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The Mediating Role of Emotion Dysregulation in the Association Between Intimate Partner Victimization Types and Symptoms of Depression in Young Hispanic Women

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THE MEDIATING ROLE OF EMOTION DYSREGULATION IN THE ASSOCIATION
BETWEEN INTIMATE PARTNER VICTIMIZATION TYPES AND SYMPTOMS OF
DEPRESSION IN YOUNG HISPANIC WOMEN

A Thesis

by

MARIA GABRIELA COPEIRO DE LESTARPE

Submitted to the Graduate College of
The University of Texas Rio Grande Valley
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THE MEDIATING ROLE OF EMOTION DYSREGULATION IN THE ASSOCIATION
BETWEEN INTIMATE PARTNER VICTIMIZATION TYPES AND SYMPTOMS OF
DEPRESSION IN YOUNG HISPANIC WOMEN

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December 2020

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ABSTRACT

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Intimate Partner Violence (IPV) is defined as the abuse or aggression that occurs in a close relationship. Statistics show that the most prevalent types of IPV are psychological, physical, and sexual. In the U.S. 1 in 4 women (24.4%, or 29.2 million) are victims of IPV before the age of 25. Minorities and socioeconomically disadvantaged women are most likely to experience it. Depression, among others, is one of the harmful consequences resulting from IPV victimization. The present study focuses on the role of emotion dysregulation in the association between IPV and depression. It was hypothesized that emotion dysregulation mediates the association between IPV and depression. The sample studied in the present study consisted of ($N = 892$) Hispanic college undergraduate females attending the University of Texas Rio Grande Valley. The age range was 18 to 29 years old. After running a parallel mediation model and ruling out possible covariates, it was found that IPV subtype—psychological—leads to variance in symptoms of depression through emotion regulation subscale, namely, lack of access to emotion regulation strategies for feeling better when distressed, that IPV subtypes—physical and sexual IPV—lead to variance in symptoms of depression through emotion regulation

subscales, namely, lack of clarity and lack of access to emotion regulation strategies for feeling better when distressed, and that even when childhood maltreatment (CM) was present, sexual IPV leads to variance in symptoms of depression through emotion dysregulation subscales, namely, lack of clarity and lack of access to emotion regulation strategies for feeling better when distressed. Further studies with Hispanic samples in other locations should be conducted as means to compare the findings across groups that contribute to the creation and implementation of effective treatments and helpful resources.

DEDICATION

I humbly dedicate my work to my husband, Edgardo Lestarpe, my children Priscila, Alain, Francis, Olivia, my mother, Irene Copeiro, the memory of my dear grandma Beba, and my sisters, whose love, support and encouragement have sustained and inspired me throughout my entire journey towards the completion of this degree. This work is also dedicated to the memory of my great grandmother, Ana, whose story taught me that a victim of intimate partner violence can rise up from the ashes, like the legendary phoenix.

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I am grateful to Dr. Ruby Charak, chair of my committee, for her competence, trust, support and advice. I will always be grateful to my committee members, Dr. Janene Israel and Dr. Po-Yi Chen. Their expertise, guidance, and valuable suggestions expanded my view and enriched my work. I could not have made it without all of them.

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CHAPTER 1

INTRODUCTION

Intimate Partner Violence Prevalence

Intimate partner violence is defined as the abuse or aggression that occurs in a close relationship. “Intimate partner” refers to both current and former spouses and dating partners. It encompasses acts of violence against an intimate partner or being a victim of the violent act. For the present study, the operational definition of intimate partner violence (henceforth referred to as IPV) would be abuse or aggression that a victim is exposed to in an intimate relationship. It can range from one episode of violence that could have lasting impact to chronic and severe episodes over multiple years (Centers for Disease Control and Prevention [CDC], 2019). Statistics show that the most prevalent types of IPV are psychological, physical, and sexual (World Health Organization, 2012). According to the, CDC (2019), 20 individuals per minute are abused by an intimate partner in the U.S. and approximately 1 in 4 women (24.4%, or 29.2 million) are victims of IPV (Phares, 2019). In many cases, victims of sexual violence, stalking, and IPV experience victimization early in life. More than 71% of the female victims first experience IPV before age 25 years (Niolon et al., 2017; Phares, 2019). IPV affects millions of individuals yearly, with more than one third (36%) of women living in the United States having experienced it. This translates to 42 million women (Chester & Dewall, 2018; DiCorcia, 2018).

IPV impacts women across countries and races, but racial and ethnic minorities and socioeconomically disadvantaged women are most likely to experience it (Phares, 2019). IPV is the most common type of violence against women (Lovestad, 2017) and young females attending college are included in this group. Studies with community and college samples suggest that between 30% and 50% of young adults are involved in some form of IPV and that ethnic minority populations are at heightened risk than their non-Hispanic White counterparts (Archer, 2006; Breiding et al., 2014; Tjaden & Thoennes, 2000; Truman & Morgan, 2014). It is of the utmost importance to examine IPV as it has devastating consequences for the victims and their families.

