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ORIGINAL ARTICLE

A Thematic Analysis of Barriers to and Facilitators of Wellbeing and Resource Access for IPV-Exposed, Pregnant Women in Mexico

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Abstract

Purpose Intimate partner violence (IPV) during pregnancy is prevalent in Mexico and is associated with deleterious effects on physical and mental health. This study explored barriers to, and facilitators of, wellbeing and access to resources for IPV-exposed, pregnant women living in Nuevo León, Mexico.

Method Participants were $N = 43$ individuals ($n = 17$ women receiving IPV or prenatal health services, $n = 20$ mental health professionals, and $n = 6$ medical professionals) who participated in nine focus groups in Nuevo León. Qualitative focus group data were analyzed using thematic analysis.

Results Several barriers to women's access to community resources and wellbeing were identified, including intrapersonal barriers, structural barriers, widespread violence exposure, and family expectations and power structures. Similarly, multiple facilitators of women's wellbeing and access to resources emerged from the data, including women's intrapersonal empowerment, support from women's immediate social circles, and supports in the broader community.

Conclusions Results suggest that women in Nuevo León who experience IPV during pregnancy face significant barriers to accessing supports that could foster wellbeing. Women also possess inherent strengths and actively seek to supports that contribute to their resilience in the face of IPV. Intervention strategies should focus on ways to overcome common barriers experienced by IPV-exposed women, while incorporating strategies to bolster personal empowerment and connection with existing community resources.

Keywords Domestic violence · Intimate partner violence · Mexico · Pregnancy · Resilience · Qualitative · Thematic analysis · Gender-based violence

Intimate partner violence (IPV) includes physical, emotional, sexual, and economic threats and abuse, as well as coercive control between romantic partners (Breiding et al., 2015). IPV is the most common type of gender-based violence, both in Mexico and globally, and perpetuates male dominance in private and public spheres (Medina Núñez & Medina Villegas, 2019). According to the most recent national survey, 26% of women in Mexico reported experiencing IPV in the past year, and 44% reported lifetime IPV exposure (Instituto Nacional de Estadistica y Geografia; INEGI, 2017). This is higher than the global lifetime prevalence of IPV for women, which a recent meta-analytic study estimated at 27% (Sardinha et al., 2022). Risk for experiencing IPV may be most pronounced during pregnancy; studies in Mexico have found that 10% to 30% of women experience prenatal IPV (Castro & Ruíz, 2004; Navarrete et al., 2021). Consequences of IPV during pregnancy are profound for maternal and child health, including increased risk for psychopathology (Navarrete et al., 2021) and hinderance to early childhood development and the mother-infant relationship (Martinez-Torteya et al., 2021). Negative effects may also include child behavioral and emotional difficulties that persist throughout development (Martinez-Torteya et al., 2016; Miller-Graff et al., 2019). Pregnancies from IPV-related reproductive coercion and/or intimate partner

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rape may also occur and can increase risk for negative physical and psychological outcomes for both women and children (Bianchi et al., 2016). At its most extreme, perinatal IPV is a potentially lethal form of violence for mothers and their unborn children (World Health Organization, 2011). The current study examined barriers to and facilitators of wellbeing and access to resources for IPV-exposed pregnant women. Qualitative focus group data was gathered from pregnant women, women exposed to IPV, mental health professionals, and medical professionals in Nuevo León, Mexico. Focusing on the intersection of risk and resilience, the study aimed to provide insight into women's experiences of IPV during pregnancy and offer guidance about how to support IPV-exposed pregnant women in Mexico and, potentially, around the world.

Most individuals experiencing IPV in Mexico do not seek formal helping services. A national survey reported 20% of IPV-exposed women sought help from public institutions (INEGI, 2017), while only 7% of women surveyed in a medical setting had sought services related to violence (Ambriz-Mora et al., 2014). Low rates of help seeking are likely associated with significant barriers to care. For example, in a nationally representative sample of IPV-exposed women in Mexico, 20% said that they did not seek support because they feared consequences, 17% reported feeling too embarrassed to seek support, and 15% said that they did not know how or where to ask for help (INEGI, 2017). Further, women may not seek formal supports due to shame, fear of their partner, concerns about their children, or because they may not want their family to know about the violence (Frías, 2013).

For many decades, research focused solely on the adverse consequences of IPV. Such research has provided a solid foundation for intervention science by highlighting the critical importance of mental health and parenting supports for women who have experienced adversity (Sousa et al., 2021). What has often been neglected in the literature, however, is the extent to which women draw upon their maternal identities as a source of resilience. Emerging research has suggested that the experience of motherhood not only affords significant protection for IPV-exposed women, but it is also a motivating change-factor, with many women identifying child protection as a primary reason for leaving violent relationships (Scrafford et al., 2020). A recent systematic review has argued that the incorporation of strengths-based perspectives on maternal responses to IPV provide critical information for understanding the intergenerational transmission of risk and resilience both directly (i.e., from mothers to children) and indirectly (e.g., via parenting and attachment; Sousa et al., 2021). Research with pregnant Mexican women has suggested the importance of personal competence, religiosity, and positive attitudes as key aspects of individual-level resilience (Nieto et al., 2018). These studies provide justification for examining patterns of risk and resilience in IPV-exposed pregnant women in Mexico, and conceptual models have suggested the relevance of this "constellation" of factors for refining models for intervention (Sousa et al., 2021).

