association of partner-alcohol abuse with intimate terrorism and situational violence, but Johnson mentions partner alcohol abuse as a common cause of conflict within the couple (Johnson, 2008).

Traditional public-health and law-enforcement approaches to address violence against women are mostly targeted to severe physical and sexual violence, and rely on the victim reporting to law enforcement agencies and other institutions. Other approaches that aim to increase female power within the household, include income generating, and micro-credit programs targeted to women. However, these have only shown promising results in a couple of interventions which also aim to transform social norms that place women as subordinate to men, engaging different gender and age groups in the community (What Works, 2014; World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Similarly, in the U.S., interventions mandated by courts and directed at perpetrators have shown a small effect (5%) in reducing recidivism of violent behavior. Programs that have higher positive effects are those that address patriarchal attitudes, power dynamics in a relationship, anger management,

communication and relationship skills, and, in some cases, alcohol abuse (Babcock, Green, & Robie, 2004). Could these interventions work for one type of violence, but not the other? We lack research to fully understand the answer to this question.

There is less information about what works to address sexual abuse. Until the late 1990s, sexual abuse had not been of interest to biomedical researches, regarded solely as a social issue (Strong, 1998). It is now known that this extremely traumatic experience has profound effects on the brain's structure and function, the stress response, the functionality of the immune system, and even causes molecular changes to DNA (Heim et al., 2000; Kuehner, 2016). Furthermore, child sexual abuse is the highest risk factor for mental disorders, even higher than having both parents with schizophrenia, and closely related to chronic and hard-to-treat conditions like self-injury, borderline personality disorder, post-traumatic stress disorder and dissociative disorders (Strong, 1998). Worldwide, girls experience 10% higher prevalence of sexual abuse than boys (Kuehner, 2016). Girls are not only more likely to be sexually abused than boys, moreover, those cases of abuse are also more likely to be raped (Frías & Erviti, 2014).

Why are some men violent against women and girls? Despite the key role of patriarchy as enabler of intimate partner violence, and non-partner sexual violence, these forms of abuse cannot be fully explained by patriarchy alone (L. Heise, 1998). Even when sharing social and economic contexts not all women are victims, and not all men are violent. Donald Dutton, a clinical psychologist and expert on intimate partner violence, has highlighted the important role that psychological and other individual factors play in violence perpetration (Dutton & Nicholls, 2005). Nonetheless, it is still important to consider the structural determinants that place men in a position of privilege and power over women, to avoid fully attributing to the individual what is in fact imbedded in the social system (Heise, 1998). Likewise, as mentioned earlier, it is

important to differentiate different typologies of intimate-partner violence as cases of intimate terrorism and situational couple violence have different associated factors and therefore may respond to different interventions. As an example, couples therapy should never be done in cases of intimate terrorism, but could be useful in some cases of situational couple violence (Johnson, 2008).

To have a better understanding of the complexity of factors that influence domestic and sexual abuse, Lori Heise (1998) proposed in the 1990s to apply the ecological model, an approach applied in the late 1970s to child abuse and later to youth violence (McLeroy, Bibeau, Steckler, & Glanz, 1988; Radford, Allnock, & Hynes, 2015) . The model describes causes and risk factors within four different influence spheres that are closely interrelated: 1) individual sphere: age, mental health, childhood adverse experiences, education; 2) situational sphere: elevated stress and lack of resources to deal with it, poverty, unemployment; 3) community: disparities, poverty, violence, gender norms and expectations, gender inequality; and 4) society: cultural values and beliefs (i.e. patriarchy) embedded in institutions, that permeate the other levels, and affect individual behavior (García-Moreno et al., 2005; L. Heise, 1998).

Cross-cultural individual risk factors have been described for both victims and perpetrators of partner and sexual abuse (E. Fulu et al., 2013; García-Moreno et al., 2005). Overall, victimization is strongly associated with younger age, orphan hood (for child sexual abuse), lower education, lower socioeconomic status, mental disorders and disabilities, alcohol and drug abuse, having witnessed domestic violence as a child, and having suffered childhood physical or sexual abuse (García-Moreno et al., 2005; What Works, 2014). Holding beliefs supportive of violence against women and high-role traditionality—such as men's provider role—have also been reported to be associated with suffering partner violence or sexual abuse

(Rachel Jewkes et al., 2012; Rachel Jewkes, Sikweyiya, Morrell, & Dunkle, 2011; What Works, 2014). According to a national survey conducted in public healthcare settings in Mexico, 3 out of 10 women believe that a good wife must do what her husband say even if she does not agree, 2 out of 10 believe the man should actively make clear that he is the boss, and 8% believe that it is a wife's duty to have sex with her partner even if she does not want to (Olaiz, Uribe, & Del Rio, 2009).

It has been found that cross-culturally perpetrators are more likely to have suffered physical and sexual abuse themselves during childhood, have witnessed domestic violence as children (however, most children who witness or suffer domestic violence do not grow up to be violent husbands (Johnson, 2008)), experience poverty and food insecurity, suffer from depression and substance abuse, and are less empathetic than non-perpetrators (Fulu et al., 2013). Likewise, attitudes and behaviors related to identification of masculinity with dominant ideals—gender inequitable attitudes, controlling behavior, multiple sexual partners, transactional sex, sexual entitlement, and being violent outside the home (Fulu et al., 2013; Jewkes et al., 2012, 2011), have also been associated with intimate partner and sexual abuse perpetration.

Violence Against Women and Mental Health in Mexico and Chiapas

After two years of caring for women with depression in rural Chiapas, it became clear to me that any attempt to improve women's mental health must include efforts to prevent, detect, and address violence from an intimate partner (including sexual violence), and non-partner sexual abuse. The narratives women told me about their illness were plagued with stories of either or both forms of abuse, and they identify them as root causes of their ailments. Likewise, they associate their partner's alcohol abuse with poverty, family conflict, and wife battering

(Arrieta, 2015). Their experiences are not exclusive to this remote mountainous region in Chiapas. A recent National Survey on the Dynamics of Relationships at Home (ENDIREH, *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares*) reports that in Mexico almost half of women suffer violence from an intimate partner, with most suffering emotional and economic violence, and 17.9% and 6.5% having experienced physical or sexual violence respectively (INEGI, 2018). Similarly, different representative national studies report that between 6.6 and 13.3 % of women have been sexually abused before the age of 15 (S. M. Frías & Erviti, 2014; Olaiz et al., 2009). A recent study using data from the Mexican National Survey about the Relationship Dynamics inside Homes (ENDIREH), a national representative household-based survey, found that 44% of the variance in depression symptoms scores was explained by intimate partner violence, gender role attitudes, and coercive control (Terrazas-Carrillo et al., 2016).

It is important to consider that gender power dynamics do not only exist between individuals. Instead, the social context is gendered in a way that shapes intimate partner violence and sexual abuse, and the way it is experienced and addressed by the victim, by her social network, and by the authorities. In the Sierra region, women very rarely own land, and often do not take part in the main economic activity—coffee growing—nor in the political activity that organizes around it. Furthermore, the few women who do own land rarely participate in community decision-making. This fact together with the scarcity of wage-paying jobs in the region makes woman economically dependent on the men in their family, be it husband, father, brothers, or sons. In this context, even situational couple violence can generate terror at the possibility of doing something wrong and being abandoned. Moreover, gender norms that give responsibility of childrearing encourage women to stay in an abusive relationship for their sake.

These expectations are supported by Catholic and Christian religions in the region, like the Pentecostal and Presbyterian churches. Likewise, gender norms that encourage alcohol abuse in men and link masculinity with dominance and control, help normalize abuse especially if it happens under the influence of alcohol (Kaufman Kantor & Straus, 1987).

In Mexico, it is expected by society that women face with dignity the normalized burden of a violent life in marriage. *Marianismo*, defined by political scientist Evelyn Stevens (1973) as "the cult of feminine spiritual superiority which teaches that women are semi-divine, morally superior and spiritually stronger than men," illustrates the culture around female gender roles in Mexico. The term arises from the nation's devotion to the Virgin of Guadalupe, *nuestra madrecita* (our beloved mother), born in colonial times when she appeared as a dark-skinned virgin upon Juan Diego, an indigenous evangelized peasant. The Guadalupe Virgin has been a symbol of cultural syncretism and Mexican identity that transcends class and ethnicity. The Guadalupe devotion has been associated with an ideal of purity, moral superiority, endurance, and service placed upon women since their early teens: "[n]o self-denial is too great for the Latin American woman, no limit can be divined to her vast store of patience with the men of her world" (Batt, 1969). *Marianismo* is regarded as "the other side of Machismo"(Stevens, 1973), the Mexican hegemonic masculinity characterized by being the bread winner, evident heterosexuality, aggressiveness, control over women, and alcohol abuse. Machismo has been described in research (Gutmann, 1998), and literature (Paz, 1950), and is illustrated in contemporary popular music, as well as being easily experienced in every-day life.

Although intimate-partner and sexual abuse cuts through ethnicity, class and socioeconomic status, poor women and girls suffer exceptionally. The disadvantages or privileges of belonging to certain gender, class, and race groups intersect on an individual's lived

experience, either increasing or reducing her risk of victimization, her access to support and services, and her capability to leave the situation (Crenshaw, 1991). Structural violence (Galtung, 1969) is defined by Farmer as the way in which the "political and economic organization of our social world . . . cause injury to people" (P. E. Farmer, Nizeye, Stulac, & Keshavjee, 2006). Based on this definition, gender inequity is a form of structural violence, irrespective of poverty. Gender inequity with poverty, exacts a burden of multiple forms of structural violence on women in rural Chiapas, constricting women's ability to protect their own physical and mental integrity (Farmer, 2003).

An example of structural violence is the scarcity of means to earn money for women, due to an *ejidal* system that favored male ownership of land at its conception after the 1910 Mexican Revolution. At that time landless peasants, tired of the abuses they suffered on the *fincas* and plantations, organized to claim ownership of the land they worked. After the 1930s, half of landless farmers had been granted land that was expropriated from private, wealthy owners, foreigners, and Mexicans. In her ethnography *Mastering the Struggle: Gender, Actors and the Agrarian Reform in a Mexican ejido*, Dorien Brunt (1992) illustrates the exclusion of women in this process. Only women who were single mothers or widowed head-of-households could petition land (Hernández-Castillo, 2012). Furthermore, the political practices mediated by male brokers who had special relationships with influential male politicians or administrators, permitted male farmers to access the state's offerings through favoritism, but not women. The highly bureaucratic processes to claim the right to land required writing a petition in paper, and long journeys to administrative offices in the capital cities on repeated occasions. Women since colonial times were not permitted to travel without close supervision of a patriarch (Stern, 1997) and would, therefore, stay at home while men engaged in such burdensome processes.

Consequently, men became *ejidatarios*—those entitled to land and what is produced from it—and became the legal decision-making unit for the *ejido:* the *ejidal* assembly. To date, women in this region do not have a voice in political and economic community affairs. Whenever there is violence between husband and wife, or cases of sexual abuse, the elected assembly president (*agente rural)* or judge (*juez rural*) has the power to enforce or bend the law. Due to their social networks, or family relations with other *ejidatarios* and elected authorities, the law usually bends in men's favor. Men can be held in the community jail for one to three days after beating his wife, or after sexually abusing a girl, or only pay a small fine (around $30 USD), and that is considered enough.

Without land and without job opportunities in the marginalized small scattered villages of the Sierra Madre, women, legal, and police services are inaccessible for women. In addition, when a woman can reach the governmental agencies, the staff is often non-responsive, or perpetrate violence themselves (Alcalde, 2011; S. Frías & Erviti, 2014). Nationally, only 2 out of 10 victims of domestic and sexual violence seek their help (Frías, 2013). This national mean may overestimate reporting rates in rural regions where reporting abuse may not only be dismissed by authorities, but may actually run counter to the victim's own safety and that of her children if they have nowhere else to go (Frías, 2013).

Interestingly, of all Mexican states, the ENDIREH report the lowest prevalence of violence from an intimate partner in Chiapas (29%). Could it be that despite striking poverty and a long history of oppression and violence towards farmers, whether identified as indigenous or not, Chiapas has indeed lower rates of violence against women? Or could it be that the instruments for the ENDIREH, does not reflect the lived experiences of women in this particular state?

In Chiapas, as well as in most Mexican states, women who hold non-traditional gender roles are at higher risk of being victimized than those with traditional roles, especially if their partner holds patriarchal beliefs and attitudes, those that support male economic and political control, and women's subordination to men. Traditional gender roles are not limited to cooking, washing, and childrearing, but include harmful norms such as "a good wife must obey his husband in all that he orders" and "it's a woman's obligation to have sex even if she does not want"(Frias, 2008).

To illustrate, except for women who live in Mexico City—the most gender equal state in Mexico—having a job, which would be a non-traditional gender role, not only does not protect women against gender-based violence, but in fact puts them at greater risk of abuse (Frias, 2008). This finding resonates with literature that states that projects that focus on income generation are rarely enough to empower women in a context of strong inequitable gender norms and roles (Fulu, 2017).

The role that gender norms play in facilitating violence from an intimate partner, sexual abuse, and other forms of violence against women has been evidenced in the public health arena, mainly through HIV prevention programs. Programs that acknowledge gender norms and engage the community in self-reflective and critical thinking processes about those norms have shown promising results proven in reducing violence against women in rural areas and urban dwellings (Jewkes et al., 2014; 2015).

Notwithstanding, e*jidatarios* do care about the health and wellbeing of their families and their communities. In various communities in the Sierra region, the *ejidal* Assembly has voted to prohibit alcohol commercialization and consumption because drunk men disturb community peace, whether it is because they fight with people in the streets, or because their wives complain

of partner violence to the local authorities. However, cases of violence against women that are not related to alcohol consumption and community disturbance, and are less visible, and seldom addressed by local authorities. This illusionary division of the public and the personal has been contested by feminist activists for over half a century, who endorse that the public—social and political—is embodied in women's personal lived experience of oppression and abuse (Walby, 1991; Eisenstein, 1999).

In Mexico, a national representative survey estimates 6.7% of high school students suffers sexual abuse before 18 years old, likely an underestimation of the true burden, since completion of secondary education is a protective factor, and high school enrollment is still low nationally and especially in Chiapas, where only 16.4% of the population had completed high school in the 2015 census (INEGI, 2015). A different national survey conducted on public health care centers reported that 13.3% of women seeking healthcare had experienced sexual abuse before age 15. The proportion of women older than 15 years old who have ever been victims of either intimate partner or non-partner sexual abuse, ascends to 1 in 4 nationally, as well as in Chiapas (INEGI, 2015).

Only 7–10% of sexual abuse cases that are not accompanied by physical violence are reported to law enforcement and government agencies throughout the country. The low reporting rate may be related to fear of not being believed, feelings of shame, blame and guilt, safeguarding family honor and stability, and mistrust in authorities. It may also be related to the fact that 80% of abusers are first or second-degree family members or neighbors, with which the child and the family have close relationships. In the Mexican culture "cohesion . . . of groups and family unit are often considered more important than the individual" (S. M. Frías, 2013; S. M. Frías & Erviti, 2014). This may be especially true in impoverished communities where social

capital—the value placed in social networks, trust in those social networks, and the willingness to do favors for people in them (Saguaro Seminar, 2016)—can be life-saving in the case of a medical emergency or other acute situations in which immediate availability of cash or transportation is crucial, and can only be accessed through that social network.

As was discussed before, historically, social networks have facilitated land acquisition for men; currently, they soften punishment by local authorities for abusers in rural Chiapas. Of note, local authorities are three to five *ejidatarios*, chosen by the rest of the *ejidatarios* every one to three years, who are in charge of maintaining community peace, and facilitating community development. Local authorities are the bridge of the community with the State. Social capital has been found to be protective of mental disorders when it is measured as individual social capital but not when it is measured at the more general societal or structural levels (Ehsan & Silva, 2015). This could be because individuals within a community may have different access to social capital. A gendered distribution of social capital has been reported in undocumented immigrants in the U.S., with men having access to a wider and more diverse social network through their occupations than women, who are frequently isolated in domestic labor (Hagan, 1998). What role does gendered access to social capital play in the way that intimate partner violence and sexual abuse are addressed by men and women in CES catchment area?

Traditional public-health and law-enforcement approaches to address violence against women are mostly exclusively targeted to severe physical and sexual violence, and relies on the victim reporting to law enforcement agencies and other institutions. But nationally, only 2 out of 10 victims of domestic and sexual violence seek their help (S. M. Frías, 2013), with rural communities probably having considerably lower reporting rates due to higher geographical, economic and cultural barriers. The low reporting rates of intimate-partner abuse to law

enforcement agencies, and social and healthcare institutions have been attributed to fear of not being believed, shame, blaming by society and self-blaming, perpetrator's undermining of the victim's credibility, and mistrust in institutions professionalism and ability to help (S. M. Frías, 2013; L. Howard et al., 2013).

There is no accurate information on the number of cases of intimate-partner violence and non-partner sexual abuse reported to law enforcement agencies in the region where CES is working, but the health jurisdictions to which CES' clinics correspond have some of the lowest rates of violence from an intimate partner detected at the primary health care level. The highest corresponding to the center and the highlands, where most governmental and no governmental services are provided (Instituto Nacional de las Mujeres, 2008). This phenomenon cannot be interpreted as women in the Sierra region suffering less from intimate-partner violence. Rather, it could suggest that women in the Sierra region are aware of the dearth of effective services accessible for them at law enforcement, social, and health institutions, and thus do not seek their help.

Violence Against Women and the State

Chiapas is Mexico's poorest state. One out of ten families had gone hungry in the last three months in 2010. More than half of the population lives in rural communities, where the breathtaking landscapes contrast sharply with the poverty of more than two thirds of the population (CONEVAL, 2012; Instituto Nacional de Salud Pública, 2013). The Sierra is a highly marginalized, mountainous region where the main economic activity consists on coffee plantations. Additionally, people grow corn and beans for self-consumption, rarely enough for families to subsist on.

Adding to the burden of economic disparity and class and ethnic discrimination, gender inequality further afflicts women's lives. During the nationalization campaign women were forced to strip and burn their clothes in front of the community, and the *ladinos* (Hernández-Castillo, 2001b, pg. 26)—the white government officials. Meanwhile, leaders of the movement discussed the vitality of changing the indigenous culture that severely punished—sometimes with death, indigenous women who procreated with *ladinos*. This, in their eyes, prevented the "enhancement" of the Mexican race.

A couple of decades later, the new generation of anthropologists denounced the nationalization approach as "ethnocidal," and advocated for a multicultural Mexico where indigenous identities and costumes would be respected and protected by law. Under this multicultural framework, the indigenous customary law (*Ley de usos y costumbers*) was created to protect the traditional community organization of the indigenous peoples, including this previously de-indigenized region. Customs protected by the law include the selection of their own community and legal representatives, and the creation of local laws through consent of the community assembly—conformed almost exclusively by men *ejidatarios* (Hernández-Castillo, 2001a).

In pre-capitalist societies, men, women and children of the family worked together. This was also true before the *enganchamiento* became popular, and before the creation of the *ejidos* (Barta, 1996; Hernández-Castillo, 2012). Although women were still mothers and raising children, their work was not limited to their sexual roles. Industrial capitalism took men "out of the home and into the wage-labor economy" (Eisenstein, 1999), leaving women to perform exclusively their sexual roles as housewives, which since is not producing capital, is not considered work. Although patriarchy precedes capitalism, there is a mutually reinforcing

relationship between them. Patriarchy facilitates sexual division of labor and "provides a sexual hierarchical ordering for political control" (Eisenstein, 1999).

The Mexican anti-poverty cash transfer program *Prospera* (which evolved from 1997 *Progresa* and the later *Oportunidades*) operates through the patriarchal structure of society, since it relies on housewives to perform the obligations related to health, nutrition, and education of the family, reinforcing gender roles in the name of economic development (Molyneux, 2006). Furthermore, although crucial in reducing food insecurity and in increasing enrollment in primary and secondary education reducing the education gap between girls and boys (OECD, 2008), *Prospera* easily turns into a weapon for oppression and abuse in the context of a patriarchal society. I have witnessed nurses threatening mothers with taking away Prospera if their malnourished children do not gain weight for not complying with their health obligations, as dictated by social norms that make women fully responsible of childrearing and nutrition.

Public health programs that *focus* on women's health literacy as a means for attaining family health and community development incur in patriarchal attitudes anytime that failure to achieve outcomes is regarded as the woman's personal failure to fulfill her gender roles and ensure the health and development of her children (Molyneux, 2006), without considering the paucity of options that arise from both impoverishment and violence against women. I have also witnessed women suffering domestic violence who do not leave their community because they are too afraid to lose *Prospera*—which would cause deeper impoverishment, if they cannot come back every month to fulfill their obligations.

The first law to address domestic violence in Mexico was enacted in 1996 (S. M. Frías, 2013). But it was until 2003 that the Law of Access to a Life Free of Violence for Women specified the State's obligation "to ensure that customs and practices in all sectors of society do

not violate human rights and individual guarantees of [women]" (Gobierno del Estado de Chiapas, 2009). Before that, the indigenous customary law—valid in most of rural Chiapas—overruled the 1996 law against violence against women. Furthermore, twenty years after the 1994 Zapatista movement, this indigenous group, along with the National Indigenous Congress, endorsed an Indigenous woman—María de Jesús Patricio Martínez—to run for Mexican presidency in 2018. Since the Zapatistas uprising, the highlands of Chiapas have become an international icon of anti-neoliberalism struggle, and home to hundreds of NGOs that advocate for social justice—some more pragmatically than others. Among these are NGOs that have partnered with researchers and anthropologists to advocate for women's rights and provide services for victims of gender-based violence.

Women in the Sierra region, however, far from the touristic hub, dispossessed of their indigenous identity, and not interesting enough for national and international revolutionary youth, have not benefited from the influx of human rights and social justice advocates to the state. It is precisely here that *Compañeros En Salud (CES)*, Partners In Health sister organization, decided to place their headquarters in 2011.

Study Proposal

I argue that attempts to improve women's mental health in this study setting and other similar settings, should include efforts to prevent, detect, and address domestic and sexual violence (L. M. Howard et al., 2010). Similarly, to address domestic and sexual violence, interventions need to engage in the active transformation of noxious gender norms (García-Moreno et al., 2005; L. L. Heise, 2011; What Works, 2014). Internationally, traditional public health and law-enforcement approaches to reduce violence against women have focused on

severe physical violence and sexual abuse, without considering coercive control, different typologies of intimate partner violence, or different contexts in which the abuse occurs. Furthermore, these approaches usually depend on women's reporting to either healthcare providers or police services, and placing a demand against the abuser, with significant barriers for poor women who live in marginalized areas.

These approaches do not engage in transformation of social norms that perpetrate and normalize violence, and rely on several assumptions that do not hold true for women in rural Chiapas: a) that the woman can press charges (which depend on availability of money, long-distance transportation, a place to stay, childcare, responsive police and legal agencies), b) that pressing charges is on her best interest, and c) that violence will stop after separation. For the women and girls in rural Chiapas, as for others around the world, these assumptions are far from reality. In fact, the next months after a separation from a violent partner are the most dangerous for a woman. Two thirds of women who are killed by their partners, are killed when the woman attempts to leave or has left the relationship (Stuckless et al., 2015). A recent study with a national representative sample reports that in Mexico, more than half of women continue to experience violence after separating from their partner (S. M. Frías, 2013).

Most of the time women who suffer severe domestic violence must (Stuckless et al., 2015) choose among terrible options: 1) separate and lose economic security (especially relevant if there are young children in the family), be stigmatized in the community with consequent loses on social network support which can be crucial in medical and economic emergencies, and face threats from the partner; or 2) continue facing terror, humiliation, beatings, rape, and risk of death.