Consequences of IPV

IPV is a growing issue that has significant long-lasting negative impact on the lives of the victims and their families (CDC, 2019; Domenech & Sirvent, 2017; Sauber, 2014). These include social, physical, and psychological problems, including family dissolution, adverse pregnancy outcomes, poor physical health, mental health disorders, and incarceration (Jackson, 2007; Loxton et al., 2017; Li et al., 2015). Post-concussive syndrome and mild traumatic brain injury may be comorbid or contributing factors to sequelae, such as anxiety or depression in IPV victims (Phares, 2019). Also, temporal or permanent physical harm, PTSD, unemployment, poverty, suicide and death, among others, are consequences suffered by the IPV victims (U.S. Department for Health & Human Services, 2019); in fact, the 2017 Federal Bureau of Investigations report indicates that 35.8% of the murdered women were wives ($n = 509$) or girlfriends ($n = 496$) who were murdered by an intimate partner (Sorenson, 2018). IPV has enormous economic consequences as well. The cost of IPV over a victim's lifetime was \$103,767 for women. The CDC reported that the IPV health-related costs of rape, physical

assault, stalking, homicide, lost productivity from paid work, criminal justice and other costs was \$3.6 trillion (Copp, 2014; Lopez-Sanchez et al., 2019).

Types of IPV

Research indicates that women experience more severe and prolonged negative effects than men as a result of any form of victimization, particularly spousal abuse (Dauvergne, 2002). Research has begun to document that many IPV victims experience several (or all) of these types of victimization and that the types of IPV often coexist (Krebs, 2011; Niolon et al., 2017). The present study focuses on the most prevalent types of victimization, namely, psychological, physical, and sexual in an intimate partner relationship.

Psychological victimization has been defined as the systemic destruction of a person's self-esteem and/or sense of safety occurring in relationships where there are differences in power and control (Follingstand & Dehart, 2000). Psychological IPV includes threats of harm, abandonment, isolation, humiliation, deprivation of contact, abusive behaviors or tactics such as denying emotional responsiveness, discounting, ignoring, denying or forgetting, minimizing, trivializing and/or rejecting (Doherty & Berglund, 2008). Nearly half of all women (47%) have experienced psychological aggression, such as humiliating or controlling behaviors (Niolon et al., 2017). Psychological IPV was the most prevalent type of violence with 21% of students reporting victimization since entering college (Wood, 2020). Physical violence is using physical force that injures a person or puts them in danger. It includes shaking, burning, choking, hair pulling, hitting, slapping, kicking and any type of harm with a weapon (knife or gun). It also includes threats to harm the victim, their children, their pets or family members. Restraining the victim against their will (by tying the victim up or locking them in a space) (U.S. Department of

Health and Human Services, 2020). More than 1 in 3 female victims of IPV experienced physical violence (Phares et al., 2019).

Sexual IPV is sexual activity when consent is not obtained or freely given. Sexual IPV has many forms such as rape or sexual assault, unwanted sexual contact/touching, sexual harassment, sexual exploitation, showing genitals or naked body to the victim without consent, and masturbating in the presence of the victim without consent (National Sexual Violence Resource Center [NSVRC], 2020). Data from the 2017 CDC technical package reports that 16% of women have experienced contact sexual violence from an intimate partner (Niolon et al., 2017). Additionally, studies indicate that among women who were raped, in 51.1% of the cases the perpetrator was either a former or current intimate partner (Phares, 2019).

Why Study IPV in Young Hispanic Women

IPV is a growing issue affecting women across latitudes and races and Hispanic women are no exception. In fact, physical violence by an intimate partner over a lifetime is estimated to be experienced by 29.7% of Hispanic women (Phares et al., 2019; White & Satyen, 2015). Research on IPV and Hispanic women posits that they are more likely to experience poor mental health outcomes and suicidal ideation than non-Hispanic female victims. Additionally, Hispanic women were at disproportionately higher risk of being killed by a partner than their non-Hispanic counterparts (Cummings et al., 2013). Also, in an exploratory study of 33 Latina women, pain and sleeping difficulty were consistently and highly correlated with various forms of IPV (Lacey, 2013; Stockman, 2015). There is a negative association between the rates of IPV among Hispanic women and the availability of resources (psychological, educational, economic, services) that they could use. Perhaps this is due to factors like low socioeconomic status, lack of

educational resources, cultural/language barriers, and immigration issues. Hispanic women experience a variety of adverse health conditions like heart attacks or chronic health problems. They report poorer self-assessed health status. Moreover, in their study Lown and Vega (2001) found that increased somatic symptoms were associated with sexually abused Mexican American women. Disordered eating patterns, physical injuries (e.g., broken bones, facial injuries, head injuries), depression, suicidality, PTSD, mood disorders, sexual and reproductive health outcomes including: discolored vaginal discharge, burning during urination, unwanted pregnancies, menstrual irregularity, as well as sexual risk taking (e.g., multiple sex partners, inconsistent condom use), and consequentially higher likelihood of HIV infection are part of the harmful outcomes Hispanic females suffer (Stockman, 2015). In the academic realm, a study by The American Association of Universities of interpersonal violence on 27 college campuses, found that 9.8% of currently or previous partnered students reported experiencing IPV since starting college (Fisher et al., 2002; Wood, 2020). The impact of IPV includes mental health and academic concerns that can limit safety and educational access in the lives of survivors. Thus, it is imperative that tailored services and policies be created in order to address the unique concerns and accommodations, especially for survivors with exposure to multiple types of IPV (Wood, 2020).

CHAPTER II

REVIEW OF LITERATURE

Link between IPV and Depression

There is a strong link between IPV and mental health symptomology (Johnson et al., 2014; Wood, 2020). Depression is among the most common adverse effects of IPV. An estimated 68% of women exposed to IPV were reported to have major depression (DiCorcia, 2016; Zlotnick et al., 2006). A sound body of research has linked IPV to depression; for example, Lovestad (2017) found that women exposed to controlling behavior, physical, and sexual violence by an intimate partner were more likely to report symptoms of depression. Similarly, other studies reported that higher levels of psychological and sexual IPV were associated with increased depression symptomology (Lovestad, 2017; Machisa et al., 2017; Wood, 2020). It has likewise been demonstrated that when psychological violence includes power and control tactics, the associations between psychological violence and depressive symptoms further increases (Lovestad, 2017). In addition, dating violence at institutions of higher education has been linked with negative mental health impacts, such as increased depression (Wood, 2020).