Recent work defines resilience as the coordinated ability of systems to adapt in the face of significant adversity (Masten, 2015). Many theoretical frameworks for understanding resilience are rooted in Bronfenbrenner's social ecological model for human development (Bronfenbrenner, 1977). This model articulates human development as unfolding processes of dynamic, interactive exchanges across the social systems that individuals inhabit. Specifically, Bronfenbrenner considers how individuals shape and are shaped by social microsystems (e.g., family relationships), exosystems (e.g., health care facilities), and macrosystems (e.g., cultural norms). Across these systems, resilience is often framed as both *process* and *outcome,* with multisystemic assets and protective factors interacting with individual variables to explain the dynamic nature of resilience over time (Gaxiola Romero et al., 2012).

Wellbeing in the aftermath of adversity can be considered as one aspect of resilience. Wellbeing is often understood as having both hedonic (e.g., life satisfaction, happiness) and eudemonic (e.g., working towards ones' values) components (Huta & Waterman, 2014). In resilience science, wellbeing can therefore be conceptualized within the dimensions of both outcome and process, with aspects of hedonic wellbeing contributing to understandings of psychological health, and aspects of eudemonic wellbeing contributing to understandings of actions taken to pursue valued goals in the aftermath of adversity (Miller-Graff, 2022). The extent to which such processes can be realized is fundamentally undermined by direct and structural violence, but wellbeing in the context of ongoing violence is possible and may be bolstered by access to resources and coping (e.g., Coker et al., 2012; Hampton-Anderson et al., 2022; Ungar & Theron, 2020). Resources are multisystemic and can be material, informational, or relational in nature (Ungar & Theron, 2020).

Current Study

IPV is a public health problem that occurs worldwide, albeit at varying rates (Sardinha et al., 2022). Some scholars have highlighted this disparate prevalence as evidence for differential cultural and societal values as causal factors for IPV (Willis & Marcantonio, 2021), yet little research has directly queried interactions between barriers to care for IPV-exposed women, and how such barriers might be conceptualized in light of women's resilience to promote equitable access to effective care, in Mexico. Further, few studies have discussed ways in which larger social ecological systems

(e.g., exosystem, macrosystem) constrain women's ability to navigate their choices in reaction to violence in Mexico. Studying these broader systems is complex, and calls have been made for the development of locally grounded theory and intervention to better identify and address mechanisms for and consequences of IPV (Bhardwaj & Miller, 2021). Qualitative data collection and analysis may be uniquely suited to capture the influence of context on women's experiences of and reactions to IPV (De Coster & Heimer, 2021).

In line with this, the current study analyzes qualitative data from focus groups of pregnant women, women exposed to IPV (i.e., have experienced IPV in the past or are experiencing ongoing IPV), mental health professionals, and medical professionals in Nuevo León, Mexico. Including both service providers and pregnant and/or IPV-exposed women in the sample allows for the study to represent the perspectives of community members with different areas of expertise regarding relevant resources and risk factors in Nuevo León. The study aimed to use this data to examine the barriers to and facilitators of women's wellbeing access to resources in the context of IPV in pregnancy. Consistent with social ecological understandings of resilience and calls to better understand factors associated with IPV and mothers' parenting self-efficacy (Bronfenbrenner, 1977; Sousa et al., 2021), this study therefore contributes to guidance regarding how to best support pregnant women exposed to IPV.

Method

Setting

About 96% of the population in the state of Nuevo León (roughly 5.3 million) lives in urban areas, with the Monterrey metropolitan area being the second largest in Mexico. According to official statistics, 24% of Nuevo León's population lives below the poverty line, and about 40% of women are economically active (Secretaría de Economía, 2022). In 2020 there were 20,131 documented cases of gender-based violence in Nuevo León, most of which occurred in women's homes (96%) and during their reproductive years (66%; Banco Estatal de Datos e Información sobre casos de Violencia contra las Mujeres, 2021). The State Women's Institute, the local community partner for this research, is the largest provider of gender-based violence services in the region, and offers psychological, social work, and legal support to women survivors of IPV.

Participants

Participants were service providers ($N = 26$) and women who were pregnant and/or had experienced IPV ($N = 17$). Of the service providers (19 women and seven men), six were social workers, 10 were psychologists, two were Obstetrician-Gynecologists (OBGYN) and eight were medical trainees. Service providers ranged in age from 23 to 52 years. Inclusion criteria for service providers were: providing services to either pregnant women or women exposed to IPV. Although providers could be included based on either experience, 92.3% reported working with both pregnant women and women experiencing IPV. Seventeen women receiving IPV-services or prenatal health services at a public health clinic were recruited. Inclusion criteria for women seeking IPV-related services at the State Women's Institute were: experiencing violence during a previous pregnancy and being pregnant or having delivered in the past year. Inclusion criteria for women recruited at the public health clinic were: being pregnant and having a romantic partner. At the time of participation, ten women were pregnant, and nine reported IPV exposure in the past year. These women were aged 16 to 35, the majority (65%) held a middle-school education or less, and most (69%) were unemployed; 35% were single or separated, 41% lived with their partner, and 24% were married.

Procedures

Following ethics approval by the Institutional Review Boards at *Universidad de Monterrey* and the University of Notre Dame, staff at the State Women's Institute identified eligible women among those currently receiving mental health, social work, or legal services for IPV and invited them to participate in a focus group. Nurses at a local public health clinic also invited pregnant women to participate in a focus group at their prenatal appointment. Finally, psychologists and social workers at the State Women's Institute were invited to participate in a focus group, and OBGYN physicians and physicians in training were invited to participate in a focus group conducted at a local hospital by the Director of Training.