Amartya Sen, the Noble-prize winning economist and philosopher, and Martha Nussbaum, American philosopher, have extensively argued about the importance of focusing on capabilities. In her article, "Capabilities as Fundamental Entitlements," Nussbaum (2003) defines capabilities as "what people are actually able to do and to be" (1). Rather than exclusively focusing on economic growth, taking Nussbaum's approach means we should instead measure development and quality of life. Nussbaum has elaborated on the capabilities approach as applied to the struggle for gender equity (Nussbaum, 2003). Promising results of a few interventions that have reduced violence against women through transformation of gender roles (Heise, 2011; Jewkes et al., 2014; What Works, 2014) suggest that this approach could help unlock, for impoverished women and girls, the central capabilities proposed by Nussbaum—namely: 1) ability to not die prematurely or have one's life reduced as to be not worth living (as happens with severe depression and suicidal ideation); 2) ability to have good health, including reproductive health, and adequate (and safe) shelter; 3) ability to move freely from place to place and be secure against violent assaults; 4) ability to enjoy experiences and avoid harmful pain; 5) ability to not live in fear and anxiety; 6) ability to reflect critically about one's life and plans for the future, and to hold a conception of the good that is not shattered by the abuse of those who are supposed to be loving and caring (like parents, partners, and close relatives); 7) ability to feel equally worthy than others, to be treated with dignity and to have self-respect; 9) ability to play and enjoy recreational activities; 10) ability to participate in political choices that affect their life and to hold land and other material and economic property (Nussbaum, 2003).

Knowledge gaps exist in how to engage men in the transformation of gender norms (What Works, 2014). Most interventions have been evaluated through changes in attitudes and behaviors but the actual reduction in violence against women has not been measured.

Furthermore, follow-up periods tend to be short, and changes in social norms and behaviors require a long time. Compañeros En Salud follows the accompaniment model of her sister organization Partners In Health (PIH). As Paul Farmer, physician anthropologist and PIH co-founder, explains:

> [t]o accompany someone is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end . . . The companion, the accompagnateur, says: 'I'll go with you and support you on your journey wherever it leads; I'll share your fate for a while. And by 'a while,' I don't mean a little while.' Accompaniment is about sticking with a task until it is deemed completed, not by the accompagnateur but by the person being accompanied" (Farmer, 2011).

To follow the accompaniment model means that CES is committed to stay in the Sierra region for the long term, and thus, the organization has the potential to implement an intervention that aims to transform gender norms and measure long term outcomes.

The objective of this thesis is to conduct a formative research to inform the design of a community-based intervention to address domestic violence and sexual abuse in non-indigenous rural Chiapas. Moving forward from regarding men as solely perpetrators, to engaging them in the transformation of norms and social structures that privileges them while harming women has been effective in Africa and Latin America (Barker, Ricardo, Nascimento, Olukoya, & Santos, 2010; E. Fulu et al., 2013; L. L. Heise, 2011; Rachel Jewkes et al., 2015; World Health Organization & London School of Hygiene and Tropical Medicine, 2010). Through epidemiological and anthropological research, this thesis aims to generate evidence to design an intervention to prevent domestic and sexual violence in non-indigenous rural Chiapas. Because women's access to health, legal, and protection services are restricted by gender norms in this

setting, I seek to generate evidence on the scope of the problem, and the role of gender norms and roles play in violence against women, to inform on how to engage men and women in the transformation of noxious gender norms. This, with the objective of alleviating their own distress, reducing gender inequality, and protecting both women and children from further abuse.

I will conduct a mixed methods convergent study. The quantitative phase will permit a comprehensive understanding on the scope of the problem: prevalence of intimate partner violence and sexual abuse, help seeking choices, coercive control, opinion on gender roles, personal freedom, and other associated factors. The qualitative phase will be conducted through individual interviews with adult women and men, adolescents of both sexes and local civil and religious authorities, as well as through participant observation of naturally occurring groups. These methods will permit me to deeply understand social and gender norms that prevail in the region, and how are they constructed and maintained in the communities where CES works, as well as the every-day experiences of living under rigid traditional gender roles, experiences of violence during childhood and experiences of violence perpetration. Through understanding what really matters to them I expect to be able to inform the design of an intervention that could succeed in engaging both men and women of different ages to unlock capabilities for women and girls, and boys and men, to enjoy freedom, and to be kept physically and psychologically safe.

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The reality that women face in rural Chiapas and similar impoverished settings around the world is far from the reality of white middle class women in developed countries (Crenshaw, 1991), and has been so for almost half a century. In the 70s, a group of social feminists from the Chicago Women's Liberation Union wrote:

> [O]ur oppression is different from that of our sisters at the turn of the century who had no legal rights, were confined to the home, and bore children from maturity to death . . . women were denied of their own sexuality because of social attitudes, inadequate birth control, the shelter of the family, women's private role in the economy, and the lack of knowledge about their bodies.

This remembrance from the past written more than 40 years ago, is still the every-day life experience for women and girls in rural Chiapas, who have yet to claim with conviction: "our bodies, ourselves."

Part 2. Depression symptoms, intimate-partner violence, and non-partner sexual abuse in rural Chiapas: A mixed-methods study and implications for Global Mental Health practice

1. Introduction

Compañeros En Salud (CES)—a non-profit partnering with Chiapas' Ministry of Health—rolled out mental health services in 2014. Soon after, care providers recognized that intimate partner violence (IPV), non-partner sexual abuse (SA), and isolation due to gender norms that restrict women's activities to the household were significant contributors to women's burden of mental disorders (Arrieta, 2015). This paper aims to portray a) the scope of IPV (physical and sexual), partner's controlling behaviors (CB), and SA in the region where CES is working, b) the gender norms and roles that prevail and the way those shape lived experiences and experiences of violence and distress for women and men. To answer these questions in depth, we designed a modified convergent-parallel mixed-methods study in one rural community where CES provides mental health services.

Mental disorders are the leading cause of disability worldwide, accounting for 32.4% of years live with disability (YLDs). Depression is responsible for 25% of the YLDs due to mental disorders (Vigo et al., 2016). Considering this burden, there is limited access to mental health care, particularly for low- and middle-income countries (LMICs) (WHO, 2014). Less than 75% of individuals with mental disorders had received adequate treatment in 2008 (WHO, 2008). To reduce the treatment gap, the WHO has called for integration of mental health services in primary care (World Health Organization, 2008). A recent study in rural Chiapas showed 7.9% prevalence of depression in primary care clinics with women having over twice the prevalence than men (Elliott, Aguerrebere, & Elliott, forthcoming.). Since 2014 CES has been working to provide evidence-based mental-health treatment in rural primary care clinics. The program

includes active-case finding, screening with PHQ-2, clinical diagnosis and follow-up monitoring with PHQ-9, and medical and cognitive-behavioral-therapy based psychosocial treatment managed by general physicians and community health workers. The program receives bi-monthly remote supervision from specialists. With this model, CES has provided mental health care for over a thousand patients in highly marginalized communities over the last couple of years (Arrieta, 2015; Compañeros En Salud, 2017; Elliott et al., n.d.).

Social determinants of mental illness

Researchers have sought to explain differences in depression prevalence between male and female through sex biological differences in the stress response, such as estrogen and progestin levels (Kuehner, 2016; Parry & Haynes, 2000), and different concentration of serotonin and its receptors in female and male´s brain (Kuehner, 2016; Wizemann & Pardue, 2001). Still, it has been acknowledged that a proportion of this sex difference might be attributable to rigid gender norms and roles (Seedat et al., 2009), unequal household labor division (Bird, 1999), and higher exposure to adversity among females, including childhood sexual abuse and IPV (Heim et al., 2000; Kuehner, 2016). At the same time, over the last decade research has shown that adverse childhood experiences (ACEs), such as witnessing IPV, experiencing physical, psychological or sexual abuse as a child, and having a parent with a substance abuse disorder or a mental illness, can change the structure and physiology of the brain (Chapman et al., 2004; Teicher, Anderson, & Polcari, 2012), increasing the risk for mental disorders in adulthood—including depression, substance abuse, and suicide attempts (Merrick et al., 2017). ACEs also increase a woman's risk of suffering IPV or sexual abuse as an adult, as well as the likelihood of marrying an alcoholic, which could further increase the risk of suffering

IPV. (Dube, Anda, Felitti, Edwards, & Croft, 2002). Alcohol abuse and binge drinking are strongly associated with intimate partner violence—although several studies indicate that less than half of violent actions are preceded by alcohol consumption (Johnson, 2008; Kaufman Kantor & Straus, 1987).

Differentiating intimate partner violence

Violence from an intimate partner, however, is not always the same. Michael Johnson (2008), a sociologist specialist on the subject, identifies several typologies: a) intimate terrorism (IT)—in which the perpetrator controls his female partner (9 out of 10 perpetrators of intimate terrorism are men according to his studies), using violence as a mean to exert this control; b) violent resistance—which is usually the response of a female victim to severe and chronic violence from her partner; and c) situational couple violence (SCV)—in which one or both partners resort to violence in the context of conflict, but violence is not exercised to control the other. In cases of situational couple violence where female partners are also violent, men's violent events are considerably more frequent and more severe. Although IPV can also be perpetrated by female partners and is not exclusive of heterosexual couples, for this work, we focus on intimate partner violence perpetrated by men against their female partners.

Partner-controlling behaviors are usually included in economic or emotional violence categories, which are regarded as a less severe forms of violence than physical and sexual violence. Consequently, the later forms are the ones addressed by health, social and legal services. The role of partner control however, is crucial in women's experiences of violence, has a negative impact on their mental health, and restricts women's liberty, autonomy and equality (Stark, 2009).

Furthermore, not differentiating between SCV and IT may be the reason why studies that evaluate the effect of conditional-cash transfers, income generating programs, and alcohol abuse treatment programs on IPV have found mixed results (Angelucci, 2008; Buller et al., 2018; Emma Fulu, 2017; Klostermann, Kelley, Mignone, Pusateri, & Fals-Stewart, 2010; Molyneux, 2006). SCV and IT may require different interventions: for a woman suffering SCV, couple therapy could work, as well as income generating projects; however, for a woman suffering IT, these same interventions could be harmful (Frias Martinez, 2008; Fulu, 2017; Johnson, 2008).

Contextualizing IPV and mental health

Experiences of violence do not happen in a neutral context. Society is gendered through the social norms expected to be fulfilled by individuals according to their sex (gender norms). Social norms are what people in a group believe is a typical or an appropriate action within an important reference group, and are maintained by positive or negative sanctions which can be overt (i.e., jail, fines, public punishment), or covert (i.e., attitudes, reputation, gossip) (Mackie et al., 2015).

In rural Chiapas, women are often exclusively dedicated to housework, caring for family and isolated within their households—which along with poverty, migration, substance abuse and experiences of violence, has been associated with depression in Mexico (Berenzon, Lara, Robles, & Medina-Mora, 2013). In addition, gender norms that uphold the man as the provider and highest authority at home, restrict women's freedom of movement, speech, and political participation, and place housework and child-rearing responsibilities solely over women are prevalent in rural Chiapas, and have been associated to IPV and SA elsewhere (Rachel Jewkes et al., 2015, 2012; Stark, 2009). For women who live confined and marginalized due to restrictive

gender norms, poverty, and intimate terrorism, the primary care provider may be their only social resource.

Furthermore, research suggests that the social norms that endorse alcohol abuse among men, could be the same that facilitate violence against women (Kaufman Kantor & Straus, 1987; Klostermann & Fals-Stewart, 2006). While biochemical effects of alcohol on cognitive functions hampers control of impulsive behavior, and alters judgement of perceived social threats (K. C. Klostermann & Fals-Stewart, 2006)—which could trigger IPV in the context of otherwise inconsequential conflict—social norms can accept this impulsive behavior while drunk as a "time out behavior" during which men are condoned of exerting IPV (Kaufman Kantor & Straus, 1987). While there are no studies comparing the association of partner-alcohol abuse between intimate terrorism and situational violence, Johnson mentions partner alcohol abuse as a common cause of conflict within the couple (Johnson, 2008). Conflict, however, could be a result of a man's failed attempts at controlling his female partner in a society ruled by unequal gender norms.

Despite the high prevalence of social determinants for mental illness and in Chiapas, only four psychiatrists were working in the Ministry of Health in 2017 (García-Morales, Gutiérrez-Martínez, Rodríguez Álvarez, & Cifuentes Tovilla, 2017), serving the poorest 35% of the 5 billion people who live there (Secretaría de Salud, 2010). Moreover, despite the high prevalence of risk factors for violence against women, Chiapas has some of the lowest reported estimates of IPV in the country. This might be a reporting bias that could be partially attributed to language barriers, lack of trust in interviewers, and lack of contextual relevance of certain questions. Still, three out of ten women who are 15 years and older have reported experiencing physical, sexual

or emotional intimate partner violence, and one out of ten have reported experiencing sexual abuse (INEGI, 2018; Instituto Nacional de las Mujeres, 2011).

Since more primary care providers are being expected to care for mental health illnesses around the world, training in recognizing and responding to SCV, IT and SA, and their risk and protective factors, is necessary to provide adequate care. To our knowledge, no studies in Mexico have evaluated different types of violence as classified by partner controlling behaviors nor their relation to mental health. To improve the mental health services provided at the primary care level, we conducted a mixed-methods convergent parallel study with the aim of understanding the scope and associated factors of IPV, CB, and SA in non-indigenous rural Chiapas, and to contextualize experiences of violence victimization and perpetration in relation to gender norms and roles, and individual lived experiences.

2. Methods

Study design

A mixed-methods modified parallel-convergent design was used, with quantitative findings informing the qualitative sampling of women, but not of other participants. To increase validity and depth of our findings, quantitative and qualitative evidence was triangulated, identifying areas of convergence and divergence of results. Data were analyzed separately and merged for interpretation.

2.1. Quantitative methods and data analysis

Quantitative sampling and recruitment

We conducted a cross-sectional survey between July and August 2017, in a rural community of about 1200 inhabitants in Chiapas, Mexico. Inclusion criteria included being female, at least 15 years, and a current resident of the community. Exclusion criteria included a) known or suspected hearing impairment, language problems, or cognitive impairment and b) having another member of the household participating (to ensure confidentiality). To select participants a list of households with women 15 years and older was obtained from the health clinic database. Households in the list were numbered and randomly selected. Eligible women within each selected household were numbered and randomly selected. A total of 159 eligible women were selected. When a selected woman had moved, died, did not fulfill inclusion criteria, or met exclusion criteria, the next household in the randomly-ordered list was selected. Again, eligible women within that household were numbered and randomly selected. In the end 289 households were selected to reach a target of 159 eligible women. Of those 159 women, 18 did

not arrive to the survey meeting after rescheduling twice; 141 women were surveyed (89% response rate).

Quantitative data collection and measurements

The survey was conducted by the PI and three female trained research assistants using tablets and Commcare® software, after informed consent was obtained. Interviews were conducted in a private room where the conversation could not be overheard. Tablets were password protected and kept at a secure location. Data were removed from the tablets after completion of data collection. Measures are described below.

Intimate partner violence

Lifetime and one-year prevalence of physical and sexual violence from an intimate partner, as well as lifetime partner-controlling behavior, were measured using a locally adapted version of a questionnaire used for the 2011 ENDIREH (Castro & Casique, 2014), a national demographic household survey that measured violence against women. Physical and sexual violence from an intimate partner were used to measure IPV. The questions on economic violence and controlling behaviors (sometimes labeled as emotional violence) were used to measure partner control (CB).

Sexual abuse

Lifetime and one-year prevalence of non-partner SA was likewise measured using a modified, locally adapted version of the sexual abuse section in the ENDIREH questionnaire. Sexual abuse was labeled positive when participants answered yes to at least one of the following questions: did someone other than your partner ever a) touched your body without your consent, b) proposed you to have sexual relationships in exchange for money or something

you wanted/needed, c) punished or mistreated you for having denied sexual propositions, d) forced, or pressured you with words, to have sexual relationships when you did not want to, or attempted to do it. Rape and attempted rape were measured together with the last question.

Depression

Depression symptoms were screened for using 2 screening questions for depression of the Patient Health Questionnaire (PHQ-2). If a response was positive for either of the PHQ-2 questions, the PHQ-9 questionnaire for depression was applied. The PHQ-2 and PHQ-9 questionnaires have been previously validated for screening, diagnosis and follow-up of depression in this specific population, with good psychometric properties (internal consistency with Cronbach's alpha coefficient = 0.81, and good predictive validity) (Arrieta et al., 2017).

Partner alcohol abuse

Measurements of partner alcohol abuse were gathered asking women the frequency with which her partner got drunk: never, less than once a month, at least once a month but less than every week, at least once every week. This measurement method was selected considering women's scarce knowledge on partner alcohol consumption quantity in this setting.

Other measurements

Measurements of social support and opinion on gender roles were collected for secondary analysis based on the ENDIREH questionnaire. Age, years of schooling and educational attainment, age at first cohabitation, number of children, average age of children in the household, family income, participation in governmental conditional-cash-transfer program *Prospera* (CCT), food insecurity, land ownership, self-employment, and hours spent in housework were documented to evaluate for associations. Food security was measured with three questions: over the last 12 months have you 1) worried that food would not be enough for you

and your family? 2) bought food but it did not last and there was no money to buy more? 3) did you or someone in your family has had to eat less or skip meals because there was not enough food? Food insecurity was considered positive when two out of three questions were positive, following the methods used by Semali and colleagues (2011) in another low-resource rural areas.

Quantitative analysis

We first conducted a descriptive analysis of socio-demographic data using frequencies and percentages for categorical data, and median and interquartile ranges continuous data. Second, lifetime and one-year prevalence of IPV and SA were calculated with point estimates and 95% confidence intervals, both aggregated and stratified by type (IPV: physical, sexual; SA: sexual abuse, and rape/attempted rape). Lifetime prevalence of partner controlling behavior was likewise calculated. Frequency of physical, sexual and controlling violent events was measured as follows: happened once, happened sometimes (*algunas veces)*, happened many times *(muchas veces).*

For a more conservative measure of IPV, women who reported having experienced one of the following violent acts once (n=21) were labeled as not experiencing IPV: pushed, hit, pulled by the hair, or had an object thrown at her. Partner sexual violence which was labeled as IPV regardless of frequency of events. Severity of IPV—physical and sexual—was categorized as low, moderate or severe. Categories were created through a combination of frequency of violent events and severity of events: being kicked, tied-up, choked, attacked with a machete, or a gun where considered severe regardless of frequency; being pushed, pulled by the hair, slapped, hit, or have objects thrown at her where defined as follows: a) low severity when events happened once, b) moderate severity when events happened sometimes, and c) high severity

when events happened many times. Similarly, being coerced to have sex, or forced to do sexual things while having sex was categorized as follows: a) low severity if it happened once, b) moderate severity if it happened sometimes, and c) severe if it happened many times. In the case of intimate partner rape, it was considered a) moderate severity when it happened once, and b) severe when it happened more than once.

Control level was categorized as a) high with more than 4 controlling behaviors reported (highest tercile), b) moderate with 1– 4 controlling behaviors reported, and c) none with no controlling behaviors reported. High-control IPV (HC-IPV) and moderate-control IPV (MC-IPV) categories were created to reflect Johnson's suggested categories of Intimate Terrorism and Situational Couple Violence, respectively. IPV was labeled as MC-IPV when a) severity was low, and control was none or moderate, b) when severity was moderate and control none or moderate, and c) when severity was severe and control none. HC-IPV was labeled when a) severity was low and control high, b) when severity was moderate and control high, and c) when severity was high and control moderate or high. To calculate relative risks, each category of IPV was compared with the reference point of no IPV.

Relative risk estimates for different types of violence (IPV, MC-IPV, HC-IPV, SA) was calculated for each socio-demographic characteristic. To measure associations between demographic data and different types of violence, Chi-square or Fisher exact tests—whenever the n in each cell was $\leq$5—were used for binary and categorical variables, and Wilcoxon rank sum test for non-parametric continuous variables. Likewise, Chi-square or Fisher exact tests were used to measure the association between IPV, MC-IPV, and HC-IPV, with depression and partner alcohol abuse; the same tests were used to measure the association of SA and rape/attempted rape with depression.

Partner alcohol abuse was categorized as a) no alcohol abuse if a woman reported her partner does not drink, b) low alcohol-abuse if a woman reported he gets drunk less than once a month, c) moderate alcohol abuse if she reported he gets drunk more than once a month but less than once a week, and d) high partner alcohol-abuse when she reported he gets drunk at least once a week. To calculate relative risks, each category was compared with the reference point of no alcohol abuse.

Depression PHQ-9 scores were categorized as low symptoms if the score was $\geq$5 and <10, and moderate-severe symptoms if the score was $\geq$10. To calculate relative risks, mild symptoms were compared to zero or minimal symptoms (PHQ-9 score <5), and moderate-severe symptoms were compared to low and minimal symptoms (PHQ-9 score <10). The latter categorization was used to compare those with symptom levels comparable with depressive disorder versus those who did not have this level of symptoms (Arrieta et al., 2017).

2.2. Qualitative methods and data analysis

Qualitative sampling and recruitment

Interviews: Inclusion criteria for adults was limited to age > 18 years and current residence in the community, inclusion criteria for adolescents included being 15-17 years and current residents in the community. Exclusion criteria for all participants included known or suspected hearing impairment, language problems, or cognitive impairment. Adult male participants were selected through purposeful sampling considering age and reputation in the community (i.e. humble, tough). Adult women participants were selected through purposeful sampling to ensure IPV and SA experience variability based on the survey results (n=8), as well as through snowball sampling considering age and singularity (i.e. employed) (n=2). Adolescents were selected

through snowball sampling considering reputation among teachers and peers (i.e. calm, restless). Informed consent for adults, and informed assent for adolescents, was obtained in a private room where the conversation could not be overheard. Parental consent was waived to protect adolescents who might have experienced abuse from a family member. The PI and two research assistants interviewed 40 individuals using a semi-structured interview guide: 10 adult women, 10 adult men, 11 adolescents, five religious authorities and four local civil authorities. Participatory observation: leaders of the Alcoholic Anonymous (AA) group and the *Legion de Maria* Catholic religious group were approached and asked for consent to observe their gatherings and take notes after explaining the study objectives (to understand how being a woman of being a man affects mental health in this community) (García-Moreno, 2001).

Qualitative data collection

The interviews and observations explored the gender norms and roles than prevail in this community, how male and female relate to each other within and outside of the family, and the way those norms and roles shape the experience of IPV, SA and experiences of emotional distress. After obtaining informed consent, interviews were conducted in a private room at a date and time accorded with the interviewer. Interviews were audio recorded, transcribed, and analyzed in Spanish. Interview excerpts were translated by the PI (bilingual) for illustration of qualitative findings. Audio recorders were erased after transcription and transcripts were saved in password protected computers.

Participatory observation: The PI and two research assistants conducted a total of 7 observations of meetings with the AA group, and a 48-hour non-AA spiritual retreat suggested by the AA group. Similarly, participatory observations were done in four Catholic religious

gatherings. At any point, one to three researchers were conducting these observations. Participatory observations provided the opportunity to observe social phenomenon and learn more about the relational aspect of gender and mental health in a naturalistic setting. Attention was focused on gender norms, gender beliefs, and gender expectations, as well as to gendered experiences of psychological distress. Observations were handwritten or typed, transcriptions where password protected.

Only sex and age were recorded in transcripts or field notes, but not names or other personal identifications. All data collecting instruments were kept in a secure place upon completion of analysis.

