UCLA
UCLA Electronic Theses and Dissertations

Title

Expanding Perspectives and Gaining Leverage: How Migrant Farmworker Women Navigate HIV Risk in Their Close, Long-Term Relationships

Permalink

Author

Albarran, Cynthia R.

Publication Date

2015

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

Expanding Perspectives and Gaining Leverage:

How Migrant Farmworker Women Navigate HIV Risk

in Their Close, Long-Term Relationships

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Nursing

by

Cynthia R. Albarrán

2015

ABSTRACT OF THE DISSERTATION

Expanding Perspectives and Gaining Leverage:

How Migrant Farmworker Women Navigate HIV Risk

in Their Close, Long-Term Relationships

by

Cynthia R. Albarrán

Doctor of Philosophy in Nursing

University of California, Los Angeles, 2015

Professor MarySue V. Heilemann, Chair

Women around the world are at risk for HIV because they are in close, long-term relationships with male partners who are unfaithful, abusive, and/or use alcohol or illicit drugs. HIV risk is particularly high among couples that migrate for work and experience extended periods of physical separation. This study used Constructivist Grounded Theory methodology to explore women's perceptions of and experiences with HIV risk among a community sample of migrant farmworkers of Mexican descent in southern California. Twenty women with a history of a close, long-term risky relationship participated in one or two in-depth interviews. After initial coding, focused coding identified the most significant areas of interest and categories were formed. Theoretical sampling helped to fill the gaps and detail how participants navigated and responded to risk in their relationships. A Community Advisory Board comprised of

stakeholders and farmworker women from the target community offered insight and advice into research design and preliminary data interpretations.

Results are presented in a theory grounded in women's words, consisting of two simultaneous, overlapping processes. The first is a process of expanding perspective. While explaining their perceptions of partner risk, women repeatedly used metaphors of eyesight and "seeing" risk over a fluid five-phase process that included being blinded by vulnerabilities, making the discovery, weighing priorities, adopting a risk perspective, and assessing the consequences. While expanding their views of what HIV risk meant to them, women were also simultaneously pushing back against the actions of their abusive, unfaithful, and/or addicted long-term male partners. In this second process, called "gaining leverage," participants did not feel that they had overcome the danger of their risky relationships. Instead, they felt they were gaining leverage over risk in small but important ways through the use of three specific categories of action: fighting the bad (pushing back against a partner's actions using personal resources), finding the good (navigating complex external resources while avoiding additional harm), and fortifying the self (helping themselves "move forward" in the aftermath of risky relationships). Future interventions should focus on the ways in which migrant women cognitively, socially and emotionally navigate their perceptions of and responses to risky relationships.

The dissertation of Cynthia R. Albarrán is approved.

Adeline Nyamathi

Deborah Koniak-Griffin

Maylei Blackwell

MarySue V. Heilemann, Committee Chair

University of California, Los Angeles

2015

Dedication

This work is dedicated to the twenty *campesinas* who participated in this study. I am deeply honored to have been entrusted with your words.

Table of Contents

List of Tables

List of Figures

Acknowledgements

And finally, to my family: thank you to my parents, grandparents, and extended family for your support. I am so grateful for the village of people who have helped to raise Jack and support me as I waded through a dissertation and motherhood at the same time – and not always gracefully. From listening to my ramblings, to providing childcare, to even editing the final draft of this entire book – I am so blessed by you. Most of all, to Daniel Cole, whose belief in me – as a researcher *and* a mother – has never wavered.

Vita

EDUCATION

MS   **University of California San Francisco, School of Nursing**, March 2008
San Francisco, CA
Specialty: Advanced Community Health and International Nursing, focus in HIV/AIDS

BSN   **Messiah College**, June 2004
Grantham, PA
Honors thesis: Experiences surrounding childbirth in rural Zambia: An ethnographic study

LICENSE & CERTIFICATIONS

2010   Certificate of Nursing in Education, UCLA School of Nursing
2008   Clinical Nurse Specialist, California. Certificate #2980
2004   Registered Nurse, California. License #642048

RESEARCH EXPERIENCE

09/2011 –   **Graduate Student Researcher, UCLA School of Nursing**
04/2012   Los Angeles, CA
"Mujeres Sanas y Precavidas (Healthy Women Prepared for Life): Qualitative Follow-up"
Principal Investigator: Deborah Koniak-Griffin, EdD, RNC, FAAN
- Collected and analyzed data using Constructivist Grounded Theory techniques with guidance and input from both the PI and MarySue Heilemann, PhD, RN

02/2010 –   **Nurse Case Manager, UCLA School of Nursing and Amity Foundation**
07/2011   Los Angeles, CA
"Health Promotion Coaching/Vaccine for Homeless Parolees"
Funding Agency: NIH/NIDA
Principal Investigator: Adeline Nyamathi, ANP, PhD, FAAN
- Conducted one component of the randomized trial intervention: nurse case management and educational sessions for homeless parolees

CLINICAL EXPERIENCE

08/2009 –   **Relief Nursing Supervisor, Simi Valley Hospital**
03/2010   Simi Valley, CA
Responsible for overseeing staffing for a 136-bed community hospital on a per diem basis

07/2008 –   **Per Diem Registered Nurse, Simi Valley Hospital Emergency Department**
08/2010   Simi Valley, CA
Worked four to twelve shifts per month, in all areas of emergency care

06/2006 –   **Clinical Nurse II, UCSF Medical Center Emergency Department**
07/2008   San Francisco, CA
Acted as preceptor to new graduate students and student nurses, in addition to ER staff nursing assignment

06/2004 –   **Clinical Nurse II, UCLA Medical Center Emergency Department**
06/2006   Los Angeles, CA
Worked as a Mobile Intensive Care Nurse (MICN), directing paramedics via radio from the hospital's base station in addition to ER staff nursing duties

TEACHING EXPERIENCE

12/2007 – 08/2009	**Nurse Consultant & Instructor, UCSF School of Nursing and the Foundation for Professional Development**

San Francisco, CA & Pretoria, South Africa
Assisted with program development and implementation for the Nurse Case Management in HIV/AIDS (NCMHA) curriculum, supervised by Carmen J. Portillo, RN, PhD, FAAN
- Co-authored a 617-page instruction manual with 11 HIV-related modules
- Provided on-site training and mentorship to the first cohort of nine South African HIV Nurse Case Managers in a two-week course

05-2008 – 06/2008	**Instructor, UCSF School of Nursing and the American International Health Alliance**

Dar es Salaam, Tanzania
Taught the Tanzania HIV/AIDS Nursing Education (THANE) curriculum to nurse educators in Tanzania as part of a team supervised by Carmen J. Portillo, RN, PhD, FAAN
- Instructed four modules to 25 nurse tutors as part of a two-week course

PEER-REVIEWED PUBLICATIONS

Albarrán, C. R., Heilemann, M. V., & Koniak-Griffin, D. (2014). Promotoras as facilitators of change: Latinas' perspectives after participating in a lifestyle behavior intervention program. *Journal of Advanced Nursing*. [epub ahead of print]

Palacios, J., Salem, B. E., Hodge, F. S., **Albarrán, C. R.,** Anaebere, A. K., & Hayes-Bautista, T. M. (2014). Storytelling: A Qualitative Research Tool For Promoting Health Among Medically Vulnerable Populations. *Journal of Transcultural Nursing*. [epub ahead of print]

Nyamathi, A., **Albarrán, C. R.,** Branson, C., Marfisee, M., Kallilifard, F., & Leake, B. (2012). Correlates of depression among methadone maintained adults who report alcohol use. *American Journal on Addictions, 21,* S49-S55.

Nyamathi, A., Leake, B., **Albarrán, C. R.,** Zhang, S., Hall, E., Farabee, D…& Faucette, M. (2011). Correlates of depressive symptoms among homeless men on parole. *Issues in Mental Health Nursing, 32*(8), 501-511.

Albarrán, C. R., & Nyamathi, A. (2011). HIV and Mexican migrant workers in the United States: A review applying the vulnerable populations conceptual model. *Journal of the Association of Nurses in AIDS Care, 22*(3), 173-185.

Nyamathi, A. M., William, R. R., Ganguly, K. K., Sinha, S., Heravian, A., **Albarrán, C. R.,** et al. (2010). Perceptions of women living with AIDS in rural India related to the engagement of HIV-trained Accredited Social Health Activists for care and support. *Journal of HIV/AIDS & Social Services, 9*(4), 385-404.

NATIONAL PRESENTATIONS

Albarrán, C. R. (2013). *Learning how to establish community partnerships for vulnerable populations research.* Podium Presentation. Western Institute of Nursing Conference. Los Angeles, CA. April 12, 2013.

Albarrán, C. R. (2012). *Storytelling: A Concept Analysis.* Podium Presentation. Western Institute of Nursing Conference. Portland, OR. April 20, 2012.

Albarrán, C. R. (2011). *Female migrant farmworkers and HIV risk: Applying the theory of gender and power.* Poster Presentation. Western Institute of Nursing Conference. Las Vegas, NV. April 18, 2011.

Chapter 1:

Introduction

Background and Context

Latina/os comprise the second largest group infected with Human Immunodeficiency Virus (HIV) in the United States (US), and carry a disproportionate burden of people living with HIV (17%) when compared with their percentage of the general population [15%; Centers for Disease Control and Prevention (CDC), 2010]. Farmworkers comprise a vulnerable subgroup of Latina/os; 72% of all farmworkers in the US are foreign-born and 68% were born in Mexico [National Center for Farmworker Health (NCFH), 2012a]. There are about one million farmworkers in the US and 18% are women [United States Department of Agriculture (USDA); 2014] . Together, California and Texas account for one-third of all farmworkers in the country (USDA, 2014).

The National Agricultural Workers Survey (NAWS) collects annual data on farmworkers around the country, however the latest report on these data was published in 2005. Combined with a recent paucity of ongoing research into the health of farmworkers, data describing this group are becoming outdated. Migrant farmworkers, who follow the harvest for work across county and state lines, are marginalized from mainstream society due to their status as foreign-born, their employment in undesirable work conditions, their lack of citizenship or documentation, and their low-income level (Carroll, Samardick, Bernard, Gabbard & Hernandez,, 2005). Although data regarding HIV infection among migrant farmworkers come from a handful of small-scale studies that are becoming outdated, these older reports indicate that farmworkers in the US appear to carry a particularly large burden of HIV infection that could be as high as 15 times that of the general population. This previous research found HIV prevalence

rates between 3.2% – 6% in farmworker communities (Denner, Organista, Dupree & Thrush, 2005; Eastern Coachella Valley Social Change Collaborative, HIV Task Force, 2008).   These numbers are extremely high compared with the 0.4-0.9% HIV prevalence rate in the general US population [United Nations Joint Programme on HIV/AIDS (UNAIDS), 2012a)]. The impact of HIV is particularly devastating in farmworker communities, as there is a paucity of care options for migrant farmworkers with chronic conditions. For example, in California's Coachella Valley, 92% of farmworkers do not have health insurance and only 36% report having seen a physician in the past 12 months despite the fact that 61% report having a chronic health problem (Colletti, Smith, Herrera, Herrera & Flores, 2006).

Women who migrate for agricultural labor experience unique vulnerabilities related to their sexual health. Migrant farmworker women of Mexican descent are most likely to acquire HIV via heterosexual contact [Centers for Disease Control (CDC), 2010]. Various factors make migrant farmworker women of Mexican descent increasingly vulnerable to HIV and other sexually transmitted infections (STIs). For example, migrant farmworker women of Mexican descent have primary partners who often are unfaithful (Hirsch, Higgins, Bentley & Nathanson, 2002) and/or partners who report high-risk activities such as problem drinking (Duke & Carpinteiro, 2009), injection drug use (McVea, 1997), sex with commercial sex workers (CSW; Brammeier, Chow, Samuel, Organista, Miller, & Bolan, 2008), and multiple partners (Ford, King, Nerenberg & Rojo, 2001). In addition, migrant farmworker women of Mexican descent live in rural areas with fewer resources, experience discrimination, live in poverty, and are often undocumented (Brammeier et al., 2008; Carroll et al., 2005).   Finally, migrant farmworker women report many perceived health problems and experience multiple barriers to receiving healthcare (Anthony, Williams & Avery, 2008).

Despite these vulnerabilities and challenges, the literature shows evidence that intrinsic strength factors may lower Latina women's risk for negative outcomes including depression (Heilemann, Lee & Kury, 2002). Heilemann et al. (2002) differentiated between intrinsic strength factors (e.g. a sense of mastery, level of satisfaction with life, importance of spiritual beliefs, and resilience) and external resource factors (e.g. education, employment, income and the number of family members supported by this income, the presence or absence of a partner, and availability of practical necessities). Others have identified a "reserve capacity" held by individuals that includes both interpersonal and intrapersonal resources and helps one to cope with stress (e.g. optimism, self-esteem, social support, and perceived control; Gallo, Penedo, Espinosa de los Monteros & Arguelles, 2009). Still other studies show that "parental protectiveness" – defined as the "parent-child emotional attachment that positively influences parental behavior" -- can support resiliency and motivate individuals towards behavioral change (Lesser, Koniak-Griffin, Huang, Takayanagi & Cumberland, 2009, p. 89). Investigators have found that maternal protectiveness positively influenced mental health and healing among adolescent mothers as they "gained access to previously untapped strengths within" and worked to improve their lives (Lesser, Koniak-Griffin & Anderson, 1999, p. 141). Finally, parental protectiveness may impact HIV risk behaviors in Latina/o couples over time (Lesser et al., 2009). In summary, a growing body of literature indicates that strength factors and inherent protective tendencies should be considered as an important component in studies that examine risk for poor health outcomes among Latina/o groups.

Problem Statement

Although migrant farmworker women are exceedingly vulnerable in relation to their health in general, and are at high risk for HIV infection in particular, the dynamics of the ways in

which migrant farmworker women experience and negotiate sexual risk are largely unknown. Understanding how women perceive and navigate these risks is integral to planning public health efforts that can prevent the spread of HIV and improve outcomes for women in the migrant population. In previous qualitative research with migrant women, Hondagneu-Sotelo (1994) explored how gender roles are transformed across the migration process. In more recent qualitative work on cultural perspectives of sexual risk and migration, research teams such as Hirsch and colleagues (2002, 2007, 2009) have focused on the wives of migrant men who have stayed behind in Mexico. In this dissertation research, I am informed by the work of Hondagneu-Sotelo (1994) and Hirsch et al. (2002, 2007, 2009) as I move forward to focus specifically on migrant farmworker women in the US and their experiences with sexual risks.

Study Purpose

Qualitative research is needed to describe the unique experiences and perspectives of migrant farmworker women in order to ultimately generate interventions specifically tailored to the needs of this population. My dissertation research explored women's perceptions regarding HIV risk and sexual health, as well as self-protective factors utilized by women to counter this risk, among a sample of migrant farmworker women of Mexican descent.

Research Questions

1) What are migrant farmworker women's perceptions of and experiences with HIV risk?

2) How do women's beliefs and values related to sexuality, migration, gender roles and power influence how they view, experience and negotiate risky situations?

3) What resources and self-protective factors do women use to mitigate these perceived risks?

Research Design Overview

Using principles of Community Based Participatory Research from the Community Partnership Model (Anderson, Calvillo & Fongwa, 2007), I partnered with community workers and migrant farmworkers from a small rural region of Southern California that I call the "Green Valley." I formed a Community Advisory Board (CAB) of local stakeholder women and spent a great deal of time getting to know the community through multiple short trips over a period of one year before I actually started collecting data. Then I spent another two years interviewing twenty migrant farmworker women (one or two interviews each) about their experiences with and perceptions of HIV risk. I analyzed data as I collected it, using Constructivist Grounded Theory (CGT; Charmaz, 2014) methodology.

Significance to Nursing Science and Practice

The issue of health among migrant farmworker women of Mexican descent is particularly important to community health and nursing. The border between Mexico and California is one of the busiest international borders in the world, with 82 million total northbound crossings in 2006 alone (Welton et al., 2008). There are an estimated 11.4 million individuals born in Mexico who live in the US, half of whom (51%) are undocumented (Gonzalez-Barrera & Lopez, 2013). No other country in the world has as many immigrants in total from all countries combined as the US does from Mexico alone (Passell & Cohn, 2009). In 2006, 30% of California's population was of Mexican origin, with more than a third of these estimated to have been born in Mexico (Welton et al., 2008).

It is clear that im/migrant culture in the US is being transformed, impacting community health in both rural and urban areas. Nurses are on the front line of care for migrant workers at community clinics, emergency departments and occupational health sites around the country.

Having knowledge of migrant farmworker women's perspectives about their lives, their background, their daily experiences, their social understandings and their perspectives regarding sexual risk will equip and guide nurses and health care teams to effectively reach this population with HIV prevention interventions and care.

There are numerous gaps in the health sciences literature surrounding migrant farmworker women. Additional work is necessary to begin to close this gap and to provide a knowledge base on which to build effective and appropriate nursing interventions. This study contributes to nursing science by offering a grounded theory of migrant farmworker women's perceptions of sexual health, power, and self-protective strategies within the contexts of their daily lives. This study also provides an understanding of women's cognitive processes to perceive and respond to personal risk, in lieu of a reliance on behavioral factors associated with HIV risk that are often used in the literature surrounding this topic. Finally, this exploratory qualitative work provides a scientific basis for subsequent quantitative inquiry into and measurement of HIV risk factors that can ultimately fuel large-scale intervention studies with migrant farmworker women.

Overview of the Dissertation

In this introductory chapter, I provided a brief overview of the problem, study purpose, research design and significance of my work. In chapter two, I go on to review the literature surrounding migrant farmworker women of Mexican descent and their risk for HIV. For this review, I queried a broad section of literature spanning three disciplines in order to provide context for the population and the problem as well as theoretical perspectives of HIV risk among women. I also seek to answer the multifaceted question, "why are migrant farmworker women at risk for HIV?" Then I review the gaps in knowledge. Next, in chapter three, I delineate my

philosophical underpinnings for both my chosen research methodology and my research design. In chapter four, I outline the methods that I used to conduct this research, including research design, procedures, data collection and analysis, data safety and management, and ethical considerations.

There are three results chapters. In the first and most brief, chapter five, I describe the setting for this research and the sample of women who participated in this project. In chapter six, I present the first process of how women expanded their perspectives regarding HIV risk in their relationships. This chapter delineates the cognitive, emotional and social micro processes used by participants to analyze risk along five phases: being blinded, making the discovery, weighing priorities, adopting a risk perspective, and assessing the consequences. Then in chapter seven, I explain the second simultaneous process of gaining leverage: as they expanded their perspectives, women were strategizing to gain leverage in their risky relationships through both small and large efforts that preserved their dignity and sense of self. With the use of both personal and external resources, participants described how they fought the bad, found the good, and fortified themselves amidst extreme personal and familial turmoil.

In chapter eight, I discuss the importance of my findings within the context of the existing literature on migrant farmworker women. My study is the first to delineate the cognitive, social and emotional micro processes in which women engage as they navigate HIV risk. In addition, the concept of "gaining leverage" is a novel way of understanding how Latinas perceive agency in their risky relationships. In the final chapter of this dissertation, chapter nine, I present my conclusions and implications for nursing science, practice, and policy.

Chapter 2:

Review of the Literature

Introduction

In order to provide both background and context for the population and the topic of interest, I queried a broad section of literature spanning health sciences, sociology and anthropology. First, I found that it was important to set the context for migrant farmworker women's lives in general by defining terms that situate the women in this study within the literature and within the research on migration and health. Also, understanding theoretical perspectives of risk among women is integral to exploring the migrant farmworker experience. And so, after setting the context and reviewing three theoretical perspectives, in this review I seek to understand why migrant farmworker women are at risk for HIV and what major gaps in knowledge need to be filled.

Setting the Context

In order to understand the context within which migrant farmworker women of Mexican descent live, I found it was necessary first to delineate the population that I am referring to in the literature, as well as what im/migration is and how im/migration affects health.

Defining the population. Migrant farmworker women of Mexican descent constitute a subpopulation comprised of several larger groups. Understanding the target population necessitates a narrowed focus on several distinct groups in the literature, including "Latina/os," "immigrants," "farmworkers," "migrants," and "individuals of Mexican-origin" (see Figure 1, Appendix A).

Latina/o. The term "Latina/o" refers to individuals of Latin American origin (Fears, 2003). This term is often used interchangeably with "Hispanic," which more commonly refers to

individuals originating from the Iberian peninsula (Fears, 2003). However, there is no common

agreement among scholars as to the "best" pan-ethnic term to use (Asencio & Acosta, 2010).

The more common term (and more appropriate term for women of Mexican descent) "Latina"

will be used in this dissertation, except when discussing studies that use other terminology.

Regardless of the term used, these identities represent individuals from extremely diverse

geographic and sociocultural backgrounds. The proposed study will focus on Latinas of

Mexican descent, who may have different characteristics from Latinas in general. Of note,

although statistics separating "individuals of Mexican origin" from the larger group of

"Latina/os" are not always available, in California, the Mexican population is such that data for

the larger group are often descriptive of the smaller subset (Morin, Carrillo, Steward, Maiorana,

Trautwein & Gomez, 2004).

Data from the US census show that the Latina/o population in the US numbers 54 million

individuals, constituting the largest ethnic or race minority in the country (US Census Bureau,

2014). Seventeen percent of the total US population is Latina/o and 64% is of Mexican origin

(US Census Bureau, 2014). California hosts the largest number of foreign-born im/migrants in

the country, with one in four residents having been born abroad (Grieco et al., 2012).

Im/migrants. Next, the terms "immigrant" and "migrant" must be distinguished.

Migration is defined by the International Organization for Migration (IOM, 2004) as "a *process*

of moving, either across an international border, or within a state" (p. 41), whereas immigration

is defined as "a process by which non-nationals move into a country for the purpose of

settlement" (p. 31). However, the line between migration and immigrant settlement is often

blurred. Workers migrate from Mexico to the US to find work and send remittances home to

their families; many intend to stay only a short time. But eventually they may settle in the US

and send for their families, creating transnational communities (Hondagneu-Sotelo, 1994). It can be difficult to differentiate where migration ends and settlement begins.

Migration can be both international and internal (IOM, 2004), meaning that an individual might initially migrate from Mexico to the US and might also continue to migrate within the US for work or other reasons. Migration is therefore a process of mobility and could be permanent, temporary, or cyclical (IOM, 2004). Migration can also have different causes, including economic pursuits, force (e.g. in the case of refugees or victims of trafficking), or family reunification (IOM, 2004).

At the international level, there exists no universally accepted definition of a migrant (IOM, 2004). The United Nations has recommended that an international migrant be defined as an individual who changes his or her usual residence for a period of at least 12 months (United Nations, 2006). This definition is more specific than that of the IOM (2004), in that it excludes travelers or international visitors who do not change their usual residence. In the US, there are two contexts for understanding migration: US migration law and the US Census Bureau. The Department of Homeland Security (DHS, 2009) defines a migrant as "a person who leaves his/her country of origin to seek residence in another country." The US Census Bureau (2008), on the other hand, does not ask about im/migration status but does distinguish between "native" (those who were US citizens or nationals at birth) and "foreign born" (anyone who was not a US citizen or national at birth, and includes all those who may be lawful permanent residents, unauthorized migrants, refugees, or otherwise claim the US as their usual place of residence on the census survey date).

In the literature surveyed for this review, the definition of migrant status was particularly problematic. No common definition of a "migrant" was utilized, however the difficulties in

consistently defining the term on international and national levels do not make this surprising.

Many articles on migrants in the health sciences literature focus on circular migrants, or those

who come to work in the US and then return home to Mexico and are interviewed in Mexico

(e.g. Fosados, Caballero, Hoyos, Torres-Lopez & Valente, 2005). Others focus on migrants as

"recent immigrants" who have lived in the US for less than three years (e.g. Shedlin, Decena &

Oliver-Velez, 2005), or less than five years (e.g. Hernandez et al., 2009; Maternowska, Estrada,

Campero, Herrrera, Brindis & Vostrejs, 2009). Others discuss subpopulations of interest that

may classify as migrants (e.g. day laborers), but do not specifically label them as such or give

enough information for the reader to determine im/migrant status (e.g. Ehrhlich, Tholandi &

Martinez, 2006). Finally, some of the literature focuses exclusively on the health of migrants

living in the US-Mexico border region (e.g. Mondragón & Brandon, 2004). In California, this

region is composed of a highly mobile group of just over 3 million residents that suffers

disproportionate rates of cervical cancer, obesity and overweight, asthma, foodborne and

waterborne diseases, sexually transmitted infections (STIs) and tuberculosis (California Office of

Binational Border Health, 2008). Findings among migrants in this region cannot be generalized

necessarily to migrants living in other regions of California or the US, and therefore these studies

were not included in this review.

General characteristics of migrants help to understand the group of interest. A survey of

N=4,836 individuals applying for a *matrícula consular*, or Mexican identity card, at Mexican

consulates in six major cities across the US highlights key information about Mexican migrants

(Kochhar, 2005). First, unemployment in Mexico plays a minimal role in motivating individuals

to migrate, and it is common for those living in the US for less than six months to remain

unemployed. However, having government-issued identification does not lessen migrants'

11

difficulty in obtaining employment. Family networks provide the most common method (cited

by 45% of respondents) for obtaining information about US jobs. Regarding the type of jobs that

migrants hold, two-thirds of this survey sample reported working in agriculture, construction,

manufacturing, and hospitality. Respondents reported median weekly earnings of $300

(Kochhar, 2005).

   Farmworkers. The fruit and vegetable industry in the US depends upon farmworkers to

hand pick and pack produce, in what constitutes one of the most dangerous industries in the

country (Arcury & Quandt, 2007). In California alone, there are estimated to be approximately

732,000 migrant and seasonal farmworkers (Larson, 2000). Because crops grow in a seasonal

pattern, those who work in agricultural labor are in a constant state of flux that is dependent upon

multiple environmental and economic factors. Typically, farmworkers will either settle in one

area and hold multiple types of field jobs during the year, or they will move from one area to

another to follow a harvest.

   In the case of Mexico and the US, structures supporting agricultural labor migration have

existed for many years since the formation of the Bracero Program in 1942. Such structures

allowed and even invited laborers from Mexico to function as a cheap labor source for US

agribusiness. Although this program ended in 1964, the demand for a source of cheap labor in

the US and the supply of workers coming from Mexico has persisted, both via documented and

undocumented channels. In 1964, the H-2 program replaced the Bracero Program, allowing

employers to hire foreign workers if they could prove there was a shortage of domestic workers

to do the same work (DHS, 2008). The Immigration Reform and Control Act of 1986 (IRCA)

allowed some agricultural workers to obtain legal status by showing proof of employment for a

period of at least 90 days.

Now, the H-2A program continues to allow US employers to petition for a certain number of temporary visas to hire foreign agricultural workers, if they can prove that domestic workers are unable, unwilling, or unqualified to do the work. The Department of State issued 50,791 H-2A visas in the fiscal year 2007 (DHS, 2008). The national farmworkers' advocacy group Farmworker Justice (2010) has critiqued this program for its inadequate prevention and punishment of employer violations.

Of course, not all migrants are farmworkers. Similarly, not all farmworkers are migrants, although they are sometimes assumed to be. A migratory agricultural worker is defined by the Public Health Service Act (42 USCS § 254b) as being "an individual whose principal employment is in agriculture, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode," whereas a seasonal agricultural worker is defined as "an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker" (p. 9). The Head Start Act (1998) defines a migrant farmworker as an individual who has "changed his or her residence from one geographical location to another in the preceding two year period" (the definition used for this study), whereas a seasonal farmworker is an individual who has not changed residence.

The National Agricultural Workers Survey (NAWS) collects demographic, employment and health characteristics from the US crop labor force each year, and is the only national information source on the demographic, employment, and health characteristics of those engaged in fieldwork (Carroll et al., 2005). The NAWS defines a migrant farmworker as an individual "who has traveled at least 75 miles within the previous year to obtain a farm job," and found that 42% of respondents fit this description (Carroll et al., 2005, p. ix). Among these, 26% traveled only within the US while 35% migrated back-and-forth across international borders (primarily to

Mexico). Thirty-eight percent were newcomers to the US (having been here for less than 1 year and therefore qualifying as migrants; Carroll et al., 2005).

Unfortunately, the most recent NAWS report was published in 2005. It showed that 75% of farmworkers in the US at that time were born in Mexico, 53% were undocumented, and 79% were male (Carroll et al., 2005). Forty-four percent did not speak English and 53% did not read English. The average highest grade completed was seventh grade (Carroll et al., 2005).

Farmworkers report multiple health problems, both in relation to occupational exposures and lifestyle exposures. Twenty-seven percent of workers report at least one injury during their working lifetime (Arcury & Quandt, 2007). Other health-related concerns include pesticide exposure, occupational skin disease, eye problems, dental problems, mental health needs, obesity, and infectious diseases including tuberculosis, HIV and acquired immune deficiency syndrome (AIDS; Arcury & Quandt, 2007).

Parra-Cardona and colleagues (2006) explored the life experiences of migrant farmworker women (N=13) of Mexican origin in Michigan. Investigators used a grounded theory approach to analyze data from three annual interviews with each participant. Women remained positive despite the many challenges that they faced, which included discrimination and exploitation in the workplace and rapid relocation for work. However, women relied on their families for support and found that the hardships they endured were bearable in order to ensure the wellbeing of their children (Parra-Cardona et al., 2006).

Documented vs. undocumented. The IOM (2004, p. 67) defines an undocumented individual as:

An alien who enters or stays in a country without appropriate documentation. This includes, among others: one a) who has no legal documentation to enter a country but

manages to enter clandestinely, b) who enters using fraudulent documentation, c) who,

after entering using legal documentation, has stayed beyond the time authorized or

otherwise violated the terms of entry and remained without authorization.

In the US, a number of terms are used to refer to individuals who lack authorized documentation,

including "illegal alien," (DHS, 2009) and "unauthorized migrant" (US Census Bureau, 2008).

For this paper, the term "undocumented" will be used to refer to individuals who meet any part

of the IOM (2004) definition.

Assumptions exist that all migrants are undocumented. Partially because the US Census

Bureau (2008) does not collect migration status information, and mostly because migrants may

not be counted in population surveys because they are in transit at the time of the survey, it is

difficult to know how many migrants are undocumented. There exists a multiplicity of numbers

estimating the number of undocumented persons in the US, and some authors warn that estimates

of undocumented migrants may not be as high as statistics indicate (Bean, Corona, Tuiran,

Woodrow-Lafield, & Van Hook, 2001). With this in mind, the Pew Hispanic Center estimates

that the undocumented population in the US totals nearly 11 million, including 6 million

individuals of Mexican origin (Passel, 2005). Approximately 80-85% of the migration from

Mexico is estimated to be undocumented (Passel, 2005). Of note, Mexican-born im/migrants

have much lower naturalization rates than other im/migrant groups (National Population Council

of the Government of Mexico & the University of California, 2008). Often (58% of the time),

Mexican households in the US are comprised of a mix of individuals with and without

documentation, lending different rights and privileges to members of the same family (National

Population Council of the Government of Mexico & the University of California, 2008).

Those who are undocumented do have access to some federal programs, including: Women, Infants and Children (WIC), Migrant Education, Migrant and Seasonal Head Start (MSHS), Community and Migrant Health Clinics, Emergency Medicaid (which includes payment for services to be stabilized in a life-threatening emergency and childbirth only), school lunch, and Title 1 services for children (including English as a Second Language; Rosenthal, 2011). However, undocumented individuals often lack the necessary paperwork to legally drive a car, establish a line of credit, or obtain health insurance, making their lives extremely complicated (National Population Council of the Government of Mexico & the University of California, 2008). Women who are undocumented are more vulnerable than those who have attained legal residence status or possess a work visa, and are therefore at a greater risk for poor health (McGuire, 2006, McGuire & Georges, 2003).

Documentation status structures US settlement experiences differently, and also may have differential effects on how women report and experience intimate partner violence and form their concept of self (Hancock, 2007). Therefore, although the proposed research will not focus solely on undocumented women, this review will highlight findings among undocumented migrants when possible.

Mestizo/a and indigenous. Although they are often assumed to be, Mexican im/migrants in the US are not an ethnically homogenous population (Fox & Rivera-Salgado, 2004). As in the US, many different groups are indigenous to Latin America and predated the European conquistadors. These groups experience broad levels of discrimination and prejudice in Mexico (Stephen, 2007). While the Mexican government has made strides towards granting formal recognition and respect to these groups, it has yet to adopt legislation on indigenous rights that is acceptable to most advocacy groups.

Of the indigenous groups that remain in Mexico today, there are estimated to be approximately 400 different indigenous languages spoken throughout the region (Montenegro & Stephens, 2006). Language remains the single most common means of identifying indigeneity (Montenegro & Stephens, 2006). In US census terms, indigenous peoples from Latin America are referred to as "Hispanic American Indians" (Murillo & Cerda, 2004). Those who are not indigenous are referred to as *mestizo/a*, a Spanish word that literally means "mixed." In California, there are estimated to be about 120,000 indigenous Mexican farmworkers (Mines, Nichols & Runsten, 2010). If estimates of the numbers of farmworkers in the Southwest region of the US are comparable, this would mean that indigenous groups could constitute approximately 40% of farmworkers in California (USDA, 2014).

Indigenous peoples in all of Latin America are particularly vulnerable to poor health outcomes, often due to resource exploitation (Montenegro & Stephens, 2006). In the US, indigenous migrants often face a kind of "double discrimination" from both their *mestizo/a* Mexican counterparts and also from mainstream US society (Farquhar, Shadbeh, Samples, Ventura & Goff, 2008). Indigenous groups can also experience gendered discrimination (Blackwell, 2009) and health disparities related to language barriers and structural racism (Holmes, 2006). For this research, only those who spoke Spanish as a primary and preferred language were eligible to participate. However, language alone is not a clear indicator of indigeneity. For this review, studies that specify ethnicity are distinguished since the indigenous migrant experience can be different from the *mestizo/a* experience (Blackwell, 2009; Farquhar et al., 2008; Holmes, 2006).

Mexico-US Im/migration. Migration has been described as a structural social and economic process that exists predictably; it is the allocation of workers from low- to high-wage

areas (Massey, 1987). This is an inevitable phenomenon when a country with many resources shares a border with one that has fewer resources. Characteristics of the sending society involve "push" factors, including inequality of land, labor and capital. In the receiving society, "pull" factors exist, which include economic segmentation and low paying jobs that have limited chance for advancement (Massey, 1987). Two components of im/migration are particularly salient to my study: the formation of transnational families and the effects of acculturation on health.

Transnational families. Among farmworkers, one third (34%) of those with children and nearly a third (30%) of childless married individuals are unaccompanied, meaning that they are living away from all nuclear family members, most of whom are in Mexico (Carroll et al., 2005). Scholars have referred to this phenomenon as transnationalism, or a "transnational life," meaning that migrants are closely linked to practices and relationships in their home country and often travel back and forth or are heavily influenced by those who travel back and forth across international borders with frequency (Smith, 2006, p. 6). Others have referred to the "translocal community," which extends to include those who are active members both in their communities of origin and their communities of settlement and organize in a "deterritorialized" space that transcends geography (Fox & Rivera-Salgado, 2004, p. 27). Another term is "transborder lives," which highlights that individual experiences may not only span national borders but also cross borders of ethnicity, class and culture (Stephen, 2007, p. 6).

Kandel and Massey (2002) developed a formal theory of the culture of migration, which posits that certain Mexican communities have developed normative expectations that large segments of the community will leave to work in the US and others will stay behind. In these communities, many individuals (particularly men) view migration as a normal part of the life

18

course (Kandel & Massey, 2002). Some men in Mexico who failed to migrate to the US express feelings of powerlessness and sadness, as if they are "less of a man" for not working across the border (Zavella, 2011). Zavella (2011) posits that the perspective of translocal life gives migrants living in the US a "peripheral vision:" that they are constantly comparing their situations to that in *el otro lado* ("the other side") and feeling very "in between" (p. 8).

While some studies related to transnationalism and health have focused on the well-being of children who are separated from their parents for periods of time (e.g. Suárez-Orozco, Todorova & Louie, 2002), other research has begun to address how these separations also have an impact on the emotional well-being of the parents (Abrego, 2014; Sternberg, 2010). This scholarship indicates that mothers perceive migration to the US for work as necessary in order to financially provide for their families. In addition to poverty, having hope for a better life is a catalyst that prompts women to choose to become transnational mothers. In this way, women are mothering from afar: recontextualizing motherhood and trying to express love and devotion to their children while living across the border (Sternberg, 2010). The existence of transnational families certainly affects migrant farmworkers communities in the US, as both women and men cope with familial separation and the repercussions that this separation may have for their health.

Acculturation and health. As a group, Mexican immigrants show particularly poor assimilation patterns related to socioeconomic status (SES), education and income when compared with other immigrant groups (Telles & Ortiz, 2008), placing them at risk for poor health outcomes. However, in the last few decades, health sciences research has uncovered a kind of epidemiologic paradox for Latina/o immigrants in the US (Acevedo-Garcia & Bates, 2008). In other words, foreign-born Latina/o immigrants have been found to experience better health than their US-born counterparts, despite low socioeconomic status. This denotes a "low

residual effect" of foreign-born status that is not accounted for by socioeconomic, demographic, behavioral or medical risk factors (Acevedo-Garcia & Bates, 2008, p. 103), and this effect is attenuated over time. For example, Ward, Tanner and Cummings (2008) compared health-related quality of life among migrant farmworkers in the US, a comparison group in Mexico, and a group of non-im/migrant Latina/os in the US. They found a range with those in Mexico reporting the best health and US-born Latina/os reporting the worst health, while migrant farmworkers were in the middle (Ward et al., 2008). Much of the emphasis in the health sciences prevention and intervention literature has therefore been focused on US-born Latina/os, since findings appear to show that they experience poorer health than their foreign-born relatives.

However, some recent studies have begun to critique the methods and instruments used in this body of literature on Latina/o immigrants and health outcomes (Carter-Pokras, Zambrana, Yankelvich, Estrada, Castillo-Salgado & Ortega, 2008). Likewise, Barron and colleagues (2004) argued that factors at play in relation to treatment adherence extend beyond acculturation factors, including language, view of health and disease, provider variables, and discrimination. One study specifically assessed cultural values and beliefs in lieu of acculturation (Caban & Walker, 2006), providing a reminder that cultural beliefs regarding health and wellness are perhaps more salient than acculturation proxies when measuring health outcomes. In other words, it seems particularly important to question an individual regarding his or her beliefs concerning health and disease instead of only querying how many years he or she has lived in the US.

Both the conceptualization and operationalization of the sociological concepts of acculturation and assimilation have been limited in the health sciences literature, bringing into question findings regarding the Latina/o epidemiological paradox. Carter-Pokras et al. (2008) argue for the use of variables including SES, education, income, health insurance coverage,

immigrant status and geographic location (in addition to standard acculturation measures) in order to provide a more comprehensive picture of why health outcomes are different for these groups. Using a proxy measure of acculturation such as nativity or time spent in the US does not explain the experiences of an individual or account for intragroup variation. Furthermore, Carter-Pokras and colleagues (2008) question if perhaps using acculturation in health research might be based more on ethnic stereotypes than on empirical cultural differences.

In summary, it is important that health sciences researchers not take for granted that foreign-born im/migrants experience better health outcomes than their US-born counterparts. Certainly in the case of migrant farmworkers, there are multiple structural, environmental, cultural, and sociopolitical factors that impact health and lead to poor outcomes. These factors may exist regardless of nativity status or which language is spoken at home.

Migration and health. The act of migration is a structural process, creating a higher standard of living in the sending society through remittances, but also contributing to the structural oppression of migrant workers themselves (Duke & Carpinteiro, 2009). This has created a population of marginalized, low-wage workers who are afforded few legal rights, lack health insurance, and are therefore at risk for poor health outcomes. International migration alone is therefore a risk factor for poor health outcomes in general while HIV and other STIs in particular are risk factors for individuals around the world (Carballo & Nerukar, 2001). Female migrants across many cultural and geographical contexts are particularly at risk for poor health and are vulnerable to sexual abuse, rape, and violence (Adanu & Johnson, 2009).

Migrant farmworkers in particular live in environments that contribute to poor health. Two qualitative studies examined how migrant farmworker women conceptualize health, and both found that women define health as the ability to be in peace (Clingerman, 2006; Rodriguez,

21

1993). Women's experiences of health are, however, contextualized by spiritual beliefs, family, gender, poverty, migration, and racism (Clingerman, 2006). In fact, what exists in the literature on migrant farmworker women's health describes processes that do not appear to create a peaceful environment. Ninety percent of migrant and seasonal farmworkers perceive barriers to healthcare for themselves or others (Anthony et al., 2008).

Housing quality is one example of an environment that contributes to poor health. Early and colleagues (2006) examined housing quality in a sample of 234 farmworker families in North Carolina, and found that crowding rates (> one person per room) were at 40% across the sample. Most farmworkers surveyed (54-71%) lived in mobile homes that lacked washing machines and other basic appliances, making it difficult for workers to appropriately wash their clothes of pesticides after a day in the fields (Early et al., 2006). In another study in North Carolina, farmworkers reported a 69.4% crowding rate, 46% of dwellings were located adjacent to fields were pesticides were applied, and most homes had structural problems and did not meet the US Department of Housing and Urban Development minimum standards for health and safety (Gentry, Grzywacz, Quandt, Davis & Arcury, 2007).

Another finding in the literature on migrant farmworkers' health relates to food insecurity. Borre, Ertle and Graff (2010) examined food insecurity among migrant and seasonal farmworker families (N=36) using a mixed methods approach, and found that 63.8% of families were food insecure and 34.7% experienced hunger. However, obesity was common in this sample. Authors conclude that the relationship between food insecurity and obesity in migrant farmworkers is unclear (Borre et al., 2010).

There is a substantial body of literature on the occupational health and safety of migrant farmworkers, which will not be synthesized in this review. However, it is important to consider

that as laborers, migrant farmworkers are exposed to a highly volatile work environment where safety regulations are not consistently met (Whalley, et al., 2009).

Research has shown that migration is not always beneficial to women. Webber's (2007) work on the impact of migration on HIV prevention for women offers a process view of how sexual risk changes across the migration continuum. She proposes that there are structural, community, and relational contexts that are interrupted and changed with the process of migration to a new destination. These shifting contexts set the stage for how a woman will or will not be prepared to respond to the cultural shifts, changes in power dynamics, and availability of resources that come with movement to a new country. Mexican women who migrate almost always have followed a husband or a parent to the US, arriving after the latter has secured work (Cerrutti & Massey, 2001). Social isolation, strained social bonds (Campbell, 2008), and changing gender roles (Maternowska et al., 2009) can ensue; all of which could lower relationship power (Parrado, Flippen & McQuiston, 2005).

Because migrant farmworkers constitute a "hidden" population (Rothenberg, 2000) and because they are often mobile, their interactions with the US healthcare system can be limited. One way in which researchers and health providers can interface with migrants in relation to health is through lay health workers, or *promotoras*. These individuals come from the target community, understand the issues, and can provide a link to health providers and researchers who are on the "outside." *Promotoras* can be particularly effective in reaching groups that experience double discrimination including indigenous farmworkers (Hester, 2009).

Theoretical Perspectives of Risk Among Women

Three theoretical perspectives concerning how women may be at risk for HIV were helpful to me as I queried the literature and formed my initial understandings in preparation for

23

this study. These include the Modified Theory of Gender and Power (Connell, 1987; Wingood & DiClemente, 2000), The Modified Vulnerable Populations Conceptual Model (Flaskerud & Winslow, 1998; Heilemann et al., 2002), and the theory of Intersectionality (Crenshaw, 1991).

       The Modified Theory of Gender and Power. The Theory of Gender and Power (Connell, 1987) was later modified to theorize women's HIV risk (Wingood & DiClemente, 2000). The original Theory of Gender and Power is social and structural in nature, and posits that the gendered relationships between men and women are characterized by three main structures: the sexual division of labor, the sexual division of power, and the structure of social norms and affective attachments (Connell, 1987). These constructs exist interdependently but are operative at both the societal and the institutional levels. The societal level is the level at which schemas of power are imbedded (via historical and sociopolitical forces), and ascribed (via gender roles and norms). At the institutional level, gender inequities and unequal power dynamics between men and women continue to be reproduced at places of work, schools, families, religious institutions, healthcare sites, and through the media (Connell, 1987). Wingood and DiClemente (2000) added a fourth structure: that of biological properties.

       Each of the four structures comprising the modified Theory of Gender and Power carry components of HIV risk for women (Wingood & DiClemente, 2000). First, the **sexual division of labor** refers to the gendered allocation of men and women to various types of work. Exposure to poverty, a high demand/low control work environment, underemployment, low achieved education, limited health insurance and unstable housing are all factors that can increase sexual risk. The sexual division of labor perpetuates gender-based inequalities and vulnerabilities that are ultimately manifested through interpersonal relationships. Second, within the **sexual division of power**, inequalities exist between the sexes related to an ability to act or change, or

24

influence others. Being exposed to physical and sexual violence inhibits sexual power as does

having high risk sexual partners, being exposed to sexually explicit media, having limited access

to HIV/STI prevention methods, having poor assertive communication skills, exhibiting poor

condom use skills, having low self-efficacy, and retaining low perceived control over condoms.

The next structure, cathexis, refers to **social norms and affective attachments,** and is

characterized by the emotional and sexual intimacy between women and men. Exposures that

might increase risk at this level include: an older partner, a desire to conceive, cultural and

gender norms, religious affiliation, mistrust of the healthcare system, lack of familial support,

limited HIV knowledge, no perceived HIV risk, and depression or psychological distress. The

final structure included in the modified Theory of Gender and Power is that of **biological**

properties. Women are physically more susceptible to HIV infection because they are always

the receptive partners in heterosexual sex, HIV is more easily transmitted from men to women,

and HIV/STIs are often initially asymptomatic (Wingood & DiClemente, 2000).

The modified Theory of Gender and Power (Wingood & DiClemente, 2000) offers a

structural conceptualization of how migrant farmworker women of Mexican descent can be at

risk for HIV/STIs at various levels, including factors related to gendered labor division,

relationship power, cultural/societal norms, and biology. However, this model is limited in that

it focuses solely on gender issues in power, and it fails to consider individual and/or collective

strengths or resilience factors that may be protective against sexual risk for migrant farmworker

women.

The Modified Vulnerable Populations Conceptual Model. The Vulnerable

Populations Conceptual Model (VPCM) was developed by Flaskerud and Winslow (1998),

originally as a way of conceptualizing health-related research with vulnerable populations. In

short, this model proposes that vulnerable populations are groups that lack sufficient resources and thus are at risk for poor health outcomes. The three constructs of resource availability, health status and relative risk exist in an interactive relationship. This model appears to be a comprehensive way of viewing both micro- and macro-level resources that impact HIV risk and health status for female Mexican migrants in the US, and I previously used this as an organizing framework for a literature review on this topic (Albarrán & Nyamathi, 2011).

The VPCM was modified by Heilemann et al. (2002) to enhance its usefulness as a framework for understanding why migrants are at risk for developing poor health outcomes (morbidity/mortality) in relation to available resources (including intrinsic strengths). Heilemann and colleagues used mastery, resilience, and life satisfaction as intrinsic factors in relation to health status, and demonstrated that women with greater health problems reported less resilient resourcefulness, less resilient adaptability, and lower life satisfaction (Heilemann, Lee & Kury, 2005). Other researchers have examined the relationship between low socioeconomic status and poor health outcomes, noting that this appears to be mediated by psychosocial factors that can be tangible, interpersonal, or intrapersonal (Matthews, Gallo & Taylor, 2010). In relation to the apparent "Hispanic Paradox," examining strength factors and concurrent cultural factors that might mitigate health risk is of particular importance for Mexican migrants (Franzini, Ribble & Keddie, 2001; Gallo et al., 2009). Therefore, the VPCM and particularly its expanded focus on intrinsic strength factors (Heilemann et al., 2002) provides the impetus for studying self-protective resources used by migrant farmworker women to negotiate sexual risk in this study.

The Theory of Intersectionality. In addition to the way that gender influences power relations at various levels, Crenshaw (1991) refers to the need to account for the existence of multiple identities in understanding the social worlds of women of color. In particular,

structural, political, and representational intersections of race, gender, class, and legal status all contribute to women's experiences related to violence (Crenshaw, 1991). Structural intersectionality refers to the convergence of factors including poverty, lack of job skills, immigrant status, lack of documentation, and language barriers that can create "patterns of subordination" in women's experiences with domestic violence (p. 1249). Political intersectionality involves racist and/or sexist sentiments held by the mainstream culture that may contribute to women's hesitancy to seek public intervention. Crenshaw (1991) proposes that the home, although it may be a place of patriarchal control and even violence, may be viewed as a "safe haven from the indignities of life in a racist society" for women of color (p. 1257). In a study of migrant farmworker women, issues of race and class are also likely to contribute to women's experiences with oppression and violence while working in the fields under white foremen and/or supervisors. Not only does the perspective of intersectionality highlight the multiple identities that may be held by immigrant women of color, but it also provides an antiessentialist critique of the focus on gender in studies surrounding HIV risk and relationship power. I cannot ignore the potential influence of race, class and legal status -- in addition to gender -- on women's identities as well as their experiences with and perceptions about HIV risk and sexual health.

Why Are Migrant Farmworker Women at Risk for HIV?

Answering the question of "Why are migrant farmworker women at risk for HIV" necessitates first a broad understanding of HIV risk among migrant populations as well as a more specific exploration into the ways in which structural factors influence personal, partner, and workplace aspects of risk among women.

Broad overview of HIV risk among Mexico-US im/migrants. On a global level, migration and HIV are linked. More specifically, migration to the US has been associated with higher HIV incidence in Mexico. And among migrant farmworkers in the US, HIV statistics have been particularly high.

Migration and HIV. The spread of HIV around the world, as with many other infectious diseases, has long been linked to international migration (Haour-Knipe, Leshabari & Wihula, 1998). The phenomenon of HIV in migrant agricultural workers in the US was first identified as a problem over 20 years ago (Castro et al., 1988). Since then, a number of studies have demonstrated that this population is at risk for HIV. Recently, attention has been given to the migration-HIV nexus, which points to the burden of HIV carried by Latina/os in the US and the spread of HIV from the US south to Mexico with return migration streams (Hirsch, Munoz-Labor, Nyhus, Yount & Bauermeister, 2009). It is postulated that migration to the US has been contributing to the increase in the HIV epidemic in Mexico (Magis-Rodriguez, Lemp, Hernandez, Sanchez, Estrada, & Bravo-Garcia, 2004).

HIV prevalence in the US is double that in Mexico. Data from UNAIDS (2012a) show that the HIV prevalence in the US in adults ages 16-49 is 0.4%-0.9%, while in Mexico the adult prevalence is 0.2%-0.3% (UNAIDS, 2012b). Approximately 11% of all those born in Mexico are currently living in the US (Passell & Cohn, 2009); a large population shift that can place those in Mexico at risk for infections acquired by family members upon their return from the US. Recently, cases of HIV in rural parts of Mexico have been increasing, many of which are the geographic origins for US-bound migrants who return and have the potential to pass HIV to their partners (Magis-Rodriguez et al., 2004). In Mexico, housewives are being diagnosed with HIV at a rate faster than sex workers (Smallman, 2007). Often, these women have a husband who has

migrated to work in the US (Hernandez-Rosete, Garcia, Bernal, Castaneda & Lemp, 2008; Sowell, Holtz & Hernandez, 2008). This implies that male Mexican migrant workers are acquiring HIV while abroad, even if the exact HIV prevalence rate is unknown in migrant populations. In fact, 25% of rural AIDS cases in Mexico in 1995 and 10% of all AIDS cases in Mexico in 1998 were attributable to those who claimed former migration to the US (Bronfman, 1998).

Women in Mexico whose husbands migrate to the US for work have expressed worry that their husbands might bring HIV back with them (Hernandez-Rosete et al., 2008). In migrant-sending communities, men are often viewed as *hombres ausentes*, or absent men. However, men who migrate do not want their virility questioned; they desire children. Women report that often, their husbands return from work in the US for the sole purpose of procreation. This precludes the use of condoms. Women worry about not knowing who their husband has slept with while in the US, and even report requesting a blood test to check her own HIV status after his return (Hernandez-Rosete et al., 2008).

Authors have postulated that both the process of migration from a more outwardly conservative culture (Mexico) to one that is more socially liberal (the US), along with a generational change in migrant beliefs over time have both contributed to alterations in behavior. Studies have alluded to the fact that some sexual practices (i.e. men who have sex with men) are more tolerated in the US than they are in Mexico (Apostolopoulos, Somnez, Kronenfield, Castillo, McLendon & Smith, 2006; Magis-Rodriguez et al., 2004). Wives of migrants view the US as a place of physical and moral danger and contagion (Duke & Carpinteiro, 2009).

HIV statistics among migrant farmworkers in the US. Due to the fact that migrant farmworkers are a hidden population, and because of their often undocumented status and on-

29

the-move lifestyle, it is difficult to reliably estimate the prevalence of HIV in this population (Apostolopoulos et al., 2006; Sanchez, Lemp, Magis-Rodriguez, Bravo-Garcia, Carter & Ruiz, 2004). Very few studies have examined prevalence rates in migrant populations in the US, and those that have are outdated and utilized convenience samples (Carrier & Magana, 1991; Castro et al., 1988; CDC, 1987; Jones et al., 1991; see Table 1, Appendix B for a review of HIV prevalence studies). These studies reported a range of prevalence rates, from zero percent (Carrier & Magana, 1991) to as high as 13% (Jones et al., 1991). Three of the commonly cited seroprevalence studies were conducted in Florida, North Carolina and South Carolina (Castro et al., 1988; CDC, 1987; Jones et al., 1991), and the two that reported ethnicity had a majority of participants that were of black, not Hispanic origin (Castro et al., 1988; Jones et al., 1991). The remainder, conducted in California, reported a study population that was mostly Mexican (Brammeier et al., 2008; Carrier & Magana, 1991; Martinez-Donate et al., 2005; Wong, Tambis, Hernandez, Chaw, & Klausner, 2003). One of the largest seroprevalence studies done in the California-Mexico border region used a probability sample of 1,041 Mexican migrants and did not find any participant to be HIV positive (Martinez-Donate et al., 2005). Limitations of this study include that it only captured travel through one border region and focused largely on documented immigrants. Other smaller studies have found between 3.2 – 6% prevalence rates of HIV in farmworker communities (Denner et al., 2005; Eastern Coachella Valley Social Change Collaborative, HIV Task Force, 2008; Inciardi et al., 1999; Weatherby et al., 1997), which is extremely high compared with the 0.4-0.9% HIV prevalence rate in the general US population and the 0.2-0.3% prevalence rate in Mexico (UNAIDS, 2012a; UNAIDS, 2012b). Unfortunately, no recent research has been conducted in US farmworker communities to shed light into how these rates may have changed over time.

Due to the paucity of HIV prevalence studies in Mexican migrant farmworkers and day laborers in the US, the prevalence of sexually transmitted infections (STIs) can assist in describing the potential burden of infection in this population. STI prevalence reports can be indicative of populations also vulnerable to HIV (Aral, 2001). In the US general population, the incidence of chlamydia in 2009 was 409.2 per 100,000, and the incidence of syphilis was 14.7 per 100,000 (CDC, 2009). Two recent studies of Mexican male agricultural workers and urban day laborers in California reported STI rates of as high as 3.5% for chlamydia (Wong et al., 2003) and 1% for syphilis (Brammeier et al., 2008), suggesting that HIV rates in these populations are also likely to be high.

Personal factors that exacerbate women's risk. Among farmworker women of Mexican descent, several personal factors have been raised in the literature that suggests women are at risk for HIV. These factors stem from larger structural origins, and include: having a close, long-term partner who engages in risky behavior, poor HIV knowledge, and low perception of risk.

Having a close, long-term partner who is risky. Although a few studies do demonstrate that some Latinas make personal decisions that exacerbate their HIV risk (for example, in one study 15% of the sample reported extra-relational sex; Sangi-Haghpeykar, Poindexter, Young, Levesque & Horth, 2003), most research cites Latinas' untraditional risk profiles in the face of high HIV prevalence (Gindi, Erbelding & Page, 2010; Harvey, Henderson & Casillas, 2006; Wohl, Garland, Cheng, Lash, Johnson, & Frye, 2010). In other words, Latina women in general do not display the usual risk factors for HIV in relation to other high-risk groups in the US, including IDU, other drug use, and multiple concurrent sexual partners. Instead, Latinas most commonly acquire HIV through monogamous, heterosexual sex (CDC, 2009). For example, one

study found, not surprisingly, that 61% of women don't use condoms with a primary partner even if he is high-risk (Sangi-Haghpeykar et al., 2003). Research into the factors that place Latina im/migrants at risk for HIV has focused on verbal and non-verbal communication strategies among Latina/o men & women related to condom use and sexual negotiation (Rojas-Guyler, Ellis & Sanders, 2005; Zukoski, Harvey & Branch, 2009). The literature demonstrates that Latinas are at increased risk for HIV acquisition primarily in relation to intimate partner risk (Raj, Silverman & Amaro, 2004).

Married Mexican immigrant women, especially those who are younger, are committed to believing that their partners are faithful (Ford et al., 2001). However, 27% of return male migrants who were married reported having multiple sex partners while away from their wives (Organista, Organista, Bola, Garcia de Alba & Moran, 2000). In a qualitative study of experiences with HIV infection among male migrants and their Mexico-based wives who were subsequently infected, women remained committed to monogamy and yet became infected with HIV upon the return of their husbands (Sowell et al., 2008).

Poor HIV knowledge. Urizar & Winkleby (2003) assessed AIDS knowledge in an agricultural community in northern California, and compared findings from men in a labor camp (N=188) to those in a community sample of men and women (N=817). They found participants had many misconceptions about HIV risk (labor camp average total score=2.6, community group average total score=4.35 out of 8). Those with the highest misconceptions about HIV/AIDS transmission included those with low educational attainment and those who were older (40-64 years of age). However, the longer that participants lived in the US, the higher their scores tended to be (Urizar & Winkleby, 2003). Ford and colleagues (2001) also found low rates of HIV knowledge in a mixed methods study of migrant farmworkers in Michigan (N=109).

Migrant farmworker women in Ohio (N=106) displayed a "good" overall level of HIV

knowledge on a cross-sectional survey, however only 44% indicated that heterosexual

individuals were at risk of HIV transmission (Fitzgerald, Chakraborty, Shah, Khuder & Duggan,

2003). Although 82% of this sample was US-born, this finding highlights the need for education

interventions in migrant farmworker communities.

      Silence about sex. One reason why some Latina women report low levels of HIV

knowledge could be due to the "sexual silence" that is prevalent among traditional Mexican

communities, particularly between mothers and daughters (Davila, 2005, p. 358). This silence

can be viewed as a byproduct of the cultural value of *simpatia* ("kindness"), which refers to the

importance of harmonious social relations (Beaulaurier, Craig & De La Rosa, 2009). Latina/o

parents are reluctant to discuss sex and sexuality with their daughters, which may be due in part

to the emphasis on women's innocence (Arreola, 2010). Findings from a large database study

indicate that Latinas do not receive any sex education from their parents and little sex education

in school (Zambrana, Cornelius, Boykin & Lopez, 2004). However, many Latina/o parents and

their children indicate that they want to break through this cultural barrier and more openly

discuss sexual topics (Romo, Nadeem & Kouyoumdjian, 2010). Sexual silence also helps explain

why women may be reluctant to openly discuss sex with their partners (Arreola, 2010).

Moreover, women who break the silence about sex may be labeled *escandalosa*: literally, a

scandalous woman, or one who dishonors the family (Zavella, 2003). Understandably, migrants

who have been diagnosed with HIV feel that they must live in secrecy and report extreme

difficulty disclosing their status even to family members (Aranda-Naranjo, Gaskins, Bustamonte,

Lopez & Rodriguez, 2000).

In her ethnographic interviews about sexuality with women of Mexican-origin, Zavella (1997) discusses how the interview itself was a transgression of the silence women had been trained to keep. As one woman said, "talking about sex meant I was a bad person. So I didn't talk about it" (Zavella, 1997, p. 393). In another ethnographic study, using life history interviews with 17 women of Mexican origin (6 born in the US and 11 born in Mexico), Zavella (2003, p. 235) did not find evidence of a "cultural continuum;" in other words, those born in Mexico did not report feeling more sexual repression and those born in the US did not appear more liberated. However, the themes of silence and violence were clear: that women were beaten or scolded for sexual experimentation as children and also experienced long-lasting damage to their self-esteem when suffering sexual abuse in a sexually silent social context. Finally, women reported rebelling against the stringent control over their bodies, which could manifest as unprotected sex and therefore place them at risk for STIs and single parenthood (Zavella, 2003).

Other studies correlate AIDS risk denial among women as a type of silence about sex. Hirsch et al. (2002) explored the social context of the migration-related HIV epidemic in western Mexico, using life histories of women in Mexico (N=13) and their sisters-in-law in Georgia (N=13) along with participant observation. Almost all the informants told stories of women they knew who were infected with HIV or an STI from a husband returning from the US. However, all denied a history of STIs themselves, and upheld the belief that they should protect themselves from HIV by remaining monogamous. Participants agreed that men who migrate for work in the US often have sexual relationships outside of marriage, but all claimed that their husbands were the exception. Hirsch et al. (2002) conclude that women are actively engaged in AIDS risk denial, and are "invested in ignoring evidence of infidelity" (p. 1227). This might be related to

34

the cultural value of upholding harmony in the family at all costs, and gravely illustrates how women experience risk in marital relationships.

Low perception of risk. Davis and Rankin (2006) analyzed beliefs about HIV held by Mexican migrant women (N=20) in Idaho using a qualitative approach. Findings showed that women believed HIV mainly affects homosexuals or prostitutes and therefore did not perceive themselves to be at risk. Women viewed HIV as a punishment for the immoral, and a blessing in order to keep their husbands from sleeping with an infected individual (Davis & Rankin, 2006). Although this study did not focus on migrant farmworker women and had methodological problems (there was no qualitative methodology specified), these findings certainly highlight the need for further investigation into the perceptions of migrant women related to sexual risk.

Relationship factors that exacerbate women's risk. A woman's partner can place her at risk for HIV due to three main factors: infidelity, intimate partner violence, injection drug use and/or other drug or alcohol abuse. These behavioral factors often originate from larger structural forces, which present here.

Infidelity. Migrant men experience loneliness and social isolation while working away from their families that prompts them to have extramarital relationships. In fact, migrant men appear to have multiple extramarital relationships and often have sex with commercial sex workers. Low rates of condom use, both in extramarital and marital relationships, compound risk for their wives at home. The existence of structures through which extramarital sex is condoned or even encouraged facilitates how migrant men are unfaithful to their wives.

Social isolation. The literature shows that migrant men, working away from their families in a foreign country, experience loneliness and social isolation that compounds their risk for HIV (Duke & Carpinteiro, 2009). Sowell et al. (2008) found that migrants who had been

diagnosed with HIV identified social isolation as a major factor that contributed to their infection. Migrant men express loneliness while working away from their families, and this can provide motivation for them to seek companionship and sex while in the US. Loneliness is associated with sexual risk behavior (r=0.64, *p*=.008), and is identified as a dominant element in the migration experience when men migrate away from home and their wives (Muñoz-Laboy, Hirsch & Quispe-Lazaro, 2009). Not surprisingly, men whose wives migrate with them are less likely to use the services of commercial sex workers (CSWs; OR=0.1; Parrado, Flippen & McQuiston, 2004). Hirsch and colleagues (2009) label extramarital sex as a social pursuit that is sought out because men "miss more than anything their normal life back home, the intimacy with a spouse" (p. 24).

Multiple concurrent partners. Generally, migrant men have more partners than migrant women do. Among migrant farmworkers, women usually have only one lifetime partner (75%), whereas men report having a mean of 6.3 lifetime partners (Ford et al., 2001). Specifically, 82% of migrant men reported having multiple sex partners in the last year (Organista et al., 2000). And while migrating, migrant men appear to mostly have sex with CSW. Of 403 male agricultural workers in California, 41.8% reported ever having sex with a commercial sex worker and 1.9% reported having sex with another man (Brammeier et al., 2008). Migrant workers in Michigan reported that 72% of their friends talk about visiting sex workers and 85% had been urged to go with them (Ford et al., 2001).

Low rates of condom use. Lack of or inconsistent condom use can be related to a multitude of factors, including relationship type (close or casual), sentiments involving love and trust, perceived risk, opinions about condoms and cultural beliefs associated with condoms. High-risk couples in the US have reported not using condoms because they identify that their

emotional needs, or love for their partner, supersedes the need to protect their own health. This is true even when the perceived risk is very high (i.e. in the case of serodiscordant couples; Corbett, Dickson-Gómez, Hilario & Weeks, 2009). Other research demonstrates that Mexican men prefer not to use condoms because condom use was linked to a perception of decreased masculinity (Sowell et al, 2008). Men have reported, "it's not cool to use a condom," and "men are in charge" (Sowell et al., 2008, p. 276). These sentiments have been contextualized with *machismo* (McQuiston & Gordon, 2000). In another study, only 10% of migrants overall (both men and women) agreed that condoms were a good protection against AIDS (Ford et al., 2001).

Many studies have examined predictors and rates of condom use and how this shapes HIV risk in the migrant worker population. The bottom line is that migrants report using condoms infrequently (Brammeier et al., 2008; Apostolopoulos et al., 2006; Ford et al., 2001; Fernández et al., 2004). Among male return migrants in Mexico, an increased number of trips to the US was positively and significantly associated with condom use (OR=4.12, *p* < .05); however 17.3% of this sample reported at least one STI symptom in the last year (Fosados et al., 2005).

Structural factors that condone infidelity. Another important body of work has focused on the structural processes that influence sexual decision-making among men around the world -- which condone infidelity and shape women's perspectives -- including extramarital opportunity structures, sexual geographies and social risk (e.g. Hirsch, 2014; Hirsch, Wardlow, Smith, Phinney, Parikh, & Nathanson 2009; Smith, 2007).

Spaces have been delineated in the literature, describing that while women are at home caring for the children, migrant men frequent "risky spaces" including bars and the workplace where employers would often arrange for CSWs to visit the male dormitories at payday (Shedlin

et al., 2005). Indeed, the spaces in which men congregate for socially acceptable leisure time outside of work (e.g. strip clubs and bars) are associated with sexual risk behavior (Hirsch et al., 2009).

Other research has found that the concept of social risk shapes how Mexican migrant men view safe sex. Instead of worrying about infection, men prioritize being discreet in hiding their infidelity by having sex with commercial sex workers instead of long-term girlfriends, and by having unprotected sex with their wives. Men consider these two actions to actually protect trust in their marriages, because they fear that a high-profile affair or condom use with their wives would tarnish the respectable identity of their marriage. They believe that "the most visible risk is a contaminated reputation rather than a viral infection" (Hirsch, Meneses, Thompson, Negroni, Pelcastre & Del Rio, 2007, p. 992).

Violence, control and power inequalities. Male forms of violence, control, and power inequalities exacerbate HIV risk for women in intimate relationships (Firestone, Harris & Vega, 2003; Wyatt et al., 2002). Traumatic experiences (including sexual, physical, and community level violence) are prevalent among HIV positive women and exacerbate risk by affecting sexual decision-making and psychological adjustment (Wyatt, Myers & Loeb, 2004). Also, sexual abuse including rape biologically places women at higher risk for HIV to enter the bloodstream through vaginal abrasions or tears (Wingood & DiClemente, 2000). In the literature, research focuses on intimate partner violence (IPV), relationship power, and gender role ideologies as conditioning concepts in partner risk for women.

Intimate partner violence. The incidence of IPV is high in rural, migrant communities (Hazen & Soriano, 2007; Kim-Godwin & Fox, 2009). Among farmworker women, few studies have explored IPV. However, when compared with other Latina immigrant women, migrant

farmworker women are more than seven times as likely to have experienced sexual coercion in their lifetime (OR=7.12, $p < .01$; Hazen & Soriano, 2007). In a sample (N=309) of foreign-born Latina women (62% from Mexico) in the southeastern US, 76% worked outside of the home and 39% had jobs in agriculture (Murdaugh, Hunt, Sowell & Santana, 2004). Seventy percent of women reported being the victim of a violent act at least once in the past year, with 43% indicating they had experienced physical violence multiple times during the year. Of those reporting at least one act of violence in the past year, 42% reported being forced to have sex against their will. Those who experienced abuse were most likely to work outside the home, to have a gun in the house, or to be single and either living with a partner, separated, or divorced (Murdaugh et al., 2004).

Other investigators found an even higher rate of IPV among 291 migrant farmworker women in North Carolina: 76.3% of women had experienced some type of violence in the last year (Kim-Godwin & Fox, 2009). Not surprisingly, there was a strong correlation between IPV and alcohol use ($r = .92$, $p < .006$). In this sample, 73% denied having a support system available to help them cope with experienced abuse (Kim-Godwin & Fox, 2009). This finding is common in the literature on Latina women who are recent arrivals to the US. For example, women who lived in the US for less than five years have significantly lower scores on every aspect of social support when compared with immigrant women who have lived their entire lives in the US (Harley & Eskanazi, 2006).

Gorton and van Hightower (1999) found a much lower prevalence of abuse: only 17% of women farmworkers seeking care at Migrant Health Centers in nine different states (N=820, 21% of Mexican descent, 35% migrants) reported either physical or sexual abuse in the past year. In this study, women with a partner who used drugs and/or alcohol were more than eight

times as likely to report abuse (OR=8.32, *p* = .000), and women who were pregnant were almost half as likely to report abuse as their non-pregnant counterparts (OR=.42, *p* = .0036).

