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ORIGINAL PAPER

Intimate Partner Violence and Depression Among Latin American Women in Toronto

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Abstract Research from the United States suggests that Latin American immigrant and refugee women are one of the groups most greatly impacted by intimate partner violence (IPV) and associated mental health consequences including higher rates of depression than women from other ethno-racial groups. In Canada, little is known about the experience of IPV and mental health among this population. Even in the broader North American context, how Latin American women themselves perceive the connection between IPV and depression is unknown. This paper presents the findings of a pilot study that examined the perceived relationship between IPV and depression among Spanish-Speaking Latin American Women in Toronto, Canada. The theoretical framework guiding this qualitative study combined an ecological model for understanding gender based violence and mental health with critical intersectionality theory. Using a convenience and snowball sampling method, semi-structured interviews (n = 12) were conducted and thematic content analysis was completed supported by Nvivo9® qualitative data management software. All participants had experienced some form of IPV in their adult lives, with psychological violence being the most common. Women perceived a powerful connection between IPV and depression, a link made stronger by the accumulation of other adverse life experiences including childhood abuse, war traumas and migration. The results suggest that IPV is just one of the challenges experienced by Latin American refugee and immigrant women. IPV is experienced in the context of other traumatic experiences and social hardships that may work to intensify the association of IPV and depression in this population.

Keywords Domestic violence · Latin Americans · Immigrants · Refugees · Mental health · Social determinants

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Background

Violence against women is a serious public health problem globally [1]. While women experience multiple forms of violence over the course of their lives, the most common form of violence occurs at the hands of someone they know, often a family member or intimate partner [2, 3]. Intimate partner violence (IPV) is defined as single or recurrent threats or acts of mental, physical, and sexual types of abuse, aggression or assault from a previous or current intimate partner [3, 4]. Although IPV can occur in same sex relationships and be perpetrated by either men or women, in the vast majority of cases the perpetrator is male

and the victim female [3]. In Canada, the 2009 General Social Survey found that 7 % of Canadian women with a current or former spouse reported being physically or sexually victimized by their spouse [5].

IPV increases women's risk for a number of physical and mental health problems, including chronic pain, injury and physical disability, drug and alcohol abuse, post traumatic stress disorder and depression [3, 6]. Depression, a leading cause of years lived with disability worldwide is one of the most prevalent mental health consequences of IPV in women. Women with histories of IPV experience higher rates of depression than women in the general population [7–10]. In a meta-analysis of studies examining IPV as a risk factor for mental health problems, it was reported that the mean prevalence of depression among female victims was 47.6 % compared to 17.1–21.3 % life time prevalence of depression among women in the general population [9].

Immigrant and refugee women are at risk for depression due to their gender and low socio-economic status and are also exposed to the stressors associated with migration and resettlement—including discrimination, language and cultural barriers, loss of social status, and social isolation—that threaten their mental well-being [11]. Among immigrants in Canada, the prevalence of common mental health problems are lower than the general population however over time the rates increase to the same levels as those of the general population (a phenomenon known as the health immigrant effect) [11, 12]. Migrants experience multiple forms of social inequity and stressors related to being a foreigner in a new country which place them at risk of developing depression [13–16]. Yet, people from immigrant, refugee, ethno-cultural and racialized groups often have poorer access to care and receive poorer treatment [17]. While IPV occurs in communities worldwide, it is a phenomenon steeped in cultural beliefs and behaviours, social constructions of gender and gender relations, and systems of social inequality and power. In the Latin American context, researchers have linked IPV to cultural factors such as *machismo*—a valuing of male's "aggressive" and "dominant" qualities—and its counterpart, *marianismo*, the a valuing of "passive" and "self-sacrificing" qualities in females, rooted in religious thought [18, 19]. Similarly, experiences of depression, health and illness are shaped by individuals' personal, cultural, social and political circumstances [20, 21]. Therefore, the understandings, lived experiences and responses to IPV and depression of Latin American women in Toronto will be significant to the development of interventions, services and programs for this group.