In intimate partner violence studies, high rates of depression were found for female Hispanic victims of abuse (Caetano & Cunradi, 2003; Terrazas-Carrillo et al., 2016). Chen and colleagues (2009) reported that among Hispanic women in primary care, approximately two-thirds had symptoms of depression.

Furthermore, the Centers for Disease Control and Prevention (CDC) reported that Latinas are more likely to experience moderate and severe depression (9%) as compared to their non-Latina White counterparts (7%) (DiCorcia et al., 2016). Stockman (2015) reported that the psychological impact of IPV on ethnic minority women includes higher rates of depression among other disorders, as compared to their counterparts who have not experienced IPV. Yet, of women who have experienced IPV, Latinas are more likely than non-Latinas to have high levels of depression (Cuevas et al., 2012; Edelson et al., 2007; Sanders-Phillips, 1995). Caetano and Cunradi (2003) found that 38% of Latinas compared to 20% of Whites exposed to IPV had depression (DiCorcia, 2016). A study by Gonzalez-Guarda and colleagues (2009), of a community sample of Hispanic women in South Florida, found an association between reporting a history of IPV (including sexual violence) by a current or most recent partner and depression symptoms in the past week (Basile, 2015).

The Importance of Examining the Various Facets of Emotion Dysregulation

IPV victims experience the symptoms of emotion dysregulation following trauma. The severity of the dysregulation and/or the disorders it evokes will depend on the nature of the trauma and the period of time the victim experience IPV. The DERS domains are broken down into five domains that measure the levels of emotion regulation difficulty. The first domain assessed is the nonacceptance of emotional responses. Research indicates that individuals exposed to traumatic events report higher levels of emotional nonacceptance. Greater cumulative violence exposure leads to increased emotional nonacceptance which in turn leads to severe mental health symptoms (Sunderman et al., 2013). The good news is that a number of psychotherapies intended to treat dysregulation in any of its forms are available. Successful treatments aimed at improving the capacity for emotional acceptance are mindfulness and

acceptance-based psychotherapies. They have already shown success in the reduction of psychological symptoms and the improvement in the capacity to tolerate painful emotional experiences. These types of treatments are especially beneficial for victims of chronic exposure to violence but addressing safety should precede any psychological intervention (Herman, 1992).

The second domain is inability to engage in goal-directed behaviors when distressed, which reflects greater problems behaving in accordance with desired goals, such as relational and health-related goals (Trent et al., 2019). The treatments administered are the Skills Training in Affect and Interpersonal Regulation, Affect Management Treatment, and DBT that incorporate emotion regulation skills (Tull et al., 2007). The third domain, difficulties controlling impulsive behaviors when distressed, is present when the victim cannot tolerate or accept negative emotions and turns aggressive or at risk of engaging in harmful behaviors (self-harm, suicidal practices, binge eating, use of alcohol or drugs (Zvolenski, 2011). According to some researchers, limited access to emotion regulation strategies perceived as effective may measure perceived self-efficacy in emotion regulation rather than effective use of strategies (Andover & Blair, 2014). The last one, the lack of emotional clarity, refers to deficits in one's ability to identify the type of emotions (e.g., fear versus anger) one is experiencing. Lower levels of it have been associated to poorer prosocial adjustment (Butler et al., 2018). The treatments for these last domains encompass the Dialectical Behavior Therapy Skills for Transdiagnostic Emotion Dysregulation (DBT-ST), the Third-wave Cognitive-Behavioral Therapy, Group and Family.

Emotion Dysregulation and Symptoms of Depression in Women

In the case of women, not all the scales of the DERS proved to have a strong correlation with their symptoms of depression (Ehring et al., 2008; Visted et al., 2018). Each one of the DERS subscales are intended to measure certain symptoms associated with depression. As an

illustration, the non-acceptance scale measures the lack of acceptance of defeating events (negative internal), that might contribute to depression vulnerability. The lack of clarity scale (Gratz & Roemer, 2004) proposes such a framework for general emotion regulation abilities consisting of clarity, or the ability to understand what the emotion communicates in order to apply a specific emotion regulation strategy (Sheppes et al., 2015). Deficits in general emotion regulation abilities have been linked to depressive symptomatology by way of negative associations between depressive symptoms and emotional clarity (Vine & Aldao, 2014) and tolerance (Preece et al., 2018). In a study exploring emotion dysregulation as a mediator the group differences were most explained by lack of clarity (29.70%), and difficulties engaging in goal-directed behavior (14.75%) (Prosek et al., 2018). The limited or lack access to emotion regulation strategies scale is associated with a deficit in general emotion regulation abilities that are suggested as complementary processes that likely influence the selection and context-appropriate implementation of emotion regulation strategies (Tull & Aldao, 2015; Visted et al., 2018). The limited access to emotion regulation strategies subscale was uniquely (incrementally) associated with depression severity after comorbidity and the other subscales were controlled (Hallion et al., 2018). In addition, being easily overwhelmed by emotions may hinder the use of effective and adaptive emotion regulation strategies possibly leading to a more rigid use of maladaptive emotion regulation strategies (Tull & Aldao, 2015).