In an older qualitative study examining healthcare realities for Mexican migrant farmworker women in rural Oregon, Farr and Wilson-Figeuroa (1997) found that women spoke openly and spontaneously about intimate partner violence and their husbands' alcohol use. One woman in this sample identified a strategy for dealing with her husband's violent behavior: she taught herself to drive so as to escape the house when he began drinking (Farr & Wilson-Figeuroa, 1997). Unfortunately, this finding was not further explored or discussed by these authors.

Apart from migrant farmworkers specifically, IPV has been shown to be an issue of great concern among im/migrant Latina women. A review of the literature shows that although the incidence of IPV is not higher for im/migrant women than it is in the general population, that women's status as im/migrants, their often limited mastery of English, their relative isolation from friends and family, their lack of access to higher level jobs, their uncertain legal status, and their experiences with authorities in their origin countries exacerbate their experiences with IPV (Menjívar & Salcido, 2002). Qualitative research with Latina survivors of IPV shows that in general, there is little awareness that IPV is a problem in the community; it is viewed as "the norm" related to cultural beliefs regarding gender and power (Crandall, Senturia, Sullivan & Shiu-Thornton, 2005). This results in a strong sense of isolation experienced by Latina women who are victims of IPV (Crandall et al., 2005). One of the greatest predictors of IPV among minority groups is having a low household income (Cunradi, Caetano & Schafer, 2002), placing migrant farmworker women who live in an impoverished environment at particularly high risk.

Gonzalez-Guarda and colleagues (2008) described the relationships between HIV risks, substance abuse, and IPV among Hispanic women in south Florida. Eighty-two women were surveyed, almost all were foreign-born (only 2.4% born in the US), had spent an average of 9.31 years in the US, and were from countries including Colombia (47.6%), Venezuela (13.4%), and Ecuador (8.5%). Most participants were employed at the time of the survey (59.8%). Perceived partner risk was quite high, with 40% of participants indicating that they suspected their partners were having sex with CSWs and 18.8% suspecting their partners were having sex with injection drug users. Just over half (51.3%) reported at least one form of abuse by their current or most recent partner. Findings included that participants who had been a victim of sexual and/or psychological abuse were more than six times more likely to report a history of STIs (OR=6.50, $p = .005$), almost three times more likely to report a partner with a suspected history of having sex with CSWs (OR=2.96, $p = .028$), and five times more likely to report a partner with a suspected history of having sex with an injection drug user (OR=5.00, $p = .005$). This study helps to corroborate the link between sexual risk and IPV among foreign-born Latina women, although women of Mexican descent do not appear to be represented in the sample.

Fuentes (2008) used a qualitative approach to understand the pathways that link experiences of abuse in women's lives to an increased risk of STIs including HIV/AIDS. Using data from 28 life history interviews with abused women (9 Latina, 12 white non-Latina, and 7 African American women) the author used text analysis to analyze the data. Codes to categorize sexual risks were developed from both the existing literature as well as the participants' own narratives. Text analysis revealed numerous ways in which outcomes of abuse constitute sexual risk, including: depression, currently having multiple sexual partners (> 3 partners in the past month), many lifetime sexual partners (> 12), inconsistent use of or failure to use condoms,

substance abuse, a partner who abuses drugs or alcohol, exchange sex, first sex at an early age (< 16 years of age), unfaithful partners, injection drug use by self or sexual partners, lack of emotional or financial support from friends and family, and hasty involvement in and escalation of intensity of relationships with men they did not know well (e.g. pregnancy or living together within weeks to months after first meeting). Depression was a key link between experienced abuse and subsequent sexual risks. Fuentes (2008) found that these risk factors were often interrelated, and that they increased as the abuse became more frequent and severe. Although this study also had a quantitative component, it was found to have major internal and external validity concerns and the reported results were not significant. In addition, this study is limited by the use of both deductive (e.g. codes developed from the literature) and inductive (e.g. codes developed from life history transcripts) approaches, since it appears that the findings from this study's qualitative data are conflated with others that exist in the literature. However, the finding is important that among battered women, depression was found to be a main pathway between a history of abuse and sexual risk-taking (via seeking affection and self-medicating with drugs or alcohol, among others).

Moreno (2007) explored the contextual risks of HIV and IPV experienced by 32 HIV positive Latina women in the greater New York area, 65% of whom were foreign born. Grounded theory methodology was used to analyze data from three focus groups and five individual interviews. Women told histories of trauma that included beatings, sexual assault, rape, and emotional deprivation. They described the abuse as "normal" and "deserved" (Moreno, 2007, p. 343). In addition, women's conceptualization of abuse extended to include the threat of deportation; participants reported that their husbands, lovers, or in-laws had threatened to report their undocumented status to the authorities. Participants also expressed

concern that an HIV positive partner had infected them intentionally, or that they were destined

for abusive relationships because of their HIV status. Moreover, women felt stifled by

traditional gender roles, and expressed difficulty talking honestly and openly about sex with their

partners. Forty percent reported acquiring HIV through heterosexual sex, having remained

faithful to their partners, and holding the assumption that their partners were also faithful.

Participants in this study identified how they were most vulnerable to HIV: having experienced a

risky childhood (many had been sexually abused or exploited as children, which led to a pattern

of abuse in current relationships), experiencing extreme poverty, and having immigrant status

(Moreno, 2007).

Davila and Brackley (1999) also used a qualitative approach to explore barriers to

condom negotiation for HIV prevention among 14 Mexican and Mexican American women in

abusive relationships, recruited from a battered women's shelter in urban Texas. Demographic

information revealed that 78.6% of women had experienced physical abuse, 21.4% reported

verbal abuse, and 42.9% reported at least one incident of forced sexual activity during the past

year. The most common perpetrator of abuse was the participants' husbands, accounting for

50% of physical abuse and 66.7% of the sexual abuse. Twenty-one percent of this sample

reported being employed outside the home. Content analysis was used to develop themes from

the data, which included women's past and present experiences with abuse, and women's lack of

power relative to men in both social and sexual relationships. Women discussed how physical

abuse sometimes resulted from their request that a partner use a condom. In addition, women

told stories of psychological abuse in the form of accusations that she had been unfaithful and

that this was the reason for her request to use condoms. Participants also described forced sexual

encounters with husbands and boyfriends, making it evident that they often did not have any

control: "He said, 'we're gonna have sex right now. You're my woman, nobody else's woman.' And he put me on the bed and that was it" (Davila & Brackley, 1999, p. 349). Force and control were often used by male partners to maintain power in the relationship, but also in retaliation if a woman attempted condom negotiation. The authors conclude that condom negotiation for Mexican or Mexican American women may put women at risk for both IPV and HIV (Davila & Brackley, 1999). Unfortunately, the sample in this study is not adequately described, thus making it difficult to link the findings to immigration status, length of time in the US, or level of acculturation.

Firestone et al. (2003) also found that Mexican-born women living in California who held less traditional views of gender roles were at higher risk for IPV than women who had adopted a more traditional view. The authors postulate that women who maintain a traditional view of gender roles in relationships could be partially protected from IPV because men feel less threatened by a more traditional partner, and are less likely to act out to assert their power (Firestone et al., 2003). This finding is similar to that of Davila and Brackley (1999), demonstrating that women are moderately constrained by traditional gendered expectations in intimate relationships (e.g. to remain submissive and not to raise the issue of condom use).

Relationship power. IPV is related to power differentials in relationships. Historically in the health sciences literature, cognitive-behavioral approaches have been the focus in HIV risk and prevention. In the mid-1990's, Amaro (1995) emphasized the reality of social and cultural factors, including gender roles, that impact HIV risk for both men and women. By the turn of the century, the use of the concept of relationship power had become widespread in the literature surrounding women's sexual health and HIV risk, using a framework of oppression (Amaro & Raj, 2000) and the modified Theory of Gender and Power (Wingood & DiClemente, 2000). As a

44

concept, relationship power has been studied in relation to HIV risk among Latina women in the US (Pulerwitz, Amaro, De Jong, Gortmaker & Rudd, 2002). These authors defined relationship power as "an interpersonal dynamic that can be expressed via decision-making dominance," which the male partner generally holds in Mexican couples (Pulerwitz et al., 2002, p. 791). Other studies have examined relationship power within the context of how women are able to take sexual initiative and have autonomy and control (Harvey & Bird, 2004), and how relationship power can mitigate intimate partner violence and sexual risk (Buelna, Ulloa & Ulibarri, 2009). Examining relationship power and its interplay with the constructs of self-concept, gender and culture over the migration continuum is a necessary next step in the study of migrant women.

Salgado de Snyder and colleagues (2000) sought to identify the specific sexual practices regarding sexual intercourse in a sample of 300 Mexican women of rural origin (living in Los Angeles and in Mexico). The majority of women (64-74%) did not feel they were at risk for HIV. Participants reported a pattern of giving in and having sex with their husbands, even when they did not want to, highlighting the low power experienced by migrant women.

Three studies have specifically examined relationship power among Latina/os. Harvey, Beckman, Browner and Sherman (2002) explored how couples defined power in intimate relationships with a sample of 39 couples of Mexican origin in Los Angeles County (over 90% born in Mexico and most had lived in the US for more than six years). Both members of the couple were interviewed separately, and data collected from semi structured interviews was analyzed using content analysis. Results demonstrated that male and female responses regarding the definition of power were similar and involved two themes: that power involved control or influence, and decision-making without partner interference or involvement. Women expressed

feeling powerful in relationships when they are able to make unilateral decisions, and when they

have economic independence from their partners. Men expressed feeling powerful in

relationships when they have control over their partner and when they bring home money. These

results indicate that both men and women feel power in relation to decision-making and

economic resources (Harvey et al., 2002). However, the desire for unilateral decision-making by

women and control by men appear to create an immense potential for conflict, which was not

adequately explored or discussed in this study.

Pulerwitz and colleagues (2002) utilized a new measure called the Sexual Relationship

Power Scale (SRPS) to understand the relationship between relationship power and condom use

among minority women at an urban community health center in Massachusetts. Most of the

sample (88%) was Latina, however no information is given regarding immigration status or time

spent in the US. Results indicate that when controlling for sociodemographic and psychosocial

variables, women with high levels of relationship power were five times as likely as those with

low levels of relationship power to report consistent condom use ($p < .05$). The authors conclude

that low levels of relationship power place women at a disadvantage and risk of acquiring HIV

and other STIs because of their inability to negotiate for protection (Pulerwitz et al., 2002).

In the only study of migrant women and relationship power, Parrado et al. (2005)

analyzed the personal, relationship, and social resources that condition the association between

migration and women's power, with a binational sample of N=271 migrant women in North

Carolina and N=271 nonmigrant women from sending communities in Mexico. All women were

in stable relationships at the time of the study. Findings from this cross-sectional survey using

one subscale of the SRPS demonstrated that, compared with their nonmigrant peers, Mexican

migrant women in the US have higher emotional consonance with their partners but lower

relationship control and sexual negotiation power. Authors postulate that the experience of migration reinforces the couple's commitment to the relationship, thus contributing to higher emotional consonance. Parrado and colleagues (2005) point out that Mexican women experience a dual risk while migrating: not only do their partners display heightened risk behaviors (as shown in other literature), but they also have less relationship control and power to negotiate for sexual protection. These authors found that the single personal trait that significantly and positively affects relationship power is educational attainment (Parrado et al., 2005).

Some research has led to the theory that HIV risk is closely related to socioeconomic and interpersonal power dynamics (Wingood & DiClemente, 2000). In the context of Mexican culture, patriarchal ideologies regarding gender and power can influence relationships (Hirsch et al., 2002). Although these ideologies may change across migration contexts, many aspects of power dynamics persist with important implications (Apostolopoulos et al., 2006). It is possible that migration can have the effect of empowering women, but it is unclear how and under what circumstances. Historically and generally, economic independence has been linked with interpersonal relationship power (Guendelman, 1987; Hirsch, 1999), although this link has not consistently demonstrated an increase in power for migrant farmworker women of Mexican descent (Parrado et al., 2005). For example, some research done over 20 years ago suggested that change appeared to accompany the migration experience; as women migrated and became employed, they seemed more likely to experience higher relationship power in their marital relationships (Guendelman, 1987). More recently, research demonstrated that migrant women had more autonomy to plan their pregnancies (Wilson & McQuiston, 2006), participate in educational opportunities (Campbell, 2008), and access birth control without the confines of patriarchal dominance (Gonzalez, Sable, Campbell & Dannerbeck, 2010). Despite these

findings, very little is known about how such dynamics play out in contemporary relationships and sexual practices among migrant farmworker women of Mexican descent.

Gender role ideologies. Traditional Latina/o cultural beliefs influence gender role ideologies (Collins, von Unger & Armbrister, 2008), which can foster relationship inequalities and exacerbate HIV risk (Beaulaurier et al., 2009; Galanti, 2003). Despite significant modern social change, the concepts of *machismo* and *marianismo* remain dominant in traditional Latin American culture (Smallman, 2007). *Machismo* views indicate that the husband takes a dominant role in the relationship, is allowed to take risks and be aggressive, and is often allowed to have extramarital affairs (Hirsch et al., 2009). In contrast, *marianismo* is a term that indicates a woman is expected to be subordinate to her husband, to remain pure, sacrificial, and subservient, and to tolerate her husband's unfaithful behavior (Smallman, 2007). These cultural beliefs are indicative of extreme power imbalances in relationships, and the concept of relationship power has emerged as an integral component to understanding HIV risk in Latina women over the past decade. A number of studies suggest that Latina women have low power in relationships, lacking the ability to effectively negotiate for protective sex including condom use (Amaro & Raj, 2000; Davila, 2000; Parrado et al., 2005; Pulerwitz et al., 2002).

Norms related to traditional cultural beliefs and gender roles are frequently cited in the health sciences literature as contributing to sexuality, health, and HIV risk for Latina/o im/migrants in the US, including *machismo* and *marianismo*. Although research shows that these values do continue to be upheld to varying degrees, the literature has been critiqued for depending too strongly on these "overused...rigid and monolithic" categories (González-López, 2010, p. 104). González-López (2010) cautions that these concepts must be used carefully so as not to overlook the heterogeneity of Latina/o cultures on both sides of the US border, but even

48

more importantly, so as not to overlook other social forces that influence the lives and sexuality of these groups. Likewise, Asencio and Acosta (2010) warn against perpetuating the "narrow and stereotypical" views of Latina/os in relation to their sexuality. However, the health sciences literature has focused on categorizing cultural beliefs and values in order to both qualitatively and quantitatively understand how cultural views affect health. Therefore, I review these simplified, categorized cultural values and gender roles briefly, while keeping in mind the multiplicity of individuals' personal beliefs and the collective differences that may be present among groups. I recognize that cultural beliefs and gender roles are only one component of the multitude of factors influencing migrant farmworker women's sexuality, perceived risks, and sexual decision-making.

In Latin America, research demonstrates that *machismo* remains a dominant cultural role related to how men should behave in general and in relationships (Smallman, 2007). This role indicates that men are dominant, strong, aggressive, and all-powerful in decision-making (e.g. in relation to condom use or choice of sexual partners outside of the primary relationship). *Machismo* is also associated with positive traits including strength, bravery, and responsibility (Beaulaurier et al., 2009). Men are also expected to be sexually experienced and to seek out this experience both before and after marriage (Beaulaurier et al., 2009). Any sign of weakness, including effeminate behavior or homosexuality, is regarded as incompatible with masculinity (Smallman, 2007). In fact, homophobia is common in Latina/o culture and HIV is often considered a "gay disease," causing many men who have sex with men to continue having relationships with women in order to protect and maintain their masculinity (Beaulaurier et al., 2009, p. 5). Heterosexuality remains the main institution regulating the sex lives of Latina/o groups (González-López, 2010).

In contrast, *marianismo* invokes the Virgin Mary (Arreola, 2010) and relegates a woman's role to being pure, subservient, sacrificial, passive, faithful, and tolerant of a man's lifestyle (Smallman, 2007). Women are not commonly expected to have sexual desires or to experiment with their sexuality (Smallman, 2007). In fact, women who suggest using condoms or who even discuss sex may be labeled as promiscuous (Beaulaurier et al., 2009). The female body is seen as existing for the purpose of procreation in lieu of pleasure, and a woman should not have intercourse without the sanction of a church-centered wedding or else her reputation is severely harmed because she is *desflorada* ("deflowered;" Zavella & Castaneda, 2005).

However, Latina/o feminist literature has long critiqued these traditional cultural frameworks and the "virgin-whore continuum" (Zavella, 2003, p. 228). Zavella (1997) argues that repressive ideologies should only be used as a cultural template, and demonstrates how Mexican-origin women use the metaphors of *juego y fuego* ("play and fire") to express bodily pleasure. Women in her ethnographic study described "playing" in their intimate relationships to test the boundaries of social convention. Women also described the uncontrollable fire-like sexual passion that consumed them, and could result in "getting burned" by transgressing social conventions (Zavella, 1997, p. 393). Castillo (1991, p. 34, as cited in Zavella, 2003) offers a vivid example of how Mexican cultural repression and social expression are intertwined:

> Sexuality surfaces everywhere in our culture, albeit distortedly, due to the repression of our primordial memories of what it truly is. We experience it in the hip gyrating movements of our *cumbias* and the cheek-to-cheek twirling sensation of the Tex-Mex polka (both dances are commonly danced by women together as well as men and women); in the blood merging reflected in our mixed heritage as *mestizas*; in the stifling of emotions by the church, its hymns and passion for the suffering of Jesus Christ

(passion derives from extreme feeling and here it arises as a result of the repressed erotic and psychic sensations). Mexican erotica is charged by all our senses: in the traditional strict costuming of each gender: low cut dresses, tight Mariachi *charro* pants, open-toed pumps and pointed, dapper cowboy boots; in sum, our culture is infamous for its intensities.

Five studies were found that examined issues related to gender roles and cultural beliefs among migrant women. Zavella and Castaneda (2005) used an ethnographic approach to conduct 12 life histories, focus groups, and participant observation with young women of *mestiza* Mexican origin (either whose parents migrated to the US or who migrated themselves) who were in high school or college. These investigators found that young women are affected by contradictory community norms: to honor their parents or to experiment with their sexuality. They question the notion of being a *mujer decente* ("good woman") in their negotiation of gendered discourses regarding sexual practices, and remain largely ignorant of the STI risks inherent in unprotected sex (Zavella & Castaneda, 2005)

Wilkerson, Yamawaki & Downs (2009) examined the effects of changing gender role ideology on the mental health of *mestiza* women in rural Mexico whose spouses migrated to the US. Using a comparison group of women whose husbands did not migrate (total N=94; 47 in each group), instruments were used to measure gender role traditionality and mental health. Findings showed that participants whose husbands migrated to the US had less gender role traditionalism and poorer mental health than those whose husbands did not migrate. Wilkerson and colleagues (2009) conclude that migration therefore influences gender role ideology among couples, even when the woman herself does not migrate. However, these findings are limited in that they only relate to non-migrant women in Mexico.

In a quantitative analysis of whether new Hispanic immigrants (with less than five years spent in the US) were influenced by patriarchal ideals of male control related to contraceptive decision-making, Gonzalez et al. (2010) found that 64% of the total sample (N=200; 100 men and 100 women) disagreed with the ideology that men are in control. The authors make a general, sweeping conclusion that patriarchal ideology does not support women's subordination to men (Gonzalez et al., 2010). However, greater nuance and detail regarding how men and women conceptualize gender roles and how these beliefs influence behavior is needed.

Maternowska and colleagues (2009) used a grounded theory approach to explore the changing perceptions of sexual and societal norms, including gender roles and reproductive decision-making, that accompany the migration process among 26 migrant women and 18 migrant men of Mexican descent in California. Participants in this study echoed ideals related to traditional gender roles, however these ideals were in a state of flux and were not always translated into practice. For example, when speaking of her role as a housewife and caring for the children, one participant said, "...this is a woman's destiny, in order to be with a man" (p. 33). However, other women expressed a strong desire to change traditional gender roles within their intimate relationships: "it's not always the women who is going to live at men's whim, things have to be fairer" (p. 34). Maternowska et al. (2009) concluded that women were able to express themselves more freely and engage in heightened independent decision-making--even related to intimate relationship issues--when they made a greater economic contribution to the household. Male participants acknowledged that it was acceptable and even desirable for women to work outside of the home: "it doesn't frighten me that she might have a career...because the day she becomes someone, I'm also going to feel better" (p. 34). However, when women identified key factors in their thoughts regarding family size, they cited their husbands, their

children, or other families--not their own goals or self--as contributing most to their decision. Investigators conclude that migration alters relationships, reproductive decisions, and contraceptive use among men and women of Mexican descent (Maternowska et al., 2009). However, more than half of the female participants in this study were unemployed and lived in urban areas, making these findings difficult to transfer to migrant farmworker women.

Guendelman and colleagues (2001) conducted focus groups with pregnant women at different stages of im/migration from five sites (low-income rural and urban communities in Mexico, immigrant communities in rural and urban California, and a group of US-born women of Mexican descent in urban California) to examine orientation towards motherhood and perceptions of their partner's roles. Content analysis revealed themes present in women's narratives, including that a woman's concept of self, her domestic orientation, and her attitudes towards childbearing differed according to her migration status and area of residence. Although the authors did not explicitly state this, the findings appeared to be situated on a spectrum, with women in rural Mexico on one end and US-born immigrants living in urban California on the other end. For example, rural Mexican women's concept of self was relatively weak; they defined themselves in relation to others including their spouses, or according to commonly held traditional views. Immigrant women expressed unrealized personal goals that they had sacrificed for their family. However, US-born women expressed more individuation, identifying aspiration and life plans that they were acting upon. Women also spoke of division of labor, with those from rural Mexico identifying that men were uninvolved in domestic tasks. In urban Mexico, men were perceived to hold a traditional perspective of "women's work" but did assist with daycare. In rural California, men and women often shared household responsibilities more equally since both were working outside the home, with economic needs appearing to trump

traditional ideals of the division of labor. Finally, US-born women completely rejected

traditional gender roles, in both a theoretical and a practical sense. Guendelman and colleagues

(2001) conclude that im/migrant women in California alternate between the conventional

discourse and that of being a working mother, depending on the family's financial stability and

their need to join the workforce. Importantly, all women in this study were pregnant, which

again limits transfer of the findings to women who are not pregnant and may therefore feel

differently about themselves and their relationships.

   Injection drug use or other drug/alcohol use. Apart from risky sex and violence,

injection drug use (IDU) is another high-risk behavior that can result in HIV transmission. Only

three studies were found that directly addressed drug use. In the first -- an outdated study but the

only of its kind in the literature -- McVea (1997) raised the issue of lay injection practices of

vitamins or antibiotics that are commonly used in Mexico. Often, syringes and needles are

reused, which could result in HIV transmission. McVea (1997) found that 12% of migrant

farmworkers in North Carolina (N=532) admitted to lay injection use while migrating in the US.

Varela-Ramirez and colleagues (2005) found that 3.8% of farmworkers near El Paso, Texas

admitted to IDU. Of these, 2.6% reported having shared needles with an HIV-positive partner

and 48.3% reported having used alcohol or drugs with sex (Varela-Ramirez et al., 2005).

   A final study used database data from the California-Mexico Epidemiological

Surveillance Pilot to demonstrate the predictors of methamphetamine and cocaine use in

migrants (Hernández et al., 2009). Findings suggested that 21% reported using

methamphetamine and/or cocaine, and 2% reported heroin use in California. Statistically

significant predictors of drug use included: multiple sex partners (OR=2.5), alcohol use

(OR=2.5), depressive symptoms (OR=2.2), any STI (OR=2.0) and higher acculturation (OR=1.4;

Hernández et al., 2009). These findings indicate that migrant men who use illicit drugs are also at high risk for HIV acquisition. In addition, the shared use of other needles (i.e. for amateur tattooing) is another risk faced by migrant farmworker men (Smith et al., 2009).

Workplace factors that exacerbate women's risk. In addition to personal and partner-related risk factors, migrant farmworker women are also at risk for HIV in relation to workplace violence that often manifests as sexual harassment but which also results in assault and even rape.

Workplace sexual violence is seen as a major problem by 90% of female farmworkers in the US (Dominguez, 1997). The US Equal Employment Opportunity Commission found that hundreds of migrant farmworker women have reported forced sex with supervisors in order to obtain or keep jobs (Tamayo, 2000), however the number of unreported cases is likely to be much higher.

Women who work in migrant farmwork experience other abuse in addition to violence perpetrated in the home. Workplace sexual violence is seen as a major problem by 90% of female farmworkers in the US (Dominguez, 1997), and as many as 80% of female farmworkers report experiencing some form of sexual harassment at work (Waugh, 2010). The US Equal Employment Opportunity Commission found that hundreds of women have reported forced sex with supervisors in order to obtain or keep jobs (Tamayo, 2000). The number of unreported cases is likely to be much higher. However, very little is known about this. Recent attention in the national news has focused on this issue (Khokha, November 5, 2013; Rodriguez & Aguilera, June 24, 2013). Also, in 2013 an investigative report called "Rape in the Fields" (Bergman & Cediel, June 25, 2013) aired on prime-time television, documenting women's experiences with violence at the workplace.

Although I could not find studies on rape in the workplace in the peer-reviewed literature, two studies were found that report on the sexual harassment experiences of women working in agricultural labor. Castaneda and Zavella (2003) obtained individual life histories from 12 migrant farmworkers *mestiza* women who were born in Mexico and working in northern California. These investigators used ethnographic methods to collect life histories along with seven focus groups to examine the contradictions that exist between power, the female body, and sexuality in rural agricultural communities in the study area. Findings show how women experience sexual harassment while at work in the fields; hearing lewd comments from male coworkers, sometimes being groped inappropriately, and occasionally being expected to give offers of sex in exchange for money or to keep their jobs. To combat this unwanted attention, women cover their bodies from head to toe with heavy clothing even while working in full sun and heat. Castaneda and Zavella (2003) conclude that women are "remapping" their social bodies in relation to a newfound independence in the US. The authors go on to explain how women have been shaped by repressive traditional forces, and are negotiating how to express their sexual desires in new ways. Without the strict social control they experienced in Mexico, women feel more freedom to go to local nightclubs and even have casual sex with men who are migrating alone. This study highlights risks that women experience, both at work and in their leisure time (Castaneda & Zavella, 2003). These findings offer some insight into the sexual risks that women either choose or are unwittingly exposed to by nature of migration and the agricultural environment.

Similarly, Waugh (2010) sought an understanding of the experiences of sexual harassment experiences of farmworker women of Mexican descent in central California. Participants (N=150) reported multiple risks for sexual harassment in the work environment:

working with mostly male counterparts, having male supervisors, having little supervisory authority themselves, working in remote areas where sexual advances may not be recognized by others, having to assume exposing positions for some kinds of work (e.g. stooping to pick strawberries), and being in precarious financial situations. Women reported that poverty is used to leverage power against them when they are presented with sexual advances from foremen, supervisors, or other coworkers. Although participants reported that sexist and degrading comments were directed towards them more frequently than sexual coercion, nearly a quarter (24%) of all those reporting sexual harassment described experiences with sexual coercion. For example, one woman recounted how a foreman told her to have intercourse with him in exchange for money, taking advantage of her vulnerable economic position and also flaunting his relative power over both her body and her job (he was her direct supervisor; Waugh, 2010).

Summary and Gaps in Knowledge

It is clear that migrant farmworker women are at risk for HIV in relation to structural factors that influence personal vulnerabilities, behavioral risk-taking among male partners, and workplace violence. However, a detailed and practical understanding of what HIV risk means to women themselves -- as well as how they navigate it -- is lacking in the literature. More specifically, through this review I found that defining the migrant farmworker population is problematic, that migrant women's perceptions of and experiences with HIV risk are understudied, and that the concept of HIV risk and research into migrant women's responses to risk is incomplete.

Defining the migrant farmworker population is problematic. Much of the focus in the health sciences literature is on US-born Latina/os, because studies appear to demonstrate that they have poorer health than their foreign-born counterparts. However, the ways in which

acculturation and assimilation have been operationalized in the health sciences literature has been brought into question (Carter-Pokras et al., 2008). More focus needs to be given to the political, economic, and sociocultural determinants of health that threaten the wellbeing of foreign-born im/migrants.

My review also highlights the importance of adequately defining and describing the sample and target population of research with migrant groups. Latina/o migrants are a heterogeneous group made up of many subpopulations described in the literature. Inadequate description of the samples in studies presented in this review (including im/migrant status, ethnicity, number of years in the US, occupation, area of residence, and place of birth) makes it difficult to generalize and apply findings. Therefore, it is imperative that studies provide a detailed description of the target population and sample in migration studies and health research. In particular, studies with the subpopulation of migrant farmworker women of Mexican descent are lacking.

Migrant women's perceptions of and experiences with HIV risk are understudied. Migration in general places women in a vulnerable position whereby they experience multiple stressors including lack of documentation status, separation from family, and occupational safety. Traditional cultural beliefs, including the practice of silence about sex (Zavella, 1997) and the gender roles of *machismo* and *marianismo* (Beaulaurier et al., 2009) contribute to Latina women's sexual risk. Unequal power relations between partners also contribute to HIV risk, in that women are often unable to negotiate for condom use (Pulerwitz et al., 2002). Migration appears to lower relationship power for Mexican women (Parrado et al., 2005), making migrant farmworker women an important population with which to focus HIV prevention priorities.

However, much of the literature on Mexican migration and HIV focuses on men who migrate alone and the risk their wives in Mexico experience upon their return.

The literature suggests that migration alters relationships, reproductive decisions, and contraceptive use among migrant men and women of Mexican descent (Maternowska et al., 2009). However, this research is limited to women living in urban areas. Because we know that im/migration status and area of residence appear to contextualize women's perceptions of gender roles (Guendelman et al., 2001), more inquiry is needed in order to understand the unique experiences of migrant farmworker women in rural California.

Migrant farmworker women of Mexican descent in particular are at risk for acquiring HIV via two main avenues: through unprotected monogamous sex with risky male partners (CDC, 2009) that is perceived as "safe" (Hirsch et al., 2002), or through sexual violence perpetrated against them at work (Castaneda & Zavella, 2003; Waugh, 2010) or at home (Kim-Godwin & Fox, 2009; Gorton & van Hightower, 1999). Although migrant farmworker women are more than seven times as likely as other Latina immigrants to have experienced sexual coercion in their lifetime (Hazen & Soriano, 2007), no studies were found that explore women's experiences and self-protective strategies related to this kind of sexual risk. And in general, no studies were found that have explored perceptions of and experiences with HIV risk and sexual health among migrant farmworker women of Mexican descent.

The concept of HIV risk and research into migrant women's responses to risk is incomplete. In the nursing and health sciences literature on migrant farmworkers and HIV, a conceptualization of HIV risk has most often been comprised of knowledge, attitudes, beliefs, and practices. However, a more nuanced understanding of risk must be expanded to focus directly on cognitive appraisal, instead of indirectly by understanding an individual's behaviors

and actions (Shattell, 2004). For example, Shattell (2004) points out that measuring risk by asking about behaviors limits its conceptualization to consequences (e.g. injury or a negative health behavior) and antecedents (prior knowledge of factors that put one at risk). This limited conceptualization therefore excludes one's recognition of risk as well as one's process of negotiating for protection when faced with a potentially harmful situation.

Although the literature on HIV risk among migrant farmworkers has focused almost exclusively on knowledge and behaviors, Vaughan & Dunton (2007) used a unique approach to understanding risk judgments perceived by migrant farmworkers in relation to environmental chemicals. These investigators acknowledged variability in individual's modes of reasoning and information processing, particularly in relation to situations of low perceived control or perceptions of vulnerability (Vaughan & Dunton, 2007). They found that participants with lower socioeconomic status and who believed themselves to be dependent on their employment situation used scientific evidence less when judging risks posed by environmental chemicals (Vaughan & Dunton, 2007). These findings demonstrate how individuals utilize knowledge differently, and engage in distinct cognitive processes of appraisal that affect decision-making and are influenced by the larger societal structure of which they are a part. However, this approach is not often taken in the HIV prevention literature. It is instead assumed that individuals with low HIV knowledge simply need more knowledge in order to protect themselves against risk. A more nuanced conceptualization of risk is necessary to acknowledge that knowledge does not necessarily translate into protection; there are complex cognitive micro processes at play.

The social sciences literature is increasingly recognizing that the institution of marriage can actually exacerbate individual HIV risk in part due to its' overwhelmingly positive emphasis on

love, trust, intimacy and mutual benefits (Hirsch et al., 2009). Globally, monogamous women are at heightened risk for HIV due to their partners' behavior, including IPV and infidelity (UNAIDS, 2014; UNFPA, 2005). Despite this trend, there is a dearth of information on women's perspectives of and experiences with HIV risk in the context of close, long-term relationships. I conducted a database search of PubMed, CINAHL and PsycInfo and uncovered very few qualitative studies focusing on women's perspectives of and responses to HIV risk in the context of close, long-term relationships around the world. These studies examined perceived risk factors and self-protective efforts among women in long-term, intimate relationships in Malawi (Conroy, 2014; Mkandawire-Valhmu, Wendland, Stevens, Kako, Dressel & Kibicho, 2013), South Africa (Fox, Jackson, Hansen, Gasa, Crewer & Sikkema, 2007), India (Varma, Chandra, Callahan, Reich & Cottler 2010), and the US among African American and Hispanic women (Corbett et al., 2009). The general consensus surrounding this body of work is that 1) women in abusive relationships are unable to take action for self-protection because of power disparities, 2) in the absence of abuse, women are constrained from condom use and HIV testing because these activities would negate other more important marital functions including love and trust, and 3) therefore women's responses to HIV risk in their marital relationships in the face of either IPV or infidelity are practically nonexistent. None of these studies detailed the cognitive, social or emotional micro processes that led to discovery and/or evaluation of risk among study participants.

In their review of the literature on HIV prevention and Mexican migrants, Organista, Carrillo and Ayala (2004) call for the identification of structural and environmental factors that relate to HIV risk among migrants, and how these factors interact with the personal agency and resiliency of vulnerable individuals. These authors argue that basic exploratory research on migrants is

needed, with an emphasis on sexuality and its interplay with social, cultural, and relational

contexts (i.e. gender roles, cultural beliefs, and relationship power), and how these contexts are

altered with the migration experience (Organista et al., 2004). Qualitative data is necessary to

understand women's cognitive and experiential process of risk, through narratives told by

women in their own words. Such inquiry will also allow for participants to identify health-

seeking or self-protective behaviors, and will lend insight into how the environment and structure

of migration, gender relations, and culture contribute to personal risk.

Chapter 3:

Philosophical Underpinnings

Introduction

My philosophical assumptions influenced my own priorities and perspectives that I brought to this work. These assumptions shaped how I thought about migrant farmworkers in the Green Valley and the concept of HIV risk, and subsequently how I worked to formulate theory during this analysis (Rodgers, 2005). The philosophical tenets of Social Constructivism (Berger & Luckman, 1966) and the main claims of the philosophical theory of Symbolic Interactionism (Blumer, 1969; Mead, 1934) informed the methodology of choice for my research: Constructivist Grounded Theory (CGT; Charmaz, 2014; Charmaz, 2008). In addition, elements from feminism (Harding, 1986) have influenced how I designed this research. In fact, the Community Partnership Model (Anderson, Calvillo & Fongwa, 2007) is a practical application of my commitment to a feminist philosophy.

Philosophical Influences on Methodology

CGT is different from the traditional, objectivist approach to grounded theory, where the researcher elicits information pertaining to a chronology of events or behaviors (Glaser & Strauss, 1967). As CGT researcher, I did not assume that I arrived at the scene of the interview or the process of data analysis devoid of any personal beliefs or interests (Charmaz, 2014). I had tacit knowledge, assumptions, and biases, as did each participant. This necessitated that I constantly remained reflexive, interrogating my views and interpretations of the data in tandem with my own background and beliefs. To this end, I worked to create codes and categories from the data itself and intentionally sought to avoid creating them from my own thoughts or biases (Charmaz, 2014). Although it is impossible to totally eradicate the effect of my assumptions and

biases, I tried hard to be aware and honest about the ways in which those assumptions and biases influenced how I interpreted my participants' situations.

Social Constructivism. I was heavily influenced by Social Constructivism, a point of view that credits reality as being dependent upon our approach to the world and our social relationships within the world (Gergen, 2009). In other words, what I perceived to be real was not an objective truth to be discovered, but instead an interpretation that was "continuously created" through my interaction with those around me (Wallace & Wolfe, 1999, p. 277). I was "constructing" interpretations of the data by taking in the women's words but mindful that I could not avoid imposing my own points of view on the world.

Influenced by his mentor Edmund Husserl, Alfred Schutz adopted the concept of a "lifeworld"-- a taken-for-granted context we assume each person to have that allows us to share common experiences and sensations (Turner, 1991). As researchers, we cannot know about the perceptions of participants independent of our own lifeworld. In fact, Schutz argued that we cannot come to know the perceptions of others unless we come to share in the same lifeworld through observation and interaction (Turner, 1991). In addition, Schutz posits that we have certain rules or "social recipes" that condition how we act in our lifeworlds and help us to interpret events (Turner, 1991, p. 388). These rules or recipes, which constitute our reality, are called stock knowledge.

Peter Berger and Thomas Luckman (1966) labeled this view as constructivist. They brought together ideas of a taken-for-granted lifeworld and assumptions about what is real and formulated a theory to assist in understanding how social constructivism is evident in our reality-making. This theory includes the components of externalization, objectivation, and internalization. First, in the process of externalization, we create and are constantly re-creating a

social reality through friendships, families, institutions, and societies. Next, we order and objectify the world in a tacit agreement that is transmitted through the currency of language. Finally, we internalize these tacit agreements, conforming to the expectations that have been created around us. We begin to legitimize the ordered and objectified world and accept it as our own reality (Berger & Luckman, 1966).

Throughout my research, I sought to understand the lifeworlds and stock knowledge that were accepted as reality by participants in my sample. The assumption that reality is co-constructed informed how I proceeded with data collection, analysis, and interpretation. Through the process of interviewing, reality was co-constructed as I engaged with participants with the goal of understanding and interpreting their worlds and as they engaged with me. However, unlike participants, I engaged in a constant questioning of my assumptions and interpretations as I analyzed the data, in order to gain a deeper understanding of women's perceptions and experiences.

Symbolic Interactionism (SI). The philosophical theory of SI, as developed by George Herbert Mead (1934) and interpreted by Herbert Blumer (1969), posits that the mind, the self, and society each come about and are sustained by social interaction. SI is built on three premises, according to Blumer (1969). First, we act toward objects and others in our environment on the basis of the meaning that they have for us. Second, this meaning arises out of the social interaction that we have with one another. The third premise is that we are constantly modifying and establishing meaning through an interpretive process (Blumer, 1969). Meaning is therefore not seen as intrinsic, but instead it is a social product that arises through social interaction. The interpretative process of making meaning involves both self-interaction and processing (revising and transforming) the meaning of the object or situation within the

65

current context. Interaction therefore takes place between the actor and objects in the environment, between the actor and herself, and between the actor and other actors. In this view, humans are necessarily purposive agents in society (Blumer, 1969).

There are several key concepts in SI, namely social interaction, the self, the act, mind action, social interaction, and the use of symbols (Blumer, 1969; Mead, 1934). In this view, social interaction is not merely a forum for the passage of culture, norms, and values; instead it is a process that actually "*forms* human conduct" (Blumer, 1969, p. 8). Mead (1934) distinguishes the self as having both an "I" and a "me," which highlights both how we act and how our social identity is portrayed. The "I" is the self that acts in the moment and the "me" is the self that is constituted by the attitudes of others (through social interaction). SI treats interaction between people as well as interaction with oneself to be equally important. Human action is viewed as a continuous stream that is dynamic and constantly changing as we make decisions in response to our environment and those around us. Interaction with oneself is called mind action, and it is the process of developing plans of action towards objects and other human around us. We act on our environment and interact with one another through the use of symbols (gestures, words, objects, or acts), which create meaning and are used intentionally to communicate. The use of symbols differentiates symbolic interaction from a mere reflex response that does not involve interpretation; again, humans are not passive agents but act purposefully on the environment (Blumer, 1969).

The concept of action in SI is central to a study of women's perceptions and responses related to HIV risk, in that women in risky situations have a constant stream of interactions that are both external to the body (e.g. actions towards a perpetrator or a partner) and internal in the mind (e.g. formulating a plan of exit, or acquiescing to avoid further harm). It is precisely this

66

mind action that I listened for, was sensitive to, and respected when asking questions that elicited women's narratives.

SI influences the methodology of CGT by assuming that social action is not a product, but a process that is constructed and must be observed in order to be understood (Blumer, 1969). In order to observe how women perceive and respond to sexual risks, I elicited participants' detailed and rich narratives that assisted me to "trace the formation of the action" (Blumer, 1969, p. 56). This did not mean, however, that I had to be present literally to observe women negotiating sexual risks. It is not the observed physical behavior, but instead the formation of action in the woman's mind that is important: action towards herself, action towards her partner/perpetrator, and action towards the objects in her environment. Blumer (1969) explains that "tracing the formation of the action" entails:

> Seeing the situation as it is seen by the actor, observing what the actor takes into account, observing how he interprets what is taken into account, noting the alternative kinds of acts that are mapped out in advance, and seeking to follow the interpretation that led to the selection and execution of one of these prefigured acts (p. 56).

Therefore, key philosophical understandings that influenced my research methodology included: understanding that women constructed their realities (both at the moment of the act and then again when they recounted the narrative to me); that women acted on the basis of what those realities meant to them; that my presence during the interview influenced how participants recounted their narratives; and that I as the researcher was a co-constructor of reality as I viewed the data, interpreted actions, and built my understandings of the processes in which women were engaged.

Philosophical Influences on Research Design

Apart from those assumptions that influenced my role as a constructivist grounded theorist, other philosophical influences shaped how I designed my study.

Feminist postmodernism. Migration cannot be studied without a focus on issues of gender: both how gender meanings influence migration and how the migratory process in turn impacts conceptualizations of, and behaviors surrounding, gender (Hondagneu-Sotelo, 2000). Likewise, science is inherently gendered (Harding, 1986). Therefore, it was imperative that I acknowledged the influence of feminist philosophy on the ways in which I thought about the world and the formation of knowledge, because these informed how I structured the design of my study on migration and sexual risk.

Feminist philosopher Sandra Harding (1986, p. 17) defines gender as being more than the "natural consequence of sex difference" and more than a "social variable" that is assigned; gender is "an analytic category within which humans think about and organize their social activity...that appears only in culturally-specific forms." Moreover, gender is one of the many hierarchical systems that exist in society (Alcoff & Potter, 1993).

Feminist epistemologies offer critique of other theories of knowledge because of their lack of attention to women as the subject, the recipient, and the purveyor of knowledge (Alcoff & Potter, 1993; Harding, 1986). Harding (1986) identifies feminist postmodernism as one of the three main forms of feminist epistemologies, identifying that this form challenges the view of the universal human (androcentric) experience. The epistemology of feminist postmodernism recognizes that gender is one of the "fractured identities" that we hold (Harding, 1986, p. 28). In this view, gender is not viewed as a simple dichotomy, nor is it the only issue of importance. Instead, we are shaped by multiple sociocultural, political, and racial identities that necessitate a resistance to universal claims regarding knowledge, science, and self (Harding, 1986). The term

"feminist," in fact, has been extended to apply not only to issues of gender, but also to other systems of domination and oppression (Alcoff & Potter, 1993). Harding claims the following regarding postmodern feminist inquiry:

> Contrary to the assumption of 'a' world out there composed of essential dichotomies, which it is science's job to reconnect through explanation, there are as many interrelated and smoothly connected realities as there are kinds of oppositional consciousness (Harding, 1986, p. 194).

Although there is a concern that the adoption of a postmodern feminist view will lead to the downfall of feminism's collective power to prioritize issues of gender and women (Cole, 1993), Harding (1986, p. 247) emphasizes that the importance of fragmented identities should only be explored within the confines of a "solid and nondefensive core identity." I interpret this to mean that we can at once acknowledge our "core" similarities (that which we have in common as humans, as women, etc.) while accepting the multiple nuances of human identity and experience.

The health sciences literature on HIV and migration has focused almost exclusively on men who migrate. By recognizing that migration is a gendered process, by taking into account the biological disadvantage of women in HIV transmission, and by focusing on the individual narratives of vulnerable women's diverse individual experiences, I adopted a feminist philosophical stance. Postmodern feminism does not necessitate the study of women alone, but highlights the multiplicity of differences in how men and women might experience migration, power differentials and role change. This view fits well with Social Constructivism and SI, since all allow for the existence of multiple realities and do not hold that life is simply explained by one metanarrative.

The focus on systems of oppression within feminist philosophy does not end at their identification; instead, the ultimate goal of feminist research in nursing is to utilize findings to improve the situations of oppressed groups (Campbell & Bunting, 1991). Instead of recreating androcentric bias and other systems of power and domination through research, adopting a feminist philosophy implies that knowledge-seeking will ultimately be emancipatory and "transfer control from the 'haves' to the 'have-nots'" (Harding, 1986, p. 20). Therefore, I have a mandate as a feminist researcher to work collaboratively with the research participants and their community to effect change.

The Community Partnership Model. My goal is that this research will not only contribute to the general knowledge base of Latinas and HIV risk and that it will assist in creating change that will improve the lives of migrant farmworker women, but that it will also directly impact the community in the Green Valley. Therefore, the Community Partnership Model (Anderson et al., 2007) was useful to me as I thought about how to collaborate with research participants, community members, and advisory board members to partner in the research process. This model highlights the joint decision-making between researchers and community members. The nurse researcher partners with the community within the macro level socioeconomic, cultural, political, and physical environment. Each are influenced by their own cultural values, beliefs, and knowledge base. Together, they engage in micro level interactions as they collaborate to: 1) identify a problem, 2) plan an intervention/evaluation, 3) identify and enhance participant/community strengths, and 4) reduce/eliminate health disparities. Although I arrived in the Green Valley with the basic outline of my study, I wanted to involve the community in planning my study, identifying community strengths, and reducing health disparities. Therefore, the Community Partnership Model (Anderson et al., 2007) is a practical

application of my commitment to critical theory -- accomplishing mutually acceptable goals by partnering with the community to confront injustice.

Conclusion

As the instrument of research, social constructivism, symbolic interactionism, feminism and The Community Partnership Model have influenced my priorities and perspectives. I acknowledge that these theoretical views have shaped my own ideas -- and thus the resulting grounded theory that I propose -- regarding migrant farmworker women and their perceptions of and responses to HIV risk.

Chapter 4:

Methods

Introduction

To conduct this study, my research design included community collaboration and in-depth interviewing of twenty migrant farmworker women in a rural agricultural community in Southern California. Constructivist Grounded Theory (CGT; Charmaz, 2014) guided how I collected data and analyzed it. In this chapter, I delineate my research design, research procedures, data collection, data analysis, data safety and management, and ethical considerations.

Research Design

Constructivist Grounded Theory methodology. CGT methods consist of general principles for collecting and analyzing qualitative data, with the goal of making analytic sense of research participants' statements and actions, and how they explain their lives (Charmaz, 2014). Grounded theory is therefore both a process and a product. The process of CGT and the principle of constant comparative analysis (Glaser & Strauss, 1967) guided how I designed this study.

Positioning myself within the research: critiquing my role as an "outsider." Across disciplines and within nursing, researchers have debated the advantages and disadvantages experienced by researchers who come from "inside" the target community and culture versus those who come from the "outside" (Allen, 2003). Some argue that only "insiders" can adequately and accurately provide a research account of their own worlds, because they are intimately affiliated with the intricacies of these worlds. Some believe that this close affiliation allows them to collect, dissect, and synthesize data in a way that an "outsider" could not. But

others counter that the "outsider" is better positioned to examine biases, question taken-for-granted assumptions, and analyze attitudes and behaviors without having insights clouded by competing agendas that could arise from close affiliation with the target community and/or culture (Allen, 2003). However, scholars have also noted that the boundaries between "insider" and "outsider" are actually quite fluid and involve factors relating to race, class and gender, in addition to culture (Merriam, Johnson-Bailey, Lee, Kee, Ntseane, & Muhamad, 2001). Certainly, as a Caucasian women who was born and raised in the United States, I am "outside" the Latina migrant community and culture. Having lived in Ecuador, travelled throughout Latin America, learned Spanish as a second language and married into a Mexican-American family, I am potentially positioned closer to what may act as a border between "insider" and "outsider." Other aspects of myself influenced my commonalities with or differences from the migrant women in this sample: I am a woman, I am a mother, I am a professional healthcare worker, I am highly educated, and I live in a middle-class neighborhood. And I am quite literally distanced from the Green Valley, living three hours away by car. I was open and honest about all of these aspects of myself when getting to know community members and study participants.

Being open, honest and constantly reflexive throughout the research process – both with myself and with others – was a crucial component that minimized the disadvantages and highlighted the advantages of my position as an "outsider." I do believe that study participants felt comfortable being open and honest with me partially because I was outside of their culture and because I lived far from their community. I was removed enough from their day-to-day realities that they could share candidly without worrying about the possible social repercussions of sharing "too much." Also, the commonality in our positions as women, wives, and mothers provided a shared space within which we could begin to understand one another. When I first

started visiting the Green Valley I was pregnant with my son, and very obviously so since I was six months along. I concluded data collection when my son was almost three years old. Occasionally throughout my involvement in the Green Valley, I brought my son to community meetings and social outings, and my husband also accompanied us at times. By establishing my identity as a mother and wife, I gained respect and was able to break down the boundaries – in small but important ways – between "insider" and "outsider."

However, one crucial component of my role as "outsider" was extremely beneficial in building trust with community members and study participants. As a Registered Nurse (licensed RN), I found that I was respected by professionals in the community and also by study participants. My motives for conducting this study were clear because of my professional affiliation, and I was able to make connections with community sites that could have been more difficult to enter had I not had background in healthcare. And with study participants, my identity as a nurse was a bridge that fostered trust and openness. Women were prepared to discuss personal issues related to their health partially because of my position as an RN and healthcare provider. In all these ways, I found that the line between "insider" and "outsider" was at times blurred, and that components of both positions were helpful to me as I built trust at both the individual and the community level.

Community collaboration. Because I was committed to utilizing a community participatory approach (Anderson et al., 2007) in my research, it was important that I collaborated with the community in which I carried out this study. In chapter five I will further describe how I gained entry into the community. After gaining entry, I formed a Community Advisory Board (CAB) of six Latina women from the Green Valley who were invested in revising my research design, who were willing to refer potential participants to me for screening,

who could provide a listening ear as I came upon questions and inconsistencies in my fieldwork, and who could ultimately offer insight into my preliminary interpretations of the data. Two were professionals working at service agencies, two were members of a farmworker women's advocacy group and were also working in the fields, and the remaining two women were farmworkers. In addition to these six women, other women in the community also acted as individual advisors to me during different points in my work.

Initially, I reviewed the screening questionnaire and semi structured interview guide with the CAB, encouraging them to dissect, delete, and add to both until we all felt they were culturally appropriate and sensitive while maintaining their original intent. I continued to meet with members of the CAB every two to three months during data collection and analysis, in order to gain their assistance with overcoming study roadblocks and participant recruitment. I also presented some of my raw, in-process ideas to members of the CAB as I was interpreting the data as a form of member checking. In this way, I shared ideas regarding category formation with the CAB and requested their input about some selected preliminary findings and suggested interpretations.

Setting. Approximately one third (36%) of all field laborers in the US work in California (Aguirre International, 2005), making this setting a prime location for examining issues that affect this population. In addition, 96% of all farmworkers in California report having been born in Mexico (Aguirre International, 2005). I collected all of my data in a rural agricultural region in Southern California, which I refer to as the "Green Valley." I describe the Green Valley in more detail in chapter five.

Sample. Twenty migrant farmworker women who lived and worked in the Green Valley during the recruitment period (May 2012 to May 2014) were recruited for this study. More details regarding the sample are reviewed in chapter five.

Sample inclusion criteria. To be eligible for the initial demographic and screening interview, participants needed to be Spanish-speaking women ages 18-60 who worked in the fields in California and were born in Mexico. Since most individuals do not work in farm labor year-round and experience extended periods of unemployment, women needed to have worked as a farmworker (or *campesina*, which could mean that she works as either a "packer" in the warehouse or a "picker" in the fields) within the year prior to the interview. They also needed to have status as a "migrant farmworker" according to the Head Start Act (1998) and Public Health Service Act, Section 330. This meant that they had either arrived to or gone out from the Green Valley within the past 2 years for the purpose of agricultural labor. Finally, to be eligible for the study, women needed to be "high risk" according to the screening algorithm developed for this study.

In order to be classified as "high risk," a woman had to state that she identified with any one or more of the following experiences: 1) had a long-term partner who had been unfaithful, had sex with men, used injection drugs, had been diagnosed with a sexually transmitted infection (STI), or had been diagnosed with HIV; 2) had a long-term partner who was physically, sexually or emotionally abusive; 3) had been physically separated from a long-term partner for more than one consecutive month during the year prior to the interview; 4) experienced rape or forced sex as an adult; 5) had ever been diagnosed with an STI herself; 6) was ever in a situation in which she worried that she could have gotten an STI, even if she did not; 7) had exchanged sex for

drugs or money in the past five years; or 8) had unprotected sex with a man outside of a long-term relationship.

Sample exclusion criteria. Women who were not interested in being interviewed, who were unwilling to provide informed consent, who spoke an indigenous language exclusively (i.e., did not speak Spanish), or who had not recently been employed in agricultural labor were excluded from this study. In addition, women who were born in the US or another Latin American county or who did not meet the criteria for "high risk" according to the screening interview were excluded from participation in this study.

The in-depth interview. I conducted one or two in-depth interviews with all 20 women who chose to participate. All interviews were conducted in the language preferred by the women; 19 interviews were conducted in Spanish and one interview was done in a combination of English and Spanish. I used a semi-structured interview guide (SSIG) for the interview. I had two SSIGs and used the version that corresponded to the category of risk that women identified during the screening interview. This helped to ensure that relevant topics were covered; it also allowed me to present the participant with open-ended questions to elicit narratives that were specific to her own perspective and life experiences.

As mentioned, the CAB reviewed a translated version of this SSIG to ensure its' cultural appropriateness. A copy of the English SSIGs are in Appendices C and D. Questions were related to the participant's migration history, her relationships, her experience with risky situations, her experience with HIV/STI testing, and general closing questions. Interviews generally lasted about 90 minutes, and were conducted in a location of the participant's choosing. Usually, the interview was conducted in her home or in the home of one of the CAB members.

In fewer cases, our interview took place in an exam room at the clinic or in a private room at the local Migrant and Seasonal Head Start (MSHS) offices.

Research Procedures

  Participant recruitment. Potential participants were referred to me either by a CAB member or by staff at the local health clinic. In most cases, CAB members arranged an individual appointment for me to meet with a woman who voiced interest in the study. I met with each woman one-on-one to describe the study and invite her to participate. At the clinic, providers (including Registered Nurses, Physicians and Nurse Practitioners) passed out study fliers (see English version, Appendix E) to their female patients on select days when I was present in the clinic, alerting them to their opportunity to participate in the study. Clinic patients were then able to follow-up with me at their own discretion; either by calling my study phone or by visiting me in my designated room at the clinic.

  In addition to these referrals, I spent time at a local migrant rest station. At this location, men and women had separate areas to shower in a trailer with running water and then could relax outside in the shade after a long day at work in the fields. I visited often during the peak migrant season and would bring a cooler full of cold beverages and small samples of lotion, soap, shampoo and conditioner to hand out to women. As I got to know women at this venue, I would tell them about my study and invite them to participate in the screening interview.

  Finally, I used a snowball sampling or chain referral procedure to recruit additional participants through women who had already participated, which is a useful strategy for populations that may be hard to reach (Faugier & Sargeant, 1997). Due to the sensitive nature of this study, I found that referrals from CAB members and chain referrals were the best ways to be

introduced to women who were not only eligible for the study, but who were also willing and interested in sharing their experiences and perceptions related to sexual risk.

Participant screening. During the initial in-person contact in a private setting, I gave a brief overview of the study. I then obtained verbal informed consent for screening by reading the screening consent form script (see English version, Appendix F). After obtaining informed consent, I went on to ask the potential participant a series of questions to determine her eligibility:

1) What is your preferred language?

2) How old are you?

3) What country were you born in?

4) Have you worked as a farmworker (either a picker or a packer) during the last year?

5) For this trip only, how long have you been in the Green Valley since you last traveled to another location for work (consecutive days/weeks/months/years)?

I then introduced potential participants to the HIV Risk Screening Algorithm that I developed for this study (see English version: figure 2, Appendix G). This algorithm presents up to four lists of risky scenarios, with a sub-list of 2-5 scenarios for potential participants to respond to; their responses were either: "yes, one of these things has happened to me," or "no, none of those things have happened to me."   I had it printed on a colored piece of paper and would gesture with my hands to illustrate how I would guide women through the algorithm. I indicated that a "yes" or "no" answer would either tell me that she was eligible for the study or direct me to read her the contents of the next box. I explained that in some cases, I only had to read the first box to determine eligibility, whereas in other cases I would need to read through four boxes. I alerted potential participants that although they did not have to disclose which item

from the box applied to them during screening, that this would be the topic of the one-on-one interview if they chose to participate. If the potential participant met all eligibility criteria for the qualitative interview and agreed to participate, a mutually agreeable time and a and safe private location were chosen for conducting the one-on-one, in-depth interview.

Informed consent. I received a waiver of signed consent from the South General Institutional Review Board (IRB) office and utilized a two-phase consent process for this study. Participants could have been wary about signing a form if they were undocumented. In addition, keeping a signed informed consent form would have necessitated that I keep a record of the participant's full name. This would have prevented me from maintaining participant anonymity. An informed consent information sheet was provided in Spanish for participants to read, but I also reviewed it verbally and in detail, as many farmworker women are not able to read. First, I obtained initial verbal informed consent for screening. Then immediately prior to starting the in-depth interview, I sought verbal informed consent a second time for those who met eligibility criteria for inclusion in the study.

Also, in accordance with my waiver of approval from the South General IRB office, I did not give a copy of the informed consent information sheet to participants to keep; however, it was available at their request. Because many participants were victims of intimate partner violence (IPV), they could have been in relationships where a partner's knowledge of their involvement in this study could have placed them at risk for harm. Therefore, I handed out my business card but other study information was not routinely given to participants.

Participation in a second interview. Participants were invited to participate in a second interview to further clarify and elaborate their experiences if the first interview did not allow for sufficient time. Out of the 20 participants, I interviewed three women twice. Although not an

original component of the study, I began requesting second interviews with participants when we were not able to cover the entire SSIG during the original 90-minute interview. Because the IRB requested that I limit interviews to 90 minutes in order to decrease participant burden, I found second interviews were necessary for some participants to share in-depth and tell a complete account of their experiences. Unfortunately, I did not obtain IRB approval to begin conducting second interviews until I had interviewed more than half of the participants. When I did conduct a second interview, it was arranged immediately after the conclusion of the first interview. Because I did not collect or retain any participant's contact information, I could not re-contact participants at a later date. Participants had the opportunity to refuse a second interview.

If, during the first interview, the participant disclosed that she was currently in an abusive relationship or a victim of violence, I asked the whereabouts of the perpetrator. If the perpetrator was living with the participant or in the same town as the participant, I was sensitive to the possibility that the participant might have difficulty scheduling a second interview without the perpetrator's knowledge. If the participant could not state a scenario (time and place) where it would be safe for her to participate in the second interview, such an interview was not scheduled. If either the participant or I had any doubts whatsoever regarding her safety in scheduling a second interview, then a second interview was not scheduled.

Privacy. Privacy was maintained by screening and interviewing women one-on-one in a private space behind a closed door, where others could not overhear the conversation. In addition, although CAB members referred potential participants to the study, I did not share with them any information regarding the screening or the interview, as applicable. For example, I did not follow-up with CAB members to tell them which women had been eligible for the study or who had chosen to participate.

In order to prevent detection of study participation by an abusive partner or other person who had perpetrated violence against them, participants were asked what location and what time would be safe for them to participate in the interview. If they could not select a time and a place for the interview that provided them with a sense of safety, then I did not enroll them in the study.

Confidentiality. Information that was shared during the screening, the in-depth interview, and during demographic data collection was not shared with anyone in the community, including the CAB members. I was the only person present at the in-depth interview. My dissertation chair read the transcribed and translated interviews, which had no identifiers.

I did not collect any identifiable data from participants, thus neither the audio files nor the written transcripts or translations were labeled with any personal identifying information. In the event that participants inadvertently disclosed identifiable data during the course of our interview (e.g. inadvertently stated their name, the name of a partner or perpetrator, their place of employment, where they lived, or the proper noun of a location where a violent act took place), they had the opportunity to erase part of the audio recording. In fact, participants had the option to erase the audio recording for any reason or to opt out of audio recording. If any identifiable information remained in the audio recording after the participant had the opportunity to opt out or erase, I inserted pseudonyms and/or dashes (--) and deleted all proper nouns in the transcript when the audio recording and transcript were compared for accuracy. Only one participant opted not to have the interview recorded.

Anonymity. Any contact information that was provided by participants in order to arrange for the in-depth interview (i.e. first name, phone number, or address) was destroyed

immediately at the beginning of the in-depth interview. No formal record was made of participants' identifying information, including their names, addresses, phone numbers, or employers. All potential participants who were screened were assigned an identification number, and those who were eligible and agreed to participate were assigned a pseudonym. This pseudonym was the only identifier that linked a participant's Spanish transcript, English translation, and demographic data sheet.

Participant compensation. Participants were reimbursed $25 cash for each interview, for a possible total of $50.

Risk protocols. In order to minimize risks, I formulated risk reduction protocols for suicidal ideation and reports of violence (Appendix H). The protocols that I include here in the appendix have been de-identified; in the original version I included names, telephone numbers, and addresses of local professionals and agencies for easy reference.

Data Collection

Demographic data form. After informed consent was obtained for the in-depth interview, I completed a demographic data form (Appendix I) with each participant. This form included women's marital status, current location of her husband/partner (e.g. if they migrate together or are separated), age of first arrival in the US, length of time in the US, migratory patterns, number of children, current housing situation, income and education level.

Transcribed and translated interviews. Out of the total 23 interviews (three participants were interviewed twice), 19 were in Spanish and two (from the same participant) were a mixture of Spanish and English. All interviews were digitally recorded and transcribed in their original language by a professional typist. I reviewed all transcripts with the audio recording in order to ensure accuracy and inserted field notes and comments. At this point, I

ensured that all transcripts were de-identified; replacing pseudonyms for any proper nouns that were used.

Next, each interview was translated into English by a professional translator who was formally trained in, and who had significant experience in, Spanish-English translation. I reviewed all translations, comparing them with the original Spanish or combination Spanish-English transcript. I made notes and comments and then conferenced with a team of two professional translators (the original translator and a second translator) regarding areas of concern. That is, when I wondered if there was a better way to portray the participant's original meaning, I conferred with translators in order to choose the most appropriate words and phrases that best described women's experiences and perspectives. Since the translation team was not of Mexican origin and did not have experience working with farmworker populations, there were a few circumstances in which I consulted with a CAB member regarding accuracy of select individual words and phrases. Once I felt confident that the English translations of the Spanish transcripts reflected women's original feelings, experiences and perspectives, I analyzed the data primarily in English.

Field notes. I kept extensive field notes each time I entered the field. Field notes included the date, time entering and leaving the field, location, description of the setting, general comments, evaluation and methodological comments, and personal notes about the experience.

Data Analysis

The aim in CGT is to produce an interpretive theory for understanding a phenomenon that is grounded in the voices and experiences of the participants (Charmaz, 2014). Using induction, CGT applies iterative strategies of comparative methods (Glaser & Strauss, 1967). Constructivist foundations of CGT indicate that the researcher has a primary role in interacting

with the data and shaping the analysis. Constructivism holds that individuals are influenced by contextual factors including cultural, social, and economic factors, as they create and construct meaning in their everyday lived world (Berger & Luckman, 1966). This meaning is also influenced by the interaction between participant and investigator during the interview (Schwandt, 1994) as well as between investigator and the data during analysis. For these reasons, I provide a detailed account of my analysis process and techniques.

Language of analysis. I felt more comfortable analyzing the data in English for two reasons. First, because English is my native language. Second, I wanted the ability to seamlessly review data with my committee members who were not all fluent Spanish speakers. I found that the process of transcription and translation actually enriched my understanding of women's stories. Not only was I present with participants during the interview to see their body language and facial expressions combined with their tone and chosen words, but I had multiple other opportunities to analyze and interpret their stories. Listening to the audio recording while simultaneously reading their words on my computer screen helped me to digest what they were telling me. And then comparing their words in both Spanish *and* English helped me to better understand some of their meanings. The back-and-forth process with the translation team and my work of mulling over the meanings of words helped me to internalize what women told me. And ultimately, I found that I could not just analyze the English transcript by itself -- I preferred to analyze the Spanish and English side-by-side so I could interpret a fuller meaning of women's experiences.

Constant comparative analysis. Analyzing Spanish transcripts side-by-side with their English translations, as well as side-by-side with other data was part of the on-going process of constant comparative analysis (Glaser & Strauss, 1967) that established analytic distinctions in

my data (Charmaz, 2014). Comparing segments of data, initial codes, focused codes, emerging categories, memos and situational maps to one another was an iterative process from the very beginning of data collection until the very end of writing the dissertation.

Memo writing. Memo writing is not a particular step in the process, but is a part of the process at every phase of data collection including initial coding, focused coding, and category formation. I wrote a variety of memos as I analyzed the data. I used memos to remain self-reflexive throughout the research process, and as an intermediary link between data collection and analysis (Charmaz, 2014). Memos assisted me in checking my assumptions, unpacking possible biases, and reflecting on interpretations to enhance understanding of each participant. Memos helped to identify the meaning that emerged from coding and to narrate an analytic story that reflected the links I made in coding. Memoing also gave coherence to my overall project.

Initial coding. When analyzing an interview transcript, first I completed initial coding. To do this, I highlighted sections of the data in order to dissect each interview into small segments that each held their own specific meaning. In doing this, I considered the meaning of each segment within the context of the entire interview. Sometimes this was a fragment of a sentence, and other times it was a description of an entire incident that spanned paragraphs. As I viewed the data in smaller segments, I thought about each one and asked myself, "What is happening in this segment? What is the meaning of what she is telling me here?" (Charmaz, 2014). I then coded the segment by giving it a short name that included a gerund (verb form), which allowed me to identify the action taking place within it (e.g. "criticizing family" or "referring to a memory"). I also identified "in vivo" codes, which anchored the analysis in the participant's own words and captured unique but poignant expressions of meaning (Charmaz, 2014).

Focused coding. After completing initial coding for the first few interviews, I started making analytic decisions regarding which initial codes best helped to categorize my data. In some cases, I chose frequent and similar initial codes and linked them together. In other cases, I actually coded my initial codes in order to better understand what was happening in the data and decide how I could best view my data as a whole. Practically, this meant that I analyzed and compared segments of data and initial codes across interviews, joining and differentiating codes in order to gain clarity. Overall, focused coding condensed, sharpened, and emphasized what I found to be integral as I moved forward in my analysis (Charmaz, 2014).

Category formation. A theory is comprised of conceptual categories and their individual properties, as well as the relationships between categories and properties (Glaser & Strauss, 1967). Categories elucidate concepts and processes in the data (Charmaz, 2014). As I continued to both collect and analyze more data, I began to identify certain focused codes or groups of focused codes that best represented what I saw happening in the data. Through intensive memo writing, I identified those that had the potential to develop into categories that brought depth of insight into the phenomena of the women's lives. As I wrote about these categories in memos, I identified the properties of the categories, as well as the dimensions of properties and the conditions and consequences of the phenomenon. I made linkages between categories, properties, and dimensions as I worked with the analysis, comparing data with data in order to gain a deeper interpretation of each category. Seeing how the categories could be linked helped me to visualize underlying processes that were occurring in women's lives. I used various analytic tools (Corbin & Strauss, 2008) to problematize these emerging categories and their linkages, which allowed me to ask questions of the data and identify gaps that needed to be filled.

Theoretical sampling. After a great deal of analysis, I identified gaps in my understanding of women's experiences. This analytic work allowed me to become clearer about what was missing in the categories I was describing based on the data. So, I did theoretical sampling to take a more focused approach to data gathering. That is, I directed subsequent interviews in such a way that I could fill these gaps by learning more from the women about the phenomena (described as categories with properties) that was perplexing to me or that I only partially understood. This CGT technique allowed me to find the relationships between categories, which ultimately led me to form an integrated theory (Charmaz, 2014). A common misconception about theoretical sampling leads to the erroneous goal of seeking to adequately represent the experiences of *all* migrant farmworker women by interviewing until nothing "new" is said by any participant. I avoided this common temptation by keeping my focus on the analytic theory I was developing using CGT techniques. Therefore, theoretical sampling directed me to focus on filling the gaps of understanding that resulted when I was engaged in analyzing properties and dimensions within an incomplete category. My goal was to seek to more fully explicate the relationships between properties within each category and the relationships between categories. I was not searching for static "themes," but for the nature of the interconnectedness between the properties and dimensions within theoretical categories or between categories (Charmaz, 2014). Ultimately, theoretical sampling and further analytical memoing brought a more nuanced understanding of the two simultaneous processes of "expanding perspective" and "gaining leverage" that I identify in this dissertation.