Qualitative analysis

Individual interviews were analyzed through an inductive, content-focused approach with category construction, comparison and interpretation. The PI and a trained research assistant open coded a subset of interviews to create a codebook, the codebook was piloted and revised. The final codebook was utilized to direct code the entire data set with the qualitative analysis software Atlas.ti.8®. The resulting coded data were examined by the PI to identify emerging themes. The PI engaged in an iterative process, returning to the data set to define and revise the initial thematic categories and come up with final thematic categories. This iterative process resulted in five cross-cutting themes about which three different generations speak in a distinct way. Each key thematic category is therefore divided into these three generations to compare their distinct experiences. Data from ethnographic field notes taken during participatory observation helped contextualize the results of the individual interviews and better relate data from different age and gender groups.

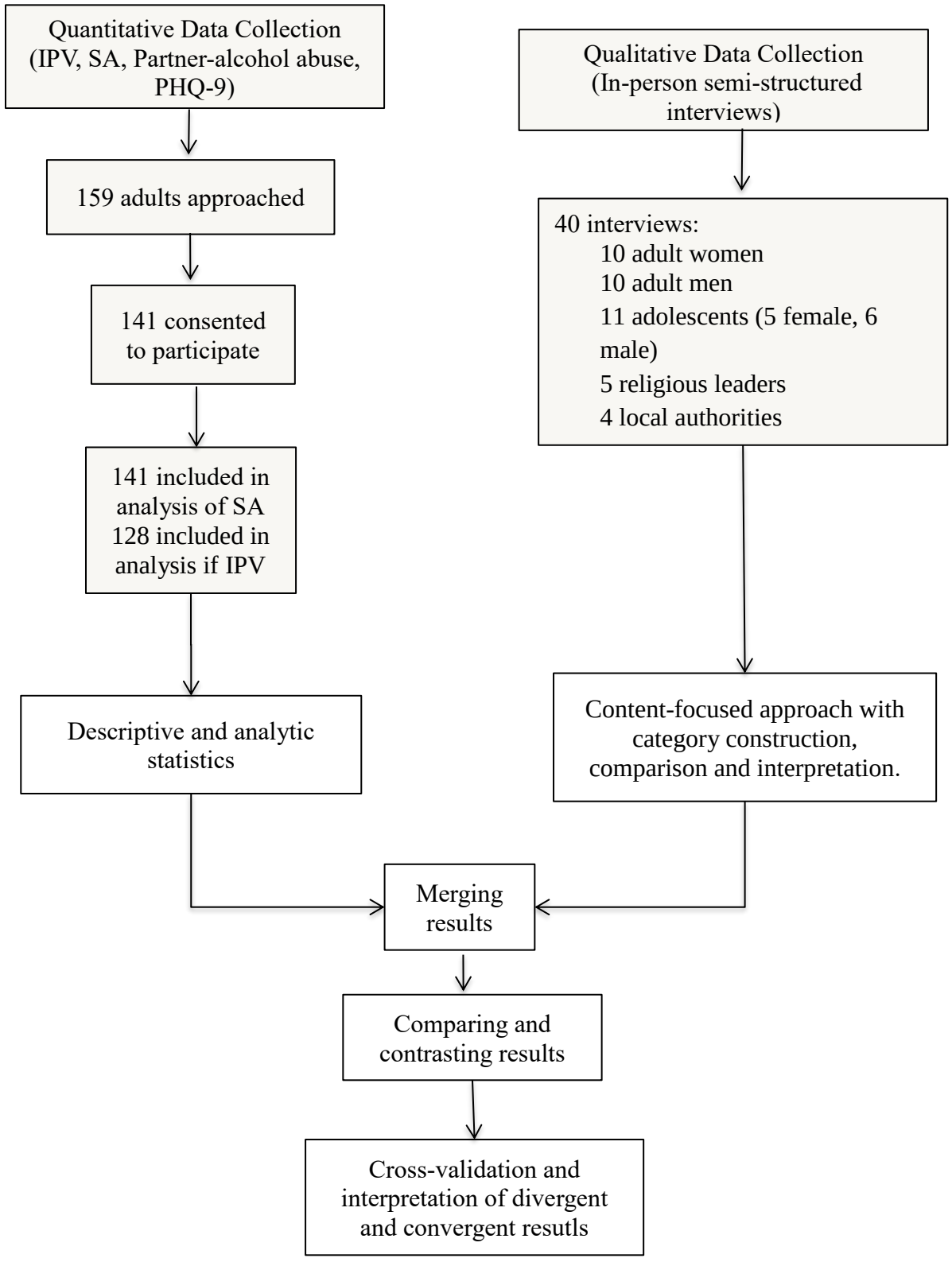
Mixed methods analysis

Quantitative and qualitative data were compared, areas of divergence and convergence were identified for final interpretation. Data from the qualitative phase contextualizes the significant and non-significant associations found in quantitative data, while quantitative data help illustrate the scope of the experiences narrated by the qualitative data. In this way, results are presented in a real life dynamic context where opportunity for health delivery improvement, and health and social interventions, can be found.

Human subjects approval

The study design followed the WHO "Ethic and Safety Recommendations for conducting research on Domestic Violence Against Women" (García-Moreno, 2001). The protocol received ethical approval from the Institutional Review Board of the Harvard Medical School Office of Human Research Administration and the Chiapas Health Institute. All adult participants provided verbal informed consent, all adolescents provided verbal informed assent.

Figure 1. *Study Diagram*



3. Results

3.1. Quantitative findings

Sociodemographic characteristics

Table 1 shows the demographic and socioeconomic characteristics of the study population. Of the 141 women 15 years of age and older interviewed, 77.3% knew how to read and write, and 53.9% had completed primary school or more. The median age of participants was 32 (IQ 26 – 45) years, the median age at first cohabitation was 18 (16 – 21), and the median number of children participants had had was 4 (IQ 2 – 5). Among cohabitating women 56.3% live in their partner or in-laws house, and 26.6% reported the house was hers, either exclusively (11.7%) or along with her partner (14.8%). The rest lived with their parents or other relatives; data on house ownership in **table 1** shows the aggregate of all participants, including those who are single. In terms of economic characteristics, 92.7% of cohabitating women's partners work in coffee-crops, 6.7% of women who reported their partners worked at coffee crops, reported that they were not the coffee-crops was not owned by the man or his family. In the case of women, 22% reported having spare cash available in case of need, 12.1% owned land, and 21% had a small business. However, of those who have a small business only 16.7% (n=5) reported having spare cash available in case of need. Surprisingly, only 69.5% of the interviewees' receive support from *Prospera*, and only 44% receive cash from other governmental programs such as *Procampo* (for agricultural development) and *Conafor* (to assure environmental protection). Finally, close to one in three families faced food insecurity during the 12-monts before the study was conducted.

Table 1. *Demographic and socioeconomic characteristics of the study population*

(n=141 unless otherwise specified)	**Median (IQ) / n (%)**
DEMOGRAPHIC	
Age	32 (26-45)
Lliteracy	109 (77.3%)
Years of education completed	6 (2-9)
Level of education	
None	33 (23.4%)
Primary School	32 (22.7%)
Middle school	36 (25.5%)
High School	7 (4.9%)
College	1 (0.7%)
Civil status	
Single	13 (9.2%)
Civil marriage	3 (2.1%)
Religious marriage	24 (17.0%)
Cohabitating	81 (57.5%)
Separated/divorced	7 (5.0%)
Widowed	11 (7.8%)
Age at first cohabitation[a]	18 (16-21)
First cohabitation before 17 years	39 (31.2%)
Have children	91 (90.8)
Number of children	4 (2-5)
Number of children in household	2 (1-3)
Average age of children in household	7.5 (5-11)
0-5	30 (21.3%)
5-10	41 (29.1%)
> 10	30 (21.3%)
SOCIOECONOMIC	
Partner works on coffee[b]	102 (92.7%)
In his own land	93 (91.2%)
In family land	7 (6.9%)
For others	7 (6.9%)
Number of sacks of coffee (57 kg) produced last year	5 (2 – 9)
Last year's income from coffee (MXN)[c]	11750 (4600-19000)
Equivalent in USD PPP/family/day[d]	3.7
House ownership	
Her own home	15 (10.6%)
Partner	52 (37.0%)
Both	19 (13.0%)
In-laws	20 (14.2%)
Father	17 (12.1%)[+]
Other	18 (13.0%)[+]
Women's access to financial resources	
Own land	17 (12.1%)
Small business	30 (21.3%)

Cash availability	31 (22.0%)	
None	73 (51.8%)	
Social programs and support		
Prospera	98 (69.5%)	
Other government programs	62 (44.0%)	
Remittances	24 (17%)	
International	17 (12.1%)	
National	7 (5.0%)	
Food insecurity[e]	38 (27.0%)	
	At least once a month	Almost every day
Worried that there was not enough food for herself and her family	18 (12.8%)	24 (17.0%)
Bought food but was not enough and did not have money to buy more	12 (8.5%)	7 (5.0%)
Someone in the family had to skip meals or eat less because there was not enough food	8 (5.7%)	7 (5.0%)

[an] Ever-partnered women n=128; [b] Women currently cohabitating with partner n= 111; [c] Among women whose partner works in coffee n=102; calculated with OECD 2017 published rates; [e] two out of three of the statements below positive during the past 12 months, even if less than once a month.

Prevalence of IPV

Lifetime prevalence of IPV in the study sample was 49.7% (95% CI: 41.1-58.2%) and one-year prevalence 22% (95% CI 15.5-29.7%). When restricting the calculation to ever partnered women, prevalence went up to 54.7% (95% CI 45.6-63.6%) and 24.2% (95% CI 17-32.3%) respectively. When quantifying physical and sexual IPV separately, lifetime prevalence of partner physical violence resulted in 48.4% (95% CI 39.5-57.4%) and partner sexual violence in 25.8% (95% CI 18.5-34.3%) respectively, among ever partnered women. For a comparative of these findings, see **Table 2.**

Table 2. *Lifetime and last-year prevalence of IPV types among ever partnered women (n=128), and lifetime and last-year prevalence of SA among women 15 years and older (n=141)*

	Lifetime prevalence (95% CI)	Lifetime prevalence among ever partnered (95% CI)	One-year prevalence (95% CI)	One-year prevalence among ever partnered (95% CI)
Physical IPV	44% (36-53%)	48.4% (39.5-57.4%)	20% (13.6-27.4%)	22% (15-30%)
Sexual IPV	23.4% (16.7-31.3)	25.8% (18.5-34.3%)	5.7% (2.9-10.9%)	6.3% (2.7-11.9%)
Physical and /or Sexual IPV	49.7% (41.1-58.2%)	54.7% (45.6-63.6%)	22% (15.5-29.7%)	24.2% (17-32.3%)
Non-partner Sexual Abuse	30.5% (23.0-38.8%)	---	6.4% (3.0%-11.8%)	---
Non-partner rape/attempted rape	11.3% (6.6-17.8%)	---	2.8% (0.7-7%)	---

Likewise, partner controlling behaviors (CB) resulted to be highly prevalent, with one in three (95% CI 23.4-40.0%) ever partnered women having experienced more than four controlling behaviors from their partners, and 35.2% (95% CI 26.9-44.8%) having experienced between one and four. Interestingly, 17% of ever partnered women in the sample had experienced some form of control, but no physical or sexual IPV (see **Graph 1)**. Of these women, most reported being constantly humiliated or accused of being unfaithful; only one reported high control from her partner and no physical or sexual partner violence.

Prevalence of SA

As illustrated in **Table 2**, sexual abuse from a non-partner was also highly prevalent, with 30.5% of the study sample having experienced at least one episode of non-partner sexual abuse throughout their lifetime, and 6.4% during the last year. When considering only rape/attempted rape, 11.3% of women 15 years and older reported lifetime exposure, and 2.8% during the past

12 months. The median age of women when rape/attempted rape first occurred was 17 years (IQ 12-20), with the youngest girl being 11 years when this happened. However, the median age of women when they were first touched or fondled without their consent was 12 (IQ 10-20), with the youngest girl being 5 years when this happened.

Factors associated with IPV

An association of lifetime physical IPV was found with women being 16 years or younger at the first cohabitation. This association showed a 1.4 higher risk of suffering physical IPV (95% CI 1.0-2.0), but not with lifetime sexual IPV. Likewise, women who finished elementary school were shown to have a 0.7 times lower risk (95% CI 0.4 -0.9) of having had suffered lifetime physical IPV than those who did not finish elementary school, but the risk of having had suffered sexual IPV is not different between them. Moreover, spending more than 12 hours in housework (highest tercile) increased the risk of physical IPV by 1.5 times (95% CI 1.1 - 2.1), and the risk of sexual IPV by 1.7 (95% CI 1.0 – 3.1). Partner coffee-land ownership was strongly associated with 0.5 times lower risk (95% CI 0.3 – 0.8) of suffering sexual IPV ($p<0.01$), and with a 0.7 times lower risk (95% CI 0.5 – 1.0) of suffering physical IPV ($p<0.05$).

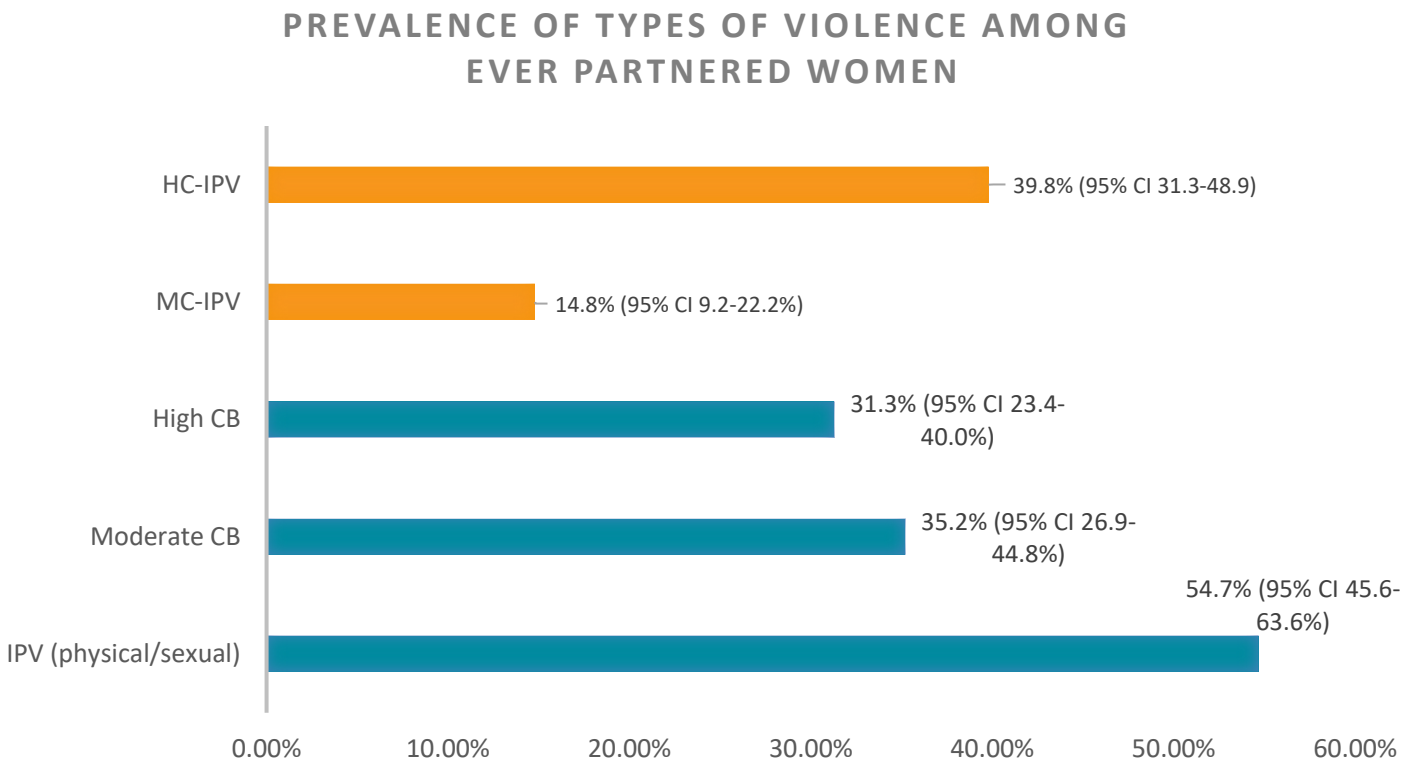
Together, lifetime IPV physical and/or sexual was shown to be positively associated with older age, no primary school completion, women self-employment, spending more than 12 hours a day in housework, and partner alcohol abuse; in contrast, it was negatively associated with partner coffee-land ownership, younger age, and having completed primary school. In subgroup analysis HC-IPV retained the same associations except for spending more than 12 hours on housework and self-employment which were marginally significant ($p<0.1$), and gained significance for age at first cohabitation $\leq$16 years. In contrast, MC-IPV only retained

significance with working more than 12 hours, self-employment and partner alcohol-abuse (see **table 3)**.

Partner coffee-crop ownership also reduces the risk of partner high CB and of partner high alcohol abuse. Bivariate analysis shows that partner coffee-crop ownership reduces the risk of high CB by 0.5 ($p<0.01$), and the risk of partner high alcohol abuse by 0.3 times ($p<0.01$). Multivariate analysis shows that when adjusting for high CB and high partner alcohol abuse, coffee-crop ownership is not associated with IPV. Moreover, after adjusting for coffee-crop ownership, the odds ratio of suffering high control if a partner engages in high alcohol abuse is reduced from 6.9 higher odds, to 4.6 higher odds. Therefore, the relationship between coffee-crop ownership and IPV might be a result of the association of coffee-crop ownership with a reduced risk high partner alcohol abuse and partner CB.

In contrast, the association between spending more than 12 hours in housework and IPV was retained after adjusting for alcohol abuse and controlling behaviors. This result should be interpreted with caution since it could be that women suffering IPV are spending more hours in housework to avoid triggers of violence.

Graph 1. *Types of violence among ever partnered women*



In blue, partner degree of controlling behaviors (CB) are represented irrespective of physical or sexual IPV. Likewise, physical/sexual IPV is represented irrespective of CB.
In orange, MC-IPV and HC-IPV are proposed as different categorizations of violence which include physical, sexual and controlling violence.
IPV: intimate-partner violence; HC-IPV: IPV with high partner control, IPV-MC: IPV with moderate partner control; CB partner controlling behaviors.

Another important difference between MC-IPV and HC-IPV is the experience of partner sexual abuse. Interestingly, only 15.2% of women who had experienced MC-IPV reported partner-sexual abuse, while 84.9% of women who had experienced HC-IPV. After analysis, women who had suffered HC-IPV presented 2.1 higher risk of partner sexual violence than those who had suffered SV-IPV ($p<0.05$).

Differences on the association of IPV with opinion on gender roles were also found between MC-IPV and HC-IPV. The risk of experiencing MC-IPV was 0.4 times lower (95% CI 0.2-1.0; $p = 0.06$) when believing that a woman is always free to choose her friends, and 3.7 times higher (95% CI 1.5 - 9.3; $p < 0.01$) when believing that it is a wife's duty to have sex with her husband ($p<0.05$). In contrast, our results indicate a 1.8 higher risk (95% CI 1.3 – 2.6; $p < 0.01$) of suffering HC-IPV with the opinion that a woman should always obey her husband in everything he orders, a 2.2 higher risk (95% CI 0.9 – 5.2; $p < 0.05$) with the opinion men should always provide for everything needed in the household, and a 1.9 higher risk (95% CI 1.2 – 2.7; $p<0.01$) with the opinion that if a woman is suffering IPV, it must stay private.

Table 3. *Demographic, and socio-economic characteristics of participants by type of IPV (n=128)*

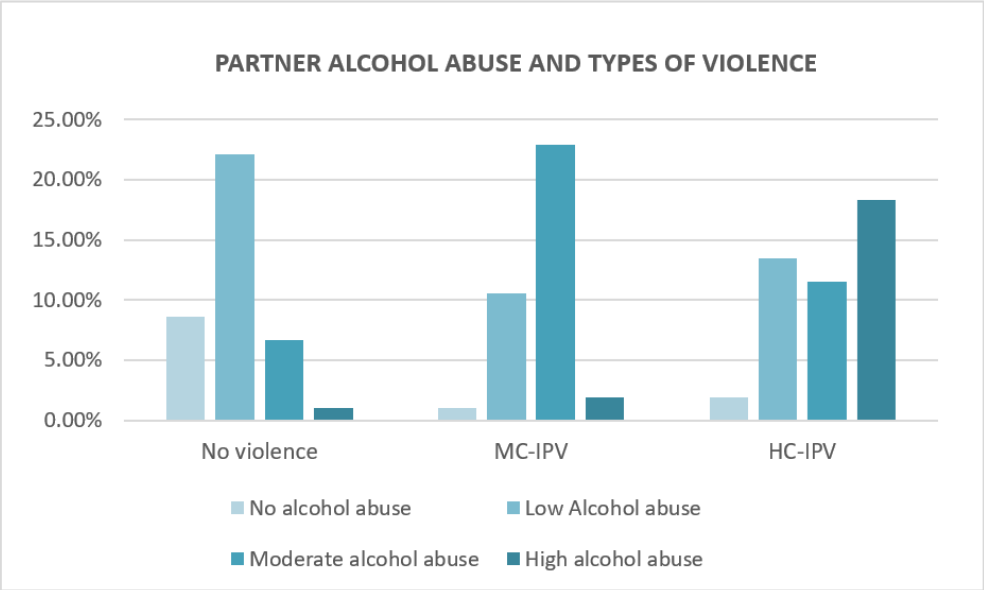
	DISTRIBUTION **n (%)** unless otherwise specified			**MEASSURES OF ASSOCIATION** **RR (95% CI)**		
	No IPV	**MC-IPV**	**HC-IPV**	**IPV**	**MC-IPV**	**HC-IPV**
AGE median (IQ)	32 (27-43)	37 (27-47)	35 (29-57)	p = 0.05	ns	p<0.1
Age at first cohabitation median (IQ)	18 (17-21)	17 (17-21)	17 (16-20)	p<0.1	ns	p<0.1
Age at first union < 17	14 (10.9)	4 (5.2)	21 (19.3)	1.5 (0.9-2.6)	0.9 (0.3-2.3)	1.5 (1.0-2.2)*
CIVIL STATUS						
Married/Cohabitating	54 (49.1)	18 (16.4)	38 (34.6)	0.9 (0.7-1.0)*	1.3 (0.2-7.5)	0.5 (0.3-0.7)
Separated	1 (0.8)	0 (0)	6 (4.7)	1.6 (1.1-2.3) $^{++}$	NA	1.9 (1.3-2.8)*
Widowed	55 (43.0)	1 (0.8)	7 (5.5)	2.2 (0.6-8.0)	1.0 (0.2-5.8)	1.6 (1.0-2.5)
CHILDREN						
More than 4 children	11 (8.6)	7 (5.5)	22 (17.2)	1.5 (1.2-2.1)**	1.2 (0.9-4.1)	1.7 (1.2-2.5)**
Death of offspring	53 (41.7)	4 (3.1)	13 (10.2)	1.5 (1.1-2.0)*	2.0 (0.9-4.7)	1.7 (1.2-2.5)*
Average age of children in household < 5	40 (31.3)	4 (3.1)	7 (5.5)	0.6 (0.4-1.0)*	0.7 (0.2-1.8)	0.53 (0.3 -1.0)*
EDUCATION						
Illiterate	9 (7.0)	5 (3.9)	18 (14.1)	---	---	---
Less than primary school	14 (10.9)	6 (4.7)	13 (10.2)	0.8 (0.6-1.2)	0.8 (0.3-2.2)	0.7 (0.4-1.2)
Primary school	19 (14.8)	4 (3.1)	8 (6.3)	0.5 (0.3-0.9)**	0.5 (0.2-1.5)	0.4 (0.2-0.8)**
Middle school	14 (10.9)	3 (2.3)	11 (8.6)	0.7(0.5-1.0)$^{+}$	0.5 (0.1-1.7)	0.7 (0.4-1.1)
High school or more	2 (1.6)	1 (0.80)	1 (0.8)	0.7 (0.3-1.9)	0.9 (0.2-5.4)	0.5 (0.1-2.5)
OCCUPATION						
>12 hours spent in housework	14 (10.9)	21 (17.8)	10 (8.3)	1.5 (1.1-2.0)	2.5 (1.1-5.2)*	1.5 (1.0-2.2) $^{+}$
Self-employed	8 (6.3)	8 (6.3)	14 (23.4)	1.5 (1.1-2.0)**	3.0 (1.3-7)**	2.0 (0.9-4.4) $^{+}$
ECONOMIC						
Prospera[1]	40 (31.3)	13 (10.2)	38 (29.7)	1.1 (0.8-1.6)	1.0 (0.4-2.3)	1.2 (0.7-1.7)
Not prospera	18 (14.6)	6 (4.7)	13 (10.16)			
Partner grows coffee in his own land	48 (51.6)	15 (16.1)	30 (32.3)	0.7 (0.5-0.9)**	0.8 (0.3-2.1)	0.6 (0.4-0.8)**
Income from coffee (hundreds of MXN)	8.35 (3.0-17.5)	15.6 (8.0-21.6)	12.0 (4.8-20.0)	ns	p<0.01	ns
Cash availability	16 (11.3%)			ns	ns	ns
One-year food insecurity	12 (9.4)	7 (5.5)	17 (13.3)	1.3 (1.0-1.8)$^{+}$	1.8 (0.8-3.9)	1.6 (0.9-3.01)
PARTNER ACLOHOL ABUSE[b]						
None	27 (21.8)	3 (2.3)	6 (4.7)	---	---	---
Low	23 (18.0)	11 (8.6)	14 (10.9)	2.1 (1.1-3.9)*	3.2 (0.99-10.5)*	2.1(0.9-4.8)$^{+}$
Moderate	7 (5.5)	3 (2.3)	12 (9.8)	2.7(1.4-5.1)**	3 (0.7-12.6)	3.5(1.6-7.7)**
High	1 (0.8)	2 (1.6)	19 (14.8)	3.8 (2.2-6.8)**	6.7 (1.7-25.5)*	5.2 (2.5-10.9)**

IPV and partner alcohol abuse

Among women who have ever had a partner, 71.9% reported partner alcohol abuse. Of those, 45.2% was low alcohol abuse, 21.2% moderate alcohol abuse, and 21.2% high alcohol abuse. Alcohol abuse was found to be significantly associated with IPV, MC-IPV and HC-IPV (see **table 3)**. When separating IPV in physical and sexual, physical partner violence was strongly associated with high alcohol abuse ($p<0.001$), but not partner sexual violence.