Research from the United States suggests that Latin American[1] women are one of the groups most greatly impacted by IPV and associated mental health sequelae. Significantly, rates of depression are higher among Latinas who report IPV than among women from other ethno-racial groups [7, 22, 23]. Caetano and Cunradi [23] examined a cohort of 673 women reporting Major Depressive Disorder (MDD), and found that abused Hispanic women had a higher prevalence of MDD (38 %) than either abused Anglo-American (20 %) or African-American women (30 %). According to the U.S. research, survivors of IPV are also more likely than women not exposed to IPV to report needing mental health services, yet less likely to seek help [4]. Moreover, in research on IPV among Latin American immigrants, it has been demonstrated that longer length of stay in the host country is associated with increasing rates of IPV [22]. This literature suggests a number of factors may be contributing to the increasing rates of IPV over time, including: post migration stressors that affect the power dynamics between partners, social status inconsistency, acculturation and adoption of new understandings of abuse, along with the loss of protective factors such as the strong social networks and connections that existed in the migrants' country of origin [22].

Although there is a growing Latin American population in Canada little research has focused on this community's mental health and mental health problems [24]. Nor can data from the United States be generalized to the Canadian population due to the two country's distinct historical, political and social conditions [24]. While a body of Canadian research is emerging on mental health among immigrant communities [11, 17, 24–26] and to a lesser extent IPV among immigrants and refugees [27–30], these two lines of scholarship have tended to develop in isolation from each other.

This study combined these two lines of inquiry by examining the perceived mental health effects of IPV in Latin American immigrant and refugee women in Toronto, Canada's largest and most multicultural city. Our research was guided by the questions, how do women of Latin American origin perceive the connection between IPV and mental health? How do they perceive the relationship between IPV and depression? And, what coping mechanisms have women employed in addressing IPV and associated mental health consequences?

Theoretical Framework

This study was guided by two key theoretical perspectives; the post-colonial feminist intersectionality framework and

[1] The term Latin America is used to refer to countries in the Western hemisphere south of the United States whose official languages are Spanish and Portuguese. This paper focuses on the experiences of women from Spanish speaking countries of Latin America. In literature from the United States the term "Hispanic" and "Latina" are often used to refer to women of Latin American descent.

an ecological framework for understanding violence against women and women's mental health [3, 31–35]. The intersectionality framework explores the complexity of individuals' multiple social positions critiquing traditional approaches that limit the analysis to individuals' experience in a single domain [33–35]. Intersectionality theory explores how the intersections of gender, 'race', class, culture and other social locations shape the experiences of individuals. Intersectionality theory directs our attention to how the complex historical, political, cultural and socio-economic environment in which human experience is embedded "affects and shapes the health and illness experience of immigrant and refugee women and their access to equitable and quality care" [35, pp. 36–37]. Given the multiple social locations and determinants of health affecting Latin American women in Canada, intersectionality theory lends itself well to the analysis of IPV and mental health among this group of women. The ecological framework, sometimes referred to as the ecosystemic framework, was also used to frame this study as it compliments the intersectionality theory through its emphasis on moving beyond the individual to examine the context or environment within which the individual is located [31, 32, 35]. Guruge and Khanlou argue that the ecological model, "helps to operationalize the concept of intersectionalities of influence in researching the health issues and concerns of immigrant and refugee women" [35, p. 37]. The model considers social phenomena as occurring through the interaction of reciprocal levels: the individual (e.g., personal experiences, biology, genetics), the family (or micro-system level), community (or meso-system level) and the larger social and cultural environment (macro-system level) [35]. Risk and protective factors at the individual, relationship, community and societal level can be identified and interventions planned accordingly.

Methods

Study Setting

Canada is a multicultural society with one in five people being foreign born. Among the G8 countries Canada has the highest proportion of foreign-born residents (20.6 %) [36]. Toronto, the site of this study, has the highest share of Canada's immigrant population with immigrants representing 46 % of the city's population [36]. The Latin American population in Canada is fairly young with the earliest waves arriving in the 1970s. Today, Latin Americans represent a growing immigrant community in Canada. According to the National Household Survey 2011, there were 381, 280 Latin Americans in Canada, and approximately one-third resided in Toronto [36].

Study Design

Qualitative methods were chosen as they are well suited for exploratory studies where few previous studies exist and importantly, for gathering in-depth understanding of issues among populations that may lack power in a society, such as immigrants and refugees [37, 38]. We conducted semi-structured qualitative interviews with Spanish-speaking Latin American women (n = 12) in the Greater Toronto Area (GTA). Given the dearth of literature on IPV and mental health among the Latin American population in Canada and the possible reluctance of Latin American women to come forward to speak due to stigma and silence that surrounds both IPV and mental health we focused on the broader category of Latin American immigrant and refugee women. The sample size was determined based on saturation, the point at which no new major themes begin to emerge from the data. According to the literature, this point is often reached at 8–12 interviews [39, 40]. This research was approved by the Research Ethics Board of the Centre for Addiction and Mental Health (CAMH).