Situational analysis. Throughout the analytical process, I used situational analysis as a tool or "analytical exercise" (Clarke, 2005, p. 83) to help me understand my data. I used my own experiences of collecting data and doing fieldwork in the Green Valley to inform these analyses.

Situational analysis involves techniques for analyzing a particular scenario or "situation" through examining its elements and the relationships between those elements. This assists the researcher to ground the analysis in the "broader situation of inquiry" (Clarke, 2005, p. 37). I used all three types of situational analyses, including situational maps, social worlds/arenas maps, and positional maps. Making situational maps helped me to elucidate the elements of migrant farmworker women's situations or positions and the relations between these elements. According to Clarke, "elements" can include individual actors, collective human actors, nonhuman actors, silent actors, discursive constructions, political/economic elements, sociocultural/symbolic elements, temporal elements, spatial elements, contested issues, and other elements specific to the situation (Clarke, 2005, p. 90). I wrote out a list of these elements and then drew lines of connection between them while dictating the nature of each relationship into my iPhone. Dragon Dictation software automatically transcribed my spoken words into text that I used to constitute written memos.

I also used social worlds/arenas maps to illustrate the "collective commitments, relations, and sites of action" (Clarke, 2005, p. 86) that were apparent in the milieu of migrant farmworker women's lives. However, I did not limit my exploration only to women in the Green Valley. Rather, I included larger arenas related to politics in Mexico and the US including issues related to border crossings, US immigration policies, and workplace dynamics. I included issues related to the ways women are socialized in Mexico and the US, divergent identities, shared ideologies, and accepted or rejected discourses. First, I identified key social worlds and then I sought to specify how social worlds were stratified, connected, segregated and legitimized for Mexican migrant women. I examined commitments and actions of each world. Again, I dictated my thoughts as I drew (with paper and pencil) and worked through each map. I gained insight from

this process and found that mapping catalyzed a deeper understanding and a wider perspective on my study. However, as is often the case with social worlds/areas mapping, many of the maps I made did not become a part of the "conceptual infrastructure" of my analysis (Clarke, 2005, p. 116).

Finally, I used positional maps to plot individual participant's or groups of participants' positions in relation to particular perspectives and experiences (Clarke, 2005). This helped me to understand the range of women's experiences throughout my sample, and to grapple with how individual women or groups of women were different from one another as they navigated a particular discourse, perspective, or experience. Ultimately, these positional maps helped me to articulate my interpretations of why and how women did what they did.

Reflexivity. The constructivist approach of CGT emphasizes that both data and analysis arise from individual experience, including shared relationships between researcher and participant. By taking a constructivist stance, I own that my personal assumptions, perspectives, knowledge and interests influenced how I saw the data. Remaining reflexive through the research process is an "obligation" of the constructivist researcher (Charmaz, 2014, p. 27), and required me to scrutinize the research process as well as my experience with the participants and the data. Reflexivity includes an ongoing critique of how my own interests, positions, and assumptions could potentially influence the inquiry (Charmaz, 2014). In order to allow for reflexivity, I engaged in an on-going process of self-reflection and feedback with myself throughout the writing of memos and via dialogue with members of my dissertation committee and the CAB. This helped me to seek understanding of the data produced through interview transcripts, analytic codes, memos, and field notes.

Trustworthiness. Trustworthiness is adequately established in qualitative research by ensuring credibility, transferability, dependability and confirmability of the findings (Lincoln & Guba, 1985). I employed the following strategies in order to establish trustworthiness in my work.

Credibility. In an effort to ensure credibility of the findings, detailed field notes and memos were created and maintained during the course of the research study. The use of reflexivity was crucial to understanding how my own interests, positions and assumptions may have influenced the inquiry (Charmaz, 2014). Additionally, as suggested by Lincoln and Guba (1985), I engaged in debriefing sessions with my dissertation chair and the CAB to examine any biases toward the research participants, the phenomenon, or the data obtained. In addition, I engaged (Lincoln & Guba, 1985) with the study population by spending time with and learning from migrant farmworker women of Mexican descent in order to accurately and thoroughly understand their perceptions regarding sexual health. Specifically, I spent a great deal of time over three years acquainting myself with migrant farmworker women from the Green Valley. I fostered relationships and engaged with the migrant farmworker community in the Green Valley through the data collection and analysis processes. Finally, Lincoln & Guba (1985) support the use of member-checking, or bringing results back to the participants to ensure that the participant's point of view is adequately portrayed in study findings. Because I did not collect identifying information from participants and therefore could not conduct follow-up interviews or member-check with the participants themselves, the involvement of the CAB helped to ensure that my interpreted findings were consistent with the experiences and realities of migrant farmworker women of Mexican descent.

Transferability. In order to increase the transferability of some findings from this research to other migrant farmworker communities, I aimed to provide thick description of the participants, their perspectives, the study context, and the setting. This will supply potential appliers of this research to other settings and populations with the information necessary to make their own transferability judgments about various portions of the findings (Lincoln & Guba, 1985).

Dependability. Steps taken to ensure credibility strengthen dependability in studies (Lincoln & Guba, 1985). As has already been mentioned, and to further enhance the dependability of this study, memos were kept throughout the entire research process and were routinely audited by my dissertation chair. This dependability audit entailed a detailed review of both the process and the product (data, findings, and interpretations) of the study (Lincoln & Guba, 1985).

Confirmability. A confirmability audit by my dissertation chair was done to check final codes and relationships between codes to ensure that the findings were indeed grounded in the data. This audit process also determined whether inferences based on the data were logical in relation to the participants of the study, and determined if the chosen codes and categories were useful and had clarity, explanatory power, and fit the original, raw data (Lincoln & Guba, 1985). In addition, confirmability attests to the degree of investigator bias. This was explored by the audit trail in reference to reflexivity (documented in memos), and ensured that I did not project my own perceptions of the women onto the data.

Rigor. Strategies for establishing qualitative rigor were outlined by Lincoln and Guba (1985) and Juarbe (1998), and were utilized in this study. To summarize, the aforementioned strategies were employed: 1) engagement within the Mexican migrant community, learning

about Mexican culture and beliefs regarding sexual health as well as building trust; 2) word-for-word transcription of audio recordings; 3) self-reflective memos regarding the relationship between participant and researcher, personal feelings and emotions during analysis and coding, and my own behavior and experiences in relation to the participants' stories; 4) review of data analysis by the dissertation committee; 5) constant awareness and researcher reflexivity in the data collection and analysis process; 6) CAB validation of my initial theoretical interpretations; and 7) detailed description of the setting and social, physical and interpersonal contexts in which the data was collected (Juarbe, 1998; Lincoln & Guba, 1985).

Data Safety and Management

Data security. All data were maintained in password-protected computers and in a locked metal file. Upon verification that the transcript accurately reflected our interview, the digital recording was deleted from my personal computer and back-up digital recordings were permanently deleted. Data from my study remain in a locked metal storage file.

Audio files from the interview were encrypted and uploaded to a secure website for transcription. All transcriptionists and translators signed confidentiality agreements. Transmission of text files was de-identified and password protected.

ATLAS.ti. Initially, I began data analysis using Microsoft Word. But after the first six interviews I became frustrated that I could not link, organize or view my codes outside of each transcript. After forming initial codes, I wanted to work with them dynamically and find a way to compare them without flipping through entire printed transcripts or scrolling down pages of computer text. In Microsoft Word, I felt that my codes were ultimately lost within large documents of text. In short, comparative analysis -- one of the hallmarks of CGT -- seemed impossible when faced with pages and pages of data that were difficult to organize and separate.

I wanted to use data management software and had heard from my colleagues that ATLAS.ti (Version 7.2.1, 2012) was helpful but that it was not easily compatible with CGT methodology. Because ATLAS.ti has one main coding function, I heard from others that doing both initial coding *and* focused coding with this software was difficult. I spent a lot of time learning about the software and practicing different ways of coding.

I ultimately fashioned my own system using ATLAS.ti that allowed for both initial coding and focused coding. I uploaded all original Spanish and English translation documents and was able to view them side-by-side as I coded and wrote memos. I found that using data management software facilitated the linkage of Spanish and English quotations, memos, initial codes and focused codes in ways that were useful to me. I also was able to organize focused codes in an on-screen diagram that helped me to visualize forming categories. Unlike situational analysis, these diagrams did not articulate relationships but simply allowed for sorting of focused codes and categories in a way that helped me to grasp the "bigger picture." Of course, this software did not actually *do* analysis. Instead, it provided a platform for organizing and sorting data as I analyzed it.

Scrivener. Towards the end of my analytical journey, I found that I needed a different platform for writing and organizing more interpretive and detailed memos on categories, properties and dimensions. These memos eventually became the first drafts of my final dissertation. I wrote these memos in the computer software program Scrivener (Version 2.5.0, 2013), which allowed for easy organization and editing of multiple small "batches" (or individual memos) of writing that comprised a larger "whole" (or chapter). Along with ATLAS.ti, I found this software to be indispensable to my analytic writing process as I poured over the data and worked to make sense of my understandings. The visual effect of moving codes, focused codes,

categories and memos around the computer screen was one of my primary methods for coming to an understanding of the processes I detail in this work.

Ethical Considerations

Anonymity and confidentiality can be difficult to secure in qualitative research, because of the detailed reporting of data and use of quotations in dissemination. In order to protect the anonymity and confidentiality of the women who participated in my study, I followed Robley's (1995) criteria for ensuring ethical and responsible conduct in qualitative research. I guided the depth of our interview and guarded against disclosure that could pose unacceptable risks. In order to do this, I enabled participants to withhold the details of private and revealing material during our interviews and also carefully negotiated the dissemination of data and choice of quotations with the help of my dissertation chair (Robley, 1995). In addition, I gave all participants the option to delete any section of our interview to protect their privacy.

Women in my study were extremely vulnerable. I referred almost every participant to local counseling, legal aid, and/or medical services in accordance with the needs that they expressed during our time together. I was prepared to follow risk protocols and remove participants from the study who demonstrated high risk for harm. In fact, one interview was terminated early due to one participant's emotional distress over the recent death of her husband. In other situations where a woman disclosed that she was in current abusive relationship, I did not pursue a second interview in order to lessen the risk of a partner questioning her regarding her whereabouts. Finally, I strove to present myself authentically and establish trust over time with members of the community, in order to allow for fairness and heightened equality of power (Robley, 1995).

Summary and Conclusion

Through initial coding, focused coding, and the development of categories, dimensions, and properties, I recognized relationships between categories. I conducted theoretical sampling to saturate categories and provide for a rich and nuanced understanding of women's perspectives of and experiences with HIV risk. Memos linked the entire process and provided for reflexivity. The methodology of CGT provided me with a means for collecting and analyzing data in a way that focused on both action and process (Charmaz, 2014). Ultimately, I was able to integrate a grounded theory with two simultaneous processes, articulating how migrant farmworker women of Mexican descent in this study understood and navigated intimate partner risk.

Chapter 5

Results Part I:

Context, Setting and Description of the Sample

Introduction

I spent three years (May 2011 through May 2014) making trips to my study site, which I call the "Green Valley" in order to protect the anonymity of study participants. During the first year, I gained entry into the community through networking with a number of stakeholders, getting to know the region, and building relationships. In the next two years of the project, I collected and concurrently analyzed data. Before going on to elucidate the two simultaneous processes that I saw in the data, this chapter will provide the context of the women's lives and detail my own process of getting to know the community, within which these findings are situated.

Gaining Entry to the Community

Before submitting my research proposal, I engaged in some informal information-gathering activities that helped me to understand the community and the problem. In early spring 2011, I conducted an informal focus group with four *promotoras* who worked in women's health in an urban center in Southern California. I wanted to hear their experiences and perspectives since they worked with women who had experienced abuse and infidelity. Their insight was valuable to me as I formulated my dissertation proposal and began thinking about this topic. I received assistance from a leader of Visión y Compromiso, a state-wide network of *promotoras*, in recruiting volunteers for this focus group. After this informal focus group, she provided me with the name and phone number of a *promotora* in the Green Valley, knowing that I was interested in interviewing farmworkers.

Through this first contact in the Green Valley, I received multiple other referrals and kept "following the chain" of stakeholders. As I got to know who the key players were, I kept asking, "who else do you think I should speak with?" and "what else do you think I should see or do?" in order to become familiar with the community. I kept a notebook with names, phone numbers, addresses and notes. I mapped out the community and spent a lot of time driving around to get a feel for its geography. I attended events at the church and the elementary school where there is an annual *Día del Trabajador Migrante* ("Day of the Migrant Farmworker"). I also spent time in the local clinic meeting with providers, at the county farmworkers service center, at the public library, and at local shops and eateries. But I spent most of my time divided between two main spaces: women's homes (trailers, cars, apartments, and houses), and the migrant rest station where those passing through the Valley stopped to shower and rest after a long day of work.

There was one instance in which I met with a well-dressed retired farmworker -- who told me that in her younger days she had rallied alongside Cesár Chavez and Dolores Huerta -- at a Panera Bread in a wealthy town that bordered the Green Valley. Since her younger days of working in the fields, her social capital had risen as she had become involved with a series of high profile political campaigns. She had actually moved out of the Green Valley as her income permitted her to achieve a higher standard of living. In contrast to this experience, the next day I was perched on the corner of a migrant farmworker woman's bed in her "studio apartment," which was really just a euphemism for the single room she rented out of a very small and run-down house next to a grape field in the center of the Green Valley. I sat on the edge of the bed because there was nowhere else to sit in the dark, cluttered space that she shared with her three grandchildren.

It was among these inconsistencies of wealth and poverty, of fame and invisibility that I navigated women's experiences in the early days of study planning. I spoke with physicians, nurses, lawyers, social workers, librarians, shop owners, teachers, developers, community service volunteers, grassroots activists and most importantly, with farmworkers themselves. I was overwhelmed with the openness and eagerness with which community members welcomed me. Because I did not live in close proximity to the Green Valley, I made the three-hour drive multiple times during this first year of study planning. I would stay at a local motel and often would bring my family.

Description of the Setting

The Green Valley is a rural desert agricultural community in Southern California. It hosts hundreds of thousands of acres of crops and between 10,000 to 18,000 farmworkers, depending on the flux of migrant labor. Almost half of those who work in the fields in the Green Valley are women. Like other farming communities in California, most farmworkers live below the poverty level. Many reside in trailer parks on unincorporated land in-between and around the fields, and were battling to obtain clean drinking water during the majority of the three years I spent doing my fieldwork. Because of the rural geographic landscape, housing communities are far from the town's center and even further from the neighboring wealthy cities. Yet public transportation is minimal, complicating matters for those without access to a vehicle, a driver's license, or both.

Due to irrigation and the desert climate, the region can support a near year-round growing season. For this reason, the majority of farmworkers live in the Green Valley year-round. However, because of swelteringly hot temperatures during the summer months (June through September), approximately one-third of all workers come in and out of the valley as migrants

99

over the course of the year. Those who have a year-round home in the Green Valley find that they have to travel north in order to continue paying bills and putting food on the table. However, many study participants recounted to me that the combined expenses of traveling and paying rent in two locations make migrating for work a task that reaps increasingly diminished pay-offs.

Description of the sample

Of the 26 potential participants who were screened, 21 were eligible and 20 women were enrolled into the study (one woman did not show up for the scheduled interview). Four women were not eligible because they had not experienced risk according to the risk algorithm. One additional woman did qualify under the risk algorithm, however she was ineligible for the study because she had last migrated north for work more than two years prior to screening. Recruitment was successful primarily through referrals from Community Advisory Board (CAB) members (70% of all participants were recruited this way), and secondarily through snowball sampling (15%), direct recruitment at community service sites (10%), and referrals from clinic staff (1%). Interviews took place in a private room that was located either at the participant's home (55%), at a community service site (health clinic, Migrant Head Start, or a migrant service center; 30%), or at the home of a CAB member (15%).

At the onset of this study I was open to hearing multifaceted stories, including both personal decisions that exacerbated women's risk as well as their experiences with male violence. And in fact, a few participants did tell of making risky decisions to work in the sex trade or have unprotected sex with short-term partners. A few others told how they were unwittingly exposed to male violence that originated from *outside* their homes -- e.g. sexual harassment at the workplace and assault and rape by male strangers. However, it was the danger that came from

inside their homes -- from women's close, long-term intimate relationships -- that became the prime focus of this study.

All women in this study experienced HIV-related intimate partner risk with at least one former or current long-term partner. This meant that: 1) he was physically, sexually, and/or emotionally abusive, 2) he had been diagnosed with a sexually transmitted infection (STI) during the course of their relationship, 3) while being monogamous, she had been diagnosed with an STI during the course of their relationship, 4) she knew or suspected that he had been unfaithful during the course of their relationship, and/or 5) they had been physically separated from one another for more than one consecutive month during the year prior to our interview. Therefore, women in this study were considered to have been in a risky relationship if their close, long-term partner was unfaithful, abusive, had an STI or given her an STI, or if they had been physically separated from one another for work-related reasons. Although not an HIV risk factor in other populations, migrants are known to be at risk for HIV largely because they are often separated from a primary partner for extended absences while working in far-away towns. They often don't have any knowledge of extramarital relationships or other risky behaviors (i.e. injection drug use) that occur during these absences (Hirsch et al., 2002). Often, participants had long-term partners whom they described as risky due to a constellation of these factors.

Therefore, my study evolved into a specific investigation of how migrant farmworker women perceived and responded to HIV risk within the context of their close, long-term relationships. Not all women in this study were formally married in the church or by the state, but all referred to risky relationships with a close, long-term partner whom they called their "husband." Women considered themselves to be in marital relationships because they themselves were committed to monogamy, they shared a home with him, they expected to share

resources with him, and they had children with him. In California, marriage is legally defined as a civil contract between two persons 18 years of age or older, who give consent and are issued a license. A license is a document issued by the county clerk and registered with the county recorder (California Family Code, section 300-310). Anecdotally, some participants informed me that they had chosen not to marry formally for a number of reasons: they lacked the legal documentation to register with the state; they lacked the funds necessary to host a wedding; their families were across the border and could not attend; they were "too old" and were already living the "married life," rendering marriage unnecessary; or a combination of these reasons. When marriage *was* important to women, it was usually most important that they marry in the Catholic Church -- in front of God, their priest, and their families. Legal marriage -- as recognized by the state -- was not a commodity or a status that women valued.

All participants had been in at least one monogamous, long-term, intimate relationship with a man that lasted more than one year. While in that relationship, 65% of participants knew or suspected that their partner had been unfaithful, 25% knew or suspected that he had had an STI, and 50% had experienced intimate partner violence. Approximately a third of the sample (30%) reported a lifetime history of STI and most of these women believed it had been acquired from a primary partner or were unsure of its origin.

Women in this study had an average age of 41 (range = 24 - 59), and had lived in the US for an average of 19 years (range = 8 - 51). Most lived in a trailer that they owned (40%) or rented (25%), but some lived in an apartment (20%) or were living out of their car (15%) at the time of our interview. Participants had completed an average of seven years of education (range 0 – 13; SD = 4) and reported earning an average of $1,789 monthly including public assistance. Just over half (55%) of the sample felt that their income was sufficient to meet their needs. All

participants were born in Mexico and although many had accompanied their parents on work-related trips to the US as young children, the majority who had come to the US for the purpose of settling, arrived as adults. Two participants (10%) identified themselves as indigenous. Table 2 (Appendix J) summarizes all demographic data.

All participants were mothers, and 7 (35%) had children living on both sides of the border. Most women were partnered at the time of our interview (80%) and of these, nearly half (44%) had experienced living apart from their partner in the last year (for at least one consecutive month), or anticipated having to do so in the next six months because of employment in different geographic regions. Although not asked about documentation status directly, almost half of the sample (45%) spontaneously identified that they were undocumented (either entering without permission or overstaying a visa). Documentation status was essential information that women felt they needed to disclose in order for me to gain a holistic perspective of their lives.

Only two women (15%) had been employed year-round during the last year; the rest had experienced multiple periods of unemployment during which some were able to apply for unemployment benefits from the state and others relied on a partner's income. The majority of participants (85%) worked as pickers in the field or packers in a packing room. The remainder worked either in a position of mid-level authority as punchers or checkers (10%), or were employed outside of farm work (1%) at the time of our interview.

Almost half of the women in this study described themselves as being the sole breadwinner in their household, either because they were single and supporting children or grandchildren, because their partner was unable to work, or because their partner was working but not contributing to household finances. Two other participants were single with grown

103

children, so they worked to provide for themselves. The rest of the sample had a long-term partner with whom they cohabitated and shared household expenses.

This sample was comprised of four women who were currently en route from their home base for work, 11 women who had a home base in the Green Valley but planned to travel north for work in the next six months, three women who had previously travelled for work but who planned to stay in the Green Valley for the foreseeable future, and two who lived in the Green Valley and were unsure about their future migration plans. Because of the desert climate in the Green Valley, farmworkers had difficulty finding work during the months from June to September. This explains why most women had plans to travel outside of the Green Valley for work within the six months following our interview.

Most participants viewed travel for summertime work as necessary in order to "make it." They were not able to find work during the hot summer months, would not receive unemployment (or if they did, it would not last all three months), and lived paycheck to paycheck. Being out of a job equaled no food on the table. As one woman said,

> The situation I'm living in makes me – I have to go [north] to work, because like I'm telling you, I can't do it all with the kids, there are so many expenses, and I can't be here and not work. And here, the work stops [for the summer]; there is no more.

Conclusion

I spent time becoming familiar with the community in the Green Valley in order to understand the context within which women were navigating their risky relationships. The migrant farmworker women who participated in my study were struggling to survive economically, many had fragmented families with children living across the border, and all were living mobile lifestyles in an uncertain world. Their ability to provide for their families was

dependent upon climate changes and the ever-present possibility of deportation among those who were undocumented. However -- as I will show in the next two chapters -- women faced these difficulties head-on as they worked to expand their perspectives of HIV-related intimate partner risk and acted to gain leverage over that which threatened to harm them.

<center>**Chapter 6:**</center>

<center>**Results Part II**</center>

<center>**Expanding Perspective:**</center>

<center>**How Migrant Farmworker Women Perceive and Understand HIV Risk**</center>

Introduction

This study focused on women who experienced partner-related HIV risk, and their

perceptions of this risk. During interviews, women spontaneously described how they came to

realize that their relationships were risky – meaning that they had experienced migration-related

separation, infidelity, intimate partner violence (IPV), and/or sexually transmitted infections

(STIs) in a relationship with a close, long-term male partner. Women referred to these

experiences with risky relationships as the "it," or the "what" of our interview; "the thing" which

was once hidden but which became clear as they engaged in a series of cognitive and emotional

phases on a continuum from perception to understanding. This continuum was a process that

ultimately expanded their perspectives over time. While describing this process, women used

language indicating they were previously unable to "see" that their close, long-term relationship

had become risky. But there was a point at which women discovered that their relationships

were risky, through their connections to social information networks and through "playing

detective." Next, women weighed their priorities and adopted a risk perspective -- they chose to

either confront risk or to overlook it. Finally, they assessed how risk was affecting their children

and their selves and often revised their perspectives accordingly. Each phase had interactive

properties and dimensions that expanded a woman's perspective little by little as she moved

through the process towards "seeing" risk.

Of course, not all participants recognized and evaluated their risky relationships in the same way. Because the women enrolled in my study were at various stages in their relationships with a risky partner and were also at different phases in their ability to "see" risk at the time of our interview, I was able to hear women's perspectives over a range of experiences. The majority of women (N=16) were partnered at the time of our interview with a man they identified as being risky. Some of these women either did not want to leave their partners or felt "stuck" in the relationship. A few were in the process of negotiating the drawn-out closure of a risky relationship (e.g. living apart but still maintaining their sexual relationship, or living together but sleeping in separate beds). Others told of initially leaving a risky partner but then getting back together. Finally, the last group of women had ended their previous relationship with a risky partner and were now either single or with a new partner. Of those who had previous experience with a risky partner, only a few participants (N=4) felt that they were not experiencing any form of partner-related HIV risk at the time of our interview -- three of these women had gotten out of such unsafe relationships and were in new relationships they did not consider to be risky. The fourth woman's risky partner had died.

Throughout women's experiences, it became clear that they adopted a particular stance in relation to their partner's risky behavior. The majority of participants (N=13) had overlooked risk at some point during an unsafe relationship. Some went on to open their eyes and confront risk, while others were still actively overlooking risk in their relationships at the time of our interview. Still others referred to always choosing to keep their eyes wide open and confront risk from the moment they first discovered that their relationship was risky. The fact that participants adopted different stances towards their relationships, were at various stages in their relationships,

107

and were also working through various phases of "seeing" risk provided breadth and depth to my analysis.

Because women were at various phases of perception and understanding in response to partner-related risk at the time of our interview, I gained a nuanced understanding of the processes by which women saw and responded to partner risk. As I heard woman after woman describe her experiences, I could see that women were engaging in a process that went from being blinded, to making the discovery, to weighing priorities, to adopting a risk perspective and assessing the consequences (see Table 3 in Appendix K for a taxonomy of the phases in this process). These phases were fluid; not necessarily sequential. First, women described how they were initially unable to "see" or recognize that a relationship had become risky; as if they were blinded to what was happening because of their own vulnerabilities. Vulnerabilities included lacking connection to social information networks, being naïve, and learning about relationships through trial and error. Over time the relationship came into partial focus, and women made the discovery that their partners had become abusive and/or unfaithful. The blindfold was removed. However, some women replaced the blindfold or looked the other way after weighing their priorities, perceiving that matters of survival and of maintaining their respectable identities necessitated that they continue on in their risky relationships as if nothing had happened. Finally, women assessed the consequences of their risky relationships -- according to how risk affected their children and their own selves -- and sometimes were able to confront risk with eyes wide open as a result. Retrospectively, some women expressed regret over not having chosen to confront risk earlier in their relationships.

Phase I: Being Blinded

Women referred to a time when they could not see risk in their relationships. As women looked back over their lives and tried to understand why they could not see risk, they found that the concept of being vulnerable was useful to them. Women looked back on their relationships and, in retrospect, could see that their own vulnerabilities prevented them from understanding that a relationship was risky. Vulnerabilities included aspects of the self that could be blinding, preventing women from seeing the reality of their circumstances. These vulnerabilities arose from isolation and knowledge deficits.

Lacking connection to social information networks. Women agreed that their lack of exposure to information about sex and relationships during both childhood and adulthood had a negative impact on their ability to see risk in their relationships. This connection to social information networks included relationships with family and confidants as well as access to information that was shared and maintained in the social sphere.

Women in this sample described how they lacked connection to social information networks over two separate time periods of their lives: growing up as children in rural Mexico and later living as adults in the US. As children in rural Mexico, women felt isolated from information and social learning. They also experienced silence about sex from the older female role models in their lives. As adults in the US, women felt isolated from family members, lacked positive relationships with their mothers, saw sex as a taboo topic, and felt unable to talk about their struggles with others. Overall, women felt as though they had to learn about relationships and risk through trial and error. Without strong social connections to others who could provide insight into their experiences, women felt alone in learning how to recognize and understand risky relationships.

Feeling disconnected as children living in Mexico. Some women who married young looked back on their childhood in rural Mexico and believed that their primary vulnerability arose from social isolation. In extreme cases, some women were not sent to school as children. This lack of interaction with social learning promoted their feelings of isolation and stunted knowledge at the time of their first intimate relationship. With sparse transportation and geographically distant neighbors, women had limited access to social experiences from which they could learn. This negatively impacted how they were able to form opinions and ideals about relationships. As one woman said, "We had always lived on a farm...and nobody ever came near, nobody ever talked to us, nobody ever told me about those things [sex]. Nobody." This feeling of naiveté continued into adulthood, until women told of being exposed to information in the US. Another woman said, "You come up from Mexico all innocent and dumb, like they say. You don't know anything about anything. I came from my *rancho*, I didn't know a thing." Women felt as though their childhoods in rural Mexico were devoid of information about sex and relationships because they were isolated from social information networks.

As children and young adults in Mexico, women's perspectives about sex and relationships were shaped by social isolation and were compounded by silence about sex within the home. Looking back, women believed that the older women in their lives -- their own mothers, grandmothers, or mothers-in-law -- were the ones who should have imparted information to them regarding relationships, love and sex. But these older women were silent. Women saw this silence about sex as a contributing factor to their heightened vulnerability and their inability to "see" risk.

110

One woman summarized her pre-conceived notions regarding relationships and her lack of any concept of intimacy. When she embarked on her first relationship at age 14, her imagined role as a housewife was shaped by what she had seen modeled by her own parents. Imagining her new relationship, she believed that, "All I have to do is cook." She went on to explain to me that, "I didn't know what sex was. I had no idea I was going to have sex, or that it even existed...I said, 'Oh, how nice. All I'll have to do is cook his food, that's nice.'" Regarding what she had learned from her own mother about being a woman, she says, "All I knew was to stand over a washboard...I couldn't have any concept of what love was, or couples, or anything like that." Her mother had taught her about her household duties as a wife -- how to serve a husband and keep a clean home -- but had not imparted information or modeled behavior regarding the relational aspects of a marriage. Essentially, women felt that they had to learn about intimacy, love and risk on their own. And women felt that they continued to be engaged in a cyclical process of silence about sex. They believed that their mothers did not give advice because they themselves lacked role models and information. One woman remembered that,

> My mom never gave me any advice about these things...nothing, ever. She herself says,
> 'I never even knew how to protect myself.' When she got married, she says she didn't
> know which end a baby came out of. Imagine her, giving advice!

Feeling disconnected as adults living in the US. As adults living in the US, migrant women continued to feel disconnected from social information networks. Women told of not engaging in conversations with their peers on topics surrounding sexual intimacy because it was considered taboo -- particularly according to older women who held more traditional views. When given an opportunity to share intimate details of their relationships during our interview, women often did so with what I consider "eager reservation." It was obvious to me that although

111

they were eager to have a safe space in which to talk about sex either "woman to woman" or "woman to nurse," they had to push through their own reservations in order to do so. They felt they had to tread carefully in order to avoid crossing some kind of invisible social boundary into the "inappropriate." Using anatomical words for the male and female body and the sexual act was difficult--even euphemisms or nicknames for "penis," "vagina," "orgasm," or "sexual intercourse" were often whispered softly under their breath.

Some women were more self-assured and used anatomical terminology, but only after stepping lightly around the subject and hearing me use anatomical terms first. When I would ask for clarification ("are you saying you never had an orgasm?" or "do you mean that he had sores on his penis?"), it was like I was giving women permission not only to use anatomical terms but also to speak more specifically about the topic. In asking for clarification, and also by not appearing flustered when women did use anatomical terminology on their own (as if they were "testing the waters"), I opened the door for women to be more candid and share without fear or reservation. But the bottom line is that it was very obvious that women were not accustomed to sharing intimate details of their lives with others--sex and sexuality were viewed as private and socially inappropriate topics. Although a few women felt that they should be able to talk about sex and sexuality with their peers, most women told me they believed that issues pertaining to their reproductive organs should only be brought up with a physician or a nurse. While some women may have felt comfortable talking candidly with me because I am a woman, others indicated that they only felt comfortable discussing their reproductive health concerns with me because of my status and experience as a health professional.

One woman felt angry that conversations amongst her peers on the topic of intimacy were so few and far between. She believed that silence about sex in the Mexican community

112

contributed to the fact that she never knew about an orgasm in her first sexual relationship. She wondered out loud, "If you don't even know [an orgasm] exists, how are you going to reach it?" She said, "My grandma [who raised me] never talked with me about it. And I assure you, she probably didn't know [what an orgasm was], either!" She recalled an instance where she was talking with a friend her own age and an older women of 60 about oral sex and orgasms. She remembered that the older woman, a mother of 12, asked if an orgasm is something that "you eat or drink," as if orgasm could be achieved via culinary delight.

Even though some women did not share this need to discuss sex and sexuality with their peers, all women expressed feeling alone in their struggles with risky relationships because they felt they had no one else with whom they could safely share. Most women lacked a confidante with whom they felt able to share. And even though others may have suspected that something was going on in their lives, women went to great lengths to conceal the truth because they thought "no one will understand." One woman recounted that she was living with her mother during a period of intense spousal abuse, yet she felt unable to divulge the truth about the abuse even when her mother asked. She said,

> While we were there with her [at my mom's house], we had gotten to the point of arguing really loud. Really loud, and my mom asked what was going on -- why we were arguing so -- but I couldn't tell her. Why should I tell her and make her worry? That he didn't care anymore if I wanted to have sex or not, that he would just take all my clothes off and do whatever he wanted, [and] I couldn't say anything. Or why he'd get home and squeeze me so hard he'd leave his handprints there and I'd have to wear shirts up to here (*pointing to neck*), so the kids wouldn't see. And sometimes he'd even bite me, and I was

113

left all -- and I'd cry, but all alone. Because what could I do? When you're in a situation like that, you can't tell anyone about it because you think no one will understand.

And even more than feeling as if no one would understand, women feared that their private secrets would make them an object of public slander once they were retold in the form of gossip. Very few participants had a trusted "other" with whom they felt comfortable sharing. Because women thought they could not tell others what was going on in their intimate relationships; they carried the truth like a burden. Given the fact that gossip was so widespread in the migrant community in the Green Valley, women preferred to maintain their respectable identity at the expense of "lightening the load."

However, provided the opportunity to share during our interview, women were eager to tell details of their relationships that they had never before shared. Many women saw our interview as a way to "get some of this off my chest." Our interview provided a safe space where women felt they would not be judged and where many hoped to obtain advice. Often, once the audio recorder was off, women would seek advice or information from me as a nurse, or, as one woman put it, "woman-to-woman." The combination of my status as both a woman and as a health professional helped women feel comfortable opening up about their relationships.

I observed that study participants who lived in close proximity did not appear to know that their stories were similar. Laura and Mariana lived across the street from one another in a low-income housing development. Both had young children enrolled in Migrant Head Start, both were picking grapes in the late spring when I interviewed them, both described their husbands as "*machista*" and emotionally abusive, and both women suspected their partners to be involved in extramarital relationships. Laura was in the process of separating from her husband, and Mariana had legally separated from her partner during the year prior to the interview but

their sexual relationship had remained intact. Their lives were like mirror images. They each told me that they had only selectively disclosed their relationship troubles to certain family members. Both women also denied knowing anyone similar to themselves whom they could refer to participate in my study. And so, although they lived across the street from one another and likely had exchanged pleasantries while watching their children play on the local playground, or attended parent functions at the Green Valley branch of Migrant and Seasonal Head Start (MSHS), or seen one another on the street or even at the workplace, the likelihood that they had shared personal details with one another regarding their risky relationships was slim. It was clear to me that although gossip was prevalent, that women did not feel comfortable sharing with one another because they lacked a trusting, intimate setting in which to share. This contributed to how women felt blinded from seeing risk.

Being naive. Because women in this sample did not learn about relationships through social information networks, they lacked the necessary knowledge and tools to be able to see risk in their primary relationships. Women identified feeling naïve when they first partnered with a man who turned out to be risky, saying, "I had no idea." Women told of leaving home to be with a partner, and "not even knowing what you're going to" -- as if they had no knowledge whatsoever about relationships and risk.

However, most women who described themselves as naive did so within the context of their first intimate partnership. After this first relationship, and after having come to the US, women saw themselves as having "wide open" eyes -- because of their experience with a risky relationship, they had become knowledgeable. Women referred to a few dimensions of naiveté within their intimate relationships. One group of women characterized naiveté as a consequence of being a teenage bride. These women told of growing up in rural Mexico and marrying men at

young ages (between 14 and 17), and saw their youth as a primary causative factor for their naiveté. Another group told stories of naiveté as adults, after being together with a partner for quite some time but having never before experienced risk. These women blamed their lack of experience as the reason why they were unable to "see" risk in their relationship. A few women who had had previous risky relationships in Mexico still felt naive in their relationships in the US, primarily because they were unaware of the resources available to them in the US. All women, regardless of which stage in life they experienced naiveté, attributed their dearth of knowledge regarding risk to a lack of examples of reciprocal relationships.

Marrying too young to know better. First, those who married in adolescence identified age as the major factor in their lack of knowledge about relationships and risk. As one woman said, "I was just a girl, and had no way of knowing about suffering and abuse." She went on to relate how her youth was a contributing factor to her naiveté, saying, "I was 17 and didn't know what being in a couple was like. At that time he treated me bad, but I didn't even know it was bad and that he shouldn't treat me that way."   Another repeated that, "When you're young, anything blinds you." Reflecting back on the decisions they made, when they were young, women agreed that marriage in adolescence was a contributing factor to their vulnerability. One woman, who married at age 16, said,

> You sometimes don't think things through very well when you're that young...I shouldn't have done it, because it was too soon. I hadn't known him very long...I think I should have waited, I should have known him better, or been older in order to marry him.

"He was the first:" Lacking the experience to recognize risk. Without having others in the community to teach them about intimacy and risk, women had to rely on their own experiences in order to form relationship ideals. Other women who felt naive and had difficulty

116

"seeing" risk in their relationships as adults, attributed their naiveté to a lack of experience. Lacking experience with infidelity, IPV, or STI blinded women from recognizing clues. But after having experienced a risky relationship, women were more likely to be on guard the second time around. One woman gave the example of never considering condom use with her first partner, because she assumed he would be faithful. She said, "I never thought about it, since he was the first." But after experiencing infidelity, she had a frame of reference with which to question a partner and consider methods for self-protection.

Lacking examples of reciprocal relationships. Another reason women told of lacking information regarding relationships was because they did not have examples of reciprocal relationships. Most women did not remember seeing reciprocal relationships modeled by their own parents -- who were frequently absent physically and/or emotionally. In this way, women's relationships with their families affected how and what they understood about intimate partnerships. And this fractured relationship with family extended to the relationship that women had with their in-laws. After marriage in Mexico, women told how they would go live in their husband's home. The stories women told of living at their in-law's home were all characterized by mistreatment and misogyny.

Conclusion: Women learned about risky relationships through trial and error.
Participants told of an inability to see risk in their primary relationships because they felt blinded by vulnerabilities that arose from a lack of connection to social information networks and a resulting knowledge deficit. Without social connection, knowledge and/or prior experience, women reflected on their risky relationships and told how they were essentially blindfolded and unable to see or understand what was happening. Women told stories from their childhood in Mexico that highlighted feelings of isolation and sexual naiveté. As adults in the US, they

117

continued to feel isolated and believed that they had to remain silent when they experienced risk in their relationships because "no one will understand." This further compounded their confusion about the meaning of a quality, reciprocal relationship.

Overall, participants described learning about relationships, risk and reciprocity through trial and error. Because they were vulnerable and unaware, women described how their perceptions of risk developed slowly and haphazardly. Without those around them to teach them about relationships and risk, women's understandings were shaped as they experienced failure, not as they strategized for success.

Phase II: Making the discovery

Women referred to initially being blinded, but then told how they eventually came to see that their relationships had become risky as their perspectives expanded. Women described two interconnected actions that expanded their perspectives: connecting to social information networks and "playing detective."

Discovering risk by connecting to social information networks. Information that women gathered from the social sphere shaped their understandings of their most personal, intimate relationships. As women shared stories of how they came to discover risk in their relationships, they often told of an "other" who delivered information (in the form of gossip, experiences, or normative ideals) and enabled them to remove the blinders and see the truth come into sharp focus. Women's social selves constituted a great deal of their understandings of risk in relationships, as others helped to define their experiences.

In phase one, I described how women felt naive, lacked information and experience, and ultimately felt as if they had to learn through trial and error. Because of this, women relied on others to help define their experiences. Once they were connected to social information

118

networks and could participate in gossip and storytelling about intimate relationships, they were better able to understand the reality of their own circumstances. In the next section, "playing detective," women told how they sometimes interrogated others in order to glean information about a partner. But here, I am referring to a social network that women could tap into, where gossip, advice and other social narratives helped to shape their understandings of reality. Within this social network, women received information passively -- meaning that they did not actively seek it out -- like a well of water from which women could draw.

Alone in their homes, without input from and access to the outside world, women were not able to tap into social information networks that could have provided insight and perspective into their experiences. Despite the fact that there were very limited social platforms on which women felt comfortable disclosing intimate details of their lives and relationships, gossip and social information networks remained a major source of information and clarity for women in this sample. Gossip and information avenues provided a way for women to begin to see risk in their relationships.

Connecting to the general social network. First, women referred to a generalized "other" -- including neighbors and others in the community -- who related common beliefs, assumptions and gossip.   Women told stories indicating that it was only after "everybody" else realized his infidelity that they were able to see it for themselves. For example, one woman remembered that, "People would say things that opened my eyes, and I started to realize [what was happening]." She told how she would take her daughter to the bus stop or be on the way to work when neighbors would clue her in to things they were seeing that made them believe that her husband was using drugs and sleeping with prostitutes. Although this information came in

the form of gossip and was detrimental to her family's social identity, this input was critical to her understanding of her partner's behavior.

When another woman got together with her first partner at the age of 14, she did not really understand what was happening to her until the situation was explained to her by her friends and other women around her. She did not understand that sleeping at his house for three consecutive nights and losing her virginity meant that she had decided to "marry" him. She did not know that living with him meant that she would cease going to school and become a housewife. And she did not realize that her decision to leave home meant that she could never return; now a married woman, she had become the financial responsibility of her husband and his family. All these things were explained to her by her friends and older women in her life. And she did not realize that his physical abuse of her was not "normal" until much, much later when she shared her experiences with others.

Hearing others voice their concerns provided women who initially distrusted their own suspicions with an opportunity to really grasp the meaning of risk. For example, one woman admitted that while she had considered she could acquire an STI from her unfaithful partner, it was not until she heard her neighbor say, "You're going to be really screwed; you must have caught this, you must have caught that," that she accepted the gravity of her situation. She heard her own fears confirmed out loud. This prompted her to consider having an HIV test and also to demand that he leave her home.

Another woman whose partner was HIV positive saw her risky relationship more clearly through her interactions with other HIV positive couples at a local clinic support group. After seeing women in the support group die and also seeing teenagers contract HIV from a male

partner, she was better able to see her own risk and face the possibility that she could contract HIV from her partner. This realization prompted her to use female condoms.

Relying on family to monitor a partner from afar. Once connected to social information networks, women were able to monitor a partner's activities from afar. This was particularly useful for women who admitted that it was impossible to have firsthand knowledge of a partner's behavior during times when he worked up north and she stayed behind. This network could be accessed passively or actively--women could be the passive recipients of information sharing via gossip, or they could actively seek out such information to either confirm or refute their suspicions. Social networks were very involved with information regarding infidelity when, as one woman said, "somebody passes on some gossip, you know, like somebody's husband is going around with other women." Information trickled through the social network and when women were connected, they were able to access it.

The family provided a social network that was integral to how women discovered and understood intimate partner risk within the context of work-related separation. Even when separated by the international border, family members (parents, siblings, children, aunts, and even nephews) would keep a watchful eye on women's partners and alert them if they saw any questionable behavior. Noteworthy clues included seeing him with another woman in public, noticing that he did not come home at night, or seeing him leave another woman's house early in the morning. In this way, social information networks alerted women to a partner's infidelity when geographic distance prevented her from seeing his behavior firsthand.

Discovering risk by "playing detective." Information gleaned from secondary sources was not satisfactory for most women; they felt that they needed to confirm this information with firsthand knowledge. Women differentiated between primary knowledge ("seeing it with my

own eyes") and secondary knowledge (hearing "things *they* might tell you") and viewed primary knowledge as the most true and important. As one woman said,

> Sometimes *they* might tell you things, and it isn't true -- maybe it is, maybe not. I mean, I'm always going to have doubts right from the moment somebody tells me, 'Your husband's going around with someone.' So you start playing detective, right? To catch him.

In this way, study participants described a kind of trial where a partner was innocent until proven guilty. They listened to key witnesses, examined the evidence, and ultimately determined the veracity of the accusations against him. While social information networks may have provided or even confirmed women's initial suspicions, most were prompted to "play detective" and uncover additional clues on their own. In doing this, women sought physical clues, interrogated him and interrogated others.

Only a few women in my sample told of actually catching a partner in a risky act, either by accident or on purpose. A couple of women accidentally encountered a partner injecting or smoking drugs -- one woman found her partner passed out on the bathroom floor with a syringe in the crook of his arm. Another woman suspected that her husband was cheating but it was not until she "actually saw" him with his mistress in public -- in plain daylight -- that she was able to confirm her suspicions. Others purposefully investigated, hoping to catch him in the act so they could have evidence to confirm their suspicions. One woman woke up in the middle of the night hearing women's voices in the backyard near her husband's tool shed. Deciding to investigate, she said, "I went and looked out and heard him talking with a woman. I knocked on the door and said, 'What's happening?'" She saw him selling drugs to a woman whom he identified as a "prostitute." After catching a partner in the act, women felt that they were no longer in the dark.

They felt empowered by seeing his behavior with their own eyes, because "he couldn't hide anymore." Once their eyes were opened, women felt that risk was illuminated and they were no longer in the dark.

Looking for physical clues. Women placed priority on physical evidence that they could see with their own eyes. Evidence that could be seen -- particularly that which could be seen by others in the public sphere -- was of utmost importance. Sometimes women perceived that something was different about a partner before actually finding physical evidence to confirm an affair. Women told of thinking initially that, "Something really strange is happening with him." But these suspicions alone were not enough to provide clarity; most women needed to see evidence of an affair with their own eyes.

Observing his attitude and behavior. In most circumstances, women had to rely on clues to substantiate his sobriety and/or his fidelity -- or the lack thereof. Some clues came from a man's attitude. Women believed that unfaithful men experienced a change in their demeanor: they became either "angrier or nicer." For example, women believed that a partner's reaction to the news of STI infection was indicative of his guilt. If he became "angry, it's because he was doing something wrong...he's guilty, probably." But if he said something "sincere" and was concerned about her well-being, then he most likely was not to blame for the infection. If he was not to blame, women would enter a state of denial and look for other excuses that could explain the infection. Because sometimes, denying the possibility that he was guilty was easier to accept than facing the reality.

Other clues came from a man's behavior. A man who openly flirted with other women or spent unexplained time away from the family was likely to be a cheater. For example, one woman saw her husband flirt with other women at the workplace and suspected that, "Because of

123

the way he acts, I'm afraid he might be cheating on me; [he] might be unfaithful, and at the same time, become infected with something." She also told how she had, "Heard him say that anything that moves, if it gives him a chance, he'll do it; it turns him on...[so that] makes me afraid that he could pass something on to me." Another woman explained how she came to doubt her husband's fidelity when he arrived home from working up north much later than she expected. She said,

> It was eight in the morning when he told me he was on the way, and he finally got home
> at eight at night. And he had hickies all over his neck, and I said, how strange he left at
> eight in the morning. It's a three-hour trip, tops, even with traffic.

In order to confirm that her partner had not paid for sex while visiting a strip club with his work supervisor, another woman reviewed her bank statement to ensure that he had not withdrawn money that day. She was able to track their money since they had a shared account. She concluded, "I know nothing happened, because that place is really expensive...I would see if he took money out or not, so I knew he hadn't paid for anything. So that's how I can be sure he didn't do anything." And since "he never has any money" because his paycheck is deposited into their account via direct deposit, she felt certain of his fidelity to her.

Once women started to suspect that a partner may have been cheating, they adopted a vigilant stance and kept "guard" on him whenever possible. For example, one woman saw her husband try to hide from her while flirting with other women while at work in the fields. But she dryly noted that he could not truly hide because she kept an eye on him at all times. She said, "He hides; he thinks I don't see him. He thinks I don't see him, but I've got sharp eyes...It's really ridiculous to have to keep a guard on him."

124

Noticing clues on his body. Physical clues often confirmed women's suspicions. Men could display visible signs of an affair: hickies on their necks, photographs and letters in their wallets or lipstick on their shirts. Men could also display telltale signs of drug abuse that women came to recognize as familiar. One woman remembered coming to a point where she thought, "I could see it in his face, and I'd say, 'He's doing drugs.'" These physical clues included sleeping "all day," and getting "really skinny." Another woman remembered the first visual clues that made her suspect that her husband was sick. She said, "I started seeing how bad he looked, his mouth and tongue were white, really white, and I said, 'Let's see a doctor.'" He ignored her suggestions for quite some time before he finally agreed to a check-up. He was diagnosed with AIDS. Unfortunately, this diagnosis was her first clue towards discovering that he was a former injection drug user and had had multiple sex partners.

Using the clinic as a private detective agency. STI diagnosis in either partner was a turning point for women who previously were not able to see a partner's infidelity or other risky behavior. Women viewed the health clinic and its providers as tools for gathering information, because, as one woman said, "If something is wrong [with me], then it'll be obvious that he has been screwing around." Sometimes, detective work was the primary objective for STI testing over treatment. Evidence of an infection often indicated to women that their partner could have been unfaithful.

However, women also described instances in which their own STI diagnosis did not ultimately lead to discovery of an affair, because they heard physicians provide alternate explanations for their illness. For example, one woman told of a time when she was diagnosed with an STI in the first few years after marrying her husband. Confused, she "played detective" by questioning the physician how she could have acquired it since she and her partner were

125

monogamous. The physician's explanation of a dormancy period was enough to confirm her

trust in her husband's fidelity -- she never even considered the alternative. Since he "swore to

me that he had never been with another person" during their relationship, but admitted that he

had had a previous relationship prior to theirs, she felt affirmed in her trust for him because of

the physician's suggestion that the infection could have remained dormant for a period of time.

Another woman also relied on the physician to be a main witness in the trial against her

husband. She "made" her partner "go to the doctor to get checked out for any infection," after

she herself was diagnosed with a vaginal infection of unknown origin.   But since he was "fine,"

she was at a loss for how to explain the origin of the STI that she acquired. She deduced that the

infection could not have come from him since he was not infected, but she was at a loss for how

to explain her own illness since she had never been intimate with anyone else.

Interrogating him. Another way that women "played detective," in addition to looking

for physical clues, was to confront and interrogate their partners. For example, women who were

separated from their partners for seasons of migratory work thought they needed to keep tabs on

his behavior during these extended absences. One woman described how she questioned her

partner and also talked to the friends that he traveled with, because, "when he leaves, I don't

know what he does." She told about a couple of times when she spoke with him on the phone

and perceived that "he was drunk." She used her prior knowledge of him along with questioning

in order to try and figure out what was going on. She asked him,

> 'Have you been drinking?' And he said 'No'...And I said, 'Yes, you have...and I hear
>
> music.' And he said, 'No.' And I said, 'Yes.' So that's why I think he was [cheating]. I
>
> mean, he had to be! There he was, drinking, music in the background, and alone?

When another woman's partner returned from a three-month visit to Mexico, she noted a change in his behavior that caused her to suspect something. She confronted him, asking "So, what's going on?" but did not get any answers. Next, she went through his wallet when he came home drunk one night. Discovering a photograph of another woman with a letter, she confronted him with the information. She explained to me,

> I opened his wallet, and in there he had a photo of a woman who wasn't me. He had her telephone number, her address, and a letter. So I took the letter and read it, he was asleep and drunk, and I was so angry, I cried, and I didn't want to wake him up, but I was so overcome with grief that I shook him. And I told him to explain what I was looking at. He sure came to pretty quick, and he said jokingly, 'No, it's not what you think,' one thing and another he said...He told me, 'Look, things aren't like what you think.' And he invented a thousand reasons, saying it wasn't true. I said, 'Do you think I was born yesterday? Don't think so.' Whatever.

Interrogating others. Women also used their connection to social information networks to corroborate their suspicions. In light of the fact that women did not trust their partners to tell the truth about an affair, they felt that they needed to question others in order to get the whole story. For example, one woman felt that she needed to glean information straight from the source: she actually called her partner's mistress on the phone to find out the truth, since she felt that her partner was just "tell[ing] me all kinds of lies." Another woman suspected her partner of cheating since she had been diagnosed with an STI shortly after he was released from jail. In order to confirm her suspicions, she decided to ask around. She says, "I went out, over to the little shop [in the trailer park], and a friend of his told me he had found him with that girl, having

127

sex, the same day he came home from jail." This information was enough to convince her of her partner's guilt.

Discovering risk by examining spaces and places. In addition to connecting to social information networks and "playing detective," women also told of discovering risk by examining spaces and places. Spaces were not neutral geographic areas, they were dynamic polar entities that conferred meaning. In this sample, migrant women defined spaces not by geographic boundaries, but by pragmatic value, moral value, and relational value. What mattered to women was not where a space was located on the map. What mattered was the utility of that space, whether the space was classified as "good" or "bad," and who moved in the space and had the potential to make it safer or more dangerous. Women classified and organized spaces in order to make sense of the world, using opposites to label and understand it: space was useful or worthless, space was good or bad, people within the space were safe or dangerous. In this way, spaces came to bear their own reputations and had their own ascribed value. Therefore, knowing which spaces were frequented by a partner helped women in their discovery and determination of his risky behaviors. Women described two general spaces in which they understood intimate partner risk: actual geographic locations "outside the home" and space that existed between partners.

"Outside." Outside the home was risky when compared with the safety of being inside. When a partner either came "in from the outside," or started "going out" -- particularly to specific spaces that women considered to have low moral value -- women lost trust and began to see that he may have been cheating or that his behavior towards her was abusive. One woman, referring to how her partner became involved in drug use outside the home, said, "It was awhile here that we lived in peace...but then he began to go out, and meet people who had been here for

128

some time, and who were addicts. And from then on, our family started going downhill."

Another woman, who saw her husband get involved in an affair outside the home, said,

>It's really hard, because sometimes your husband comes in, and you see he's been with
>
>another woman, and that's the way things are. You're there at home, but he comes in and
>
>you don't know with how many women he's been, nor what he's done.

The comparison of her presence within the safety of the home and his absence while visiting

others outside the home assisted in her understanding of risk.

Space between partners. In addition to considering spaces outside the home and/or

outside the relationship to be risky, women also referred to spaces between partners that were

indicative of risk. Spaces between partners that occurred during migration-related spousal

separation could incite risky male behavior. And emotional spaces between partners could be

indicative that his interest was elsewhere.

Women accepted that the absence of physical contact with a partner could result in

infidelity. When they were physically present with their partners (i.e. in the same town, working

at the same job, etc.), women believed that infidelity was impossible -- or, at least, difficult. But

when partners were physically distant from one another, women were more likely to have doubts

in their mind that their partner might be engaging in extramarital activities. For example,

Gabriela acknowledged that her partner had one mistress, but wondered if there were other

women in his life as well. She worked in the same field as her partner but they did not work side-

by-side. She said, "At work you see all kinds of things, so-and-so with so-and-so, like that."

She wondered if he could be "carrying on" with other women at the workplace. She said, "I

don't know. When I'm working, I don't work near him. I look for my spot; he has his." This

space between them -- when she could not keep a vigilant eye on his behavior -- created

uncertainty in her mind. However, the presence of physical space between partners did not always render doubt. In fact, many women believed that they could easily account for a partner's unseen behavior as long as *he* could give a believable verbal account of his activities. But in the presence of existing suspicions, space between partners was a clue that assisted women in discovering infidelity and/or alcohol/drug abuse.

Another absence of contact included physical intimacy: when women felt distanced from their partners -- even while sharing the same bed -- they wondered if his intimate affections were elsewhere. For example, when Yasmín's partner returned to their home in the Green Valley after a three-month visit to Mexico, she noticed that, "He was really distant with me, he wasn't affectionate." This, combined with the fact that he was constantly "going out" of the house with a friend after his return, led Yasmín to ask herself, "What's going on?" After "playing detective," she discovered that he had had an affair while on his extended trip.

At the time of our interview, Yasmín and her partner were still together. Having made up after this incident, she continued to question his fidelity to her years later. She noticed that he "puts the blanket between us in bed," and that they are "like brother and sister" because of their lack of intimacy. She sees him masturbate and wonders if that could also be a sign that "he's thinking about somebody else." She recently had "a really bad vaginal infection" of unknown origin. She wondered if it could have come from him, but discounted her suspicions after hearing a doctor in Mexico tell her that it had not come from him. As a result of all this, she admitted through tears that, "I have no desire to be intimate with him." She felt the effects of a great divide between them. She said, "I don't know what is happening...I don't know what to think. A thousand ideas come to mind." One of these ideas was that he might be cheating again, although she was afraid to say these words out loud.

Phase III: Weighing Priorities

After making the discovery that their relationship was risky through connecting to social information networks, "playing detective" or examining spaces and places, women went on to weigh their priorities. Subconsciously considering their priorities was another action that helped women to expand their perspectives, even though sometimes their gaze paradoxically narrowed as a result. Often, women's desire to survive -- both in terms of practicality and in terms of respectability -- trumped the desire to confront a risky relationship. This prompted women to overlook risk and discount their own suspicions.

Considering risk in terms of identity. While telling me stories of how they discovered and understood intimate partner risk, women referred to the ways in which they thought about identity. The fear of a tarnished public identity was enough to prompt women to overlook abuse and infidelity in their relationships. Women also constructed their concept of HIV-related intimate partner risk by considering typologies of "shameful" others in comparison with their own respectable selves.

Fearing a tarnished public identity. Although access to social information networks was integral to helping women see risk in their intimate relationships, gossip conditioned how women assessed their own meanings of risk. Gossip was concurrently viewed as hurtful and formative -- women's judgments and decisions were shaped by how they felt others viewed them. They felt intense shame at being made the object of gossip. Some women voiced worries that their own identities could be tarnished by gossip about their unfaithful partners. One woman told how she had become the brunt of neighborhood jokes after others in her housing complex saw her partner leaving another woman's apartment early in the morning. At the time of our interview, she was still living the effects of his affair, seeing other women make faces and laugh at her when she

131

went out in her neighborhood. When another woman acquired an STI from her partner, she felt that, "I couldn't go out because everybody knows me." She did not want anyone to discover that she had an STI, so her respectable identity would not be tarnished. She worried that others could somehow see that she was sick, or discover her secret just by looking at her.

A third woman believed that since her husband lacked self-control and would easily "get all excited" if another woman propositioned him, that there was a fairly high chance he would cheat during his extended trips up north for work. She assessed that an immediate consequence of his infidelity would be that, "Then the gossip starts, that 'so-and-so was shacking up with so-and-so.'" She considered that gossip would be devastating to her reputation and to the reputation of her family. Because of this, during our interview, she was actively engaged in overlooking the possibility that he was having a second affair.

Although gossip could impart knowledge of an affair or an STI, physical wounds would let the world know that a woman was being abused by her husband. Women perceived that a physical wound would proclaim evidence of an intimate squabble to the public world -- to children and also to neighbors, family, and strangers. One woman thought she was able to hide the evidence from her children until her husband hit her in the face and gave her a black eye. She said, "Before, they didn't see what you used to do to me, but now it was all over my face. And what am I going to tell them? I have to tell them what happened." Women told of wearing long sleeves and scarves to hide wounds on their arms and necks, but found that wounds on the face and hands were impossible to hide. Sometimes, women admitted that they would stay inside in order to avoid the shame of "what people would say when they saw me."

Differentiating self from "shameful" others. Women in this study used the term "prostitute" to refer to a myriad of women who were different from themselves, not simply to

132

refer to women who made a choice to work in the sex trade. The term "prostitute" was a vulgar, negative term that referred to a group of women who were considered to be shameful, who chose to have sex with multiple men for their own pleasure, and who "took" from men instead of participating in a reciprocal relationship. Most participants denied that "other women" had sex in exchange for money in order to survive, saying "It's not for the money. Often it's because they want to." In addition, "prostitutes," "easy" women, or "streetwalkers," were characterized by the fact that they had "had one, two, or three husbands. You know. [They] like to be with one guy, then another...they're the ones who love parties." Women described how being a "shameful" woman actually meant being *sinverguenza* ("shameless") and selfish. A woman who was *sinverguenza* would earn money from sex as a kind of hobby, and spend the money on herself. As one woman said, she would be *sinverguenza* if she would "buy a wig and go dancing, get extensions for my hair, buy some shoes, and my kids have nothing to eat, but at least I bought what I wanted." This was considered selfish, since not only were a "shameful" woman's children not receiving what they needed, but she was creating a bad reputation for herself that they would also bear.

Women in this study did a lot of blaming of other types of women – "*those* women" or "shameful women" or "prostitutes" – who caused men to go astray or who made the world a riskier place for "respectable women." Women were more likely to blame another woman than they were to blame their partners for infidelity and/or an STI, saying "It's *her* fault, it's not [his] fault." For example, Ines viewed the "other woman" – the person with whom her partner cheated – as a "prostitute," as "someone who is not honest" and who "came in" from the outside and damaged the relationship "just to stir up trouble." She clarified that a "prostitute" was "a person who likes to go out with one man, then another. Not a good person. Someone who leaves her

children to be with a man." In the absence of this outside meddling, Ines perceived that she and

her husband had been "living together so happy." In her eyes, it was the other woman's fault that

her husband had cheated and that the relationship was damaged.

In contrast, if a man had an affair with a respectable woman, then there was no need to

worry about contracting an STI because he was considered "safe." Only "shameful" women had

STIs. For example, Amalia knew that her partner had been cheating on her for years. She

spontaneously brought up the topic of HIV during our interview, and noted that migrant women

are at high risk because they often have risky partners. However, Amalia denied that she herself

was at risk for HIV, even though she identified that her partner had been abusive towards her and

had also had a long-term affair with another woman. She never once thought it was necessary to

be tested for any STIs including HIV, because she so strongly believed that a woman with a

respectable identity was risk-free. Amalia told me that since she knew her partner's mistress,

and because this woman was a respectable housewife, that her husband's parallel monogamy was

protection enough for her. She saw no chance for HIV to enter the relationship because she

trusted her partner's mistress to be safe.

Throughout our interviews, women were constantly engaged in a process of identity

preservation while comparing themselves with "other women," saying things like, "I'm not one

of *those people* who goes around a lot, from here to there. I don't like that; I just stay here at

home, go to work, make our meals, go to the store and come back." Another woman noted that

she was different from "other women" because she was a family woman. She said,

> You see the women and how they come around, with their little halters, the blouse with
>
> no bra, or the short little shorts, with no underpants – almost all of them come from
>
> Mexico, alone. And they don't have anybody, no mother or father who came with them.

134

But we're different. We've always been here as a family with our kids -- or we moved

here -- all of us together.

Through this constant comparison of self to others, women were constructing and

affirming their own respectable identities. As one woman said, "Wherever I go...people know

me and respect me, because I earned it. My girls never had to see me -- today one man,

tomorrow another." Even though she experienced two violent relationships, she felt pride in

telling me, "Everybody knows me as a serious person. Even with everything he did to me, I

never -- never! -- let a man flirt with me or come on to me. The fact that my husband was in jail

or he treated me bad didn't mean I could bed down with somebody else, no!" Insinuating that

her respectability came from her fidelity to her husband -- regardless of his own behavior -- she

was differentiating herself from "other women" who chose to have extramarital relationships for

reasons that she would consider to be less worthy.

Because only "shameful" women got STIs, and because women also worried that their

own identity as caring wives could be ruined by accepting that their partners were indeed abusive

or unfaithful, many participants chose to overlook risk at some point during their risky

relationship. They purposefully averted their eyes in order to preserve their respectable identities

-- both to themselves and to the social world.

Considering risk in terms of survival. The second priority that women weighed was

that of survival. Women's primary ideal for relationships was that they be reciprocal, mostly

because they were so in need of help in order to survive day-to-day. Women needed partners to

provide tangible help and to share resources in a constant form of give-and-take. In all their

relationships with others (intimate and otherwise), women viewed and measured commitment

through the exchange of helping gestures. In other words, when a woman received help from a

135

partner, family member or friend, she was able to see the value of that relationship. Reciprocity was the purpose of relationships -- as one woman said, "that's what a partnership is for."

Therefore, when a partner did not provide reciprocal helping in a relationship, women realized that his love and commitment to her was lacking. In the absence of reciprocity, women thought that the relationship was worthless and therefore they were motivated to confront risk with eyes wide open. However, when a risky partner continued to provide reciprocity, women were more likely to continue the relationship because they highly valued this help.

At times, women told of feeling naive in their quest to partner for survival. They did not know that there were alternative sources of help available to them, and chose to partner with a man "out of necessity." For example, Laura described her decision to get together with her partner at a time of dire need. She had left her previous partner after being "exploited" by him, she had a newborn child, she was homeless, and she was living with a woman who was "really mean." The woman was trying to convince Laura to give up her newborn's social security number in exchange for room and board. Laura summarizes the situation by saying, "I didn't know what to do...and I didn't have any place to go...I was alone. Nobody was there, I had nobody." She ended up getting together with her current partner because "he was nice" and "he wanted to help me." After initially refusing his advances, she finally gave in after "he kept coming around looking for me, until he convinced me [to be with him]." She did this because she felt that,

> I had so many problems where I was living, and didn't have anyone else, and he helped me, and well, I accepted him, like a door – as they say – like a door that opens so I could be [okay]. I just didn't know what to do with my little girl who was two months old. That's why I *had* to get together with him.

Laura did not see another way out, other than to get together with a man who ultimately turned out to be controlling. Looking back on this relationship, she said that,

> When the problems started with him, if I had known then what I know now, I wouldn't have decided to be with him. I would have found out where they could help me and where I could go without having to take on a so-called partner out of necessity.

At the time of our interview, Linda was more aware of the resources that were available to her, including food stamps, low-income housing, and welfare. Because of this knowledge, she no longer thought she needed to partner with a man in order to get by. She knew that she could access government aid to help support herself and her children.

Women operationalized the concept of reciprocity into two categories: financial help and instrumental help. Both were important, but women deemed financial help to be much more valuable and necessary. While women appreciated instrumental help from their partners, they were much more likely to stay with a partner who did not help around the house than one who did not help pay the bills. Reciprocal relationships were of utmost importance to women because, through them, their respectable identities were maintained and they received help that was necessary to their survival.

Financial help. Participants saw financial support as a proxy for commitment and quality in their relationships. When asked to describe how their relationship had been before she discovered his infidelity, Gabriela said that it was, "Good, because before when the rent had to be paid, he paid it. When we had to do some shopping, [he'd say], 'Here's some money, use it for what you need for the kids.'" But, after he started seeing another woman and channeling his income towards her, Gabriela's opinion of the relationship abruptly changed. She believed that if her partner did not provide her with financial support, then the relationship was worthless. She

137

said sadly, "There's no point in keeping on in a relationship like this, when you see there's no support in any way, I mean, why go on? There's no point in it." Women believed that a man's hard-earned money *should* be directed to support his wife and children, but knew that a man could withdraw his financial support simply "out of spite" or because his attention had shifted elsewhere. In fact, women often told of understanding that their relationships were risky only when they realized that their partner was not "helping out with the expenses."

Apart from relationship quality, a man's level of caring for his family could be measured by his commitment to financially supporting them. One woman said, "He only cares about sending money for the old lady back there [in Mexico], but for us...he doesn't care about [us]." For this woman, it was not her partner's affair that hurt her. Instead, his lack of financial support for her and her children was at the core of "what he did to me." The pain of losing financial reciprocity in a relationship was even more profound than the actual act of infidelity.

Women felt that they were owed financial reciprocity because they, too, contributed to the family's income by working outside the home. Women who were in a long-term relationship and worked shorter periods of time (just for one season, or for approximately 4-6 weeks out of the year), relied on their partner's year-round work and saw their own income as supplementary (as one woman said, "I help him"). Other women attempted to work year-round and saw their partner's assistance with domestic duties as the way that "he helps me." When both partners worked year-round, women thought, "You have to help each other out. I mean, why should you be shortchanging each other, right? Both of us are working, both have to eat. So we share." The fact that women in this study had all been employed during the previous year was an important component of why both financial and instrumental reciprocity held so much importance.

Participants did not define a "marriage" as being bound by a legal or religious contract; marriage was instead defined in terms of a financial arrangement. A "wife" received a man's financial help. In contrast, a "lover" did not receive his financial support but could receive other things from him (i.e. sharing his bed, his time, his attention/affection, and his instrumental help). Financial support was the primary indication of commitment in an intimate relationship. Therefore, when a man withdrew financial support from his "wife," it became clear that he was focusing his resources elsewhere.

One woman in my study told of having a long-term relationship with a man who was married to another woman, and clearly distinguished her role as a "lover" versus that of a "wife." Carolina did not consider herself to be a "prostitute" or a "shameful woman" because she did not steal money that was otherwise owed to his family. Carolina was his companion, she kept his home in the US, and she was financially independent from him. Since he never gave her a penny of financial support and was financially faithful to his wife, Carolina did not consider their relationship to be an affair. Since she never took his money, Carolina saw herself as a "good" and "respectable" woman. She defined a prostitute as a woman who *takes*, whereas a primary partner or a wife was one who *gives*. In her view, prostitutes take a man's money, respect, and affection for his family. Carolina described how she had seen "lots of men who have had *that* happen" – referring to being seduced by a prostitute and losing their families – "because he's been all over, shameless, dancing and everything. Doesn't care anymore about his children." Instead of being a selfish, shameless woman who was out for her own interests, she "helped" her partner to support his family back in Mexico. She worked to pay her own bills and even helped him to get sober and worked out the details of bringing his children to the US. Whereas a

139

prostitute would have stolen his money away from the family, Carolina worked to preserve his status as provider.

She told me, "It wasn't a problem for me that he was married," because she did not view his financial obligation to his family as getting in the way of their relationship. As a "lover," she did not impede the money that his wife was rightfully owed. She was okay with being in second place and supporting herself financially. She said,

> When we first got together, he told me he was married. But I was young, strong. I didn't need to have him help me with any money. I worked right alongside him. I was earning my own money...I was 35 then and I could work...It wasn't a problem for me that he was married. I used to tell him, 'Send her money for the kids, I don't want your kids to go hungry.'