Aims of the Study and Hypotheses

The aims of the present study are two-fold:

1. To examine the rates of lifetime face-to-face IPV types among emerging adult Hispanic women in the age range of 18-29 years.

2. Emotion dysregulation strategies would mediate the association between IPV types—physical, sexual and psychological—and symptoms of depression in adulthood.

Hypothesis

I. It is hypothesized that the rates of intimate partner violence victimization would be higher among the Hispanic young adult women in the Rio Grande Valley when compared with previous studies on White non-Hispanic women (Howard et al., 2019; National Latina Network, 2019; Petrosky et al., 2017).

II. There will be a positive association between the three IPV types and symptoms of depression, and this association will be mediated by emotion dysregulation, in that higher scores on emotion dysregulation subscales will lead to a stronger effect on the association between intimate partner violence victimization types and symptoms of depression.

CHAPTER III

METHODOLOGY AND FINDINGS

Participants

The sample consisted of female college students ($N = 892$) self-identifying their ethnicity as Hispanic, attending the University of Texas Rio Grande Valley. The age range of the sample was 18-29 years old. All protocols were approved by the University of Texas Rio Grande Valley Institutional Review Board for the protection of human subjects (PI: Dr. R. Charak). The age range of the participants was 18 to 29 years old. The present sample self-identified as Hispanic. The reported marital status of the participants was as follows: 780 single, 36 married, 66 cohabitating, 6 separated and 4 divorced. The educational level of the participants was 21.5% Freshman, 28.6% Sophomore, 10.5% Junior, and 19.4% Senior. The yearly household income ranged from less than \$10,000 (14.7%), \$10,000 to 19999 (18.8%), \$20,000 to 29,999 (16%), \$30,000 to \$39,999 (11.2%), \$40,000 to \$49,999 (10.7%), \$50,000 to \$59,999 (9.6%), \$60,000 to \$69,999 (5%), to more than \$70,000 (13.9%).

Measures

Demographic details. The present study assessed the gender, relationship status, income, and education of the participants.

Intimate partner victimization (IPV). The Conflict Tactics Scale-2 Short Form (CTS 2SF; Straus & Douglas, 2004) consists of the subscales of psychological aggression (comprising eight items, including behavior, such as being insulted, sworn at, or shouted at by one's partner), physical assault (comprising 12 items, including behavior such as being pushed or beaten by one's partner), sexual coercion (comprising seven items, including behavior such as being made to have sex with one's partner without using a condom and being physically forced by one's partner to have sex), and injury (comprising five items that described various injuries that were received as a result of partner violence, such as a sprain, bruise, or small cut, and passing out due to a head injury). However, six of the items for the subscale negotiation (actions that are taken to settle a disagreement through discussion) were not used as they were not a part of the study design.

The internal consistency reliability of the subscales ranged from 0.79 to 0.95 (Straus et al., 1996). Given the high correlation between the short and long form version of each CTS2 scale, it is not surprising that the construct validity analyses found that the correlations of five risk factors for partner violence with the maltreatment of a partner measured by the CTS2S scales were generally parallel to the correlation of these risk factors with maltreatment measured by the full CTS2. Certain items required amendment (Straus & Douglas, 2004). Controlling for scores on the socioeconomic status and social desirability scales and for gender of the respondent, resulted in the following correlations between the short form and the full scale: Negotiation. $r = .89$ for Negotiation by the respondent. and $r = .88$ for Negotiation by the partner Physical Assault. $r = .72$ for Assaults by the respondent on the partner. and $r = .69$ for Assaults by the partner on the respondent, Injury $r = .94$ for Injuries to the respondent, and $r = .94$ for Injuries to the partner as reported by the respondent, Sexual Coercion $r = .65$ for Sexual

Coercion by the respondent, and $r = .67$ for Sexual Coercion by the partner, Psychological Aggression, $r = .77$ for Psychological Aggression by the respondent. and $r = .69$ for Psychological Aggression by the partner. These indicates that both constructs are highly correlated (Straus & Douglas, 2004). The Cronbach's alpha coefficient of the CTS-2 total scale and subscales suggests good internal consistency (Lau et al., 2008). The Cronbach's alpha for the present study indicates high internal consistency and reliability for the sample, ($\alpha = .90$).

Emotion dysregulation. The Difficulties in Emotion Regulation Scale-16 (DERS-16; Bjureberg et al., 2016) was created by selecting items from the DERS based on their item-total correlations and their ability to represent or improve the construct validity of the subscale in questions, and by eliminating redundant items. Five of the original six subscales were represented by the items (lack of emotional awareness was omitted in DERS-16). The psychometric properties of the DERS-16 were examined using a Swedish sample of women in therapy for deliberate self-harm and two American samples of individuals with mood or emotion dysregulation. As with the original DERS, respondents rate the extent to which each item applies to them on a 5-point Likert-type scale from 1 (*almost never*) to 5 (*almost always*). Total scores on the DERS-16 can range from 16 to 80, with higher scores reflecting greater levels of emotion dysregulation. The results of the analyses showed that the DERS-16 retained excellent internal consistency, good test-retest reliability, and good convergent and discriminant validity. The internal consistency of the DERS-16 has been found to be excellent ($\alpha = .92$) for the Swedish sample. Likewise, test-retest reliability of the DERS-16 was also found to be good ($\rho_I = .85$; $p < .001$). The correlations of the DERS-16 and original 36-item DERS with the other measures were very similar (with only minor differences ranging from $r = .00$ to $r = .04$) and did not differ significantly from one another. The DERS-16 was shown to have satisfactory psychometric

properties, similar to those of the original DERS. Specifically, the DERS-16 consistently demonstrated high magnitude correlations with the original 36-item version of the DERS, excellent internal consistency, good test-retest reliability, and convergent and discriminant validity (Bjureberg et al., 2016).