Recruitment for the study was conducted through the use of advertisements that were placed in the waiting room areas of Latin American psychiatrists, therapists and community agencies serving the Latin American community in Toronto. A convenience sampling method was used as well as a snowball technique as a couple of participants indentified other women who would be willing to participate and provided them with the study information. Since the objective was to gather Latin American women's perspectives, participants were not screened for IPV experience. Inclusion criteria were being a self-identified Latin American women over the age of 18. An honorarium of $30 was provided to study participants as per the standard practice for research studies at CAMH.

An open-ended semi-structured interview guide was developed by the research team based on the literature and objectives of this study. After receiving participant informed consent, interviews were conducted by the first author in Spanish, at the preference of the research participants. Interviews lasted 45–90 min and were tape recorded, and transcribed in their original language. Thematic content analysis served as the principle method of analysis [37]. Nvivo 9® qualitative data management software was used to help organize and facilitate data analysis. Thematic content analysis involved a careful examination of interview transcripts, identifying key themes that emerged and classifying themes [37] (see Table 1 for themes and subthemes). Once the interviews were completed, an initial coding framework was developed by the research team based on the literature, the questionnaire, and importantly by observations of the first author with regard to salient themes emerging from

Table 1 Themes and subthemes from analysis

IPV experience
Physical IPV
Psychological IPV
Sexual IPV and rape
IPV during pregnancy
Involvement of mothers and sisters in law
Perceived causes of IPV
Stressors in partner's life
Partner's alcohol or drug abuse
Machismo
Perceived connections between IPV, depression and other mental health problems
Worried, nervios, not sleeping well
Lowered self-esteem, feeling worthless
Sadness and depression
Considering suicide
Self harm
Alcohol use
Other factors contributing to depressive feelings
Childhood sexual abuse
Accumulation of adverse life experiences
Social Isolation
Coping, help-seeking and resilience
Tolerating abuse/remaining silent
Seeking medical help
Talking to friends and relatives
Support groups in the community
Religion
Giving back, helping other women

the interviews. Interview transcripts were coded by two individuals fully fluent in Spanish, the first author who has extensive expertise in qualitative analysis, and a senior psychology student. The coding framework was refined with test coding conducted on two interviews prior to beginning. Test coding enabled the research team to add new themes to the framework not previously thought of. Coding then proceeded in an iterative fashion: when a new significant theme was identified interviews formerly coded were reviewed for the presence of the new theme. Interview codes were compared and when there was disagreement, discussed until consensus was reached. The analysis of themes and subthemes was led by the first author, in consultation with the full research team. Only the interview quotes selected for this article were translated into English. For the purposes of confidentiality, pseudonyms have been given to research participants.

Results

Participants

There were 12 participants in this study. One participant was from Guatemala, one from El Salvador, Honduras, Colombia, Argentina and the Dominican Republic respectively, two were from Peru and four women were from Mexico. The ages of participants ranged from 30 to 60 years of age. Four participants were in their 30 s, five were in their 40 s and three were over 50. All participants were first generation immigrants to Canada. Two of the Central American participants arrived in Canada more than 20 years ago as refugees due to the civil wars taking place in their home countries, three women arrived in the 1990s, and 7 in the 2000s. Six women reported being currently separated, four were currently married, re-married or in common-law unions and two reported being single. Three women had a university education and most were low income.

IPV Experience

All 12 women interviewed had experienced IPV. Five of the respondents reported IPV experiences within the last year; the remaining seven indicated they had experienced IPV at some point in their adult lives. Women reporting being raped and experiencing more severe physical assaults described these experiences taking place with former, as opposed to current, partners. Eight of the study participants described having experienced physical IPV. The most common form of IPV among the women interviewed (mentioned in 11 interviews) was verbal or psychological abuse in the form of insults, name calling, and putting a woman down, telling her she was a bad mother, unfaithful, "worthless" or insulting her appearance. For example, one woman indicated, "He would insult me horribly, saying that I was garbage" (Susana).