All focus groups were conducted by the second author and an assistant facilitator, and were audio recorded. Facilitators explained the goals of the study, risks and benefits of participation, confidentiality, and mandated reporting laws. Participants completed a written informed consent and a demographics survey, and they received a handout that outlined the topics to be reviewed during the focus group. Participants received a gift certificate as compensation for participation. Students at [BLINDED FOR REVIEW] transcribed the audio recordings of the focus groups. IPV-exposed and/or pregnant women were in separate focus groups from service providers, but the transcripts of their interviews were analyzed together, with coders noting whether quotes came from IPV-exposed women or service providers.

Data Analysis

Qualitative data were analyzed using Braun and Clarke's (2006) framework for thematic analysis. Authors (1) read and re-read the transcripts to become familiar with the focus groups' contents, (2) generated an initial codebook, (3) organized the codebook into themes and related subthemes, (4) revised subthemes to ensure they accurately reflected the meanings within the focus groups, (5) named themes and subthemes, and (6) finalized the thematic map. The authors read through the dataset multiple times, and each developed their own list of initial codes based on the contents of the interview transcripts. Across multiple meetings, they combined their lists to create the study's codebook, which consisted of 45 codes, by combining codes that overlapped and eliminating codes that were insufficiently supported in the text. Codes represented the most detailed annotation of the transcripts that could eventually be collated to form themes. The first and fourth author trained two undergraduate research assistants who separately coded the focus groups by connecting quotes in the transcripts with the codes that best represented those quotes' meanings. There was 79% agreement in their coding; coding disagreements were resolved by the first author in a consensus meeting with coders. After the completion of data coding, all authors met to form an initial thematic map, which grouped codes into subthemes and themes, by focusing on the underlying relationships between codes. Themes emerged inductively from the data within the codes. The first author reviewed the data that comprised each subtheme to ensure that the data in each subtheme reflected the same meaning, and then reviewed the full dataset to ensure the themes reflected the primary emphases of the focus groups.

Results

Two key themes emerged from the focus groups data: 1) barriers to care and wellbeing, and 2) facilitators of help-seeking and wellbeing (see Table 1). Each theme encompassed three or four subthemes, described below, and each subtheme encompassed multiple codes. Participants' (i.e., service providers' and pregnant and/or IPV-exposed women's) quotes are presented below in Spanish as well as their English translations both to represent the participants' quotes as accurately as possible and to make the article more accessible for readers who speak Spanish.

Theme 1: Barriers to Care and Wellbeing

Participants acknowledged that many barriers exist to pregnant women's wellbeing in the face of IPV in Nuevo León. They reported that these barriers may emanate from within women (i.e., intrapersonal barriers), as well as structural barriers, and interpersonal barriers (i.e., family expectations, widespread violence exposure).

Intrapersonal Barriers to Wellbeing

Women and service providers discussed intrapersonal factors that may prevent women from accessing services or leaving the violent partner. For some, this may be a lack of awareness about what constitutes IPV; this was noted by one service provider who discussed how women do not identify economic control and psychological abuse as partner violence:

> Many experience violence, but they say that they do not because they don't recognize psychological violence, they don't recognize economic violence, it seems normal to them that their partner is in charge of all of the expenditures, that the partner is the one who makes all of the decisions, and that's part of, I'm the one that's in charge of the house and he is in charge of everything else regarding providing. They don't see the violence.
> *Muchas viven violencia, pero dicen que no, porque no identifican la violencia psicológica, no identifican la violencia económica, se les hace normal que la pareja sea la que se encargue de todos los gastos, que la pareja sea la que tome las decisiones y es parte de, yo soy la que se encarga de la casa y él es el que se encarga de lo demás, de proveer. No ven la violencia.*

Participants described overwhelming negative affect (e.g., fear, shame, guilt, helplessness, hopelessness, low self-esteem) that impeded women's help-seeking. One woman, for example, discussed the fear and pain that women experience because of IPV and how it can impede their feelings of self-efficacy and power, saying, "they feel shame, like they are afraid…" "*que se sientan con pena, así como que tengan miedo…"*

Finally, participants discussed an internal pressure to remain silent, and as such that they cannot tell others about experiencing IPV. For example, one woman said, "they tend to not speak and to not speak, to always stay silent, and to not ask for help," "*tiene la tendencia de decir, de no hablar y de no hablar y quedarse siempre callada y si, no hablar más de pedir ayuda,"* reflecting internalized social pressure to keep familial violence private.