In a study by Charak et al. (2019), this scale was administered to samples consisted of (635 adolescents and 1807 adults) Caucasian, Hispanics, Asian, African American and multi-racial female participants admitted to a specialized psychiatric hospital in the Southern USA, and hence DERS-16 can be administered to adults and adolescents from varied racial/ethnic background. Education level was above the national average with 88.0% indicating some college experience. Charak's study indicated that the internal reliability for the subscales ranged from .80 to .92 for adolescents and .80 to .90 for adults. These results were consistent with those of Bjureberg et al. (2016), in which the results obtained indicated that the scale had high internal consistency across three samples of women from the community and in psychiatric care ($\alpha = .92-.94$), good test-retest reliability ($p = .85, p < .001$), and adequate construct validity. The internal reliability for the full scale for adults was 0.94. The internal reliability for the subscales ranged from .80 to .90 for adults. The Cronbach's alpha for the five emotion regulation subscales in the present study were lack of emotional clarity $\alpha = .91$; difficulties engaging in goal-directed behavior $\alpha = .81$; difficulty regulating behavior when distressed (Impulse) $\alpha = .83$; limited/lack access to emotion regulation strategies for feeling better when distressed $\alpha = .90$; and willingness to accept certain emotional responses (Nonacceptance) $\alpha = .89$, indicating optimal reliability and consistency for the sample.

Symptoms of depression. The Patient Health Questionnaire (PHQ) evaluates passive thoughts of death or self-injury within the last two weeks and is often used to screen depressed

patients for suicide risk (Kroenke et al., 2001). The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as “0” (not at all) to “3” (nearly every day). The PHQ-9 was completed by 6,000 patients in 8 primary care clinics and 7 obstetrics-gynecology clinics. Construct validity was assessed using the 20-item Short-Form General Health Survey, self-reported sick days and clinic visits, and symptom-related difficulty. Data from 2 studies totaling 6,000 patients provide strong evidence for the validity of the PHQ-9 as a brief measure of depression severity. Criterion validity was demonstrated in the sample of 580 primary care patients who underwent an independent re-interview by a mental health professional.

The internal reliability of the PHQ-9 was excellent, with a Cronbach's α of .89 in the PHQ Primary Care Study, and 0.86 in the PHQ OB-GYN study. Test-retest reliability of the PHQ-9 was also excellent. PHQ-9 scores were greatest for the scales that previous studies have shown should be most strongly related to depression, i.e., mental health, followed by social, overall, and role functioning, with a lesser relationship to pain and physical functioning. Third, most pairwise comparisons within each SF-20 scale between successive PHQ-9 levels were highly significant. The PHQ-9 correlated most strongly with mental health (.73), followed by general health perceptions (.55), social functioning (.52), role functioning (.43), physical functioning (.37), and bodily pain (.33). When the PHQ-9 was examined as a continuous variable, its correlation was .39 with disability days, .24 with physician visits, and .55 with symptom-related difficulty. Correlations of the single symptom-related difficulty item with the SF-20 scales in the primary care sample were .53 for mental health, .42 for general health perceptions, .40 for social functioning, .38 for role functioning, .27 for bodily pain, and .27 for physical functioning. Although slightly lower in the obstetrics-gynecology sample, correlations showed a similar rank order (Kroenke, Spitzer, & Williams, 2001). The PHQ-9 has been used in

Hispanics as well. Merz et al. (2011) conducted a study in which the participants were a community sample of 479 women who self-identified as Hispanic American (English-speaking = 245, Spanish-speaking = 234) from San Diego County. The ages of participants ranged from 18 to 80. In general, English-speaking respondents were born in the United States (63.7%) and had some college education (40.0%). Spanish-speaking respondents were mostly born in Mexico (87.6%) and had less than a high school education (72.5%). Mean PHQ-9 scores were not significantly different between groups, $t(477) = -.356, p > .05$. In total, 12.9% ($n = 62$) of all participants in the sample met criteria for depression with scores ≥ 10 , the clinical cut-off. Cronbach's alphas were calculated for the English and Spanish groups. In the sample, the internal consistency was good for English ($\alpha = .84$) and Spanish ($\alpha = .85$) versions (Merz et al., 2011). Internal consistency and reliability for the sample in the present study were high as indicated by the Cronbach's alpha coefficient ($\alpha = .91$).

Procedure

Data for the present study were collected from students enrolled in undergraduate psychology courses at UTRGV through an online survey in Qualtrics via SONA, an automated student participatory pool. The UTRGV Institutional Review Board approved the study protocol (PI: R. Charak) and the students were asked to provide consent before participating. The inclusionary criteria in the present study were (i) age range of 18-29 years, (ii) a United States citizen or legal resident, and (iii) having or had been in a romantic relationship in the past. Data collection took place between January 2017-December 2019.