Interestingly, partners who perpetrate MC-IPV as reported by women, seem to engage in moderate alcohol abuse more frequently, while partners who perpetrate HC-IPV as reported by women, seem to engage more frequently in high alcohol abuse. This suggests a dose response in frequency of alcohol abuse and severity of violence with HC-IPV being the most severe type of IPV (**see graph 2**). Likewise, it suggests a relation between high alcohol abuse and high partner controlling behaviors. Among partners who exerted high control over women participants 5% did not alcohol abuse, while 27.8% engaged in low alcohol abuse, 25% in moderate alcohol abuse, and 41.7% in high alcohol abuse. The differences in partner alcohol abuse between MC-IPV and HC-IPV were statistically significant.

Graph 2. *Differences in partner alcohol abuse frequency by types of IPV*



IPV: physical and sexual intimate-partner violence; MC: moderate partner control, HC: high partner control; $p<0.01$

Furthermore, two thirds of women who reported experiencing events of physical violence from their partners reported that either sometimes or all the times the man was drunk when the violent event occurred. Still, 30.9% of women mentioned that their partner was not drunk when violent events happened.

Factors associated with non-partner SA

No association was found between sexual abuse—including rape/attempted rape—and the demographic, social and economic characteristics presented in **table 3**. This may be because sexual abuse occurred for most before the age of 20, and socioeconomic characteristics may have changed considerably if a woman got married (only 9% of women interviewed were single). We did not measure socioeconomic characteristics or family dynamics during childhood.

In contrast, having experienced sexual abuse seems to be related to a woman's opinion over certain gender roles. Of note, women who were victims of rape/attempted rape were 4.4 times more likely to respond that it is a wife's duty to have sex with her partner (95% CI 1.3-14.8). Likewise, women who experienced sexual abuse have 1.9 times the risk of having suffered from control by their partners, 2.5 times more likely to have suffered moderate control (95% CI 1.1-5.3), the same was observed for high control though the association was marginally significant with a 2.2-fold higher risk (95% CI 0.97 4.8).

Generational distribution of risks and outcomes

Due to the social and structural changes that happened in the country and the state around the 1980s, which was mentioned by the participants during the qualitative interviews, we decided to create a binary category for age dividing participants between those raised before and after the 1980s, setting a cutoff point at 35 years (those born in 1982). We then compared several quantitative findings between those two subgroups. Among these findings (see **Table 4**) the increase in primary school completion in the younger generation is higher, as well as the reduction in partner alcohol abuse. In contrast, it interesting that coffee-ownership has not increased and, in fact, is lower in the younger generation. The same pattern occurs with the percent of women who receive *Prospera*, the government CCT program. In the case of violence against women, it is interesting to note the contrast between the change in physical intimate-partner violence and the persistence of sexual intimate-partner violence, as well as the increase—although not statistically significant—of non-partner sexual abuse. In **Table 5** we present generational differences in opinion among certain gender roles. Adding to the table, it is important to note that 15% of women from both generations responded "sometimes" to the

statement “a woman is free to choose if she wants to work,” following by the explanation “in the city, maybe, but not here.” Likewise, participants who responded that a woman is free to decide if she wants to work, frequently meant that no-one could force them to work at the field. Qualitative findings provide more insight on these generational differences and similarities.

Table 4. *Generational distribution of selected risk factors and types of violence*

	GENERATIONAL DISTRIBUTION OF RISK						**GENERATIONAL DISTRIBUTION OF OUTCOMES**				
	Primary school[**]	**First cohab. ≤16y**[a]	**Partner owns coffee**[b]	**Receives *Prospera*** [**]	**Partner Low AA**[a]	**Partner Mod/High AA**[a +]	**Physical IPV**[a *]	**Sexual IPV**[a]	**MC-IPV**[+]	**HC-IPV**[+]	**SA**
< 35 years	79.76 %	23.8 %	79.7 %	54.8%	36.3%	46.6%	39.4%	25.4%	9.5%	29.7%	32.1%
≥ 35 years	15.79 %	33.3 %	91.3 %	91.2%	38.6%	65.7%	59.6%	26.3%	19.3%	45.6%	28.7%
TOTAL	53.9%	30.5%	84.5%	69.5%	37.5%	55%	48.44%	25.8%	13.5%	36.17%	30.5%

AA: alcohol abuse; cohab: cohabitation; IPV: physical and sexual intimate-partner violence; MC: moderate partner control, HC: high partner control: SA: non-partner sexual abuse.
[**] $p<0.01$, [*] $p<0,05$, [+] $p<0.1$. Refers to significance of the change between generations.
[a] n=128 ever partnered women; [b] n= 110 currently partnered women

Table 5. *Generational distribution of opinion on gender roles. Results correspond to the percent of women who responded positively to the statement on the left.*

	< 35 years	**≥ 35 years**	**TOTAL**
A woman should always obey her husband in anything he orders[**]	17.9%	45.6%	29.1%
A woman should sometimes obey her husband in anything he orders[**a]	67.9%	42.11%	57.45%

Men should always provide for everything the family needs [**]	73.8%	94.7%	82.3%
A woman does not have the same capacity than a man to earn money[**]	14.3%	33.3%	51.77%
Women have the right to always choose her friends	65.5%	50.9%	59.6%
It is a wife's duty to have sex with her husband[**]	9.5%	31.6%	18.44%
A woman is always free to choose if she wants to work	82.1%	80.1%	81.6%
Caring for children should be shared between man and woman	94.0%	92.2%	92.9%
Parents have the right to hit their children[*]	44.0%	64.3%	52.1%
If a woman is suffering IPV it must always stay private	15.5%	26.3%	19.9%

[a] Most women who responded sometimes would further elaborate "if he asks for good things, not for bad things." Good things were serving food, having clothes clean and ready, warm water for bathing, things related to the children, and other women's roles. When asked about "bad things" they would say "other things" but nothing concrete.
IPV: intimate-partner violence
[**] $p<0.01$, [*] $p<0,05$, [+] $p<0.1$ refers to significance of the change between generations.

IPV, SA, and Depression

The association of different types of violence against women and depression are presented in **table 4.** Women who had ever experienced sexual IPV had 4 times the risk of experiencing moderate-severe depressive symptoms in the past two weeks than those who did not experience sexual IPV. Likewise, women who had ever experienced physical and/or sexual IPV had 4.4 times the risk of presenting moderate-severe depressive symptoms than those who had not experienced any kind of violence. High severity of violence, and high partner controlling behavior were also associated with an increased risk of presenting moderate-severe depressive symptoms with 5.7 and 3.9 times higher risk, respectively. Not surprisingly, HC-IPV resulted to pose a 5.3 times higher risk of moderate-severe depressive symptoms when compared with not suffering IPV, while MC-IPV was not significantly related. Finally, women who had ever experienced non-partner sexual abuse presented twice the risk for moderate-severe depressive

symptoms than those who did not experience sexual abuse. In **graph 4**, the prevalence of moderate-severe depressive symptoms is illustrated within each violence category.

Table 6. *Association of types of violence and depression (n=128)*

	DEPRESSION SYMPTOMS BY TYPES OF VIOLENCE				
	No symptoms of depression n(%)	Mild symptoms n(%)	RR (CI)	Moderate-severe symptoms n(%)	RR (CI)
No IPV	42 (32.81)	13 (10.16)	---	3 (2.3)	---
Physical IPV	27 (28.9)	11 (8.6)	0.82 (0.4-2.6)	19 (14.8)	2.0 (0.71-5.76)
Sexual IPV	12 (9.38)	10 (7.8)	2.2 (1.2-4.1)*	11 (8.9)	4.0 (1.7-9.0)**
Physical and/or sexual IPV (IPV)	39 (30.5)	15 (11.7)	1.2 (0.6-2.2)	16 (12.5)	4.4 (1.3-14.4)**
SEVERITY					
No violence	42 (32.8)	13 (10.6)	---	3 (2.3)	---
Low severity	4 (3.1)	1 (0.8)	0.8 (0.1-5.2)	1 (0.8)	3.2 (0.4-26.4)
Medium severity	12 (9.4)	4 (3.1)	1.1 (0.4-2.8)	1 (0.8)	1.1 (0.1-10.1)
High severity	23 (18.0)	10 (7.8)	1.3 (0.6-2.6)	14 (14.8)	5.7 (1.8-18.9)**
CONTROL					
No control	29 (22.7))	11 (8.6)	---	3 (2.3)	---
Moderate control (MD)	32 (25.0)	8 (6.3)	0.7 (0.3-1.6)	5 (3.9)	1.6 (0.4-6.3)
High control (HC)	20 (15.6)	9 (7.0)	1.1 (0.5-2.4)	11 (8.6)	3.9 (1.2/13.11)*
TYPES OF IPV					
No violence	42 (32.8)	13 (10.6)	---	3 (2.3)	---
MC-IPV	12 (9.4)	5 (4)	1.2 (0.5-3.0)	2 (1.2)	2.0 (0.4-11.3)
HC-IPV	27 (21)	10 (7.8)	1.1 (0.6-2.3)	14 (10.9)	5.3 (1.6-17.4)**
NON-PARTNER SEXUAL ABUSE					
Sexual abuse	18 (12.8)	10 (7.1)	1.5 (0.8-2.7)	10 (7.1)	2 (0.99-4.4)*
Rape/attempted rape	9 (6.4)	5 (3.6)	2.4 (1.2-4.7)*	1 (0.7)	0.74 (0.2-2.9)

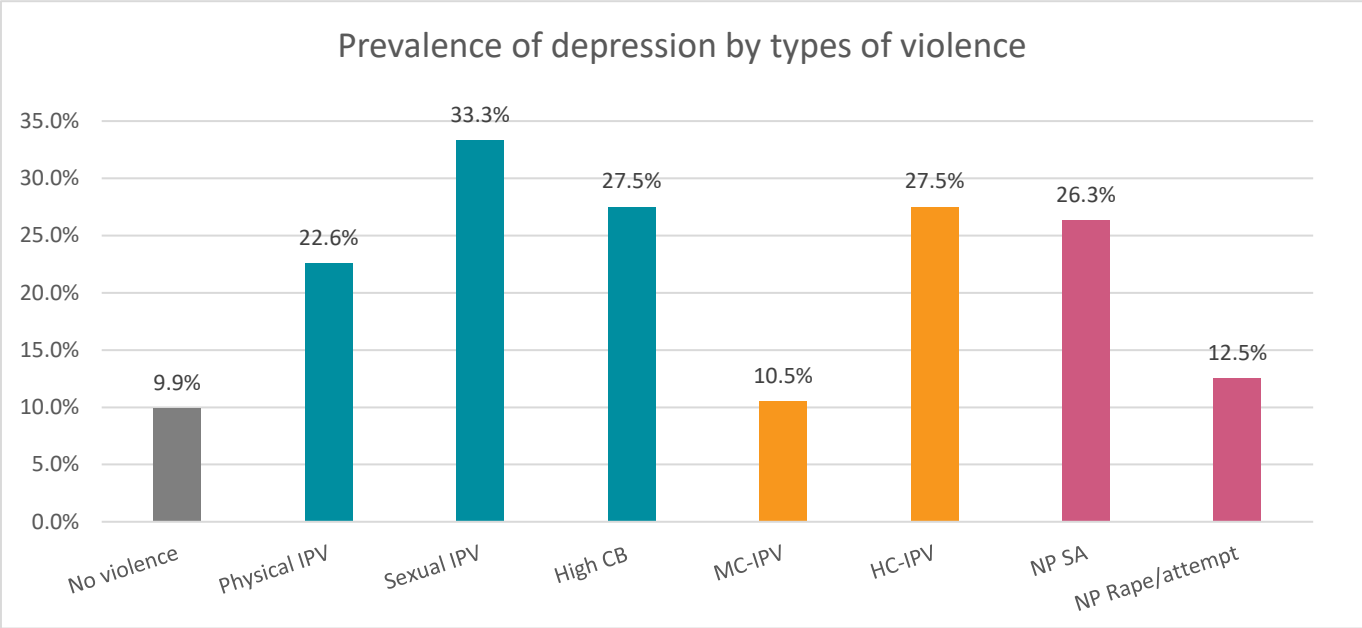
Relative risks are calculated a) between mild symptoms (PHQ-9 score 5 - 9) and minimum/no symptoms (PHQ-9 score <5) and b) between moderate-severe symptoms (PHQ-9 $\geq$ 10) and mild symptoms or less PHQ-9 < 10).

$^{+}p < 0.1$, $*p \leq 0.05$, $**p < 0.01$

Finally, since experiences of different types of violence often overlap, **Graph 4** shows the proportion of women 15 years and older who suffered none, less than three and three or more types of violence at least once during their lifetime, and a dose response of experiences of violence with moderate-severe depressive symptoms in the last two weeks.

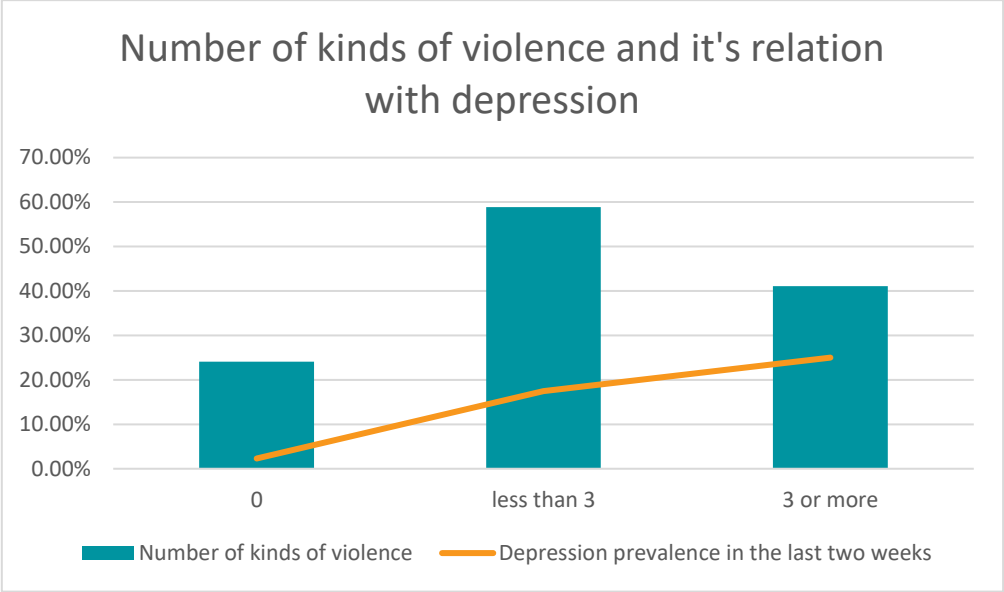
Graph 3. *Depression prevalence by type of violence*

Blue: traditional categorization of IPV; Orange: proposed categorization by Johnson et al.



IPV: physical and sexual intimate-partner violence; MC: moderate partner control, HC: high partner control: SA: non-partner sexual abuse.

Graph 4. *Number of kinds of violence (physical IPV, sexual IPV, CB, and non-partner SA) suffered by women and its relationship with depression prevalence*



3.2. Qualitative findings

Our qualitative findings are presented in two sections. The first section presents five salient cross-cutting thematic categories: a) socio-economic context shaping childhood exposure to adversity and parenting practices, b) men and human inhabiting different spheres, c) alcohol abuse relationship with IPV, d) experiences of IPV and SA, and e) community and church efforts to improve wellbeing. In addition, the iterative process of qualitative analysis revealed that three generations of participants were speaking about these themes in a specific, distinct way in relation to their socioeconomic conditions. These distinctions are relevant to understand experiences of IPV, SA, and mental health problems in this community. To account for such an important finding, results are presented for each of the three generations, within each thematic category. The second section constitutes a case in which the cross-cutting thematic categories are placed in the context of one individual's experience throughout her life course. This case presentation is vital to illustrate that experiences of violence in childhood and adulthood are not

experienced in isolation, and the way they interact to shape the experiences and decisions of this one woman, Magdalena, whose experience is similar to that of other women in the community.

To contextualize our findings, it is important to mention that data shows a significant improvement in living conditions, identified by participants in the mid-1980s. Two important factors at the core of this change are notable: a) coffee crop ownership, which started to yield and became an important source of cash, and b) community-organized Catholic religious activities for married couples (mainly common-law marriage) geared towards improving their "ways of living." Interestingly, these two changes coincide with the broader social movement that was happening in the state as a response to structural adjustment politics: priest and nuns influenced by Liberation Theology were working with peasants to create spaces of reflection on social and structural oppressive forces, and then organizing for change. As a result, coffee cooperatives were founded, increasing the earnings that families made from their job. For a more detailed description of structural, social and local changes across the generations, see **Figure 2.**

Currently, there are three generations interacting in the community: the elders (>50 years), the adults (~30-50 years) and the youth (<30 years). These generations grew up in very different living conditions, which shaped their exposure to adverse experiences during childhood, as well as their experiences of violence as adults, both as victims and perpetrators. Many of these experiences create conflict within the individual, as well as with partners and among generations. At the same time, these differences across generations have opened a space of reflection on "ways of living" and enables imagining of a more peaceful living. Over the next section, I present the most salient findings on the adversity and struggle that shape the experiences of men, women, boys and girls, mapped throughout these three generations. All generations speak about their experiences as children, and reflect on their parents in the

generation before. Experiences include parent-to-child violence and neglect, child abuse, sexual abuse, alcohol abuse, witnessing male-to-female intimate partner violence, as well as suffering and perpetrating intimate partner violence. Following, a brief description of the setting contextualizes these findings.

The setting

The community where this study takes place originated approximately 100 years ago, with families from *tierra fria:* the cold highlands in the Sierra region, mostly from Siltepec municipality. Fleeing from the revolutionary troops who would ransack peoples' property out of necessity, the first few families arrived during the early 1900s. Other families in search of land, soon followed. These families had cattle and planted *milpas* (corn and bean crops) for subsistence, they also hunted deer, wild pigs and other animals. From this generation—known as the *Originarios*—only two or three people are still living, approaching 100 years. Around mid-century more families arrived, fleeing from their landless condition in the arid highlands that forced them to become wage-laborers at coffee *fincas* (privately owned coffee plantations) where they lived in precarious conditions. Struggling with destitution and hunger, these families settled in this community to plant their *milpas* and traveled to worked as seasonal wage-laborers at the *fincas* near the coast.

Between the1960s and the 1980s a third wave of migration arrived when word spread that coffee was grown in this region. Families arrived at the community to work on the coffee crops and settled permanently, instead of going to the *fincas.* Around this time, 85 men organized to consolidate the community as an *ejido* (communal arable land and its habitational settlement) and became *ejidatarios básicos* (those who own the land). Since then, from 1,200 inhabitants,

only 85 men have decision-making power in the community. When these men die, their sons inherit the rights of the land through a burdensome bureaucratic process in the capital city. The other hundreds of men who have bought land from the *básicos*, are called *congregados* (assembled), and they have no decision-making capacity in community affairs, along with women and men who don't own land.