Structural Barriers to Wellbeing

Both women and service providers acknowledged structural barriers in Nuevo León that obstruct wellbeing in the face of IPV. Structural barriers included problems both with access to existing resources and gaps in available resources. Women

Table 1 Thematic map of themes, subthemes, and annotations

Theme	Subtheme	Annotation
Barriers to care and wellbeing		
	Intrapersonal barriers	Helplessness/hopelessness
		Women in denial
		Women not aware of what constitutes IPV
		Women's shame
		Being silenced/remaining silent
	Structural barriers	Lack of childcare support/number of children as a barrier
		Economic barriers
		Problems with transportation
		Resource absence or access problems
		Importance of knowledge about legal processes/laws
		Importance of education about family planning/sexual health
		Need for health literacy and advocacy
		Women need information about the perinatal period
	Family expectations and power structures	Others' distrust or discouragement about accessing helping systems
		Partner coercive control
		Monitoring by partner's family members
		Women's primary or expected role as dedication to their family and spouse
		My cross/bearing difficulty without complaint
		Ongoing violence as a barrier to care
		Baby as a blessing
		Cultural stigma/mitos
	Widespread violence exposure	Risk in independent travel
		Community violence
		Intergenerational violence against women normalizes IPV
		Medical abuse
Facilitators of help-seeking and wellbeing		
	Women's empowerment	Women are empowered for positive change
	Supportive social relationships	Parenting strengths related to concrete behavioral changes
		Parenting strengths related to internal processes
		Social and emotional supports as resilience
	Community support systems	Importance of teaching women about helping systems
		Religion as a protective factor

emphasized that lack of access to transportation made it difficult to leave home to access support. For example, one woman stated,

> Well, you just said something about Uber, that seemed like a good idea to me because we come from really far away. I have to take metro 1 and 2 and because I came with my kid, that is why I almost didn't make it, because like I said, I come from so far away on foot.
> *Pues ahorita que dijiste eso del Uber, a mí me pareció muy bien porque yo... sí venimos desde bien lejos. Tengo que tomar metro 1 y el 2 y luego como vengo con el niño, por eso llegué raspando, porque te digo, vengo bien lejos caminando.*

Others discussed a lack of childcare support that hinders the ability to leave the home to access resources, such as this woman who stated, "well, work, not having time, they have children and they don't have the support of anyone else to take care of them," *"pues el trabajo, la falta de tiempo, bueno que tengan hijos y no tener apoyo de quien los cuida."* The structural effects of poverty were also noted as barriers to wellbeing that prevented women from leaving violent partners. For example, one woman stated,

> And how do I leave? If I go, well I have nothing, I don't have work, I don't have work experience, I'm not going to have any of the things I'm accustomed to, my children won't be in private school.
> *¿Y cómo me salgo de aquí? si yo me voy pues no tengo nada, no tengo trabajo, no tengo experiencia laboral, no voy a tener nada de lo que estoy acostumbrada, mis hijos no van a estar en un colegio.*

Participants also emphasized that women are not provided with information about maternal health. For example, participants reported not knowing where to access information about factors that contribute to mothers' wellbeing,

including a lack of knowledge around family planning and sexual health. One service provider stated, "it's important to discuss sexuality and birth control, this could be included in the context of their sexual and reproductive rights, since this will determine whether they want to have more children or not," "*es importante hablar de la sexualidad y los métodos anticonceptivos, esto puede incluirse en el contexto de sus derechos sexuales y reproductivos, ya que de esto va a depender si quieren tener más hijos o no."*

For others, this need for health resources extended to a need for health literacy and advocacy, because women did not have sufficient information about the perinatal period, such as breastfeeding. One woman said,

> Breastfeeding, because many times they don't tell you that it's going to hurt when you breastfeed, that it will crack your breasts. They always talk about how giving birth and c-sections will hurt, but in my case, they never told me that it hurts when you feed the baby, that it's going to be a lot of work.
> *La lactancia, porque muchas veces no te dicen que va a doler cuando das pecho, que se te agrietan los pechos. Siempre hablan que va a doler el parto y la cesárea, pero en mi caso, nunca me dijeron que va a doler cuando le des de comer al bebé, te va a costar mucho trabajo.*

Other women described that they had not been educated about the labor process by their doctors, such as one mother who said, "no, they don't give you anything, because you see, what you're telling me, they'll fight with you about whether or not to have a c-section, they don't tell you anything until the moment you're giving birth," "*no, no te dan nada, porque ya ves, lo que tú me estás platicando, se andaban peleando porque cesárea o no, entonces, este, no te dicen nada, hasta el momento que lo vives."*

There was also discussion regarding women not knowing about legal processes related to separation, divorce and child support. For example, participants noted that women believed their partner's threats that they could use the legal system to take children away, or force women out of the family home. For example, one service provider stated,

> It also has to do with the house where they will live, if they don't have a house and especially if they don't know their rights; like in a civil marriage, they don't know if they have the right to stay in the house, if the husband will give them child support if they don't live together, the constant worry is that the husband will take the children.
> *También tiene que ver que la casa donde van a estar, si no tienen casa y sobre todo cuando desconocen de sus derechos; como matrimonio civil no saben si tienen derecho a quedarse en la casa, el esposo le dará pensión o no sin la convivencia, que el esposo se lleva a los hijos es una preocupación constante.*

Others discussed that resources exist, but women do not know about them. This service provider said, "I'm thinking about the lack of knowledge about the supportive institutions, these women don't know about these institutions that could help them and they see themselves as alone, because they don't have a support network," *"considero que el desconocimiento a las instituciones que dan apoyo, estas mujeres no tienen conocimiento de estas instituciones que le pueden ayudar y se ven solas, porque como no tienen una red de apoyo."*

Family Expectations and Power Structures as Barriers to Wellbeing

Women and service providers highlighted women's familial roles, such as dedication to motherhood, domesticity, and family, as inextricably intertwined with the responsibility to "bear the cross" of violence as a standard part of motherhood and marriage. This familial influence on IPV included cultural expectations that babies are blessings that fix problems between parents. One service provider described how the expectation that the baby will remedy interparental problems keeps women in violent relationships and prevents them from seeking support, saying,