Participants' interviews revealed that frequently more than one form of IPV was experienced. Psychological abuse often occurred prior, during or following physical and sexual assaults by intimate partners. The length of the abusive relationship was wide-ranging with one participant reporting her partner hitting her on one occasion at which point she ended the relationship to, at the other end of the spectrum, one woman reporting enduring IPV for years and being hospitalized multiple times due to injuries resulting from physical assaults. The latter participant stated, "I went to the hospital about seven times. They have records there of all of the beatings and injuries I had, and the police too they have all those records" (Susana). Three women described experiencing sexual IPV in the form of rape by their former spouses. One participant recalled,

> The father of my children would hit me so hard, he wouldn't stop until he saw blood. I remember the last time that he hit me against the wall, then he threw me in the shower and he raped me. He raped me constantly. I didn't know that was rape at the time, but now I do (Doris).

Of the eight women who indicated they had experienced physical violence at the hands of their spouse, half stated that they experienced violence during pregnancy.

Thus one participant indicated,

> He started to be violent with me when he found out that I was pregnant, he began being aggressive, to hit me, and I lost my first baby. I got pregnant again and I was also going to lose this child due to beatings at three months but for some miracle my daughter was saved (Linda).

Three of the women interview described the involvement of in-laws, particularly mother-in-laws and sister-in-laws, in supporting the violence of their sons or brothers towards them and in some cases perpetrating abuse themselves. A participant in her late thirties described constantly receiving verbal insults from her mother-in-law and sister-in-law. She stated, "they would say such hateful things to me. […] that they didn't understand why their son would marry me, that I was nothing for him" (Linda).

Perceived Causes of IPV

Participants in this study shared many thoughts about the perceived causes of IPV. Among the most frequently identified causes were the stress husbands experienced in trying to be good providers when work opportunities for them were limited to low-paying jobs or when they did not have work, and their alcohol and/or drug use.

Sometimes these were mentioned together as in the following:

> Well, when we didn't have work he started to drink and we didn't speak English and he would get very violent, especially during Christmas […] It's like the man surely feels he is stuck, and you can't do anything as a woman, I wasn't going to leave my kids. We needed money, and we didn't have any, we didn't have even legal status, so we began to get depressed. He [my husband] would drink and drink. […] Maybe men need help too. There are courses for women and children but not for men. So men look to alcohol or drugs (Daniela).

Five of the women interviewed described alcohol use by partners as contributing to IPV. Of these, two women described their partners' use of both alcohol and other drugs.

One participant indicated,

> One day he arrived around 9 pm with really red eyes, he was drugged up and I asked him, "what's wrong?" He looked like the devil with his eyes and face very red and looked very angry. I asked him, "did you take or drink something? You look so different." He replied, "what do you care stupid?" and he punched me in the face and I fell, and I was already pregnant already with our second daughter (Susana).

Participants indicated that *machismo*, the cultural valuing of "masculine" and "aggressive" traits in males, and gender socialization patterns that assign women a "passive" role in relationships, were also implicated in male IPV towards females. As one participant in her forties stated, "In Latin America the majority of people are machista and authority is given to men. This brings lots of problems for the couple because the man thinks women should do as they say" (Nancy). Seven of the women raised gender socialization as a key factor behind the violence of men toward women and women's reluctance to leave the marriage.

IPV and Mental Health

Participants described a strong connection between mental health problems and their lived experiences of IPV. Low self-esteem and feelings of worthlessness were mentioned in the majority of interviews as an outcome of IPV. Feeling trapped, constant fear, stress, worry, anxiety and nervousness (*nervios*), disrupted sleep patterns, and experiencing sadness and depression were mentioned consistently throughout the interviews. One participant stated, "I would get very nervous, or stressed, worried, not sleeping well, I would fall asleep maybe for an hour and I would wake up" (Claudia).

Depression

Participants in the study strongly linked experiences of IPV to feelings of sadness and depression. For example, one participant, the mother of three, in recalling years of physical and verbal IPV indicated,

> I think it's also when your self-esteem is very low, and you feel miserable, you feel you're nothing, you feel that nobody else is going to notice you. You do not want to eat sometimes […] You want to sleep, nothing else, you want to be sleeping (Susana).