As a "lover," Carolina was willing to sacrifice this commodity in exchange for other relationship benefits that she was seeking -- companionship and instrumental helping.

Instrumental help. A reciprocal relationship was not just sharing of money; equality in gender roles was a second important commodity that women valued that indicated relationship commitment and quality. Women not only saw instrumental help as being indicative of love in a relationship, saying "When you love your partner, you do all kinds of things for them," but they also saw the receipt of instrumental help as necessary to their survival. Women repeated over and over again that, "A couple has to be like two equals, each one gives their part." Adriana described how she and her partner both worked to generate income, and as a result "we are both tired" at the end of the day. For this reason, she said, "He helps me wash the dishes, he helps me fold the clothes, too...Both of us, that's why we're two...That's why there are two of you, to help each other." In reciprocal relationships, women saw themselves as part of a team, saying "it's

140

the two of us." Camila agreed that one of the main purposes of a relationship was for partners to help one another. She said, "Between the two of us we 'keep shop'...We share it all."

Women in this sample described working either as much as possible during the year (meaning, they worked about 8-10 months out of the year at the most, since farmworkers go from job to job with periods of unemployment in-between that range in length from a few days to an entire month) or working a select number of harvests per year in order to supplement a partner's income (sometimes only one or two, equaling approximately 4-12 weeks of employment total for the year). One could distinguish that the first scenario was "full-time" work (attempting to work year-round) and the second was "part-time" work in the fields (limiting work to part of the year; although one might work 40 hours per week while employed, periods of employment were brief and sporadic). In either scenario, both partners had periods of work that were interspersed with periods of unemployment -- meaning that one or both partners were frequently at home in-between jobs. This caused a fluctuation in gender roles and responsibilities. When both partners were working, both shared the responsibilities at home (food preparation, running errands, childcare, cleaning and laundry). For example, one woman remembered how "he'd look after the kids while I'd work in the evening, and he'd work during the day [while I would care for the kids]." Another explained how she and her partner shared the household duties when they were both working, but stipulated that, "When I'm working, I don't have a chance to do anything. [I] just get home, fall down [onto the couch], fix something to eat, and that's it."

Although traditional views of gender roles -- women work in the home and men work outside the home -- permeated how women understood relationships, women expected instrumental reciprocity from a partner regardless of how many hours she worked outside the

home. Women referred to a time in the past when gender roles were strict and oppressive, condoning *machismo* and rendering women as servants to the home. But women perceived that things had changed. Women viewed themselves as being equal with men, primarily because they worked in the fields in what were formerly male dominated jobs. A woman's employment in a male dominated job granted her equal standing with men. One woman said, "These days it's not like that. Women work, we do the same work men do. There's no reason they shouldn't help out. If we're equals, we both work. I come home tired, and I have to do everything, just like him."

And beyond needing instrumental help in order to survive, women in my sample who had experienced reciprocity in their intimate relationships found a sense of joy and companionship in sharing with their partners. For example, one woman said,

> We'd get home and I'd start fixing supper, while he swept the porch. Or he'd heat water for a bath because we lived in a tiny little trailer, we barely fit the two of us standing up [in] the bathroom, it was so small. He'd put the water on to heat when we'd come in from work. He'd take a bath while I fixed supper. Then I'd put on another kettle of water. [When] he'd finished with his bath, he'd heat up the tortillas [and] make the coffee. [Then] I'd take a bath, and when I'd come out, he had the plates all served up. And we'd have supper. It was really nice.

Phase IV: Adopting a Risk Perspective

Women weighed their priorities of identity and survival after making the discovery that their relationships were risky. They compared their own identities to those of "other women" and valued their intimate relationships according to the level of reciprocity that they perceived. These priorities enabled them unconsciously to adopt a risk perspective, which influenced how

they either confronted risk or overlooked it. Regardless of which stance women adopted, their perspectives were expanded as they came to a new level of understanding and critiqued their position in the relationship in relation to their priorities.

Overlooking risk by averting eyes. When faced with suspicion or gossip, women almost always overlooked the possibility that a partner was having an affair. Sometimes, even when confronted with direct evidence, some women also overlooked the possibility of infidelity because they either distrusted their own suspicions or because their priorities of identity and/or survival were too important. It was as if they did not allow themselves to see what was really happening as a kind of defense mechanism. In the case of abuse, women at this point were not often willing to admit that a partner was abusive because it was more meaningful to maintain the relationship in order to enjoy economic, social and physical security.

Even when they *did* notice red flags, they tended to ignore them at first because of their initial shock and disbelief. Because women often wondered, "How could he do something like that?", they were initially paralyzed by disbelief. Without a frame of reference for understanding risky behavior, women easily disregarded their own suspicions, saying things like, "they were just ideas of mine...I didn't pay them much mind." One woman told how she stayed with her partner for a year after learning of his long-term affair with another woman because she kept second-guessing herself. It took one full year before she could trust herself enough to *really* see that her relationship had become risky.

In some circumstances, women even felt infidelity was acceptable as long as their partners kept their affairs adequately hidden. They thought that, as long as they could overlook the possibility that their partners were being unfaithful, the integrity of the relationship would be maintained and there would be no problems. One woman, who admitted that her husband may

143

have had an affair in the past when she was diagnosed with an STI, differentiated between affairs that could be easily excused versus those that were too blatant to ignore. She said, "I think they all [men] get involved with other women. But as long as you don't know, everything is fine...But if they do it right in front of you, that's really horrible." In other words, as long as she felt she could cover up her own knowledge of his affair, she thought "everything is fine." But if he went public with his affair it would become "horrible" because she could no longer claim ignorance.

Using excuses. One way in which women overlooked risk was by using excuses to explain why the relationship felt strained. Instead of admitting that he was cheating or that he had become abusive, women offered up other explanations that excused the changes in his behavior. In my study, women told of using two excuses: differences between partners and trust in a partner. Women admitted that these taken-for-granted assumptions could disguise the truth and protect them from the emotional and social ramifications of risky relationships.

Differences between partners disguised risk. One excuse that women used to explain relationship strain was to describe to themselves how they and their partner were different. Differences between partners could involve religion and ethnicity and/or sexual synchrony. Women initially blamed trouble in the relationship and/or changes in his behavior on these differences.

Differences in religion and/or ethnic background were two basic issues that women saw as contributing to difficulties in their relationships. Initially, women used excuses involving religion and culture/ethnicity to explain or excuse a partner's risky behavior. Instead of seeing that he was abusive, controlling, or unfaithful, some women blamed their strained relationships on differences in religious beliefs or culture/ethnicity. In doing so, these factors could also

144

contribute to how women were blinded to risk, especially if they relied on these excuses as explanations for relationship difficulties. For example, one woman initially blamed her disagreements with her partner on the fact that she was Mormon and he was Catholic. It turned out that their difference in religion was just the "tip of the iceberg," so to say. She said, "from there -- the thing about religion -- a lot of other problems arose." Another woman wondered if she could blame her partner's behavior on his Nicaraguan upbringing. She said, "People there in his country are different, I don't know...it's like they have a different way of thinking than us." She wanted to blame their differing relationship perspectives on their ethnic/cultural roots, wondering if "there in his country" it was acceptable for a man to shirk his responsibilities to the family. Even though she lived across the border from two of her children and her parents, she felt very connected to them by talking on the phone every day and sending them money and gifts. In contrast, she never saw her partner on the phone with his family in Nicaragua nor did she see him share his money with her or their children.

However, over time, participants came to see that the limits a partner placed on her religious freedom and/or his lack of apparent care and affection for her and their children actually stemmed from infidelity or an underlying desire for control. Until women could come to this realization and could view the relationship with a fresh perspective, excuses displaced blame and disguised risk.

Other women used excuses related to sexual synchrony to explain why differences existed in a relationship. For example, one woman was actively working through her thoughts during our interview, trying to understand why she lacked desire to be intimate with her partner and why they had intercourse so infrequently (about once per month). She initially explained how they seemed to be on different timetables -- he was interested in intercourse when she was

145

not, and vice versa. But the more she reasoned through this issue of sexual synchrony, the more

she used language indicating his attempt to harness sexual control over her. She said, "When I

want to [have sex] and he doesn't want to, I feel him put the blanket in between us and we don't

even touch each other...it's only when he wants it. When he doesn't, there's nothing." He

controlled the act of intercourse. And when he wanted to have sex and she was not interested,

she admitted that, "We end up bad; a sure fight. It's better not to cross him." Although she did

often refuse his advances, particularly regarding oral sex -- an act that she could barely stomach

because, "I feel like I'm going to throw up" -- she sometimes gave in because he got angry when

she refused. Although she did admit that he was asserting sexual control over her, she struggled

to explain why he was doing this. She blamed it on sexual synchrony and her lack of interest in

oral sex, but she seemed to be insinuating something more that she was not yet willing to admit.

She said, "It's been for awhile, and I don't know what to think. A thousand ideas come to

mind." One of the alternatives she was considering was the possibility that he may have been

cheating on her for a second time. But she could not admit this out loud to me; her body

language, the questions she asked me after the interview, and her nervous demeanor all clued me

in to the fact that she suspected he was having an affair but she was yet willing to admit it -- to

me or even to herself. In favor of preserving her relationship, she was actively involved in

overlooking risk.

　　Trust disguised risk. Women wanted to believe that their relationship was safe, that their

partner was faithful, and that *machismo* existed in other homes but not in theirs. Women thought

their instincts to trust their husbands were rock solid, saying "it never entered my head" that he

could have been unfaithful. As another woman said, "I just felt sure of myself, I guess. I didn't

146

think he'd get involved with another." Even with evidence to prove the contrary, women's desire to trust their partners was difficult to shake.

One reason women appeared to feel this way was because they wanted to believe that their relationship was built on love and respect. They did not want to consider the alternative. One woman, while reflecting on her relationship with a man who was a drug addict and who cheated on her, said, "I was blind, I think. In love." Women also used these excuses as a way to protect their partner's identity as a faithful, loving husband. It was very important to women that their partners -- and more importantly, the fathers of their children -- had a respectable identity. In this way, women actually adopted a limited scope of view in order to keep themselves from "seeing" reality, because it was socially more acceptable to have a faithful, loving partner than an abusive cheater. Because women *wanted* to trust that their partners were faithful, they made unrealistic and overly optimistic generalizations about their partner's intentions and behavior. Women used the mantras of "he's always with me" and "he doesn't go out" as explanations for the trust they had for their partners -- even in the presence of contrary evidence.

Women used the concept of "knowing him" as a way of explaining trust in relationships. "Knowing" a partner means that women thought they could predict his behavior. Either he was "capable" of flirting with other women and having an affair, or he was not.

Women equated time in a relationship as the biggest component in "knowing him." The longer a woman was with a man, the greater the expectation that she would be able to understand or predict his behavior. As one woman said, "I've been with my husband for 12 years, and I know what he's like. I know if he is able to flirt with a woman or not."

Women often used the phrase "he's always with me" as rationale for the trust they had in their partners. Women thought even if they were physically apart from their partner, that "he's

147

always with me" if they could account for his whereabouts. For example, one woman told of

never having reason to doubt her current partner's fidelity even though they were apart for hours

each day (working at different jobs and sleeping at different houses). She described his daily

schedule in detail in order to support this claim, illustrating that there was just no time in the day

for "extra" activities that could involve an affair. Another reported her confidence saying,

"Well, because he doesn't go out! At what point in the day [would he have time]? He gets home

late from work, tired, and he goes to bed."

In order to confirm their trust, women relied on their first-hand knowledge of their

partner's activities that they could see with their own eyes. One woman explained that there was

no way her partner could have had an affair, since, "He never leaves the house, ever...So I don't

see anything going on."

Women who travelled for months out of the year away from their partners used the

excuse that "he doesn't go out" as a way of explaining their trust in a partner. They believed that

"bad" things happened outside the house, not inside. Furthermore, women saw the desert

climate in the Green Valley as a limiting factor to a partner's potential infidelity, since many

preferred to stay indoors when the temperatures climbed. One woman stated that her husband

stayed inside and "doesn't get too far away from the air conditioning." She heard him say, "Why

should I go out in this awful heat?" Domestic duties kept other men inside; one woman reported

that her partner was in charge of their baby son and "has no one to leave him with," and for this

reason "he doesn't go out anywhere" while she is away picking grapes.

The refrain that "he's always with me" became an excuse that disguised the underlying

reason for a partner's changed behavior. For example, one woman was diagnosed with an STI

and heard the physician warn her, "it could be that your husband is involved with another

woman." But she used the excuse of "he's always with me" to convince herself otherwise, saying, "He hardly goes out with his friends. If we do go, we all go out together...We've always been together, the whole time, that's why I think he's never done anything." This incident took place years prior to our interview, and she never questioned him or allowed herself to consider that he might have been unfaithful. Similarly, another woman chose not to listen when her sister warned her that she had seen her partner with another woman. After asking for specific details including, "What day, where, and when?" this woman dismissed the sightings. She says, "He hasn't left my side, ever...what she was saying was not possible."

So my participants overlooked risk by averting their eyes through using two types of excuses: either differences between partners or trust in the relationship itself. Another way these women overlooked risk involved their personal feelings.

Downplaying risk due to feelings of personal complicity: "I'm the fool here." Women at times blamed themselves, believing that they had allowed or even caused a partner to cheat or become abusive. Some women wondered if the abuse they were suffering was a curse -- "some kind of punishment I deserve or something." They told themselves, "it's your fault" and asked, "What did I do to him?" in order to deserve abuse or infidelity. Women saw themselves as "softhearted" and assessed that their pain and hurt from risky relationships was their fault because they had not "stood up" for themselves. Sometimes, this was a reflection of the ways their partners manipulated them towards feeling complicit. Other women felt an intense sense of blame due to misogynistic perspectives about the female body and relationships that they internalized from others. These perspectives contributed to the ways women overlooked risk and even felt silenced in their intimate relationships.

Seeing self as "softhearted." One reason women saw themselves as complicit was that they viewed themselves as weak or "softhearted"-- lacking "respect" and "value" for the self. Because of these perceived character flaws, women thought that "sometimes we bring it [risk] upon ourselves." Women believed that men were controlling only to the extent that women allowed them to be. They saw themselves as complicit because they had "allowed" a partner to manipulate them. One woman in particular felt complicit after hearing her neighbor tell her, "You're a real fool. After all he has done to you and you still love him? You can't live without him, you're nothing without him." She internalized this assessment and it became part of her own explanation for why she stayed with her partner for an entire year after discovering news of his affair; she concluded that she had done this because she was weak.

As a result of being "softhearted," participants continued to give of themselves. Looking back, the felt that they had allowed themselves to be manipulated in relationships that had become unilateral and oppressive. They concluded that instead of standing up for themselves and putting a stop to their partner's behavior, they instead compensated for areas where he was lacking and offered excuses that made his behavior feel okay. In retrospect, these women looked back on their risky relationships and felt "foolish" or "stupid." For example, one woman described feeling this way because she said, "[I] let him lord it over me, and ruin my self-esteem. I shouldn't have let him do that." Another woman described it this way:

> [When he] starts saying this and that, and all this bullshit, my head -- I begin to think, 'Oh, you stupid girl' -- like he says sometimes when he starts talking dirty. I say, 'Sure, I'm stupid, I'm an ass. But because I'm still here [with you]!'

Mariana described how she played the role of an obedient "puppet" in her relationship. She felt complicit in her partner's scheme to control her body and emotions, and believed that he

was able to manipulate her to the extent that he did only because she allowed him to -- because she was "softhearted" and did not put a stop to his manipulative behavior. She said, "He would manipulate me according to his every whim." In return she "obeyed" him, ultimately feeling he had "played me like a puppet." Going on to describe how she felt, she ultimately was able to take control of the relationship by changing her behavior. She described how she felt "in the wrong" and "silly" for allowing his controlling behavior to go on for so long. She said:

> Even when it was his fault, I'd beg him to forgive me. I started out wrong, doing that. It was silly of me. And now that I'm alone, I look back and realize that I did a lot of things wrong, things I didn't put a stop to until recently.

Some women gave opposite examples, illustrating how they did not allow their partners to become abusive and controlling. For example, one woman's husband tried to tell her what to wear and what length to keep her fingernails. But instead of conforming to his demands, she said, "I didn't let him." She did not believe that he could control her choice of outfits, and she pushed back. She wore what she wanted and kept her fingernails like she wanted, and therefore believed that she was able to control his behavior through pushing back against his demands.

Another woman also challenged her partner, in order to "make him understand" her own views of how marriage should be. She admitted that although he had *machista* (or, sexist) tendencies, she believed that she prevented him from becoming *machista* because she did not "allow him" to control her. Instead, she reminded him of how modern gender roles are "supposed to be."

Women who felt that they were "softhearted" assessed that they were this way because of the way they were raised by their parents and the experiences they had as children. For example, one woman attributed her softheartedness to being raised by a single mother who did not teach

151

her to "stand up" for herself. She remembered allowing others to "humiliate" her as a child. Another woman perceived that being raised by her grandparents while her mother came to work in the US negatively shaped how she felt able to assert herself in relationships. She did not feel supported by her grandparents and felt abandoned by her parents; this had deep psychological effects on her. She wondered if her upbringing was to blame for the way she allowed herself to be taken advantage of by men. She felt strongly that her childhood experiences shaped how she responded to risky relationships, because, "What the woman brings with her [to the relationship] affects her."

Internalizing partner's accusations of blame. In addition to seeing themselves as "softhearted," there was another way in which participants downplayed risk due to feelings of personal complicity. Women heard their partners accuse them of being to blame for everything that went wrong in the relationship. Furthermore, according to unfaithful partners, men don't cheat; women do. Women noted how their partners asserted power by deflecting attention from his own infidelity and passing the blame on to her. These accusations shook the core of the women's identity as respectable women. As a result, women were made to feel vulnerable and obligated to comply with a partner's demands, because they prioritized their respectable identities over the risk of an infection.

One woman told how her partner made her feel inferior, as if she were a scapegoat for "everything, for all the problems he might have and for things at home." For example, if her son would trip and fall, "he would blame me for the fall, [saying], 'It's your fault,' and I would feel so bad." As a consequence, she told how her self-esteem fell as she internalized the blame. His blaming words had a big effect on her. She said, "I used to cry-- when he'd blame me for things and tell me I was to blame, I cried." And he said their separation was her fault, too: "That's why

I left, because of you, because you wouldn't listen." In response to this, she said, "I figured, 'Once again, I'm the one to blame. Guilty again.'"

When participants told of expressing concern to a partner that they could have acquired an STI from him, they noted that he immediately responded by blaming them. One woman warned her husband that she would not be intimate with him until he showed her a clean bill of health (in writing) from the clinic. But he turned it around, saying, "Well, you haven't gotten yourself checked either...you're really a bitch, you bring other men to the house." In response, she laughed incredulously and said to him, "The thing is, I'm not the one looking around out there for what I shouldn't be, *you* are...Here I am having to get checked out anyway just because I've been with *you*! And God knows how long you've been screwing around, and maybe I've got something now." She imagined that maybe her own potential STI diagnosis would make it "obvious that he's been screwing around." But deep down, she knew that if she was diagnosed, he would turn it around and claim that it was her fault; that *she* was the one who had cheated.

Another woman had to start working in the fields in order to pay the bills once her partner stopped providing for the family as a result of his drug habit. In what she saw as a desperate attempt to maintain his power and control over her, he used these reverse accusations to maximize her vulnerabilities and get what he wanted from her. He questioned her every move, bombarding her with questions of, "why are you doing this, why are you doing that?" and at night "he'd stand at the window to see if I was alone [or] if I was with somebody, and then he'd get in bed and say I was breathing hard, as if I'd been there with a man." In a kind of controlling paranoia, he even claimed that her reason for working outside the home was because she "had taken up with some guy."

Internalizing institutionalized sexism. Beyond seeing themselves as "softhearted" and internalizing their partners' accusations of blame, there was still another way in which participants downplayed risk due to feelings of personal complicity. For some participants, sexist or *machista* discourses became part of the explanatory model for their experiences and caused them to blame their own selves for their partners' risky behaviors. The noun *machismo* refers to a sexist mindset or a set of beliefs that promotes male privilege, and the adjective *machista* (or the shorter version, *macho)* refers to that which is considered sexist, or describes a person who has adopted sexist beliefs and attitudes. Another synonym for *machismo* that helps to define how women used it in our conversations is "misogyny" – a term that confers behaviors involving sexual discrimination, denigration of women, violence against women, and objectification of women. Women identified having experienced all of these forms of *machismo* or misogyny during our interviews. These forms of *machismo* were institutionalized in both the Mexican medical system as well as in the families in which women were raised.

Women equated *machismo* with behaviors that involved oppression, imprisonment, control, alcohol abuse, infidelity and violence against women. In other words, *machista* beliefs condoned male behaviors that perpetuated control of the female body. Women described *machista* views as oppressive, stripping women of their basic human rights and causing them to feel inferior to men. One woman illustrated that, according to *machista* beliefs, "the man always has the first word, and then the woman, after. Like saying the woman is less than the man." And when women were made to feel "inferior," they felt silenced.

Women told of having internalized the *machista* perspective, believing that the use of contraception could cause marital strife or that once a woman had committed to a marriage, she was "stuck." Women heard male health professionals in Mexico make disparaging comments

154

about the female body, and found that they internalized these beliefs about their own anatomy. In addition, participants heard female peers and family members condemn women's rights, making comments like "damn you if you didn't stay" with a risky partner, and "you're nothing without him." Women constructed negative self-deprecating views of their selves and their bodies partially because they felt influenced by oppressive, misogynistic, *machista* discourses that permeated their community. Interestingly, these views were often related to them by other women: neighbors, mothers, grandmothers, and sisters.

Some women indicated that they had internalized a negative perspective about their bodies by repeating discourses that they heard from Mexican male health professionals. For example, one woman related that a male physician in Mexico told her that she should have a hysterectomy in order to stop having "problems" with her uterine fibroids, because, "When a woman doesn't have any more kids, the uterus isn't good for anything. The only thing it does is give her problems." Similarly, when another woman sought care for a vaginal infection in Mexico -- worrying that her husband may have given it to her -- she heard a male physician tell her that, "Infections are not just transmitted sexually...Your *uterus* is what is damaged." These disparaging comments about female reproductive organs contributed to the oppressive milieu within which women formed their own perspectives and opinions about their bodies. Women said they were made to feel that their bodies -- particularly their reproductive organs -- were worthless and even self-destructive unless they were being used for procreation.

One woman gave the following example of the way she internalized these misogynistic discourses and blamed herself for her partner's risky behavior as a result. She believed that she was to blame for the marital discord that prompted her husband's abusive behavior and infidelity. She remembered taking oral contraceptives for three years – the first time that she had

155

ever used contraception after having six children in quick succession -- and saw a change in her libido and in her attitude towards her husband. She was desperate to stop having children, but internalized the perspective of her male physician in Mexico: that "whatever contraception you use is going to harm you." She remembered feeling physically ill at the thought of intimacy with her husband after starting the oral contraceptives and described the pill's effect on her body as "torture." She said,

> I put up with that torment [from the pills] for three years, the torture it caused me, fights with my husband, arguments, dirty words, all of it, because those pills made me push him away. When he wanted to get near me, I was like this (*holding out hands in front of her as if to push him away*). I didn't even want to look at him. He got near me and I'd want to throw up, because he made me feel sick. And that's where the trouble started for him – for both of us – because we began to fight. [He'd say], 'You don't want to do it, this and that. No doubt you're looking around out there; you've probably got another man.'

Because she believed that "those pills made me push him away," she heard her husband conclude that she was cheating on him. She therefore deduced that he became physically and emotionally abusive and even cheated on her as a form of retaliation. She took the blame for his behavior, believing that he never would have changed had she not taken the oral contraceptives that "harmed" her body.

Other women repeated what they later considered to be *machista* perspectives that had been passed down to them by family members. While the discourses that women internalized from healthcare professionals involved female anatomy, the perspectives passed down from family had to do with women's rights. Women internalized the belief that once they chose to

partner with a man, they were stuck. They took the blame for making a poor choice and felt that they had to live with the consequences of their actions -- regardless of their partner's actions.

For example, when one woman began experiencing physical and verbal abuse in her first relationship, she remembered hearing her mother say, "You wanted to get married, so there you are." She went on to say, "And that's how it was, you had to stay married. You had to stay that way, not because somebody gave you advice about how to, but because that was your choice. And damn you if you didn't stay." Living in rural Mexico and not having any other influences in her life that condoned divorce or separation, this woman stayed with her first husband for quite some time. In a void of other alternatives, she internalized this ideal and saw her abusive marriage as her own fault.

Not only did women feel pressure to stay in risky relationships, but they also felt that those unsafe relationships could have been avoided if only they had been able to "see" early on that their partner was not a wise choice. Some felt that if they had heeded the advice of an older family member, then they would not have been in a risky relationship. One woman said that she kept telling herself, "I've got to put up with it, because I went looking for it." As an adolescent embarking on her first relationship, she blamed herself for having chosen to run away with her husband despite her grandparent's warnings. Even though her partner had raped her and then shamed her into staying with him, she saw the entire relationship as having been a string of poor decisions on her part.

Minimizing his complicity. A third way in which women overlooked risk, beyond using excuses and downplaying risk due to feelings of personal complicity ("I'm the fool here"), was to minimize his complicity. Women thought that being able to explain that he was under the influence of a supernatural power, lacked self-control and/or had been following his natural male

instincts helped excuse and minimize his complicity in extramarital sex. Women who believed that a partner had been changed by an outside force or made a mistake were likely to believe that their relationship had only been temporarily altered. They saw their risky partners as essentially "good" men who underwent some kind of temporary transformation. Women therefore held onto hope that he could escape from the spell or avoid making the same mistake twice, overlooking what might otherwise have been blatant and concerning causes to take action against him.

"This is something bigger than me:" Supernatural powers caused his behavior. Some women looked to supernatural explanations for infidelity, believing that their partners had been placed under a spell or a curse that had caused them to cheat. For example, Renata saw two sides to her ex-husband: the man she left Mexico to be with, and the man who was "bewitched" by his mistress. She described his mistress as a "witch" and a "streetwalker," who had turned Renata's husband against her. She related that before he was under the spell, her husband "never treated me bad, like other men who fight or hit women. Not him – yeah, he treated us good. Later a couple of times he tried to hit me, but [that was] because of the other woman he had." And when he kept coming back to stay with Renata at her trailer in the Green Valley, saying that "you are my first wife, so I want to stay with you again," she decided to allow him in. She remembered telling him, "Well you know what? If you want to stay with me, yeah, I'll give you another chance, to live well, like we did before...but that old lady...isn't going to leave you alone." Renata wanted things to work out between herself and her husband, and wanted to believe that things could change, but knew that ultimately it was his mistress who had ultimate power over him. While they were back together, she became infected with an STI that she acquired from her husband. She also noted that he had difficulty maintaining an erection – she

attributed both afflictions to witchcraft. And sure enough, it was only a "little while" before his mistress "was able to pull him back down there [to Mexico]."

Gabriela wondered if her unfaithful husband was possessed by some kind of negative power. She did not specify whether this was the result of a spell placed on him by his mistress (as Renata did), but she did make some references to "badness" as contrasted with God and the Bible. Her husband was having an overt affair and prior to our interview, she had kicked him out of the house. But he had not actually left. Gabriela perceived that he wanted to fight the forces that were controlling him and make things right with her, but he felt unable to do so. She told about a time when, "he caught me by the hands and said, 'You just don't understand, this is something bigger than me, that gets ahold of me, I'm so sorry.'" And then, "he just caught me and held me and hugged the kids and didn't want to leave and didn't want to leave them, and he keeps sleeping in his truck [outside my house, instead of leaving to be with his mistress]." One night before he started sleeping in his truck, she clarified that he was not drunk but he was acting very strangely. After he fell asleep, she described that she saw him levitate above the bed:

> And his hands were flailing, and when they flailed down, he fell to the bed, bathed in
>
> sweat. And he woke up just like that and his head was spinning...his head was spinning
>
> around, and he yelled, 'Why don't you help me? I told you to help me!'

It was as if she was failing to help him overcome his demons. At the time of our interview, Gabriela noticed that he was making an effort to clean up the yard around the trailer, showing investment in the wellbeing of the family. She said, "I see him now taking an interest, like he wants to be here, but he can't decide. Or *they* don't let him decide." She saw two sides to him; his normal self, and the side controlled by some unseen power. She felt conflicted regarding her

decision to send him out of the house, as she saw him vacillate in his desire to leave and heard him cry out for help.

He made a mistake: "Men are men" and "nobody is perfect." Beyond seeing supernatural powers as the cause of their partner's change in behavior, other participants perceived that their partner had simply made a mistake, using explanations like, "men are men," and "nobody is perfect." Infidelity was perceived to be so commonplace that some women went so far as to proclaim: "all men get involved with other women." Furthermore, the belief that infidelity was a "mistake" prevented women from considering "all men" to be bad and corrupted. When men made mistakes, women tended to believe that his essential core as a "good person" was maintained. So they were quick to pardon him and give him a second chance. As one woman said about her cheating husband, "He's not a bad guy; I've never said he's a bad person." Believing that both men and women can make mistakes, she went on to say,

> I mean, women have problems, too, not just the man, and sometimes the woman makes mistakes. But he's responsible at his job, he's responsible as a father, and as a husband, too. He's responsible, and there will always be problems, maybe just small things, but here we are.

In this case, her partner's identity as a "responsible" father and husband -- meaning that he reciprocated both financial and instrumental helping -- was his redeeming quality and gave her reason to overlook his "mistakes" of sexual infidelities. Another woman expressed her desire to believe that her partner was inherently a good man. She tried to not let "it affect me" when he gets drunk, saying that "I don't want to get mad, because nobody is perfect; all of us have flaws." She saw his alcoholism -- which she believed was the root of both his infidelity and his controlling, violent behavior -- as a flaw that could be corrected.

160

The main reason women believed that their male partners made mistakes was because they believed that men had an internal inclination to "wander" into the arms of other women. This inclination was comprised of three beliefs: men have natural sexual needs, men have a need to procreate, and men have a selfish lack of self-control.

Women told of believing that men have natural tendencies to cheat when their primary sexual needs are not met. For example, Ines believed that her husband cheated while he was away from her – across the border for almost a year – and she was unable to meet his sexual needs. She admitted that his infidelity devastated her and forever changed their relationship. But she also easily forgave his decisions, saying, "I don't see him as a bad person. Maybe in moments of feeling lonely – as they say – men are men, and they wander."

Women perceived that the natural tendency to wander varied from man to man, and arose from traits that men were born with. However, this was not assumed to be genetic. For example, one woman wondered if her sons will have a natural tendency toward promiscuity like their HIV positive father, saying, "You know what they say, 'Like father, like son.' But you never know how they might turn out. Some kinds just have a different heart." She believed that, despite her best efforts in teaching them otherwise, her sons might still have a natural tendency towards promiscuity.

Another woman, while planning for her partner's impending four-month trip up north, felt that she could not trust her partner to remain faithful to her because of his natural sexual needs. She desperately wanted to trust that he would be different from her two previous unfaithful partners. But because she believed that all men have a natural tendency to wander -- regardless of their faithful intentions to their wives -- she confided in me that she would never be able to fully trust her partner. She said,

'You can trust in me because you've already seen [that I'm faithful]. But I have no real way of knowing about you, because of everything I saw before,' I tell him. Two weeks, you never can know. If he goes up north to work for two weeks and I can't be watching him...a man alone for two weeks, that's pretty hard. It's hard, because there are plenty of women, who roam around the camps, looking for money, where there are lots of men, and the women are there for the asking, right? They live there in the fields, all the men do, so the women go to give them their fun.

Women believed that men are also driven by sex as a means to procreate, and that this prompted them to engage in behaviors that they did not intend. Women accepted that all men want to have children, and some tied this in with *machista* beliefs regarding virility. One woman gave in to her husband's demands to have more children than she originally wanted, insinuating that he would leave her if she did not comply. She said, "I accepted the idea of having a lot of children just so I could live with him." Another woman, after being with a much younger partner for three years, thought to herself, "I know that at any moment he's going to take off with a younger woman, who will give him children." She accepted that because she was menopausal, she could not expect her younger partner to remain faithful. And sure enough, he did cheat on her with at least one younger woman.

Finally, women believed that men cannot help but wander because they are plagued by selfishness and lack self-control. In this view, women perceived men as mindless rodents who could easily infect themselves, since they are selfishly driven by their sexual urges. As one woman said, "Men are out there roaming around, and they have no idea who they are with, like rats, right?" Some women believed that "the majority of men do [cheat]" in response to a lack of self-control, not a physical need. The urge to cheat could be "just a man wanting to be free to do

162

whatever he wants...[men are] quick to leave and find other arms to embrace them." This wandering was rooted in selfishness; in some men's inability to be "fair or decent," or have "affection or respect" for their wives. Women agreed that a man's sexual needs were more urgent than women's, and that men exhibited less self-control. As one woman said, "a woman can last longer without sex than a man."

Confronting risk with eyes wide open. In contrast to women who overlooked risk by averting their eyes, others confronted risk with their eyes wide open. The dark lenses that once obscured their vision were long gone, and had been replaced by a lens that magnified their partner's current and potential short-comings. Some women felt they had to purposefully "keep your eyes open" in order to see and process potential future risk. Out of the sample of 20 women, 13 told of averting their eyes to risk at some point during the relationship. But over time, as they re-examined their priorities and considered the consequences, six of the 13 women shifted their stance and confronted risk with their eyes wide open. An additional six women told of confronting risk from the start; they did not see a need to avert their eyes. These women were constantly vigilant; they were on the look-out for risk and danger -- both in their current relationships and in future potential relationships -- and they felt equipped to recognize and process risk because of their past.

Instead of excusing risk, women with their eyes wide open admitted that despite *wanting* to trust a partner, "you never know" what he might be doing just out of sight. Women who confronted risk took a moral stand and labeled his behavior as "bad" and "wrong," instead of minimizing his complicity. Finally, by looking at risk with eyes wide open, women offered up explanations for why or how he had been corrupted using rationale that demonstrated how unlikely he was to change. They believed that if a partner lied about who he really was, changed

as a result of a *machista* mentality or entered "his own world" of mental illness, then he was

unlikely to be reformed. As one woman who described her partner as *machista* said, "He says

he's going to change; who knows! We'll see if it's true, but I don't think so, because somebody

like *that* doesn't change." Believing their partners were unlikely to change provided women

with the impetus to act.

     Admitting that "you never know." Despite all that women *wanted* to believe about how

well they knew a partner and his behavior, those who confronted risk with eyes wide open

admitted that trust disguised risk because, "you never know." These women acknowledged that

the mantras of "knowing him," "he's always with me," and "he doesn't go out" were faulty --

they were comforting excuses that disguised the truth. In contrast, those who continued to avert

their eyes did not acknowledge that their excuses were faulty. One woman, with eyes wide open,

admitted that although "I've never seen anything going on, with my own eyes," that it was

possible that her partner was having sex with other women. She could see beyond her own

current reality and acknowledge risk because she was no longer averting her eyes and hiding

from her suspicions. Another woman acknowledged that it would have been relatively easy for

her partner to cheat, because, "It only takes a minute to be unfaithful. To get an infection, it only

takes a minute."

     Others who experienced physical separation from a spouse due to migration for work also

confronted risk with eyes wide open. One woman acknowledged that, "Who knows what he

does when I go up to work, right?" Another woman recalled saying to her husband:

     I never know, *there's no way for me to know* if you're going to be a little saint [up]

     there...I don't know who's going to come around and get your hormones all juiced

up...Somebody's going to come around, you're going to get all excited, and you['ll] do it [cheat]." [Italics are mine, added for emphasis]

Women admitted that trusting a partner was not enough to predict what he might do during an extended trip for work or even a trip alone to the market. When women confronted risk, they found that claiming knowledge of a partner's behavior provided a comforting excuse that enabled them to overlook risk -- and nothing more.

Taking a moral stand. Because women did not learn much about "right" and "wrong," "good" and "bad," or "normal" and "abnormal" in intimate relationships from other women in their lives, they found themselves to be forming their own moral views *after* having experienced risk. Because they did not usually enter relationships with clear expectations, they told of judging and determining the morality of risk as they went -- again, experiencing relationships through trial and error. But I found that women were only able to take a moral stand when they confronted risk with eyes wide open.

Armed with a typology of "shameful" versus "respectable" reputations that women referred to in phase two (making the discovery), they were prepared to label certain public identities as "good" or "bad." What they found difficult was making moral judgments of their own spouses. However, women found these moral judgments were extremely valuable to help them ultimately make decisions and take action in their risky relationships. As they evaluated their relationships, one way women formed ideas of "right" and "wrong" was by imagining what they might have done in their partner's shoes. By imagining what they would have done (being in the "right"), they were able to label his actions as "wrong."

Another way that women made moral judgments was by considering what was "normal" versus what was "abnormal." When Alejandra was evaluating her partner's behavior, she was

165

able to better understand her risk by framing his actions in terms of what was "normal" and what was not. Deciding that it was not "normal" to be raped by a husband was the primary judgment that enabled her to understand how her relationship was risky. She said,

> You don't know if what he's doing to you is normal. At that time – because now I do understand – but at that time, that they have to beat you to have sex, to have a relationship like that with a partner...I say, you should do that out of *love*, not because they have forced you.

Another woman told how she was only able to determine what "normal" sex was after having a reciprocal sexual relationship where her partner showed her what it meant to have an orgasm. She said that prior to this, she had never experienced pleasure with sex, and had only associated sex with violence and force. She said, "I didn't even know [the orgasm] existed," until she was with her second partner and he showed her how sex could be pleasurable. Looking back on her first relationship, she was finally able to understand how it had been risky once she was able to make this comparison.

Women also judged "good" versus "bad" when trying to understand a partner's behavior. For example, Mariana found a discrepancy between her value judgments and her husband's-- he saw "going after the things of God" as "bad," and "going out all night with his friends and coming back at dawn" as "just fine." But she saw it the other way around, and found that this value judgment was at the root of their problem. Whereas she had previously believed that their marital difficulties were due to religious difference, once she framed their differences in terms of value judgments, she was able to fully understand how she was at risk. She determined that he was making faulty value judgments and realized they would never see eye to eye. She concluded: "I always felt really humiliated. I felt like he humiliated me -- that I was lesser --

that's how I felt. And I think it shouldn't be that way in a marriage." Mariana came to this conclusion over time; she did not consider that a husband should respect his wife until she determined that she was not being respected in her marriage.

In this way, women told of reactively and retrospectively navigating and forming moral views concerning values, love, and respect in intimate relationships. In this higher, more sophisticated assessment, women came to understand what abuse and infidelity meant to them on a deeper level. They were able to look at their relationships with eyes wide open as they made moral judgments and took a moral stand.

Viewing men as liars. Despite valuing honesty and wanting their partners to be truthful regarding infidelity, women who were able to look at risk with their eyes wide open admitted that they did not trust their partners at all. They agreed that their partners would never tell the truth about infidelity. For example, one woman was separated from her husband but still had sex with him when he came to visit her. She asked him if he had been with another woman as a kind of formality, but did not trust that he would tell the truth. She said, "He might say, 'No one,' but I don't know if it's true." She went on to say, "I know he's not going to answer the truth. I don't trust him...He's always going to deny it." Questioning made her feel better about sleeping with him even though she knew he would lie. In this way, even women who admitted that their partners could be cheating were not further protected from infection by keeping their eyes wide open. Adopting a confrontational stance did not always translate into avoidance of risk. Another woman threatened her partner to either "talk to me about it" or "not even try to come back" if he had an affair while working up north. But, referring to all men as liars, she admitted, "But of course, they won't do that. Obviously they won't do it." Others acknowledged that even if she

"sees" him going out with another woman with her own eyes, a man would never admit to an affair. As one woman said, a man would *always* say that "nothing is going on."

A few women perceived that their partners had been "bad" from the start; they had lied about their true selves from the very first date. These women felt duped into entering into the relationship in the first place. One woman remembered when she first met her husband:

Little by little he sweet-talked me into liking him...but I really didn't know him at all, because he lied to me...When I met him, everything was nice, he really behaved good....If I had known who he was when I met him [I might not have done it]. Because when you meet, you're just getting to know someone, they show you the moon and the stars. They tell you things-- they're lies, and they change, and that's what he did. He pretended to be something he wasn't.

Perceiving that external influences had corrupted his being. While women who overlooked risk held on to the hope that their partners would only temporarily be changed by supernatural powers or their own mistakes, those who confronted risk believed that external influences had actually corrupted the core of his being. They clarified that he originally "wasn't bad," but that after some time in the relationship, "he turned into a bad person." After being influenced by others, by the mentality of *machismo*, or by personal afflictions, women saw their partners become caught up in addiction, become abusive, and/or be unfaithful.

While some women who overlooked risk described men as mindless rodents who lacked self-control, those who confronted risk called for men to be held to a higher standard, saying "each of us is responsible for what we do." One woman said emphatically, "Where is the responsibility? Where's the trust? Where's the love?" Those who confronted risk with eyes wide open demanded more from their partners. They were not willing to accept that he had

168

made a mere mistake or was under a spell. While allowing for the fact that he had been influenced by external forces, they demanded accountability.

Others caused him to change. Some participants reported that the influence of others prompted change in their partners. For example, women blamed the friends who invited him out to drink or to visit a strip club as having incited his addictive, unfaithful behavior. As one woman said, "he turned bad" when he started spending time with members of a gang. However, women also noticed that other outside influences also caused their partners to change, including the addition of children into their relationship dynamic and the ways that his parents influenced his behavior and ideals regarding marital relationships.

Some participants noticed that their partners underwent a change when their children were born and entered into the dynamic of their relationship. They could not explain why, but for some reason the arrival of children resulted in a change in some partners' behavior. For example, one woman said, "When we started having the children, that's when he started getting more and more violent." Another woman, who saw her first partner become involved in drugs and turn against her after her first child was born, worried that the same might happen in her next relationship. Upon discovering that she was pregnant with her second partner's child, she said,

> I was happy, but at the same time I wasn't like too excited. Because I already knew what it was like. I knew that if I got pregnant again, I knew I'd be left on my own. And that's what happened. I was left by myself.

A similar scenario took place when another woman's adult children moved in with her and her partner (who was not their father). She noted that her partner began drinking, staying out late at night, and spending time with "prostitutes" around the time that her children moved into their

169

home. She blamed her partner's change on their arrival -- as if they had unwittingly upset the relationship's equilibrium. She said, "when they came up, he started to change."

A partner's parents were another external source that women perceived "put ideas in his head" regarding women's rights and marital ideals. Women perceived that their partners acted in "the way he was taught." One woman described how her mother-in-law influenced her husband to embrace an objectified view of women: that women were meant to be prisoners in the home and should be corrected with physical punishment if they disobeyed orders. She saw her partner's behavior change and become physically abusive as he became increasingly influenced by his mother's perspectives on traditional marriage. She said:

> His mother used to say, if I would go out to the little stand nearby to buy some churros or something – we were just married – 'Why did you let her go out? She shouldn't go out. She's married now.' That's what his mother said. [He'd say] 'Mama, she's not doing anything wrong, she's just gone to get some 'churros.' But after that, seems like she talked to him all the time and I started getting my face slapped. 'Why did you leave?' 'I just crossed the street to get a churro.' 'That doesn't matter.' And I'd be slapped around. And soon it was more; soon, whatever I did, it was a punch, a push, my hair pulled.

The machista mentality changed him. Women considered these misogynistic, oppressive ideals regarding women's rights and male forms of control to be *machista*. Women did not believe that men could be born *machista*, but considered they could become influenced by *machista* beliefs and attitudes and adopt certain behaviors as a result. These sexist, misogynistic beliefs could change a man and corrupt his "good" self. When compared with women's perspectives and opinions -- which were considered to be wrong -- the *machista* mentality perpetuated the belief that men were actually infallible. Women felt that, "When you speak your

170

opinion" to a *machista* man, "it's never right." The man, however, is always right. Women found this to be especially maddening; even when they saw a partner flirting with another woman and confronted him, he denied it. As one woman said, even though "you see what he's doing with your own eyes, but he still keeps saying 'no'...that's how he's a *macho*, to just sit right there and say 'no.' That's how he thinks." She also said, "I can't be right, because he gets crazy, he gets angry." And so, in the *machista* perspective, the man says "no" (imposing restrictions) and the woman must say "yes" in order to avoid his anger. As a result, women felt they had to conform to his wishes, because, "What [else is] left for me to do? As they say, 'you'd better dance at the party.'" Conforming to his wishes was different than overlooking risk, however. In this case, women were acknowledging that a partner had become *machista* or controlling with wide open eyes, yet they felt that they had no other option than to "obey" him or go along with his wishes because he held more power.

Women also viewed *machismo* as a mentality of imprisonment, referring to *machista* partners as one might refer to prison guards. For example, Mariana described that husband believed "that a woman *shouldn't* go out...Shouldn't go out, have friends; just has to stay at home." She was not allowed to have friends and could not even see her sisters. And he also monitored her phone contact with her family members, often hanging up the phone after telling them that she was not available when she was in fact sitting right in front of him.

In addition, women saw their *machista* partners ascribe to the belief that "women *have* to stay at home," while men are the ones who "*have* to work." What on the surface might look like attitudes surrounding gender roles was actually much more oppressive than simply believing that a wife *should* sweep and cook. Women described that a *machista* partner would actually assert the authority to restrict and control her environment in such a way that she *had* to sweep and

cook. As Camila said, "[Being *machista* means] that whatever he says, has to be done." Another woman also described her partner as controlling, saying, "Everything has to be like he says, like he wants. It doesn't matter what he's doing, what he wants to do; it has to be how he wants it. And because he says it, that's the way it's got to be, because he's the boss. That's the way it is."

When women did not heed the demands of "the boss," they found that they suffered the consequences of his anger. One woman's husband forbade her to wear makeup, and she said, "If I did wear makeup some day, wow he'd get really angry because I had. That's what *machista* is." She decided to "give in to a few things because I wanted to get along with him;" deciding that refusal to follow his orders ultimately was not worth it. Women also perceived that *machista* beliefs condoned violence as a form of female control. One woman heard her *machista* mother-in-law tell her husband, "You mustn't let her do what she wants, you have to beat her so she'll understand...That's why she married you, so you'll control her.'"

Because women perceived that this *machista* mentality arose from traditional Mexican beliefs, they saw *machismo* as being commonplace in their predominantly Mexican migrant community in the Green Valley. It was a perspective to which they saw many of their partners fall prey. One woman said, "Almost by nature, or by a twist of fate, every woman who works in the fields, and every woman who comes up from Mexico...There are so many of us women who have been used." When she uses the word "used" (*usada* in Spanish), she is referring to her belief that *machista* men use women as "sex objects." She uses this term to describe *machista* men who know how to give sexual pleasure to a woman but do not; they selfishly view the sexual act as a way to exclusively pleasure themselves, to procreate, or to control women by controlling their pleasure. Another woman described having seen violence against women often in her community, and believed that this violence arose from male corruption by *machista*

172

beliefs. She said, "I would see couples where the man beat the woman so bad, he'd pull her out to the street by her hair. Women would come to me crying because they didn't have -- even their teeth were knocked out from punches and blows." In this way women with their eyes wide open perceived that the *machista* mentality had taken a strong hold among men of Mexican origin, and considered female oppression and risky relationships to be a widespread consequence. Among women who were averting their eyes, *machismo* was considered to be a normal component of gender roles. In their view, if a man became "too" *machista*, it was only because his wife had allowed it.

"His own world:" Addiction and mental instability changed him. Apart from assessing that a partner had been negatively influenced by others or by the *machista* mentality, some women perceived that he had been changed by addiction and mental instability. Like the other two explanations, women saw this as evoking a permanent change. They described witnessing a partner enter "his own world" -- an alternate reality in which his behavior became erratic. In "his own world," women saw their partners falling "further and further" away from them, into a space where wives and children did not even exist. In this world, women described their partners as being "too into drugs" and as a result "he didn't really care no more." He would only care about paying off his drug-related debts and would steal from her in order to do so. And on yet another level, women described how partners were "so drugged" that they would force them to have sex "all night long." As one woman said, "[The sex] was never enough for him because he was completely out of it on drugs." Another woman who suspected her husband of being bipolar told how his intense mood swings between "fine" and "awful" prevented her from knowing which side of him she'd get on a given day. She said:

I don't understand why sometimes it's just – it's not all the time, it's just a little while

that he gets so mean. He mentions that word a lot, 'bipolar,' and I think, I don't know. I

think maybe he knows he has some problem and doesn't tell me. That's what I think,

because sometimes he's just fine, and other times he's awful.

We have seen three views women adopted as they grew to perceive that external

influences had corrupted their partner's being: either others caused him to change, the *machista*

mentality changed him, or "his own world" of addiction and mental instability changed him. To

summarize Phase IV, we have seen that the study participants adopted a risk perspective through

two contrasting approaches: on the one hand overlooking risk by averting their eyes and on the

other hand, confronting risk with eyes wide open.

Phase V: Assessing the consequences

In this final phase, women went even deeper into their understandings as their perspective of

intimate partner risk expanded. Some women who initially averted their eyes found that they

were moved to confront risk after assessing the immediate or long-term consequences to

themselves or to their children. Those who did change their perspective often expressed regret

over not "seeing it" sooner.

Assessing how risk is affecting me. Because risk judgment was a fluid process, women

found that their initial perspective -- overlooking or confronting risk -- often changed either with

the passage of time or as they assessed negative immediate consequences of infidelity or abuse.

Assessing more immediate consequences. In the short-term, women judged that their

partner's abusive and/or unfaithful behavior resulted in negative consequences for their own

selves. However, these more immediate consequences did not often prompt women to

reconsider the meaning of their partner's risky behaviors.

Experiencing emotional damage. As one more immediate consequence of their risky relationships, women described emotional suffering including sadness and depression. One woman described how she felt:

Closed off from everyone for about three months, when I first found out [about his affair]. You say, 'Why?' 'How?' You feel so helpless, what can you do? So you don't do anything. I lose weight like you can't imagine. You can't imagine how much weight I lost. I cried all the time. It's something awful I don't wish on anyone.

But even after this initial sadness over his infidelity, even 10 years later she felt as though there were still moments when she felt "really sad, or maybe I just want to cry, so I cry." Although she tried "to not let the sadness get to me," she admitted that as a result of having an unfaithful partner, that "you just don't feel like the person you used to be." She wanted to be happy and did not want "to let the sadness get me down," but found this to be difficult even a decade after his affair. Perhaps surprisingly, her long-lasting sadness did not prompt her to confront her partner or make any changes to their relationship. She actually made a conscious decision to overlook his infidelity and moved on with the relationship as if nothing had happened, because it was more important to have his presence as father to their children and because she valued the domestic duties that he carried out while she was away at work.

In contrast to her story, other women found that their emotional pain brought damage that was too deep to overcome and therefore they needed to end the relationship. Mariana remembered feeling sadness and depression while she was still living with her controlling husband. She said, "I didn't even want to keep going, or [go] to work, or go out with my kids. Because of that [how he controlled me], I didn't even want to do these things, because I felt so sad about all he wouldn't let me do." But at the time of our interview, she was separated from

175

him and felt she had been able to leave the depression behind. Her depression had been a motivating factor that had enabled her to see her relationship in a different light. Now that she was on her own, she reported:

> I have the desire to get ahead and make it, and do what I have to do. But when he was around, I didn't. I'd get depressed and not want to do anything anymore. Everything I'd ever -- the whole mountain of dreams I'd made came tumbling down, it came crashing down. But not now. I have dreams, I have ideas, and I want to get ahead.

Experiencing bodily harm. Apart from emotional damage, women also experienced bodily harm in their risky relationships. Many women in this study assessed that they were at risk for a sexually transmitted disease, stating their fears clearly to me. One woman told of waking up the morning after being forced to have sex with her husband, saying, "I wouldn't be able to sleep all the next day. I'd be working and thinking, 'What if he's given me something?'" Another woman said, "I'm afraid he might be cheating on me...it makes me afraid that he could pass something on to me." With their eyes wide open, women were able to see that their partners were involved in risky behaviors and assessed that the risk to their own bodies was real. However, in many cases, this realization of risk was not greater than a woman's desire to maintain a respectable identity and/or to reap the rewards of helpful relationships.

Another physical consequence of risky relationships was unintended pregnancy. Women often felt that they could not access contraception either because a partner forbade it or because they were not allowed outside of the house and lacked knowledge of contraception. Mariana never intended to have eight children, but avoided contraception because her husband wanted to have a big family and she decided to go along with his wishes. Another woman described why her first three daughters were born in quick succession:

176

The first one I had because I was just married, the second and the other two because I was raped. And I couldn't leave and protect myself [with contraception]. I couldn't go to a doctor, and that's why my girls are only a year apart. I'd get pregnant, have the baby, and then right away again, get pregnant. But it was because of abuse, never because I wanted it to be like that.

And in the absence of STIs and unintended pregnancies, women told how the stress of their risky relationships still took ahold of their bodies, causing physical symptoms. Not surprisingly, all participants told of having heightened levels of stress in relation to the discovery of risk in their relationships. Women referred to this stress as "problems spinning around" or "stuck" in their heads. Women felt as though their lives were already fraught with problems, and that risky relationships only added to the constant barrage. One woman said, "Right now I can take my problem away, but for the next day there are one or two problems more, and it's more in my head and more in my head. And it keeps on going." One consequence of experiencing a high level of stress was that women felt distracted. For example, a woman reported that "everything starts, like, getting stuck inside my head. And like, I don't pay attention to anything else." Stress could also cause women to feel as if they were losing themselves. Isabel said, "Right now, I've got so many problems going around in my head and my mind, I don't even know where I'm at from all the problems." Women also attributed physical maladies including headaches, insomnia, fainting spells, and even diabetes to the stress that they were experiencing in relation to their risky relationships.

One woman had a partner who was physically and emotionally controlling; he also flirted right in front of her with other women at work. She described her headaches, saying:

177

[My headaches are] because of so much pressure from everything going around in my head and the stress I've been under these days. Like when -- yeah, I think it's like when all the tension goes up to your head. My brain, my head, I feel like it's really tense, all day long. All day long my head hurts. All day long. There's not a day, or even a moment that it doesn't hurt. I take pills, but they don't take it away, it comes back again, but I figure it's all the tension I'm under...There's no break. That's why my head, my mind, is about to explode from all the pressure, all the things going on. Sometimes I'm scared of getting sick, and I try to calm down and say to myself to calm down, try to think about other things so I don't keep on going crazy.

Another woman felt desperate while trying to prepare for her future as a single mother, believing that her husband would soon die of AIDS.   She felt a great deal of stress, wondering, "What will happen to me when he's not here; when I'm alone? That's what I think about. Like, how will I be able to [help] my kids get ahead. Not from work -- it's too little what I earn." She was not sure how she would get by financially without her husband's disability checks that helped to support the household and provide for their kids. As a result of all this worrying, she reported having intense stress and depression. She said, "last year I got sick at work, from thinking so much and for so long about all the problems [I have] in my head. I, I fainted at work." She said the heat was not a contributing factor to her loss of consciousness, but that, "I think you can just be thinking and worrying so much about things, that sometimes your head starts to spin. And I got sick, and [the ambulance] had to take me away." After this episode, she was prescribed medication in order to "feel more relaxed." She felt that she needed to take the medication in order to avoid being "completely stressed and scatterbrained," to avoid a future fainting spell, and even to avoid a future stroke resulting from all her stress.

Another woman believed that the stress and emotional upset of her risky relationship actually caused her to become diabetic. She said that the discovery of his affair made her get "really angry, seeing how he didn't take any responsibility for things. He didn't give me [money] for expenses, the kids were always asking for things and there wasn't anything to give them." As a result of this, she said, "I began to feel sick, my body would hurt, I couldn't stand the headache." She was ultimately diagnosed with diabetes and believed that her emotional upset triggered her physical symptoms: that "maybe that's why my sugar developed." But not only was she found to be diabetic; she also experienced other physical symptoms that she believed originated with her stress over her husband's affair. She described her health during this time, saying, "It was getting kind of complicated. My blood sugar was high, and high blood pressure, and sometimes I would black out, like I would faint."

Again, even though women assessed these physical consequences to be grave, the threat or existence of a physical malady usually was not enough to change women's perspectives and prompt them to view risk with eyes wide open. Instead, they often viewed these physical difficulties as consequences that were worth bearing in order to achieve other more important goals.

Coming to conclusions over the long-term. Study participants admitted that their understandings regarding risk continued to change over time. They also found that they could more adequately assess risk when looking back retrospectively on their relationship. As one woman said, "There are things a person doesn't realize when they're living in the marriage." With the passage of time, women gained perspective and understanding. Another woman recalled that even though she was unhappy in her first marriage, she did not realize that she "was

179

really at risk" until years later. Women made contrasts between "then" and "now," telling how ideals regarding relationships had modernized and that they, too, had adopted new views.

Some adopted views that allowed them to relinquish their feelings of self-blame for their partner's behavior. As one woman said, "Before, it wasn't like it is now." She went on to say, "Things change a lot as life goes along, as far as how you look at things...I started thinking differently." She stopped blaming herself and ultimately rejected the traditional belief that she had to stay with her husband no matter what. This paradigm shift allowed her to leave her first husband, and shaped her reciprocal ideals and values for subsequent relationships. Another woman told how she originally blamed herself for the sexual abuse that she experienced in her first relationship. But at the time of our interview years later, she admitted, "At the time, maybe you see it one way. But now that I've grown up, I see it differently." Having originally wondered if forced sex was "normal," years later she was able to admit that he was at fault, saying, "he raped me."

While women admitted that early on they had wondered if abuse and infidelity were "normal" in close, long-term relationships, as they analyzed risk over time, women came to describe abuse and infidelity as an exertion of control. They saw this power imbalance as being divergent from their reciprocal relationship ideal. Women came to a new level of understanding. They were able to judge and differentiate between "normal," reciprocal relationships and those that were oppressive with incredible clarity and detail, describing how they felt manipulated, oppressed, controlled and even imprisoned. While reflecting on their relationships, participants assessed what their partners' actions meant to them and often characterized them as *machista*. Far from normalizing abuse and infidelity, women were able to describe how their partners had attempted to harness control over them. This realization helped them to open their eyes.

However, since I interviewed women who were at various places in their risky relationships, some had not yet arrived at a place where they were ready or able to assess the long-term consequences. Some were still so involved in overlooking risk that they had not yet taken a step back to assess what his behavior really meant for them. Being invested in excusing, downplaying and minimizing his behavior was all-consuming. It was only after some time had gone by that women were able to assess fully how abuse and infidelity had impacted them.

Feeling like an indentured servant. Many women described things that a partner would do or say that would make them feel like they were their husband's property. On one end of the spectrum, a woman told how she heard her husband say, "She's mine, nobody else's," when his friends made a comment about her good looks. At the other end of the spectrum, verbal statements became orders like a master would give a slave. For example, one woman heard her husband demand that she wake up at four in the morning to make his tortillas, even the morning after she gave birth to their first child: "Get up! Did you think I wanted you here because you're a pretty girl? No! Make me something to eat!" And despite the fact that many women felt more independent in the US than in Mexico, those in abusive relationships continued to feel like indentured servants to their partners regardless of which side of the border they were on. This feeling that their body was not their own, extended beyond verbal comments and demands; women described how risky partners also used physical and financial displays of authority in ways that left women feeling out of control.

Women saw their partners use financial displays of power in order to establish their position of control, believing that money conferred power. One woman described that her partner would steal her food stamps, claiming that the food stamps actually belonged to him since she was undocumented and "he's got his social security number and all that." So, by

taking them away from her, he was reinforcing his position of power and compelling her to

depend on his good graces in order to feed herself and her son. Another woman felt as if her ex-

husband continued to "dominate" her because he gave her monthly child support. She said:

> He feels, well, since he gives me money for the kids...he feels like he's got the right not
>
> to let me go where I want, and like, still take charge of things, or do the things he did
>
> when he was living here, like manipulate me.

Whenever he gave her a check, he told her that he was experiencing extreme financial difficulty

and made her feel guilty for accepting money from him. She had reached the point where she

thought extreme poverty was preferable to his manipulation and control: "I don't want even a

penny from my husband...I want him instead to give me that freedom I really need to have with

the kids. I don't want to feel bound to him because he's giving me money." Overall, women

agreed that abusive men felt entitled to "more rights" in a relationship when there was an

exchange of money-- as if they had purchased their wives as indentured servants.

In addition to experiencing financial displays of control, women also told stories of being

punched, strangled and slapped by their partners. Some women felt their partners would hit

them "anytime [he] wants," as a way to reinforce their control. Another way that men exerted

control over the participants was to commit marital rape. One woman remembered how her

husband would require her to have sex with him shortly after childbirth. She said,

> Scarcely a week had gone by [when] he'd take my clothes off me, he'd tear them off,
>
> really rough. He never cared what he did to me. He was really rough...[saying], 'I didn't
>
> want you here so you'd be a little princess; I brought you so you'd be my woman.'
>
> Another woman told how her partner would "force himself on me; he would obligate me

[to have sex]." He would come home and, "slap me around, twist my arm, or [say] 'do it and

don't make a sound.'" She had no voice: "he would just take all my clothes off and do whatever he wanted, I couldn't say anything." He'd tell her, "'you're my wife and you're going to do what I tell you.'" For this reason, she said, "that's why my girls are only a year apart...but it was because of rape, never because I wanted it to be like that." She went on to say,

> He got to being rough, tough, with me; there was no affection at all. Hard and rough; he may have felt some kind of pleasure, but it hurt me, I felt awful and ugly. I was left wishing I hadn't had to give in, crying, and he'd leave and bolt the door, or sometimes he'd just leave it closed, but I was the one left suffering. I begged him not to do anything to me, because when he was drugged it was all night long. Can you imagine all night long? He'd do it once, then again, one thing, another, but it wasn't enough for him because he was completely out of it on drugs, and I was in my right mind. There were nights when it was from when he got home until I'd go to work the next morning. All I'd be able to do was change into my clothes and go off to work, without breakfast, not having slept at all. I'd crawl off to a furrow by the edge of the field and just groan, 'Oh,' that's all I could do, or cry, because what else could I do? Everything hurt, my whole body hurt: legs, breasts, everything...I suffered so much from what he would do to me, I didn't know if it hurt or didn't hurt anymore.

As a result of these experiences, women felt intense shame and emotional distress. As one woman said, "I died from the pain and sadness."

Feeling like a prisoner. Another way in which women felt the effects of a power imbalance with their risky partners was in the form of social controls. In Phase II, I highlighted how women viewed their connection to social information networks as integral to their ability to "see" intimate partner risk. Here, women acknowledged that one way in which their partners

183

displayed their authority was through the restriction of their social selves. When women were not free to move in the social sphere and were disconnected from social information and support, they felt disempowered.

Women who told of feeling imprisoned with partners back in Mexico told of actually being locked inside the house; not allowed to work or socialize with friends. One woman described life in the prison of her in-law's home, saying, "During the day I couldn't step outside, just in the evening when it was dark," and only with supervision. It was as if she was a commodity that needed to be hidden by the cover of night. She as not even allowed to attend family holiday parties that were held at the house. She said, "I didn't go out, I would just cook the food, with my head down." Her every move was questioned by her partner. And since she could not leave the house, she was not able to obtain birth control or information about "diseases and everything."

Since all women in this study worked in the fields in the year prior to our interview, none had recent stories of being held in the house under lock and key. Instead, women felt that their partners had found other less literal ways to imprison them. Women acknowledged that their partners were crafty; they willfully kept the women away from others who might, as one woman said, "put ideas into my head so I'll know how to defend myself and know about my rights as a woman." She went on to describe how her husband worried out loud that other women with whom she could socialize were "sweet-talking you into thinking you can leave me." And so he limited her interactions with others by keeping an eye on her while at work (they worked together under the same supervisor), and making sure she stayed inside the house when he was at home. During our interview, which was held at a neighbor's house, this woman kept looking out the window to make sure he did not return home earlier than expected.

184

Other women saw their partners as an ever-vigilant presence. One woman got the sense that, "He doesn't like me to be alone with the kids, because he wants to be there, always." And when men could not be present, they would closely monitor their wives' activity. For example, one woman described that when she went shopping, her husband called multiple times to ask, "Where are you?" And when she returned home, he inspected her purchases and had further questions: "Why did you take so long?" and, "You didn't buy very much, and you took so long," as if he suspected that she was hiding other activities from him. Likewise, another woman recounted that her partner continually questioned her about her conversations with others at work. Describing how he controlled her access to social information networks, she said,

> If I talk with somebody at work, [he'll ask], 'So what did you tell them?' and 'What did you say?' and 'What were you talking about?' and 'What did they ask you?' I mean, I can't talk in peace, I can't hang out with the other girls at work.

Other women were not even allowed to have friends, and one woman's partner did not even allow her to see her family-- "they had to reach me by phone." But then when they would call, he would tell them, "No, she's not here," when in fact she was sitting right next to him. If they came to the house, he would not let them in.

In this way, some women viewed their partners as prison guards, having control over what they did, heard, and said. One woman who was undocumented described feeling disempowered in fighting back against her partner because if she called the police, he threatened, "'I'll call immigration for them to come and take you away.'" This ignited fear in her as she wondered what might become of her son if she were to be deported. Another woman said that her partner actually moved the family to a town far away from her family, further isolating her and making it nearly impossible for her to access support and help. As a result of feeling held in

their relationships like prisoners or indentured servants, some women felt as if "my life has practically turned into a hell, in a relationship that's going nowhere." This realization was a wake-up call that prompted women to open their eyes and confront risk.

Feeling manipulated. Some participants perceived that their partners said and did things with the intention of manipulating and controlling their minds. Women also saw their partners use lies and "half truths" as tools to assert control and take advantage. For example, one woman believed that her partner "only says what's convenient for him, and what's not, he keeps to himself."

Women also told how they felt increasingly vulnerable as a result of a partner's actions towards them -- especially at times when they were seeking independence from him. For example, one woman believed that her partner "cut the cords from the car" as a way to make her more vulnerable. She thought that he did this because "he wanted to see me, like, down. Like, asking for him." She interpreted his actions as an effort to strand her at home and render her unable to work so she would need his help. Another woman, who described her partner's behavior as lazy, erratic and fueled by drug-induced vacations away from work and family, noticed that he would start working again and providing for the family right around the times when she would threaten to leave him. She perceived that he would do this "so I would distance myself from the people who were trying to help me." In this way, women noted that their partners would wield authority by either rendering them more vulnerable or more dependent -- both would cause the women to lean towards him and away from outside help.

Assessing how risk is affecting my family. But even more than the way they assessed themselves to be affected by their risky relationships, women cared how their risky relationships could potentially affect their children. Women weighed partner risk based on how it affected

186

their children, using their children's well-being as a scale on which to measure the collective risk to the family. As one woman said -- while warning her partner that he could get sick if he decided to sleep with a prostitute -- "If either of us gets sick down the road, who's going to pay for it? The children will." Women perceived, understood and analyzed sexual risk according to how their children could be affected, repeating, "It's not for you, it's for the kids." Or, as one woman said, "I don't think I really want anything for myself. I want things for my children. For myself, I don't want anything." Through an understanding of how a risky partner's behavior was affecting the family system, women were mobilized towards confronting risk. This is described in greater detail in the next chapter, where I illustrate how children were a motivator or a roadblock for women to take action in "fighting back."

Over and over again, as women told me about their risky relationships, I heard how they prioritized their children above themselves. Women felt motivated to prioritize their children because they believed that children were easily "traumatized." Compared with the ways that they assessed risk to be affecting their own selves, women appraised the potential harm to their children as much greater. Even though women felt like indentured servants, prisoners, and scapegoats -- even though they recognized that their partners were manipulating them, putting them at risk for infections and tarnishing their identities -- all this felt manageable and tolerable when compared to the potential harm they worried their children were suffering as a result of their risky relationships. Women were concerned that their children, particularly their sons, could internalize an abusive partner's behavior. As one woman said, "What scares me is that my son could grow up seeing that way of behaving and turn into somebody like that when he grows up." The fear of raising a young boy who could turn out like his father was paramount. Another woman explained why it was so important for her to separate from her controlling partner:

because the kids "realize something is going on...if we keep on like this, I don't know what we're going to get to, and the kids are going to be traumatized. Because they see everything, they know everything." Even though women went to great lengths to prevent their children from "seeing" their fathers' abusive and cheating behaviors, women were honest in assessing that their efforts could not be successful all the time. For this reason, women often changed their way of looking at risk and chose to confront it with eyes wide open. The reality of the way their children were being affected or could be affected by an unfaithful or abusive partner was enough to change their perspective.

     Feeling regret over not seeing it sooner. As a result of assessing the consequences, I saw how some participants changed their perspectives on risk. After years of averting their eyes, they came to see that the consequences to their own selves or their children were too great to bear. However, in spite of the fact that participants were embracing more modern perspectives on relationships and women's rights, most retained feelings of self-reproach while reflecting on their risky relationships. Women had great difficulty relinquishing their feelings of self-blame. They expressed deep regret over their choices that they felt had led to their risky relationships, and they wished that they could have "seen" risk in their relationships sooner. Their initial lack of awareness made them feel complicit in the way their partners were able to garner control over them. Looking back on her relationship, one woman admitted, "There were a lot of things he did to me that would show I shouldn't have been with him." She wished that she had picked up on his behavioral clues sooner, instead of staying with him and suffering for five more years. Women wished they could go back in time and take back their decision to get together with their partner -- even though they admitted that at the time, it was impossible for them to know how the relationship would turn out. One woman expressed her regret by saying, "When I look at my

situation now, how it is, I'm really sorry about it. And I say, why? If you could wave a magic wand and go back in time -- but you can't."