Data Analysis

Before conducting the analysis, the dataset was checked for missing data. The data were then analyzed using statistical software SPSS version 26. Cases from the dataset presenting missing values were selected and removed along with those cases that did not meet the inclusionary criteria (e.g., participants older than 29 years-old and graduate students). Then, descriptive and frequency tables were created. Pearson's correlation analysis (r) was conducted to determine correlation between the study variables. The PROCESS 3.5 macro in SPSS was employed to examine the mediating role of five subtypes of emotion dysregulation on the association between the three types of face-to-face IPV—physical, sexual and psychological—and symptoms of depression among college-going young women. The number of Bootstrap samples used were 5,000 for all the analyses. Since PROCESS allows examining mediation models with only one independent variable, three-separate multiple mediation models were run with independent variables, namely, Physical IPV, Psychological IPV, and Sexual IPV (Figure 1). Thus, in each model (Models 1, 2 and 3), the path a coefficients for the psychological, physical, and sexual IPV to the five subscales of difficulties in emotion regulation—lack of emotional clarity, difficulty engaging in goal-directed cognition and behavior when distressed, difficulty regulating behavior when distressed (impulse), lack of access to emotion regulation strategies for feeling better, and willingness to accept certain emotional responses (nonacceptance)—and path b , difficulties in emotion regulation subscales to symptoms of depression were calculated. Next, the dependent variable (symptoms of depression) was regressed onto the IPV types and difficulties in emotion regulation/emotion dysregulation subscales to determine if IPV no longer predicts the symptoms of depression or is lessened

predicting it when controlling for the emotion dysregulation variable. Finally, childhood maltreatment was added as a covariate controlling for its effects of emotion dysregulation subscales and symptoms of depression.

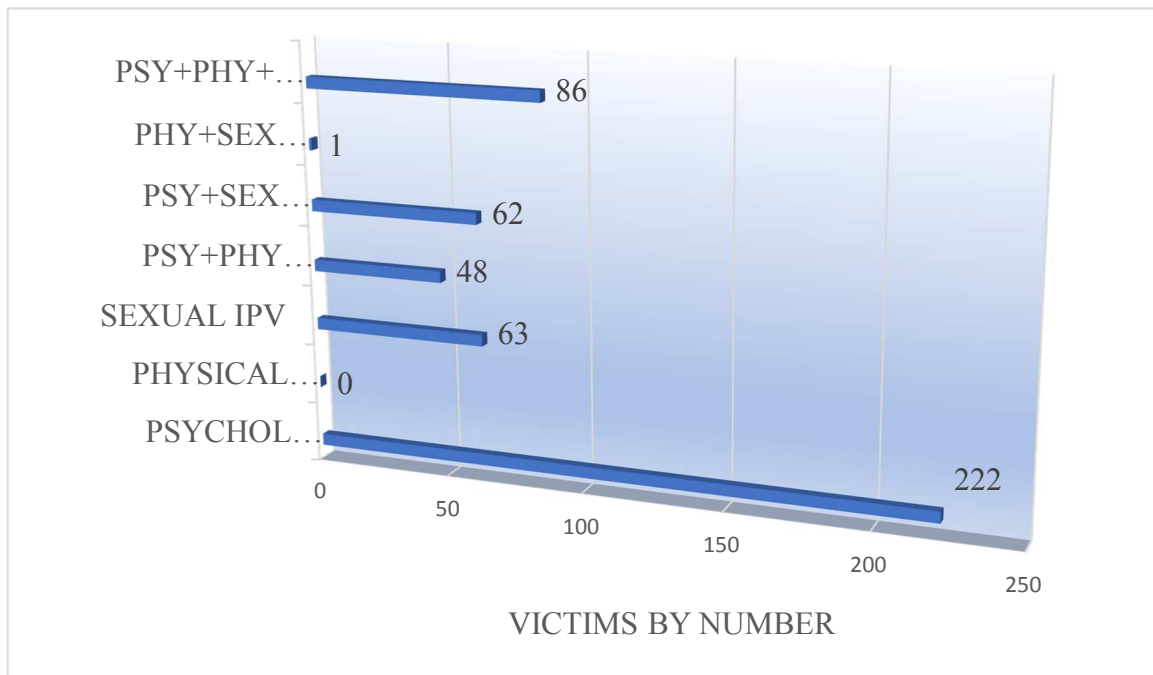
CHAPTER IV

RESULTS

The cases from the dataset presenting missing values were selected and removed along with those cases that did not meet the inclusionary criteria ($n = 35$). Descriptive and frequency tables were created. Findings pertaining to the distribution of participants per IPV types are depicted in the Figure 1 below.

Figure 1.

Frequency distribution of young adult females as per Intimate Partner Violence (IPV) Types



Note. PSYC = Psychological face-to-face IPV. PHY = Physical face-to-face IPV. Sexual = Sexual face-to-face IPV. $N = 892$.

The correlation analysis between the variables indicated significant and positive correlation between these (**Table 1**).

Table 1.
Correlations between IPV types, five domains of the difficulty in emotion dysregulation and depression among Hispanic women (N = 892).

	1	2	3	4	5	6	7	8	9	Mean	SD
1 Psychological IPV										0.47	0.5
2 Physical IPV	.44**									0.15	0.36
3 Sexual IPV	.25**	.40**								0.24	0.42
4 Clarity	.04	.07*	.11**							4.8	2.34
5 Goals	.04	.06	.06	.61**						7.6	3.53
6 Impulse	.12**	.17**	.09**	.53**	.62**					5.45	3.13
7 Strategies	.08*	.11**	.11**	.66**	.78**	.74**				11.18	5.5
8 Nonacceptance	.05	.07*	.06	.63**	.71**	.65**	.84**			7.14	3.63
9 Depression	.08*	.07*	.10**	.58**	.53**	.49**	.61**	.55**		8.7	6.53

Note. IPV = Intimate partner victimization during adulthood. Clarity = Lack of emotional clarity.