Illustration 2. Illustration of the different generation's experiences considering the national and stat sociopolitical context

SOCIOPOLITICAL CONTEXT	*DESCRIPTIONS OF LOCAL CONTEXT*	*COMMON EXPERIENCES*
1920-1940s • *Post-revolution and civil war.* • *Nationalization campaign aimed at unifying the country in "one Mestizo Mexico." Mam Mayas of the Southeastern Sierra highlands forbidden to speak indigenous language and practice traditional customs.* • *Agrarian reform aimed at returning land to indigenous (male) peoples. Conflict of interest from wealthy and powerful landowners limited its aim.*	"[My parents were] from Siltepec, but my grandfather, they say he came from Guatelama. My dad was born in the cold highlands, but there was no land there, one could not grow corn, beans. That is why they came here. They settled here, and we were born here." **H, 61**	*The Originarios:* People migrated from the highlands fleeing revolutionary troops and hunger. Looking for more arid lands. Men, and sometimes women would constantly work at the coffee *fincas* during the harvesting season, since they could not subsist on what they planted in their own land.
1950-1970s • *Land redistribution continues. Ejidos are formed.* • *The Nationalization campaign is called a "cultural genocide."* • *The national strategy changes from "Mexico mestizo" to "Multicultural Mexico" aimed at celebrating indigenous diversity. However, people of this region had already lost their language and customs.* • *The new strategy did not improve living conditions for poor coffee farmworkers.*	"Some went to the coast, they told me there was a *finca* there that was colled *finca* El Triunfo. . . But then they came here because they knew that coffee could be grown here, so they came here to harvest coffee. And they say that this neighborhood needed people. So they left there to come here. And not only my mom came, her brothers came too." **H, 60**	*The elders as children:* Experienced orphanhood, parental neglect, destitution. Did not go to school, most did not learn to read or write. They learned to labor through physical and psychological mistreatment and started to work for themselves as young as 12 years old at *fincas* or other people's coffee-crops. Male alcohol abuse is frequently mentioned as a cause of parental neglect. Boys would drink alcohol as young as 9-12 years. Witnessing IPV was common. *The elders as parents:* Their children describe them as being "delicate", short-tempered and irascible. The elders repeated their parents' parenting strategies, violently disciplining their children. Parents, especially fathers, are often described as emotionally distant, only providing the most basic needs to their children (mostly food).
1980-1990s • *1980s international economic crisis. Structural adjustment reduces public spending on healthcare, education, and agricultural subsidies.* • *Liberation-theology influenced priests and nuns help peasants organize for change. Coffee cooperatives are founded.* • *1994 NAFTA is signed. The Zapatista Army of National Liberation (EZLN) takes arms against the government in Chiapas condemning neoliberal policies that further impoverish peasants. Women demand equal rights.* • *Health institutions are founded. Agricultural workers remain uninsured, and receive few services for free (mostly growth monitoring, oral rehydration, immunization)* • *A conditional cash-transfer program provides cash to the poorest families conditioned on sending children to school, and attending health literacy workshops and preventive health checkups at the local clinics.*	"And when we had gathered 20-30 couples, we asked that they would live [the spiritual retreat] again. And so we expanded the [Catholic] community. And so many people were awoken, their minds were awoken. . . And so many couples started to live more peacefully, happier." **H, 58** "Now, ways are better. Many people planted coffee back in the day, so today it is producing. So parents say 'here, I give you [money] for your studies, or go wander [*vete a pasear*], I have money here." **H, 61**	*The elders as parents:* Organized for the foundation of the ejido. Organized to create spiritual retreats with the Catholic church to improve people's "ways of living," focusing on cohabitating/married couples, advising against alcohol abuse and IPV. Labor was prioritized over school attendance. Learning to labor was regarded das key for survival. *The adults as children:* Grew up under their parent's "delicate" ways, which caused them significant distress. Many describe the experiences as being traumatic. Male alcohol abuse is still mentioned as a cause of parental neglect. Witnessing IPV was common. Boys and girls grew up in different spheres, fathers taught boys to labor in the field, mothers taught girls to labor at home. Few completed more than three years of primary school, girls as young as 12 years would go to the cities to find a job, being exposed to sexual and physical abuse.
2000s • *Conditional cash-transfer program succeeds at increasing educational attainment, increase prenatal visits and immunization rates, and reduce severe malnutrition (providing food supplements to pregnant women and children under 5 years old).* • *Institution of Seguro Popular partially improves health care delivery in rural Mexico.* • *Legislation on violence against women (2007) upgrades to state that customs in rural and indigenous communities must not violate women's rights.*	"With regard to studies, sometimes the government support [the youth] with scholarships so they continue their training. . . now there are more opportunities for these young people to get prepared and live a more peaceful life." **H, 60**	*The adults as parents:* Access to contraceptives, smaller families. The adults struggle to protect their kids from the situations they lived when they were children, while they deal with past trauma and current IPV or alcohol addiction. Women mention that they are not as harsh on children as their own parents were on them. A group of men is organizing the community to reduce the prevalence of alcohol abuse through the 4th and 5th step experience, where alcohol abuse is analyzed as a consequence of emotional pain due to past trauma. *The youth as children:* Grew up in smaller families. Although teaching to labor is still considered vital to avoid destitution, school is prioritized. Boys and girls usually engage in each other´s gender roles due to small family sizes. Parents are regarded as trustworthy and accessible. Most wish to continue studying after high-school, however, few parents can afford it. *The youth as parents:* Men struggle to fulfill societal expectations that dictate they must provide for all the needs of their family. However, many do not have coffee-crops, and must migrate to the cities to find a job. Alcohol abuse is frequent among men. Hitting children is considered necessary to ensure good behavior, but less women from this generation consider it is the parents right to hit their children. Gender roles are still taught during puberty, however, school attendance is prioritized over labor.

I. THEMATIC CATEGORIES

‘Material’ times and ‘delicate’ parents

How socio-economic context shapes parenting practices across generations

The elders

People who grew up before and around the foundation of the *ejido*, describe the people of their generation as living a life that is largely focused on what they call “the material.” This word has a particular connotation for these respondents, and it is used as a general descriptor for a set of behaviors associated with the deep poverty that they experienced as children: 1) expectations of hard labor from an early age either at home for girls or in the fields for boys, 2) parents prioritizing child labor over school attendance, 3) going without: shoes, toys, cash, running water, and 4) geographical marginalization and isolation due to lack of roads. At an extreme, many describe experiences of destitution in which orphan hood, hunger, young siblings dying, and no medical attention stand out. For many kids, this meant having to leave home early on to make a living otherwise, either getting married for girls, or find work at the *fincas* or ranches around the region for boys. A woman narrates:

> I had my first husband. . . I was 12 years. Very young because we suffered with my dad. We didn’t have a house, we didn’t have blankets, we didn’t have food, we didn’t have clothes . . . my mom went to find some cloth in the dump, she would fix our clothes . . . My dad drank, he once attacked my mom with a knife. We suffered a lot so that is why I went with that man, and the man loved me, but the mother in-law didn’t because I was from a race of drunks, my dad was a drunk, we were poor people, that is why this lady did not love me. So, I left. **(F, 68 y)**

Deep poverty made it difficult for the parents of this generation to adequately care for their children. All energy had to go towards working the land to have food, and sometimes working at the *fincas* to have some cash for soap, clothes, medical attention, and alcohol. At the same time, these parents had to assure that their children learned what was needed to have some economic stability and avoid destitution. Participants explained that this generational focus on the "material" was associated with extremely strict parenting when teaching children to labor. Labor was divided by gender: boys were taught to raise and harvest corn, beans, and coffee as well as to chop firewood for cooking. Girls, in contrast, were taught to grind corn, make tortillas, keep the house clean and tidy, and take care of younger siblings.

Failure to comply with these gendered expectations resulted in scolding, and sometimes physical beatings. Children lived in fear of these repercussions. These sons and daughters—now adults—describe their parents using the phrase "*muy delicados."* This term "*delicate*" refers to their parents' strict, irritable, short-tempered, often irascible character. While children feared their parents' *delicate* ways, as adults they now perceive such behavior as integral to the struggle for survival. Some participants, explained, however, that this "*delicate*" nature was too much for them as children, and they preferred to leave their homes to avoid harsh and sometimes violent surroundings. One man who left his parent's house at the age of nine explained:

> "At that time my dad was very delicate, it was not as it is today, today it is different . . . Because he has one word only, you did that thing and, *pum*! He wouldn't repeat twice. If we didn't do it he would beat me with the whip or the belt, two lashes and we had to run away and do what he said, quickly and without crying . . . [If we cried], they beat us more. So, I had to put up, and when I was

older I said “I am not going to put up [*aguantar*], I better leave” and yes, I left.” **(M, 61 y)**

In the context of deep poverty, and lack of stability—both economically and emotionally in the household, the figure of the mother stands out as shaping lived experiences of individuals of this generation. Mothers are described either as a strict but caring figure, or as too soft. Having a mother who was too soft was often mentioned by men as a possible reason for their alcohol abuse starting when they were young. Likewise, the absence of a father engaged in disciplining his children—mostly due to alcohol abuse—is perceived to have an important role in the behaviors these children have now as adults. For many, orphanhood and their father’s alcohol addiction resulted in feeling “defenseless,” which could only be overcome by boys through wage labor, and by girls through marriage. This man who lost his mother at the age of seven, mentions how boys were forced to grow up too soon, finding work at other people’s lands as young as 12 years old, so they could “defend themselves”:

> When [my dad] was drunk well, it was different. He would disdain us more than anything . . . But when he was sober no, he was different, but he was mostly drunk, he would keep himself drunk . . . More than anything [I felt] sad, of not having the mother, [my dad] disdained us, because without a mother, sometimes a mother gives us comfort or something like that. And the father is different, so, on that side, one felt, well, sad, of being an orphan as I was, one was sad because maybe one wanted something, but it was not possible. But in the end after all one would build courage, we started to become young men, and we could defend ourselves more or less. **(M, 62 y)**

The adults

When having their own children, the elders repeated their parent's strategies. People from the adult generation mention that their parent's 'delicate' character caused them significant suffering and distress when they were children, and identify this as triggers for them to leave their parent's house. Moreover, although a public elementary school had been built in the community, prioritizing child labor over school forced early school drop-out, and persisting extreme poverty perpetuated the need for young teenagers to leave their parent's house in search of a better way of living.

> I did not study because my mom was very delicate, she sent us to school sometimes until 9, and that wasn't the time to get in . . . I felt ashamed to go to school because we came so late, we preferred not to come because we had to leave the food prepared, the breakfast, the house clean, everything clean, the *nixtamal* cooked. Sometimes we didn't even have time to have breakfast because if we came to school and left the house without cleaning, well, when we came back at recess my mom would beat us. When we had left everything clean, then we drank *atole* (a semi-liquid porridge made with corn and sugar), she was happy. But when we left the house dirty we would not drink *atole* during recess, she would beat us. (**F, 37 y**)

Quantitative findings show that only one out of three children from the adult and elder generations completed primary school. Many women of the adults' generation, who had spent less than three years at school, but had learned to read and write, left their parent's house as children to find jobs in bigger towns or at the city. Domestic work seemed to be a good deal for these young girls who already knew how to run a house; unfortunately, experiences of sexual

abuse by men in the house—father or son. Others talk about experiences of severe physical abuse from their employers, who would not pay them and lock them up during the weekends. Now as parents, this generation of women struggles to avoid or limit the noxious parenting practices that were common when they were young, so they can transcend the "material" way of living and unlock different possibilities for their children. Quantitative findings show a decrease among generations in the percentage of women thinking that parents have the right to hit their children. This woman brilliantly summarizes:

> But as I say, the generation of before is not like today, before people were material, and today it is no longer like that. I mean, what I lived, my kids are not going to live it. Because I have to be a more conscious mother and if I was not pampered, then at least I have to do it with my kids […] I tell my kids "you go to school, I will give you your breakfast" […] I prefer that they leave early for school, even if I am left with the mess, little by little I will do [the housework] . . . I tell them "I never had that chance, but you do, you have a good mother that supports you and values you." When one lives like [I lived] one cannot pay attention to the letters, and before, teachers also hit at school, we came, our mom beat us, we came to school, and we didn't know, well the teacher would hit us . . . he would bang our heads on the table. **(F, 34 years)**

The youth

One of the main differences between generations is educational attainment. Since 1997, the conditional cash transfer (CCT) governmental program *Prospera* (formerly *Oportunidades)* provides cash directly to women on the condition that they send children to school. This cash is

mostly spent on food, shoes, and school material. Women from the adult generation learned the hard way that having a middle or high school diploma is important when looking for jobs in the city and see school completion as a tool for their daughters to avoiding economic, physical and sexual abuse. At the same time, increase in family income has made prioritizing school over child labor a possibility and has significantly changed parent-children relationships. One of the elders describe:

> Now, ways have gotten better, many planted coffee at that time, well, now they are producing, now parents say 'I will give you [money] for your studies, or to travel, I have money here' so with that, they don't need to work [at the field], they can look for laborers. **(M, 61)**

While parenting has become more flexible and caring, hitting young children to ensure good behavior is still a common practice. The adults, however, stress on the different "way of hitting" while describing less harsh physical punishment than the one they suffered as children. As a result, participants from the youth generation do not describe being hit by their parents as a significant source of distress. In fact, older children from the youth generation identify their parents lived experiences of deep poverty, strenuous labor, and 'delicate' parents as something that shaped their parents' character, and especially their fathers' emotional disengagement, frequent impulsivity, and alcohol abuse. The fact that children have this insight reflects a greater emotional connection between parents and children than in previous generations.

> My dad, he would not hug us, but he is affectionate . . . he almost does not show it (smiles), he is a little bit hard, because his dad was hard and his mom too, he was very mistreated, and since he was young he left his home so I think that is why he does not show it . . . he would have to do hard work, he was not well dressed, he

did not have shoes, all that . . . I can see that [my grandfather] never gave him love.

(M, 17 y)

Furthermore, participants from the youth generation depict their parents as trustworthy and accessible. They often talk with them about their hopes for the future and value their advice. Advice is mostly focused on not marrying young, preventing teenage pregnancy, continuing with school, and selecting a good partner. For girls, a good partner is described as one that is not jealous, a *mujeriego* (womanizer), or drinks alcohol. Likewise, advice on avoiding alcohol and tobacco is frequent for boys.

"Each one goes their own way"

Male and female inhabiting separate spheres

The elders

Men and women live in separate spheres. Their interactions are minimal since childhood through adulthood, and when someone interacts in each other's spheres it comes as a surprise. For the elders, the separation of male and female spheres started early, around 7 years old. Boys would accompany their fathers to the field, chopping and bringing firewood for cooking. Closer to puberty they started working more seriously with their father in the corn, bean and coffee fields. Girls, in contrast would help their mothers with housework. They would grind corn, make tortillas, wash dishes and clothes, keep the house clean and tidy, and take care of younger siblings. During coffee harvesting season they would also help with the harvest. If their mothers died, older girls took on her responsibilities. The lack of interaction between men and women is recognized by the elders as the "custom," and a custom that is still practiced today by the

generations of the adults and the children. However, reflecting on their life course, the elders mention that this "custom" may not be ideal:

> Well you know that when one is growing up one starts realizing that one carries those same customs. As of today, I would be surprised if my daughter-in-law, or if I had daughters, that they would go to the field, it comes as a surprise, because it is not the custom here. But yes, that relationship is good, that pact of the woman, that we would work woman and man in the field, there would be more contact, more relation, related with love. Unfortunately, here we don't do that, here field is field, kitchen is kitchen. Each one goes their own way. I do my things, she does hers. **(H, 64)**

The adults

The adult generation perceive gender roles on God's will and not a matter of choice. When asking about how people felt about being assigned certain tasks because of their sex, most replied that it was okay because that is what God had wanted for them, that "one cannot choose to be male or female." At the same time, the adults recognize that gender roles are learned traditions that are not rigid to change, stating that to execute the opposite gender role "is more difficult but nothing is impossible, one can learn, everything is learned." This contradiction between God's mandate and socially-constructed of gender roles creates an ambivalence in the adult's minds that opens-up to reflection on the possibility to live otherwise. Still the adults consider that learning gender roles is still necessary to prevent destitution, and that separate spheres are required to learn them, as a mother of 4 explains below:

> For example, with girls it's different because they are girls. What are they going to do? the job of one as women, let's say I have to teach my daughters to grind corn, make tortillas, cook . . . As for my boys well, that is their dad's job to teach them to work at the field. As well as the study, learning a little bit of everything, a little of the field, a little of study, and also a little walking around. Cause we as human beings have a time for everything: a time to cry, to laugh, to work, to study. . . Cause we don't know what gift they bring, if they are going to be teachers or maybe not, they will be coffee agricultures . . . so that is why they need to learn a little of everything. **(F, 34 y)**

Furthermore, people from the adult generation identify gender roles as "*machista"* traditions, in which women are left with most of the work. Most male participants confessed that women´s labor was more demanding that men´s labor because women worked all day long. Quantitative data shows that most adult women spend around 10 hours in housework. On the other side, men who do housework are seen as a "*mandilones" (whipped,* dominated and weak) and subjected to social sanctions, which makes the construction of more equitable relationships at home more difficult. One of the participants, who was labeled as "*mandilon,"* explained:

> You see, here we are ranch people, so the man is very *machista* . . . the man only wants to be giving orders to the woman, he does not help her not even washing a dish. And I was not like that. If my wife was out I wanted to surprise her, I would fix the bed, the couch, or something for the house to look different, and wash the dishes, make food, change my children . . . and people would tell me 'why are you like that, that is your wife's duty' . . . That is why there is this word *mandilón*. **(M, 40 y)**

The youth

Children from the youth generation spend more time at school, which increases the interaction between boys and girls. Moreover, the adult generation have had access to contraceptives, which resulted in smaller size families. Many times, the adults as parents have only daughters or only sons. Due to the lack of sisters or brothers, the youth engage in each other's gender roles for the sake of house and labor efficiency, which is necessary to ensure the family's health and economic sustenance. In the youth generation, gender roles are frequently traversed while in previous generations this happened only at extreme cases such as orphanhood or parental neglect. Interestingly, quantitative findings show that more women of the youth generation believe that women have the same capacity than men to earn money, when compared with the adult and elder generations. Despite this change, specific roles are still considered female or male roles, and if there is someone from the "correct" sex to perform a specific task, it will be his or her main responsibility. The following is an example of a 15-year-old trying to articulate the rationale behind asking for help from her brothers to do things that are traditionally considered a female's role.

> When a lot of work has accumulated, and for example my dad is not here and it's only me and my mom . . . And if we have to wash the dishes, or we have yet to sweep the floor, well it could be the support that, if he already chopped firewood and, he is just lying there with nothing else to do, well, I don't know, tell them that. . . there must be support in both ways, because as I tell my mom that we go support them [at the field] well, it could be both ways, they could support us at home. But well, clearly, sometimes they obey and sometimes they don't: 'no, my tv show is

on,' 'no, tomorrow I'm waking up early.' And that is a bit difficult . . . my mom tells me 'don't keep getting mad' **(F, 15 y)**

Even if male and female spheres are closer to each other, they are still separate worlds. Boys play sports, *trompo*, *canicas*, wandering around in the community or the mountain, they play with other children, usually other boys. Girls' activities, in contrast, are closer to the household. Mothers are careful that girls are not wandering around too far as they are perceived to be more in danger of sexual abuse than boys. Some women recognize that this *confinement* could be less strict and try to make things different for their daughters. School teachers have worked to include women in sports such as soccer and basketball, but female and male teams have different times to train and different tournaments, restricting interaction between genders. In community events like school graduations and festivals, or sports tournaments, it is easy to observe groups of men and women of all generations not mixing together at all.

"He would get 'crazy' on alcohol"

Uses and consequences of alcohol abuse

The elders

At the *ejidal* assembly, several decades ago the *ejidatarios basicos* created a local law that forbids selling alcohol in the community. Since then, this local law sets a fee of ~ $300 USD for those who sell, and a fee of ~$30 USD for those who disturb community peace while drunk. Disturbing community peace includes fighting with others in the community, or physically or verbally abusing their wives. The elders mention that when they were younger, the punishment for transgressors was a lot harsher than it is today because authorities were stricter. Still, all the participants from this generation have had negative life experiences related to alcohol abuse

either by their parents or by themselves. The elders started drinking alcohol at 12 years or even younger, many times provided by their father to keep warm, as medicine, or just because it was a men's thing. This man illustrates:

> And the truth is that he [my father] was the one who taught us. And because he drank we would go look for him . . . and he went very far away, he went out with his friends. And there he was sitting, chatting with his friend 'daddy, let's go,' 'wait my son,' chatting and chatting, 'daddy, come on,' 'give me a sec, son' and so then he would say 'oh, my little sons maybe they are cold' . . . and well, he would give us [alcohol], and we would drink, not a little, but large gulps. With that we would feel warm and we stayed there. . . and that's when I started drinking. I was 12 years old. **(M, 53 y)**

It is frequent to hear from women, that men turn 'crazy' when they drink alcohol, referring to them turning aggressive and violent: insulting and hitting their wives and children, not listening to reasons, and not respecting anyone. When their husbands turned 'crazy' women would frequently run away with the children and spend the night elsewhere. For women of this generation, refuge was frequently found somewhere in the mountain under a tree, rain or shine. Though they did ask for help from their parents or in-laws, geographic and social marginalization limited their options, as this woman narrates:

> My daughter in law tells me 'mom, why did you put up [*aguantó*] with so much?' she says, 'oh my daughter, where would we go? I didn't know La Lucha, I didn't know Montecristo, not even Las Brisas.' You see, it was not like it is today, there were three houses only, where would we go? The house in the middle of the

> mountain, no one would see us. We suffered a lot, I suffered with my dad and I suffered with my husband. **(F, 68 y)**

Frequently, men excuse themselves afterwards stating that they don´t remember what they had done. Nevertheless, reflecting on their adult years, the elders identify the many negative consequences of drinking. “Gifting [their] children with nothing but poverty” as one participant said, due to spending money on alcohol instead of providing for the family, as well as giving their wives “mala vida” (a bad life, trouble), referring to being unfaithful, violent, and neglectful.

The adults

While living conditions have improved considerably, alcohol addiction continues to place a huge burden on four out of ten men and their families. Experiencing their father getting crazy with alcohol and spending the night outside was so common for the adult generation as children, that as adults women leave the house whenever they see their husband coming home drunk, even if he has never hit them. Getting ‘crazy’ on alcohol is regarded as something outside of men’s control, excusing whatever he does under the influence of alcohol because ‘he was not himself.’ Importantly, while conducting the surveys, many women would not report violent incidents that happened under the influence of alcohol until the interviewed probed about it. A woman who grew up witnessing sever intimate partner violence against her mother narrates her experiences in adulthood with her own husband:

> He would get lost in alcohol, but not sober. Sober no, he is different, but drunk he would get violent . . . I lived the same story my mom lived to be honest. . . he would start drinking and then he would beat me, and he was crazy, he would get crazy and he would not respect who stepped in front of him… To the drunk man

> you see, it is not that they get angry at something, drunk men, they are crazy because they are crazy, because they drink and in their drunkenness who knows what they are thinking or what they will do . . . who knows if they remember or if they outright lose it **(F, 34y)**

Like men from the elder generation, men from the adult generation started drinking alcohol at a young age. Participants from the adult generation describe drinking alcohol for the first time because it was offered by friends or older siblings, or to cope with the death of a loved one. At wakes, it is common to see men drinking for several days outside the room where the body is laying. Further on, men continue drinking to cope with life problems including the death of a loved one, being cheated on by one's wife, and the guilt of not having been a good father or a good son. In this generation, negative consequences of drinking alcohol described include having accidents, fights and injuries, neglecting their children, disappointing their parents, and being unfaithful to their wives.

The unfaithfulness along with not fully addressing their family responsibilities generates conflict with their wives. Interestingly, many women would mention that men were violent when they had a *querida* (mistress), they would come home drunk and accuse their wives of being unfaithful when they were the one's doing it. When asking for the reason why women believe some men hit their wives the most frequent reasons were a) *machismo*—thinking men are superior to women, b) men being jealous, c) women provoking men—by talking back or not giving him what he is asking for, d) men abusing alcohol, and e) having a mistress, where among the most frequent responses.

The youth

More than half of the teenagers interviewed have witnessed their father get 'crazy' on alcohol and beat or mistreat their mother. These children recognize IPV and their father's alcohol abuse as a significant source of distress, and many talk about their need to defend their mothers, some deciding to stay in the community instead of going to the city to find a job for fear of leaving her alone. One teenager, when asked about the hardest part of being a woman in this community, responded:

> Once we have finished our studies, it is taking care of our mom first so that she is not being mistreated by my dad. Once nothing is happening, then one can go to work far away. **(F, 15 y)**

On the other side, the elders and community authorities seem to worry more about these teenagers consuming alcohol than about what they witness and experience at home. When asked about what the main social problems of the community were, all men were concerned with the fact that young people were drinking a lot more alcohol, some worried that they might be consuming drugs, because a few young men have "gotten crazy" for no good reason. In contrast, quantitative data suggest that both alcohol abuse is lower in the youngest generation. The recently formed *alcoholics anonymous* (AA) group in the community, organized by a group of adults, has been working to get teenagers and young adults to participate, with the hope that their children will not follow their parent's steps. Many are hopeful that sharing their own experiences of suffering with alcohol addiction will persuade the youth to stay away from 'the vice.'