> They still idolize him… they see the violence but they say he will change, with the baby it'll be different, he's going to realize his problems and going to try to be a better person, so they idealize all of this and might not want to participate in an intervention.
> *Todavía están idealizándolo mucho… ven la violencia pero dicen va a cambiar, con el bebé ya va a ser diferente, ya él va a ver sus problemas, va a tratar de ser mejor persona, entonces idealizan toda esa cuestión y se pueden desistir de alguna intervención.*

Further, women's families were described as central in transmitting religion, culture, and beliefs regarding patriarchy in the family dynamic. These factors were described as coalescing to keep women in relationships with their violent partners. For example, one woman described the pressure from her mother to endure partner violence as an inherent part of a marriage, stating, "My mother told me to keep this quiet… this is my cross and I have to bear it," *"mi mamá me dijo que eso se calla… esta es mi cruz y la tengo que seguir."*

The family influence also includes the coercive control, monitoring, and direct violence inherent in the women's relationships. Women described partners controlling their time; for example, one woman said, "it could also be that the husband says, 'don't go'… 'why would you go'… to have them very controlled and don't let them do anything,"

"también puede ser que el esposo le diga 'No vayas' … 'Y para qué vas' … que las tengan muy controladas y que no les dejen hacer nada." Participants also described the impact of monitoring by the partner's family members as part of keeping women engaged in the relationship*;* one service provider said, "it's very common here that women live in their aggressor's mother's home, with the mother-in-law. So it's not only the aggressor, but also the mother-in-law, his sisters," *"aquí es muy común que la mujer viva en casa de la mama del agresor, con la suegra. Entonces ya no solamente es el agresor, sino la suegra, las hermanas,"* indicating that female family members can uphold the power structures that enable IPV.

Finally, participants reported that family members may discourage women from receiving support from community organizations. For example, a woman described how women are seen as selfish or deviant for neglecting their domestic responsibilities to receive care, stating, "they will also say you're going to waste time that could be better spent at home," *"también va a decir que vas a perder el tiempo pudiéndose quedar mejor en casa."*

Widespread Violence Exposure as a Barrier to Wellbeing

In this subtheme, women and service providers discussed how women are exposed to multiple types of violence, beyond IPV, which constrains their wellbeing. For some women, exposure to violence began when they were young, including witnessing violence against women in their families. One woman stated, "in my case, yeah, my mom experienced a lot of violence," "*en mi punto, mi mamá si vivió mucha violencia."* This intergenerational pattern was discussed as a factor that makes it seem as if partner violence is inevitable in intimate relationships, such as when this service provider stated, "our culture normalizes violence… in Mexico it's super ingrained across generations, so it's normalized, so like the way we talk, you normalize the violence," *"que la cultura de nosotros pues normaliza la violencia… si en México es súper arraigado eso por generaciones, entonces se normaliza, o sea nosotros hablamos pues normalizas la violencia."*

Beyond the family context, others commented on violence in their neighborhoods that prevented leaving the home without accompaniment. One service provider elaborated,

> Something that I forgot to mention is that there are a lot of violence, assaults, drug addiction and alcoholism. I don't know about you, but in the northern zone this also impacts in some way whether they leave their home, women need accompaniment to ensure safety (when they leave their homes).
> *Algo que se me había olvidado mencionar es que hay mucha violencia, asaltos, drogadicción y alcoholismo, no sé si ustedes en la zona norte eso también afecta, de cierta manera que salga de sus casas, por su seguridad que tienen que ir acompañadas.*

Finally, participants discussed medical abuse and violence as part of maternal health care. This may entail physical abuse, such as when one service provider stated, "also, I have seen that nurses are violent if the pregnant woman is young," *"también me ha tocado violencias, las enfermeras son violentas si las ven jovencitas."* Emotional abuse from doctors during delivery was also described, such as when another service provider said, "when the mothers are unmarried, the doctors make a lot of comments about, I don't know, why did you open your legs, or why did you do this, so don't complain," "*cuando son mamás que no están casadas, se hacen muchos comentarios de, no sé, para que abrías las piernas, o para que hacías eso, entonces no te quejes."* Participants also described physicians prioritizing the consent of women's husbands rather than asking women themselves. A service provider said, "sometimes in the hospitals, they don't give them information, or for some surgical procedures they ask the husbands for consent," *"es que a veces en los hospitales no le dan la información o para algunos procedimientos de cirugía les piden el consentimiento de los esposos."*

Theme 2: Facilitators of Help Seeking and Wellbeing

Participants highlighted co-occurring protective factors that promote resilience in the lives of pregnant women exposed to IPV in Nuevo León. They reported that the factors that foster wellbeing may come from multiple systems, including from within women (i.e., women's empowerment), as well as from their immediate social circles (i.e., supportive social relationships) and the broader social context in Nuevo León (i.e., community support systems).