Goals = Difficulties Engaging in goal-directed behavior. Impulse = Difficulties regulating behavior when distressed. Strategies = Lack of access to emotion regulation strategies for feeling better when distressed. Nonacceptance = Willingness to accept certain emotional responses.

* $p < .05$, ** $p < .01$.

The Psychological, Physical, and Sexual IPV Models

Psychological IPV → DERS subscales → Depression. For model 1, psychological IPV victimization was positively associated with lack of access to emotion regulation strategies, which in turn was associated with depression. Furthermore, the indirect/mediating effect of psychological IPV victimization on depression through lack of access to emotion regulation strategies was significant ($B = .317$; $SE = .146$; $CI = .0703-.628$). Partial significant associations

were found between Psychological IPV and Difficulty regulating behavior when distressed (Impulse) (Path *a*, $B = .742$, $SE = .209$, $p < .05$, $CI = .332-1.152$); and between Lack of emotional clarity and symptoms of depression (Path *b*, $B = .852$, $SE = .097$, $p < .05$, $CI = .661-1.04$). There were no significant associations between Psychological IPV and lack of emotion clarity (Path *a*, $B = .164$, $SE = .157$, $p = .295$); difficulty engaging in goal-directed cognition and behavior when distressed (Goals) ($B = .024$, $SE = .035$, $CI = -.027-.113$); difficulty regulating behavior when distressed (Impulse) (Path *b*, $B = .090$, $SE = .079$, $p = .256$, $CI = -.065-.246$); and willingness to accept certain emotional responses (Nonacceptance) ($B = .037$, $SE = .048$, $CI = -.033-.159$).

There was no direct effect of psychological IPV on depression ($B = .397$; $SE = .335$; $p = .236$, $CI = .1241-1.804$). **Physical IPV → DERS subscales → Depression.** For model 2, the indirect effect of physical IPV victimization on depression through two emotion dysregulation subscales—lack of clarity and lack of access to emotion regulation strategies—were found to be significant (lack of clarity: $B = .410$; $SE = .196$; $CI = .047-.819$) and (strategies: $B = .585$; $SE = .225$; $CI = .196-1.064$), with physical IPV victimization predicting more difficulties in emotional clarity and lack of access to strategies, which in turn lead to greater scores in depression. Partial associations were found between Physical IPV and Difficulty regulating behavior when distressed (Impulse) (Path *a*, $B = 1.46$, $SE = .29$, $p < .05$, $CI = .89-2.01$); and between willingness to accept certain emotional responses (Non-acceptance) (Path *a*, $B = .688$, $SE = .34$, $p < .05$, $CI = .022-1.35$). Moreover, there were no significant associations between Physical IPV and difficulty engaging in goal-directed cognition and behavior when distressed (Goals), ($B = .007$, $SE = .008$, $CI = -.006-.028$), difficulty regulating behavior when distressed (Impulse) (Path *b*, $B = .098$, $SE = .079$, $p = .217$, $CI = -.058-.255$); and willingness to accept certain emotional responses (Non-acceptance) (Path *b*, $B = .100$, $SE = .085$, $p = .239$, $CI = -.067-.268$). There was not a significant

association between physical IPV and Depression ($B = .006$; $SE = .469$; $CI = -.917-.928$). **Sexual IPV→DERS subscales→Depression.** For model 3, the indirect effects of sexual IPV victimization on depression through two emotion dysregulation subscales—lack of clarity and lack of access to emotion regulation strategies—were found to be significant (lack of clarity: $B = .515$; $SE = .170$; $CI = .205-.874$) and (lack of access to emotion regulation strategies: $B = .488$; $SE = .183$; $CI = .172-.892$), with sexual IPV victimization leading to lesser emotional clarity and deficits in strategies (lack of clarity and lack of access to emotion regulation strategies subscales), leading to greater scores in depression. Partial associations were found between Sexual IPV and Difficulty regulating behavior when distressed (Impulse) (Path a , $B = .67$, $SE = .25$, $p < .05$, $CI = .18-1.14$). There were no significant associations between difficulty engaging in goal-directed cognition and behavior when distressed (Goals) ($B = .433$, $SE = .049$, $CI = -.034-.167$); difficulty regulating behavior when distressed (Impulse) (Path b , $B = .097$, $SE = .079$, $p = .217$, $CI = -.057-.253$), and willingness to accept certain emotional responses (Non-acceptance) ($B = .055$, $SE = .064$, $CI = -.044-.207$). In addition, the association between sexual IPV victimization and depression was not significant ($B = .343$; $SE = .394$; $CI = -.429-1.116$). A summary of the significant and non-significant associations found among the variables are presented below in Tables 2 and 3 respectively.

Table 2*Significant indirect effects in the association between Psychological, Physical, and Sexual**Intimate Partner Violence Victimization (IPV), based on development of emotion dysregulation**symptoms as per DERS subscales and depression among young adult females in the Rio Grande**Valley.*

Pathways	Indirect effect (B)	Indirect effect 95% CI
IPV Types→ DERS Subscales→ Depression		
1 Psychological IPV→Lack access to effective E.R. strategies→Depression	.32	.07-.63
IPV Types→ DERS Subscales→ Depression		
2 Physical IPV→Lack of emotional clarity→Depression	.41	.04-.82
3 Physical IPV→Lack access to effective E.R. strategies→Depression	.59	.20-1.07
IPV Types → DERS Subscales→ Depression		
4 Sexual IPV→Lack of emotional clarity→Depression	.51	.20-.87
5 Sexual IPV→Lack access to effective E.R. strategies→Depression	.49	.18-.88