Building a peaceful life

Experiences of intimate partner violence and non-partner sexual abuse

The elders

The findings presented above explain the milieu in which experiences of intimate partner violence (IPV) and non-partner sexual abuse (SA) happen. While experiences of violence are significantly less frequent in the generations that grew up after the 1980s, IPV and SA are still highly prevalent. However, the socio-economic context in which people lived and related to each other had an important influence in how such events where experienced. For the elders, experiences of violence remained private due to geographical isolation and lack to social networks. For women from this generation, only their mothers and sometimes parents-in-law could provide some limited support. Leaving their partner would result in destitution for women who had no land, no schooling, no job opportunities, and whose parents were struggling with extreme poverty; moreover, women would stay in a violent relationship for the sake of their children. In the words of a woman who suffered severe physical violence with high control from her partner narrates:

> 'Look,' I told him, 'I don't want you to mistreat me, I'm sick. Your sons are speaking to you and you don't understand, your sons-in-law speak to you, you don't understand. It maybe because you are illiterate and you don't understand . . . we are old now, you are 72 years, a 72-year-old man must think. I am 68 years, I want to live some happy days, so, each one our own way, you have your room . . . I want to live some days in peace with my children. I don't want to suffer anymore . . . my patience is over, why? Because my daughters are gone, they are all married, I don't have daughters now, I don't have anything.' **(F, 68 y)**

The adults

Our findings indicate that although there are some cases in which violence was a response to a specific conflict, many times these conflicts were generated from women questioning men's authority or decisions. This questioning was mostly over children's disciplining—with women advocating for less harsh punishment—or over the man being unfaithful or drinking alcohol, to which men usually respond that *"no-one tells me what to do in my own house."* When alcohol is not involved, the violence is attributed to *nervios*. Being *nervioso* is described as getting angry or upset easily and responding aggressively. *Nervios* is seen as a disturbance of the mind—or a character trait—that can be controlled but is hardly cured. While its presentation can be similar to generalized anxiety disorder or depression, it is not always related. Justifying violence because the man is *nervioso* or was drunk is common among women and men, as well as male civil authorities. The following response to the question 'did your husband ever hit you' provides some insight:

> He did, but it was on one occasion, it was because, I told you the other day . . . because I was defending the kids. But it was only once, he didn't do it again (laughs) . . . He is not as violent as he was, I tell him 'control your *nervios* go to the clinic so they support you with some pills to control your *nervios'* **(F, 34 y)**

These are the cases of violence men usually talk about, the ones that result from women transgressing their gender expectations. In the interview with the *agente rural*, the local authority in charge of keeping community peace and order, and therefore frequently in charge of resolving cases of intimate partner violence, mentioned that when a woman accuses her husband of being violent he must investigate with the couple "who had the mistake," he further elaborates:

> One goes to the field, and we arrive, and she doesn't have the food [ready] and all that, so one has to get angry, and the man comes hungry and there is nothing. Sometimes that is how problems start, so there must be some justification for why that person scolded or got angry with his wife or something, but one has to accept when one made a mistake. There are people who do accept it, they apologize, but well, that happens in the family, not at the authority [office]. **(M, 52 y)**

Alternatively, the most severe cases of IPV have no apparent reason other than the man "turning crazy" whether with or without alcohol. Usually, cases of severe physical violence come accompanied by controlling behaviors from the partner, including impeding their wife visiting family or friends, not giving money for household expenses when they do have the resources, humiliating her, and threatening her with frightening consequences that range from leaving her to killing her. As a response, women engage in certain behaviors that would reduce the possibility of physical violence, at expenses of their own mental health.

Maira, a 39-year-old woman who experiences severe violence from her husband told us what she has arranged in *her* life to get some peace. Her husband was a *mujeriego* since they were dating, her parents used to tell her that he wasn't a good man to be with, but Maira loved him and trusted that he would change. He didn't, soon after getting married he started beating her. However, what stands out in her narrative is not the physical violence she suffered, but the controlling she was subjected to, and how frightened she felt.

> When we were dating he would always watch over me, he wouldn't let me go out, he didn't let me have friends . . . maybe that is why I don't like to go out, because I have gotten used to be confined there . . . When we got together I was afraid. Because when I went out and he came back home, well, I had to be there because if

I wasn't there I would really get in trouble. He would say mean things and treat me bad, right? So, I got used to not going out. **(F, 39 y)**

This experience is not unique but shared among three out of ten women in this community. Social isolation is common in women from this generation as a response to a) strict parenting that confined women in their households, b) controlling behaviors from their partner, or c) as a preventive measure to avoid "provoking" men. Because of this isolation, women's social networks are severely constrained. Quantitative data shows that less than half of women have someone they can trust enough to talk about their problems, concerns, and emotions. When they do have someone they can trust, it is usually a sister.

Within this context, women strive to prevent their children from living the same experiences they have. Socializing their children into gender norms, strongly advising against marrying young and drinking alcohol, and strongly advising in favor of completing school and obtaining their middle school or high school diploma, are some of the strategies women engage in to secure a more peaceful life for their children. School completion is seen as a tool that could help their sons and daughters "*defend themselves*," either in the city if they decide to go work, or at home if they decide to stay. A 34-year-old woman who left her house at 12 years of age to look for jobs in the city, where she repeatedly experienced physical, psychological, and sexual abuse, explained:

Studies are highly valuable. So that [my children] can defend themselves one day . . . because that is the development of a person . . . defending themselves when they are mistreated with words, they must defend themselves with words, because with words one can reach an agreement, with beatings nothing is solved . . . and sometimes I tell them that that is what school is for **(F, 34 y)**

The youth

For the younger generation, witnessing experiences of violence against their mother are among the main sources of emotional distress. For women of this generation who are already married (those around 25 years), witnessing IPV at home, and experiencing an independent life in the city, opens-up the possibility of imagining a different reality. However, that possibility is usually limited by the lack of resources in the community. Many women talk about the difficulty for women to realize themselves and "develop" as they would wish due to the lack of job opportunities. While conducting the quantitative survey, women would frequently say that women have the same capacity than men to earn money "in the city, but not here." Furthermore, their experiences contrasted with that of their mothers or grandmothers in the adult or elder generation, as can be seen in the following quote from a woman who lived and worked in the city for several years:

> So [after witnessing my father beating my mother] I said I will never permit that a man hits me. Why? I tell [my mom] that it is so easy to live apart, 'Oh but as a woman, one must give in [*ceder*],' I tell her 'maybe in your times, not in mine. If I don't like it no,' 'but how are you going to build a family, build a home if you will not endure [*si no vas a aguantar*]?,' 'no' I tell her, 'I am not an animal to be enduring [*no soy animal para estar aguantando]*' **(F, 26 y)**

For the younger ones who are still at home, IPV is still day-to-day experience that impacts the way they think about their future. On one side, the role that jealousy plays in violence from their fathers towards their mothers permits them to see jealousy as "a vice" that can easily lead to "offending words or even beatings." In this regard, a boyfriend or girlfriend who is not jealous is preferred among teenagers who start dating, and jealousy of one or both in

the couple is a common reason for breaking up. Furthermore, watching women being mistreated makes female teenagers think twice about getting married, and even male teenagers mention witnessing IPV as "traumatizing." Another thing that girls are cautions about when thinking about marrying is that if a man drinks, "that he is not one that will be beating a lot." The kind of IPV that teenagers have witnessed ranges from the single violent event that resulted from a specific conflict, to the severe violence associated with getting 'crazy' under the influence of alcohol. The following young man narrates an event he witnessed at the age of 13:

> When my dad drank, he did [beat my mom], but not anymore. But it would get nasty when he drank. Some say he would get really crazy, he would take us out of the house, it is terrible, all that. . . Once he broke a door, because we were inside, and he had an iron stick, but the front door was a metal door and he could not open it. So, he went and opened the metal-foil roof with the stick, and he came down and broke the wooden door, and he went it in through one corner and we went out and opened the door in the other corner and that is how we could escape, and we spent the night with an aunt. And once they had to tie him up. **(M, 17 y**)

'Breaking down' and moving on

Trauma and religion, healing to lead better lives

Therefore, if anyone is in Christ, the new creation has come: The old has gone, the new is here!

2 Corinthians 5:17

"*Which are the old things? If I was a smoker, a caperer, if I liked to drink, if I had my wife and I was jealous, all of that. Or if I had a mistress around. Those are the old things"* (Presbyterian church leader)

The elders

As mentioned earlier, men who want to stop drinking engage in a difficult quest and have limited resources for support. In recent years, a few have found it useful to change religions from Catholic to Presbyterian or Pentecostal in which drinking alcohol is prohibited. However, leaders of these religions overtly expressed, citing the bible, that men are the head of the household, have greater capacity to govern than women, and that women must submit to men's authority. These perceptions seem to be different than those from the Catholic church leaders.

Around the 1980s, a group of *ejidatarios* from the elder generation, with support from the Catholic church, organized one-day or several-days religious retreats that targeted couples, with the intention of teaching people who were "living their own way" (*a su manera)* to live according to God's word. When asked about what "living their own way" meant catholic ministers would talk about men getting drunk, mistreating their wives, not providing for their kids, having one or several mistresses, and disrespecting their parents or the authority. Interestingly, participants would only talk about men "living their own way," after probing about women's behavior male participants had a hard time answering. The church would organize "spiritual exercises" and "marital days" with around 30 couples participating. Many identify this process as key in reducing alcohol abuse and violence against women. A women *ministra* (minister) from the Catholic Church explains:

> [Men] shouldn't mistreat their wife, or children…and it's worse if he is an alcoholic, he has money for alcohol, but not to bring food to the table, so the woman needs to find a way, sometimes there are women that move forward with their kids. . . So that is what the church talks about . . . men who want, the priest has helped them. Because in this community before there was a lot of alcohol. A

> lot of alcohol, most men were drunks, batterers. . . so the priest [taught] them how to live as a couple, with the kids, with the family, and people calmed down, a little, but as time goes by since they are not going anymore, they go back to the same. **(F, 54)**

These spiritual exercises were key in the elders' life as adults, to fight alcohol addiction, and break a cycle of generational violence that went beyond marital relationships. As this man illustrates:

> Even if my father was a killer, if I educate I can be better. . . I wanted to be a professional killer, I used guns, because my uncle was killed, and my cousin. . . I wanted to avenge the death of my family, but one day I was invited to a spiritual meeting and they awakened my conscience. I dropped the guns, I stopped drinking for 15 years. It was called the Matrimonial Day [*Jornada Matrimonial]*, in Villaflores **(M, 64 y)**

The adults

To prevent the community to "go back to the same," in 2017, a small group of men from the adult generation re-organized an abandoned Alcoholics Anonymous (AA) group in the community. The participants were heavily engaged in outreach to bring more men to participate in what they called "the experience." The 4th and 5th step is a popular spiritual experience that deals with traumatic experiences and emotional distress in a 2-day retreat. They borrow the name from AA 4th and 5th steps of their 12 steps program which are the focus of the retreat, although it is independent from AA. Wives encourage their partners to assist to this

experience—sometimes even borrowing money themselves to pay the transportation fee—with the hope that they will stop drinking and/or stop being violent.

While the experience is said to be nonreligious, it is evidently Christian, and their methods include significant verbal and emotional abuse toward the group of people who are "living the experience," while they are forced to fast, and sleep deprived for over 36 hours. This process is called the *sometimiento* (subjugation, submission). The *sometimiento* is employed to "break down" the participants' psychological barriers, and get to the core of their emotional pain, which drive their 'defects in character' and their emotional disease—alcoholism, drug addiction, neuroticism, hypersexuality.

Despite their controversial methods, the retreat is deeply appreciated by many men who have experienced it, as well as by their wives and families. Similarly, despite the strong opinions of the group against contraceptives, abortion, and homosexuality, living the experience has been reported by some to result in changes in their loved ones, including some flexibility of gender roles. A 26-year-old woman testifies about his dad's change:

> He was a *machista*, he was the one who gave the orders, he shouted, and I couldn't talk back. But I don't know if you've heard about the 4th and 5th step, my dad went there and came back and there is where he changed. What he does now, he arrives and sometimes we are watching TV, he will serve himself his food, when we see him he is warming up his tortillas and eating. . . So, we are equal, if the man helps in the kitchen, the woman must help the man, both equal. So that is a change, but before he was one of those that 'I mount my *macho* (donkey) and no-one brings me down.' **(F, 26)**

During the experience, participants reflect on four instincts: the sexual, the social, the emotional, and the material. Between writing down the role each instinct has played in their life, participants listen to monologues of the experiences of selected staff members, the *padrinos* (godparents). These monologues are mostly about sexual abuse, child physical abuse, sexual experiences with animals, and with people from the same sex (portrayed in a very negative way), parental neglect, poverty, alcoholism, intimate partner violence, infidelity, and abortion. In sum, there is a lot to which men and women from this community can relate to. Likewise, *the experience* is identified as an opportunity to face traumatizing experiences, deal with them, and break a cycle of transgenerational trauma.

> [When I was 9] I left home, aggressively. And that is something I had in my conscience, when I lived the experience I had to take that out. It was less the resentment that I had towards my dad than the resentment I had towards myself because I didn't spend time with them. So, sadly I left home, I drank alcohol . . . I had to engage in prostitution. . . . where did I finally recognize myself? In that blessed experience. **(M, 61 y)**

The youth

Older generations feel that they are out of resources to exhort the youth in avoiding alcohol, tobacco and drugs. Moreover, they are worried that the youth have lost respect for authority, and shocked that even young women are drinking alcohol and walking around late. While parents, AA group leaders, and some religious leaders have been trying to get the most problematic young men into *the experience*, word has spread about their methods and many are not interested in experiencing them. Not only the differences in lived experiences, but also the

gap in educational attainment between the older generations and the youth generation is a barrier adults and elders have, to provide useful advice to adolescents and young adults. The woman Catholic *ministra* expressed this common frustration:

> We want people who are prepared, people who can provide that instruction to the youth, someone who has more capacity than we do, as I say, we didn't have any studies, we cannot go that far, as a person who has more studies. For the youth, and for couples **(M, 65 y)**

While the adults and the elders are worried about the youth, the youth don't seem to be concerned about their own actions as much as they are about their father's alcohol abuse and violent behaviors. They are also more concerned about doing well at school while they fulfill their gendered expectations at home. Struggling with homework and housework/fieldwork is still a common cause of dropping out of school, with the difference that the decision is theirs and not their parents. They are also more concerned about their own romantic relationships as both male and female deal with jealousy, and decisions over when to have sex. Gladly, jealousy is frowned-upon, and young women are clear that respect over their decision on having sexual relationships is paramount on a relationship. Overall, both male and female adolescents would like to continue studying after high-school and work somewhere for a while before getting married.

II. CASE STUDY

To illustrate the way that the previous thematic categories play within an individual's life experience, we present the case of Magdalena[3], a 31-year-old woman from the generation of the adults. Throughout the case, some insights are presented about the elder generation when she reflects on her mother's childhood and teenage years, and about the youth generation when she reflects about her children and her wishes for them. The case is a summary of the interview, presented in a narrative way with some direct quotes for clarification.

Magdalena's case

Childhood

We met Magdalena at the front of her house. She was taking care of a 12 months-old baby boy who was playing with a pile of gravel. "He'll be a constructor," she said, greeting us with a wide smile.

Magdalena was born in a nearby ranch to a 16-year-old single mother who two years later assumed the responsibility of caring for her younger siblings due to their parents' death. When Magdalena was born, her mom tried to give her away and she would constantly say to her, "I wish you had died you son-of-a-bitch." Magdalena's childhood was bittersweet. The sweet part was when she used to play around with her young aunts and uncles. The bitter part increased a couple of years after her mother got together with her current husband. Her step-father didn't want the children with them, he used to beat her and her mother, and forced her mother to beat Magdalena if she tried to defend her from the beatings. Once, her mother sent her to run an errand at a ranch that was half an hour away; on the road, a man started

[3] Names are changed to maintain confidentiality

following her. Suddenly, he grabbed her and covered her mouth and nose. She couldn't breathe. She squeezed out from his arms and he tripped. She ran and ran and managed to escape the attempted rape. Today, she still has nightmares in which she cannot breathe and sees a strange man that frightens her. Six years after her mother got together with her husband, the uncle that used to take care of Magdalena and the other children past away; they were all sent to live with different family members at this community, "everyone took their own way," she says with regret. Magdalena continued her studies for two years, but then she flunked 5th grade; she said,

One cannot concentrate if there isn't a stable home. So, I flunked and to go in again one had to pay again, and I didn't have anyone to pay . . . [my aunt] said that instead of paying my studies she should be paying for her children's food. . . . Then a teacher came, she was working here, and she took me to Tuxtla.

Teenage years

At 14 years old, she went with the teacher "with the illusion," as she said, that she would be taken care of and have a better life. She would help the teacher with the housework in exchange of shelter, clothing and food. Her surprise came 15 days later when humiliation and physical abuse started: "you are an India, from the sierra, you cannot grow materially nor spiritually," the teacher would say. The teacher´s husband would pull her hair if she complained. They locked her up whenever both went out, and she was forbidden to talk to the neighbors who came to ask her if she was being mistreated. Once, the teacher's young kid complained that his milk didn't have enough sugar and the teacher's husband slapped

Magdalena on her face. Magdalena further elaborated "he was big, he had a big body and height, I was a kid, very thin. With a slap he made me turn twice."

Adult life

To get away from that house, she got married at 15 to a man who was 30 years old. "He was violent, he was bitter," her husband would drink, and beat her, and scream at her, however, she stayed: "I did not want my children to live the same story I had lived. Because of that I stayed 12 years," she said. Magdalena's husband would not give her money for rent, food, soap, or to buy school materials or pay school fees, yet, he still expected her to take care of it. To provide for her children, Magdalena worked every job she could find:washing her neighbor's clothes, working at a *tortilleria*, assisting a dentist; anything she could find. Nevertheless, when her husband came back home he would tell the kids "look, your mom, who knows with how many [men] she's slept that she even made enough money for food." Magdalena said,

> I just stepped aside and cried . . . and suddenly I felt a whack. I didn't try to defend myself or anything, but my boy was there, he said 'daddy why are you hitting my mom, only because of money, if you don't want to give me money, let it go,' 'your mom is at fault' he would say, he slapped me, beat me, kicked me . . . when he wanted to hit us he wanted to outright kill us. Sometimes with the kids he was the same. Sometimes when I saw that he was angry I would tell my kids to go out 'no mommy he will hit you,' 'never mind, I am an adult, for you the hitting is worse.'

After 12 years, Magdalena was able to leave him and came back to this community with her two boys, after a while, she decided to re-marry; her children agreed. Then, her ex-

husband started visiting the children and bribing them with money and gifts. Two years ago, during the coffee harvest season, Magdalena went to help her husband at the field. She told her uncle about her suspicion that her ex-husband was up to no good, and begged him to take care of her sons. When she came back, the boys were gone. Magdalena tried to explain what had happened he took them for three days, since those three days it will soon be two years" she hasn´t been able to see them or speak with them since, she further reflects on the situation:

Maybe if I had had support from my husband, if he had given me permission to go look for them, but he didn't. He told me they were with their father and that the father had the right. That he could take them away and have them there as long as he wanted . . . then my mom told me that when they were older they would come back . . . If I were living in a community where there are jobs, well I would have worked to be able to go find them. But I couldn't.

Magdalena´s uncle offered to help her with legal aid, but she could not afford the cost he was proposing "they are men, they don't feel the same as a woman or a mother," she explains. Magdalena's story sheds an insider and an outsider view of the community for having lived for 15 years in the capital city. One of the main differences she notices is that in this community women cannot work, on one side because the husband will not let them, but also because there are not a lot of options for women to work, and when they have young children it is difficult to go to the field with them. Also, when she went to the field with her husband people in the community would start talking, saying that she was jealous and was supervising her husband.

In contrast with most women in the community, Magdalena had to learn her gender role as an adult, taught by her mother-in-law. Magdalena talks about how this was for her:

You see, here they tell us that our duty is, at least, when our husband is coming home, serve him food, *pozol* (a traditional corn-dough drink), warm the water for him to take a bath, everything. Give them their clothes in their hands, give them their shoes if necessary . . . that is what [my mother in-law] taught me . . . it was a strange change but I think it is okay, because that is how one lives in tranquility. Because if the husband comes and we are not serving him [he will say] 'oh you don't love me anymore or maybe you are with someone else,' so to live in peace, one must do things as they are used to

The changes Magdalena makes in her life to avoid conflict, are commonly regarded by women in the community as crucial to avoid IPV and live *tranquilas* (in peace), which is highly valued. When talking about what Magdalena wished for her sons, she said: "A good future or a good life more than anything, maybe not economically but a life full of tranquility and peace, love, that is what I wish, that they are okay, that they don't feel this resentment of not having grown-up with a family."

Sadly, Magdalena's story is not rare, six out of the 10 women we interviewed have very similar life stories: orphanhood or parental neglect, child physical and sexual abuse, leaving the community to find job at the city, sexual abuse at work, and getting married to a man that dinks and 'gets crazy,' or is '*nervioso'* and beats her for no good reason, or as Magdalena told me that "think that they can treat us badly just because one depends on them." Although Magdalena was severely beaten by her first husband, what stands out in her narrative is the constant oppression by others in her life: her step father, her aunt who did not support her studies, her first husband,

and the gender norms that are embodied by her mother in law, and her current husband. These overlapping oppressions occur in a context of poverty and limited of opportunities to foster a different reality.

4. Discussion

This paper aims to illustrate the scope of IPV considering the role of the partner's controlling behaviors, as well as the scope of SA in one rural community located in the region where CES is working. Likewise, this work aims to illustrate the significance of these experiences by contextualizing them in the individual lived experience. In addition, we strive to interweave the gender norms and roles that prevail and the way those shape community and individual experiences of IPV, SA, and emotional distress for women and men, boys and girls.

Intimate partner violence

Based on our results, lifetime prevalence of IPV and of SA was much higher than the state estimates (49.7% vs. 34.9% and 30.5% vs 20.4%, respectively) (INEGI, 2018). One-year prevalence was also considerably higher than the state estimates for IPV, but lower for SA (22% vs 17.6% and 6.4% vs 11.8%, respectively) (INEGI, 2018). Variations in the instruments used to measure IPV and SA may account for this discrepancy. In the case of rape and attempted rape our findings indicate a 11.3% lifetime and 2.8% one-year prevalence, which contrast with the 7.7% lifetime and 1% one-year prevalence found at the national level (Frías, 2018). Supporting our findings, the literature suggests that individuals who live in poverty, suffer a higher proportion of distinct adversities—including physical, sexual and emotional abuse during childhood, as well alcohol abuse—which increase their likelihood of IPV and SA perpetration and victimization (Bruner, 2017; E. Fulu et al., 2013).

Socioeconomic data from the quantitative findings illustrate the grinding poverty in which women live. Most partnered women depend on their husband or in-laws for food and shelter, and even the few who manage to run a small business do not earn enough to sustain themselves nor a

family in this community. The fact that many participants responded that women have the same capacity than men to earn money "in the city, but not here" is echoed by Magdalena's narrative when she says, "If I were living in a community where there are jobs, well I would have worked to be able to go find [my children]. But I couldn't." On the other side, moving to the city to find a job exposes women and girls to physical and sexual abuse.

Poverty also increases the demand of time spent in housework due to the lack of washing machines and other tools, resulting in women often spending ten hours or more in housework and child care, as reflected by quantitative findings. Our findings show that spending more than 12 hours in housework per day is associated with a 1.5 higher risk of suffering IPV, even after adjusting for partner alcohol abuse. Although we did not find any associations between hours spent in housework and depressive symptoms, research in Mexico has shown that being exclusively dedicated to housework, along with poverty, social isolation, and experiences of violence are associated with higher risk of depression (Berenzon et al., 2013).