Participants also described unstoppable crying and a diminished desire to talk to anyone or do anything. A study participant described feeling sad, crying constantly and wanting to isolate herself from others. She stated,

> I did not want to speak to anybody, I would isolate myself, and have negative thoughts. I would be there with my daughter and son, doing the household chores, but I felt very sad […] I think that for a long time I didn't realize it was depression, but I would cry a lot, I would feel alone and no desire to talk to anybody. I still feel that way. I don't want to talk to anyone, or answer the phone, or watch television, or read, it's as if my mind is blank (Doris).

In describing past experiences of IPV, four participants recalled having experienced intense feelings of depression to the point where they started to consider acts of suicide or other acts of self-harm. As such, one participant indicated,

> I was scared, I was in agony, devastated. I was sad, could not bear my loneliness. I felt fear, I felt worthless, I felt I was a bad person who did not deserve to live and started thinking about suicide. I seriously started getting the desire to stop living (Ana).

Another participant stated,

> Because I tell you, after that situation happened that left me with a black eye […] sometimes I would clutch a can of spray or something like that and I would hit myself in the head, I would hit myself against the wall and would ask myself, why did this have to happen to me? (Susana).

In four interviews, participants described alcohol use as a coping strategy for women experiencing IPV and mental health repercussions. The women described knowing other women who had endured IPV and turned to alcohol as a way to "numb the pain". In one case a participant indicated personal experience with heavy drinking. She stated,

> Well, I started to drink, I got very involved with alcohol to the point that I would lose consciousness, I ended up going to Alcoholics Anonymous because I felt lost in alcohol. But thank God I was able get out of it, and I could get my kids back (Doris).

"It's Not Just IPV that Causes Depression"

While the women in this study made reference to a range of perceived mental health outcomes resulting from experiences of IPV, participants also connected depression to other adverse life experiences and circumstances. They mentioned childhood sexual or physical abuse, sexual assaults and rape, war traumas and the loss of loved ones in the home country, migration, social isolation, not being able to speak English and unemployment. Therefore, a participant who had experienced IPV and mental health problems also noted, "I was abused, sexually by a family member and all of that left scars, which I still have not been able to overcome" (Juliana).

A mother of two shared various life experiences she felt contributed to her ongoing physical and mental health problems including depression for which she was on medication. She described how the physical, sexual, and verbal IPV by two ex-spouses were connected to her experiences of depression. At the same time, she explained that it was a combination of factors and interconnected life experiences that affected her physical and mental wellbeing. In her home country, when she left her first spouse who had repeatedly assaulted her physically, sexually, and verbally, he took her children away from her for a number of years. This, she said, combined with the murder of her mother, led to her state of despair and alcohol abuse. After she became sober and regained her children, she received death threats and was forced to flee to another country with her two children. There, she was assaulted and raped by a stranger. Her daughter was also raped. As a result of the rape, the participant contracted a sexually transmitted disease. She also developed fibromyalgia and experiences pain and tiredness. She attributes her depression to the accumulation of these adverse and traumatic experiences rather than to the IPV alone. Now in Canada she feels she is without a strong social network. As she stated in her interview,

> being far away from my country, feeling like I have no family aside from my two children, but my mom is not here, not having a partner who respects me and being sick– all of this depresses me. […] I am tired, I forget things, so that makes me more depressed. And taking so many pills, there have been moments where I have take up to 10 different medications (Doris).

Coping, Help-Seeking and Resilience

Study findings revealed that participants experiencing IPV and related problems of depression and other mental health concerns often kept silent for many years, "tolerating" (*aguantando*) situations of abuse due to shame and fear. One participant stated, "We have it so engrained in us that we prefer to cry and aguantarnos ("to tolerate") but we don't say things" (Claudia). This is consistent with research that finds that gender socialization, particularly the messages received by women of "having to make relationships work" or if a "relationship fails it's her fault" can be detrimental to women's health when they prevent her from seeking outside help or leaving a situation of

partner violence [41]. In a U.S. sample of Latin American women survivors, a qualitative study found "keeping things inside" was perceived as a cause depression and other health problems [42].

The findings of this study also speak to women's resilience as all but one participant who reported current IPV indicated they had extricated themselves from abusive relationships. Moreover, women also frequently sought support by reaching out or speaking to other Latin American women—typically, friends or relatives.

Participants shared the following reflections:

> I have Latin American friends and we talk about the problems we have in our relationships (Maria).