So we have seen in phase four how participants assessed the consequences of intimate partner risk through three means: assessing how risk is affecting me (assessing more immediate consequences and coming to conclusions over the long-term), assessing how risk is affecting my family, and feeling regret over not seeing it sooner.

This is the final phase of the process of expanding perspective. In phase one, women felt blinded. Then they went on to make the discovery in phase two, weigh their priorities in phase three, adopt a risk perspective in phase four, and finally assess the consequences in phase five. But this was not all that was going on in women's minds and bodies as they experienced intimate partner risk. In the next chapter, I go on to explain a second simultaneous process at play: a strengths-based approach to how women worked to gain leverage over the struggles that threatened to overcome them.

Chapter 7:

Results Part III

Gaining Leverage Over Intimate Partner Risk:

Strategies Employed by Migrant Farmworker Women to Fight the Bad, Find the Good,

and Fortify the Self

Introduction

In chapter six, I explained how migrant farmworker participants used cognitive, emotional and social micro processes to expand their perspectives of HIV-related intimate partner risk. Now in chapter seven, I go on to elucidate how women were simultaneously strategizing to take action against risk and danger through a process that I call "gaining leverage." I use the term "gaining leverage" because migrant women in this sample were very actively involved in pushing back against intimate partner risk. But at the same time, women did not feel that they were in full control or that they had overcome the danger of risky partnerships. Instead, participants used narratives that illustrated how they felt they had achieved leverage over risk through the use of specific actions.

As a verb, the term "to leverage" can mean "to gain strategic advantage," or "the use of a small initial investment to gain a relatively high return" (Webster's Universal College Dictionary, 1997). As a noun, it is synonymous with "power" or "ability." But perhaps the most useful illustration for "leverage" is "the mechanical advantage gained by using a lever" -- like wedging a crowbar underneath a huge boulder, resting it on a fulcrum, and pushing down on the crowbar with all your strength to raise the boulder just an inch (see Figure 3, Appendix M). Even raising the boulder an inch or so might give some room to work or gain advantage; it may not be enough to free an object trapped beneath, but it might be enough at least to relieve some

pressure. This is the core of "gaining leverage" for participants. They were pushing back against risk and danger with all their strength and with the resources available to them, in order to gain some kind of advantage in the face of what were at times overwhelming odds.

In this chapter, three main categories of the process of "gaining leverage" are addressed. First, I will describe how women used their own personal resources as a form of protection to "fight the bad" of intimate partner risk. Then I will discuss how women needed additional outside assistance in order to gain leverage over a risky partner. However, gaining this outside help was complex because women learned that external sources could also inflict additional harm. Thus, women felt they needed to "find the good" in these outside sources. Finally, I will discuss how women used their own personal resources in order to "fortify the self;" to help themselves emotionally get through and get over painful relationships with the goal of "moving forward" or "getting ahead." See Table 4 in Appendix L for a taxonomy of the categories in the process "gaining leverage."

If there were pictures to illustrate each category, "fighting the bad" would be pictured as a woman standing with her fists clenched. "Finding the good" would be a woman extending an outstretched hand as if asking for help. And "fortifying the self" would be depicted by a woman with her hands embracing her shoulders with her arms crossing her chest -- as if she were hugging herself.

These three categories of gaining leverage exist in a step-wise, cumulative fashion. Initially, women relied on their own individual resources to combat partner risk. But eventually, they came to a point where they realized they needed to look outside themselves for support and turn to others for help.   Finally, in the aftermath of a risky incident or a risky relationship,

women again used their own internal resources in other to "move on" and overcome emotional and physical consequences.

Participants were motivated by a variety of factors. The most common motivator was children. As one woman said, her children and grandchildren motivated her because "I have somebody to keep going for," and caused her to feel that "I have to make the effort." At other times, women were ready to take action in order to gain leverage but came up against roadblocks that caused them to change direction, slow down, or stop.

Fighting the Bad

The first way that migrant farmworker women in this sample gained leverage in risky relationships was to "fight the bad," or to use their own individual resources to personally fight back against a partner's actions with the goal of self-preservation. In order to fight the bad, women calculated moves to resist harm and took measures to control a partner's behavior. These actions were prompted by motivating factors and suppressed by roadblocks. This section highlights how and why migrant farmworker women felt able to take action, or felt restrained from taking action, as well as what action they did take to gain leverage over an abusive, cheating, and/or substance-abusing partner.

Even when study participants did not feel that their efforts had the intended result, they found that their actions against a risky partner were useful. By making attempts to resist harm and/or control his behavior, they asserted their roles as active agents who strove to gain leverage in order to protect their children and maintain their personal dignity. In their narratives, women constantly told how they fought back. It was only after they were repeatedly struck down that women assumed a silent or submissive role; but this was not a role to which women resigned

192

themselves. At the next possible opportunity, they took another chance to fight back, again and again.

Motivators. Women demanded reciprocity in their relationships primarily because of their status as workers and wage earners. They also felt motivated to labor towards gaining leverage in order to maintain their respectable identities, to care for themselves so they could be present for their children, and to protect their own dignity and happiness. Finally, women were also prompted towards action when they felt they had reached their limit and could no longer take a submissive role in their risky relationships, or when they could imagine being independent without the financial or instrumental support of a partner.

Feeling that their status as workers provided them with leverage. Women believed that they should have equal decision-making authority in their relationships primarily because they were working just as hard as their partners. Carolina clarified that even if a woman did not work outside the home, that household work required just as much effort. She said:

> The two should get together, and then decide things together. Because one works just as much as the other. Even if she doesn't go out and work in the fields, she's working at home. She's caring for him, fixes his meals, gets his clothes ready for him -- she's working with him, anyway. Right? That's why I think both of them should make decisions together.

This perspective on helping and sharing money results from evolving beliefs adopted by Mexican women who work in the US. Women perceived that that, "There [in Mexico], women don't work. Just the men do. Even though she might suffer at home, the woman doesn't work." Because women considered working outside the home to be less culturally acceptable in Mexico, they saw their ability to work outside the home in the Green Valley as a benefit of evolving

193

perspectives and a more modern locale. After seeing adult role models in her family enact

traditional gender roles, Laura was inspired to break free and demand reciprocity in her own

partnership as a way of gaining leverage. She told how her alcoholic uncle had full control of his

family's finances in Mexico, saying, "He was the one who always bought the food, he was the

one who oversaw what he did with the money he earned...but he never bought many things [for

the family]." Meanwhile, Laura observed that her aunt "never even so much as touched a

dollar." Her aunt was just waiting at home to see if her husband would bring enough food to

feed the children. Laura worried that her own relationship could take on some of these

oppressive qualities if her partner did not start to share his income with her, saying, "I don't want

it to be that way."

Maintaining their identities. Because women believed that their identities could be

altered by relationships with risky partners, they weighed risk according to whether a partner's

affair was hidden or outright in the public world. If a man had an affair in public -- if he was

seen by others with his mistress -- the affair was considered to be especially risky. For example,

Gabriela was willing to continue living with her partner (albeit "like strangers") for a year until

he brought his affair out into the open. When he did this, it invited gossip to start and allowed

the reputation of the family to be tarnished. When she realized that "he was actually being seen"

with his mistress -- when the mistress came to pick him up at home and others in the trailer park

saw her -- the affair took on new meaning for Gabriela. Once the affair became outright,

Gabriela could no longer permit her husband to live with her in the house. The social harm he

was inflicting upon her was just too great. Gabriela was able to forgive him for a hidden affair,

but she was compelled to take action for an outright affair. She said to him:

194

I don't want you here causing the kids any pain, nor making the neighbors talk. They

say, 'Look at so-and-so, she's got him sleeping outside,' or something. I tell you that

here with these people you can't do that. The truth is, I just want to be at peace.

The effects of neighborhood gossip impacted how she weighed the severity of her partner's

behavior as well as her subsequent response. The inability to keep her personal life private while

living in the trailer park -- where she felt everybody could see what was happening in her

relationship -- was conditioning her perceptions and ultimately, her actions. And so, how men

dealt with evidence of their affairs was very important for women. Once the men stopped trying

to hide evidence, women felt that the reputation of the family was at risk and they were prompted

to take action.

Caring for self because kids need me. In the previous chapter I illustrated how

participants prioritized their children above all else, saw their children as an extension of their

own selves, and assessed intimate partner risk primarily in terms of how it affected their

children. Here, I will explain how women were motivated to engage in self-preservation and

self-protection according to their children's needs. For example, they downplayed matters of

intrinsically-valued personal safety. In fact, women valued their personal safety only in relation

to their ability to mother their children. Women actually viewed their children as an extension of

their own bodies/selves, and this extended view of self offered rationale for self-protective

strategies. Women cared for their bodies in order to be healthy enough to care for their children.

Some women saw a partner's capability for personal harm as motivation to leave the

relationship. As one woman said, "if I had stayed there [with him], he would have killed me and

his girls would have been left without a mother." In other circumstances, women worried not

that a partner would kill them but that they could suffer a grave illness and be unable to provide

195

or care for their children. Sometimes, being healthy for the children meant that women felt they must end a relationship in order to avoid a sexually transmitted infection (STI). One woman contracted an STI from her partner when he came to visit from his mistresses' home in Mexico. She said, "I want to take care of myself because my kids are going to need me--they're still little." She cut off all ties from her partner after coming to this realization. Another woman decided to break off her sexual relationship with her ex-husband because she reasoned that there could be a "bigger" consequence to their sexual relationship, "like me getting sick." She recognized that she had no way of knowing if he had other partners, and acknowledged the risk she was taking by continuing to sleep with him. But she framed the chance that she could become infected with an STI in terms of her children's well-being, not her own. She said, "My kids are the ones who will suffer because they're with me. And if I'm not with them, they're not going to be okay."

In a similar case, Mariana's perspective on her separation from her partner was framed within the context of her children's well-being. She said, "I could have kept on [with him] as far as I was concerned, but more because of the children; I didn't want them to see all that...I did it more for them." She felt that she would have been able to tolerate staying with him, but wanted to limit her children's exposure to him so that they would not be "traumatized."

Other women framed the need to seek an HIV test in terms of, "I know I have to for my kids, because I have to be here for them." One woman who said this perceived that she would not be able to care for her kids if she contracted HIV, because she viewed HIV/AIDS as a debilitating and deadly disease. This motivated her to get tested; however, she felt fear when considering the likelihood that the test could be positive. She heard her oldest son encourage her to get tested, saying, "Maybe I might not need you as much, nor my other sister who's eight, but

196

think about the babies. They still need you, Ma. You have to do it for them." She felt she had to harness her fear for her children's sake, because she needed to be around for them. She saw the purpose of HIV testing as making sure that "*we're* okay." She viewed her children as an extension of herself--she was willing to get an HIV test for their sakes, because their health was really an extension of her own health. In other words, the welfare of her kids was inextricably linked to her own health and well-being.

   Protecting dignity and desiring happiness. However, women were also motivated to act in response to personal desires to protect their own dignity and prioritize their own happiness. Women felt as if they could gain leverage when they stood up for themselves, even if their efforts did not actually minimize their risky relationships. There was something compelling about taking action against a partner that proved to a woman that she was strong and that she had the ability to stand up for herself. This is the opposite of being "softhearted," which was a roadblock that prevented women from acting. When women felt "softhearted," they were constrained from action.

   Women also admitted that they were motivated to take action against their risky partners because they wanted to be happy. Although their own well-being was not the deciding factor -- children were, after all, more important -- the pursuit of happiness encouraged women to fight back against their partners. For example, Laura acknowledged, "If he doesn't make the changes I asked him to, I'm not going to want him around here. Because I want to be happy, not having to put up with [him]." The opposite of happiness, therefore, would be "putting up with him." She went on to add that, when she saw him drinking daily, "Seeing him like that makes me feel so bad, and I don't want to feel that way about anything." Laura realized that she was not going to be happy or "at peace" if she stayed with him, and acknowledged that there was enough stress

197

in her life -- tearfully referring to the fact that she left her older children behind in Mexico -- that it was not worth it for her to "live here, so far away [from my kids], and like this." This realization provided leverage for her decision to break up with him.

Reaching a limit. Moved to action by both internal and external motivators, women came to a point in their risky relationships where they felt they had reached their "limit." Women came to a point of feeling "fed up" with a partner's behavior, and decided to take action because "the damage is already too much." Some women reached their limit after the accumulation of many incidents over many years. When women came to this "limit," it was like a switch was flipped. Whereas they previously felt unable to act, becoming fed up or reaching their limit prompted women to act.

Other women hit their limit and decided to take action in response to one particular incident. For example, one woman reached her "limit" when her partner, who had been a moderate drinker, started "drinking every day." In response to this, she made the decision that their relationship needed to end, saying that that day, "I'd had enough, reached my limit...I don't like it. No, no, I don't want this anymore...If he wants to be that way, well, he can. But not here, not with me anymore. Because I told him I have a limit, and that day I got to my limit. So, no more." Another woman also decided to leave her partner when she contracted an STI that she believed came from him. She said, "It's happened once, I got sick, and there's no reason I should keep on getting sick because he's in my life." After this, she swore to herself that she would not allow him back with her again: "No more, you're never, *ever* going to come back to my house again."

Other women reached their limit as a result of repeated behavior on the part of their husbands; it was not one particular incident but the accumulation of many transgressions that

motivated women to act. For one woman, it took seven years of abuse before she reached her point of saturation when she realized that she had stayed in the relationship for so long. She said, "It had been so long, I just couldn't put up with it anymore." After hoping that he would change, she finally accepted the fact that the only way for her to end the abuse was to find a way out of the relationship. Another woman decided to leave her husband and come to the US when she got "tired" of the abuse and infidelity. She said, "Finally I just got fed up...I was so tired [of it]." She told him, "No, that's enough, no more. I'm not going to put up with you anymore," reasoning that it was time to take action "because I had already had to put up with so much with him."

Each individual woman had a different point at which she drew the line. Some women reached their limit when they came to the realization that, if a partner was not going to provide financial support for the family, then it was not worth it to stay with him. One woman said, "I finally said, 'Why do I want you around? If I'm going to be the one to support the kids, better I just do it [alone].'" Other women worked hard and "try to give in to him," but upon realizing that he was not "going to change even a little" and that "it was always the same thing, always the same," some decided that "I couldn't take it anymore -- and couldn't continue to give in to his demands any longer." As one woman said, "They [men] can do a lot of things to you, but you have a limit. And I got sick and tired finally of all the things he did that I didn't think were right."

Imagining independence: "I can do it on my own." As participants considered life as single women -- either having already left or thinking about leaving a risky relationship -- they found strength and meaning in their ability to work and provide financially for themselves and their children. Their ability to work in the fields was like a lifeline to them -- without their jobs,

199

they imagined feeling hopeless. In this way, a woman's role as a farmworker changed her self-concept and even changed how she viewed her intimate relationships. Having the ability to work in the fields provided women with a sense of leverage and independence. Yasmín, whose husband cheated on her once, figured that she would be able to "care for [the kids] and move on" without him if he were to cheat again. She told him, "Maybe I never studied enough to be a better person, with a job that pays better, but I think if you were unfaithful to me and I -- we left each other, I wouldn't feel unable to take care of the kids." She believed that she could be self-sufficient, without "even a penny of help" from him.

When they felt they were able independently to provide for themselves and their children, study participants felt that they had gained enough leverage no longer to feel the draw to stay in risky relationships. Previously feeling blind and foolish, women told me how they imagined that they could make it on their own because "now I know a lot of things." As one woman said:

> If he's not going to behave nicely...I can get by on my own, because I know how to live
> on my own...I feel like I just don't need him. I can do it by myself. I do everything on
> my own anyway, right?

In essence, becoming independent is the opposite of "needing help," which was a motivator for entering into relationships in the first place. Renata remembered saying to her ex-husband, "I'm not going to be begging you to come back. Never more, because I can take care of myself now. You taught me how to work...So I don't need you anymore." Renata first came to the US because of her husband, and he taught her what she needed to know in order to make it. He helped her get her papers and he taught her to work in the fields. But when he became abusive, she realized that she had enough resources to make it on her own and she separated from him.

200

She described her transformation from a dependent, submissive wife, to an assertive, independent single woman.

In contrast to the first time her husband cheated and she decided to get back together with him, Ines felt like a repeated infraction would end their relationship because she no longer was dependent upon him due to her role as the primary breadwinner in their household. Having discarded the traditional view that men work and women stay home, Ines said, "Before, when I came back from Mexico, I was like, more close-minded. 'How can I be on my own?' I thought. Your mindset is like what you live in Mexico. There, they're [the men are] the ones who work, for the most part, and that's what keeps you going. And here, I'm the one who works." Her role as a working woman gave her the strength to see her relationship as disposable if necessary. She said:

> Now that I'm working, I'm the head of everything. Before, I thought I couldn't live on my own. [I used to wonder] how would I be able to face it on my own, paying the bills, for my kids, for the rent, for this and that. So now I realize I can do it on my own. And if something else should happen, if it ever happened -- if I ever even *heard* something was going on, it would be over. Over. I can get along on my own with the kids...It's not about having confidence in him, it's about if you do this again, I'll leave you, and that's that. It wouldn't be about staying together. Because I know now I can work. I know I can do everything by myself and be on my own. I've done it. So, not anymore.

Roadblocks. In contrast with motivators, women also identified roadblocks that prevented them from taking action to fight back against their risky relationships. These roadblocks included protecting their children's well-being, fearing him, reaping benefits from partnership, and maintaining their identity.

Protecting children's well-being. Just as children provided motivation for women to engage in self-care and take action to protect themselves within risky relationships, children were also at times a roadblock to action. In these circumstances, women perceived that taking action would cause harm to their children and therefore chose to take a submissive role in their relationships.

For example, one woman often chose to be submissive in response to her husband's verbal and physical assaults in order to protect the children. She said, "I figured, either I stop [yelling] or he stops, right? Because the children shouldn't be hearing all this yelling, and I'd say, 'Okay, I'll stop.'" While pregnant, she prioritized the safety of her unborn child to standing up to her partner; she would "try not to argue or anything, because he'd already beat me up, and what if I fell down with this baby inside me?" And she ultimately felt that she had to give in to him in order to try and keep the children from discovering how badly he was abusing her. She felt she had to leave doors open and unlocked in order to keep the noise down. These doors and locks are like a metaphor for her body--she opened herself up to his abuse in an attempt to shield the children from the truth. At night, she decided not to "even bolt the door," because he was out for most of the night and "I didn't want him to make a ruckus when he'd come home." And when she'd take a bath, she knew he would come in to rape her. She said, "I knew I had to leave the [bathroom] door open, because I didn't want my girls to hear anything."

Study participants thought they had to protect their partner's role as "father" in order to prevent their children from growing up "with a lot of resentment" towards their father or from growing up without a father figure at all. One woman verbalized fear that if she left her partner, he would no longer be present for the kids. She said, "You don't want your children to grow up

without a father...if you leave their dad, well, dads aren't dads. If you leave them, they don't care about the kids anymore."

Fearing him. Some women thought they had to acquiesce to their abusive partner's demands because they worried that any little thing could spark his anger. Women noted that their behavior was shaped by the fear of what he could do to retaliate. One woman said about her partner:

> He was very jealous and he used drugs. When he'd take me to visit my mom, for instance, I had to always be watching for him, because when he came, we'd have to just take right off and leave. No saying goodbye or anything, because he used to get really angry. Sometimes I didn't even go out, I'd just stay closed inside, with the kids, taking care that they not make a sound and make him angry, because he was real hot-tempered and violent.

The fear that women felt when thinking of their partners could be paralyzing. One woman said, "You start feeling so scared, you don't know what to do." Another woman struggled to understand why she was so fearful of her partner, and clarified that her fear did not stem from his physical authority but instead from the emotional control he held over her. She said:

> Right from the beginning when we got together, it was like a mix of respect, some fear, I don't know how to put it--but it was fear, I was afraid of him. I was afraid of him, and he only comes up to here on me (_gesturing to her shoulder_), he's really short...But real fear, even today, I'm afraid of him. I don't know why, I'd like to know why I'm so afraid of him, I'm really afraid, and I don't even know why.

However, some women were afraid that their partners _could_ physically harm them. Women with violent partners discovered that their actions against him were not successful

203

because he was physically stronger. Some women displayed scars on their bodies as evidence of this power inequality. These women found that it was better to remain silent or be submissive within the context of controlling, violent relationships. For example, one woman told how she tried to control her partner's behavior when he was drunk and belligerent. She remembered trying to be the voice of reason, telling him:

Go sleep out there with your friends because you're drunk, and tomorrow when you're better, come and we'll talk. Because we can't fix things this way, and it's better for you to shut your mouth and not keep on insulting me. Otherwise, it's going to get worse for you, because you don't even know what you're saying. You're just saying stupid things because you're drunk. You'd better be quiet, and tomorrow we'll talk.

In response, her partner grabbed her phone from her hands and refused to leave the house, blocking her exit with his body. She quickly found that verbally fighting back only escalated his violence towards her.

Other women also perceived that their efforts only worsened their situations. For example, one woman referred to a cycle in which her partner would exert control over her and she would disobey, only causing him to shout louder. She said, "You know how it goes, you start trying to stick up for yourself." But she soon realized that it was not worth it to stoke his anger by talking back to him, saying, "No, that sure wasn't the way to do it." In this sense, her own efforts to push back against his controlling behavior did not ultimately help her; they were a hindrance. Her situation with her partner worsened over time, and she believed that this was partially due to the fact that she was not willing to sit back and remain silent. For example, he would bolt the fence shut to keep her in the house, and she would jump the fence and go to work.

Women also thought it was impossible to fight back physically against a controlling partner, even though some wanted to or even tried to strike a partner in return. One woman, who never thought she would actually be able to physically overpower her partner, said, "Sometimes I'd take something in my hand, thinking, 'I'd better have this close by, like a stick or something, in case he wants to do something to me.'" Only one woman told of actually striking a partner, and she only did so because her son "got right in the middle" of a fight, trying to defend her. She saw her husband raise his hand to strike her son, and she told me, "I put a stop to that, though. I didn't let him, and I hit him right back." She might not have used physical force as a defense strategy had her son not intervened. She was clear that she did not hit her partner in order to protect herself -- she did it to protect her son.

In other circumstances, women recounted complete submission to a violent partner. For instance, women who told stories of marital rape admitted that they would "just bite the pillow" and bear it, because "What else could I do?" Feeling that they lacked the physical ability to fight back, women assessed that the best course of action was to wait for it to end.

At the most extreme end of the spectrum, women viewed their abusive partners as executioners who had the ability to kill them. As a result of these threats, some women believed that the actions they could take to fight back were constrained because they feared the ultimate consequence of death.

In some circumstances, women strategized to stay with a risky partner because even though they viewed him as an executioner, they assessed that staying with him was ultimately better for the children. Although most women saw their children as a motivator to leave risky relationships, others decided to stay in a risky relationship for their children's well-being. For example, Isabel decided to stay with her abusive partner after assessing that "enduring [the

relationship] for my son" was her best option. She feared her partner and believed that, "he'd

kill me first, before I could leave...and what's going to happen to my boy?" Her biggest concern

regarding her partner's threats on her life was that then "my baby will be left all alone."   Her

son's welfare was her first thought, trumping her own physical safety. Instead of being sent

down to live with her family in Mexico, Isabel worried that "the [US] government" would take

custody of her son if something happened to her. This was an unacceptable thought for her. She

did not believe that he would be safe without her. And even if she could manage to sneak away

from her partner undetected, Isabel ultimately believed that she would never escape his

omniscient powers. She said with certainty, "he's going to look for me," and "he's going to find

me."

Isabel viewed her choice to stay with her abusive partner as strategic. She said, "I realize

what's happening, but my son keeps me in it. I get it, I see it." She had come a long way since

initially being fooled by her partner's good behavior that "showed me the moon and the stars,"

wooing her to him before he changed and became abusive.

And so even though she believed that "I'd be better off" without her partner, she

remembered the possibility that her son could be left without his mother. She said, "I think about

all that, and I figure, 'No, I'd better stay,' whenever I want to leave...If I were alone, I'd be gone

already." She did not see a clear alternative that also provided for her son's wellbeing, and so she

chose to place his needs over her own. She said, "I have to put up with it all for his [son's] sake,

so he'll never have to see something I never want him to see." Like other participants, she

viewed her presence in her son's life as protective; believing she -- and *only* she -- could shield

him from harm. With her family across the border in Mexico, Isabel felt as if she lacked the

necessary help and resources to protect her son from both her abusive husband and/or the state's foster program.

Reaping benefits from male partnership. Study participants were not likely to take action or leave a relationship that conferred what they considered to be irreplaceable benefits. The cornerstone of the reciprocal relationship was that women were both giving *and* receiving benefits that were useful. When women perceived that the benefits of the relationship continued to outweigh the risks, they were likely to remain in the relationship. Women chose to stay in relationships primarily in order to survive. And women acknowledged that often, the pragmatic value of partnership superseded the risk. Of course, when women noticed that they were no longer receiving sufficient benefits from a relationship, the value of the relationship plummeted and women's priorities changed.

Legal benefits. A few women understood the pragmatic value of their relationship in terms of legal benefits. In relationships where a woman was not documented and the man was, women saw partnership as a potential avenue for obtaining papers. A number of documented participants told of obtaining their papers through a partner. Others acknowledged that partnership -- even with a risky partner! -- was valuable because of the possibility of obtaining papers. For example, even after one woman found out that her partner was cheating on her, she stayed with him because "he was helping me for my papers. So, it was like I had to have him here." She opted to avoid physical contact with him in order to protect herself from contracting any infections that he might acquire while having sex with other women. But she felt that it was necessary to "have him here" with her -- in her life, in her house -- in order to get important legal benefits.

Protection from external dangers. It seems ironic that, although women in this sample characterized their partners as threats, they also viewed these same partners as the best form of protection from external dangers. As one woman admitted, she would rather "go back to what I know, which is his drinking," than open herself and her children up to the unknown dangers that were present in her life apart from him. In the previous chapter, I illustrated how women experienced power differentials in their risky relationships. But here, I am contrasting how male partners (corrupted or not) provided benefits to women. Even if a partner was abusive, the relationship still served an important function by offering women protection from threats outside the home.

Within the farmworker community in the Green Valley, it was commonly accepted that male partnership protected women from harm. Particularly among women who traveled through the Green Valley and camped in their cars, the general consensus was that "You bring somebody along to take care of you." For some women, a father figure or male companion could suffice for protection while on the move. But for women in risky partnerships, relationship maintenance was key in order to stay safe from outside threats. Women who worked alone in the fields experienced greater dangers than women who were partnered and worked alongside a man who could protect them. Illustrating this point, one woman paraphrased a comment her 14-year-old son made to her while he picked lemons with her one weekend after she left his father. He said to her:

> Ma, why don't you get together with someone, with a man who loves you, who helps you out? I feel really sad that you work here all the time all by yourself, in these big trees you work. Better for you to find someone to be with. These trees are so big, so spread out, and who knows but what all of a sudden somebody appears who might want to hurt you.

208

It would be better for you to get together with someone so you'll have somebody to work with.

Apart from the workplace, women were also afraid that harm could come to themselves or to their children at nighttime. One woman told of a time when two male strangers knocked on the door in the middle of the night and confronted her and her partner with a shotgun. She ran into the bedroom to call for help while her partner "took a beating" in his efforts to defend himself and protect her. She added that, "Nothing has ever happened to me because I am always with my husband." Her partner's presence in her life shielded her from harm, and this provided motivation for her to stay with him despite her suspicions that he was cheating. Another woman decided to get back together with her abusive partner because she was afraid to be alone with her kids at nighttime. She said, "I felt like during the day everything is fine, but at night, it's like, I don't know. I felt kind of weird [to be alone at night]."

Women also perceived that their partners offered protection from sexual harassment at the workplace. The presence of a male partner provided a buffer to the outside world, filtering and sometimes preventing inappropriate comments from male strangers. For example, even though most participants were not formally married (in the church or by the state), they referred to their partners as "husband." One woman explained that she does this because she believed that, "if you don't, [other men] come around and bother. And who wants that?" When he was present with her, she believed that other men thought, "How can we *not* respect her, if she has her husband right there?" Another woman admitted that men still said "obscene" things to her, "insinuating things" with her partner just out of earshot. So, a partner's presence could provide protection from what other men might have *done*, but not necessarily from what they might have *said*.

Economic benefits. Economic benefits were another reason that women stayed in risky relationships. Women admitted that it was next to impossible to survive in the Green Valley on one income and provide for multiple children. Despite their desire to be independent and their assertion that "I can do it on my own," the harsh reality was that most women would struggle to make ends meet without a second income from a partner. As one woman said, "There's nothing like living by yourself, but it's so hard, being alone to pay the rent. I used to pay rent by myself, but ever since work got scarce and all that, I can't do it on my own." When her partner left, another woman remembered asking herself, "How am I going to buy shoes for the kids? How can I pay the rent?" For this reason, many viewed partnership as necessary in order to have two incomes to pay the bills. Another woman stayed with her partner because if she separated from him, she would be homeless. She worked in the US and lived out of her car, then returned to the home she shared with her husband in Mexico. Their home was the only one that she had, and she hoped that someday she would be able to pass the land down to her children. This land in Mexico was the only tangible thing that she felt she had rights to -- rights she would lose if she left her partner.

Women told how men used the promise of economic benefits in order to lure women to come back to or to stay with them. After one woman separated from her partner, he convinced her that she would not be able to get by without his help. She remembered thinking how "it was really hard for me because I don't have any family here. I'm by myself." He used this reasoning in order to help her see that it would be difficult for her to make it, providing for her kids alone as a single mother. She said:

210

He said that if I'm alone, how would I get along with the kids and everything? I tell him

I'll be fine, I know how to work, I can drive and everything. I do everything on my own.

But since he kept insisting...I told him it was okay [to come back].

When another woman was worried that her younger partner would leave her for a woman

his own age, she told him, "Don't keep calling me, I'm going to leave you. You find a young

girl." But he wanted to stay with her and said through tears, "Please don't leave me. I'll give

you all my checks, just don't leave me." She changed her mind and decided to stay with him for

four more years -- until he did in fact leave her for younger woman. The promise of financial

secondary benefits was enough for her.

Women felt that being a single mother was "hard," primarily because it was so difficult to

survive financially on just one income. But women told of having to "just do what you have to,

out of necessity." And necessity sometimes drove women to make uncomfortable decisions in

order to provide for their families. One woman in this sample needed to supplement her income

from fieldwork with work in the sex trade in order to get by. When her husband left, she did not

know how she was going to financially make it on her own. Choosing to work in the sex trade

was a difficult decision, but she did it because she believed that it ultimately benefitted her

children. Acknowledging that she viewed sex work as wrong, she felt justified in her decision

because the ends justified the means. She said:

God isn't going to chastise me for helping my kids. And at some point if God wants to

take me, I'll die and I won't have to pay for anything because I'm helping my kids; taking

care of them and giving them what they need now.

Instrumental benefits. As if simply surviving financially on one income was not hard

enough, women also worried that being a single mother would leave them to do all of the

financial providing for the family *and* all of the emotional work -- the caring work that mothers did to raise their children. Being a single mother and working in the fields was a daunting task -- not only because living on one income was a financial hardship, but also because a single mother had to do most of the instrumental work of parenting. Another benefit that women received from male partnership was instrumental help: sharing the work of the household and of child rearing. When women considered fighting back against a risky relationship, their thoughts were tempered by the ways in which their partners provided instrumental help.

For example, Ines was the breadwinner in her relationship. She was documented and her partner was not. Because her partner was undocumented and had difficulty finding work near their home in Arizona, she was the one who worked to generate an income and he was the one who worked to run the household. In essence, Ines thought, "even though he doesn't help much economically by working, he's helping. He helps me." While other participants referred to their partner by using the "we" form -- as if they were part of a team -- Ines spoke individualistically about her life. As women in reciprocal relationships did, she did not see herself as part of a team with her husband. Without him, she'd have to spend part of her hard-earned income on childcare and a housecleaner. Because he felt "desperate" about this situation and would prefer to work outside the home and generate income for the family, he was considering returning to Mexico. Imagining the possibility that he could return to Mexico, Ines thought that then, "I'm going to struggle because he's the one who takes care of the boy." She had no reservations about how his move across the border would affect their relationship or the family -- her thoughts immediately went to how she would continue to work and run the household without him. She said:

He helps out around the house. He sends our boy off to school. When I get home, everything -- he washes, he does everything around the house. I don't have to pay for a babysitter. I don't have to pay somebody to do the housework.

Apart from the financial savings of having her husband at home to provide childcare, Ines also thought, "someone has to take care of him [my son], and better he be with his father than with a stranger." When Ines referred to the way her partner was a "good" partner, or how the relationship was quality, she measured value by how her partner was willing to do as she asked and keep the house clean. She said:

Like when I go to work sometimes I tell him, 'Hey, how about making some beans? Or, you know what? Wash these clothes for me because tomorrow I have to work again.' He even does that, divinely. He's the kind who hangs the clothes out...[then] brings it in, folds it, puts it away in the drawers. Doesn't leave things half done. Really awesome. That's why, I have to say, he has his flaws, but he has some really good qualities. Lots of them.

When Ines referred to her partner's "flaws," she was referring to the fact that he cheated on her with another woman ten years ago. For her, his qualities that give their relationship redeeming value involved how he helped instrumentally around the house.

Another woman's situation provided an example of why women chose to stay with a risky partner because of the value added to the relationship by his instrumental help. Even though Mariana viewed her ex-husband as a *machista* man who created an oppressive home environment for her -- literally keeping her in the house like a prisoner and preventing her from seeing even close family members -- she still brainstormed out loud the circumstances under which she would be willing to take him back. She remembered back to the start of their

relationship, when he did not want to help her with the children or the household work because he believed that it was "woman's work." He worked outside the home to generate an income, and saw this as his role and his contribution to the family. But over time, Mariana said, "He saw me with the kids, and realized I couldn't keep up with it all, and saw that I really needed his help." It had been his idea -- his desire -- to have a large family, and managing eight children plus a household while he was gone at work all day was a lot for her to manage singlehandedly. He realized that he could not just come home from work and sit on the couch with a beer in hand; his help was necessary to get everything done. She admitted that:

> I couldn't do it all, I just couldn't. Some of the kids were bigger, and the other little ones in arms, and -- wow! -- You couldn't make any noise or walk around when the baby was in bed. Just imagine how hard it was. I guess that's how he started helping out.

And when Mariana was working in the fields alongside him, the household responsibilities were even greater for her. She went on to say that because of this, "He did help me. Sometimes he'd get home and say, 'I'll help you with the kids. You do what you have to do.' And he'd take care of the smallest ones, or take them to the park, and I'd do things around the house." In fact, this instrumental help was the only reason Mariana decided to "put up with him for so long." His redeeming quality was that he was a good father. She said,

> He was always an excellent father to them. He was always a father who was -- he'd get back from work tired, but he liked to sit down and play with them. He paid attention to them, he helped them with their homework, he went to school meetings, he helped out with them in every way. Of everything, he was [a] good [father]. That's the only thing I can't complain about. And I liked living with him because he helped me so much with

the children. But as far as the relationship between us was concerned, that's a different thing.

She considered both alternatives: being a working single mom of eight, or getting back together with her partner and relying on him to provide for the family while she cared for the kids. Even though she felt oppressed in the relationship, the practicalities of life rekindled her desire to be with an abusive partner. She went back and forth in her thinking throughout our interview. She said, "On my part, I'd like to see him back here again. As far as I'm concerned. But if things are going to be the same with him, no. Because it's hard for me not to have him here." Just in this statement, her indecision was obvious. She wanted him back in her life because even though being with him was hard, living on her own without him was harder. But at the same time, she admitted that she was not willing to be with him if "things are going to be the same." She appreciated the financial and instrumental support that he provided, but had difficulty choosing to be with a man who was emotionally abusive and controlled her every move.

These two examples illustrate how women felt they were walking a thin line between managing the necessities of survival and the dangers of risky relationships. Choosing to fight back against a risky partner carried dire consequences for women living life at the margins.

Maintaining her identity. Women at times felt constrained from taking action against a risky partner because they prioritized identity preservation. When confronted with a choice, it was often more important for migrant farmworker participants to protect and preserve their identities as respectable women than it was to fight back against risky relationships. In general, women did things that protected their respectable reputations and avoided behaviors that might tarnish their reputations. For example, one woman thought about withdrawing her instrumental

215

support of her husband as a way to punish him for being physically abusive to her. However, she reconsidered after being reminded that, when other men noticed that she was not making his lunch or washing his clothes, they would "criticize" her and could say things like, "Your woman is a stupid old bitch. A real mule. Wow, man!" Hearing this reminder, she decided that punishing him by withdrawing her instrumental support would only damage her own reputation in the long run. Instead of being seen as a respectable woman who takes care of her husband, she worried that she could be seen as lazy or spiteful.

When Ines was deciding whether or not to get back together with her unfaithful partner, her main deciding factor was that she did not want to let the other woman "butt into my life and get away with it," inciting unwanted negative gossip about how another woman "stole" her husband. Perceiving that the other woman would publicly "laugh at having destroyed [our relationship]," Ines decided that her own identity maintenance was more important than leaving her husband. "So," she says, "we got back together."

In this study, women told how their desire to maintain a respectable identity constrained them from taking action in their risky relationships. Women chose to stay with risky partners, have unprotected sex with risky partners, and look the other way when they suspected that a partner was engaged in risky behavior -- all for the sake of preserving their status as a respectable woman.

Unprotected sex maintained women's respectable identity. Women perceived three reasons for needing to use condoms with their intimate partners: 1) if he had been proven guilty of cheating, 2) if she had cheated, or 3) as a form of contraception. In the absence of one of these reasons, condom use would suggest guilt. As one woman said, "It's not that it's hard to talk about [condoms] with him, it's that -- because I can't have kids and he's supposedly not

being unfaithful to me. Supposedly he's not being unfaithful, right? Who knows." Averting her

eyes, she pushed aside her suspicions and held firm in her belief that he was faithful. She went

on to explain that, "Never, in the whole time we've been together have we had that conversation

about what to use [for STI prevention or contraception]." When I clarified if she meant that she

and her partner had never used any barrier prevention, she said, "No, never. He and I, as a

couple? No, never."

Women felt that they needed to have unprotected sex with their husbands in order to

maintain their own status as respectable women and preserve their marriage as a respectable

union.   Apart from contraceptive purposes -- for which condoms were usually not deemed

acceptable anyway -- the use of condoms in close, long-term relationships was either an

admission of one's guilt or a suggestion of a partner's guilt. Not only did women consider that

condom use was not acceptable within the context of marriage -- "It's not normal for a married

couple to use them" -- but they also believed that a *machista* man would rather "be shot" than use

a male-led form of contraception. But a woman's primary motivation for having unprotected sex

with her husband was to avoid raising his suspicions about *her* respectability. Even those who

were convinced that a partner was cheating and were "scared that he could pass something on to

me" did not suggest condom use because then "he's going to suspect I'm doing it with someone

else." As one woman said,

> He wanted to have sex with me and I told him to wear a condom. And he said, 'So what
>
> kind of a woman are you?' [He said that] I was his wife, and I had to have sex with him
>
> without a condom; he never did anything wrong.

217

She saw his accusation as "so insulting" that she gave in and said, "No, okay" to unprotected sex, even though she knew that she was opening herself up to infection. Her acquiescence to unprotected sex was proof of her own fidelity and maintained her respectable identity.

Even if a partner did not assume that she was cheating, requesting condoms would surely reveal a woman's suspicions of her husband's wayward activity. One woman described that, if she asked her partner to use a condom, it would be akin to saying to him, "Well, since you are -- excuse the word -- 'whoring around,' why don't you wear one of those things if you want to be with me." In order to avoid admitting or suggesting guilt, women preferred to have unprotected sex with their husbands in order to preserve their respectable identities.

Calculating moves to resist harm. Despite all of these roadblocks, participants did find ways to fight back and gain leverage in their risky relationships. These ways included: deceiving him, getting tested, postponing sex, using condoms, "managing" risk through partner collaboration, maintaining intimacy, and holding a new partner at arm's length.

Deceiving him. A few women used deception as a tool for self-protection. One woman received information from the *promotoras* at Planned Parenthood, saying that "I *always* took the classes [given by the *promotoras*] and they would always give the little bag of condoms." She tried to convince her husband to use the condoms by lying to him. Instead of admitting that she suspected him of cheating, she said, "I, as a woman, might get some kind of infection from my panties, or a kotex pad, or from the air while the clothes are drying on the line." By claiming that she could get a vaginal infection from an environmental source, she felt as if she could remove the blame inherently placed on condom use. Although her efforts were not successful because he argued that condom use within the context of marriage is not "normal," she found strength in her ability to attempt to deceive him.

After talking with her sisters, who told her, "Don't have too many children, take care of yourself," another woman thought she had the leverage she needed to deceive her partner. Although her partner told her, "Don't listen to them," she felt inspired. She said, "I had to do something. I was so young in those days." So, she had an IUD placed without him knowing, telling herself that, "This is for my benefit because I'm so young still to have a lot of kids." She kept it in for five years, and says that, "He was really angry because I wouldn't get pregnant. But I was the only one who knew why." He wanted her to keep having children in quick succession, but she never wanted more than two or three children and felt that she had to lie to him about using birth control because "he was such a *machista*." The act of lying to him gave her a strategic advantage.

Getting tested. Getting tested was another way that women exerted their ability to fight back against a risky partner. Overall, participants felt a sense of necessity in relation to HIV and STI testing, along with pap smears and wellness checks. They had no issue with routine HIV testing and most were eager to accept a routine test at a primary care appointment. Although they did admit fear in correlation with testing, all women spoke of overcoming this fear. One woman was motivated to have a pap smear and HIV test as often as her physician recommended, despite the fact that she faced multiple hurdles in visiting the clinic. She went to extreme measures -- even leaving the house behind her partner's back -- because she was afraid that she could die young and leave her son alone, just like her mother died of cervical cancer and left her alone as a young girl. She said:

Sometimes I even take the car out myself when he doesn't want to take me, and I go out. Because I don't want to have something like that, some disease or something, if they can

detect it early...So yes, I have to. I have to do that even though he might get angry, but I have to.

Another woman, whose partner cheated on her nine years ago, felt that "there is always a lack of trust" in her relationship. For this reason, she said that, "I always go to the doctor's. I always get checked out and have the Papanicolaou. I always do." A previous breach of fidelity left her careful not to place too much trust in his future fidelity to her.

Getting tested did not come without additional risks. For example, one woman's partner was angry with her when she told him she'd had an HIV test, saying, "What do you think I am, a son of a bitch?" But she responded by stating her belief that, "The doctor asked me if I wanted to have it done and I said yes...There wasn't anything wrong in that. It was just a prevention." She felt like, "Well, he got really angry, but that doesn't matter." What mattered to her is that she knew that she was HIV negative and that she would be around for her children.

Postponing sex. Women also told of trying to postpone sex in order to protect themselves from infections, pregnancy and marital rape. Gabriela told how her partner had wanted to have sex with her "all the time," even though she had kicked him out of the house. But she fended him off, saying, "I've told him that as long as he doesn't get himself checked out and [know that] he's okay, I won't have sex with him...As long as there is no paper saying he's okay, I tell him there won't be anything." She felt like she "just can't" put herself at risk by having sex with him after knowing that he was cheating on her with another woman, because, "he just might have something and I wouldn't know it, and what a huge risk!" In response to her demands, she admitted that "he gets angry, and he says he's sure he doesn't have anything." But she stayed firm in her resolve to postpone sex and not put herself at further risk, saying, "Well, bring me a paper from the clinic. Otherwise, no."

Alejandra also tried to fend off her partner's sexual advances, using the excuse that, "No, I can't, because I have my period." When he would protest, she'd say, "Well, you don't even keep count! How could you know -- you're not even here -- but it's that time of the month." Alejandra saw this excuse as "the only way" to postpone sex with her partner, but eventually she admitted that "the day came when I couldn't do that anymore." When she had an STI, she would "try to calm him, so he wouldn't do anything to me. 'Just wait, later,' I kept telling him, 'because they're treating me for an illness.'" Later, when her verbal tactics failed her, as a back-up measure, Alejandra would stay in the living room. Her mother slept in a bedroom adjacent to the living room, so Alejandra strategically positioned herself so that "if anything happens, she'll come out." But even this strategy was not fool-proof, since her mother went to work in the mornings. Alejandra said:

> Because I didn't want to have sex with him anymore, I would take a bath, and start to take the baby out for a walk, when he would *tear* my clothes off me. [He'd say], 'You have to give me sex, you're making me crazy.'

Using condoms. Although almost every woman in my study acknowledged that condom use was not an acceptable alternative in their close, long-term relationships, there were a few exceptions to this rule. When women had legal separations from their spouse but maintained their sexual relationship, condoms were admissible. And when women established that a partner was guilty of cheating or of contracting an STI, they found they are able to suggest condom use -- even though actual follow-through might not always happen.

Mariana told of using condoms with her ex-husband when he returned to her home for conjugal visits, because she said, "No, not any more [kids]." For her, motivation for condom use was directly related to contraception as well as protection from STIs. Regarding condoms,

Mariana said, "I have always gotten condoms. I have them saved away, even though I get an injection, but I always have condoms saved away, always." Perhaps Mariana has more leverage in convincing her partner to use condoms since visiting a health fair with him years ago. She remembered how "at the beginning in Mexico we never used them. Never, ever." But then, she remembered that the first time she used a condom with her partner was after "we had gone to a health fair, where lots of people go and they give you little pamphlets to read. And some people talked to him and explained to him about the condoms, and to me, too. And from then on he began -- *we* began to use them...Because they gave him the talk about condoms and all the protection they offer, so he accepted. And from then on we always had some saved away."

And once Mariana and her partner were separated, she saw herself as being in control of whether they used condoms or not. She said:

> It's my decision...Before, he spoke for himself, but not now. Now I have to be the one to say. Because he comes from outside. For me he's like a stranger, because just imagine, I have no idea who he's been with. So can he just come right in? No. I can't be like that, so I have to be the one to say [we're going to use a condom].

Outside of their marriage, she had control over condom use. Within marriage, she had no say at all.

Once partners established the possibility of guilt, condom use was admissible. For example, one woman was able to use condoms with her partner after she found undeniable proof of his affair and confronted him with it. Another woman told how her current partner was willing to use condoms upon his return from working up north, as a way to quell her worries regarding his fidelity during their separation. Having established that he would only use

condoms to quiet her fears and not because of his guilt, he was willing to do whatever it took, saying "I'll do it for you, not because I have done anything."

Another woman's HIV positive partner did not use male condoms consistently, and so she sought out "all kinds of opinions and advice" from people at the clinic where he was receiving treatment. Eventually, she found "something for me" at the clinic and began using the female condom. She said, "So now I have two things. I wear something, and he does, too." She believed that, "If you don't protect yourself, who will?"

"Managing" risk due to partner separation. Whereas some women felt as if they were fighting back against a corrupted, controlling, "bad" partner, others told of fighting back against the opportunities that a man had for making poor decisions during work-related spousal separations. Instead of fighting a person, in this case women felt as if they were fighting against an environment capable of exploiting a man's natural sexual needs. They were not pushing back against an individual, but against an opportunity. When a partner went up north for work where women "can't be watching him," they worried that he could "wander."

During periods of work-related spousal separation -- when partners lived and worked in separate towns for a period of time -- one partner had stable work and another needed to migrate to follow the harvest, or one partner had to go north in advance of the other. As previously noted, most farmworkers travelled north during the summer months (July to September) because temperatures in the Green Valley hovered between 100 - 120 degrees Fahrenheit and there was little work during these months. For this reason, most women in this sample viewed work migration as a necessity.

Women referred to work-related spousal separation as something that necessitated a certain degree of collaboration in order to mitigate risk and maintain the partnership. In the

Green Valley, it was common for couples to work side-by-side in the fields under the same supervisor. However, there were circumstances where this was not possible or was subject to change (e.g., if the female partner took time off to stay home, or if partners worked for different contractors or companies). In this sample, at least seven participants told of having periods of physical separation from a primary partner that lasted at least one month in duration. Women acknowledged that, in order to mitigate risk and maintain the partnership, they needed to work together with their partners and come to certain understandings.

In order to mitigate the risk of migration-related spousal separation, some migrant families simply chose to stay together while moving from place to place. For instance, one woman said, "We go together. We don't do the thing where he goes first, or I go first." This was their agreement, that "where he goes, we all go." In this way, she believed, "That way we avoid problems, right? Because, like you say, sometimes you just never know. That's why, if he goes somewhere, we all go together."

Other women told of negotiating agreements with their partners in order to preemptively avoid the need to "wander" while one partner left town for work. Two-week intervals were an acceptable amount of time for expecting a partner to remain abstinent. Pragmatically, women accepted the fact that their partners would tend to cheat if they were gone for more than two weeks. But even a two-week interval seemed like a lot to some women, who wondered if they could trust their partners to not succumb to their natural sexual urges. Acknowledging the difficulty that men had controlling their sexual urges, one woman said, "a man alone for two weeks, that's pretty hard." She added:

> I don't know at this point what else can be done in these situations, except protect
>
> yourself. I don't know if he can go [work up north], or if I just have to trust him and

believe that nothing is going to happen...If I can keep myself for him until he gets back, why can't he keep himself for two weeks? To come back to me?

She went on to explain how she and her partner were brainstorming their options to "manage" the risk if he went north to work for the summer. She referred to how "we talk about the whole thing," considering each person's point of view and weighing the options: either to avoid migration separation, to visit every two weeks, and/or use condoms upon his return.

Regarding how she and her partner worked together to manage their physical separation, another woman said:

> We call each other, talk, see how the other is doing or what each other needs -- if I have to come back, or whatever. But we've never had to be apart for very long; two weeks and we always get back together, for one thing or another (*chuckles*).

So, the separation was manageable through phone contact and responding to what the other partner "needed." When she chuckled at the end, she was indicating that the "one thing or another" referred to sexual intimacy. She was glad that "he always calls me and says, 'Come on back.' In order to not look around for somebody else, right? I don't want to risk it, either." This woman credited her partner's awareness that cheating could result in an infection as being crucial to his ability to remain faithful to her. She heard him say that "he's not going to get involved with anybody just to satisfy his urges, and then give me a disease or something. So, he's aware of that." This arrangement has worked for this couple for the last six years, while she was traveling up north every summer and her partner stayed in the Green Valley at his year-round job.

Maintaining intimacy: "I give it my all." Participants believed that they had partial control over their partner's fidelity; that if they could keep their partner satisfied and continue to

pique his sexual interest, he would not need to look elsewhere. Some women believed that, "When they cheat on you it's because they don't like you, how you have sex with them. They don't like it anymore because they're looking for it somewhere else, just to get relief. They could do it with you, so why don't they? Because they're not -- there's no more interest." Most women worried, apart from how their partners "liked" having sex with them, that sex was a necessary commodity that women must provide to their male partners, to keep them from finding "relief" elsewhere. After discovering that he had visited a strip club, one woman asked her partner, "Have I failed you as a woman?...Has anything ever lacked here at home, and so you're looking for it outside?"

Another woman worried that her partner's natural tendency to "wander" would be magnified because they had not had recent opportunities to be intimate. The trailer they lived in was too small to accommodate the extended family they lived with, meaning that they had to share a bedroom with their children. Because this woman had not been able to meet her partner's sexual needs prior to his trip up north a few weeks after our interview, she worried that he would be more prone to seek "relief" elsewhere.

Even though some women may have expressed personal disinterest in sex, they noted that a man "always wants it, and I have to give it to him." Sexual intercourse was an act that women felt they must participate in to maintain their relationships. One woman found it difficult to feel aroused because she felt so "tired" after working all day and taking care of the household, that she could not imagine being able to summon the energy to please her partner when he asked for sex. But she reasoned:

I can't let our relationship die, right?...So sometimes I just tell him, 'Okay, let's do it.'

Sometimes I just try to forget how tired I feel, but other times I can't. It overwhelms me,

and I can't [shake it]. Sometimes I say, 'Well, I've just got to go through with it. Like a habit, almost, that's how I'm going to [fake it].' But there are times your body just can't even respond to faking it, you know what I mean? That's how it is. What has to happen happens, and my husband can settle down a little, and it takes away his curiosity, like they say -- and that's it, things go back to normal.

For this woman, "faking it" was an important component of her responsibility to protect her partner's fidelity. In order to not "let the relationship die," she felt it was necessary to overcome her disinterest and tiredness and give him what he wanted so that he could "settle down a little." She said to him, "There is no need for you to have sex with anybody else, I'm going to do everything I need to." And she would continue to "fake it" even though she admitted that "it's hard sometimes, because of what happened. But I give it my all." She wondered if the abuse she experienced in her first relationships was continuing to effect how she was able to enjoy sex with her new partner. But she stuck to the refrain of "giving it my all" in an attempt to overcome these feelings and maintain the relationship.

Constructing an emotional wall. Some women in this sample had gotten out of risky relationships and were with new partners. These women were negotiating how to fight the bad that could be lurking around the next corner. They found it hard to trust again and worried that a new partner could change and that they could find themselves in a risky situation again. One strategy for self-protection, therefore, was to construct an emotional wall. For example, even though Alejandra loved her partner, she held him at arm's length because she was afraid to become too emotionally attached and then suffer more hurt in the future. She told me that since her new relationship has been so "good" because "he never mistreated me, he's never yelled at me," that she would have no regrets and minimal suffering when he someday decides to leave

her. She mentally prepared herself for what she viewed as fact: that "the time *will* come when he falls in love with a younger woman." She had already released him to leave her when he felt ready to move on, saying, "The day he may want to leave, he can." She loved him but held him at arm's length because she wanted to protect herself from future hurt. She added that when he someday decides to leave her for another woman, "I'm not going to get angry, rather, I'll thank [him], because maybe this [having known him] has made me calmer and more patient with my kids."

In contrast, another woman did not allow herself to think about the future with her new partner because she was afraid of experiencing disappointment if her dreams were not realized. Instead, she chose to keep her mind grounded in the present. She said:

I don't think about the future. No. Right now all I want is to think about the moment I'm in, not about the future. Because if I think about the future, I'm going to think about living with him -- having kids with him and everything -- and if I don't get to the future, it's going to hurt more. So, right now I'm thinking for the present, for the next day -- the happiness for the next day.

This woman also wanted to leave the decision-making regarding how the relationship progressed in the hands of her new partner. She wanted him to initiate the seriousness of the relationship; for example, if they were to decide to move in together or even marry, she wanted it to be his idea and not hers. She allowed him to view her as noncommittal, telling him, "Come, go, whenever you want." She wanted him to make the big decisions so that she would not be vulnerable, as she had been before.

Taking measures to alter or control a partner's behavior. The next main group of actions that participants took to fight back and gain leverage in their risky relationships was to

take measures to alter or control a partner's behavior. These actions included: avoidance, ignoring him, holding her ground, subverting traditional gender roles, giving verbal warnings or threats, and imposing verbal rules or limits.

Avoiding her partner. Some women found that avoidance was useful in order to control a partner's behavior. For example, one woman took action in order to avoid the potential negative consequences of an argument with her partner. She said:

> When I know there's something he didn't like and when he starts saying things to me, what I do is open the door and walk out toward the park. And I leave him there talking to himself. Why? Because I want to avoid getting hurt, I want to avoid him telling me something I don't like, I want to avoid shouting and yelling, I want to avoid the kids hearing us.

She clarified that this strategy had "worked" for her when she anticipated that her partner was going to berate her for doing something that he "didn't like."

When she discovered that her partner had visited a strip club with his work supervisor, as a treat to celebrate the end of the work week, she also tried to avoid saying things that she would later regret. She says,

> I was so mad. And when you're mad sometimes you say things you don't really want to say, and then you have to say you're sorry, you know? So I take care to not say things I'll have to later say I'm sorry for. So I told him, 'Just go, and leave me alone. I don't want to talk to you, I don't want to see you, get out of my sight.' But he didn't want to leave. So I had to call the police.

In this case, she had to resort to enlisting outside help in order to avoid a heated argument that she knew would not have desirable results.

When Ana discovered that her partner was cheating, she did not leave the relationship because the benefits were too important to her (she was trying to obtain her papers through him). However, she did choose to avoid physical contact with him as a strategy for self-protection. She said:

> I didn't have sex with him, nothing with him when I started noticing he was getting out of my house and people was telling me things...I didn't even kiss him, and I didn't even hug him...I never did take hold of him, ever again.

Ignoring him.   Other women found that ignoring their partners gave them leverage in controlling their behavior.   Gabriela did this after discovering that her partner was having an affair.   He never left her home but stayed there for a year, during which time she remembered that "we were like two strangers."   She went on to explain how she ignored him and only spoke to him when absolutely necessary.   She said:

> I would talk to him only if it concerned the kids; if something was wrong...That's all I need him for -- if something happens to the kids, something goes on at school or they're sick, that's when I talk to him.   Otherwise, no.

Even though Gabriela did not kick her partner out of the house until his affair became public, she imposed verbal limits at home; letting him know that he was not invited to continue a marital relationship with her while carrying on with another woman.

Another woman reached a point when her partner's complaints fell upon deaf ears.   She was sending remittances to two of her children who lived back in Mexico, and spoke to them on the phone daily.   This bothered her partner, who "gets angry" because she was spending a significant amount of her own resources (time and money) to mother children on the other side of the border.   She denounced his anger, telling him "that I have my kids and my family there,

230

and I love my family, and he's not going to forbid my talking with them. She reasoned that because her partner "didn't buy my telephone, and he doesn't pay for it," that he had no reason to get mad. She chose to ignore his attempts to exert control over her, saying that when he would complain or get angry, that "for me, it's as if I were listening to the wall."

Holding her ground. Some study participants came to a state of confidence and decided to hold their ground and stand up against a risky partner; they did not change their perspectives despite input from others that could have potentially swayed them to think differently. For example, when Gabriela saw her partner refusing to leave (after she kicked him out of the house), she anticipated that he would appeal to the sympathies of the children who were requesting that she take him back. But she believed that "the damage is already too much." When debating whether she would consider taking him back, she said, "I just really can't. I can't do this anymore. Because if he did it once, he'll do it again. And it's just not worth it, I think it's so much more harmful for the kids if that happens." She saw the big picture and acknowledged that even if her children did ask her to take him back again, that it would be worse for them in the long run if she did. So she remained firm -- in our interview she was convincing herself that she needed to leave him and hold her ground, despite how her children might have attempted to sway her.

After filing a restraining order against her partner, another woman also decided to hold her ground, feeling strong, firm, and confident. She said, "He knew I wasn't letting my guard down, and the police were going to help me, and however it turned out, I was going to beat this thing." And then years later, after her partner had been admitted to a rehab program, she was approached by the pastor from the program who asked if she would visit her partner in rehab. She said:

He tried to make me understand that the whole thing was a thing of the past, that it would all get better, and all that. But that's not true. A long time has to go by before you can start putting something like this behind you, but you cannot forget it.

She knew that the abuse that she suffered at the hand of her partner was something she would not soon forget. When confronted by a professional who tried to convince her to forgive and forget, she held her ground and stayed strong in her conviction that, "if he did it once, he'll do it again."

After her first partner was released from jail, Carmen reported that he only returned to her house one time to bother her before he left for Mexico and never returned again. Even though she was home alone, and despite the fact that he made a real threat against her, she stood her ground and responded to his threat with stubbornness. She says that when he came and knocked, that:

The kids were in school; I was the only one at home. And I didn't even open the door for him. I just raised the little window there, and looked at him, and he told me he was going to burn the trailer. But I closed the door and bolted it, and said, "'Well that's pretty bad, and I'm going to be in it, because I'm not coming out.'" And he did -- he started taking gasoline out of the car, I suppose to light a fire. But then he thought better, I guess, and left. And I called the police again and told them, but after that he never appeared again.

Subverting traditional gender roles. Some women told how they pushed back against a partner's behavior by subverting the traditional gender roles that they felt pressured to enact. For example, one woman told how, even though she knew that her partner would not eat unless she was there to serve him his supper, she planned nights out with the kids to shop and eat at a Chinese restaurant and left dinner for her partner. She said:

232

So he wouldn't be waiting for me to give him his food, I left it all ready for him. But he

didn't eat; he didn't eat until I got home. It was dark already and he hadn't eaten. He

was drinking with his friends outside, and hadn't eaten because I hadn't served him his

supper...Even if there's food and I tell him to help himself, he doesn't pick up a plate and

serve himself. He's just like that.

In response to her feelings that her partner was lazy and would not do anything around

the house -- including serving himself his supper -- she said to him, "I work a lot, too. I get tired,

too. And [you have] to help me in everything." His lack of reciprocity with household duties

caused her to push back and give him small challenges, as if she were daring him to serve

himself when his food was left hot on the stove. She made a conscious decision to be gone at

dinnertime, knowing that he would not be happy about it. This was a way of asserting her

independence. But she was also giving him an ultimatum, saying:

If he doesn't start helping me, then why should I want to be with him? He's staying with

me just to take advantage of me, to have somebody to cook for him, wash for him,

somebody to do everything for him! Things he should be doing...I feel like sometimes, I

feel he's with me just to have those benefits, at my expense. It doesn't cost him anything.

Giving verbal warnings or threats. Some women even thought they could reform a

partner and tried to modify his behavior through the use of verbal threats. Women thought they

were not heard unless they used verbal threats, thinking this gave them a voice. Sometimes

women just could not help themselves -- even though they acknowledged that their words might

not change anything, they felt the need to "answer back." While telling how her partner stole her

food stamps, one woman admitted, "I put up most of the time with the stuff he says -- what

comes out of his mouth -- but I can't stay quiet with everything he says...sometimes I answer

back." She felt the need to stand up for herself and confront his "crazy" behavior, saying to him, "You know what? Just swallow them. What else are you going to do with them?"

Other women hoped that reminding a partner that "respect is a two-way street" would help to shape his decision-making in regards to illicit sex. But in light of the fact that women believed that their partners often lacked self-control and easily gave in to their sexual urges, it was likely that this type of a threat served an emotional purpose instead of a practical one. For example, because Carmen felt she could never be sure of her partner's fidelity while he went up north to work, she invoked the golden rule as a kind of a threat. She said to him, "Remember not to do what you don't want others to do to you." Her use of this well-known maxim was likely an expression of the control she *wanted* to have in the relationship; she was posturing and asserting her leverage. But her actions probably did not translate into actual behavior change -- and indeed, she may have not expected that they would.

Threatening to leave. One type of verbal threat that women made was threatening to leave a risky partner. One woman threatened to leave her partner if he did not "learn." She went on to clarify: "As soon as he starts in [saying things I don't like], I say, 'Don't be like that, behave well like other people,' I tell him. 'If you don't behave well here, I'm going to leave you all by yourself.'" As a result of her verbal threats to leave him, she saw that "he's more careful now," and appeared eager to reciprocate in their relationship.

Women often did not believe that they could get through to their partners unless they made serious threats. For example, it was not until one woman threatened to leave her cheating partner that she felt that he really heard and believed her. As a result, he asked for her forgiveness and she stayed with him. Another woman saw her partner as absent from the children's lives, and felt like "I have to practically scold him" to spend time with his kids. She

234

threatened to leave him if he did not work harder to be a present husband and father, saying, "If you're not what we want you to be, we don't want you."

When another woman discovered that her partner was cheating on her, she threatened to leave him. She told him:

> [I said], 'I left my drunk husband for another drunk? No way. I'm leaving.' 'When?' he asked. 'On Saturday,' I told him... 'Because I can't stand you anymore. You're a drunk, you've got a bad temper, and I don't want somebody like you anymore.'

She immediately made plans to leave and pick grapes in a town up north, and the next day her partner stopped drinking. She said, "That was it, and he didn't have another drink. And I stayed, because by then we were both worth, both of us doing okay, and he started behaving himself...It all stopped." Her verbal threats were successful; she saw him change his behavior as a result.

Giving him a verbal ultimatum. Others challenged their partners to leave -- voicing feelings that they no longer cared about the relationship, asserting their own independence, and offering an ultimatum -- as a way to try and control his behavior. Women saw this as a way of "putting the cards right out on the table." For example, one woman said to her partner:

> You don't have any right to be doing anything to me...So there's the door -- the lock is off, so you can leave and go wherever you want, wherever you're going to be happy, and that's it. But I'm not going to be begging you to come back. Never more, because I can take care of myself now.

Another woman continued to use verbal threats in an attempt to shape her partner's behavior and ensure that he continued to remain faithful to her, years after finding out about his first affair. She reminded him of the big picture in order to scare him towards fidelity by saying, "If

you go up there and you get involved with somebody and she gives you some disease, you'd better not even come back." Another woman confronted her partner with a challenge to make a decision; to choose her and the kids, or to choose to be with his mistress. She said to him,

> Make a decision: here or there. Because I don't want someone like you. When I do need you for something here at the house, you're not here. This is no way to live, neither for me, nor your kids. So decide whether you want to be there with her, or here at home.

Threatening to make private matters public. Other women gained leverage through their ability to threaten a partner via their connections to social information networks. Women attempted to utilize the threat of a third-party's involvement in private matters to shape a partner's behavior. For example, one woman threatened her partner by saying, "I'm going to talk to your sister and tell her to come, so she can see what you're doing." This threat was sufficiently serious enough for him to take notice. She said, "And that was that, he didn't say anything back. He just left."

Threatening that a second infraction will end the relationship. All women who forgave a cheating partner and stayed with him made it clear that they would only pardon his infidelity once. For women in this sample, forgiveness did not mean a clean slate; women never forgot what happened. A second infraction would signal the end of the relationship. For example, when one woman's partner asked her, "What do I have to do to get the trust you had in me back?" she told him that,

> Look, what happened you're not going to be able to erase. It happened. I'm simply going to ask you a favor, since you might want to do it again: think twice about it because I'm not going to forgive you again...I'd rather be by myself.

Women were motivated to make these threats because they imagined the possibility of providing for their kids on their own. Their potential for independence offers women the hope of leverage. One woman agreed that if she even had the slightest suspicion that her partner was cheating again, that she would not waste any time in leaving him. She said, "If something else should happen, if it ever happened -- if I ever even *heard* something was going on, it would be over. Over. I can get along on my own with the kids."

"Don't waste my time again." Even women who had gotten out of risky relationships thought they were continuing to "fight the bad" as they asserted themselves in their new reciprocal relationships. They worried that their new partners could change, be corrupted, or make mistakes just as their previous partners did. In this sense, risk was always lurking just around the corner. To mitigate this risk, women felt as if they had to warn their new partners that, "I don't want to waste my time again." For example, even though her new partner did not use drugs, one woman felt like she needed to make him aware that she would not stay with him if he started using. She still felt the pain of her previous risky relationship with a man who was an addict, was violent towards her, and who cheated on her. She asserted, "No way am I going to go through the same thing twice." So she used verbal threats to caution her new partner against becoming involved with drugs or "doing something bad." She told him,

> I don't want to waste my time again. If you're using drugs, don't ever come to my house. If you want to do something bad, don't come to my house...'Cause I have two kids, and I don't want to be wasting my time having partners that use drugs or sell drugs or anything...I prefer to be by myself that to have somebody like that.

Another woman said, "There are just certain things I tell my husband I don't want to have happen, right? Because I already went through them." She told him,

I am just never going to let you raise your hand to me, like to hit me. Never do that, because it would be something that would drive me away from you. Because I went through it once and I don't want to go through it again.

Women who previously had unfaithful partners warned their new partners that they would not put up with even the suspicion of infidelity in their new relationships. One woman said, "The day I find out there has been one act of unfaithfulness in our marriage, that's the only one there will be. I will never, *ever* forgive him that. Never."

Imposing verbal rules or limits. A final way in which study participants took measures to alter or control a partner's behavior was to impose verbal rules or limits; they did this by either drawing the line or giving him conditions.

Drawing the line. Women were willing to give a partner control in the relationship, but only to a certain extent. In this way, they were drawing the line between what they would allow and what they would not. For example, one woman was willing to give her partner more authority in decision-making, but she was not willing to be made a prisoner by allowing him to restrict her movement. She said to him, "I agree that you want to be in control, but if you're going to start with this 'don't go here' stuff, forget it. You'll have to leave." The way she formed her argument to him was very interesting; she said, "I agree with you," regarding his wishes for control in the relationship. She might have even admitted that he could be in control regarding *most* things, but drew the line when he attempted to exert control over her own body. She might have allowed him to have the last say in decision-making about other matters, but maintained control over her own bodily freedom.

Another woman imposed a rule when her partner started coming home drunk. She said, "I started getting mad and saying, 'Okay, don't even come into the room because you stink of

alcohol.' And the arguments started, and he'd go outdoors and sleep at night, and me inside."

Her motivation for doing this was because she felt stressed, when he'd "go out all night and

come in at all hours," while she had to get ready for work early in the morning and get the kids

ready for school, all while feeling extreme fatigue after getting little sleep. She was standing up

for herself and protecting the little sleep she could get before going to work early the next

morning.

Mariana described how her partner always wanted her to do everything his way. She was

willing to "give in to a few things because I wanted to get along with him." For instance, she

stopped wearing makeup because he did not like it, and she stopped using birth control because

he wanted to have a number of children in quick succession. But she clarified that, "The only

thing I couldn't give in on was religion, doing what he wanted [related to that]. But in every

other way, I did things like he wanted." For Mariana, matters of religion constituted a line that

she was unwilling to cross in her relationship with a partner who she described as *machista*. She

could only give in to her partner's wishes to a certain extent. Religion was the area in which she

stood her ground. Referring to her partner as one of many *machista* men, she says, "They always

want to impose their own will, and...well, you can't always be in agreement [with a person like

that]."