Women's Empowerment as a Source of Resilience

Women and service providers emphasized that women possess personal strengths that empower them to seek support and positive change in their lives, such as an intention to make positive changes. One service provider said, "they intend to change things, so from here we can work with their strengths," "*tienen una intención de cambiar las cosas, entonces pues desde ahí ya podemos trabajar fortaleza."*

Supportive Social Relationships

Women and service providers described factors in women's immediate social environments that facilitate resilience and their ability to seek support in the community. For example, the sense of personal power described in

the subtheme above may result from story sharing with other women who have created a better life after or in the midst of IPV. One service provider described this process, stating,

> Ultimately, they don't see themselves as alone. They recognize that there's someone else who is experiencing what she is experiencing, and that she is not the only one, but there's someone else who went through this who is progressing and this motivates them to keep moving themselves forward.
> *Al final no se ven solas, ellas reconocen que hay alguien más que están viendo y que está viviendo lo que ella está pasando y no es la única, sino que venga otra persona que pasa una situación así, que van avanzando y pues eso les anima a seguir a ellas adelante.*

Participants also discussed how women's resilience is bolstered by their role as a mother. Women's desire to improve their lives was discussed within the context of hoping to benefit their children, including instilling strength and values around gender equity. Women also discussed feeling motivated because of their children, like this mother who stated,

> Above all else, the kids, the kids make you stronger, you say you can do it, avoid all of these things and, above all else, get them past it… you have to work hard, you have to make an effort, because if you don't do it for your children, nobody else is going to do it for you.
> *Más que nada, los hijos, los hijos te hacen más fuerte, dices tú puedes, evitar todas esas cosas y más que nada sacarlos a ellos adelante… pues tienes que trabajar, tienes que echarle ganas, porque si tú no le echas ganas por tus hijos, nadie lo va a hacer por ti.*

As a result of this desire for a better life for their children, some women are empowered to take actionable and concrete steps to improve their own, and their children's, lives. For example, one woman said,

> Sometimes it makes you brave enough to move forward, at least in my case, I separated from my partner and started to work, for a while I was working as a domestic employee… and where I worked, I always said that I had a son and they gave me the chance to bring my son with me, I always brought him with me…So I've felt that this is strength.
> *A veces eso te hace que tú agarres valor para salir adelante, bueno en mi caso yo me separe del señor y empecé a trabajar y así, bueno hasta hace un tiempo ahorita yo trabajaba, era empleada doméstica… y donde trabajaba siempre decía tengo un niño y a veces me dan chance de llevarme a mi hijo, siempre lo traigo... Entonces lo que yo he sentido, esa es la fortaleza.*

Other women try to protect their children from witnessing IPV. Multiple women discussed the desire for their children to remain unaware of the IPV, such as this woman who said, "simply not to fight in front of the child, because he is the most affected," *"simplemente no pelear enfrente del niño porque es al que más le afecta."*

Women also emphasized the social support that they received from their own families as imperative to their well-being. Participants shared the importance of familial support in the context of raising children, such as this woman, who said:

> Your children and sometimes it's good if someone in your family comes to you and tells you "you can do it, you can do it,"… there are some days when you relapse and you say "no, I feel like I can't" and there's always someone there by your side, in your case it's your mom, in my case it's my sister, that told me "no, work hard and your child will grow" and now here I am and thank God, we are ok.
> *Los hijos y a veces también es bueno que alguien de la familia se acerque y te diga "tú puedes, tú puedes" … pero hay días en que recaes y dices "no, siento que no puedo" y ya, siempre que hay alguien ahí a tu lado, bueno en su caso es su mamá, en mi caso es mi hermana, que me decía "no, tu échale ganas y el niño va a crecer" y pues sí, ahorita aquí estoy y gracias a Dios estamos bien.*

Another woman described her family's support saying, "the support from your surroundings, like having support makes it easier to face your abuser, or to leave him, if you have family support it's easier to leave him," *"el apoyo de su entorno, o sea teniendo un apoyo es más fácil afrontar a su violentador por así decirlo, o dejarlo, si tiene un apoyo de su familia es más fácil dejarlo."*

Community Support Systems

Looking to the next stages of fostering the wellbeing of pregnant women exposed to IPV, participants discussed how helpful supports exist in Nuevo León, such as the church described below, but women need to be informed about and connected to these supports. One service provider explained, "I think the most important thing would be to connect women with support networks that can meet the needs that they can end up having," *"yo creo que sería lo más importante, conectarlas con redes de apoyo que puedan satisfacer todas las necesidades que ellas puedan llegar a tener."* As such, community strategies to support IPV-exposed pregnant

women could focusing on connecting women to resources that could foster their sense of efficacy and empowerment, as this service provider stated, "bolster the support networks, the knowledge can help women orient themselves, the need to be oriented, to be informed about the services," *"reforzar las redes de apoyo, el conocimiento ubica, desde ahí necesidad de ubicación y los servicios, de que ya se les esté informando."*

Women and service providers also described the church community as one useful local community support. It was the only source of formal support that participants discussed. As one example, this woman said,

> In the church where I go, which is Catholic, there's a priest who is really open to these things… he also provides a lot of classes for women, for marriages, he talks with us a lot about how we shouldn't leave each other. Right now, there is a class for families, so men and women go and he talks with us about this, about how to get along within a couple. Although he is Catholic, the priest also is giving a lot of his help so that the families aren't so divided.
> *En la iglesia que yo voy, que es católica, ahí está un padre que es como que muy abierto a estas cosas… da muchos cursos para mujeres, para matrimonios, nos habla mucho de que no nos dejemos. Ahorita hay un curso de familia, para que vaya hombre y mujer y nos habla de eso, de cómo vamos a llevarnos entre pareja. Aunque sea católica pero también el padre está poniendo mucho de su ayuda para que las familias ya no estén tan separadas.*