> I am always distressed, then what do I do to clear my head? I walk. […] or else I grab the phone and call my sister, I get to talk to her and tell her my problems (Pilar).

In addition to speaking to friends three participants in this study described how they had been helped by participating in support groups in the community. One woman stated,

> I felt like leaving this country because I felt fear that this man was going to kill me. My only refuge was to talk to others I met in a support group for women (Susana).

The desire to "give back" and help other women was also highlighted, as illustrated by the quote below.

> I have helped about three women. […] I told one of them, when she asked me what she should do, I said, "listen when he hits you, you have to call the police, you also have to find a women's group, so they can help you" (Susana).

Three participants described their faith and going to Church as helping them cope.

> Well, what would help me sometimes would be to pray. I would ask God to help me, to illuminate me on what to do, because I am alone here, I don't have other family (Claudia).

Four women described seeking help from a doctor or psychiatrist. Another participant described seeing her doctor frequently for treatment of a sexually transmitted disease due to rape and also seeing a psychiatrist to work through depression and anxiety. She stated, "I am in therapy with a psychiatrist, she prescribes pills for me for depression, to be more stable, because I could not sleep, I was constantly having nightmares" (Doris). However not all the women received help when it was desired. One participant described going to one intake appointment at a Toronto hospital and then being placed on the waiting list to see a therapist, and never being called.

Discussion

The main purpose of this study was to gain an understanding of Latin American women's perceptions of IPV and its connection to mental health problems, particularly depression. This was an exploratory study as few studies have been carried out on IPV and depression in migrant groups in Canada. To our knowledge this is the first study to examine IPV and depression specifically among Latin American women. Arising powerfully from the narratives were the participants' personal experiences of IPV and the number of other women they knew (friends, neighbors, family members and women in their community) with similar stories to tell. This finding may be indicative of the fact that women knew it was a study of IPV and therefore raised many examples. At the same time, the lived experiences of IPV of participants and their ready provision of multiple additional examples amongst their family, friends, and acquaintances, suggests this may be a significant problem in the community that requires further research. The most common form of violence amongst this sample of women was psychological violence, consistent with a study by Guruge et al. [43] on IPV among immigrant communities in Canada. Furthermore, several women experienced physical IPV during pregnancy, experienced rape within the context of marriage, and involvement of mother and sister-in-laws in the abuse, which might indicate a need to address these issues in particular.

While there is a limited body of literature on mental health and IPV among immigrant and refugee women in Canada, few studies have linked these issues. In the United States, although there is an extensive literature on IPV and depression among Latino groups, little is known about how Latin American women perceive the connection between the two phenomena. The data from this study reveals a strong perceived connection between IPV and experiences of depression along with a range of other emotional and mental health problems. In addition to clinically diagnosed depression, participants described a range of experiences from feeling sad, crying a lot, and sleep disturbances and linked these to IPV. These feelings persisted years after the abusive relationship had ended, findings confirmed in the research [44]. IPV and depression are mutually reinforcing; IPV can lead to depression and depression can render a woman more vulnerable to IPV [45]. Further research that unpacks the intricate connection between IPV and depression among this population of women is warranted. Given the close association

between IPV, depression and other mental health problems screening Latin American women for IPV, including psychological IPV, in health settings may provide an opportunity for early intervention.

New Contributions to the Literature

In addition to filling a gap in the literature, a significant finding of this study is the extent to which women perceived IPV as experienced in the context of other highly traumatic experiences such as childhood sexual and physical abuse, rape experienced during the migration process, and the loss of home and its supportive family and community networks. In addition, other factors such as lack of a legal status in Canada, unemployment and underemployment and language barriers were also raised by participants as adding to stress and exacerbating the emotional effects of IPV. These accumulated stressors and traumas may serve to compound the already highly prevalent association of IPV with mental health problems, particularly depression, and may provide a tentative explanation for the high rates of depression noted among Latinas who experience IPV [7, 23]. Other studies have found that abused Latin American women perceived "keeping things inside" and the inability to talk about the abuse as leading to depression [42]. While some parallels can be drawn, in this study women frequently connected IPV and depression, within a context of multiple social hardships and other traumatic life experiences. IPV's connection to depression was stronger when other difficult individual, family, and social circumstances were present. Several of the women interviewed indicated that their husbands would become violent when they were stressed, in response to pressures to provide for the family when there was no job or only low paying ones, and pressures associated with not having legal status in Canada. Applying the intersectionality model, women's individual experiences of IPV were shaped by the multiple social locations they inhabited: being a woman, a migrant, having a low-socioeconomic status, and the historical and political circumstance of their home and receiving countries, among others. Using the ecological model we see how factors at the individual level (such as childhood and migration histories), the micro-level (family supports and/or stressors), meso-level (social networks, community supports) and the macro-level (social policy and the organization of services) framed women's experiences of IPV and associated mental health consequences.