Partner's controlling behavior

To the author's knowledge, this is the first study that looks at the combination of severity of physical and sexual partner violence, severity of partner control, and measures MC-IPV and HC-IPV as well as their associated factors in Mexico. Previous studies have treated IPV as a dichotomous variable, and its components—emotional, economic, physical, sexual—as independent, which disregards their interconnections, and depicts controlling behavior from the partner as the least severe kind of violence. Our findings indicate that high control comes together with physical and/or sexual violence, which further increases suffering and risk of mental disorders. In our study sample, 83% of women who suffered high control from their

partner also suffered severe physical/sexual IPV, only one reported not having suffered physical or sexual IPV throughout her lifetime. Moreover, the fact that HC-IPV was strongly associated with depression, but not MC-IPV, points to the harmful effects of controlling behaviors on women's mental health. Framing coercive control as violence that restricts women's freedom and autonomy highlights its role as a "liberty crime" (Stark, 2009), which must be addressed. In contrast, our findings are different to the literature (Johnson, 2008) that mentions that MC-IPV is the most common in population-based surveys. In this study setting HC-IPV was more than twice as prevalent than MC-IPV, which suggests that poverty could play a role in the higher prevalence of controlling behaviors.

Sexual abuse

The fact that the prevalence of both partner and non-partner sexual abuse have not significantly changed across generations despite social and economic development, highlights the importance of considering the role of gender norms—within institutions and individuals—that allocate social and economic power to the male population, and endorse hostile attitudes towards women. Earlier studies have found similar results (Jewkes et al., 2011). Research on SA in rural settings in other LMICs has shown that a sense of sexual entitlement among men increase the risk of SA perpetration in a context in which achieving economic success was not a possibility (Fulu et al., 2013; Jewkes et al., 2012, 2011). Our findings add to the literature since the association we found between high control and partner sexual IPV, suggest that deeply imbedded gender norms are preventing the reduction of SA despite socioeconomic improvement. The fact that women's opinion on gender roles has moved towards more equitable attitudes, but violence against women is still highly prevalent, highlights the fact that interventions directed

towards changing women´s opinion about IPV and SA does not necessarily protect them from suffering these kinds of violence. Hence, we support Jewkes and colleages (2015) invitation to include men and boys in prevention interventions

Childhood adverse experiences

An important issue raised by our qualitative findings is parent-to-child violence and neglect, which exposes children to other adversities such as physical and sexual abuse from extended family, neighbors, and employees in the city. We did not find any reliable estimations of the prevalence of ACEs experiences in Mexico. Our quantitative and qualitative findings, however, showed that hitting children is regarded as necessary to ensure good behavior, although the severity of physical punishment has decreased over time. Supporting our findings, previous studies have found that the belief that corporal punishment is necessary to discipline children is more common among mothers who have suffered from IPV, and who live in countries where social norms endorse or condone IPV. (Guedes & Mikton, 2013; Lansford, Deater-Deckard, Bornstein, Putnick, & Bradley, 2014).

Poverty is one of the few socio-demographic factors that increases the risk of IPV consistently across different countries and, economic inequality—in the context of poverty—at the community or societal level has been more strongly associated with IPV than income itself (Jewkes, 2002). Our qualitative findings provide a clear illustration of how poverty and ACEs play a role in an individual's life's experiences of violence, and emotional distress. Recent research has shown that in settings of poverty, ACEs affect young children living in poverty in higher proportions than they affect children who live in more affluent settings (Bruner, 2017).

Gender norms, alcohol abuse and violence against women

While partner alcohol abuse prevalence has decreased among those who were raised after the 1980s, high controlling behavior, and sexual violence have remained constant. Alcohol abuse and controlling behaviors are associated, which points towards the hypothesis that gender norms—ideas of masculinity that support dominance and control, aggressiveness, risk taking, emotional suppression, and being self-reliant, might be driving both (Kaufman Kantor & Straus, 1987; Klostermann & Fals-Stewart, 2006). Despite prohibiting alcohol consumption, qualitative findings show that Presbyterian and Pentecostal religions in this community reinforce norms that endorse male authority over women. Furthermore, the fourth and fifth step experience in Chiapas is highly Christian, and highly heteropatriarchal—discriminating against homosexuality and reproductive rights. A national group leader, Alejandro Castro Rosas, cites in his book *Reclamando el Señorío* (Reclaiming the Lordship), the biblical evidence that endorses women´s submission to men authority (Castro-Rosas, n.d.). Notwithstanding, "the experience" provides a space in which men are pushed to break down, and break the silence about their emotional pain (Garcia, Anderson, & Humphreys, 2015)—albeit through a tough, aggressive, "masculine" method that is named by the fourth and fifth step group members the *"sometimiento"* (submission). While the fourth and fifth step experience is anecdotally effective in stopping men's alcohol abuse and wife battering, no research has been done to evaluate the impact of this community-based intervention, and unintended consequences are yet to be disclosed.

The impact of structural violence

The term structural violence was coined by Johan Galtung, (1969) to refer to "violence [that] is built into the [social] structure and shows up as unequal power and consequently as

unequal life chances." Our qualitative findings show that structural violence is at the foundation of the participants' experiences of distress, as these are a consequence of poverty and marginalization: from orphanhood and child abuse, to alcohol abuse and violence against women and lack of health and social services. In the words of Gustavo Gutiérrez:

> The poor person does not exist as an inescapable fact of destiny. His or her existence is not politically neutral, and it is not ethically innocent. The poor are a by-product of the system in which we live and for which we are responsible. They are marginalized by our social and cultural world. They are the oppressed, exploited proletariat, robbed of the fruit of their labor and despoiled of their humanity. (Quoted in Farmer, 2003)

Our quantitative findings show that coffee-crop land tenure reduces the risk of IPV and high CB, possibly through the reduction of alcohol abuse. However, four out of ten men do not have the privilege of land tenure. Since availability of land is limited due to the surrounding natural reserve, limited land-ownership becomes an impasse that hinders the improvement of living conditions, including the reduction of IPV in this study setting. But as Gutiérrez mentions, the impoverishment of peasants in Chiapas is not accidental. In fact, it has its roots in colonial times, when the Spanish monarchy abusively became the owners of the fruits of the indigenous' people's labor (Sahagún, 1975). Several centuries later, during the 1800s, Porfirio Diaz chose coffee as a profitable cash-crop for southern Mexico and offered the fertile land in Chiapas to foreign capital, which pushed indigenous farmers to the arid highlands. The government then endorsed abusive and aggressive recruitment of peasants to work, in precarious conditions, at the foreign-owned coffee *fincas*, where they were taught to labor through physical and psychological

violence. (Barta, 1996; Hernández-Castillo, 2012). Possibly influencing the way that male and female participants were taught to labor by their own parents during the "material" times.

After the 1910 Mexican Revolution, a process began to give land back to its original proprietaries, and thus the *ejidal* structure was instituted, delegating land tenure to a handful of men, leaving women and less powerful men at the expense of *ejidatarios* (Brunt, 1992). At the same time, after the 1930s a strong governmental nationalization campaign disposed Mayan Mam people in southeastern Chiapas of their indigenous identity, in the name of modernization and progress (Hermández-Castillo, 2001; Hernández-Castillo, 2012), a process that stigmatized indigenous peoples, fomenting a discrimination that persists nowadays.

Throughout history, peasant groups in Chiapas have mobilized to demand social justice from the government, which resulted in the 1980s in the formation of coffee-cooperatives that provide some economic protection to coffee farmers. However, the economy of thousands of families who depend on their own or their neighbors' coffee crops is subjected to the prices of coffee set at the stock market in Washington D.C. Albeit frail, today, coffee-crop land tenure is one of the few things that provides some economic security to families in this study setting.

Although we were not looking for contextual or experiential generational differences, participants framed their responses around these. Our findings showed that the elders generation, who grew up when most families were landless, and whose fathers had to migrate during the harvesting season to the coffee *fincas* to provide for their families, experienced more ACEs compared to the adults and the youth generations. The elders as parents, taught their children to labor and to behave well through physical and psychological violence—as they themselves and the generations before had learned. Participants from the adults generation, who grew up experiencing their parents "delicate ways," suggesting challenges or a fragility in emotional

regulation, identified those adverse conditions as sources of suffering and distress, and referred them as "traumatic" experiences that continue to affect them in their present lives. In response, the adults generation struggle to protect their children from these conditions, while they fight their own battles dealing with past trauma and current IPV and/or alcohol addiction. Recent literature on ACEs supports our qualitative findings, since children who live in poverty have been shown to experience a higher number of ACEs (Bruner, 2017). ACEs in turn, increase the risk of alcohol abuse in adulthood as well as the risk of perpetrating and suffering IPV (Mair, Cunradi, & Todd, 2012; Nikulina, Gelin, & Zwilling, 2017), and synergistically increase the vulnerability to depression and other mental health disorders (Chapman et al., 2004; Merrick et al., 2017).

What about the women?

Gender inequality is one of the many faces of structural violence. It is a "political and economic organization of our social world . . .[which] cause injury to people" (Farmer, Nizeye, Stulac, & Keshavjee, 2006): men, women, boys and girls. However, discourses about structural violence is usually gender-neutral, which fails to illustrate the way that poor women suffer from overlapping structural forces of oppression, both outside and within the household, a fact named *structural intersectionality* by Kimberle Crenshaw (1991), and attributed to *Kyriarchy* by feminist-theologian Elizabeth Schüssler-Fiorenza. Kyriarchy—a term constructed from the Greek *kyrios* = lord/master—builds from patriarchy and intersectionality to raise attention to the power structures that operate in the globe, the country, and the community, constructing "interlocking systems of oppression" within which people relate to each other (Schüssler Fiorenza, 2017).

Our study findings show that partner coffee-crop ownership is protective of IPV through the reduction of partner alcohol abuse. However, the social and economic structure of the country, obstructs the possibility to have land for many men, and almost all women. At the same time, historical marginalization of the people who live in the region of the study setting, limits the availability of job opportunities for women. To make a living, women often migrate to the city, where they are the object of physical, sexual, and psychological abuse by their male and female employers, or "masters." As a result, they come back to their community, where in order to "live in tranquility." they must submit to gender norms that endorse male domination and authority, and fuels male alcohol abuse in a setting of high economic uncertainty where he is expected to provide. This "tranquility" is plagued with experiences of IPV for adult women, and with experiences of physical and sexual abuse, and IPV witnessing for boys and girls, which increase their vulnerability to mental health illnesses such as depression, anxiety, and substance abuse.

Implications for global mental health care delivery

Several studies have found synergistic effects of public health programs directed at reducing HIV/AIDS and income-generating programs in other LMICs that address inequitable gender norms, including reduction of IPV and parent-to-child physical violence (Jewkes et al., 2014; Kyegombe et al., 2015). Our findings highlight that substance abuse causes significant social suffering, including but not limited to the suffering caused by IPV. Moreover, research in international settings suggests that men engage in higher occupational hazards and risk behaviors, but look for health services less frequently than women, which increases their

suffering and lowers their life expectancy (Baker et al., 2014; Read & Smith, 2017). This is true especially for mental health issues (Courtenay, 2000; Emslie, Ridge, Ziebland, & Hunt, 2006).

ACEs, poverty, unemployment, and alcohol abuse increase the risk of suicide, which is an important cause of mortality in Mexico that affects men five times more than women (Cervantes, Torres, & Rodríguez, 2015). In our study setting, 25% of the population reported suicidal thinking during the previous two weeks in 2014 (Arrieta et al., 2017). Moreover, the dearth of resources to affront past traumatic experiences, "emotional pain," depression, and alcohol addiction is evidenced by the community efforts to tackle the problem and the popularity of the fourth and fifth step experience (Anderson & Garcia, 2015; Garcia et al., 2015; White, 2015), however, their methods may be inadequate and even harmful for many.

Through the mixed methods analysis, I hypothesize that the cumulative effect of adversities experienced by the study participants, fueled by poverty and structural violence, in the context of a highly patriarchal society, increase the risk of IPV and SA for women in the study setting. In turn, IPV and SA increase women's vulnerability to mental illness. In addition, both men and women in rural Chiapas, lack access to mental health services due to a dearth of mental health care providers, and a lack of understanding of local conceptualization and expressions of illness and distress by health-care providers (Arrieta, 2015; Kleinman, Eisenberg, & Good, 1978). Our analysis show that providing mental health care in settings for poverty is complex, and thus requires composite solutions that address the needs of women, men, boys and girls.

5. Limitations

Since we sampled in only one community, our results are not generalizable to rural Chiapas or rural Mexico. However, many rural communities in Mexico share similar characteristics—*ejidal* structure, gendered land-tenure, monocrops as cash crops, poverty, geographical marginalization, lack of effective legal and social services. Thus, we believe that findings from our study can inform the implementation of future DHS on violence against women, to account for partner's controlling behavior in addition to the standard measures used for IPV.

Because we were not planning to compare quantitative data across generations, we did not sample to ensure power to examine associations for age subgroups. Therefore, to avoid losing power, we decided to categorize quantitative data in two generations instead of three, based on qualitative findings of the time when "everything changed," around 1985. Comparison of quantitative data across generations thus puts together the elders and most of the adults generations and compares it with the youth and the youngest of the adult generations. Differences between generations should be interpreted with caution since the younger generation could have had less exposure to IPV due to having lived less years with their partner. However, triangulation with qualitative data supports quantitative findings of a reduction of IPV and alcohol abuse across generations.

The cross-sectional study design of the quantitative sample does not permit us to evaluate temporality between risks and outcomes. This is especially true for results on opinion of gender roles, since these opinions could be formed as a consequence of having lived IPV or SA, or witnessed IPV as a child, instead of the other way around. Qualitative data, however provide

valuable information on childhood adversities that have been shown to increase the risk of IPV, alcohol abuse, and depression in the literature.

The PHQ-9 measures depressive symptoms in the past two weeks, thus, we are comparing the experiences of abuse during a woman's lifetime with her symptoms of depression two weeks before the survey, which could attenuate the relationship of IPV/SA with depression and biasing the findings towards the null. In addition, since depression is difficult to measure there can be random variability in the measurement, also attenuating the relationships and biasing the findings towards the null. These two limitations could be underestimating the effect of IPV and SA as risk factors for depression.

Furthermore, some limitations of the IPV measuring instruments were found. When asked about physical IPV, several women would first answer negatively, and then answer positively after prompting for violent events when she first got together with her partner, and after prompting about violent incidents when her partner was drunk. Qualitative findings support the notion that women may disregard experiences of violence while her partner is drunk, which is also supported by literature that suggest that a socially acceptable "time out" might condone men who are violent while drunk. Prompting about these two situations may increase the reporting rates of IPV in rural Chiapas. Despite these limitations, the physical IPV measuring instrument had a Cronbach's alpha of 0.8.

Moreover, language differences between the survey designers and the participants proved to be important in the understanding of some questions. Of note, the question "has your partner ever put the children against you" (*poner a los hijos contra ti*) was understood by some women as "having the children alongside you" (*siempre estan/estaban contra de mi*). Still, Cronbach alpha of the controlling behaviors scale was 0.86. Likewise, the second question of the sexual

IPV scale “has your partner ever forced you to do sexual things while you were having sex” was often not understood by participants and reduced the Cronbach’s alpha to 0.002 when included in the three-item scale; when this item was removed, Cronbach’s alpha increased to 0.74. We suggest that more specific questions should be asked to evaluate the prevalence of forced anal and oral sex, as well as other sexual acts. Moreover, some of the questions in the controlling behavior scale might not be relevant in all settings. In this study setting, the question “has your partner ever taken away property from you” might not be relevant since, as shown in the results section, women often do not have any property in this setting. Similarly, caution should be placed on interpreting negative answers. Of note, many women who were asked “has your partner ever prevented you from working outside of the house” first answered no, but when prompted, they told us that they had never tried or been interested in working outside of the house. In a social context where women are at a two-fold risk of being restricted through rigid gender norms, and lack of resources and opportunities due to poverty, some responses to might be difficult to interpret. The mixed methods design permitted us to triangulate quantitative and qualitative data, and understand the significance of the quantitative findings despite the limitations described.

6. Conclusion

This study aimed to illustrate the scope of IPV—considering the role of CB—and SA in the region where CES is working, and to understand the gender norms and roles that prevail and the way those shape lived experiences and experiences of violence and distress for women and men.

Our findings illustrate an increased burden of IPV and SA among rural women in Chiapas, as compared with state estimates. Given that half of the population in Chiapas live in rural communities, these differences suggest an opportunity to utilize sampling methods that account for representability of the results at the municipal level, so that funds and services can be allocated and strengthened where they are most needed, instead of concentrated in the major cities.

Quantitative analysis revealed the of importance considering partner controlling behaviors as an experience that intersects with physical and sexual violence increasing the risk of depression. We suggest that physical, sexual, and controlling violence should be measured as composite variables, considering the severity of each violent behavior, and classifying types of violence as suggested by Johnson (2008), to avoid dismissing the negative effects of partner-control and account for the synergistic negative effects that these overlapping experiences have on women´s mental health.

Although our findings cannot be generalized outside of this setting, other rural communities in Chiapas and in Mexico could present similar characteristics. Since HC-IPV increases the risk of depression 5.3 times, and sexual abuse is likewise highly prevalent in this context, primary care services must be equipped to provide trauma-sensitive mental health care services for victims, providers must be trained in how to ask about and respond to disclosure of

traumatic events—including IPV and SA (OPS, 2016), as well as to link women and girls to other services when these are both accessible—physically and economically—and effective.

Our mixed methods analysis, which included the voices of men and male and female adolescents as well as the voices of women, permitted us to unveil the toll that adverse childhood experiences—fueled by structural violence, including gender inequality—place in the lived experiences of individuals in this community, which might be shared by individuals in other rural settings in Mexico. Moreover, speaking with people of different ages provided a picture of socioeconomic change in the past century, and envisions the wish of a more just, equal future for women. Unfortunately, alcohol abuse, IPV, and SA continues to cause considerable suffering to individuals and their families, which is exacerbated by the lack of adequate mental health services to address its acute and long-term consequences.

In addition, the fact that IPV and child maltreatment can occur within the same household calls for an effort to design synergistic interventions to address both (Guedes & Mikton, 2013; Kyegombe et al., 2015). Programs and interventions directed to improving early child development can be leveraged to promote healthy parenting strategies and address inequitable gender norms that facilitate IPV and SA. Although the severity of child physical punishment seems to be decreasing in younger generations, further studies are needed to understand the scope of harmful parenting strategies and their impact on children's mental health in this context. Likewise, SA needs to be further studied in rural Mexico with special attention on risk and protective factors for perpetuation, as well as considering boys' and men's experiences of SA victimization.

Furthermore, research on ACEs, with special emphasis on the age, gender and rural/urban distribution, and its relationship with alcohol abuse and violence victimization and

perpetration—inside and outside the home—is crucial to understanding the scope of services that must be made available in rural Mexico to permit each individual's integral development. Moreover, mental health services must address situations that cause significant distress in boys and men, and find ways to move mental health services closer to them. Mental health care services must act in synergy with community-based groups like AA to strengthen community efforts and avoid harmful effects on those participating.

In the light of continuing budgetary constraints for governmental primary care mental health services, which receive less than 20% of the resources allocated to mental health care—themselves 2% of overall health expenditure—CES provides a unique opportunity to provide these much-needed services through expanding the scope of its Mental Health program to meet the burden of determinants of mental illness in its catchment area. Beyond health care delivery, structural changes are necessary to reduce social determinants that increase the risk of mental illnesses. Development programs and *Procuraduria Agraria* in rural Chiapas should be aware of gender and power dynamics in rural communities, and plan accordingly to prevent perpetuation of gender inequality. Similarly, Conditional Cash Transfer (CCT) programs must be leveraged to engage men in conversations on more equitable "ways of living," following the steps of the community-organized groups of AAs and the Catholic church in this study setting, with special care on addressing gender inequitable norms and roles.

Worldwide, as mental health care services availability in primary-care settings increases, information on ACEs distribution will be vital to construct trauma-informed, responsive, and contextually competent mental health care systems. This will require adequate training of health professionals on trauma and mental health during their medical, nursing, psychology and social-work training.

7. References

Akyüz, A., Yavan, T., Şahiner, G., & Kılıç, A. (2012). Domestic violence and woman's reproductive health: a review of the literature. *Aggression and Violent Behavior*, *17*(6), 514–518. https://doi.org/10.1016/j.avb.2012.07.005

Alcalde, M. C. (2011). Institutional Resources (UN)Available: The effects of police attitudes and actions on bettered women in Peru. In *Anthropology at the front lines of gender-based violence* (pp. 91–106). Vanderbilt University Press.

Anderson, B. T., & Garcia, A. (2015). "Spirituality" and "cultural adaptation" in a Latino mutual aid group for substance misuse and mental health. *BJPsych Bulletin*, *39*(4), 191–195. https://doi.org/10.1192/pb.bp.114.048322

Angelucci, M. (2008). Love on the Rocks: Domestic Violence and Alcohol Abuse in Rural Mexico. *Journal of Economic Analysis & Policy Contributions The B.E. Journal of Economic Analysis & Policy*, *8*(1). https://doi.org/10.2202/1935-1682.1766

Arrieta, J. (2015). *Understanding depression in rural Chiapas: contextualizing quantitative measures and-- patients' experiences*. *Unpublished Master's Thesis. Harvard University*. Boston: Harvard University.

Arrieta, J., Aguerrebere, M., Raviola, G., Flores, H., Elliott, P., Espinosa, A., … Franke, M. F. (2017). Validity and Utility of the Patient Health Questionnaire (PHQ)-2 and PHQ-9 for Screening and Diagnosis of Depression in Rural Chiapas, Mexico: A Cross-Sectional Study. *Journal of Clinical Psychology*, *73*(9), 1076–1090. https://doi.org/10.1002/jclp.22390

Babcock, J. C., Green, C. E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review*, *23*(8), 1023–1053. https://doi.org/10.1016/j.cpr.2002.07.001

Baker, P., Dworkin, S. L., Tong, S., Banks, I., Shand, T., & Yamey, G. (2014). The men's health gap: Men must be included in the global health equity agenda. *Bulletin of the World Health Organization*, *92*(8), 618–620. https://doi.org/10.2471/BLT.13.132795

Barker, G., Ricardo, C., Nascimento, M., Olukoya, A., & Santos, C. (2010). Questioning gender norms with men to improve health outcomes: Evidence of impact. *Global Public Health*, *5*(5), 539–553. https://doi.org/10.1080/17441690902942464

Barta, A. (1996). *El México Barbaro. Plantaciones y Monterias del Sureste Durante el Porfiriato*. Mexico City: El Atajo Ediciones.

Batt, C. (1969). Mexican character: An Alderian Interpretation. *Journal of Individual Psychology*, *5*(2), 183–201.

Berenzon, S., Lara, M. A., Robles, R., & Medina-mora, M. E. (2013). Depresión : estado del conocimiento y la necesidad de políticas públicas y planes de acción en México. *Salud Pública de México*, *55*(1), 74–80. https://doi.org/10.1590/S0036-36342013000100011

Bird, C. (1999). Gender, household labor, and psychological distress: The impact of the amount and division of housework. *J Health & Soc Behav*, *40*, 32–45.

Blackwell, M. (2006). Weaving in the spaces. Indigenous Women's Organizing and the Politics of Scale in MExico. In *Dissident Women: Gender and Cultural Politics in Chiapas* (pp. 115–154). Austin: University of Texas Press.

Boston Women's Health Collective. (1970). *Women and their bodies. A course*. *New England Free Press*.