Discussion

Understanding risk factors for pregnant, IPV-exposed women, including community-level and cultural barriers to resource access and wellbeing, is imperative to providing accessible care for this population. Yet, focusing exclusively on risk ignores women's resilience in the face of IPV exposure. Findings from the current study suggest that, in Nuevo León, Mexico, significant barriers impede pregnant women's access to wellbeing and supports, including intrapersonal factors (e.g., hopelessness, shame, and internalized pressure to remain silent about IPV), structural barriers (e.g., lack of childcare, finances, transportation, and a dearth of information about relevant laws and perinatal health), structural and cultural violence as enforced by families (e.g., pressure for women to be primarily dedicated to the household, family members pressuring women to "bear the cross" of IPV without complaint), and widespread community violence (e.g., assaults in neighborhoods and in the medical setting, as well as intergenerational violence against women). Despite these risks, many women display resilience and empowerment, and some are supported by their social circles (e.g., immediate family), strengthened by their role as a mother (e.g., make changes to better their children's lives), and access some, community supports (e.g. the church), albeit limited in number. These findings indicate a complicated and dynamic interaction between both strengths and challenges that influence pregnant, IPV-exposed women's ability and willingness to seek supports that could foster their wellbeing. Wellbeing in the context of IPV is complex, dynamic, and may look different across women. It is important to consider how various forces across social ecological systems interact to shape pregnant women's risk and resilience in this context.

Macrosystemic Influences on Wellbeing and Access to Resources

Culture underlies social norms, laws, relationships, and role expectations that directly influence how women experience and navigate IPV. One conceptualization suggests culture sets the stage for how violence is perpetrated, experienced, understood, reported, and prevented (De Coster & Heimer, 2021). Patriarchal norms (e.g., traditional gender roles) have been identified as significant risk factors for IPV perpetration (Ozaki & Otis, 2017), but anthropological work demonstrates relational, contextual, and individual risk factors are complex and ever changing because violence is shaped by culturally bound narratives (Kowalski, 2021). Study participants discussed widespread cultural acceptance of violence against women, which manifests in high rates of gender-based violence and cultural narratives about how women should (and should not) react to IPV. Further, participants discussed cultural narratives regarding women's familial roles – mother, daughter, daughter-in-law, wife – and how cultural values regarding family may be simultaneously harmful in reinforcing gender-based violence and helpful sources of social support and facilitators of help-seeking.

Exosystemic Influences on Wellbeing and Access to Resources

The Exosystem represents the large social spaces that indirectly affect an individual (Bronfenbrenner, 1977). Structural barriers to women's wellbeing, including lack of knowledge and information about existing community resources, legal processes and laws, and maternal health pertain to the exosystem. Although resources exist in Nuevo León (e.g., advocacy and mental health care at State Women's Institutes, workshops about perinatal health in local hospitals), IPV-exposed pregnant women do not know about them and thus cannot access them. Women in the present study reported that they were unaware of what resources existed in the community other than Catholic or Christian churches. As

such, women stated that they needed more information about sexual and reproductive health, breastfeeding, and information about their rights and where to access legal supports. Given recent research that knowledge about how to access resources in the face of stressors is a key contributor to resilience (Carney et al., 2021), and findings that few IPV-exposed women in Mexico seek help from public institutions (INEGI, 2017), IPV-exposed pregnant women in Nuevo León could benefit from more information about the existence of supports in the community and how to access them. Indeed, one recent study with IPV-exposed women in Mexico City found that each additional community resource that women were aware of was associated with a 20% increase in the number of resources she utilized (Willie et al., 2020). Future policy efforts and media campaigns in Nuevo León should therefore focus on increasing women's awareness and access to existing supports in the community, including those directly related to IPV as well as general healthcare.

Microsystemic Influences on Wellbeing and Access to Resources

The Microsystem entails interconnected relationships with one's immediate social surroundings (Bronfenbrenner, 1977), such as the people and institutions with which one has direct contact. Study participants discussed the structural impact of the microsystem on their wellbeing. Intersecting structural barriers were described as limiting women's ability to leave their homes and access resources, including lack of money, transportation, and childcare. The adverse effects of poverty in relationships where IPV is occurring is well-documented (e.g., Stylianou, 2018), and the government in Mexico has taken steps to increase women's access to finances through cash transfer programs (e.g., *Prospera*; México Gobierno de la República, 2016). However, findings on the benefits of cash transfer and workforce participation for IPV-exposed women in Mexico are mixed; while some have found that economic participation decreases risk for IPV (Villarreal, 2007), others have found that it may increase risk for IPV (Canedo & Morse, 2021). This research suggests provision of financial or material resources as part of services for pregnant women should be done carefully to avoid potential exacerbation of violence. To address other institutional barriers to resources for IPV-exposed pregnant women in Nuevo León, programs should include funds for women's transportation to and from appointments, provide childcare, or offer tele-health modalities to increase accessibility.

Another important institution within women's microsystem is their churches, which emerged in the present study as a contributor to both risk and resilience. Related to risk, women discussed churches' emphasis on family unity and discouragement of divorce as contributing to their shame about considering leaving the violent relationship. Conversely, some participants described their church community and religious leaders as a source of strength and support, in alignment with existing literature on the relationship between spirituality and resilience in women living along the Mexico-U.S. border (de la Rosa et al., 2016). The complicated influence of religiosity and religious institutions on IPV-exposed pregnant women's wellbeing in Mexico requires deeper examination in future research.