Giving him conditions. Laura broke up with her partner for three months and then got

back together with him but told him that she would stay with him only if he fulfilled three

conditions: 1) stopped drinking, 2) married her, and 3) combined his paycheck with hers and

allowed her to administer the family finances. These conditions were very well thought-out,

indicating the level of strategizing she had done. She knew that his alcoholism was the primary

source of his anger issues, and that if he was sober, he would be easier for her to manage. She

also knew that if she was legally bound to him through marriage, that she could be included on his tax return and be entitled to his income. Finally, she suspected that he made a lot more money than he actually disclosed to her, and hoped that if they shared their money that she would have enough to send in remittances to her family in Mexico, while concurrently providing for her family in the US.

Regarding the necessity for these conditions, she said, "If he liked being with me, if he wanted to really be with us, it was going to have to be this way." She placed limits on his continued involvement in her life, after strategizing that being with him would afford her important benefits that she needed. When they first decided to get back together, she outlined these conditions and said to herself, "If he accept[s] them, fine, and if not, then there's the door." At the time of our interview, she was still waiting to see him fulfill these conditions. She was preparing to end the relationship, realizing that he was not prepared to change.

Conclusion

Participants acted in a variety of ways as they fought back to gain leverage in their risky relationships. Even though some of these forms of "fighting back" appear to be small, their cumulative effect over time felt significant to the women that I interviewed. Here, the concept of the lever is helpful. When a rigid bar is balanced over a fulcrum with one end of the bar underneath a boulder, a certain force applied to the other end of the bar will result in moving the boulder ever so slightly (see figure 3, Appendix M). This is what it means to gain leverage: that the force upon the boulder is indirect and is in fact magnified by the fulcrum. And so, just as some of the women's actions appear to be indirect, they are often significant enough to help women gain leverage and achieve their goals in relationships.

Finding the Good

Participants felt that they were constantly dodging danger and threats to their health and safety. Apart from intimate partner risk, women spontaneously told of experiencing multiple other dangers and risks, some of which are beyond the scope of this dissertation. A few of these dangers came from sources meant to provide help. For example, a few women told stories of being molested by healthcare professionals in Mexico. Others felt taken advantage of by law enforcement officials in the US, whose help they considered to be necessary in order to protect themselves from controlling, violent partners. Most participants struggled with their family relationships, but concurrently needed assistance and support from family in order to fight back and gain leverage over their risky relationships.

Although they felt as if they could gain leverage by using their personal resources to fight back against a risky partner, all the women in this sample who left a risky relationship felt they were able to do so only because they had outside help. This constant interplay between accessing help while at the same time side-stepping further harm is called "finding the good." As women fought back to gain leverage over intimate partner risk, they were actively looking to "find the good" in others in order to leverage help for themselves. Women reached out for help but felt that they could not let down their guard -- they used discretion because not all sources of help were beneficial. This section explains the nuances of this dance.

Finding the good in family. Participants thought their families *should* have been a source of help when dealing with risky relationships. However, even though a few women did feel able to harness assistance from family, most felt their family relationships were not strong enough to afford them much help.

Struggling with family relationships. Women struggled with their family relationships. While repeating the common refrain that, "Men may come and go, but family is the only thing that's left," they thought that family did not live up to their expectations. Women wanted to confide in their family members, "Because they're supposed to be your family, and they have to understand you better and try to help you, more than another person who is nothing to you." But this belief was not enough to inspire trust for women who *wanted* their family's help and thought that family *should* be a source of help, but who ultimately felt very much alone. As one woman said, "I think from my family, it's not good to talk to them. I don't know. I do visit them, but it's not like I'm gonna go and talk to them for hours, or tell them what's wrong with me." She went on to say, "So, I think I'm by myself. I know I have my family and everything, but I think I'm by myself, like, in here."

Being separated from family back in Mexico. Many women identified having fragmented families due to physical separation by the international border. Women referred to the fact that being undocumented had changed since "the border crossing got so difficult," with heightened immigration law enforcement. In fact, many women told how in the past "we used to come and go" across the border to visit family, but that they were no longer able to do so. Most women had family members back in Mexico that they were not able to see, knowing they might never make it back to the US due to their undocumented status. A few women even told of family members who died in Mexico, yet they were not able to return either to see them before they died or to visit their grave or attend their funeral. For women in this sample, the reality of feeling stuck in the US was a complex issue. They were grateful to have increased earning ability and be with their US-born children, but they concurrently felt intense sadness and longing for those they left behind. Lack of documentation produced feelings of isolation, as women

lived across the border from close family members (often, parents and/or children) whom they could not return to visit and who were not available in their time of need.

Lacking close ties with family in the US. Women described having fragmented families due to border and documentation issues, but this is not the only reason that participants felt distant from their families. Even those with family members in the US often described having fractured relationships. Many women were troubled that they were not as close to their families as they felt they should have been.

Women believed that one of the main purposes of family should be to help one another -- they expected reciprocity from their family relationships just like they did from their partners. Carolina described sacrificially giving of her own resources to help various family members, yet she felt "rich from all [the] promises" of help that her children and grandchildren offered her in return. After giving and giving for many years, Carolina said:

> What do I get for it? Now that they're grown, I don't have anything to give them. 'Now, my son, what do I have? I don't even have enough to give you anything, and you don't have enough to give me anything.' Every one of them has their own kids, what are they going to be able to give me? What can I expect from them? Nothing.

At the time of our interview, Carolina had health issues and felt she was getting older. She confided to me that she would not be able to work with the same intensity and frequency that she worked with when she was younger. She was no longer able to help her adult children like she used to, and unfortunately, worried that she could expect nothing from them in return. Although she was surrounded by approximately 200 family members living in California, she felt very alone in her struggle to survive. She found that she must stand up for herself and ask for what she needed, or else she would be taken advantage of by her own family. Recognizing

this, Carolina said, "So, what do I have to do? Get up, fend for myself. Why? Because if I get hungry one day, and there's no food, I'll have to ask for some money in order to eat. That's what a family is for." Carolina learned that her children would not readily give her help unless she asked for it; hence her decision to "fend for myself."

One reason women offered for why their family relationships were fractured was that they had to migrate north and experience forced separation from their young children. Carolina and Amalia, both grandmothers at the time of our interview, lived with abusive husbands for many years and needed to work in order to provide for themselves and their children. When the kids were younger, these two women saw no other option than to leave their children in Mexico in the care of a family member while traveling north for work in order to make ends meet. Looking back on this decision, both women expressed sadness over their fractured relationships with these now adult children. Through tears, Carolina told how she believed her children felt angry towards her because "They say I left them alone, [when] I came here to work in the United States." She heard other family members criticize her adult children, saying they turned out "crazy, as if they raised themselves." Carolina was deeply hurt and troubled by this, believing that she did what she considered to be best for her children at the time. And although Amalia knew that her adult children loved her, she was troubled by the fact that they never offered her a place to stay, or a meal. She said, "they don't even offer me a glass of water." Despite the fact that they lived near her in Southern California and had professional jobs and homes, they never reached out to her when she traveled nearby year after year and lived out of her car. At the time of our interview, Amalia was dependent upon her work supervisor, who paid for her ride from Mexico and was giving her lunch in the field each day since she had arrived in the US

completely broke. In her dire circumstances, never once did Amalia consider contacting her children to ask for help because her relationship with them was so troubled.

Having a troubled relationship with mother. Although women described experiencing tensions within their families and with their adult children, it was their relationships with their mothers that appeared to be particularly troublesome. While some women told of feeling distanced from their children as a result leaving them behind in a family member's care, other participants described how having been left behind as children while their parents came to work in the US had deeply affected them. In this way, transnational parenting takes a toll on both parties. In this sample, both participants who made the choice to leave children behind and participants who had been left behind by their parents felt long-lasting effects. For example, one woman explained feeling "abandoned" in Mexico by her parents when they came to work in the US. She wondered if, as an adult, she could seek to reestablish a relationship with her mother. She migrated to the US in an attempt to reclaim this severed relationship. She said, "I wanted to recover the lost time that my mom wasn't with me, when I wanted to come here [to the US] with her." Unfortunately, she added:

> When I got here [to the US], everything got worse. Things got worse in that there was a difference between her other children and me, her husband and me, and I decided that instead of getting closer to her, it was like we got farther apart, you know?

At the time of our interview, this woman admitted that even though she would talk sporadically with her mom, they did not have any kind of a relationship. Carmen, who was also raised by family members in Mexico while her mother worked in the US, remembered hearing her mother say, "I just never had time to show [my kids] love" because she was always working across the border. Carmen saw herself as an extension of her mother, saying, "That's how I am,

so I don't hold it against her." In this way, fractured relationships between women and their mothers were cyclic--unintentionally reproduced as a result of women's perceived need to work in the US in order to provide for their families.

Not only did women feel physically distant from their mothers, but most participants viewed their mothers as emotionally distant and even abusive. One woman described her mother as, "A woman with a very strong personality. So I couldn't talk with her. You couldn't talk with her, give her a kiss, you couldn't ask her anything." Another woman admitted that, "My mom is pretty irritable, and she actually told me I had cursed all the family...She used to mistreat me all the time." She even blamed her mother for driving her out of the house and into the arms of a man who was twice her age when she was 14 years old. She said:

My mother was very -- well, she wouldn't hit us, but she was very mean to us. She didn't let me even have any friends, never let me go out with a boy, have a boyfriend. She was very strict, so when I met my husband, the first one, I was 14 and he was 27. I was going to school. And I figured, since I was already fed up with my mother's way of mistreating me, of scolding me, never letting me go anywhere; she never gave me a party, never anything, not even a piñata. So, I fell head over heels for this guy.

Ana felt intense sadness at the realization that her mother did not demonstrate affection towards her, even after Ana defended her mother as a child when her stepfather became violent. She said, "I was always with my mom. When he screamed at her, I defended her. When he tried to hit her, I defended her. Every single time. For every reason, I was in back of my mom." But as an adult, Ana said through tears, "I don't think she shows me the love like she shows the love to my sisters." She believed that her mother had difficulty loving her because Ana bore close

resemblance to her abusive father, a person whose memory was especially painful for Ana's mother.

Study participants found that our interview provided them with an outlet for their feelings, especially those who identified that they did not have anyone else in their life with whom they felt they could confide. Ana was eager to participate in our interview because she was not comfortable sharing with her mother, and she knew that she needed an outlet for expressing her emotions. She said,

> I can't [share] with her. I know I can't. She knows every single thing about my life, but I don't tell her. If I need something, I don't tell her. I don't tell her. I don't tell her because it's like if I want to like have a conversation with her, I know she's going to tell me like, I know she wants to tell me something good, but she says it in a bad way. So, when I try -- like if I want to tell her, express, or something, I know she's going to act in a bad way...So, I prefer not saying anything, and keep it in. And if I want to talk with my sisters, it's the same. I try to talk with them, uh, private, but they don't tell me everything. They go and tell my mom. So, I don't trust them either to talk to. So, that's why I think I keep it in, and I know it's hurting me: keeping things to myself.

Receiving help from family. Far more women told of struggling with their family relationships than those who told of actually harnessing help from family members to manage their risky relationships. A few women did credit their families with providing assistance in their time of need. For example, one woman felt she was only able to escape her abusive relationship with an older man because she said she "Sent word to my grandma and an aunt who had raised me, and they came to get me. And that was it, we went to the police." She felt unable to go to

247

the police on her own; she needed the assistance of her family members to physically remove her from her risky relationship and also to support her in making a police report.

Some women were able to get their papers to live legally in the US with the help of a father, and told how this made all the difference for them. For example, one woman finally felt able to escape her abusive marriage because "I had papers finally, and could come [to the US] and work...I didn't want to stay with him anymore. So I came here." For her, crossing the border was her ticket to escaping the relationship and moving on, after the accumulation of many years of abuse and unhappiness. Because her father was able to secure papers for her to live and work in the US, she finally experienced the freedom she had been looking for.

Another woman, Alejandra, found that her mother was particularly supportive throughout her two abusive relationships. She summed up this support by saying, "My mother was with me there; she has always helped me...I knew I could always count on her." Alejandra told how her mother provided her with housing and childcare -- the two most important resources -- as she was fighting back against her controlling and violent partner.

After years of trying to escape, Alejandra was finally able to leave the house he had kept her in like a prisoner and return to her mother's house. Overcome with emotion and barely able to speak as she told the story, Alejandra recounted how she was finally able to leave after years of abuse and being held prisoner by her partner. She felt great relief at being able to return to her mother, who had been her only source of help and hope. She said:

> He told me to get out. To get out. I grabbed my baby by the arm, and had the other girls
> by the hand...I had to cross the entire village [to get to my mom's house]. And he said to
> me, 'Don't come back for your things, don't ever come back here for anything.' He
> started throwing my clothes outside, and I never turned around. I took my daughters and

walked on the other side of the street, and I never turned around to look back. He took up

the hose and the water that came out of it was really hot, and he sprayed it on me; he

grabbed the hose and wet my entire back with the hot water. I didn't turn back, I kept

walking. And I crossed the whole town, and everybody looked at me and saw I was all

black and blue: my arms, my legs.

   Finally I reached my mother's house. One of my sisters was there, at the screen

door, [the kind] with the netting. I couldn't even knock, all I could do was say, 'Mama!'

I yelled it three times and she came out. I was there in the doorway; I had wet myself

because of the beating he gave me in my stomach. I had wet [urinated on] myself. All I

heard was my sister yell, 'It's Alejandra, Mama!' And she caught me and I lost

consciousness.

After this, Alejandra's partner came to her mother's house to try and get her back. Her

family intervened to protect her from him: first Alejandra's mother went out and threatened that

the police were on their way. He returned one more time, later that night, but Alejandra's three

brothers met him at the door and threatened that "they didn't want to leave him like he'd left me.

[That] they weren't the kind to look for fights, but he'd better get out of there." He never came

looking for her again.

   Finding the good in others. Apart from family members, women felt they could seek

limited help from others in their community-- principally, co-workers and neighbors. Since

many participants told of having fragmented and distant families, these "others" were sometimes

all they had to turn to in their time of need.

   Deferring negative influences. Although others could be sources of help, the study

participants told of having to do a lot of screening in order to determine who was a true helper

249

and who was trying to take advantage. Women felt that dangerous people could be anywhere, and could even be disguised as helpers. For example, Gabriela thought she was constantly having to analyze others' motives. She had to be strategic in how she did this, in order to find the good in others and ultimately, to help herself. But ultimately, she believed that you "never know" whether someone was actually going to help you or not. She found it difficult to filter offers of help from others, since "you never know" who you're going to "run into." Some people helped and others -- albeit well-intentioned -- ended up causing harm. Often, it was a game of chance. She said:

> Sometimes you just don't know what kind of people you're going to run into. They may try to get close to you to help, say they're going to help, but in the end [they] don't do anything. It's hard for everybody, but there are times you run into people who you never think they could actually help or lend you a hand, but they do, right? So you never know.

So, some people may have been helpers in disguise, while others may have seemed like helpers but turned out not to "do anything." In the past, Gabriela had to fend off others in her life who suggested that she use drugs or alcohol to dull the emotional pain of her husband's affair. She said, "There are lots of people who, because they see me like this with problems, or because they know about the problems, they say, 'Here's the best answer. Take one of these, and another.'" She did not always have the emotional strength to turn down these suggestions. But after an incident where she overdosed and nearly died, Gabriela was much more cautious in who she decided to listen to, feeling as though negative gossip was everywhere. She said, "Some people just try to fill your head with things." She was looking for people who would "look to keep my mind busy so [I can] feel a little lighter, as if some of the weight has fallen off. And that helps me."

Fending off meddlers. Other women told how others tried to "put ideas in my head" by trying to repair women's relationships instead of minding their own business. I call these people "meddlers:" those who meddled in relationships by following their own agendas. In this study, two women told of male "meddlers" -- influential men who sided with the male partner and intervened under the guise of helping to assist the couple in reconciliation. In the first example, Laura gave in to the meddler's advice and got back together with her partner. In the second, Alejandra confronted the meddler and helped him to see her perspective, ultimately gaining his assistance to fend off her partner's advances.

When Laura first decided to leave her partner, she had decided, "I'm not going to keep on being with you, because it's impossible like this." But then she went right into telling how their *compadre*, who happened to also be her foreman, came to her house to speak with her. When she did not show up for work because she was in the process of leaving her partner and he would not allow her to use the car, her foreman got the details of the separation and intervened. Laura told him, "Look, so many things have happened that you don't know about, and I don't want to be there [with my partner] anymore." But, after hearing his insight, Laura decided to return to live with her partner. It was obvious that the foreman's words were influential in her decision.

Like Laura, Alejandra also told of an influential man who tried to meddle in her relationship. The pastor of the church where her partner was completing his court-ordered residential rehabilitation came to Alejandra, telling her that, "He [your partner] is doing really well, and that we should try to make a home together again." She remembered that "the pastor would come to the house to try to get me to go to church to be with him." She went one time, but warned the pastor that, "this is going to be the last time you come to my house and try to take my kids to church...I can't try to explain it all to you, because I'm not staying here [in your

251

church]." When the pastor tried to explain to Alejandra that "the whole thing was a thing of the past, that it would all get better, and all that," Alejandra denied this. She refuted his words, believing that it would take more than a year for her to get over physical and sexual abuse. She said, "A long time has to go by before you can start putting something like this behind you. But you cannot forget it."

But the pastor continued to meddle, and intervened when Alejandra's partner requested a conjugal visit with Alejandra after he had completed the first two weeks of the program. At this point, Alejandra decided that she needed to tell the pastor "a tiny bit of what had happened to us: he and I had lots of problems and I don't want to start over." Once the pastor heard the story from her perspective, he denied permission for the conjugal visit. This caused Alejandra's partner to "get real mad -- he blew up and got mad at the pastor." Alejandra used this as an example, telling the pastor, "You see, if he gets like this here he's your responsibility. If he goes home with me and doesn't like something, he's going to get the same way." Fortunately, the pastor was able to see and respect her point of view. Ultimately, she was able to turn his meddling behavior into a helpful form of protection from her partner.

Receiving help from others. Not all women thought they had coworkers or neighbors to lean on. After being assaulted by her partner and being told by the police that she should go the hospital for an exam to document her injuries, one woman said:

> I'm alone here. With my neighbors it's pretty hard that one of them would say, 'Sure, I can take care of your baby [so you can go to the hospital].' Doesn't happen much, very few people will help you or call the police. You have to do it.

Because of her lack of support from others, she was not able to document her injuries and "lost out" in her fight against her partner. Women often felt they had no one to rely on but

252

themselves. They saw themselves as their only source of help, giving me quizzical looks when I asked about sources of outside help.

In rare circumstances, participants disclosed to me that they had one other woman in their lives that they could trust -- a neighbor, a cousin or a landlady -- but all of these women expressed worry that they could over-burden this other person with their difficulties and pain. For this reason, they censored how much they shared and went through periods of holding back when they sensed that this other person had had enough. Despite the negative influences that she had to deflect, Gabriela did describe how several of her neighbors did "lend a hand" in both instrumental and psychosocial ways. Women told of receiving help from others to assist with their personal finances, transportation, lay medical advice or services, and of course, advice.

While making observations during my fieldwork, I observed a few other opportunities that women had to share with another woman who was available to listen. I got to know a women who worked as a community outreach assistant for Migrant and Seasonal Head Start (MSHS), who advised me at various stages of my study and also referred potential participants to me for screening. She described how the mothers of the children enrolled in MSHS would confide in her during home assessments. Without their husbands present, women were eager to share their experiences and difficulties with someone who listened, who really cared, and whom they felt they could trust. Going above and beyond her scope within MSHS, this community outreach assistant would provide an opportunity for women to "lighten the load" and share about their lives in a safe environment. During my interviews with women she had referred, they disclosed to me that she was the only other person they felt they could trust with the sordid details of their risky relationships -- she was the only one who had taken the time to listen.

The other venue in which I heard women share about risky relationships was in a small group setting outside of my own participant recruitment and enrollment. A farmworker women's advocacy group -- comprised of local women who either currently worked in the fields or who had previously worked in the fields and subsequently gone on to attain other work in hotels or even in professional careers -- was instrumental to my work in the Green Valley and the networking that I was able to do in order to form the Community Advisory Board (CAB). I was privileged to attend monthly meetings held at one member's home in the Green Valley, where multiple generations of farmworker women sat around the living room and corroborated the fact that my study was timely and necessary because they themselves had also experienced risky relationships. Within their network, women found community and belonging primarily because they were women farmworkers, and secondarily because they wanted to advocate for women's rights particularly within intimate relationships. And sharing their own personal experiences was a natural component of this advocacy and belonging.

One of the first activities I did after getting connected to this advocacy group in the Green Valley was to hold a small focus group type conversation with three members who had all experienced risky relationships. They shared eagerly and openly, already having been acquainted with one another's stories because of their involvement in this advocacy group. Within the group setting, women appeared to feel safety in their numbers and in their involvement in something that was bigger than themselves.

I also met and spoke with *promotoras* who worked with local service agencies in various capacities and who provided information to peers in their neighborhoods on topics including mental health, diabetes, hypertension, and women's health. I was able to sit in on some of these "classes," one of which involved an instruction board and hands-on materials including the male

condom and the female diaphragm, and one or two "participant" women. The *promotora* led the instruction and the women participants looked somewhat uncomfortable. At the conclusion of the 10-minute rehearsed instruction, the *promotora* signed her timesheet and then proceeded to engage in more personal, social conversation with her peers. It was during this informal conversation that I observed women felt more at ease. And I did hear a few participants in my study echo that they had been able to find encouragement and support from a local *promotora* who shared openly and encouraged them to do so as well.

A couple of women found that they needed help from a new partner in order to permanently end a risky relationship. These women told of feeling "softhearted" and vulnerable, to the point that they felt unable to leave their abusive partners on their own. They had already broken up with a risky partner, only to feel pressured to get back together with him because he kept asking and because they had children together.

One woman described that when her partner left rehab, he came to her house and tried to convince her to get back together with him. She wept and did not know what to do. She did not feel she had enough leverage to end the relationship with her abusive partner until her new partner came and stood at her side. She said, "All he did was take my hand and I felt, well, like I was holding on to something good, and I gathered strength." This transfer of positive energy, or strength, gave her the leverage she needed to verbalize her decision to leave her ex for good. Looking back at this experience, she believed that, "I think I got together with him so I wouldn't *have* to get back together with my second partner." Another woman echoed, "So, he [new partner] started making *him* [ex] disappear. So, he erased it." She refers to her current partner as having "separated me from him [ex-partner]," and feels "glad" that her current partner came into her life at the moment that he did -- right at the time when she was feeling vulnerable and was

considering getting back together with her risky partner. She feels like she never would have been able to permanently separate from her second partner on her own; the new partner showed her what a reciprocal relationship could be like and erased her perceived need to get back together with the father of her son.

Women appealed to a higher power in the face of overwhelming emotional pain. Amalia admitted experiencing depression as a result of her partner's abusive behavior towards her, but acknowledged that "God took me out of it." Isabel said, "sometimes I ask myself where I get my strength from, to feel okay," and wondered if her prayers to God were helping to sustain her. She said, "I tell Him [God] to take care of me because I have to take care of my boy." Gabriela also feels strength through trusting God, saying, "What is happening to me, it is pure misery, suffering what I have been through. But I hold on to God's hand, He is the one who can do all things, and only He knows why -- why I'm going through all this." After originally overdosing on pills after discovering the news of her partner's infidelity and ending up in the hospital, Gabriela made a conscious decision to "hold onto God's hand" instead of taking matters into her own hands. She said that after she woke up in the hospital, "From then on I promised myself that whatever happened...I'd rather take God's hand, get His help, so I don't go back and make the same mistakes." She believed that, "He can do all things, and I know He is going to help me get out of all this for my children...may God help me have the strength to put up with whatever comes, and get beyond it."

Other women did not specifically mention that it was God who helped them get through difficult times. They referred to their religion and religious activities as providing a "refuge" from pain. Mariana said that her "refuge" was to "get closer to my religion...that's been my

refuge in so many problems I've had." And Alejandra identified church as a place for healing and for discovering that she was not the only one who suffers. She said:

> That's how I'd get better; I'd take the kids to church on Sundays. And it always seemed as if the priest was talking directly to me. Everything he said touched me. As if he were telling my life story, and directly to me. Everything that he said was what was happening to me. I felt more at ease, and realized there were people who are worse off than myself and who don't have any help. It's like they are closed in a box, and haven't been able to ask for help.

Finding the good in professional help. Along with help from family and help from others, women perceived that help from professionals (including law enforcement, healthcare professionals and government workers) was simultaneously helpful and potentially risky. Women thought they needed to carefully assess the need to seek professional help and then tread carefully while utilizing it. Women were constantly on guard. However, unlike other sources of help, women saw professional help as a necessity for gaining leverage. For this reason, they attempted to overcome roadblocks and, in some cases, thought the help they received from professional sources ended up making all the difference for them. Other times, women felt further violated by professionals and/or felt they had fallen through the cracks of a broken system.

Using professional help to fight back. Some women used professional help as a tool to fight the bad, often feeling that they had to go through the motions of interacting with the legal system before any real change occurred. Women with abusive partners often told of filing police reports for years. After one particularly bad beating, one woman said, "The police took a report of everything. Of course they never did anything to him, but at least a report was filed."

257

Another woman called law enforcement and filed reports against her abusive husband four different times in the US and once in Mexico. In the long term, she did not see these reports make any difference in his behavior. Sometimes, women simply felt that involving law enforcement was the only way that they could fight back. Having the option to call the police helped women to feel safer, even though there were no long-term changes that they benefitted from as a result. For some participants, calling the police was more of a threat than a long-term solution; it afforded them leverage without actually affecting change. It provided them the chance to do *something*, when they perceived that the alternative would be to do *nothing*.

Women found they could also use the threat of involving the police as a way to fight back, without actually making the call. For example, one woman threatened to call the police when her partner accused her of cheating on him in a drunken rage. Although she was not actually planning to call the police, she felt as if the threat of accessing professional help would help her to leverage some control of the situation. She threatened her partner, taking her cell phone in her hand and flipping it open while saying, "If you keep on insulting me," I'll call the police." She went on to tell me, " I told him I was going to call the police so they'd come and calm him down, or take him away." But she never actually planned to call the police; she only wanted to use the threat of the police as a way to deter his abusive behavior towards her. Having the police just a phone call away helped her to garner strength in the moment, when she felt as though she had run out of options.

Managing independence through public aid. Because women considered that male partnership afforded them so many material benefits that they needed in order to survive, most viewed professional help as necessary in order to establish their independence apart from a risky partner. Although women often referred to forms of public aid as undesirable -- because they

258

felt pride in their ability to provide for themselves -- some participants did refer to public aid as necessary in order to establish their independence and leave their risky partners. Women used public aid to compensate for a partner's lack of financial support, to watch their children while they went to work, and to identify sources of alternative housing in order to live on their own.

I previously mentioned that living on one income in the Green Valley was particularly difficult for women with children to support. Renata picked grapes in order to pay the rent, but without receiving food stamps she would not have been able to feed her children. Other women felt desperation after losing a partner's financial support, and said, "I don't know how I'm going to do it." Without public aid, many participants believed that they and their children would have been either homeless or hungry.

And sometimes, the unthinkable happened and women found they had to strategize in order to fill unexpected gaps in income. Laura suffered a miscarriage one week before she was due to travel north to work for the summer, and had to stay behind because "I couldn't travel like that." She dipped into her savings but found that she still could not make ends meet while out of work for three months, so she applied for food stamps for the first time. She remembered, "I'd never asked the government for help, I've always worked." Working to support herself engendered pride, and she felt disappointed that she had to depend on government support for a short time.

When another woman decided to leave her partner, she needed professional help to make it happen. She was afraid that if he discovered she was looking for another place to live that he would retaliate in anger. So, she did not tell him that she was applying for low-income housing. Finally, one day she got the news that she had qualified. Once Laura received notice that she had qualified for this new low-income housing, she arranged her finances (taking a loan from her

brother to cover what she lacked), set up all the utilities (feeling proud that "everything was in my name"), and sought help from another woman to give her a ride back to the old place to pack clothes and food staples. Then, after everything was all set up, Laura broke the news to her partner, saying, "We're leaving. Because they gave me an apartment, and we're going to live at (*gives her new address*). When you want to see your kids, there they'll be. And tomorrow I'm going to look for somebody to help me move the furniture...We're leaving." The availability of low-income housing made it possible for her to gain independence and leave her partner.

In addition to finances for food and housing, women needed childcare while they went to work. Those who had previously been able to stay at home for part of the year had to return to work in the fields full-time after leaving a risky partner. They had to scramble not just to find reliable childcare but to pay for it. Many of the participants in this sample had children enrolled in Migrant and Seasonal Head Start (MSHS) and identified MSHS as an invaluable resource that helped them to achieve independence as they fought back against a risky relationship. For example, Mariana thought that MSHS really made her life possible as a single mom of eight. She said, "I have to go work, because like I'm telling you, I can't do it all with the kids, there are so many expenses." Women told me how they had been helped by MSHS not just with childcare, but with their own personal objectives including obtaining a driver's license, enrolling in English language courses and taking advantage of other adult education courses.

When Laura first hit financial straits, she was not aware that support was available through the US state government. She referred to this knowledge as something that she had to "learn" while becoming accustomed to life in the US. In fact, I told part of her story in the previous chapter under "partnering for survival." Laura saw partnership as an "open door" that helped her to survive, but which ultimately made her vulnerable and blinded to risk.   Over time,

she discovered that she could access public aid and therefore not have to rely on a partner for financial support. Her discovery of public assistance enabled her to take action and leave her abusive partner. She said:

> They told me to call a number where they would help me with WIC. When I called they did all that for me and gave me help. I got really happy, and I told him [former partner] that with all that I was going to be able to eat, and then with what I earned I would send it to my kids there [in Mexico], and I didn't need him to be exploiting me. And I left the older girl's father.

All participants were seeking help from *somewhere*. Often, they found that their source of help was an intimate partner. Less frequently, women discovered they could find help from another source without needing to partner. In this way, forms of public aid actually protected women from compromising their own safety and the well-being of their children. Public aid could remove the need to partner out of necessity.

In her current relationship at the time of our interview, Laura thought she had gained enough leverage to place conditions on her partner and give him an ultimatum because she had found professional sources of help. She said:

> Now I know a lot of things, and that's why I tell him, if he's not going to behave nicely, and stop drinking and all that -- because I don't behave badly with him -- I can get by on my own. Because I know now how to live on my own, I tell him. I have to fill out the MediCal sheet on my own, go by myself to the doctor's with the kids, take them by myself; he's never taken them, because he says he doesn't know how it goes. I mean, he knows what to do, but if they give him something to fill out, he doesn't know how to, he

261

never wants to. And I do everything by myself. So I tell him, if he doesn't help me out

with everything, what I want...well, I'm better off alone.

Because she could manage her own independence through public aid, she felt that she

would be "better off alone."

Seeking fortification from healthcare. Participants turned to healthcare in order to obtain

information and care to fortify their bodies and minds and help them to fight back. One

participant told a story that encompassed this well. When her husband was diagnosed with HIV,

Olivia immediately worried, "Wow, I'm going to get the same thing. If he's got it, I'm going to

get sick, too." Her worry turned into action as she saw her husband become more sickly and

depressed over his illness. She considered that she could become infected, and so she said:

> I went to the clinic and told them I needed to know everything I could about it. Because I
>
> was living with him, I needed to know what was going to happen to me because we were
>
> together...[I] was asking for all kinds of opinions and advice, asking them about —how I
>
> could protect myself from it. At the beginning they gave me something that looked like a
>
> condom for me, too. And then they gave him a special one, from the clinic there. And
>
> that's what I've been using to protect myself, up 'till now, thank God. And I go every six
>
> months, and I still don't have anything.

Then, when Olivia found that she was feeling stressed and even depressed over her

husband's diagnosis, she put off seeking care for quite some time until she became more and

more anxious and finally fainted while at work in the fields. After a full medical work-up, she

was told that, "What I had was a lot of stress. I had a lot of stress in my head." She was given

some pills in order to "feel more relaxed," and was told by a physician that:

If I didn't take the pills, then I'd just be completely stressed and scatterbrained, and it

could happen to me again. And, [the physician] told me, 'You could even have a stroke

from thinking about all this.' So that's what I'm taking now, that's why I feel stronger.

Olivia thought the pharmaceutical management of her stress helped her so that "my head is not

all a mishmash of crazy thoughts." She said that, prior to taking the pills, "I was depressed.   I

mean I felt like I wasn't here, I was somewhere else, like I wasn't myself. Like I was just a shell

-- I was here, but I wasn't, I was far away." After starting the pharmacological therapy, she felt

relaxed and able to cope with the stress of her husband's HIV diagnosis as well as the increased

demands to run the household, provide for the family, and care for him as he became more ill.

    Enlisting professional help to fight in her place. In addition to using professional help

as a way to fight back, women also enlisted professional help to fight in their place. Seeking

professional help was a last resort; it was not the first place to which women turned. After

exhausting their own personal resources to fight back against a risky relationship, women saw

professional help as their last resort for the preservation of their own well-being and the well-

being of their children. Throughout women's narratives surrounding how and why they accessed

professional help, they used words that indicated feelings of necessity -- for example, "I *had* to

call the police." The hope of professional assistance was the only thing that some women thought

could help them take the offensive. As one woman said:

    I'd like to see him locked up for awhile, truth be known. To see if he tries -- tries to think

    better -- tries to see how bad he is. Because the things he does are so bad. That's the only

    thing that would help me relax. That's what I tell my neighbor, maybe I'll relax a little

    while if they lock him up. Otherwise, I'll have to keep fighting.

Another woman expressed her exasperation, telling the police when her partner raped her a few days after she suffered a miscarriage, "I have to talk to you because I can't do anything more. He's even done *this* to me, now what else can I do about it? What's left for me to do?"

Waiting for just the right time. Aside from using professional help as a last resort, women also felt that the timing of *when* they accessed professional help was pivotal. For example, Carmen stayed with her abusive partner for many years, adapting to her circumstances by restricting her activity and stepping lightly around him so as not to "make him angry." She said, "Sometimes I didn't even go out, I'd just stay closed inside with the kids, taking care that they not make a sound and make him angry, because he was real hot-tempered and violent." She was thinking of leaving him the entire time, but stayed because "I couldn't figure out how to [leave]." She was looking for a way out -- looking to find him cheating or be able to catch him in an act of violence with eye witnesses present, so that she would "have a good reason" to leave. She was searching for undeniable proof of his unfaithful and abusive behavior, so that when confronted with her proof, "he couldn't say 'no,' or that if I did tell him to get out, he wouldn't *not* leave." When I asked her if he had been cheating on her, she says with a chuckle, "I wish!" Because catching him with another woman would have given her enough leverage to end the relationship.

She was very strategic, waiting for just the right opportunity -- an opportunity when she knew she would have had enough evidence to convict him. She was not willing to call the police multiple times and not have enough evidence for a conviction. She also expected that if he was charged and then released back home, that his behavior might become even more violent and possessive. For all these reasons, she described waiting until just the right moment when she

finally called the police. When the moment finally came, she felt victorious. Finally, she felt

successful because "they [the police] got him."

Unfortunately, Carmen's experience with involving the police did not go as smoothly as

she expected. After he was released from jail, she remembered that "he'd come by all the time

and threaten me." Since she had a restraining order against him, she'd call the police and he'd be

"locked up" for only 15 days at a time before he'd be released and return to bother her.

However, when Carmen's partner ultimately returned to Mexico and then tried to reenter the US,

he found that "they took his papers away from him. He couldn't come back and he stayed

there." The international border provided an extra layer of security and safety for Carmen. Her

partner could not return to bother her.

Using the court as an intermediary. Others felt that the only way to gain leverage over a

risky partner was to utilize the court system as an intermediary. One woman hoped that, through

court orders regarding child support and custody agreements, she would be able to put a stop to

her ex-husband's continued verbal and emotional abuse. She thought she lacked the ability to

singlehandedly prevent her ex from verbally abusing her; only the judge could put a stop to it.

She had great hopes that this would happen: "I'm hoping now that I talk with the judge, things

will change...hopefully things will change."

Another woman thought she would finally experience some relief when finally "a judge

ordered him not to get near me. Three years, he couldn't get near me." He was incarcerated for

one year and then ordered to complete a two-year rehab program. Alejandra gives all the credit

to the judge and to law enforcement officials for her freedom from her partner, saying that "they

got him off me." She says that for those three years, "I was at peace. I knew he couldn't get

out."

Encountering roadblocks when seeking professional help. Although some women told of being able to access professional help in a way that was useful, others explained how roadblocks prevented them from obtaining what they needed from professionals. These roadblocks included gendered political roadblocks and fearing the law.

Gendered political roadblocks. In the previous chapter, I described how participants internalized components of the *machista* mentality as a result of comments made by Mexican healthcare professionals, and how this mentality had contributed to women's sense of complicity in their partner's risky behaviors. Here, I explain how women thought their legal rights and their rights to their bodies were exploited in Mexico. Some women went so far as to describe feeling as if the entire country was *machista*. For this reason, women perceived that gendered political roadblocks constrained their ability to seek help from professional resources across the border.

For example, one woman worried that her husband would file a report that she had abandoned him in Mexico when she came to work in the US. His home in Mexico was the only shelter she had; when she traveled throughout California during the grape season, she lived out of her car. She did not consider Mexican law to be on her side; she worried that she could face legal ramifications for having abandoned her home and her husband. Another woman believed that, "everything there is all about money, what they want there in Mexico." She perceived that her partner could easily bribe a Mexican authority (physician, police officer, or judge) to take his side regarding their legal separation, child support, and the STI with which they both were infected. She thought her rights would be exploited in Mexico. She did not see herself as having the ability to pay a bribe, and therefore felt that any efforts to maintain her own rights, in Mexico, at least, were futile.

In the US, in contrast, women thought the law was on their side and they would receive assistance and hear the truth from medical professionals when seeking care for an STI. For this reason, women preferred to seek medical care in the US. However, when they had the choice (i.e., when they were documented), women perceived that men preferred to seek medical care for STIs in Mexico. This is one situation where being documented could actually be a hindrance for women, when their partners wanted to take disputes across the border where Mexican authorities and/or healthcare professionals were more likely to favor the man. So, when a partner preferred to go back across the border to seek health care, women thought they were going to "lose out."

Formal marriage could also be a roadblock when women's partners used marriage as rationale for continuing a sexual relationship despite her desire for separation. One woman, whose husband left her to live with his mistress in Mexico, told how he returned to stay at her house when he was in the Green Valley to work the harvest every year for three years. She said:

> Because I was his first wife, he [reasoned that he] could just come back. Because we're married, in the church and everything. So he could just come back. He could come back home and I was his wife and he was my husband and he could come around whenever he wanted.

Having a legal marriage meant that male partners thought they could retain rights to a woman's body and her home. This woman felt that her partner could come back and expect her to serve him a hot meal or have intercourse with him when he happened to be in town -- regardless of his other relationship commitments and regardless of her own wishes/desires. She realized that ending her formal marriage was the only way to reclaim her sense of agency and prevent him from taking advantage of her.

Deciding that she wanted a divorce was only the beginning of her quest to rid herself of her partner, once she realized that ending her formal marriage in Mexico was the only way to stop her husband from treating her like his marital property. She saw her formal marriage as affording him a claim to her body. She felt owned by her partner because they were formally married; it contributed to her vulnerability and took away her agency to make decisions over her own body and her home.

She and her partner agreed to separate in front of witnesses, and the Mexican police told her partner, "You have no right, in Mexico...[to be] bothering that woman." Regarding child support, the Mexican police told her partner halfheartedly that "he was obligated to help his son," with "whatever money he had." This command fell upon deaf ears. Not surprisingly, he never gave her a penny. Even though he stopped treating her as his marital property, she continued to feel resentment over the fact that the authorities in Mexico displayed no concern for her rights to child support.

Also, a woman's undocumented status could also be used by an abusive partner to threaten her and place constraints on her behavior. Women were afraid to seek help because they heard an abusive partner say, "If you call the police I'll call immigration. I'll call immigration for them to come and take you away." So, both documented and undocumented women in this sample faced gendered political roadblocks when seeking professional help. Those with papers often were persuaded by a partner to have legal and/or medical matters addressed across the border, where women thought their rights were not protected. And those without papers felt vulnerable, particularly in relationships with partners who *were* documented and who threatened to turn them over to the authorities.

Fearing the law. Women admitted fearing that they could be mistakenly blamed when accessing help from the police. For example, one woman feared that she could be incarcerated -- as her partner's previous girlfriend was -- for fighting back against her abusive husband. She worried that he could turn it around and make it appear as though she attacked him first. Although women with abusive, controlling and violent partners relied on the US legal system as a source of help, they worried that their crafty partners could somehow be able to misconstrue reality and cause them to suffer the blame.

Falling through the cracks. Although they agreed that they were more likely to have their rights protected in the US than in Mexico, women trying to get out of risky relationships often thought they were falling through the cracks of an already fractured system. Although some women were able to "find the good" and access professional help, others fell just short of receiving help that they found useful. They told of near misses -- of circumstances under which they thought they were being helped to leave a risky relationship only to be told that they did not quite meet the requirements or that their situation was too dangerous for outside involvement. Women also told of situations where their trust in professionals was shattered. In both of these situations, women thought they were close to being able to leave a risky relationship with the help of professionals, only to discover otherwise.

Failing to meet the requirements for professional help. One way in which women thought they were falling through the cracks was when they were told they could be helped by a professional, only to later have this help revoked because they did not meet the requirements. For example, one woman was told by a county social worker that her situation with her violent husband was too dangerous -- that the social worker "couldn't keep coming because she was putting her own welfare at risk." In response, this woman said, "It was fine, because why should

she risk her life, right? But at that point I asked myself, 'What help do I really have?'" Another woman also thought she fell through the cracks when her application for a housing grant available to single mothers was denied because she was still living with her partner at the time. Planning to use this resource as a way to leave her risky partner, she found this requirement to be particularly frustrating. She thought she needed to set up her housing without his knowledge, fearing that, "What if he finds out what I'm doing, and wants to do something to me? Because whenever he'd get [drunk] like that, I'd get kind of scared, and maybe he'd think I wasn't happy."

  Experiencing shattered trust. Other women felt as though they were falling through the cracks because they saw their trust in professionals shattered by a significant breach. Participants felt extremely vulnerable, as if they could easily be taken advantage of by those who were intended to help. For example, when one woman sought care for vaginal bleeding at a local emergency department, the hospital staff did not use a professional interpreter. With great emotional pain, she told me how a nurse had interpreted for the physician, but that this nurse did not speak fluent Spanish. Because of this, she believed that the hospital staff misinterpreted her story and made a grave mistake in their determination of the cause of her injuries. Instead of listening to her insist that she had suffered an abrasion as a result of consensual sex, she heard them conclude that she had been raped. She saw the truth lost in the misinterpreted details. Ultimately, she believed that her family was greatly affected by the conclusions of these healthcare professionals. She concluded that healthcare professionals "just don't believe you"-- that they have their own agenda. She told of having great distrust for healthcare professionals and because of this, she only presented for health care when absolutely necessary. She said:

270

They [healthcare professionals] never tell you much, and they write down what they want. I say, so why go? If I get sick, I get sick. If I look for something to take and I get better, good, and if I don't, then I go to see what I've got. If it's something I can't cure myself of, okay, but I only go if I really have to. Otherwise, no.

Another woman had difficulty trusting the police after an incident with a law enforcement officer who overstepped boundaries. She said that before this incident, "I trusted the police, because they're [supposed to] help you." But then one day she called the police after her partner attempted to rape her and then fled. The officer asked her to not just recount what had happened, but to actually reenact the scenario with him as if he was the offender and she was the victim. In her bedroom, alone with no one else at home, he asked her to demonstrate how her partner had treated her, asking, "How did he get you on the bed?" and "What did he do to you?" and "How did he throw you?" She felt extremely uncomfortable when the officer touched her and lifted her up in an embrace. She perceived that his intentions were to take advantage of her, and she left the room before anything more happened. She goes on to say that, before the officer left:

He told me he was going to catch him [partner] and that when he had him he'd call me. But he came around after that about three times. The same policeman, even though I hadn't called him. And I didn't open the door for him because he scared me. I figured he was coming because I was alone, not because I'd called in a report.

As a result of this incident, this woman decided not to utilize law enforcement as a source of help because she no longer trusted that they would ensure her safety. Why seek help for one problem, only to create another? She said, "I wasn't calling the police anymore, because I said

to myself, 'What for? The policeman is going to do something else to me.' So I didn't call them anymore."

Fortifying the Self

So far I have explored two of the three strategies migrant farmworker participants employed to gain leverage over intimate partner risk. First, in "fighting the bad," women used their personal resources to fight back to gain leverage over risky relationships: drawing upon motivators and overcoming roadblocks, they calculated moves to resist harm and took measures to control a partner's behavior. Second, in "finding the good," women told how they strategized to harness help from family, others, and professionals, while at the same time trying to avoid further harm in order to gain leverage. With outside assistance, some women were able to leave their risky relationships. Third, after telling how they fought back and acquired help, women described the ways in which they worked to "move on," both within their risky relationships or outside of them by "fortifying the self" in order to gain leverage. They accomplished this by pushing pain to the background, finding meaning in motherhood, and focusing on the positive, with the encouraging result that they were able to "move on."

This concept of "moving on" was important to participants. In fact, "moving on" is a critical component of "gaining leverage." Some women who had left a risky relationship were eager to be able have a new, reciprocal relationship. All women -- regardless of whether they had left a risky relationship or not -- were eager to maintain their identities as respectable working mothers who were not bogged down by the memories of a painful past. The concept of "moving on" involves being able to live life without feeling paralyzed by pain or fear, and working to combat all the ways in which women felt that they were suffering the consequences of their risky relationships.

But, "moving on" was complicated by the fact that women thought their experiences with risky relationships had actually damaged the core of their being -- that they were "totally traumatized" and changed as a result. Those who ended their risky relationships worried that they were so damaged that this would affect their future relationships. Women thought that violence and infidelity had actually been "etched" into their souls, saying, "The damage had been done...I never thought anyone was going to love me, or that I was ever going to love somebody, after all the violence I had suffered." This feeling of suffering hindered women from gaining leverage and "moving on" after the end of a risky relationship.

Apart from fear that a new relationship could also become risky, women worried that they could actually *cause* the new relationship to become risky because they had been so affected by risk in the past. Again, women struggled with fears of complicity. One woman explained that it was "hard for me to begin a new relationship," because she figured that she would "take *it* from relationship to relationship." The "it" that she was referring to was her own emotional scarring as a result of being with an abusive man. She initially told the man who pursued her, "Don't expect me to be your partner. Because I'm not -- I'm no good as a partner." She felt so damaged from her previous relationships that she could not imagine the possibility of being in a reciprocal relationship. She said, "You know, that's the least you imagine after [going through all] those problems, that you could love someone again. Or that someone could want to love you, even less!" The "baggage" that women perceived they brought from one relationship to another caused them to feel distant and have difficulty being intimate.

Women also noticed a change in their temperament as a result of being with men who were unfaithful and abusive: they were filled with anger. One woman said:

Sometimes it just comes out, what I suffered. Sometimes I just get angry for any old thing; I get altered, nervous, or I get hysterical because of the slightest thing. But it's because of all of this. I know it damages you, it really leaves its mark on you.

Another woman described how she always felt on the defensive after experiencing risky relationships. She said, "I'm always, like, defending myself, or at least, defending things for my kids."

Pushing pain to the background. One way that participants worked to gain leverage over their damaged sense of self was to repress their memories and emotions. Women felt that repression had pragmatic value because they did not find it useful to dwell on painful memories and their corresponding emotions. As one woman said, "It's [his affair is] something you can't erase, right? So why keep thinking about it?" Another woman agreed that, "I don't try to think about what happened to me, because it's over, anyway. I mean, it's not like it's going to come back -- I hope that my life doesn't return!"

Seeing repression as necessary to "moving forward." In fact, some women viewed repression as necessary in order to "move forward." Instead of dealing with their emotions, they pushed them to the background because it was more important to "keep going forward." One woman tried to forget about her abusive partner, saying, "I didn't think about it anymore, or about him. I had to move on and keep going. Why think about what had already happened, if it was in the past already? What was done was done. I had to keep going forward."

And for women who chose to stay in a risky relationship, repression was particularly necessary. When Ines got back together with her husband after his affair, she did so without the chance to discuss the alleged affair, her feelings, or his possible guilt. She had to continue the relationship as if nothing had happened, since he continued to deny the affair despite the

evidence. At the time she told herself, "if we get back together it's not so I can shove it in his face, bitching and arguing." She swallowed her feelings of anger, and did not allow them to resurface. To her, allowing her anger to resurface would only bring her more hurt but would not change anything. She said:

> I try never to argue or fight [with him]...I think if I did that, I would be hurting myself because I'd be remembering, remembering, bringing to mind always. And that's no way to live. I try to live. What's behind is behind, and I want to keep going. That's how I do it. Yes, though, it is hard. It's hard.

> Ines saw that her only option for gaining leverage over her risky relationship was to "leave it behind, way back, leave it way back behind." Along with her anger, she repressed her feelings of sadness. She said, "there's always sadness, although you want to pretend it's not there." And talking about it won't help. She said, "it's like you end up doing something bad by keeping on talking about it.   But I say, it can't be undone. Things happen, and that's it. You can't do anything more about it except leave it behind."

Another reason that women value repression is because experiencing emotional pain could be viewed as a weakness. Women preferred not to let others see them cry because they wanted to "be strong." As one woman said, "I think everything that happens to you is for a reason. You won't forget about it, but when you think about it, I think you have to be stronger to not let it affect you. So, that's what I'm trying to do." As a single mother, Ana felt that she needed to "be strong" in order to establish herself as an independent woman. She did not perceive that she could exhibit emotional vulnerability and simultaneously assert herself as the sole provider and protector of her children. She said:

I have to keep going. So, now that I'm by myself, I don't try to think about my past

relationships, or about the past, because I have my two kids. And like, I know that if I'm

focused on thinking about the past, I'm going to stay there. So, right now, I'm not

thinking about the past.

However, this facade of strength lasted only as long as women were not confronted with

an opportunity to be vulnerable. For example one woman told me that she was only able to

"keep going" and "be strong" as long as "nobody asks me anything." Because she knew that if

someone asked, a flood of emotions would overtake her and break down her defenses. Her

mantra was, "Just keep going, and leave it behind me and keep going. Not keep thinking about

what happened, but think about what is going to happen, what might come, and be prepared for

everything."

Seeking distraction to overcome emotional scars. Similar to repression, women told of

wanting to find ways to be "distracted" in order to take their focus away from their emotional

pain and be able to "move on." The idea was to "keep my mind busy with something" in order

to quell bad memories. Participants told of being able to occupy their minds by keeping busy,

focusing on the children, and being distracted by a new relationship.

Women found joy in their role as mothers but mostly found that mothering provided a

distraction from their own traumatic memories. By focusing on their children's

accomplishments, they could replace their feelings of pain and suffering with those of pride and

joy. In a sense, women wanted to lose themselves through prioritizing their children, so that "the

bad things started to fade more and more."

Many women welcomed their ability to work and be involved in other activities that

could occupy their minds and cause a distraction from thinking about their risky relationships.

Some women tried to fill their days with activities -- including caring for the kids, helping with homework, and taking English classes -- in order to "hear other voices, so I wouldn't be so focused on my own pain." As one woman said, "Work keeps me entertained a lot...As long as I'm working, I'm fine...Not thinking all the time on the same thing, the same thing, over and over."   Keeping occupied with "other" things helped to keep their minds "busy," in order to "feel a little lighter, as if some of the weight has fallen off." Women felt that if they did not keep busy enough, that then, "it was really hard. Because being here at home all you do is think. You clean and in a little while you're done...You start thinking so many things."

Other times, women found that the excitement of a new relationship could provide distraction from pain and sadness. For one woman, this distraction came from a new neighbor friend. This relationship was helpful because Ana tells how, "She talked to me every single day. We started going to work together, or like, sometimes we went out together. So, it was a big distraction for me." For other women, the possibility of a new intimate relationship with a man distracted them from bad memories of a previous relationship. For example, Carolina saw her new suitor as having "lifted me out of sadness; he lifted my spirits."

Admitting that repression was not healthy. Despite the belief that repression was necessary in order to "move forward," some women did admit that repression ultimately was not healthy and expressed a desire to "let it all out." However, only one woman in my study felt that she had found a trustworthy place in which to divulge her deepest secrets: at a couple's support group at her husband's HIV clinic. While a handful of other women could identify one other person with whom they felt comfortable talking about their risky relationships, for the most part women felt that repression was actually a *necessity* because there were so few sources of emotional support within the community. This was why women were so eager to share during

277

our interview; because they felt they had no one else to talk with whom they could trust. Women felt that they did not "have anyone to unload on and talk about problems with." Although some women tried to find "somebody to listen to me," they discovered that neighbors and family members preferred to give unsolicited advice. They worried that they could not trust others who could instead "make me feel like it's my fault." And so, in lieu of taking the risk of sharing, women preferred to "stay quiet."

Instead of sharing her feelings with her family members, Ana told me that she prayed and talked to her deceased grandfather as an outlet for her pent-up emotions. Since he was the only one in her life whom she felt she could trust and depend on, she would stay up late at night and talk to a photograph of him that she kept next to a framed painting of the Virgin Mary and a silk rose in a plastic vase.

Repression can have negative consequences. Staying quiet had undesirable consequences that women noticed in themselves. For example, one woman said, "I feel bad sometimes because of all the things I'm keeping inside." She noted that memories came and went in waves. And during those times when "the memories come back" and "everything comes on top of you," she felt that, "it's even worse because you don't have any way of getting it all out." Women who correlate physical illness with emotional pain were more motivated to find an outlet for their emotions, because they saw their emotions as "a heavy burden you're carrying around, and as long as you're carrying it you'll never get well." Another woman admitted that, "I know it's hurting me, keeping things to myself." She worried that if she was not able to "let it out," that "then I'm going to explode; I'm going to explode in a bad way." She believed that her "bad attitude" and anger were a result of the violence she had experienced, coupled with her repression of feelings.

Needing professional help. Because of the fact that women assessed a need for an outlet for their feelings but concurrently felt they had no one with whom to share, many concluded that professional counseling help was necessary in order to "move forward." And although sometimes women found solace in brief emotional releases while at home alone where no on else could see them cry, they acknowledged that "you just can't cry it out." They acknowledged the benefit of having another person available who would be able to "give an encouraging word" as well as allow them space to "blow off steam." Even though Ana found some comfort in being able to talk to a photograph of her deceased grandfather, she still concluded, "I know I need like a psychologist, because I've passed like, too many things in life. So, I think they're stuck inside of me still." She went on to say, "my head is full of thoughts [and] I don't know how to get them out." However, despite their desire for professional counseling, only one woman in my study told of having the opportunity to speak with a psychologist -- and only because her husband had recently passed away and she was attending counseling sessions with her daughter at her daughter's school.

Finding meaning in motherhood. In the midst of their chaotic lives -- all of the insecurities, dangers and risks – study participants were grounded in and found ultimate purpose and meaning in motherhood. As one woman said after separating from her partner, "I don't know what he's going to do with his life, but what I want to do with mine is clear to me. And the main thing now is the kids." Throughout their risky relationships, their self-doubt and their feelings of complicity and regret, women saw motherhood as the thing that saved them from losing themselves. In other words, even though women may have felt negatively about themselves and wondered if they were to blame for their risky relationships, they ultimately did not feel like failures as long as they could continue to mother their children. Women viewed

279

themselves as ambassadors to their children, who otherwise would be resigned to follow in the footsteps of those who have gone before them. Women believed that if they were not able to offer alternative options to their kids, their children would not have the necessary tools to break free of the cycle of poverty, violence, or hardship. As women used their personal resources to fortify themselves in the aftermath of risky relationships, they found that their primary source of strength came from their children. They found meaning in the distraction and joy of mothering, in their role as guardian and protector, and in their hope they could ultimately gain enough leverage to "break the cycle" and provide a better future for their children.

"You've got your kids to perk up and live for." Participants spoke of ways that their children would enable them to focus on the happiness in their lives, helping them to forget the pain of risky relationships. As one woman said, "I just start thinking about him until the headache goes away." In this way, women actually felt emotionally cared for by their young children. For example, women felt able to demonstrate love to their children in a way that allowed them to release pent-up emotions. One woman said:

> I would hug them to me all the time; just hug them. I'd kiss them, and then all the
> sadness would come over me and I'd grab them and just cry. And they'd come up beside
> me and dry my tears.

Women saw their children as being "everything I have."

Participants said, "I have my kids, and if [my partner] doesn't take care of me, my kids will." Gabriela's children were in grade school, so when she said that they would "take care of me," she meant that they would take care of her emotionally and give her a reason to live. Overcome with emotions and barely able to get words out, she told me, "My kids are going to help me be strong. My kids and God aren't going to leave me alone, they're going to give me

the strength I need to keep going." She describes going back and forth in her feelings, like riding a roller coaster of emotions while she fights back against her risky relationship. She said, "Sometimes it hurts, sometimes it doesn't. I feel bad, and [then] I don't feel bad." This flux of emotions was based on the presence and involvement of her children, who "look for ways to brighten my day." While they were away at school, Gabriela felt sad and was not sure what to do with her empty days while she was off work on disability. But when her children came home, they occupied her time with talking about school and homework, helping with meal preparation, or playing music. In other words, Gabriela felt that "they look for ways to encourage me," and this lifted her spirits and changed her outlook. She heard her neighbors reinforce the idea that her kids will help her to get through this difficult time, saying, "Wow, you've got amazing kids! You've got your kids to perk up and live for, not for some stupid guy."

Children provided joy and distraction that was therapeutic. Another woman saw the process of "getting better" as being facilitated by the way she was able to focus on the joy her children could provide, instead of thinking about her husband's abuse and infidelity. She said:

> A sad song would come on and I'd cry a lot because of the song, but afterwards I'd say, "'Why am I listening to a song that makes me sad, instead of a song that makes me laugh or dance?' So I'd put on a song or a fast *cumbia* and dance by myself. And my little girl would start in dancing with me, and I'd take a video of the two of us, dancing and jumping and doing the *cumbia*...It was so painful for me to have her fall asleep, because she always made me laugh; and in those moments I wouldn't remember anything [bad]. So what I used to do was turn the video on and start watching it, lying down, holding her in arms, and I'd watch the video and start laughing. That's how I'd fall off to sleep peacefully. That's how I'd get better.

Appointing self as guardian and protector. Another way that women found meaning in motherhood was to appoint themselves as the guardian of the children, to protect them from their father, saying "even if he doesn't care about them, I do." In order to guard and protect their children, women felt that they must guard and protect their own reputation in order to prevent generational disgrace. One woman said to her daughters:

> Wherever I go I am not ashamed of who I am, and you should not be either. You can go anywhere I was and nobody will *ever* tell you that your mother talked with anyone in the street, or took any stranger in to her house, that you can be ashamed of me.

Despite all that their partners did that threatened their respectable identities, women took pride in their attempts to maintain a respectable identity for their children.

Women perceived that a father's identity could be equally as damaging to children. For this reason, women shielded their children from the truth about their fathers. They hoped that if they could hide wounds, save arguments for behind closed doors, and withhold the truth, that their kids could grow up with a positive image of him. Women could not change the fact that their risky partner was the father of their children. But they hoped to at least mitigate the damage and preserve his dignity in front of the children.

Believing that their partners did not have the children's best interests in mind, women found meaning in their efforts to shield children from seeing, hearing, or experiencing any of the violence or dysfunction that was a part of their own daily lives. One woman said:

> Sometimes the kids would hear our arguments, but I would always hug them to me, and tell them that this was not normal for two people living together, in a couple, to fight all the time. But that I loved them, anyway, and I still do, and 'Whatever happens, you will always have your mother's love,' I'd tell them...They were always with me, I never left

them alone, ever. I never abandoned them. Even though I had to put up with yelling and screaming.

This ability to mother through the violence and feel as though they could protect their children from any collateral damage was what helped women to get through and get over their risky relationships.

However, losing the ability to mother through a risky relationship resulted in devastating emotional consequences for one woman. Carmen's deepest wound did not come from her husband's violence but from the fact that her children were placed in foster care for seven months after she involved health professionals and law enforcement in her struggle to leave him. Her greatest wound from her risky relationship was that "they took my kids away from me." She blamed her son's lack of direction as an adult -- and his resulting homelessness and addiction -- on the fact that he had been through the foster system and was away from her during a formative time in his childhood. She was supporting him in rehab in Mexico at the time of our interview. When I met Carmen, she was still reeling from the long-term consequences of her stolen opportunity to guard and protect her children. Looking back on this experience, Carmen continued to feel intense pain and described herself as being withdrawn and isolated. She harbored feelings of guilt, regret and anger over her ex-husband's violence and the fact that her family had continued to be so affected as a result. She said, "That's why I don't go out, I don't visit anyone. Because they start asking me questions -- my family, my mom -- and I don't want to get talking about it." She made it a point to avoid her mother and other members of her family for this reason. But it was not just her family that she felt distanced from; she had withdrawn from most social situations. She said, "Outside of work I don't have any kind of relationship

with anybody." As a result of losing her ability to mother her children for a time, she felt she had lost her grip on her own self and her ability to connect to others for meaning and support.

Hoping to "break the cycle." Women felt a need to differentiate themselves from their parents and "break the cycle" in order to protect their own children from living in poverty, working in unskilled manual labor, and having risky relationships. Because of this, women tried to adopt parenting styles and tactics different from those used by their own parents. Women's greatest fear was that they would one day hear a daughter say, "I'm going to pick peppers out in the field, like Mama" or "I'm going to marry at 18, like my mom did." This desire to be different offered women hope and meaning, as they believed that their children -- whom they viewed as an extension of their own selves -- could "move forward" and have a better life than their own. In a way, this hope was redemptive. If they could help their children to have better outcomes in their finances, careers and relationships, then participants could feel that their own struggles were more meaningful.

Wanting kids to pursue a professional career. Apart from their risky relationships, women described how their primary objective in life was to help their children complete their education and obtain a professional career. Women agreed that, "he best thing you can leave your child is a good education." As one woman said, "That's why I am here [in the US]. Not 'cause I'm really so crazy about being here. So I'm here, for that – for my kids I'm fighting, so they can...I want my son to study." And within their risky relationships, this hope for their children to "get ahead" provided purpose and meaning as women fought back, found assistance, and fortified their selves. Most participants were unable to complete their education, and therefore viewed education as one primary way that their children could "get ahead," so that "they won't go through what I had to." Women hoped that their children would "have the

chance to study, to do something, to be somebody," and "have a different life" than their own.

They considered their lives to be plagued by "limitations," and hoped to help their children break free of them.

Like other women, Daniela would have preferred to live at home in Mexico. But she chose to work in the fields in California so she could financially support her son through culinary school. She had a home with her husband back in Mexico, but they worked together in the US. in order to make extra money to pay for their house and also to support their son who was a full-time student. She viewed her decision to pay her son's way through college as "my great sacrifice," believing that "with an education he'll have a lot of knowledge, and if he wants, he can make it [in life]." And if a child makes it, then women could feel like "it's going to be better for [my kids] than it was for me." Since women viewed their children as an extension of their own selves, seeing a child succeed made them feel as if they themselves were succeeding. For example, one woman feels so grateful that her children are studying, because "They got to be someone, since I couldn't."

"Breaking the cycle of violence." But compared with studying and seeking professional careers, women's greater hope was that their children would not have to grow up and perpetuate the "cycle of violence." Women feared that their sons might grow up to be like their fathers, saying, "Someday he may get married and say, 'This is what I saw in my home, and this is the way I'm going to treat you.' And the suffering continues." Similarly, women feared that their daughters could be more at risk for getting involved with drugs and alcohol or bad company because of "everything they saw their father do."

Not all women told of success in "breaking the cycle." The desire was there, but particularly for women who grew up in households that were plagued by violence, women found

it difficult to differentiate themselves from their parents. They felt they had been too accustomed to violence and abuse to be able to break free. For example, while she was growing up and trying to defend her mother against her violent stepfather, Ana said through tears, "I told my mom I wasn't gonna be -- my life wasn't gonna be the same as hers. But I think it was the same. It was worse." She went on to explain that since she was deeply affected by the violence in her childhood home -- as she learned to act defensively both verbally and physically -- that this affected how she responded in her own relationships with men. At the time of our interview, she was in a reciprocal relationship with a new partner, hoping that this new relationship would provide an environment in which she could raise her kids differently.

Making self emotionally available. Most women felt that their own parents -- particularly their mothers -- were emotionally unavailable to them both in childhood and adulthood. Often, this was a result of a physical distance and even separation by the international border. Women felt affected by this emotional distance and made their own relationships with their children a priority. One woman, who told of feeling distanced from her mother even though they always lived under the same roof, said about her relationship with her mother, "I don't want to be with my kids like that. I want to be different. I want to be there when they need me." She wanted to be approachable and emotionally available, two qualities that her own mother lacked.

Ximena was left in Mexico with extended family while her parents migrated to the US for work, and made a point of never leaving her own daughter behind because of all the emotional pain that her own parents' absence had caused her. Instead of perpetuating the cycle of abandonment that she saw as plaguing transnational families, Ximena made a conscious choice *not* to be a transnational mother. She wanted to bring her daughter up differently, in the hopes that she could spare her the emotional turmoil of a distant mother. When Ximena

migrated to the US, she was proud that she took her daughter with her. She said, "there's no point in my passing on to my daughter what I went through...I protect her as much as I can, which nobody did for me." Once her daughter became a teenager, Ximena heard her say that "she's not going to be like me." She felt grateful that she was able to be available to her daughter and protect her. She said with pride, "Even in the way she acts, she's nothing like me. She sees things differently." This encouraged Ximena to believe that her daughter could "get ahead" without the emotional baggage that she had -- reinforcing the idea that she was able to alter her daughter's fate and break the cycle. She said, "The difference was that my daughter had me. I always worked right beside her so what happened to me wouldn't happen to her." Believing that her daughter is now less likely to have risky relationships because she has a strong relationship with her mother gives meaning to Ximena's own previous risky relationship.

Breaking the silence about sex. In addition to wanting to be emotionally available to their children, some women also hoped to "break the cycle" by breaking the silence about sex with their daughters. After being raised in homes where they were taught nothing about relationships, reciprocity, and risk, participants hoped to provide a different and more open environment for their own children. And being more open helped them to heal in the aftermath of their own risky relationships. They remembered their own naiveté and wanted to prevent their daughters from the same. They saw their children's knowledge as something they could control, even when they lacked control in their own risky relationships. One woman said, "With my girls, ever since they were each twelve, as they'd reach puberty, I'd say, 'Daughter, this is what happens, that is what happens. Relations are meant to be nice, they're done out of love, not arguments.' I'd tell them things. Now there are ways to be more open." Other women did not feel as comfortable passing on first-hand information, but would take their daughters to Planned

Parenthood to obtain information, contraceptives and condoms so "at least they'll be protected."

Women also felt that it was easier to be more open in the US than it had been during their

childhoods in Mexico. One woman said:

> No one ever said to me, 'This pill is for you to take so you don't get pregnant; this pill is
>
> for this.' Back there in Mexico it wasn't the custom to talk about condoms. There in
>
> Mexico people didn't talk about certain things, so here in the United States life really
>
> opens up your thinking. And I talk a lot with my daughter.

During the initial months of my study planning, I worked with a *promotora* in the Green

Valley to discuss recruitment techniques. She suggested that I hold a small forum on "how to

talk to your kids about sex," because like herself, other mothers viewed this openness as

necessary but unnerving. Unfortunately, despite their desire to be open with their children about

sex and sexuality, many women lacked the informational and emotional support to do so.

Focusing on the positive. Another strategy that study participants actively used to fortify

their selves was not only to push pain to the background and to find meaning in motherhood, but

also to focus on the positive -- to highlight how they have ultimately seen a positive change in

themselves as a result of all the pain they have endured. Women saw themselves as having

experienced a transformation, or having entered into a new reality after living through one or

more risky relationships. They literally saw themselves as being changed -- and this section

focuses on the positive changes that women highlighted. Women acknowledge having

experienced extreme suffering, yet they were able ultimately to focus on the positive as they

looked towards the future.

Having a new reciprocal relationship. Some of the women in this sample told of

moving forward with a new partner; building a new reciprocal relationship in the aftermath of a

risky relationship. All of these women described their new relationships as reciprocal, healthy, and beneficial to their well-being. Although they found it difficult to trust again, they also found that focusing on the good qualities of a new relationship helped them to "move forward" and get over the pain of previous relationships. Women told of feeling surprised by love, saying things like:

> You know, that's the least you imagine after [going through all] those problems; that you could love someone again. Or that someone could love you, even less!...I also thought that after all the violence I suffered that I would never have anything so good. But I do, and I'm at peace now...I feel more relaxed, calmer, that nothing bad has happened to me. No yelling and shouting, no forcing himself on me, no 'Go to work!' or that my kids are in any danger because of some crime or argument on his part. Nothing like that. You know, I say, maybe after so much heartache, something good has happened to me, right?

> ***"Learning from the school of life."*** Those who had reached the other side of a risky relationship -- who were either single or with a new partner at the time of our interview -- felt stronger because they had "learned from the school of life." Women had to do a lot of learning on their own -- in fact, "learning from the school of life" actually implies that women had to learn on their own because there was no one around to teach them. In a childhood devoid of female counsel regarding relationships and intimacy, I have already demonstrated how women were initially blinded to and had to learn about relationships and risk through trial and error. However, some women felt able to harness their ability to learn independently as a strength. They focused on the positive and felt stronger because they were able to learn on their own without outside help.