Bruner, C. (2017). ACE, Place, Race, and Poverty: Building Hope for Children. *Academic*

Pediatrics, *17*(7), S123–S129. https://doi.org/10.1016/j.acap.2017.05.009
Brunt, D. (1992). *Mastering the Struggle: Gender, Actors and Agrarian Change in a Mexican Ejido*. Amsterdam: CEDLA Centro de estudios y documentación Latinoamericanos.
Buller, A. M., Peterman, A., Ranganathan, M., Bleile, A., Hidrobo, M., & Heise, L. (2018). *A mixed-method review of cash transfers and intimate partner violence in low and middle-income countries*. Retrieved from https://www.unicef-irc.org/publications/pdf/CT IPV_Review_Innocenti WP 2018-02.pdf
Castro-Rosas, A. (n.d.). Recuperando el Señorío.
Castro, R., & Casique, I. (2014). *Expresiones y contextos de la violencia contra las mujeres en México*. Cuernavaca, Mor.
Cervantes, C., Torres, M., & Rodríguez, I. (2015). Análisis del impacto de la mortalidad por suicidios en México. *Salud Colectiva*, *11*(4), 471–484. https://doi.org/10.18294/sc.2015.784
Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, *82*(2), 217–225. https://doi.org/10.1016/j.jad.2003.12.013
Compañeros En Salud. (2017). Compañeros En Salud. Retrieved October 1, 2017, from companerosensalud.mx
CONEVAL. (2012). Informe de pobreza y evaluación en el estado de Chiapas 2012, 1–57.
Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine*, *50*(10), 1385–1401. https://doi.org/10.1016/S0277-9536(99)00390-1
Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241–1299. https://doi.org/10.2307/1229039
Dube, S. R., Anda, R. F., Felitti, V. J., Edwards, V. J., & Croft, J. B. (2002). Adverse childhood experiences and personal alcohol abuse as an adult. *Addict Behav*, *27*(5), 713–725. https://doi.org/10.1016/S0306-4603(01)00204-0
Dutton, D. G., & Nicholls, T. L. (2005). The gender paradigm in domestic violence research and theory: Part 1 - The conflict of theory and data. *Aggression and Violent Behavior*, *10*(6), 680–714. https://doi.org/10.1016/j.avb.2005.02.001
Ehsan, A. M., & Silva, M. J. De. (2015). Social capital and common mental disorder: a systematic review. *J Epidemiol Community Health*, *69*, 1021–1028. https://doi.org/10.1136/jech-2015-205868
Elliott, M., Aguerrebere, M., & Elliott, P. (n.d.). Depression in rural communities and primary care clinics in Chiapas, México. *Journal of Epidemiology and Global Health*.
Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity? *Social Science and Medicine*, *62*(9), 2246–2257. https://doi.org/10.1016/j.socscimed.2005.10.017
Farmer, P. (2003). *Pathologies of Power: Health, human rights, and the new war on the poor*. *University of California Press*.
Farmer, P. (2011). Partners in Help: Assisting the Poor Over the Long Term. *Foreing Affairs*. Retrieved from https://www.foreignaffairs.com/articles/haiti/2011-07-29/partners-help
Farmer, P. E., Nizeye, B., Stulac, S., & Keshavjee, S. (2006). Structural violence and clinical medicine. *PLoS Medicine*, *3*(10), 1686–1691. https://doi.org/10.1371/journal.pmed.0030449
Frías, S. (2018). *Violación e intento de violación de mujeres, patrones de búsqueda de ayuda y denuncia. Un análisis a partir de la ENDIREH 2016*. *Papeles de Población*.

Frías, S. M. (2013). Strategies and help-seeking behavior among Mexican women experiencing partner violence. *Violence against Women*, *19*(1), 24–49. https://doi.org/10.1177/1077801212475334

Frías, S. M., & Erviti, J. (2014). Gendered experiences of sexual abuse of teenagers and children in Mexico. *Child Abuse and Neglect*, *38*(4), 776–787. https://doi.org/10.1016/j.chiabu.2013.12.001

Frias Martinez, S. (2008). Gender, the state and patriarchy: Partner violence in Mexico. *ProQuest Dissertations and Theses*, 415–n/a.

Fulu, E. (2017). We Cannot Achieve Gender, Racial And Economic Equality Just Through Self-Empowerment. Retrieved January 1, 2017, from http://www.huffingtonpost.co.uk/emma-fulu/gender-equality-empowerment_b_15205774.html

Fulu, E., Warner, X., Miedema, S., Jewkes, R., Roselli, T., & Lang, J. (2013). *Why do some men use violence against women and how can we prevent it? Summary report of quantitative findings from the United Nations Multi-country Study on Men and Violence in Asia and the Pacific.* Bangkok: UNDP, UNFPA, UN Women and UNV.

Galtung, J. (1969). Violence, Peace, and Peace Research. *Journal of Peace Research*, *6*(3), 167–191.

García-Morales, I. V., Gutiérrez-Martínez, M. T., Rodríguez Álvarez, C., & Cifuentes Tovilla, A. (2017). Panorama del trabajo de la salud mental en Chiapas. *Salud En Chiapas*, *17*(188), 96–99.

García-Moreno, C. (2001). Putting Women First. Ethical and Safety Recommendations for Research on Dometic Violence Against Women. *World Health Organization*, 33.

García-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., & Watts, C. (2005). World Health Organization Multi-country Study on Women's Health and Domestic Violence against Women Initial results on prevalence, health outcomes and women's responses Full Report. *World Health Organization*. https://doi.org/10.1016/S0140-6736(06)69523-8

García-Moreno, C., Zimmerman, C., Morris-Gehring, A., Heise, L., Amin, A., Abrahams, N., … Watts, C. (2015). Addressing violence against women: A call to action. *The Lancet*, *385*(9978), 1685–1695. https://doi.org/10.1016/S0140-6736(14)61830-4

Garcia, A., Anderson, B., & Humphreys, K. (2015). Fourth and fifth step groups: A new and growing self-help organization for underserved latinos with substance use disorders. *Alcoholism Treatment Quarterly*, *33*(2), 235–243. https://doi.org/10.1080/07347324.2015.1018784

Gobierno del Estado de Chiapas. Ley de acceso a una vida libre de violencia para las mujeres en el estado de Chiapas, Pub. L. No. 186, 1 (2009). Mexico: Periódico Oficial del Estado de Chiapas.

Guedes, A., & Mikton, C. (2013). Examining the Intersections between Child Maltreatment and Intimate Partner Violence. *Western Journal of Emergency Medicine*, *14*(4), 377–379. https://doi.org/10.5811/westjem.2013.2.16249

Gutmann, M. (1998). El machismo. In T. Valdés & J. Olivarrieta (Eds.), *Masculinidades y Equidad de Género en America Latina*. FLASCO. Retrieved from http://dx.doi.org/10.1016/j.asw.2013.04.001%5Cnhttp://journals.cambridge.org/abstract_S0140525X00005756%5CnLib scanned%5Cnhttp://www.br-ie.org/pub/index.php/rbie/article/view/1293%5Cnhttp://www-psych.nmsu.edu/~pfoltz/reprints/Edmedia99.html%5Cnhttp://urd.let.rug.nl

Hagan, J. M. (1998). Social Networks, Gender, and Immigrant Incorporation: Resources and

Constraints. *American Sociological Review*, *63*(1), 55. https://doi.org/10.2307/2657477
Heim, C., Newport, D. J., Heit, S., Graham, Y. P., Wilcox, M., Bonsall, R., … Nemeroff, C. B. (2000). Pituitary-Adrenal and Autonomic Responses to Stress in Women After Sexual and Physical Abuse in Childhood. *JAMA*, *284*(3), 592–597.
Heise, L. (1998). Violence Against Women. An Integrated Ecological Framework. *Violence Against Women*, *4*(3), 262–290. https://doi.org/0803973233
Heise, L. L. (2011). *What works to prevent partner violence: An evidence overview*. https://doi.org/978 0 902657 85 2
Hermández-Castillo, R. A. (2001). *Histories and Stories from Chiapas*.
Hernández-Castillo, R. A. (2001a). From Mestizo to Multicultural Mexico. In *Histories and Stories from Chiapas: Border Identities in Southern Mexico.* (pp. 100–121).
Hernández-Castillo, R. A. (2001b). Organic Growers. In *Histories and Stories from Chiapas* (pp. 161–186). University of Texas Press.
Hernández-Castillo, R. A. (2001c). Postrevolutionary project and Nationalization of the Mam people. In *Histories and Stories from Chiapas: Border Identities in Southern Mexico.* (pp. 18–48). University of Texas Press.
Hernández-Castillo, R. A. (2006). Between Feminist ethnocentricity and ethnic essentialism: The Zapatistas' Demands and the National Indigenous Women's Movement. In S. Speed, R. A. Hernández-Castillo, & L. M. Stephen (Eds.), *Dissident Women* (pp. 57–74). Austin: University of Texas Press.
Hernández-Castillo, R. A. (2012). *Sur profundo: Identidades indígenas en la frontera Chiapas-Guatemala*. Publicaciones del a Casa Chata, CIESAS, CDI.
Howard, L., Feder, G., & Agnew-Davis, R. (2013). *Domestic Violence and Mental Health*. (L. Howard, G. Feder, & R. Agnew-Davis, Eds.). London: Royal College of Psychiatry.
Howard, L. M., Trevillion, K., & Agnew-Davies, R. (2010). Domestic violence and mental health. *International Review of Psychiatry (Abingdon, England)*, *22*(5), 525–34. https://doi.org/10.3109/09540261.2010.512283
Humboldt, A. Von. (1877). *Political Essay on the Kingdom of New Spain.* London: London, Printed for Longman, Hurst, Rees, Orme, and Brown.
INEGI. (2015). Cuéntame. Información por entidad. Chiapas. Retrieved from http://www.cuentame.org.mx/monografias/informacion/chis/poblacion/educacion.aspx?tema=me&e=07
INEGI. (2018). Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares 2016. Retrieved August 20, 2004, from http://www.beta.inegi.org.mx/proyectos/enchogares/especiales/endireh/2016/
INMUJERES, ONU México, & PNUD. (2016). *Desarrollo humano y violencia contra las mujeres en México*. Mexico City.
Instituto Nacional de las Mujeres. (2008). Estudio de Investigación en los Municipios del Estado sobre Violencia de Género. Chiapas. ENDIREH 2006. *Instituto Nacional de Las Mujeres*.
Instituto Nacional de las Mujeres. (2011). *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares (ENDIREH) 2011. Reporte*. *Instituto Nacional de las Mujeres*.
Instituto Nacional de Salud Pública. (2013). *Encuesta Nacional de Salud y Nutricion 2012. Resultados por Entidad Federativa. Chiapas*. Cuernavaca, Mor: Instituto Nacional de Salud Pública.
Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *Lancet*, *359*(9315), 1423–1429. https://doi.org/10.1016/S0140-6736(02)08357-5

Jewkes, R., Flood, M., & Lang, J. (2015). From work with men and boys to changes of social norms and reduction of inequities in gender relations: A conceptual shift in prevention of violence against women and girls. *The Lancet*, *385*(9977), 1580–1589. https://doi.org/10.1016/S0140-6736(14)61683-4

Jewkes, R., Gibbs, A., Jama-Shai, N., Mbatha, N., Misselhorn, A., Mushinga, M., … Washington, L. (2014). Stepping Stones and Creating Futures intervention: outcomes of a formative evaluation of behavioural and structural pilot intervention for young people in urban informal settlements in South Africa. *BMC Public Health*, *14*, 1–10. https://doi.org/10.1186/1471-2458-14-1325

Jewkes, R., Morrell, R., Sikweyiya, Y., Dunkle, K., & Penn-Kekana, L. (2012). Men, prostitution and the provider role: Understanding the intersections of economic exchange, sex, crime and violence in South Africa. *PLoS ONE*, *7*(7). https://doi.org/10.1371/journal.pone.0040821

Jewkes, R., Sikweyiya, Y., Morrell, R., & Dunkle, K. (2011). Gender inequitable masculinity and sexual entitlement in rape perpetration south africa: Findings of a cross-sectional study. *PLoS ONE*, *6*(12). https://doi.org/10.1371/journal.pone.0029590

Johnson, M. P. (2008). *A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence.* Boston: Northeastern University Press.

Kaufman Kantor, G., & Straus, M. A. (1987). The Drunken Bum Theory of Wife Beating. *Social Problems*, *34*(3), 213–230. https://doi.org/10.3868/s050-004-015-0003-8

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, *88*, 251–258. https://doi.org/10.1059/0003-4819-88-2-251

Klostermann, K. C., & Fals-Stewart, W. (2006). Intimate partner violence and alcohol use: Exploring the role of drinking in partner violence and its implications for intervention. *Aggression and Violent Behavior*, *11*(6), 587–597. https://doi.org/10.1016/j.avb.2005.08.008

Klostermann, K., Kelley, M. L., Mignone, T., Pusateri, L., & Fals-Stewart, W. (2010). Partner violence and substance abuse: Treatment interventions. *Aggression and Violent Behavior*, *15*(3), 162–166. https://doi.org/10.1016/j.avb.2009.10.002

Krieger, N. (2003). Genders , sexes , and health : what are the connections — and why does it matter ? *International Journal of Epidemiology*, *32*, 652–657. https://doi.org/10.1093/ije/dyg156

Kuehner, C. (2016). Why is depression more common among women than among men? *The Lancet Psychiatry*, *0*(0), 282–288. https://doi.org/10.1016/S2215-0366(16)30263-2

Kyegombe, N., Abramsky, T., Devries, K. M., Michau, L., Nakuti, J., Starmann, E., … Watts, C. (2015). What is the potential for interventions designed to prevent violence against women to reduce children's exposure to violence? Findings from the SASA! study, Kampala, Uganda. *Child Abuse and Neglect*, *50*, 128–140. https://doi.org/10.1016/j.chiabu.2015.10.003

Lansford, J. E., Deater-Deckard, K., Bornstein, M. H., Putnick, D. L., & Bradley, R. H. (2014). Attitudes justifying domestic violence predict endorsement of corporal punishment and physical and psychological aggression towards children: A study in 25 low- and middle-income countries. *Journal of Pediatrics*, *164*(5), 1208–1213. https://doi.org/10.1016/j.jpeds.2013.11.060

Mackie, G., Moneti, F., Shakya, H., & Denny, E. (2015). *What are Social Norms ? How are*

They Measured ? San Diego, California.
Mair, C., Cunradi, C. B., & Todd, M. (2012). Adverse childhood experiences and intimate partner violence: Testing psychosocial mediational pathways among couples. *Annals of Epidemiology*, *22*(12), 832–839. https://doi.org/10.1016/j.annepidem.2012.09.008
McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. *Health Education Quarterly*, *15*(4), 351–377. https://doi.org/10.1177/109019818801500401
Merrick, M. T., Ports, K. A., Ford, D. C., Afifi, T. O., Gershoff, E. T., & Grogan-Kaylor, A. (2017). Unpacking the impact of adverse childhood experiences on adult mental health. *Child Abuse and Neglect*, *69*, 10–19. https://doi.org/10.1016/j.chiabu.2017.03.016
Molyneux, M. (2006). Mothers at the Service of the New Poverty Agenda : Progresa / Oportunidades, Mexico ' s Conditional Transfer Programme. *Social Policy and Administration*, *40*(4), 425–449.
Nikulina, V., Gelin, M., & Zwilling, A. (2017). Is There a Cumulative Association Between Adverse Childhood Experiences and Intimate Partner Violence in Emerging Adulthood? *Journal of Interpersonal Violence*, *0*(0), 1'28. https://doi.org/10.1177/0886260517741626
Nussbaum, M. (2003). Capabilities As Fundamental Entitlements: Sen and Social Justice. *Feminist Economics*, *9*(2–3), 33–59. https://doi.org/10.1080/1354570022000077926
OECD. (2008). *Growing Unequal? : Income Distribution and Poverty in OECD Countries. Country note: Mexico*.
OECD. (2012). *Better Policies for Inclusive Development. Mexico*.
OECD. (2016). *Income inequality (indicator)*. https://doi.org/10.1787/459aa7f1-en
Olaiz, G., Uribe, P., & Del Rio, A. (2009). Encuesta Nacional sobre Violencia contra las Mujeres (ENVIM2006). *Centro Nacional de Equidad de Género Y Salud Reproductiva*, 125.
OPS. (2016). *Atención de salud para las mujeres que han sufrido violencia de pareja o violencia sexual. Manual Clínico*. Washington D.C.
Parry, B., & Haynes, P. (2000). Mood Disorders and the Reproductive Cycle. *Journal of Gender Specific Medicine*, *3*(5), 53–58.
Paz, O. (1950). *El laberinto de la soledad*. (E. M. Satí, Ed.) (5th ed.). Mexico City: Fondo de Cultura Económica.
Radford, L., Allnock, D., & Hynes, P. (2015). *Preventing and Responding to Child Sexual Abuse and Exploitation : Evidence review*.
Read, J. G., & Smith, P. B. (2017). Gender and national origin differences in healthcare utilization among U.S. Immigrants from Mexico, China, and India. *Ethnicity and Health*, *0*(0), 1–17. https://doi.org/10.1080/13557858.2017.1297776
Riecher-Rossler, A. (2016). Sex and gender differences in mental disorders. *The Lancet Psychiatry*, *25*, 9–10. https://doi.org/10.1016/S2215-0366(16)30348-0
Roberts, M. (2009). *Violence Against Women: The Dynamics Associated with Traditional Gender Attitudes and Social Capital*. Washington State University.
Saguaro Seminar. (2016). About Social Capital. Retrieved from https://www.hks.harvard.edu/programs/saguaro/about-social-capital
Sahagún, F. B. de. (1975). *Historia general de las cosas de la Nueva España (1499-1590).* Ciudad de Mexico: Editorial Porrúa.
Schüssler-Fiorenza, E. (1975). Feminist theology: A critical theology of liberation. *The Cambridge Companion to Liberation Theology, Second Edition*, 605–626. https://doi.org/10.1017/CCOL0521868831.006

Schüssler Fiorenza, E. (2017). *Congress of Wo/men: Religion, Gender, and Kyriarchal Power*. FSR books.
Secretaria de Desarrollo Social. Reglas de Operación PROSPERA 2017, Diario oficial de la Federación § (2016). Mexico: Diario Oficial de la Federación. 29, diciembre, 2016.
Secretaría de Salud. (2010). *Población usuaria de servicios de salud*.
Seedat, S., Scott, K. M., Angermeyer, M. C., Berglund, P., Bromet, E. J., Brugha, T. S., … Kessler, R. C. (2009). Cross-national associations between gender and mental disorders in the World Health Organization World Mental Health Surveys. *Archives of General Psychiatry*, *66*(7), 785–95. https://doi.org/10.1001/archgenpsychiatry.2009.36
Semali, I. A., Edwin, T., & Mboera, L. E. G. (2011). Food insecurity and coping strategies among people living with HIV in Dar es Salaam, Tanzania. *Tanzania Journal of Health Research*, *13*(4), 1–13.
Sen, G., Östlin, P., George, A., Cook, R., Keleher, H., Dwyer, J., … Maguire, P. (2007). *Unequal , Unfair , Ineffective and Inefficient Gender Inequity in Health : Why it exists and how we can change it Final Report to the WHO Commission on Social Determinants of Health Women and Gender Equity Knowledge Network Gita Sen and Piroska Östlin Rev*.
Silva, M. J. De, Huttly, S. R., Harpham, T., & Kenward, M. G. (2007). Social capital and mental health : A comparative analysis of four low income countries, *64*, 5–20. https://doi.org/10.1016/j.socscimed.2006.08.044
Speed, S. (2006). Rights at the intersection. Gender and Ethnicity in Neoliberal Mexico. In S. Speed, R. A. Hernández-Castillo, & L. M. Stephen (Eds.), *Dissident Women Gender and Ethnicity in Neoliberal Mexico* (pp. 203–221). University of Texas Press.
Speed, S., Hernández-Castillo, R. A., & Stephen, L. M. (2006). *Dissident Women: Gender and Cultural Politics in Chiapas*. (S. Speed, R. A. Hernández-Castillo, & L. M. Stephen, Eds.). Austin: University of Texas Press.
Stark, E. (2009). Rethinking coercive control. *Violence Against Women*, *15*(12), 1509–1525. https://doi.org/10.1177/1077801209347452
Stern, S. J. (1997). *The secret history of gender:. Women, Men, and Power in late colonial Mexico*. University of North Carolina Press.
Stevens, E. P. (1973). Marianismo: The Other Face of Machismo in Latin America. In A. Pascatello (Ed.), *Female and Male in Latin America Essays* (pp. 89–101). University of Pittsburg Press.
Strong, M. (1998). The Unkindest Cut of All. The Legacy of Childhood Sexual Abuse. In M. Strong (Ed.), *A Bright Red Scream: Self mutilation and the language of pain.* (pp. 64–84). New York.
Stuckless, N., Toner, B., & Butt, N. (2015). Perspectives of Vioence against Women. In N. Khanlou & F. B. Pilkington (Eds.), *Women's mental Health: Resistance and Resilience in Community and Society*. Springer International Publishing Switzerland.
Teicher, M. H., Anderson, C. M., & Polcari, A. (2012). Childhood maltreatment is associated with reduced volume in the hippocampal subfields CA3, dentate gyrus, and subiculum. *Proceedings of the National Academy of Sciences*, *109*(9), E563–E572. https://doi.org/10.1073/pnas.1115396109
Terrazas-Carrillo, E. C., McWhirter, P. T., & Martel, K. M. (2016). Depression Among Mexican Women: The Impact of Nonviolent Coercive Control, Intimate Partner Violence and Employment Status. *Journal of Family Violence*, *31*(6), 721–734. https://doi.org/10.1007/s10896-016-9827-x

Toledo-Tello, S., & Garza-Caligaris, A. M. (2006). Gender and stereotypes in the social movements of Chiapas. In S. Speed, R. A. Hernandez-Castillo, & L. M. Stephen (Eds.), *Dissident Women* (pp. 97–114). Austin: University of Texas Press.

UN. (1993). Declaration on the elimination of violence against women general assembly resolution 48/104 of 20 december 1993, (December), 115–122. Retrieved from http://www.ohchr.org/Documents/ProfessionalInterest/eliminationvaw.pdf

United Nations Development Program. (2015). Inequality Adjusted Human Development Index. Retrieved December 21, 2016, from http://hdr.undp.org/en/content/inequality-adjusted-human-development-index-ihdi

Vigo, D., Thornicroft, G., & Atun, R. (2016). Estimating the true global burden of mental illness. *The Lancet Psychiatry*, *3*(2), 171–178. https://doi.org/10.1016/S2215-0366(15)00505-2

Walby, S. (1991). *Theorizing Patriarchy*. Wiley-Blackwell.

What Works. (2014). A Summary of the Evidence and Research Agenda for What Works: A Global Programme to Prevent Violence against Women and Girls. https://doi.org/http://dx.doi.org/10.1016/S0140-6736(14)61703-7

White, W. L. (2015). The History of 4th and 5th step Groups: An interview with Dr. Angela Garcia.

WHO. (2014). 2014 Mental health atlas. *Who*, 72. https://doi.org/10.1037/e360882004-001

Wizemann, T. M., & Pardue, M.-L. (2001). Sex Affects Behavior and Perception. In T. M. Wizemann & M.-L. Pardue (Eds.), *Exploring the biological contributions to human health: Does sex matter?* (p. 115). National Academy of Sciences.

Woodin, E. M., & O'Leary, K. D. (2010). A Brief Motivational Intervention for Physically Aggressive Dating Couples. *Prevention Science*, *11*(4), 371–383. https://doi.org/10.1007/s11121-010-0176-3

World Health Organization. (2008). *mhGAP Programa de Acción para Superar las Brechas en Salud Mental*. Geneva. Retrieved from http://www.who.int/mental_health/evidence/mhgap_spanish.pdf?ua=1

World Health Organization, & London School of Hygiene and Tropical Medicine. (2010). Preventing intimate partner and sexual violence against women: taking action and generating evidence. The WHO Multi-country Study. *Injury Prevention*, *16*(5), 1–102. https://doi.org/10.1136/ip.2010.029629

Zillah Eisenstein. (1999). Constructing a Theory of Capitalist Patriarchy and Socialist Feminism. *Critical Sociology*, *25*, 196–217. https://doi.org/10.1177/089692059902500209O1