Social relationships within the microsystem also emerged as important contributors to women's risk and resilience. Participants particularly emphasized the influence of family. Support from family was described by some women as the most important cornerstone in their capacity to survive and overcome the stress of IPV. Further, women's maternal role fostered a sense of purpose and motivation to improve their lives for their children's wellbeing. Resources for pregnant women exposed to IPV may benefit from capitalizing on the role of supportive family members, perhaps including them in the provision of services to women, where safe and appropriate to do so.

Despite the positive contributions of family to women's wellbeing, family was also described as contributing to risk for IPV and presenting a barrier to IPV-exposed women's access to community supports. This finding aligns with existing literature from Mexico about negative effects of family networks on IPV-exposed women's wellbeing (e.g., Frías & Agoff, 2015). Study participants described family pressure to conform with norms of devotion to the domestic sphere. This pressure compounded women's shame about considering leaving the relationship, feelings of being trapped, and sometimes dissuaded women from pursuing formal supports that would require them to spend time outside of the home. Notably, pressure from family members for pregnant women to tolerate IPV in order to maintain an intact family unit is a worldwide phenomenon (e.g., Sigalla et al., 2018). Importantly, however, descriptions of familial pressure to stay in violent relationships contain a culturally-specific undercurrent (i.e., the religious connotations of the need to "bear the cross"), which gives insight into how these concerns can be addressed in a way that is culturally and contextually meaningful.

Women's experiences of interpersonal violence throughout their lives and across contexts was described as negatively impacting their ability to navigate their world. The intergenerational cycle of IPV and gender-based violence is well-documented in Mexico (e.g.,Valdez-Santiago et al., 2013) and study participants described that this cycle normalizes IPV, thus making familial relationships a context wherein cultural norms that harm women are enacted and reified. Experiencing neighborhood violence was also described as contributing to women's fears about leaving their homes to access resources, as were experiences of

physical and emotional abuse of pregnant women by medical providers. The most recent national survey of violence against women found 33% of women in Mexico reported experiencing violence from medical providers during pregnancy, including yelling, berating, and pressure to accept medical procedures (Castro & Frías, 2020). Women in Mexico could benefit from community supports that provide safety planning both within women's relationships and their broader lives, as well as trauma-focused content that addresses posttraumatic stress symptoms from intergenerational and cross-contextual violence. Finally, the high prevalence of medical providers' abusive behaviors towards women highlights the need for a multi-pronged approach to heighten awareness about pregnant women's rights as patients, along with training on trauma-informed care for doctors and nurses.

Individual Influences on Wellbeing and Access to Resources

Individuals in the socioecological model are both influenced by and active influencers of the larger systems in which they reside (Bronfenbrenner, 1977). Intrapersonal factors from the present analyses are byproducts of and contributors to women's relationships, resource access, knowledge about resources, and cultural messages. For example, intrapersonal barriers influence whether women can or are willing to access supports, including women's lack of awareness of what constitutes IPV, women's shame, and IPV's effects on women's self-esteem. At a societal level, efforts to continue to raise awareness about the forms that IPV can take should be prioritized. This work is currently being undertaken by State Women's Institutes across Mexico, and efforts could be made to expand the scope of these campaigns to reach a broader audience.

Women's inherent sense of personal power also emerged as an important intrapersonal factor. This empowerment often arose from women's sense of purpose as a mother and their supportive social relationships, thus demonstrating the interaction between the individual and their microsystem. Interventions for this population should therefore capitalize on women's resilience and help expand feelings of personal power. Interventions should also focus on reducing shame, which study findings indicate may be best addressed in the context of group interventions. Many participants suggested that women realizing that they are not alone in their experiences of violence by hearing other women's stories could mitigate intrapersonal barriers like shame and isolation.

Limitations

This study has some notable limitations. Given that participants were recruited from an urban setting in Nuevo León, findings about risk factors and resource access may have been different had participants been recruited from suburban or rural areas. We did not collect information about whether or not service providers had experienced IPV in their own relationships, and thus cannot address the relationship between service providers' personal experiences and their responses during the focus groups. Finally, the focus groups did not ask participants how they would define wellbeing, so we cannot be sure of how participants conceptualized wellbeing in this study.

Future Research Directions

Findings suggest multiple future research directions. First, research to understand the impacts of IPV on pregnant women and their children would benefit from a multisystemic perspective that recognizes the intersection of the various types of adversity and abuse women experience, including poverty, community violence, violence from other family members, and violence from medical providers. Moreover, additional research is needed to disentangle the complex relationships between factors that were identified as sources of both risk and resilience, including women's determination to protect their children, family supports, and religion. In addition, feasibility, accessibility, and effectiveness studies are needed to evaluate interventions that integrate the elements identified as central to women's help-seeking and resilience, such as promoting women's empowerment, increasing awareness of women's rights and community resources, strengthening social supports, and expanding accessibility through transportation and childcare. Although the current study did not explore quantitative relationships between women's experiences of IPV and quality/quantity of community resources accessed, additional research in this area would be valuable. Finally, the study should be replicated in other contexts internationally. It would be beneficial if a cross-contextual comparison of barriers to and facilitators of wellbeing for IPV-exposed pregnant women could be advanced, to understand which of the current study's findings have global implications.

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Declarations

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