By focusing on the positive, women highlighted their personal strength in being able to "learn to get over it" and their ability to do this "on my own" without outside help. Women saw life experiences as their one teacher, saying "Life teaches you. Life taught me some really hard blows." Another woman said, "they're experiences you go through, and as you do you learn to be better every day, right?" In saying these things, women were trying to make it feel okay that they were so isolated. But women did admit that, if given the option, they would have preferred to have outside help to work through their emotions and obtain counsel. In the absence of this help, women choose to focus on the positive and construct their self-concepts around their own strengths and resilience.

Carolina, at the age of 59, was the oldest participant in my study. She told me her life history and went into detail about her series of risky relationships. At the time of our interview, she told how she would offer relationship advice to others when asked. In response to requests for relationship advice from her granddaughters and from others around her -- "even men!" -- Carolina said, "I start answering them, according to how I see things now. Not because I've had any therapy or anything. I never had anything like that. Everything I learned was in the school of life." Carolina felt like she was able to learn from life, instead of allowing herself to be trampled by the difficult circumstances that she encountered. She saw herself as the wise woman of counsel -- she had become the role model to others that she never had for herself. And she made it a point to comment that she never "had any therapy or anything," as if to acknowledge that some kind of therapy would have been useful to her along the way. She saw herself as strong, smart and resilient because she was able to evaluate and process her life experiences on her own without professional help.

Attaining financial independence. For participants, being able to attain financial independence was paramount to feeling that they could fortify their selves and their families in the aftermath of risky relationships. Women felt pride and security in the fact that they could "maintain" themselves without a partner. Whereas "imagining financial independence" motivated women to feel as though they would be able to get along on their own, the actual *attainment* of financial independence provided meaning and strengthened women's resolve to "move forward" to get through and get over risky relationships.

Even though women saw field work as their only option, they felt immensely grateful for the opportunity to work instead of resentment that they could not find a more skilled or higher-paying job. Women value the opportunity to work -- even above their own bodily safety at times. For example, even when her partner forbade her to work outside the home and would beat her when he discovered that she had been working in the fields, Alejandra continued to work. Working gave her a strength and a sense of purpose that justified the blows that she would receive as a result. She was able to continue working with the wounds that he inflicted. She said:

> I went out to work, and when I'd get home -- wow! It didn't go so well for me because I had been out to work. But I didn't mind getting beat up, I knew that by the weekend I'd have some money and be able to buy food for my girls. And he'd argue, and grab a knife and yell, 'I'm going to kill you!' or things like that. And one time I tried to defend myself, and he slashed open my arm up to here, and I told him, and he left. I covered my arm with something and went to work.

And when she ultimately left him, Alejandra saw work as a way to be independent and provide for her children. Work was ultimately the most valuable commodity in her ability to get through

291

and get over her risky relationship. And she saw that she and her children prospered as a result. She said:

> But...so we left him, after everything we went through, I left him. And I started working in the field [in Mexico]: harvesting onions, broccoli, whatever was there...I'd get up at three in the morning, get into a big truck with lots of other people, and they'd take us about an hour away to work, in the heat and in the cold. But it wasn't really bad, because I didn't have him around to hurt me. And what money I earned I gave to Mom; I don't know what she spent it on, but I knew it was for my girls and me. On food, and everything, and my girls started filling out, their cheeks were rosy--because I have two girls who are white skinned, and one dark. Their faces were pink, they were plump, and their hair was shiny. And we could eat in peace. If there was a party somewhere, I'd take them without feeling afraid that he might come and try to hurt me, because I knew he was here [in the U.S.]. I was so happy.

Upon attaining financial independence, women guarded this independence carefully. Another woman, whose previous relationship with a drug addict had deeply influenced her opinions about sharing finances in a relationship, said, "I've always preferred to have my own money and take care of it, because it takes you too long to earn it for somebody to grab it out of your hands." In her new reciprocal relationship, she demanded that she and her partner share all expenses 50/50. They split rent down the middle and each paid half, alternating buying groceries and paying for laundry. Regarding what they each earned from their respective jobs -- hers in the fields and his at a landscaping company -- she said:

> Each keeps his own [money]. So we don't have problems. That way, he can't say he was maintaining me...I don't want to be that kind of person who says, 'Oh, I want this or

that; will you buy it for me?'...I don't like that. If I'm out somewhere and I see something I like, I have money and I buy it. And I don't have to be, 'Will you get it for me?' No begging, no asking him for things.

Because of her previous experience with a man who kept his income from her, she felt that her attainment of financial independence had afforded her leverage in her new relationship.

Accepting it. Another way in which women tried to focus on the positive was to accept their risky relationships as things that could not be changed. When women were able to accept that they could not change events in the past, they were often able to find peace. "I'm going to try to forget him...I want to take care of myself because my kids are going to need me...Why should I try to force something out of him? Better to leave it all alone now." For a long time, she had hoped to get back together with her cheating husband. But after accepting that he had chosen a different life, she was able to "move on." Another woman said multiple times during our interview that she was able to "move forward" after accepting her husband's HIV diagnosis. She said, "that's the way it is...that's the way it's turned out." She asked, "What good does it do to feel bad?" believing that, "You can't do anything but move along with it." She accepted that this was her destiny, saying, "Of course, sometimes I get to thinking what would have happened if he hadn't done that, if he had been different, what it would be like if he were better. But well, it's fate. So there's no changing it."

Once deciding to accept it, women told of giving themselves pep talks in order to reinforce their decision. Ines remembered how she shut down and closed herself off from everyone for about three months after finding out that her husband had been unfaithful to her. She remembered asking, "Why?" and "How?" and says, "You feel so helpless, what can you do? So you don't do anything." She lost weight and "cried all the time." But then she got to a point

where she realized that she needed to lift herself out of her sadness. She asked herself, "Why should you live like this? Why let yourself get so low? Why? You're a person. You have to pick yourself up. You have children." She had gotten so low that she had to remind herself of her own personhood and of her children in order to try and lift herself out of her despair and try to regain control of her emotions and her life. The news of her husband's affair really threw her into a tailspin, but after accepting it, she believed that, "You're never going to forget, but you have to keep going. I mean, life is not going to end just because of that...You have to survive." Another woman also gave herself pep talks, saying to herself in the mirror, "You've come through this now, and you can do it if you want to," and "'You're going to be fine, you're not bad off anymore. You have to get well. You have to eat and take care of yourself."

Being on the road to peace and happiness. As they reflected back on how they were able to "move forward" after getting out of risky relationships, women felt like they had achieved some semblance of peace and happiness. One woman admitted, "The [violence] will always be a part of you, right? But you'll be able to get over all this and keep on making the home you have." She went on to say, "I've come through all this and gotten to this point, though I still remember all the pain and the sadness. But I am better now. I'm a little better." Another woman told of having a peace in her heart and felt like "I'm happier on my own." She said, "For now, I'm alone and struggling, but at peace. And why? Because he doesn't say anything, doesn't make me feel bad, and I'm happy." She admitted that while she initially felt depressed and felt that "the whole mountain of dreams I'd made came tumbling down," that after the passage of time she viewed her situation differently. At the time of our interview, she felt hopeful, saying, "I have dreams, I have ideas, and I want to get ahead."

Chapter 8:

Discussion

Introduction

In this study, I sought to understand migrant farmworker women's perceptions and experiences related to HIV risk. I also explored how these risks were related to women's values and beliefs about sexuality, migration, gender roles and power. Finally, I pursued an understanding of how women worked to mitigate these perceived risks, using a variety of resources and personal factors.

Overall, I found that migrant farmworker women in my study were engaged in two simultaneous processes. The first is a process about expanding perspective. This process details how women moved through five phases that helped them to expand their perspectives on their risky relationships. The second is a process about gaining leverage; it provides a strengths-based narrative illustrating how women were never fully victims. Despite overwhelming obstacles, women were constantly engaged in meaningful actions -- no matter how small -- that preserved their dignity and maintained their sense of self. Over time and with the help of others, women perceived that these actions provided them with leverage in their risky relationships.

While explaining their perceptions of partner risk, women in my study repeatedly used metaphors of eyesight and "seeing" risk. Originally blinded to risks all around them, women were eventually able to discover that their relationships were risky when they connected to social information networks and began "playing detective." Then, depending on their priorities of identity maintenance and/or survival, women navigated their risky relationships by choosing one of two perspectives: overlooking risk by averting their eyes, or confronting risk with their eyes wide open. Ultimately, it was their children that determined how they "looked" at risk, because

without their children women felt that their social identity would be ruined and there would be little reason to survive. Specifically, women's assessments of how their risky relationships were affecting their children caused them to reevaluate previous perspectives. Then they were either motivated to act or constrained from action in response to the risks that they perceived.

Throughout my analysis, the dynamic of "gaining leverage" was central. Realizing this, I began to frame women's agency in their relationships less in terms of "power" -- a term that women shied away from during our interviews -- and more in terms of the developing concept of "gaining leverage." Women gained leverage by fighting the bad, finding the good, and fortifying the self. They used their own internal resources and they also accessed external resources in order to take useful action. Whether they worked to confront risk or overlook it, women in my study worked to gain leverage in their risky relationships in order to preserve their dignity. While working to gain leverage, women felt that they were preserving their sense of self -- that they were doing something useful instead of doing nothing. Even if a woman's actions did not result in safer sex or the end of a risky relationship, being able to leverage even just a little bit of agency within a relationship was useful.

Operationally, women in my study felt that they gained leverage when they were working and could provide for themselves and their children -- particularly in circumstances where they could do so without assistance from a male partner. Within their relationships, the two most useful actions that women felt they could independently take to gain leverage were to calculate moves to resist harm and take measures to control his behavior. Women also gained leverage when they learned by experience, when they gained valuable information from others, and when they had others to lean on for emotional support and/or instrumental support. Maintenance of a respectable identity along with preservation of the ability to mother through the violence also

296

helped women to gain leverage. Finally, the ability to see risk and maintain a vigilant or guarded stance in the face of HIV risk provided women with leverage.

Notably, women felt as though they could not gain enough leverage to cause lasting change in their relationships without assistance from external resources. In chapter seven, I referred to figure 3 (Appendix M): the image of an individual using a lever to gain leverage. The metal rod rests on a fulcrum and the fulcrum is what magnifies the individual's own effort and gives the advantage needed to raise the boulder -- even just an inch. In fact, external resources or help from others that I delineated in "finding the good" are like the fulcrum. Women's own internal resources are the effort that enacts force on the metal rod. But without a fulcrum, women cannot gain leverage and move the boulder. It is just too big.

In this way, public assistance programs are actually providing a "way out" for women who could otherwise feel stuck in risky relationships. Without the fulcrum, women could feel as though they are independently applying resistance but not seeing a change. Over time, individual efforts could decrease as desperation and hopelessness develop. Without having access to external support and public assistance programs, women in my study would have likely told different stories. The importance of public assistance programs for migrant farmworker women cannot be overstated. Public assistance programs are often a lifeline for women who depend on their risky relationship for survival.

Those women who did get out of risky relationships felt as though they were breaking free -- not only from an oppressive home environment but also from the traditional mentality that men provide and women nurture. Independence fostered a feeling of liberation. Their risky relationships, combined with their exposure to more modern and open ways of thinking in the US, contributed to the way women viewed and desired independence. Women reiterated to me

that they valued the ability to provide for themselves and their children on their own, and saw their independence as both a process for gaining leverage and a product of it.

In sum, gaining leverage to protect the self against HIV and sexually transmitted infections (STIs) within the context of close, long-term relationships is a multifaceted concept. Women access internal and external resources and must navigate through the pros and cons. In their pursuit of leverage, they come up against roadblocks and are spurred ahead by motivators as they push back against risks, reach out for help from others, and cope with the emotional aftermath of intimate partner risk.

It is not uncommon for healthcare providers to perceive that women are "just reinfecting themselves" when they acquire multiple STIs from the same long-term intimate partner and yet continue to have unprotected sex with him. However, as I listened to women's stories, I was not listening to timid women who did everything their partners asked. I was not hearing stories about women who did not care about their health or who were naive to the fact that their partners were risky. Their perspectives had expanded as they navigated through the five phases and reached varying levels of "seeing" risk in their relationships. They were aware, vigilant, strong, and even stubborn as they highlighted their priorities. Women displayed a cunning sense of agency and awareness as they described the various ways in which they strategized to gain leverage in their risky relationships.

I did talk with women who had decided to stay with a risky partner and/or who had been reinfected with an STI multiple times. I also spoke with women who had chosen to stay with an abuser for many years because they did not see a clear way out of the relationship and their priorities made it obvious to them that staying in the relationship was a better option than trying to leave. I spoke with others who *were* able to negotiate for condom use and/or leave a risky

partner after years of waiting for just the right moment to make their escape. But it was clear to me that even if women did *not* use condoms, abstain from sex, or leave a risky partner, they *were* engaged in other forms of action that were causing them to gain leverage in small but important ways. Women were constantly acting in the pursuit of gaining leverage – however, they were not always employing action that health providers might consider "protective." In other words, participants were working to push back against their risky relationships but often were not able to fully mitigate the present dangers. Using their own personal resources, women were not usually able to prevent scenarios that placed them at risk for HIV. However, with outside help, women were more likely to engage in behaviors that would actually prevent infection in the long-run. However, this study's focus on personal strengths provides a foundation for planning practical intrapersonal, interpersonal and structural interventions that will capitalize on women's own preventative efforts and provide population-specific resources for decreasing HIV risk among migrant farmworker women. Perhaps most importantly, such interventions have a greater likelihood of being appropriate to the women of the target group, and thus, more often accepted than other interventions that providers may favor but that women find inappropriate or unacceptable in their real life context.

Overall in this study, I found that women's perspectives of HIV-related intimate partner risk and the ways in which they strategized to gain leverage were dependent upon their priorities. Women in my study prioritized matters of survival, social identity, and their children's well-being above their own physical health and safety. However, even in the face of competing priorities, women took action in their risky relationships in a variety of ways -- they used their own personal resources as well as external resources in order to gain leverage. Overwhelmingly, the two most useful resources that helped women to gain both perspective and leverage was their

role as mothers and their connection to social information networks. Women expressed hope

that they would be able to "break free" from certain negative familial and/or sociocultural cycles

in the hopes that their children would be able to enjoy lives characterized by awareness, safety,

and reciprocity.

My study is the first to examine how women who migrate from Mexico to the US

navigate abuse and infidelity in their close, long-term relationships via cognitive, social and

emotional micro processes. To date, no other studies have explored Mexican women's

perceptions of and responses to HIV risk within their close, long-term relationships in a way that

highlights individual micro processes in the context of macro-level structure. Published

literature has examined how women in abusive relationships are unable to protect themselves in

light of power disparities, but more specific analyses of how women respond to risk within close,

long-term relationships have been nonexistent until now. While research has confirmed that

women are at risk for HIV due to intimate partner violence (IPV) and infidelity (e.g. Conroy,

2014; Corbett et al., 2009; Fox et al., 2007; Mkandawire-Valhmu et al., 2013; Varma et al.,

2010), none of these studies detailed the cognitive or emotional micro processes that led to

discovery and/or evaluation of risk. These findings confirm the results of other research that

describes how understandings of HIV risk are closely tied to issues of public identity (Hirsch et

al., 2009). However, my findings extend this prior work by proposing that women actually

engage in five phases of cognitive work in order to arrive at and work through issues of identity

within the context of other priorities. In contrast with other research that has focused on the

social structural forces that influence individual behavior within the context of Mexican

migrants' close relationships (e.g. Hirsch, 2014), my work highlights the more immediate

experiences of twenty migrant farmworker women and details their individual cognitive, social, and emotional micro processes in their own words.

In addition, previous research has highlighted how Latinas in close, long-term relationships feel constrained from self-protective action in the face of HIV risk -- particularly in relation to condom use (e.g. Rojas-Guyler et al., 2005; Zukoski et al., 2009). I actually found the opposite. Although women in my study did agree that condom use was not a reasonable request to make of their partners, they did take action in a variety of other ways that they found useful and appropriate. Instead of focusing on power in relationships, my study is the first to re-define how Latinas conceptualize their agency in risky relationships through the concept of "gaining leverage."

In this discussion, I highlight the processes of "expanding perspective" and "gaining leverage" within the context of existing research. Finally, I illustrate how women's identity as mothers -- both in my study and in the broader health sciences literature -- is integral to how Latinas are able to see and respond to HIV-related intimate partner risk.

"Expanding Perspective" and Existing Literature

The micro process of women's cognitive work is akin to the mind action process described by Herbert Blumer (1969) in Symbolic Interactionism. Whereas physical action takes place in the body and is directed towards others, mind action is a cognitive process that is directed towards the self (Blumer, 1969). In my study, mind action involved the cognitive processing patterns that women engaged in as they evaluated information and analyzed potential causes, consequences, and responses.

Viewing cognition as a continual process over a series of phases is not only useful from the standpoint of planning risk reduction interventions, but it is also more true to the human

301

experience. As humans our minds are in a constant state of flux. Filtering new information, discarding some viewpoints and refining others -- cognition is dynamic. Although my analysis attempts to present an alternative to other more static descriptions of how individuals assess risk, the apparent simplicity of my five-phase model fails to capture the true nuance of the mind.

While expanding their perspectives, women relied on external input to condition their perceptions. Other work has presented how structural forces including "sexual geographies" can shape and even encourage male infidelity (Hirsch et al., 2009, p. 16). This concept of "sexual geographies" proposes that sexual behavior can be thought about in terms of spaces that are socially meaningful in accordance with gender, generation, social class and shared moral beliefs (Hirsch et al., 2009). For example, distance from wives in Mexico, cantinas, certain street corners and even certain aspects of the agricultural fields in which farmworkers labor constitute a "sexual geography" for migrant farmworker men. I found that not only do these "sexual geographies" exist in migrant farmworker women's perceptions of their own risk, but that women actually used typologies of people and spaces within their cognitive framework for characterizing their own risk. Looking at a partner's movement between "inside" and "outside" spaces helped women to classify him as "risky" or "not risky." In this way, women actually used "sexual geographies" (Hirsch et al., 2009) as a way of classifying people and behavior and this helped them to gain perspective and "see" risk.

However, women's priorities sometimes supersede their desire to avoid infection. As others have pointed out, the meaning of sexual risk for some individuals can be defined as "chances *worth* taking" (Christianson, Lalos, Westman & Johansson, 2007, p. 60; emphasis is my own). In my study, women's priorities arose from structural forces: sociocultural influences encouraged women to maintain their respectable identities, and sociopolitical influences either

provided a way out of a risky relationship or exacerbated the need to remain in a risky

relationship. And so, these structural forces impacted the stance that women took in viewing

their close, long-term relationships.

Indeed, women in my study prioritized issues related to survival, social identity, and the

health and well-being of their children above their own physical health. Because relationships

assisted with survival and provided multiple benefits -- making even risky relationships

beneficial -- women felt constrained in fighting back against their risky partners. In certain

cases, women preferred to maintain their risky relationships in order to subsequently maintain

their opportunity for shelter, food, and resources for their children. The stability of family and

the continuance of resources made it "worth it" to stay. In light of this, interventions that provide

information and counseling for at-risk migrant women can assist them in gaining enough

leverage – particularly with outside help – that will make it possible for them to leave risky

relationships because the instrumental, financial and relational value of those relationships could

be found elsewhere.

Although other research has shown that issues of trust, love and intimacy preclude the

desire to confront HIV risk in close relationships (Conroy, 2014; Corbett et al., 2009), my study

demonstrates that other higher-level priorities can also constrain women's desire to face intimate

partner risk with their eyes wide open. Women in my study did not prioritize love or

companionship, but they did prioritize identity, survival, and their children's well-being.

Although other studies have also mentioned this trend -- that women's actions against their

abusive partners were constrained by their desire to maintain their source of economic provision

(McLellan-Lemal et al., 2013) and/or their role as mother to their children (Alcalde, 2010) --

other research has not centered in on how these priorities actually shape women's perspectives of risk and/or assist women in gaining leverage over their life difficulties.

Women in my study chose to partner and to stay in their intimate relationships primarily because they needed reciprocity. They viewed their partner's financial and instrumental support as necessary to their survival and to the survival of their children. This is different from the concept of "survival sex," whereby women participate in sexual acts in exchange for money, food, clothing, shelter or drugs (Warf et al., 2013, p. 1205). Although women in my study chose to partner with men and often decided to stay in relationships in order to reap some of these same benefits -- namely, financial support and instrumental support -- this is not about the mere exchange of sexual acts for material resources. I am not concluding that women did not originally choose a partner for other reasons including companionship and love; but these secondary relationship benefits were not as apparent to me in women's accounts of their decisions to partner and certainly were not relationship byproducts that women in my sample reaped in their risky relationships. I did not sense that women were desperate in their decisions to partner for survival, just that they were using deliberate strategies to gain leverage and ensure the most secure life for themselves and their children.

The need to preserve a respectable identity is one reason why women desire to trust a partner's fidelity. This desire for trust can blur perceptions of reality. Women very much *want* to trust their partners. They see their partners as "innocent until proven guilty" and use explanations for risky behavior that remove personal blame. For example, women blame personal afflictions, external powers, *machismo* and natural male tendencies before admitting that a partner's core attitude and behavior has been altered/corrupted. Women will go so far as

to deny or ignore risk in order to protect the integrity of their relationships and maintain trust in their partners.

There is an important distinction to be made between that which women work to hide from public knowledge and that which women actually attempt to hide from *themselves*. While other work illustrates how women purposefully choose to make public demonstrations that illuminate their partner's affairs instead of remaining publicly silent (Hirsch, Wardlow, Smith, Phinney, Parikh & Nathanson, 2009), my work demonstrates that there is another very important internal process by which migrant farmworker women of Mexican descent choose to avert their own eyes in order to hide the reality of a partner's risky behavior from themselves. After discovering that a partner was abusive or unfaithful, women in my study weighed their priorities in order to adopt a risk perspective for how they themselves viewed risk -- not for how they presented their risky relationships to others in the form of public displays.

Priorities shaped and constrained behavior but also shaped the lens through which women viewed their partners. Either they confronted risk with their eyes wide open or they overlooked risk by averting their eyes. In this sense, structural forces impacted women's cognitive work as a kind of micro process. Other work has demonstrated that some married couples around the world have adopted a "shared silence" (Hirsch, Wardlow, Smith, Phinney, Parikh & Nathanson, 2009, p. 3); accepting extramarital sex as a reality and choosing to live under the "fiction of fidelity" (Hirsch, 2014, p. 3). My findings extend this work by proposing that there are certain priorities and conditioning factors that determine whether women overlook risk (ascribing to the "fiction of fidelity") or confront it with eyes wide open. Not all women in my study ascribed to the "fiction of fidelity" (Hirsch, 2014, p. 3). By delineating the two perspectives or stances that women took towards their relationships after discovering that their partners were abusive or

unfaithful -- and also by specifying that women did what they did in order to achieve the overarching goal of gaining leverage -- I have added nuance and detail to this existing work.

"Gaining Leverage" and Existing Literature

Women considered their lack of connection to social networks to be a major roadblock that made them vulnerable to risk and also prevented them from gaining information and support to manage risk. Fractured families, distance from children and close others, turbulent work environments, desperate financial situations, and high-risk intimate partnerships necessitated that migrant farmworker women had connection to others for enlightenment and support. Similar to findings with HIV positive young adults in Sweden (Christianson et al., 2007), women in my study felt like they could not "see" HIV risk in their relationships due to vulnerability that arose from their own naiveté as well as silence from others surrounding sex.

In the literature, social connectivity can be understood within the three categories of social support, social integration, and negative interaction (Cohen, 2004). The women I interviewed did appear to be socially integrated. They were members of a local church, they worked outside the home in an environment that most felt fostered at least some kind of camaraderie and community, and they participated in school functions with their children. All women found identity and meaning in the fact that they were members of the migrant farmworking community in the Green Valley, whether they resided in that location for most of the year or whether they were just passing through. Women also were socially integrated in terms of their Mexican heritage and the commonalities that they shared with other Mexican women around them.

But this apparent social integration did not assist women as they worked to gain leverage in their risky relationships. Simply being a member of the farmworking community and sharing

their Mexican heritage with others in a predominantly Mexican community was not enough. Women needed a safe space within which they felt comfortable to share with their peers – in order to receive both information and emotional support. The negative interactions that women perceived in their community -- in the form of gossip -- detracted from their ability to experience social support. Although women in my study told of needing all three aspects of social support -- instrumental support, informational support, and emotional support (Cohen, 2004) -- it was the latter two aspects that women deemed particularly necessary in being able to "see" risk in their close, long-term relationships and to get through and get over the emotional pain that risky relationships caused.

Women felt that they wanted to have more open and trusting communication with their peers; effectively "breaking the silence" of societal taboos that called for silence surrounding issues of sex and sexuality. Fox and colleagues (2007) also found that women at risk for HIV related to intimate partner violence in South Africa considered "breaking the silence" to be integral to how women felt they could respond to their risky relationships. It was clear that women in my study considered themselves to have less leverage in their risky relationships when they were isolated, naive, and silent. In chapter six I told the story of Laura and Mariana, two study participants who lived across the street from one another but likely had never exchanged stories of their experiences with controlling, *machista* spouses. Even though most women assessed *machismo*, male infidelity and intimate partner violence to be common in Mexican migrant communities -- and even though gossip was prevalent about "who was cheating on who" and who was "shameful" and who was not -- the overwhelming sentiment was that women in my study felt alone and isolated.

Gossip was concurrently formative to experience but destructive to women's well-being. Although women constructed their understandings of their own relationships based in part upon normative ideals passed along via gossip channels, the experience of hearing gossip about themselves made them feel torn apart instead of built up by their neighbors. Risky relationships were accepted as a common reality yet they were not a topic that women felt comfortable sharing about openly in order to gain support. This was partially because women wanted to maintain their respectable identities and partially because they did not have a safe space in which they felt comfortable sharing -- they assumed that anyone they told would turn around and make them an object of public slander.

However, there were a few settings in which women did feel comfortable sharing their life stories including the good *and* the bad with an understanding "other" who was able to guard their secret [e.g. *promotora*, Migrant and Seasonal Head Start (MSHS) staff, or other members of local women's groups]. These one-on-one and small group settings were integral, particularly in a community where women felt that they had to constantly dodge negative influences and avoid public embarrassment if they divulged their stories to the wrong person. But, like the community outreach assistant from MSHS, the *promotoras* who spent time in women's homes after giving a "class," or even as a nurse coming in to interview women about their risky relationships -- women were eager to obtain informational and emotional support through sharing with another woman who was willing to listen. Just as I found in another study with my colleagues, *promotoras* can be an excellent resource of both informational support and emotional support to Latina women who might otherwise feel isolated (Albarrán, Heilemann & Koniak-Griffin, 2014).

The concept of "gaining leverage" is comparable but distinct from the concept of "relationship power." Relationship power has been defined as "an interpersonal dynamic that can be expressed via decision-making dominance," which the male partner generally holds in Mexican couples (Pulerwitz et al., 2002, p. 791). Other work highlights how relationship power can be understood within the context of the ways in which women are able to take sexual initiative and have autonomy and control (Harvey & Bird, 2004). Relationship power has been shown to be increased by educational attainment (Parrado et al., 2005).

Instead of viewing women's advantage in relationships as an issue of dominance or control, I found that women instead felt comfortable with strategically asserting themselves in ways that preserved their partners' position of authority. They believed that responsible men *should* be seen as leaders within the family system and did not want to usurp their dominance. However, when that authority was abused as in the case of risky relationships, women wanted to push back in order to protect what they valued and maintain their sense of self. Furthermore, most women agreed with men that condoms were not desirable, problematizing the definition of relationship power as a hallmark of ability to negotiate for condom use (e.g. Pulerwitz et al., 2002).

In the health sciences literature, use of the male condom has long been hailed as the primary strategy for protection among women with high-risk partners. Quantitative analyses report condom use as a proxy for HIV risk, particularly among women with high-risk partners and regardless of their relationship status. Qualitative analyses explore relationship dynamics that prevent women from successfully negotiating for condom use with their partners. But within the context of close, long-term risky relationships, no other studies to date have explored what other strategies women view as useful.

As others have pointed out (e.g. Hirsch, 2002), if we expect partners in close, long-term relationships to use condoms consistently as the gold standard for HIV/STI prevention, then we -- as public health researchers and healthcare providers -- have failed. Marriage can constrain women's self-protective sexual agency -- particularly related to condom use (Mkandawire-Valhmu et al., 2013). Although I did not specifically ask about condoms, women in this study did spontaneously confirm that the male condom is not a desirable method for protection because it signifies distrust. As one woman said, suggesting that her partner use a condom would be akin to saying, "Well, since you are -- excuse the word -- 'whoring around,' why don't you wear one of those things if you want to be with me." This supports the findings of multiple other studies: condoms signify distrust, and trust is a cornerstone of intimate relationships. We must differentiate between casual and close relationships when asking about condom use, and acknowledge that in the context of close, long-term relationships, condom use is irrelevant as an HIV/STI prevention measure.

Perhaps even more importantly, when we focus solely on whether or not women in close relationships are able to negotiate for condom use, we actually silence women and ignore the courageous efforts that they *are* taking to protect themselves. By adopting the narrow-minded perspective that women in long-term relationships can only protect themselves if they are able to convince their partner to wear a condom, we are missing the point. Women in this study did not focus on condom use because they channeled their energies into other efforts that they considered useful. So, let us focus on the self-protective strategies that women in close, long-term relationships *do* use.

The Importance of Motherhood

Women in my study concurrently engaged in their own "respectable" identity construction and preservation as they compared themselves with "shameless" others. In fact, maintaining a respectable identity was one of the conditioning factors that led women to either confront risk or overlook it. Collins et al. (2008) found that Latinas in New York City aligned themselves with identities that conferred dignity and respect in order to combat the stigma of their diagnosis of severe mental illness. In order to "regain their sense of power" (p. 394), authors found that women viewed themselves as "church ladies" or "good girls" in order to overcome the stigma of being *loca* ("crazy"). In a similar fashion, women in my study worked to gain leverage by aligning themselves with the virtues of a respectable woman who provides for her children and cares for her husband. In fact, the respectable identity that women prioritized encompassed the roles of both "wife" and "mother."

Maintaining a respectable identity involved preventing others from seeing her as less than a "good wife." Similar to women interviewed in Nigeria (Smith, 2007), women in my study worried that they could be blamed for their partner's infidelity and therefore preferred to keep infidelity a secret from their neighbors and family members whenever possible.

However, women's role and identity as a mother was the most important factor in both their perspectives of risk and in how they worked to gain leverage. Another important body of work illustrates how adolescent mothers (in a predominantly Latina sample) were motivated to make positive changes in their lives in relation to their establishment of maternal identity (Lesser et al., 1999). The concept of "parental protectiveness" illustrates how attachment between adolescent mothers and their children is a critical factor that fosters resiliency and positive behavior change (Lesser et al., 2009). In my research, adult women's identity as mothers was

primary. Women desired to see their children not only escape the collateral damage of their parents' risky relationship, but also to "get ahead" and "break free" from cultures of silence.

Focusing on their role as mothers was a major way in which women in my study worked to gain leverage. Women viewed their own health and safety primarily in terms of their children's well-being. The desire to maintain the family -- for the *children's* sake -- is what sometimes prompted women to stay with their partners despite infidelity and abuse. Other research indicates that a close family structure is emphasized as being very important among Latino families (Beaulaulier et al., 2009), with particular importance given to motherhood in Latina/o culture (Arreola, 2010). Women in my study wanted their children to have a father figure, often because they themselves lacked a father figure and they wanted better for their children. In other scenarios, women told me how they had chosen to stay with a partner in order to continue parenting their children, because they imagined that leaving their partner would be akin to a suicide mission or because without his financial support, the children would suffer.

Others have labeled this as a kind of "self-sacrifice" (Davila, 2005) of Mexican American women; that they put their children's and families' well-being ahead of their own and often choose not to adopt certain health behaviors if they do not perceive them to directly benefit the family as a whole (Gallo et al., 2009). The concept of self-sacrifice implies that women actually give something up and endure difficulty in order that their families might prosper. But instead of propagating the image of the Latina mother as self-sacrificing -- although this identity certainly promotes social legitimacy for women -- I propose that women actually prioritized their children because doing so carried immense personal pragmatic value. Instead of giving something up, it was a strategy that women used in order to gain a stronger sense of self. More than adherence to a cultural stereotype, putting the children first was a useful point of view that helped women to

retain their sense of personal dignity and perspective in the face of infidelity and abuse. That women could still maintain their identity and role as mothers despite the turbulence in their identity and role as wives helped to foster their sense of personal dignity and meaning. Because the alternative -- leaving him and therefore failing in their duty to provide their children with a father figure -- held much more destructive consequences for their psyches. Similar to the way in which addicted Puerto Rican women viewed motherhood as a "lifeline" into recovery (Hardesty & Black, 1999, p. 602), women in my study saw their role as mothers as a similar kind of "lifeline" that helped give meaning and purpose to their struggles with abuse and infidelity.

Because women viewed most forms of social isolation, naiveté and silence as being cyclic, they were concerned that their children would continue to be caught up in a cycle of risk. They wished that the contradicting parallels of gossip and silence had not been so formational of their own negative experiences and wanted their children to grow up in a more open, supportive environment than they did. Women wanted to break free from this cycle but were not sure how.

They perceived that they were more vulnerable to risky relationships because they lacked family support, both as children growing up in rural Mexico and as adults living and working in the US. Because women lacked examples of reciprocal relationships and did not receive information or encouragement from their female adult role models regarding intimate relationships as children, they were not only blinded to risk but actually believed that they had been pre-programmed to enter into risky relationships. Learning about relationships through trial and error had grave consequences. And the subsequent lack of family support to "get through" and "get over" risky relationships in adulthood had a crippling effect on women who were desperate to be able to depend on their families because they believed they had few alternatives for instrumental as well as emotional support. Therefore, as they looked back over their lives

313

and assessed how their lack of family support had been detrimental, women in my study sought to differentiate themselves from their own parents in an attempt to "break the cycle."

One component of this cycle was the silence about sex. While women told of having never been taught about relationships or intimacy, they also discussed how they were attempting to have open channels of communication with their own children regarding these topics. In this way, there appeared to be a generational shift taking place. This finding is interesting in light of other research, in which Latinas considered their parents' silence about sex to be a strategy to promote abstinence (Davila, 2005), or a natural extension of a domineering and conservative parenting style (Lefkowitz et al., 2000). Women in my study, who were all foreign-born, felt empowered to be open and honest with their children because they themselves had experienced risky relationships and they wanted to prevent their children from experiencing the same fate. They felt strongly that opening channels of communication with their children would be almost redemptive -- that they could be the kind of parent that they wished their own mothers had been.

Limitations

This study focuses on how women in close, long-term relationships perceive and respond to HIV-related intimate partner risk. Therefore, conclusions cannot be made regarding women's participation in personal risk-taking behaviors outside of their close, long-term relationships. In addition, findings from this study cannot be generalized to women in casual, short-term relationships.

In addition, my research relates to how migrant women negotiate physical separations from their intimate partners while working in separate locations. Although other literature on migrants refers to work-related physical separation in relation to male migration to the US from Mexico (while their wives stay behind), no other studies have explored migrant couples in the

314

US who experience periods of physical separation while responding to the chaotic demands of migrant farm work. However, how couples "manage" these extended separations was a small component of this work. More investigation into this phenomenon is necessary, to understand how women individually and collaboratively manage migration separations in both risky and reciprocal relationships.

Chapter 9:

Implications and Conclusions

Introduction

Until now, nursing has been unequipped with knowledge regarding how to promote culturally appropriate sexual health promotion interventions that decrease HIV risk among migrant farmworker women. This study provides a unique view of the ways in which women expanded their perspectives of intimate partner risk and how they all mitigated their risks by gaining leverage to various degrees in the midst of restrictive cultural beliefs and a transient, vulnerable lifestyle. These findings have important implications for nursing practice, nursing science, and public policy. These implications involve a spectrum that includes basic interpersonal interactions between healthcare providers, research teams and migrant women, community level interventions that can assist migrant women to gain leverage in their relationships, and structural public policy implications that relate to resource availability for migrant women. Of course, targeting research and interventions towards migrant women's male partners in order to decrease the incidence of infidelity, intimate partner violence and substance abuse is essential in protecting women from HIV. Within the context of other male-centered and couple-focused research and interventions, this study has important implications for acknowledging, supporting, and capitalizing on women's own perceived strengths and abilities while minimizing their vulnerabilities.

Implications for Nursing Practice

First, on an interpersonal level, these findings can inform how nurses and other health professionals provide primary prevention counseling to migrant women. Equipped with an

316

understanding of how women "see" risk and work to gain leverage in their risky relationships, healthcare providers can most effectively provide counseling and treatment.

In relation to counseling women, clinical nurses and providers should be careful not to blame a woman's partner when counseling migrant farmworker women in risky relationships. Rather, providers should acknowledge that women may utilize blame-shifting and even risk-denial as cognitive strategies to help them protect their own respectable identities as well as the respectable identities of their partners. Providers should maintain a neutral stance and provide a listening ear as integral strategies that will invite women to share their experiences with and perspectives of risk in their relationships without feeling judged or blamed. Providers should be neutral because they may not be aware of -- or even agree with -- women's perspectives, motives and priorities. In addition, when providers assume that condom use, abstinence, and/or ending the relationship are the only actions that women can take to protect themselves in their risky relationships, women can perceive that they are being silenced. Instead, clinical nurses and providers can assist migrant women to gain leverage by acknowledging that migrant women are working to preserve their sense of self and their dignity -- albeit in small but important ways -- and by engaging in problem-solving with women to help them capitalize on these abilities. A key strategy for clinical nurses and providers it to use metaphors of gaining leverage because they are likely to be more effective than using phrases that include words migrant women in my sample found distasteful such as "power" or "empowerment."

Using the process of expanding perspective that was developed through this study, nurses and other health providers can determine which phase(s) a migrant woman is working through. Women who are still blinded by their vulnerabilities or who are averting their eyes have different understandings and needs from those who have moved ahead towards confronting risk and/or

317

considering the consequences. Likewise, the process of gaining leverage (also developed in this study) can assist providers in framing their problem solving work with women who have just begun to fight back against a risky partner or who are having difficulty working through the aftermath of a risky relationship towards "moving on." Because all women in this study found that they were unable to gain enough leverage to make a change in their relationship without outside help, one of the most important components of counseling involves directly linking women to outside sources of assistance. Clinicians should help women analyze their options and be an active listener as the women work through how they can best "find the good" in those from the "outside" such as professionals or others who might be able to help equip them with the necessary tools for gaining leverage.

Finally, providers should acknowledge that children help women to "focus on the positive" and move forward after experiencing risky relationships. In counseling sessions, helping women to focus on the positive aspects of their ability to "mother through" their risky relationships, or "mother despite" all of their struggles is emotionally protective and socially respectable. Potentially, counseling that focuses on how women can become better mothers instead of how they should be better wives could potentially help to remove the blame that women take on because they are in a risky relationship. Knowing that it is ultimately how women think about their children's well-being, and not their own physical safety, that prompts them to want to gain leverage will give providers an advantage in how they counsel women for HIV prevention. Armed with knowledge and sensitivity towards migrant women's priorities will enable providers to speak in terms that women resonate with.

Implications for Nursing Science

Also on an interpersonal level, my study highlights a few issues related to research design when a study involves talking about sex and sexuality with migrant farmworker women of Mexican descent. How women of my sample constructed their social identities was of primary importance to them. In previous research, Nigerian women were reluctant and even unwilling to share their experiences of male partner infidelity -- even in one-on-one interviews with an interviewer of the same gender -- because of the social risks inherent in disclosure (Smith, 2007).

Research design and interviewing techniques really matter when collecting data regarding intimate partner risk and other sensitive issues related to sex and sexuality. In a number of prior studies, researchers sought to understand the intricacies of HIV risk within the context of marriage but have used focus group methods for data collection. Not surprisingly, results from the majority of these studies reported on community-wide agreed-upon discourses but did not reveal interpersonal nuance or detail. One pitfall of focus groups is that, while they may hit upon certain components of individual experience, they are more likely to confirm socially accepted realities. Through the rigors of data analysis, I gained insight into how, even during individual interviews with the participants in my study, women were actively engaging in maintaining their respectable identities. As my study progressed, I increasingly became aware of the ways women were hesitant or covert in how they described their husband's behaviors. Careful data analysis showed me that this was particularly evident among women who were actively overlooking suspicions of their husband's infidelity.

It is likely that women would feel more comfortable sharing experiences in one-on-one interviews, especially those experiences that deviate from social norms. In addition, being referred to the study by a trusted individual [a Community Advisory Board (CAB) member who

worked for a local community service agency or advocacy group, and knew the participant] may have facilitated how women felt comfortable in sharing with me. It was not that they were deeply socially connected [most farmworkers interacted with some kind of social service agency, including a clinic, or Migrant and Seasonal Head Start (MSHS), or a neighborhood *promotora*], but each participant had at least one trust-based relationship with a local community worker and that worker was the one who introduced them to me. Indeed, the fact that women in my study shared candidly about their husband's infidelities and often wept as they told how they had been affected as a result, indicated that they felt able to put aside their concerns about being seen as "respectable" and allow me to see them in their vulnerability. Divulging these private details in an emotionally vulnerable way -- which could be seen as a sign of weakness and shame from a cultural perspective-- could have resulted in public ridicule outside of the privacy of a one-on-one interview. It seemed to me that even women who had not previously acknowledged to themselves that their relationships could be risky sometimes gained a deeper understanding of themselves during the interview, and therefore, appeared to alter their perspectives emergently during the course of the interview. It seemed that, instead of using the interview as a way to further overlook risk, they actually underwent a kind of transformation through the process. This seemed to suggest that the interview itself actually was a tool that helped them to appraise their relationships in a new light.

Beyond interpersonal implications, this work suggests that community-level interventions with migrant women are necessary in order to decrease their perceived vulnerabilities and equip them with tools that will supplement and capitalize on their strengths. Even though most women were referred to me by a community worker and/or expressed having one trusted woman in their life with whom they felt they could confide, women in this study felt overwhelmingly isolated

320

and alone. They desperately wanted emotional and informational support, but most did not know how best to access it. They were eager to have an outlet for safe discussion of their risky relationships. For this reason, subsequent research surrounding migrant women and HIV risk should move towards planning interventions to help women "see" risk and provide insight regarding how women can maximize their ability to gain leverage in their relationships. In contrast with other research that focuses on "empowering" women (Gomez, Hernandez & Faigeles, 1999), making what may seem like a small shift to think and talk in terms of "gaining leverage" rather than gaining "power," may result in a crucial and effective shift in women's ways of acting. That is, by shifting the focus to first highlight all the actions that women *do* take to preserve their dignity in the face of risk, providers' ability to partner with women may be more efficacious in deepening and expanding the range of actions the women are able and willing to take to protect themselves from HIV risk.

Apart from other important bodies of research that focus on HIV prevention efforts with solitary male migrants (see Rhodes, Foley, Zometa, & Bloom, 2007 for a review of this work) and with couples (see Burton, Darbes & Operario, 2010 for a review of this work), interventions with migrant women that focus on building peer relationships with the goal of providing information and emotional support are key. These interventions must incorporate networking with various service agencies that can provide financial support for migrant women, since finances are often a primary motivator for staying in a risky relationship. Women need to know what their options are; sometimes, just knowing that financial support is available through Women, Infants and Children (WIC), food stamps, or other public assistance programs is enough to make it possible for a woman to consider leaving her partner. In addition, providers should design interventions that consider the formational yet detrimental effects of gossip in migrant

communities, and strive to provide spaces in which migrant women can feel safe and be heard. In addition, interventions should include components of both professional and lay support, since migrant women feel that they should only discuss certain aspects of their sexuality and anatomy with healthcare professionals. Finally, future interventions would be most successful if they focused on women's primary identity and role as mothers. For example, Project CHARM (Children's Health and Responsible Mothering; Koniak-Griffin, Lesser, Nyamathi, Uman, Stein & Cumberland, 2003) – an HIV prevention intervention with adolescent mothers – capitalized on pregnant teenagers' feelings of maternal protectiveness as motivation towards making positive lifestyle changes. Similarly, an intervention with migrant farmworker women that focused on motherhood as a reason for building healthy relationships could be an effective way of imparting knowledge about HIV, domestic violence, and substance abuse.

The bottom line is that future interventions for migrant women should involve components of expanding perspective as well as components of gaining leverage, in an atmosphere that supports women's respectable identities and fulfills their primary goal of mothering. From my experience working with community outreach assistants from MSHS as well as grassroots farmworker advocacy groups in the Green Valley, I found that one potential intervention could involve a partnership between these groups that would take the shape of a parenting class for mothers at MSHS. I met with influential women who had previously worked in the fields and had experienced risk in their own relationships. Having eventually moved on to attain employment outside of farmwork, end their risky relationships, and gain political and social influence within the community, I saw these individuals as beacons of hope and information for others who were isolated and alone. Inviting these women to function as *promotoras* or instructors/small group leaders in a course that could be designed to center on

children's health and parenting could provide those who might otherwise be isolated with a source of emotional and informational support. Among other topics, adult family relationships could be introduced as an important component of children's emotional, social and physical health and wellbeing. While emphasizing women's strengths, information regarding how risky parental relationships can affect children and the family system could motivate women to take action in order to gain leverage. Providing direct linkages to public assistance and community resources as well as offering a safe space where women could share about their own experiences and harness emotional support would be essential components of such an intervention.

Policy Implications

Crucial to the concept of gaining leverage is the idea that women felt they could not gain a strategic advantage in their relationships without a fulcrum (see figure 3, Appendix M). Women found that their own efforts were ultimately not effective enough without external help -- particularly help from public assistance programs that made it possible for them to gain financial independence from their partners. Indeed, without forms of public assistance for both documented and undocumented women, participants in my study would have told very different stories. Therefore, it is important that these programs continue to be funded in order to provide women with the strategic advantage that they need to gain *just enough* leverage in their risky relationships to be able to take the crucial steps needed to become more independent and safe.

Conclusion

Throughout this work, I have sought to fill the gaps in knowledge surrounding migrant farmworker women, issues described in the literature as being about relationship power and individual agency, and experiences with close, long-term partners who are abusive, unfaithful, and/or addicted to substances. The concept of HIV risk among this vulnerable population is

indeed complex; it is complicated by patterns of mobility, silence about sex, transnational experiences, life at the margins of society, and priorities of survival and social respectability. Through the two simultaneous processes of expanding perspectives of risk and gaining leverage over risk, I have illuminated women's experiences by presenting a theory that is grounded in their own words. In turn, this theory can inform interpersonal interactions and prevention counseling among research teams, healthcare providers and migrant women, community level interventions, and structural policy decisions. Ultimately, healthcare professionals, researchers and policy makers can use the findings of this research to provide care and interventions that are culturally appropriate and socially acceptable to migrant women, in order to decrease health disparities and assist women as they continue to work to gain leverage in the face of overwhelming odds. By working to capitalize on women's perceived strengths and abilities while simultaneously equipping them with the resources to decrease risk in their relationships, we have a responsibility to create interventions and sustain policies that support the health and minimize HIV risk among migrant women.
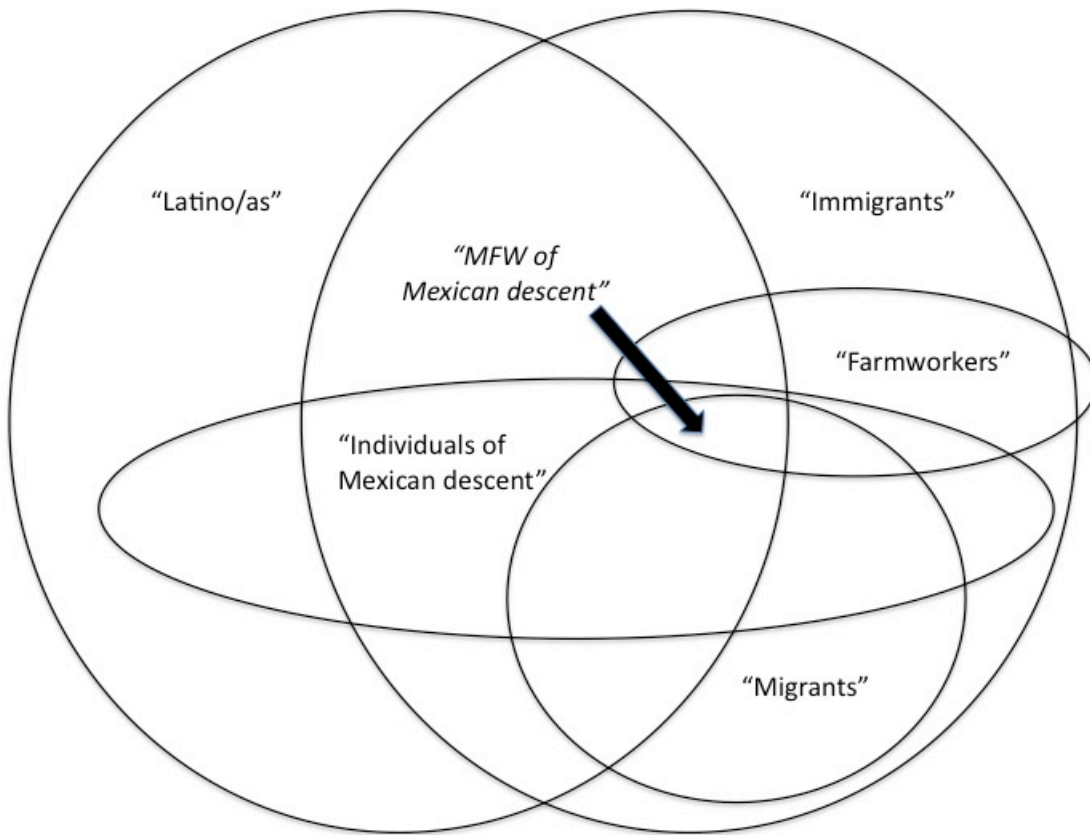
Figure 1. (Sub)populations of interest related to migrant farmworker women of Mexican descent.

Note: The target population is rightfully further stratified according to gender, location (e.g. Mexico or US, migrant stream, etc.), and ethnicity (e.g. *mestizo/a* or indigenous).

Appendix B

Table 1. *HIV and STI Prevalence in Migrant Workers*

Year	Author(s)	Setting	Sample	HIV +	STIs
1987	CDC	Health clinic in North Carolina	N=426 migrant and seasonal farmworkers	2.6% (3.5% males, 1.5% females)	
1988	Castro et al.	Agricultural community in Belle Glade, Florida	N=877 randomly selected from community, >18 years old, 50% male, 53% black	3.2%	
1991	Jones et al.	15 agricultural migrant camps in South Carolina	N=198 convenience sample of farmworkers at a rural health clinic, 91% black, 85% male, 75% single	13%	
1991	Carrier & Magana	AIDS Community Education Project (ACEP), an outreach program for IV drug users in Orange County, California; Orange County STI clinic	N=50 sexually active immigrant Mexican male farmworkers; N=3000 males tested at STD clinic, majority are Latino	0% in ACEP <2% in STI clinic	
1997	Weatherby et al.	Agricultural community in rural southern Florida	N=116 Hispanic migrants from Mexico	3.4%	
1997	Lopez & Ruiz (as reported in Wong et al.)	Northern California	N=176 Mexican farmworkers	0%	Lifetime history of STI: 9% 1% syphilis
1999	Inciardi et al.	Agricultural community on peninsula of Delaware, Maryland & Virginia	N=151 migrant farmworkers who were current drug users; 84.8% male, 69.5% black	4%	
2003	Wong et al.	Urban day laborers in San Francisco	N=292 male, Latino, recent immigrants		3.5% chlamydia 0.5% gonorrhea 0.4% syphilis
2005	Martinez-Donate et al.	Border region of Tijuana and San Diego	N=1041 probability sample of Mexican migrants	0%	7.9% lifetime history of STI
2005	Denner et al.	Agricultural community in central California	N=366 Spanish-speaking, marginally housed adults	6%	Lifetime history of STI: almost 25%
2005	Varela-Ramirez et al.	El Paso, Texas	N=210 Hispanic migrant and seasonal farmworkers	.47%	Lifetime history of STI: 1.5%
2008	Brammeier et al.	6 agricultural regions in CA	N=403 males, majority Mexican		1.6% chlamydia 0% gonorrhea 1% syphilis
2008	Eastern Coachella Valley Social Change Collaborative	Coachella Valley, California	N=124 Latino migrant and seasonal farmworkers	3.2%	

Appendix C

Semi-Structured Interview Guide
ENGLISH VERSION
"Campesinas Health Study"
To be used with partner risk (algorithm boxes 3a, 3b, 4a and 4b)

"I am interested in hearing about the experiences of women farmworkers in relation to being in various kinds of risky intimate situations with men, including decisions that you have made or things that have happened to you that have been out of your control."

MIGRATION HISTORY
First, I'd like to get to know a little bit more about you. Tell me about what led to your decision to work in the Green Valley as a farmworker.
- With whom did you originally come from Mexico to the US?
- What led to your decision to work in the US?
- For what reasons do you leave the Green Valley to seek work elsewhere?
- Tell me about what it's like to be a migrant farmworker, and move from one place to another for work.

CURRENT/MOST RECENT RELATIONSHIP
Tell me about your current/most recent relationship.
- How do you define this relationship (for example, married, common-law, boyfriend/girlfriend)? What makes you define it this way?
- Are you happy with your relationship being defined this way, or do you wish it were different?
- How long were you/have you been together?
- What makes you feel good in this relationship?
- What makes you feel bad in this relationship?

PARTNER SEPARATION
If you have ever been separated for period of time (like, living in different towns), tell me about what that was like.
- I've heard of some women worrying that their partners might be unfaithful to them while they are apart. How does the issue of him potentially being unfaithful to you while you are/were separated affect you if at all?
- I know that women can get lonely too, and sometimes it's safer to be with a man than living or traveling by yourself. Tell me about a time, if there was one, when you thought about being with another man while you were separated from your partner.
- Have you experienced any dangerous situations as a woman travelling and/or working alone without your partner? Tell me about them.

RISKY SITUATIONS
Now let's change course a bit and talk about risky intimate situations. Let's talk about what could put you at risk for getting a sexually transmitted infection.
- Do you currently have any worries about getting a sexually transmitted infection? If so, what are they?

- Have you had any worries in the past that you could have gotten a sexually transmitted infection from a man? Can you tell me about that?
- Has there ever been a time when you wondered if your partner should have used a condom so that you would be protected from getting a disease (not to avoid pregnancy), but he didn't and the two of you had sex anyways? If so, could you tell me about that time?
- If you have never had any of these worries, could you describe a make believe scenario where you would be at risk of getting a sexually transmitted infection?
- Who was/could be involved?
- What did you think about doing or what did you try to do/what could you do to keep yourself safe?
- If this has never happened to you, what do you think you might do if you were in this situation?
- What about this situation makes it risky?

Tell me about a time when something, some service, or some person helped you protect yourself during or after a risky situation.
- What resources were helpful to you at that time?
- How did you get access to that resource?

Tell me about a time when you had to draw on your own strengths to help yourself out of a risky situation.
- What aspects of your own self have helped you to be able to protect yourself from being in a situation that was risky?
- What aspects of your own self have helped you to be able to deal with a risky situation either while it is happening or after it has happened?

PARTNER RISK
Many women have told me that they wondered (sometimes just once) if their partner was being unfaithful to them. What would you think if you found out that your current/most recent partner was with another woman or man, in an intimate way? What would you do?
- If there was a time when you suspected that your partner was being unfaithful, tell me about it. What happened?
- What led you to think this? How did you feel? What did you do?
- What were your thoughts about the consequences of his infidelity for your health?
- What did you do to protect yourself?
- What happened?
- If your relationship changed as a result of this, how did it change?

Have/did you ever used a condom with your current/most recent partner?
- If yes, tell me about that time.
- Who suggested using a condom, you or him?
- What did you think? How did he respond?
- What was the primary reason for using a condom?
- Were there any other reasons to use a condom?

328

- If no, can you think of any situation in which you might want to use a condom with him in the future? Tell me about that. How would you bring it up? How do you imagine he would respond?
- Can you think of any situation in which he might suggest using a condom in the future? Tell me about that. How would you respond?

Have you ever used a condom in your life? Or, have you ever wanted to use a condom, even if you didn't end up using one?
- Tell me about that time.
- Who suggested using a condom, you or him?
- What did you think? How did he respond?
- What was the primary reason for using a condom?
- Were there any other reasons to use a condom?

Regarding condoms, please rate the importance of using condoms with your current partner (now, when you were reunited with him after a physical separation, after you found out he had been unfaithful, etc.) on a scale from 0 to 10, with 0 being "not important at all" and 10 being "extremely important."
- Why did you choose ___ instead of ___?
- What makes it so important / What makes it not so important for you to use condoms with him?
- What would have to happen in order for this number to be higher / lower?

Besides condoms, what other methods of protection have you used/would you consider using to protect yourself from diseases?
- Are there any other products or medicines, besides condoms, that you have used or that you might consider using for disease protection if you ever needed it?
- Are there any other strategies to protect yourself from sexually transmitted diseases, that you have used in the past or that you might consider using?

(*If it hasn't already been brought up*) During the screening interview, I asked you a few questions about risky activities that you may know or suspect your current or most recent partner might be/have been involved in (like, if he has ever been unfaithful to you, or had sex with men, used injection drugs, been diagnosed with or showed symptoms of a sexually transmitted infection, or been diagnosed with HIV). Can you tell me more about this?
- How did you come to know or suspect that this was going on?
- What did you think about it?
- What did you do?
- What services or other resources were available to help you? How did you get access to that resource?
- What aspects of your own self helped you get through this situation?
- How did he respond?
- What worries did you have about his health as a result?
- What worries (if any) did you have about your own health? What did you do about this?

- Were you ever worried that you could get a sexually transmitted infection from him? What did you do about this?
- What has happened since?

IPV
Have you ever felt worried that this (current or most recent) partner could become angry or upset enough to hurt you?
- If yes, tell me about that time.
- What went through your mind?
- What did you do?
- What services or other resources were available to help you? How did you get access to that resource?
- What aspects of your own self helped you get through this situation?
- How did he respond?
- What worries did you have about his health as a result?
- What worries (if any) did you have about your own health? What did you do about this?
- What has happened since?

HIV/STI TESTING
Many women don't feel comfortable talking with their partners about getting tested for HIV or STIs. Tell me about your experience with this.
- Tell me about the last time you discussed this with a partner. How did that conversation go?
- Who brought it up? How did it meet/not meet your expectations about how it should have gone?
- What do you think your partner would do if you asked him to get tested today?
- What do you think he would say?

Tell me about your own experience with getting tested for HIV or STIs.
- When was the last time you got tested?
- What led to your decision to get/not to get tested?
- Where did you go?
- What was the result?
- How did you feel after you were tested?
- What are your thoughts about getting tested in the future?
- OR What kept you from getting tested?

RELATIONSHIP ASPIRATIONS (algorithm item 3b or 4b only)
So currently, you are single (not in a relationship). What kinds of hopes or wishes do you have for a relationship right now?
- Tell me about the person you imagine yourself being with; the "partner of your dreams."
- What would a relationship with this person look like?
- Would you prefer to just date/live with/marry in the church/have a civil marriage with this person? What makes you choose that over the other options?

- If you had a choice today between being single or being in a relationship, which would you choose? Can you tell me more about that?

Can you tell me what it's like for you to be a single woman right now?
- What kinds of things can you do as a single woman that you couldn't do if you were partnered/married?
- What is the best part about being a single woman?
- What kinds of things can you NOT do as a single woman that you COULD do if you were partnered/married?
- What is the worst part about being a single woman?
- In your opinion, which is better for *you*: being single, being in a relationship with a partner but NOT married, or being married? Tell me more about this.

CLOSING QUESTIONS
What helps you to stay healthy as a woman? / What motivates you to reach your goals?

What would you say that your strengths are?

At this point, is there anything that I have not covered that you feel would be helpful for me to know?

Do you have any questions for me?

Appendix D

Semi-Structured Interview Guide
ENGLISH VERSION
"Campesinas Health Study"
To be used with abuse (algorithm boxes 3c or 5)

"I am interested in hearing about the experiences of women farmworkers in relation to being in various kinds of risky intimate situations with men, including decisions that you have made or things that have happened to you that have been out of your control."

MIGRATION HISTORY
First, I'd like to get to know a little bit more about you. Tell me about what led to your decision to work in the Green Valley as a farmworker.
- With whom did you originally come from Mexico to the US?
- What led to your decision to work in the US?
- For what reasons do you leave the Green Valley to seek work elsewhere?
- Tell me about what it's like to be a migrant farmworker, and move from one place to another for work.

CURRENT/MOST RECENT RELATIONSHIP
Tell me about your current/most recent relationship.
- How do you define this relationship (for example, married, common-law, boyfriend/girlfriend)? What makes you define it this way?
- Are you happy with your relationship being defined this way, or do you wish it were different?
- How long were you/have you been together?
- What makes you feel good in this relationship?
- What makes you feel bad in this relationship?

PARTNER SEPARATION (algorithm item 5 only)
If you have ever been separated for period of time (like, living in different towns), tell me about what that was like.
- I've heard of some women worrying that their partners might be unfaithful to them while they are apart. How does the issue of him potentially being unfaithful to you while you are/were separated affect you if at all?
- I know that women can get lonely too, and sometimes it's safer to be with a man than living or traveling by yourself. Tell me about a time, if there was one, when you thought about being with another man while you were separated from your partner.
- Have you experienced any dangerous situations as a woman travelling and/or working alone without your partner? Tell me about them.

RISKY SITUATIONS
You indicated that you were eligible for this study because you have previously been in a long-term relationship with a man who abused you (physically, sexually, or emotionally) OR because

you have been a victim of rape or forced sex as an adult. If it's okay with you, I'd like to talk about this now.
- Which of these applies to you?
- Can you tell me about what happened?
- Who was involved?
- What did you think about it?
- What did you do?
- What services or other resources were available to help you? How did you get access to that resource?
- What aspects of your own self helped you get through this situation?
- How did he respond?
- What worries did you have about your own health? What did you do about this?
- Were you ever worried that you could get a sexually transmitted infection from him? What did you do about this?
- What has happened since?

Can you think of any other circumstances that could put you at risk of getting a sexually transmitted infection?
- Do you currently have any worries about getting a sexually transmitted infection? If so, what are they?
- Apart from what we've already discussed, have there been other times in your life when you've been worried that you could have gotten a sexually transmitted infection? Can you tell me about that?
- If you have never had any of these worries, could you describe a make believe scenario where you would be at risk of getting a sexually transmitted infection?
- Who was/could be involved?
- What did you think about doing or what did you try to do/what could you do to keep yourself safe?
- If this has never happened to you, what do you think you might do if you were in this situation?
- What about this situation makes it risky?

Tell me about a time when something, some service, or some person helped you protect yourself during or after a risky situation.
- What resources were helpful to you at that time?
- How did you get access to that resource?

Tell me about a time when you had to draw on your own strengths to help yourself out of a risky situation.
- What aspects of your own self have helped you to be able to protect yourself from being in a situation that was risky?
- What aspects of your own self have helped you to be able to deal with a risky situation either while it is happening or after it has happened?

Have you ever used a condom in your life? Or, have you ever wanted to use a condom, even if you didn't end up using one?
- Tell me about that time.
- Who suggested using a condom, you or him?
- What did you think? How did he respond?
- What was the primary reason for using a condom?
- Were there any other reasons to use a condom?

Besides condoms, what other methods of protection have you used/would you consider using to protect yourself from diseases?
- Are there any other products or medicines, besides condoms, that you have used or that you might consider using for disease protection if you ever needed it?
- Are there any other strategies to protect yourself from sexually transmitted diseases, that you have used in the past or that you might consider using?

HIV/STI TESTING
Many women don't feel comfortable talking with their partners about getting tested for HIV or STIs. Tell me about your experience with this.
- Tell me about the last time you discussed this with a partner. How did that conversation go?
- Who brought it up? How did it meet/not meet your expectations about how it should have gone?

Tell me about your own experience with getting tested for HIV or STIs.
- When was the last time you got tested?
- What led to your decision to get/not to get tested?
- Where did you go?
- What was the result?
- How did you feel after you were tested?
- What are your thoughts about getting tested in the future?
- OR What kept you from getting tested?

RELATIONSHIP ASPIRATIONS (algorithm item 3c only)
So, currently you are single (not in a relationship). What kinds of hopes or wishes do you have for a relationship right now?
- Tell me about the person you imagine yourself being with; the "partner of your dreams."
- What would a relationship with this person look like?
- Would you prefer to just date/live with/marry in the church/have a civil marriage with this person? What makes you choose that over the other options?
- If you had a choice today between being single or being in a relationship, which would you choose? Can you tell me more about that?

Can you tell me what it's like for you to be a single woman right now?
- What kinds of things can you do as a single woman that you couldn't do if you were partnered/married?

- What is the best part about being a single woman?
- What kinds of things can you NOT do as a single woman that you COULD do if you were partnered/married?
- What is the worst part about being a single woman?
- In your opinion, which is better for *you*: being single, being in a relationship with a partner but NOT married, or being married? Tell me more about this.

CLOSING QUESTIONS
What helps you to stay healthy as a woman? / What motivates you to reach your goals?

What would you say that your strengths are?

At this point, is there anything that I have not covered that you feel would be helpful for me to know?

Do you have any questions for me?

Women volunteers needed for a health study

This is a research study for migrant farmworker women between the ages of 18 – 60 conducted by Cyndi Albarrán, RN, from the UCLA School of Nursing. This study, which includes 1-2 interviews, explores experiences with women's health among migrant farmworker women in California.

Please call for more information:
(760) 501-6389
UCLA School of Nursing
Student Affairs Office
Box 951702
Los Angeles, CA 90095

You will be given more information about the study and be asked a few questions to see if you meet criteria to be in the study

You could receive up to $50 cash for participating

UNIVERSITY OF CALIFORNIA, LOS ANGELES
SCREENING CONSENT SCRIPT

CAMPESINAS HEALTH AND RELATIONSHIPS STUDY

Thank you for contacting me, Cyndi Albarrán, regarding the Campesinas Health and Relationships Study.   I would like to ask you a few questions in order to determine whether you may be eligible for the research. But before I begin the screening I would like to tell you a little bit about the research. The purpose of this research study is to understand more about the health needs and risks to a woman's health experienced by migrant farmworker women in California. These risks to a woman's health can include both choices that women make about their bodies and/or risky situations that women may find themselves in with men. The findings of this study will be used to help improve reproductive health services for women farmworkers like yourself.

The screening will take about 5 – 10 minutes. I will ask you your age, where you were born, and what you do for work. I will then ask you a series of very personal questions about risky situations that you could have experienced with men. This includes decisions that you have made or things that have happened to you that have been out of your control, including domestic violence, having a partner who was unfaithful, or worrying about getting a sexually transmitted infection (among others). I will give you a list of 3-5 scenarios, and ask you to tell me "yes, one of those things has happened to me," or "no, none of those things have happened to me." You do not need to identify which scenario in the list applies to you. I may need to ask you only two questions to see if you are eligible for the study, but I may need to ask you as many as six questions, depending on how many times you say "yes" or "no."

You do not have to answer any questions you do not wish to answer or are uncomfortable answering, and you may stop at any time. Your participation in this screening interview is voluntary. There is no compensation for your participation in the screening questions. If you are eligible to participate in the study and are interested in completing the one-on-one interview, you will be compensated $25 cash for your time.

Your answers will be confidential. No one will know your answers except for the research team (myself, and my committee of 4 professors from UCLA). If you are eligible to take part in the study and wish to participate, your answers to these questions will be kept with your research record, which will not have your name or any other identifying information (i.e. your date of birth, address, phone number, place of employment, or any other information that could identify you with your answers). If you are not eligible to take part in the study or you decide not to participate in the study after the screening questions are complete, your answers to these questions will be kept without your name or any identifying information.

Would you like to continue with the screening? **[If no, thank the person and discontinue screening]**

[If yes, continue with the screening]

How old are you? _____ years

What country were you born in? _____

What town do you currently live in? _____

Do you have a home where you live year-round? yes / no

How long have you been working in the Green Valley (consecutive time)? ____ months / days / years

Have you worked as a farmworker (picker or packer) in the past year?   yes/no

I am looking to interview women who have experienced some kind of risk to their reproductive health. This kind of risk can mean many different things, and I am going to read you a series of scenarios to see if you have experienced any of these things. I am using a question map, which I can show you. Would you like to see it? **[show algorithm to participant if desired]** Your answer to each question will direct me to either ask you another question, or tell me that you are eligible (green boxes) or not eligible (red boxes) for the study. You do not need to indicate which scenario in the box applies to you, just say "yes" or "no" if any of the scenarios apply to you. So, let's start at the top with the grey question and work our way down. I'll read the questions out loud unless you tell me that you'd rather read it to yourself. **[proceed with algorithm]**

When the algorithm indicates that a participant is either eligible or not eligible: Thank you for answering the screening questions. If you read the question map to yourself, would you mind showing me where you stopped?