Women's Agency, the Role of Social Support, and Resilience

The findings of this study also reveal the important role that can be played by social support in women's process of leaving an abusive relationship as well as in mediating the effects of IPV on mental health, which oftentimes persist after the abuse has ended. While some women remained silent, "aguantando" or putting up with IPV and not seeking help for years, sometimes decades, their narratives also spoke to tremendous resiliency and agency. Women sought help from friends, other women, joined a support group and brought others to the support group, sought support at Church, left violent relationships, found a Spanish-speaking doctor and referred others. Social support played a critical role in the transition from leaving an abusive relationship and in reducing emotional and mental health effects of IPV. A large body of research demonstrates how social supports are positively linked to general health status in women, a reduction in physical and psychological distress and lower levels of depression [44, 46, 47].

Past IPV continues to adversely impact women's physical and mental health after leaving the relationship and therefore social supports are also important to address in women's lives after abuse. In situations of IPV the role of family and friends may be varied. Family and friends may minimize experiences of abuse or blame the women [44, 48]. At the same time, friends and family, "may provide refuge, resources and emotional support" [44, p. 1022]. In this study three participants described the role of family members in reinforcing and encouraging IPV against them. At the same time, the majority of participants discussed the importance of a family member or a friend for talking about marital problems, their feelings and in reducing stress and worry. While issues of access where raised, participants also described the positive role of seeing their doctor or going to a support group in their community, or even their church, for emotional support and for being able to leave an abusive relationship. An important topic for future research among this population would be how to enhance Latin American women's access to personal, economic and social supports and resources.

Women in this study expressed a willingness and motivation to "give back" and help others, a finding consistent with a study among South Asian immigrant survivors of IPV in Canada [28]. This finding suggests that Latin American immigrant and refugee women survivors of IPV and depression can be valuable resources in the design and delivery of services for this population.

Limitations

This study was limited by the focus on both immigrants and refugees and a focus on the broader Latin American population. The issues experienced by immigrant and refugee women may be distinct, and separate studies among both groups might shed light on important differences with

implications for service design and policy. The cumulative effects of multiple forms of trauma, including war-related traumas, could impact the relationship between IPV and mental health sequela in distinct ways and may be stronger among refugees who have experienced war. Future research should be conducted among refugee and immigrant women respectively. Furthermore, the countries making up Latin America are many and diverse. An in-depth understanding of the cultural beliefs around IPV and depression would be best considered among specific ethno-cultural groups. Finally, it would be important for future research to examine different forms of IPV specifically, with a focus on severity of abuse and length of IPV exposure. Women may experience different health outcomes based on type and severity of IPV, its duration and length of time since exposure.

Conclusion

The data signals a strong perceived connection between IPV and depression along with other mental health and emotional problems among Latin American origin women in Toronto. The connection between IPV and depression was seen as stronger when other stressors, at the individual, micro-, meso- and macro-levels were present. Social supports in the form of friends and family, support groups and Spanish language health services were perceived as critical in mediating IPV's effects on mental health and in women's process of leaving an abusive relationship. The data signals a need for research, policy and service design targeted at reducing IPV and depression among Latin American origin women in Toronto to incorporate a social determinants approach that addresses the complex interactions among the individual, family and societal factors that frame women's experiences of IPV and mental health [35]. Implications for future research might also include examining whether this study's findings on the effects of accumulative traumas and stressors on the relationship between IPV and depression, are replicated when analyzing the experiences of other immigrant and refugee communities in Canada. Finally, researchers, service providers and policy makers need understand and highlight sources of women's resilience. Knowing what helps a woman break the cycle of violence and seek mental health services is as important in designing effective interventions as knowing the causes and effects of violence. We have much to learn from the perspectives of Latin American women.

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