If eligible: You are eligible to participate in this study because you are a migrant farmworker woman between the ages of 18 – 60, you speak Spanish, you were born in Mexico, you currently live in the Green Valley, and you have experienced some kind of risk to your health as a woman. This study consists of a one-on-one interview with myself that will last between 45 – 90 minutes and will take place in person in a private location of your choosing. For example, we could do the interview at your home, at the home of one of the research consultants (the Community Advisory Board member who may have referred you to the study), or at a private room in one of the community agencies (the library or Migrant Head Start). It is up to you where we do the interview and when we do it. In this interview, I will ask you to tell me about which kind of risk applies to you (from the list that I read to you). We will discuss this as much as you are willing and comfortable. At the end of the interview, you will receive $25 cash for your participation. Just because you participated in this screening process does not mean that you must take part in the interview; it is completely voluntary. If you are interested in doing the interview we can choose a time and a place right now, and I will meet you there. You can feel free to call my cell phone at (760) 501-6389 if you need to make any changes to our appointment. Would you like to take part in this study and schedule an interview appointment?

If NOT eligible: You are not eligible to participate in this study because [insert eligibility criteria that she did not meet].

Do you have any questions about the screening or the research? I am going to give you a couple of telephone numbers to call if you have any questions later. Do you have a pen? If you have questions about the research screening, you may call me back at (760) 501-6389 and I will answer your questions.

If you have questions about your rights as a research subject or if you wish to voice any problems or concerns you may have about the study to someone other than the researchers, please call the UCLA Office of the Human Research Protection Program at (310) 825-7122.

Thank you again for your willingness to answer my questions.

Appendix G

1. Have you been partnered with a man (boyfriend, lover, spouse) in the past year?

Yes
3a. At any point in this relationship, have you ever known or suspected:
That he has ever been unfaithful to you
OR
That he has had sex with men
OR
That he has used injection drugs
OR
That he had been diagnosed with, or showed symptoms of a sexually transmitted infection (like, pain while urinating, or sores on his penis)
OR
That he had been diagnosed with HIV, the virus that causes AIDS?
Have you ever known or suspected any of these things about your current partner?

No
2. When was the last time you were in a relationship with a man (boyfriend, lover, or spouse)?

≤ 5 years
3b. At any point in this most recent relationship, have you ever known or suspected:
That he had ever been unfaithful to you
OR
That he had sex with men
OR
That he used injection drugs
OR
That he had been diagnosed with, or showed symptoms of a sexually transmitted infection (like, pain while urinating, or sores on his penis)
OR
That he had been diagnosed with HIV, the virus that causes AIDS?
Did you ever know or suspect any of these things about your most recent partner?

> 5 years
3c. Have you have ever been in a long-term relationship (lasting more than one year) with a man (boyfriend, lover or spouse) who abused you (physically, sexually, or emotionally)
OR
Have you ever been a victim of rape or forced sex as an adult (over 18 years of age)?
Do either of these two circumstances apply to you?

Yes
Eligible

No
4a. At any point during this relationship, has your partner (boyfriend, lover, or spouse) ever abused you (physically, sexually, or emotionally)
OR
Have you been physically separated from him for more than one consecutive month during the last year (for example, he went to work in another town and you stayed behind)
OR
Have you ever been in a situation where you wondered if he should have used a condom for disease prevention (not to avoid pregnancy), but he didn't and the two of you had sex anyway?
Do any of these circumstances apply to you?

No
4b. In your most recent relationship, did your partner (boyfriend, lover, or spouse) ever abuse you (physically, sexually, or emotionally)
OR
Were physically separated from him more often than you were together (for example, he went to work in another town and you stayed behind), towards the end of your relationship
OR
Were ever in a situation where you wondered if he should have used a condom for disease prevention (not to avoid pregnancy), but he didn't and the two of you had sex anyway?
Do any of these circumstances apply to you?

No
4c. In the past year, did you have sex (even once) with a man without using a condom
OR
In the past five years, did you ever (even once) have sex with a man in exchange for drugs or money
OR
Have you ever been diagnosed with a sexually transmitted infection
OR
In the past five years, were you ever in a situation (even once) where you worried that you could have gotten a sexually transmitted infection (even if you didn't get one)?
Do any of these circumstances apply to you?

Yes
Eligible

Yes
Eligible

Yes
Eligible

No
5. Have you ever been in a long-term relationship (lasting more than one year) with a man (boyfriend, lover or spouse) who abused you (physically, sexually, or emotionally)
OR
Have you ever been a victim of rape or forced sex as an adult (over 18 years of age)?
Do either of these two circumstances apply to you?

Yes
Eligible

No
6. In the past five years, did you ever (even once) have sex with a man in exchange for drugs or money
OR
Have you ever been diagnosed with a sexually transmitted infection
OR
Have you been in a situation in the past five years where you worried (even once) that you could have gotten a sexually transmitted infection (even if you didn't get one)?
Do any of these circumstances apply to you?

Yes
Eligible

No
Not eligible
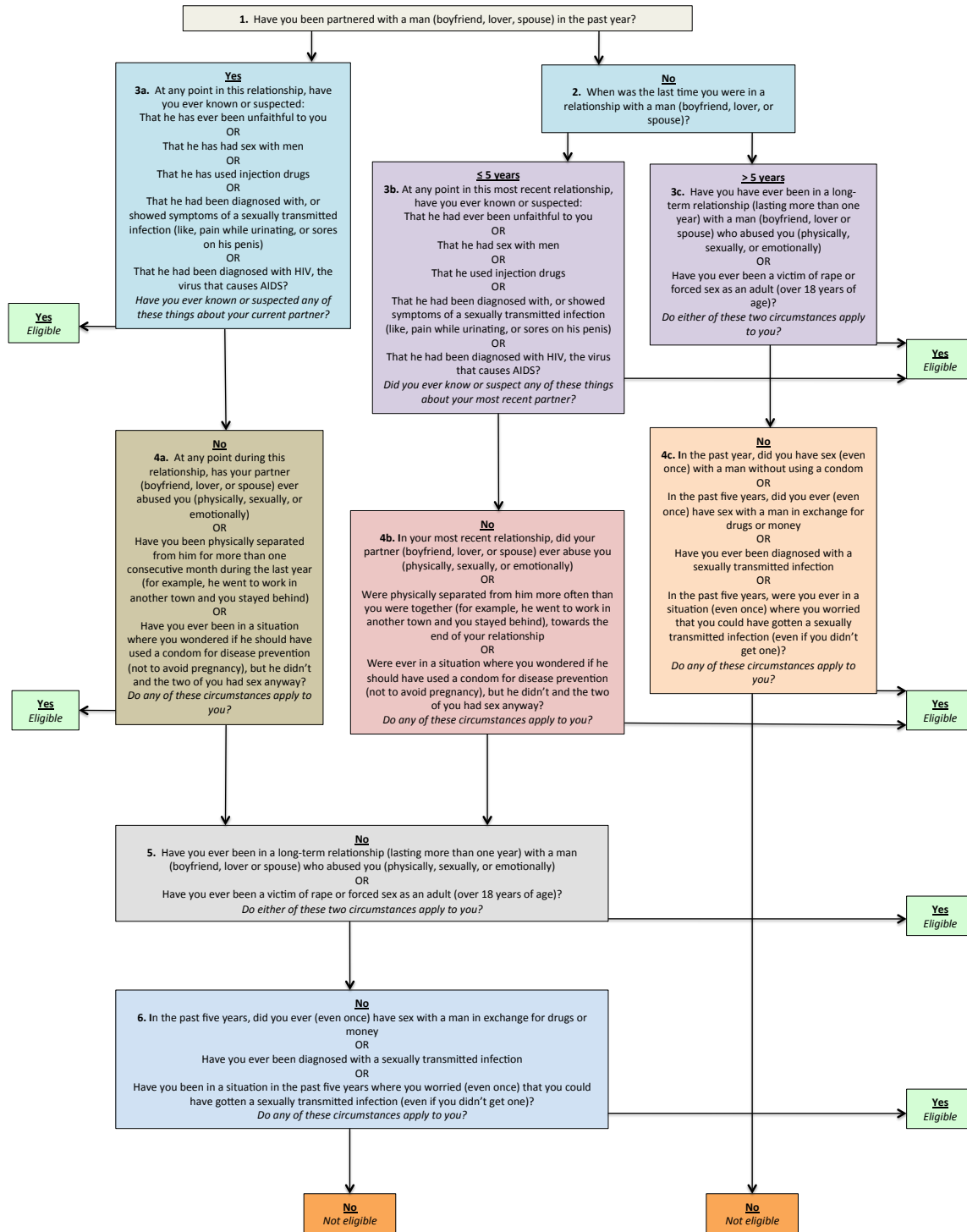
No
Not eligible

Figure 2. HIV risk screening algorithm.

Appendix H

Risk Management Protocols

*names and contact information have been removed in order to protect the anonymity of the

Green Valley

Serious adverse events will be reported to the dissertation chair in person, by phone, or by e-mail within 24 hours of the event. A more complete written report documenting the event will be completed within 72 hours of the event and submitted to the UCLA IRB.

I will promptly report to the dissertation chair and to the appropriate authorities if I suspect possible suicidal ideation. I have 18 months' experience working as a research assistant and have completed the Basic Course in the Protection of Human Research Subjects/ Social and Behavioral Focus through the Collaborative Institutional Training Institute CITI. A certification of completion is in my file at the UCLA School of Nursing. In addition, I will maintain an up-to-date referral list of health agencies, Migrant Health Clinics, and other resources for farmworkers to be shared as needed with participants. I have substantial clinical experience, allowing me to make clinical assessments and referrals that might be necessary during screenings and interviews.

All study participants will receive full information and disclosure about the mandatory reporting laws for child and elder abuse during the informed consent process and discussion of confidentiality. If I suspect elder or child abuse, I will file both verbal and written reports with the necessary county agencies. I will maintain the primary responsibility of monitoring data to ensure safety of participants throughout the data collection process.

Risk Management Protocol for Reports of Violence

There is a potential for participants to report various types of violence during the interview, including but not limited to: work-related sexual violence, work-related sexual harassment, intimate partner violence, and rape. In the event that any of these forms of violence are disclosed during the interview, I will take the following actions at the conclusion of the interview:

- I will assess for current health needs related to the report of violence, and provide referrals to local healthcare providers for follow-up care as necessary.

- If the participant is interested in filing a police report, I will provide the participant with the address and phone number of the local Sheriff's office, and provide support for her as she files the report.

- I will inform the participant that the California Rural Legal Association (CRLA) provides high-quality legal advice and services for low-income individuals in rural communities in California, and is very active in the Green Valley. This organization provides frequent workshops related to family law as well as labor law, as well as free legal services on an individual basis. If she is interested, I will provide the participant with the address and phone number of the CRLA's local office and provide support for her as she makes an appointment via telephone.

- I will provide referrals for the participant to seek mental health care to assist in coping with experienced trauma. For example, I will provide the participant with the address and phone number of the county mental health clinic. I will offer support for her as she makes an appointment via telephone.

- I will provide the participant with the address and phone number for a local shelter that offers transitional housing, emergency support, and ongoing counseling for women who may have experienced intimate partner violence or otherwise need a safe refuge.

- I will provide the participant with the number for the county domestic violence hotline as appropriate.

- I will provide the participant with the number for the county 24-hour rape crisis hotline as appropriate.

- In addition, if the participant voices suicidal ideation during the interview, the additional criteria for this protocol will be followed.

Risk Management Protocol for Suicidal Ideation

In the event that a participant expresses suicidal ideation, I will take the following steps to ensure safety:

- Stop the interview.

- Assess the participant for the existence of a current suicide plan or past history of suicidal ideation or attempts.

- If the participant and I are in the immediate area of the county mental health office, I will walk the participant to this office, where she can receive same-day services.

- If the participant and I are not near the county mental health office, I will call the local mental health center, where the participant can have an emergency screening conducted over the phone and be given further directions for either calling 911 or making a same-day appointment.

- If the participant is not in danger of suicide but has other mental health needs, I will support her in obtaining an appointment at the county mental health office.

Appendix I

Campesinas Health Study: Demographic Questionnaire

Participant Screening #: _____

Date: _____

Recruitment From: _____

How did you hear about this study? _____

Age: _____ years

Race/Ethnicity: _____

Place of birth (state, country): _____

Place of parent's birth (state, country): _____

Age at first arrival to the US: _____ years

Length of time in the US: _____ *(circle one)* days / months / years

Housing
What town do you currently live in? _____

In what kind of dwelling do you currently live (where will you sleep tonight): *(circle one)* house / apartment / trailer / labor camp / car / other _____

Does this dwelling belong to you or to someone else? *(circle one)* myself / other

How many people live in that dwelling with you? _____

Who do you currently live with? *(circle all that apply)* Alone / partner / children / father / mother / brothers / sisters / male friend I came here with / female friend I came here with / man I didn't previously know / woman I previously didn't know / other (specify gender)

_____

Partner/Family
Marital Status: *(circle all that apply)* single / living with partner / in a relationship but not living together / legally married / common-law married / separated / divorced / widowed

If married/partnered, is your current partner a man or a woman? *(circle one)* man / woman

If married/partnered, where is your partner? *(circle one)* here with me in the Green Valley / we are apart, s/he is: _____

   If apart, for how long have you been apart? _____ *(circle one)* days / months /   years

   If you had to pick one main reason why you are apart, what would it be?
   _____

If together, are you always together in the same city/town? *(circle one)* yes / no

If no, how many days or months are you apart from one another in one year (365 days/12 months)? _____ days / months

If you had to pick one main reason why you are apart, what would it be?
_____

Number of children: _____

Location of children (city, state, country): _____

Ages of children: _____

Number of children for whom you are financially responsible: _____

Income/Education
Your income (current monthly earnings): $_____

Family income (monthly): $_____

How many people contribute to family income? _____

Were your financial resources adequate to meet your daily needs in the last month? *(circle one)* yes / no
Highest level of education achieved: *(circle one)* primary school / secondary school / college / graduate school

Number of total years spent in school: _____

Work
What crop are you currently working in? _____

What is your role/title at work? _____

How long have you been employed in farm work? _____ days / months / years

What did you do for work before becoming employed in farm work? _____

Last year, were you employed in farm work year-round? *(circle one)* yes / no

If no, what other jobs did you hold during the last year when you were not employed in farm work? *(list all jobs held)* _____

Do you currently hold other jobs besides farmwork? *(circle one)* yes / no

If yes, what other jobs do you currently hold? _____

How many hours a week do you currently spend in farmwork? _____

How many hours a week do you currently spend in your other jobs? _____

Migration

Do you follow the crops for work? *(circle one)* yes / no

How long have you been in the Green Valley (consecutively, this time)? _____ days / months / years

How long do you plan to stay in the Green Valley? _____

Where were you before you came to the Green Valley? _____

Where do you plan to go after you leave the Green Valley? _____

Where is your "home base?" _____

How often do you return to your "home base?" _____

Healthcare
Have you seen any of the following in the last year for your *own* healthcare (not for your children or for someone else in your family): *(circle all that apply)* doctor / nurse / dentist / *promotora* / *curandero* / other: _____

Where did you see this person? *(circle all that apply)* A private home / health clinic / hospital / ER / other: _____

Table 2. *Participant Demographic Data*

	%	Freq.	Mean (range)	SD
Age			41 (24-59)	10
Time in US (years)			19 (8-51)	12
Indigenous	10	2		
Number of children			4 (1-8)	2
Has children living in Mexico	35	7		
DOCUMENTATION				
Documented	35	7		
Undocumented	45	9		
Did not specify documentation	20	4		
RELATIONSHIP STATUS				
Partnered	80	16		
Single	20	4		
HOUSING				
Car	15	3		
Apartment	20	4		
Trailer (rented)	25	5		
Trailer (owned)	40	8		
INCOME				
Monthly household income			$1,789 ($290-$2,800)	$477
Number of people in household			4 (1-9)	2
Perceive income to be sufficient to meet current needs	55	11		
EDUCATION				
Total years completed			7 (0-13)	4
WORK HISTORY				
Total years working in farm work			17 (5-43)	10
Currently employed in farm work or seeking a job in farm work	95	19		
Currently employed outside of farm work	5	1		
Current/most recent position: picker or packer*	89	17		
Current/most recent position: puncher or checker*	11	2		
Any job experience other than farm work	50	10		
Employed year-round last year	15	3		
MIGRATION FOR WORK				
Currently en route from home base for work	20	4		
Currently residing at home base	80	16		
Plans to move for work in the next 6 months**	69	11		
Plans to stay in the Green Valley**	19	3		
Unsure about future migration plans**	12	2		
RISK PROFILE				
Intimate partner violence (current relationship)	15	3		
Intimate partner violence (previous relationship)	35	7		
Total intimate partner violence	**50**	**10**		

Infidelity (current partner)	30	6		
Infidelity (previous partner)	35	7		
Total infidelity	**65**	**13**		
Partner history of STI	25	5		
Physical separation from partner for > 1 month in last year	45	9		
Sex in exchange for drugs/money	5	1		
Personal lifetime history of STI	30	6		
Multiple concurrent partners	15	3		
Rape perpetrated by man other than primary partner	5	1		

* Among those employed in farm work
** Among those residing at home base

Table 3. *Taxonomy of the Phases in "Expanding Perspective."*

Phase 1: Being Blinded	Phase II: Making the Discovery	Phase III: Weighing Priorities	Phase IV: Adopting a Risk Perspective	Phase V: Assessing the Consequences
1. Lacking connection to social information networks - *feeling disconnected as children living in Mexico* - *feeling disconnected as adults living in the US* 2. Being naïve - *marrying too young to know better* - *"he was the first:" lacking the experience to recognize risk* - *lacking examples of reciprocal relationships* 3. Learning through trial and error	1. Discovering risk by connection to social information networks - *connecting to the general social network* - *relying on family to monitor a partner from afar* 2. Discovering risk by "playing detective" - *looking for physical clues* - *interrogating him* - *interrogating others* 3. Discovering risk by examining spaces and places - *"outside"* - *space between partners*	1. Considering risk in terms of identity - *fearing a tarnished public identity* - *differentiating self from "shameful" others* 2. Considering risk in terms of survival - *financial help* - *instrumental help*	1. Overlooking risk by averting eyes - *using excuses* - *downplaying risk due to feelings of personal complicity: "I'm the fool here"* - *minimizing his complicity* 2. Confronting risk with eyes wide open - *admitting that "you never know"* - *taking a moral stand* - *viewing men as liars* - *perceiving that external influences had corrupted his being*	1. Assessing how risk is affecting me - *assessing more immediate consequences* - *coming to conclusions over the long-term* 2. Assessing how risk is affecting my family 3. Feeling regret over not seeing it sooner

Appendix L

Table 4. *Taxonomy of the Categories in the Process "Gaining Leverage."*

| Fighting the Bad	Finding the Good	Fortifying the Self

1. Calculating moves to resist harm
  - *deceiving him*
  - *getting tested*
  - *postponing sex*
  - *using condoms*
  - *"managing" risk due to partner separation*
  - *maintaining intimacy: "I give it my all"*
  - *constructing an emotional wall*
 	
2. Taking measures to control a partner's behavior
  - *avoidance*
  - *ignoring him*
  - *holding her ground*
  - *subverting traditional gender roles*
  - *giving verbal warnings and threats*
  - *imposing verbal rules and limits*
	1. Finding the good in family
	  - *struggling with family relationships*
	  - *receiving help from family*
	
	2. Finding the good in others
	  - *deferring negative influences*
	  - *receiving help from others*
	
	3. Finding the good in professional help
	  - *using professional help to fight back*
	  - *enlisting professional help to fight in her place*
	  - *encountering roadblocks when seeking professional help*
	  - *falling through the cracks*
		1. Pushing pain to the background
		  - *seeing repression as necessary to "moving forward"*
		  - *seeking distraction to overcome emotional scars*
		  - *admitting that repression was not healthy*
		
		2. Finding meaning in motherhood
		  - *"You've got your kids to perk up and live for"*
		  - *appointing self as guardian and protector*
		  - *hoping to "break the cycle"*
		
		3. Focusing on the positive
		  - *having a new reciprocal relationship*
		  - *"learning from the school of life"*
		  - *attaining financial independence*
		  - *accepting it*
		  - *being on the road to peace and happiness*

350
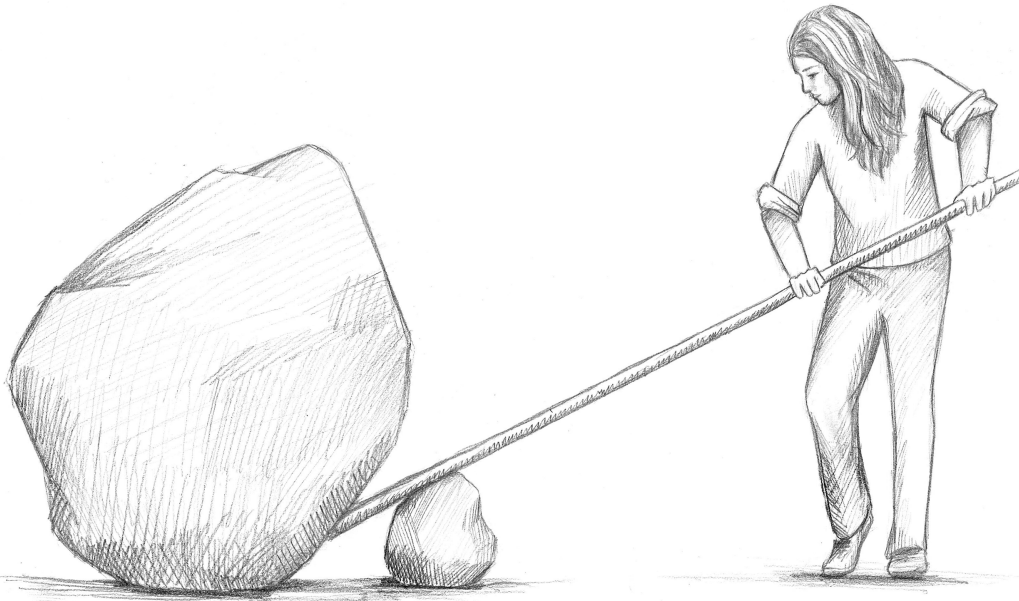
Figure 3. The concept of "gaining leverage."

References

Abrego, L. J. (2014). *Sacrificing families.* Stanford, CA: Stanford University Press.

Acevedo-Garcia, D., & Bates, L. (2008). Latino health paradoxes: Empirical evidence,

explanations, future research and implications. In H. Rodríguez, R. Sáenz & C. Menjívar

(Eds.), *Latinas/os in the United States: Changing the face of América* (pp. 101-113).

Retrieved from http://www.springerlink.com/content/p73k6q0g6117643j/fulltext.pdf

Adanu, R. M., & Johnson, T. R. (2009). Migration and women's health. *International Journal of*

Gynecology and Obstetrics, 106, 179-181.

Aguirre International. (2005). The California farm labor force: Overview and trends from the

National Agricultural Workers Survey. Retrieved from

http://agcenter.ucdavis.edu/AgDoc/CalifFarmLaborForceNAWS.pdf

Albarrán, C. R., & Nyamathi, A. N. (2011). HIV and Mexican migrant workers in the United

States: A review applying the vulnerable populations conceptual model. *Journal of the*

Association of Nurses in AIDS Care, 22, 173-85.

Albarrán, C. R., Heilemann, M. V., & Koniak-Griffin, D. (2014). *Promotoras* as facilitators of

change: Latinas' perspectives after participating in a lifestyle behavior intervention

program. *Journal of Advanced Nursing, 70*(10), 2303-2313.

Alcalde, M. C. (2010). Violence across borders: Familism, hegemonic masculinity, and self-

sacrificing femininity in the lives of Mexican and Peruvian migrants. *Latino Studies, 8*,

48-68.

Alcoff, L., & Potter, E. (1993). Introduction: When feminisms intersect epistemology. In L.

Alcoff & E. Potter (Eds.), *Feminist epistemologies* (pp. 1-14). New York, NY:

Routledge.

Allen, D. (2004). Ethnomethodological insights into insider-outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry, 11*(1), 14-24.

Amaro, H. (1995). Love, sex and power. *American Psychologist, 50*(6), 437-447.

Amaro, H., & Raj, A. (2000). On the margin: Power and women's HIV risk reduction strategies. *Sex Roles, 42*(7/8), 723-749.

Anderson, N. L. R., Calvillo, E. R., & Fongwa, M. N. (2007). Community-based approaches to strengthen cultural competency in nursing education and practice. *Journal of Transcultural Nursing, 18*(1-S), 49s-59s.

Anthony, M., Williams, J. M., & Avery, A. M. (2008). Health needs of migrant and seasonal farmworkers. *Journal of Community Health Nursing, 25*, 153-160.

Apostolopoulos, Y., Somnez, S., Kronenfeld, J., Castillo, E., McLendon, L., & Smith, D. (2006). STI/HIV risks for Mexican migrant laborers: Exploratory ethnographies. *Journal of Immigrant Minority Health, 8*(3), 291-302.

Aral, S. O. (2001). Sexually transmitted diseases: Magnitude, determinants and consequences. *International Journal of STD & AIDS, 12*(4), 211-215.

Aranda-Naranjo, B., Gaskins, S., Bustamonte, L., Lopez, L. C., & Rodriguez, J. (2000). La desesperación: Migrant and seasonal farm workers living with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care, 11*(2), 22-28.

Arcury, T. A., & Quandt, S. A. (2007). Delivery of health services to migrant and seasonal farmworkers. *Annual Review of Public Health, 28*, 345-363.

Arreola, S. G. (2010). Latina/o childhood sexuality. In M. Asencio (Ed.), *Latina/o sexualities: Probing powers, passions, practices, and policies* (pp. 48-61). New Brunswick: Rutgers University Press.

Asencio, M., & Acosta, K. (2010). Introduction: Mapping Latina/o sexualities research and scholarship. In M. Asencio (Ed.), *Latina/o sexualities: Probing powers, passions, practices, and policies* (pp. 1-12). New Brunswick: Rutgers University Press.

Asencio, A., & Acosta, K. (2010). Introduction: Mapping Latina/o sexualities research and scholarship. In M. Asencio (Ed.), *Latina/o sexualities: Probing powers, passions, practices, and policies* (pp. 1-12). New Brunswick: Rutgers University Press.

ATLAS.ti Version 7.2.1. [Computer software]. (2012). Berlin, Scientific Software Development.

Barron, F., Hunter, A., Mayo, R., & Willoughby, D. (2004). Acculturation and adherence: Issues for health care providers working with clients of Mexican origin. *Journal of Transcultural Nursing, 15*(4), 331-337.

Bean, F. D., Corona, R., Tuiran, R., Woodrow-Lafield, K. A., & Van Hook, J. (2001). Circular, invisible, and ambiguous migrants: components of difference in estimates of the number of unauthorized Mexican migrants in the United States. *Demography, 38*(3), 411-422.

Beaulaurier, R. L., Craig, S. L., & De La Rosa, M. (2009). Older Latina women and HIV/AIDS: An examination if sexuality and culture as they relate to risk and protective factors. *Journal of Gerontological Social Work, 52*(1), 48-63.

Berger, P. L., & Luckman, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge.* New York, NY: Anchor Books.

Bergman, L., & Cediel, A. (Writers). (June 25, 2013). Rape in the fields (Television series episode). In A. Cediel (Producer), *Frontline.* The Center for Investigative Reporting, PBS and Univisión.

Blackwell, M. (2009). Líderes Campesinas: Nepantla strategies and grassroots organizing at the intersection of gender and globalization. *Aztlán: A Journal of Chicano Studies, 35(*1), 13-47.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method.* Berkeley, CA: University of California Press.

Borre, K., Ertle, L., & Graff, M. (2010). Working to eat: Vulnerability, food insecurity, and obesity among migrant and seasonal farmworker families. *American Journal of Industrial Medicine, 53*, 443-462.

Bronfman, M. (1998). Mexico and Central America. *International Migration, 36*(4), 609-642.

Brammeier, M., Chow, J. M., Samuel, M. C., Organista, K. C., Miller, J., & Bolan, G. (2008). Sexually transmitted diseases and risk behaviors among California farmworkers: Results from a population-based survey. *Journal of Rural Health, 24*(3), 279-284.

Buelna, C., Ulloa, E. C., & Ulibarri, M. D. (2009). Sexual relationship power as a mediator between dating violence and sexually transmitted infections among college women. *Journal of Interpersonal Violence, 24*, 1338-1357.

Burton, J., Darbes, L. A., & Operario, D. (2010). Couples-focused behavioral interventions for prevention of HIV: Systematic review of the state of the evidence. *AIDS Behavior, 14*, 1-10.

Caban, A., & Walker, E. A. (2006). A systematic review of research on culturally relevant issues for Hispanics with diabetes. *Diabetes Education, 32*(4), 484-495.

California Office of Binational Border Health. (2008). *Border health status: Report to the legislature 2006-2007*. Retrieved from http://www.cdph.ca.gov/programs/cobbh/Pages/COBBHCore.aspx

California Family Code, Section 300-310. Retrieved from http://www.leginfo.ca.gov/cgi-
bin/displaycode?section=fam&group=00001-01000&file=300-310

Campbell, W. S. (2008). Lessons in resilience: Undocumented Mexican women in South
Carolina. *Affilia: Journal of Women and Social Work, 23*(3), 231-241.

Campbell, J. C., & Bunting, S. (1991). Voices and paradigms: Perspectives on critical and
feminist theory in nursing. *Advances in Nursing Science, 13*(3), 1-15.

Carballo, M., & Nerukar, A. (2001). Migration, refugees, and health risks. *Emerging infectious
diseases, 7*(3), 556-560.

Carrier, J. M., & Magana, J. R. (1991). Use of ethnosexual data on men of Mexican origin for
HIV/AIDS prevention programs. *Journal of Sex Research, 28*(2), 189-202.

Carroll, D., Samardick, R. M., Bernard, S., Gabbard, S., & Hernandez, T. (2005). *Findings from
the National Agricultural Workers Survey (NAWS) 2001-2002: A demographic and
employment profile of United States Farmworkers.* Burlingame, CA: US Department of
Labor.

Carter-Pokras, O., Zambrana, R. E., Yankelvich, G., Estrada, M., Castillo-Salgado, C., & Ortega,
A. (2008). Health status of Mexican-origin persons: Do proxy measures of acculturation
advance our understanding of health disparities? *Journal of Immigrant and Minority
Health, 10*(6), 475-488.

Castaneda, X., & Zavella, P. (2003). Changing constructions of sexuality and risk: Migrant
Mexican women farmworkers in California. *Journal of Latin American Anthropology,
8(*2), 2-27.

Castro, K. G., Lieb, S., Jaffe, H. W., Narkunas, J. P., Calisher, C. H…& Witte, J. J. (1988).

Transmission of HIV in Belle Glade, Florida: Lessons for other communities in the

United States. *Science, 239*(4836), 193-197.

CDC. (1987). HIV seroprevalence in migrant and seasonal farmworkers--North Carolina, 1987.

MMWR Morbidity and Mortality Weekly Report, 37(34), 517-519.

CDC. (2009). *2009 sexually transmitted diseases surveillance.* Retrieved from

http://www.cdc.gov/std/stats09/default.htm

CDC. (2010). *HIV and AIDS among Latinos.* [Fact Sheet]. Retrieved from

http://www.cdc.gov/nchhstp/newsroom/docs/FastFacts-Latinos-FINAL508COMP.pdf

Cerrutti, M., & Massey, D. S. (2001). On the auspices of female migration from Mexico to the

United States. *Demography, 38*(2), 187-200.

Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative*

analysis. London: Sage.

Charmaz, K. (2008). Constructionism and the grounded theory method. In J. A. Holstein & J. F.

Gubrium (Eds.), *Handbook of constructionist research* (pp. 397-412). New York, NY:

The Guilford Press.

Christianson, M., Lalos, A., Westman, G., & Johansson, E E. (2007). "Eyes wide shut" --

Sexuality and risk in HIV-positive youth in Sweden: A qualitative study. *Scandinavian*

Journal of Public Health, 35, 55-61.

Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn.* Thousand

Oaks, California: Sage.

Clingerman, E. M. (2006). Conceptualizations of health among Mexican and Mexican American women employed in migrant farm work. *Hispanic Health Care International, 4*(1), 45-55.

Cohen, S. (2004). Social relationships and health. *American Psychologist,* 676-684.

Cole, E. B. (1993). *Philosophy and feminist criticism: An introduction.* New York, NY: Paragon House.

Colletti, J., Smith, D., Herrera, S., Herrera, T., & Flores, L. (2006). 2006 Coachella Valley farm worker survey: Final report. Retrieved from http://www.riversidehomeless.org/pdf/FarmWorkerSurvey.pdf

Collins, P. Y., von Unger, H., & Armbrister, A. (2008). Church ladies, good girls, and locas: Stigma and the intersection of gender, ethnicity, mental illness, and sexuality in relation to HIV risk. *Social Science & Medicine, 67*, 389-397.

Connell, R. W. (1987). *Gender and power.* Stanford, CA: Stanford University Press.

Conroy, A. A. (2014). 'It means there is doubt in the house:' Perceptions and experiences of HIV testing in rural Malawi. *Culture, Health and Sexuality: An International Journal for Research, Intervention and Care, 16*(4), 397-411.

Corbett, M., Dickson-Gómez, J., Hilario, H., & Weeks, M. R. (2009). A little thing called love: Condom use in high-risk primary heterosexual relationships. *Perspectives on Sexual and Reproductive Health, 41*(4), 218-224.

Crandall, M., Senturia, K., Sullivan, M., & Shiu-Thornton, S. (2005). Latina survivors of domestic violence: Understanding through qualitative analysis. *Hispanic Health Care International, 3*(3), 179-197.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence

    against women of color. *Stanford Law Review, 43*, 1241-1299.

Cunradi, C. B., Caetano, R., & Schafer, J. (2002). Socioeconomic predictors of intimate partner

    violence among white, black, and Hispanic couples in the US. *Journal of Family*

    Violence, 17(4), 377-389.

Davila, Y. R. (2000). Hispanic women and AIDS: Gendered risk factors and clinical

    implications. *Issues in Mental Health Nursing, 21*, 635-646.

Davila, Y. R. (2005). The social construction and conceptualization of sexual health among

    Mexican American women. *Research and Theory for Nursing Practice: An International*

    Journal, 19(4), 357-368.

Davila, Y. R., & Brackley, M. H. (1999). Mexican and Mexican American women in a battered

    women's shelter: Barriers to condom negotiation for HIV/AIDS prevention. *Issues in*

    Mental Health Nursing, 20, 333-255.

Davis, P. C., & Rankin, L. L. (2006). Gay men and loose women – Southeast Idaho Mexican

    migrant women's beliefs about who gets HIV. *Californian Journal of Health Promotion,*

    4(3), 42-46.

Denner, J., Organista, K. D., Dupree. J. D., & Thrush, G. (2005). Predictors of HIV transmission

    among migrant and marginally housed Latinos. *AIDS and Behavior, 9*(2), 201-210.

DHS. (2008). *Fact sheet: H-2A temporary agricultural worker program.* Retrieved from

    http://www.dhs.gov/xnews/releases/pr_1202308216365.shtm

DHS. (2009). *Definition of terms.* Retrieved from

    http://www.dhs.gov/files/statistics/stdfdef.shtm#15

Dominguez, M. M. (1997). Sex discrimination and sexual harassment in agricultural labor. 6

       Am. U. J. Gender & Law 231, 255.

Duke M. R., & Carpinteiro, F. J. (2009). The effects of problem drinking and sexual risk among

       Mexican migrant workers on their community of origin. *Human Organization, 68*(3),

       328-339.

Early, J., Davis, S. W., Quandt, S. A., Rao, P., Snively, B. M., & Arcury, T. A. (2006). Housing

       characteristics of farmworker families in North Carolina. *Journal of Immigrant and*

       Minority Health, 8(2), 173-184.

Eastern Coachella Valley Social Change Collaborative, HIV Task Force. (2008). Farmworkers

       health survey pilot project. Retrieved from

       http://www.desertaidsproject.org/pdf/Farm_Worker_Report_4-16-09.pdf

Ehrlich, S., Tholandi, M., & Martinez, S. (2006). *HIV risk assessment of Latino day laborers.*

       California Department of Health Services, Office of AIDS.

Farquhar, S., Shadbeh, N., Samples, J., Ventura, S., & Goff, N. (2008). Occupational conditions

       and well-being of indigenous farmworkers. *American Journal of Public Health, 98*(11),

       1956-1959.

Farmworker Justice. (2010). *Introduction to the H-2A program.* Retrieved from

       http://www.fwjustice.org/guestworker-programs/h-2a

Farr, K. A., & Wilson-Figueroa, M. (1997). Talking about health and health care: Experiences

       and perspectives of Latina women in a farmworking community. *Women & Health,*

       25(2), 23-40.

Faugier, J., & Sargeant, M. (1997). Sampling hard to reach populations. *Journal of Advanced*

       Nursing, 26, 790-797.

Fears, D. (2003, August 25). Latinos or Hispanics? A debate about identity. *The Washington Post*, p. A01.

Fernandez, M. I., Collazo, J. B., Hernandez, N., Bowen, S., Varga, L. M., Vila, C. L. et al. (2004). Predictors of HIV risk among Hispanic farm workers in South Florida: Women are at higher risk than men. *AIDS and Behavior, 8*(2), 165-174.

Firestone, J. M., Harris, R. J., & Vega, W. A. (2003). The impact of gender role ideology, male expectancies, and acculturation on wife abuse. *International Journal of Law and Psychiatry, 26*, 549-564.

Fitzgerald, K., Chakraborty, J., Shah, T., Khuder, S., & Duggan, J. (2003). HIV/AIDS knowledge among female migrant farm workers in the Midwest. *Journal of Immigrant Health, 5*(1), 29-36.

Flaskerud, J. H., & Winslow, B. J. (1998). Conceptualizing vulnerable populations health-related research. *Nursing Research, 47*(2), 69-78.

Ford, K., King, G., Nerenberg, L., & Rojo, C. (2001). AIDS knowledge and risk behaviors among Midwest migrant farmworkers. *AIDS Education and Prevention, 13*(6), 551-560.

Fosados, R., Caballero-Hoyos, R., Torres-Lopez, T., & Valente, T. W. (2005). Condom use and migration in a sample of Mexican migrants: Potential for HIV/STI transmission. *Salúd Pública de México, 48*(1), 57-61.

Fox, J., & Rivera-Salgado, G. (2004). *Indigenous Mexican migrants in the United States.* La Jolla, CA: Center for US-Mexican Studies and the Center for Comparative Immigration Studies at the University of California, San Diego.

Fox, A. M., Jackson, S. S., Hansen, N. B., Gasa, N., Crewer, M., & Sikkema, K. J. (2007). In their own voices: A qualitative study of women's risk for intimate partner violence and HIV in South Africa. *Violence Against Women, 13*, 583-602.

Franzini, L., Ribble, J. C., & Keddie, A. M. (2001). Understanding the Hispanic paradox. *Ethnicity & Disease, 11*(3), 496-518.

Fuentes, C. M. (2008). Pathways from interpersonal violence to sexually transmitted infections: A mixed-method study of diverse women. *Journal of Women's Health, 17*(10), 1591-1603.

Galanti, G. A. (2003). The Hispanic family and male-female relationships: An overview. *Journal of Transcultural Nursing, 14*, 180-185.

Gallo, L. C., Penedo, F. J., Espinosa de los Monteros, K., & Arguelles, W. (2009). Resiliency in the face of disadvantage: Do Hispanic cultural characteristics protect health outcomes? *Journal of Personality, 77*(6), 1707-1732.

Gentry, A.L., Grzywacz, J. G., Quandt, S. A., Davis, S. W., & Arcury, T. A. (2007). Housing quality among North Carolina farmworker families. *Journal of Agricultural Safety and Health, 13*(3), 323-337.

Gergen, K. (2009). *An invitation to social construction.* London: Sage.

Gindi, R. M., Erbelding, E. J., & Page, K. R. (2010). Sexually transmitted infection prevalence and behavioral risk factors among Latino and non-Latino patients attending the Baltimore City STD clinics. *Sexually Transmitted Diseases, 37*(3), 191-196.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New Brunswick: Aldine Transaction.

Gomez, C. A., Hernandez, M., & Faigeles, B. (1999). Sex in the new world: An empowerment model for HIV prevention in Latina women. *Health Education and Behavior, 26*, 200-212.

Gonzalez, E. U., Sable, M. R., Campbell, J. D., & Dannerbeck, A. (2010). The influence of patriarchal behavior on birth control access and use among recent Hispanic immigrants. *Journal of Immigrant Minority Health, 12*, 551-558.

Gonzalez-Barrera, A., & Lopez, M. H. (2013). A demographic portrait of Mexican-origin Hispanics in the United States. Retrieved from http://www.pewhispanic.org/2013/05/01/a-demographic-portrait-of-mexican-origin-hispanics-in-the-united-states/

González-Guarda, R. M., Peragallo, N., Urrutia, M. T., Vasquez, E. P., & Mitrani, V. B. (2008). HIV risks, substance abuse, and intimate partner violence among Hispanic women and their intimate partners. *Journal of the Association of Nurses in AIDS Care, 19*(4), 252-266.

González-López, G. (2010). Heterosexuality exposed: Some feminist sociological reflections on heterosexual sex and romance in US Latina/o communities. In M. Asencio (Ed.), *Latina/o sexualities: Probing powers, passions, practices, and policies* (pp. 103-116). New Brunswick: Rutgers University Press.

Gorton, J., & van Hightower, N. R. (1999). Intimate victimization of Latina farm workers: A research summary. *Hispanic Journal of Behavioral Sciences, 21*, 502-507.

Grieco, E. M., Acosta, Y. D., de la Cruz, G. P., Gambino, C., Gryn, T., Larson, L. J., Trevelyan, E. N., & Walters, N. P. (2012). The foreign-born population in the United States: 2010. Retrieved from http://www.census.gov/prod/2012pubs/acs-19.pdf

Guendelman, S. (1987). The incorporation of Mexican women in seasonal migration: A study of

gender differences. *Hispanic Journal of Behavioral Sciences, 9*, 245-264.

Guendelman, S., Malin, C., Herr-Harthorn, B., & Vargas, P. N. (2001). Orientations to

motherhood and male partner support among women in Mexico and Mexican-origin

women in the United States. *Social Science & Medicine, 52*, 1805-1813.

Hancock, T. U. (2007). Sin papeles: Undocumented Mexicanas in the rural United States, *Affilia,

22*(2), 175-184.

Haour-Knipe, M., Leshabari, M. K., & Wihula, G. L. (1998). Interventions for workers away

from their families. In Gibney et al. (Eds.), *Preventing HIV in developing countries:

Biomedical and behavioral approaches* (pp. 257-282). New York: Plenum Press.

Hardesty, M. & Black, T. (1999). Mothering through addiction: A survival strategy among

Puerto Rican addicts. *Qualitative Health Research, 9*(5), 602-619.

Harding, S. (1986). *The science question in feminism*. Ithaca, NY: Cornell University Press.

Harley, K., & Eskenazi, B. (2006). Time in the United States, social support and health behaviors

during pregnancy among women of Mexican descent. *Social Science & Medicine, 62*,

3048-3061.

Harvey, M., Beckman, L. J., Browner, C. H., & Sherman, C. A. (2002). Relationship power,

decision making, and sexual relations: An exploratory study with couples of Mexican

origin. *The Journal of Sex Research, 39*(4), 284-291.

Harvey, S. M., & Bird, S. T. (2004). What makes women feel powerful? An exploratory study of

relationship power and sexual decision-making with African Americans at risk for

HIV/STDs. *Women & Health, 39*(3), 1-18.

Harvey, S. M., Henderson, J. T., & Casillas, A. (2006). Factors associated with effective contraceptive use among a sample of Latina women. *Women & Health, 43*(2), 1-16.

Hazen, A. L., & Soriano, F. I. (2007). Experiences with intimate partner violence among Latina women. *Violence Against Women, 13*, 562-582.

Head Start Act, 42 USC 9801 et seq. (1998). Retrieved from http://www.rcoe.k12.ca.us/childFamily/migrantHeadStart.html

Heilemann, M. V., Lee, K. A., & Kury, F. S. (2002). Strengths and vulnerabilities of women of Mexican descent in relation to depressive symptoms. *Nursing Research, 51*(3), 175-182.

Heilemann, M. V., Lee, K. A., & Kury, F. S. (2005). Strength factors among women of Mexican descent. *Western Journal of Nursing Research, 27*, 949-965.

Hernandez, M. T., Sanchez, M. A., Ayala, L., Magis-Rodriguez, C., Ruiz, J. D., Samuel, M. C…& Lemp, G. F. (2009). Methamphetamine and cocaine use among Mexican migrants in California: The California-Mexico epidemiological surveillance pilot. *AIDS Education and Prevention, 21*(Supp B), 34-44.

Hernandez-Rosete, D., Garcia, O. M., Bernal, E., Castaneda, X., & Lemp, G. (2008). Migration and ruralization of AIDS: Reports on vulnerability of indigenous communities in Mexico. *Revista De Saude Publica, 42*(1), 131-138.

Hester, R. (2009). *Embodied politics: Health promotion in indigenous Mexican migrant communities in California.* Retrieved from ProQuest Digital Dissertations. (UMI 3367724)

Hirsch, J. S. (1999). En el norte la mujer manda: Gender, generation, and geography in a Mexican transnational community. *American Behavioral Scientist, 42*, 1332-1349).

Hirsch, J. S., Higgins, J., Bentley, M. E., & Nathanson, C. A. (2002). The social constructions of

    sexuality: Marital infidelity and sexually transmitted disease—HIV risk in a Mexican

    migrant community. *American Journal of Public Health, 92*(8), 1227-1237.

Hirsch, J. S., Meneses, S., Thompson, B., Negroni, M., Pelcastre, B., & Del Rio, C. (2007). The

    inevitability of infidelity: Sexual reputation, social geographies, and marital HIV risk in

    rural Mexico. *American Journal of Public Health, 97*(6), 986-996.

Hirsch, J. S., Munoz-Laboy, M., Nyhus, C. M., Yount, K. M., & Bauermeister, J. A. (2009).

    They "miss more than anything their normal life back home": Masculinity and

    extramarital sex among Mexican migrants in Atlanta. *Perspectives on Sexual and*

    Reproductive Health, 41(1), 23-32.

Hirsch, J. S., Wardlow, H., Smith, D. J., Phinney, H. M., Parikh, S., & Nathanson, C. A. (2009).

    The secret: Love, marriage, and HIV. Nashville: Vanderbilt University Press.

Hirsch, J. S. (2014). Desire across borders: Markets, migration, and marital HIV risk in rural

    Mexico. *Culture, Health & Sexuality: An International Journal for Research,*

    Intervention and Care. Epub ahead of print.

Holmes, S. M. (2006). An ethnographic study of the social context of migrant health in the

    United States. *PLoS Medicine, 3*(10), 1776-1793.

Hondagneu-Sotelo, P. (1994). *Gendered transitions: Mexican experiences of immigration*. Los

    Angeles: University of California Press.

Hondagneu-Sotelo, P. (2000). Feminism and migration. *Annals of the American Academy of*

    Political and Social Science, 571, 107-120.

Inciardi, J. A., Surratt, H. L., Colon, M. H., Chitwood, D. D., & Rivers, J. E. (1999). Drug use and HIV risks among migrant workers on the DelMarVa Peninsula. *Substance Use and Misuse, 34*(4-5), 653-666.

IOM. (2004). *Glossary on migration.* Retrieved from http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/published_docs /serial_publications/Glossary_eng.pdf

Jones, J. L., Rion, P., Hollis, S., Longshore, S., Leverette, W. B., & Ziff, L. (1991). HIV-related characteristics of migrant workers in rural South Carolina. *Southern Medical Journal, 84*(9), 1088-1090.

Juarbe, T. C. (1998). Cardiovascular disease-related diet and exercise experiences of immigrant Mexican women. *Western Journal of Nursing Research, 20*(6), 765-782.

Kandel, W., & Massey, D. S. (2002). The culture of Mexican migration: A theoretical and empirical analysis. *Social Forces, 80*(3), 981-1004.

Kim-Godwin, Y., & Fox, J. A. (2009). Gender differences in intimate partner violence and alcohol use among Latino-migrant and seasonal farmworkers in rural southeastern North Carolina. *Journal of Community Health Nursing, 26*, 131-142.

Kochhar, R. (2005). *Survey of Mexican migrants: The economic transition to America*. Retrieved from http://pewhispanic.org/reports/report.php?ReportID=58

Khokha, S. (November 5, 2013). Silenced by status, farmworkers face rape, sexual abuse. *National Public Radio.* Transcript retrieved from http://www.npr.org/2013/11/05/243219199/silenced-by-status-farm-workers-face-rape-sexual-abuse

Koniak-Griffin, D., Lesser, J., Nyamathi, A., Uman, G., Stein, J. A., & Cumberland, W. G. (2003). Project CHARM: An HIV prevention program for adolescent mothers. *Family & Community Health, 26*(2), 94-107.

Larson, A. C. (2000). Migrant and seasonal farmworker enumeration profiles study: California. Retrieved from http://www.fwjustice.org/guestworker-programs/h-2a

Lefkowitz, E. S., Romo, L. F., Corona, R., Au, T. K., & Sigman, M. (2000). How Latino American and European American adolescents discuss conflicts, sexuality, and AIDS with their mothers. *Developmental Psychology, 36*, 315-325.

Lesser, J., Koniak-Griffin, D., & Anderson, N. L. (1999). Depressed adolescent mothers' perceptions of their own maternal role. *Issues in Mental Health Nursing, 20*, 131-149.

Lesser, J., Koniak-Griffin, D., Huang, R., Takayanagi, S., & Cumberland, W. G. (2009). Parental protectiveness and unprotected sexual activity among Latino adolescent mothers and fathers. *AIDS Education and Prevention, 21*(Supp B), 88-102.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* London: Sage Publications.

Magis-Rogriguez, C., Lemp, G., Hernandez, M. T., Sanchez, M. A., Estrada, F., & Bravo-Garcia, E. (2009). Going north: Mexican migrants and their vulnerability to HIV. *Journal of Acquired Immune Deficiency Syndrome, 51*, S21-S25.

Martinez-Donate, A. P., Rangel, M. G., Hovell, M. F., Santibanez, J., Sipan, C. L., & Izazola, J. A. (2005). HIV infection in mobile populations: The case of Mexican migrants to the United States. *Revista Panamericana de Salud Pública, 17*(1), 26-29.

Massey, D. S. (1987). Understanding Mexican migration to the United States. *The American Journal of Sociology, 92*(6), 1372-1403.

Maternowska, C., Estrada, F., Campero, L., Herrera, C., Brindis, C. D., & Vostrejs, M. M.

  (2009). Gender, culture and reproductive decision-making among recent Mexican

  migrants in California. *Culture, Health & Sexuality, 12*(1), 29-43.

Matthews, K. A., Gallo, L. C., & Taylor, S. E. (2010). Are psychosocial factors mediators of

  socioeconomic status and health connections? A progress report and blueprint for the

  future. *Annals of the New York Academy of Sciences, 1186,* 146-173.

McGuire, S. (2006). Agency, initiative, and obstacles to health among indigenous immigrant

  women from Oaxaca, Mexico. *Home Health Care Management Practice, 18*, 370-377.

McGuire, S., & Georges, J. (2003). Undocumentedness and liminality as health variables.

  Advances in Nursing Science, 26(3), 185-195.

McLellan-Lemal, E., Toledo, L., O'Daniels, C., Villar-Lourbet, O., Simpson, C., Adimora, A.

  A., & Marks, G. (2013). "A man's gonna do what a man wants to do": African American

  and Hispanic women's perceptions about heterosexual relationships: A qualitative study.

  BMC Women's Health, 13, 27-41.

McQuiston, C., & Gordon, A. (2000). The timing is never right: Mexican views of condom use.

  Health Care for Women International, 21, 277-290.

McVea, K. (1997). Lay injection practices among migrant farmworkers in the age of AIDS:

  Evolution of a biomedical folk practice. *Social Science & Medicine, 45*(1), 91-98.

Mead, G. H. (1934). *Mind, self, and society: From the standpoint of the social behaviorist.*

  Chicago, IL: The University of Chicago Press.

Menjívar, C., & Salcido, O. (2002). Immigrant women and domestic violence: Common

  experiences in different countries. *Gender and Society, 16*(6), 898-920.

Merriam, S. B., Johnson-Bailey, J., Lee, M., Kee, Y., Ntseane, G., & Muhamad, M. (2001).

Power and positionality: Negotiating insider/outsider status within and across cultures.

International Journal of Lifelong Education, 20(5), 405-416.

Mines, R., Nichols, S., & Runsten, D. (2010). *California's indigenous farmworkers.* Retrieved

from http://indigenousfarmworkers.org/index.shtml

Mkandawire-Valhmu, L., Wendland, C., Stevens, P. E., Kako, P. N., Dressel, A. & Kibicho, J.

(2013). Marriage as a risk factor for HIV: Learning from the experiences of HIV-infected

women in Malawi. *Global Public Health, 8*(2), 187-201.

Mondragón, D., & Brandon, J. (2004). To address health disparities on the US-Mexico border:

Advance human rights. *Health and Human Rights, 8*(1), 178-195.

Montenegro, R. A., & Stephens, C. (2006). Indigenous health in Latin America and the

Caribbean. *The Lancet, 367*, 1859-1869.

Moreno, C. L. (2007). The relationship between culture, gender, structural factors, abuse,

trauma, and HIV/AIDS for Latinas. *Qualitative Health Research, 17*, 340-352.

Morin, S. F., Carrillo, H., Steward, W. T., Maiorana, A., Trautwein, M., & Gomez, C. A. (2004).

Policy perspectives on public health for Mexican migrants in California. *Journal of

Acquired Immune Deficiency Syndrome, 37*(Suppl 4), S252-259.

Munoz-Laboy, M., Hirsch, J. S., & Quispe-Lazaro, A. (2009). Loneliness as a sexual risk factor

for male Mexican migrant workers. *American Journal of Public Health, 99*(5), 802-810.

Murdaugh, C., Hunt, S., Sowell, R., & Santana, I. (2004). Domestic violence in Hispanics in the

Southeastern United States: A survey and needs analysis. *Journal of Family Violence,

19*(2), 107-115.

Murillo, J. H., & Cerda, I. (2004). *Indigenous Mexican migrants in the 2000 US Census: "Hispanic American Indians."* In J. Fox & G. Rivera-Salgado (Eds.), Indigenous Mexican migrants in the United States. La Jolla, CA: Center for US-Mexican Studies and the Center for Comparative Immigration Studies at the University of California, San Diego.

National Population Council of the Government of Mexico & the University of California. (2008). *Migration and health: Latinos in the United States*. Mexico: Consejo Nacional de Población.

National Center for Farmworker Health (NCFH). (2011). *HIV/AIDS farmworker factsheet.* Retrieved from http://www.ncfh.org/docs/fs-HIV_AIDS.pdf

NCFH. (2012a). *Facts about farmworkers.* Retrieved from http://www.ncfh.org/docs/fs-Facts%20about%20Farmworkers.pdf

NCFH (2012b). *Demographics.* Retrieved from http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf

Organista, K. C., Organista, P. B., Bola, J. R., Garcia de Alba, J. E., & Moran, M. A. (2000). Predictors of condom use in Mexican migrant laborers. *American Journal of Community Psychology, 28*(2), 245-265.

Organista, K. C., Carrillo, H., & Ayala, G. (2004). HIV prevention with Mexican migrants: Review, critique, and recommendations. *Journal of Acquired Immune Deficiency Syndrome, 37*(Supp 4), S227-S239.

Pan American Health Organization. (2008). *Fact sheet: Gender and HIV/AIDS.* Retrieved from http://www.paho.org/spanish/ad/ge/Gender-HIV1sp.pdf

Parra-Cardona, J. R., Bulock, L. A., Imig, D. R., Villarruel, F. A., & Gold, S. J. (2006). "Trabajando duro todos los dias": Learning from the life experiences of Mexican-origin migrant families. *Family Relations, 55*, 361-375.

Parrado, E. A., Flippen, C. A., & McQuiston, C. (2004). Use of commercial sex workers among Hispanic migrants in North Carolina: Implications for the spread of HIV. *Perspectives on Sexual and Reproductive Health, 36*(4), 150-156.

Parrado, E. A., Flippen, C. A., & McQuiston, C. (2005). Migration and relationship power among Mexican women. *Demography, 42*(2), 347-372.

Passel, J. S. (2005). *Estimates of the size and characteristics of the undocumented population*. Retrieved from http://pewhispanic.org/reports/report.php?ReportID=44

Passel, J. S., & Cohn, D. (2009). *Mexican immigrants: How many come, how many leave?* Retrieved from http://pewhispanic.org/files/reports/112.pdf

Public Health Service Act, Section 330 (42 USCS § 254b). Retrieved from http://bphc.hrsa.gov/policiesre gulations/legislation/authorizing330.pdf

Pulerwitz, J., Amaro, H., De Jong, W., Gortmaker, S. L., & Rudd, R. (2002). Relationship power, condom use and HIV risk among women in the USA. *AIDS Care, 14*(6), 789-800.

Raj, A., Silverman, J. G., & Amaro, H. (2004). Abused women report greater male partner risk and gender-based risk for HIV: Findings from a community-based study with Hispanic women. *AIDS Care, 16*(4), 519-529.

Rhodes, S. D., Foley, K. L., Zometa, C. S., & Bloom, F. R. (2007). Lay Health Advisor interventions among Hispanics/Latinos: A qualitative systematic review. *American Journal of Preventative Medicine, 33*(5), 418-427.

Robley, L. R. (1995). The ethics of qualitative nursing research. *Journal of Professional Nursing, 11*(1), 45-48.

Rodgers, B. L. (2005). *Developing nursing knowledge: Philosophical traditions and influences.* Philadelphia: Lippincott Williams & Wilkins.

Rodriguez, R. A. (1993). *Female migrant farmworkers: The meaning of health within the culture of transience.* Doctoral Dissertation, Texas Women's University. Ann Arbor, MI: UMI.

Rodriguez, R., & Aguilera, D. (June 24, 2013). Female farmworkers and rape: Sexual assault and harassment persist in San Joaquin Valley. *The Huffington Post.* Retrieved from http://www.huffingtonpost.com/2013/06/24/female-farmworkers-rape_n_3491939.html

Rojas-Guyler, L., Ellis, N., Sanders, S. (2005). Acculturation, health protective sexual communication, and HIV/AIDS risk behavior among Hispanic women in a large Midwestern city. *Health Education & Behavior, 32*, 767-779.

Romo, L. F., Nadeem, E., & Kouyoumdjian, C. (2010).Latina/o parent-adolescent communication about sexuality. In M. Asencio (Ed.), *Latina/o sexualities: Probing powers, passions, practices, and policies* (pp. 62-74). New Brunswick: Rutgers University Press.

Rosenthal, R. C. (2011, May). *The crisis in US immigration policy: What does it mean for migrant families?* Presentation conducted at the meeting of the National Association of Community Health Centers, 2011 National Farmworker Health Conference, Delray Beach, FL.

Rothenberg, D. (2000). *With these hands: The hidden world of migrant farmworkers today.* Los Angeles: University of California Press.

Salgado de Snyder, V. N., Acevedo, A., Diaz-Perez, M., Saldivar-Garduno, A. (2000).

    Understanding the sexuality of Mexican-born women and their risk for HIV/AIDS.

    Psychology of Women Quarterly, 24, 100-109.

Sanchez, M. A., Lemp, G. F., Magis-Rogriguez, C., Bravo-Garcia, E., Carter, S., & Ruiz, J. D.

    (2004). The epidemiology of HIV among Mexican migrants and recent immigrants in

    California and Mexico. *Journal of Acquired Immune Deficiency Syndrome, 37*(Supp 4),

    S204-S214.

Sangi-Haghpeykar, H., Poindexter, A. N., Young, A., Levesque, J. E., & Horth, F. (2003). Extra-

    relational sex among Hispanic women and their condom-related behaviours and attitudes.

    AIDS Care, 15(4), 505-512.

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K.

    Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118-137).

    Thousand Oaks, CA: Sage.

Scrivener Version 2.5.0. [Computer software]. (2013). United Kingdom, Literature and Latte.

Section 330, Public Health Service Act (42 USCS § 254b). Retrieved from

    http://bphc.hrsa.gov/policiesre gulations/legislation/authorizing330.pdf

Shattell, M., (2004). Risk: A concept analysis. *Nursing Forum, 39*(2), 11-17.

Shedlin, M. G., Decena, C. U., & Oliver-Velez, D. (2005). Initial acculturation and HIV risk

    among new Hispanic immigrants. *Journal of the National Medical Association, 97*(7),

    32S-37S.

Smallman, S. (2007). *The AIDS pandemic in Latin America.* The University of North Carolina

    Press: Chapel Hill.

Smith, R. C. (2006). *Mexican New York: Transnational lives of new immigrants.* Berkeley, CA:

    University of California Press.

Smith, D. J. (2007). Modern marriage, men's extramarital sex, and HIV risk in Southeastern

    Nigeria. *American Journal of Public Health, 97*, 997-1005.

Smith, S. F., Acuna, J., Feldman, S. R., Vallejos, Q. M., Fleischer, A. B…& Arcury, T. A.

    (2009). Tatooing practices in the migrant Latino farmworker population: Risk for blood-

    borne disease. *International Journal of Dermatology, 48*, 1397-1403.

Sowell, R. L., Holtz. C. S., & Hernandez, G. (2008). HIV infection returning to Mexico with

    migrant workers: An exploratory study. *Journal of the Association of Nurses in AIDS*

    Care, 19(4), 267-282.

Stephen, L. (2007). *Transborder lives: Indigenous Oaxacans in Mexico, California, and Oregon*.

    Durham, NC: Duke University Press.

Sternberg, R. M. (2010). The plight of transational Latina mothers: Mothering from a distance.

    Field Actions Science Report, 1-4.

Suárez-Orozco, C., Todorova, I. L., & Louie, J. (2002). Making up for lost time: The experience

    of separation and reunification among immigrant families. *Family Process, 41*(4), 625-

    643.

Tamayo, W. R. (2000). The role of the EEOC in protecting the civil rights of farm workers. 33

    U.C. Davis Law Review, 1075, 1080.

Telles, E. E., & Ortiz, V. (2008). *Generations of exclusion: Mexican Americans, assimilation,*

    and race. New York, NY: Russell Sage Foundation.

Turner, J. (1991). *The structure of sociological theory*. Wadsworth Publishing Company.

UNAIDS. (2012a). *UNAIDS global AIDS response progress reporting 2012: United States of America country progress report.* Retrieved from

http://www.unaids.org/en/regionscountries/countries/unitedstatesofamerica

UNAIDS. (2012b). *UNAIDS global AIDS response progress reporting 2012: Mexico country progress report.* Retrieved from

http://www.unaids.org/en/regionscountries/countries/mexico

UNAIDS. (2014). *Unite with women: Unite against violence and HIV*. Retrieved December 27, 2014 from

http://www.unaids.org/sites/default/files/media_asset/JC2602_UniteWithWomen_en_0.pdf

United Nations. (2006). *Report of the expert group meeting on measuring international migration: Concepts and methods.* Retrieved from

http://unstats.un.org/unsd/demographic/meetings/egm/migrationegm06/FINAL%20REPORT%20L3.pdf

UNFPA. (2005). The promise of equality: Gender equity, reproductive health and the millennium development goals. Retrieved December 27, 2014 from

http://www.unfpa.org/sites/default/files/pub-pdf/swp05_eng.pdf

USDA. (2014). *Farm labor: Background.* Retrieved from http://www.ers.usda.gov/topics/farm-economy/farm-labor/background.aspx#data

Urizar, C. G., & Winkleby, M. A. (2003). AIDS knowledge among Latinos: Findings from a community and agricultural labor camp survey. *Hispanic Journal of Behavioral Sciences, 25*(3), 295-311.

US Census Bureau. (2008). *American community survey: 2005 subject definitions.* Retrieved

from

http://www.census.gov/acs/www/Downloads/data_documentation/SubjectDefinitions/200

8_ACSSubjectDefinitions.pdf

US Census Bureau. (2014). *Facts for features: Hispanic heritage month 2014.* Retrieved from

http://www.census.gov/newsroom/facts-for-features/2014/cb14-ff22.html

Varela-Ramirez, A., Mejia, A., Garcia, D., Bader, J., Aguilera, R. J. (2005). HIV infection and

risk behavior of Hispanic farm workers at the west Texas-Mexico border. *Ethnicity &

Disease, 15*, 92-96.

Varma, D. S., Chandra, P. S., Callahan, C., Reich, W., & Cottler, L. B. (2010). Perceptions of

HIV risk among monogamous wives of alcoholic men in South India: A qualitative study.

Journal of Women's Health, 19(4), 815-821.

Vaughan, E., & Dunton, G. F. (2007). Difficult socio-economic circumstances and the utilization

of risk information: A study of Mexican agricultural workers in the USA. *Health, Risk &

Society, 9(*3), 323-341.

Wallace, R. A., & Wolfe, A. (1999). *Contemporary sociological theory: Expanding the classical

tradition.* Fifth Edition. Upper Saddle River, NJ: Prentice Hall.

Warf, C. W., Clark, L. F., Desai, M., Rabinovitz, S. J., Agahi, G, Calvo, R., & Hoffman, J.

(2013). Coming of age on the streets: Survival sex among homeless young women in

Hollywood. *Journal of Adolescence, 36*, 1205-1213.

Weatherby, M. L., McCoy, H. V., Bletzer, K. V., McCoy, C. B., Inciardi, J. A., McBride, D. C.,

& Forney, M. A. (1997). Immigration and HIV among migrant workers in rural Southern

Florida. *Journal of Drug Issues, 27*(1), 155-172.

Webster's Universal College Dictionary. (1997). New York: Random House.

Ward, L. S., Tanner, A. D., & Cummings, C. E. (2008). Farmworker health: Measurement and comparison. *Hispanic Health Care International, 6*(2), 89-96.

Waugh, I. M. (2010). Examining the sexual harassment experiences of Mexican immigrant farmworking women. *Violence Against Women, 16*(3), 237-261.

Webber, G. (2007). The impact of migration on HIV prevention for women: Constructing a conceptual framework. *Health Care for Women International, 28*, 712-730.

Welton, M., Bonafonte, M. T., Fernandez, A., Gonzales, P., Kller, V., Mack, M., et al. (2008). Border health status: Report to the legislature, from http://www.cdph.ca.gov/programs/Documents/Border%20Health%20Status%20Report%202006-08.pdf

Whalley, L. E., Grzywacz, J. G., Quandt, S. A., Vallejos, Q. M., Walkup, M…& Arcury, T. A. (2009). Migrant farmworker field and camp safety and sanitation in Eastern North Carolina. *Journal of Agromedicine, 14*(4), 421-436.

Wilkerson, J. A., Yamawaki, N., & Downs, S. D. (2009). Effects of husbands' migration on mental health and gender role ideology of rural Mexican women. *Health Care for Women International, 30*, 614-628.

Wilson, E. K., & McQuiston, C. (2006). Motivations for pregnancy planning among Mexican immigrant women in North Carolina. *Maternal and Child Health Journal, 10*(3), 311-320.

Wingood, G. M., & DiClemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior, 27*(5), 539-565.

Wohl, A. R., Garland, W., Cheng, S., Lash, B., Johnson, D. F., & Frye, D. (2010). Low risk

    sexual and drug-using behaviors among Latina women with AIDS in Los Angeles

    County. *Journal of Immigrant & Minority Health, 12*, 882-893.

Wong, W., Tambis, J. A., Hernandez, M. T., Chaw, J. K., & Klausner, J. D. (2003). Prevalence

    of sexually transmitted diseases among Latino immigrant day laborers in an urban setting

    - San Francisco. *Sexually Transmitted Diseases, 30*(8), 661-663.

Wyatt, G., Myers, H. F., Williams, J. K., Kitchen, C. R., Loeb, T., Vargas, J…Presley, N. (2002).

    Does a history of trauma contribute to HIV risk for women of color? Implications for

    prevention and policy. *American Journal of Public Health, 92*(4), 660-665.

Wyatt, G. E., Myers, H. F., & Loeb, T. B. (2004). Women, trauma, and HIV: An overview. *AIDS*

    and Behavior, 8(4), 401-403.

Zambrana, R. E., Cornelius, L. J., Boykin, S. S., & Lopez, D. S. (2004). Latinas and HIV/AIDS

    risk factors: Implications for harm reduction strategies. *American Journal of Public*

    Health, 94(7), 1152-1158.

Zavella, P. (1997). Playing with fire: The gendered construction of Chicana/Mexicana sexuality.

    In R. N. Lancaster & M. di Leonardo (Eds.), *The gender/sexuality reader: Culture,*

    history, political economy, (pp. 392-408). New York, NY: Routledge.

Zavella, P. (2003). Talkin' sex: Chicanas and Mexicanas theorize about silences and sexual

    pleasures. In G. F. Arredondo, A. Hurtado, N. Klahn, O. Nájera-Ramírez & P. Zavella

    (Eds.), *Chicana feminisms: A critical reader* (pp. 228-253). London: Duke University

    Press.

Zavella, P., & Castaneda, X. (2005). Sexuality and risks: Gendered discourses about virginity

    and disease among young women of Mexican origin. *Latino Studies, 3*, 226-245.

Zavella, P. (2011). *I'm neither here nor there: Mexicans' quotidian struggles with migration and poverty.* Durham. NC: Duke University Press.

Zukoski, A. P., Harvey, S. M., & Branch, M. (2009). Condom use: Exploring verbal and non-verbal communication strategies among Latino and African American men and women. *AIDS Care, 21*(8), 1042-1049.