Note. E.R.= Emotion Regulation

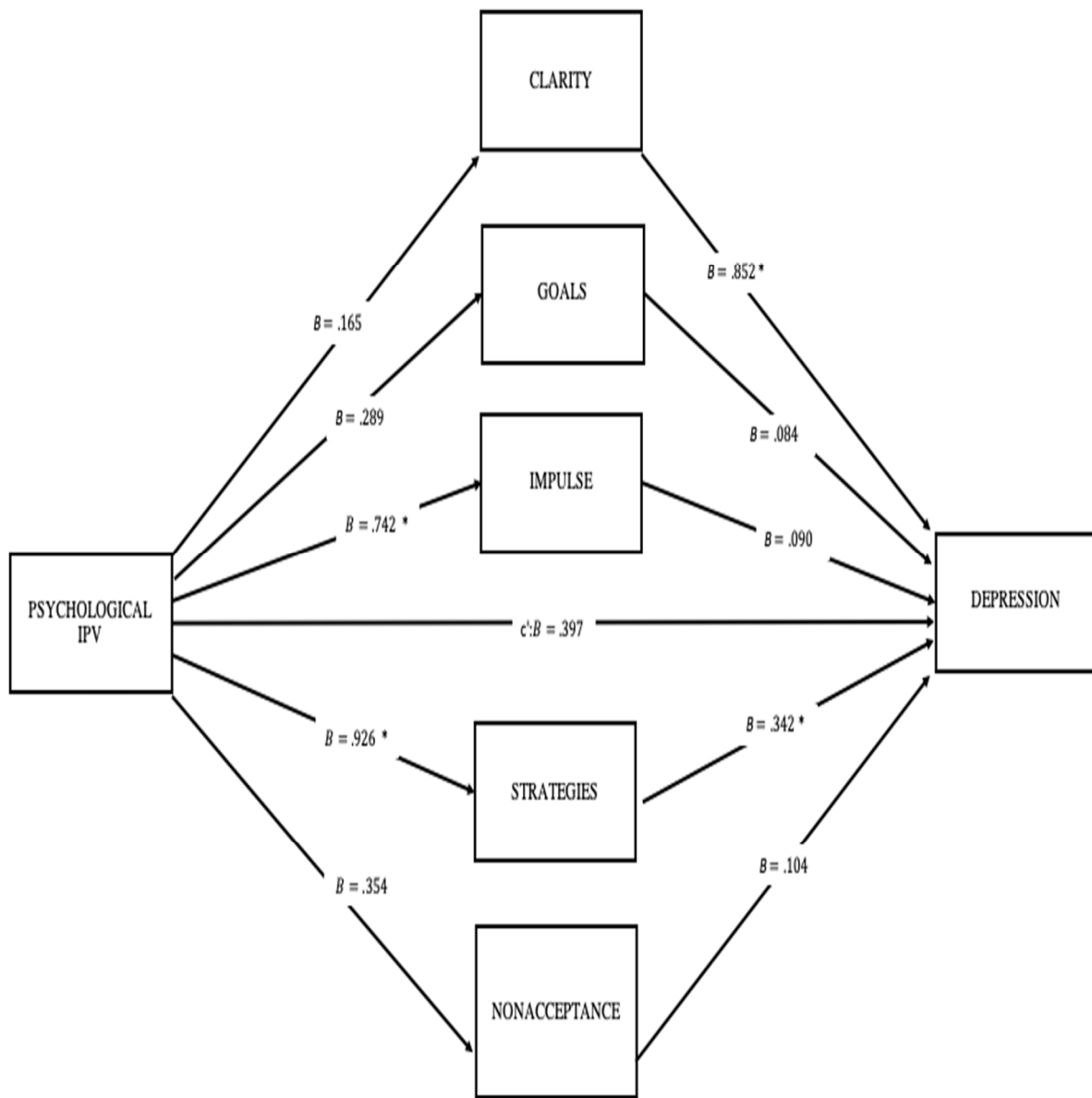
Table 3

Non-Significant indirect effects in the association between Psychological, Physical, and Sexual Intimate Partner Violence (IPV) Victimization based on development of emotion dysregulation symptoms as per DERS subscales and depression among young adult females in the Rio Grande Valley.

Pathways	Indirect Effect (B)	Indirect Effect 95% CI
IPV Types → DERS Subscales → Depression		
1 Psychological IPV → Lack of emotional clarity → Depression	.14	-.11-.42
2 Psychological IPV → Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) → Depression	.03	-.03-.11
3 Psychological IPV → Difficulty regulating behavior when distressed (Impulse) → Depression	.07	-.07-.23
4 Psychological IPV → Willingness to accept certain emotional responses (Non-Acceptance) → Depression	.04	-.03-.16
IPV Types → DERS Subscales → Depression		
5 Physical IPV → Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) → Depression	.46	-.04-.18
6 Physical IPV → Difficulty regulating behavior when distressed (Impulse) → Depression	.14	-.11-.44
7 Physical IPV → Willingness to accept certain emotional responses (Non-Acceptance) → Depression	.07	-.07-.26
IPV Types → DERS Subscales → Depression		
8 Sexual IPV → Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) → Depression	.04	-.03-.17
9 Sexual IPV → Difficulty regulating behavior when distressed (Impulse) → Depression	.07	-.05-.21
10 Sexual IPV → Willingness to accept certain emotional responses (Non-Acceptance) → Depression.	.06	-.04-.21

Based on these findings, there was an indirect effect of the three types of IPV victimization on depression through two emotion dysregulation facets, namely, lack of clarity and lack of access to emotion regulation strategies subscales.

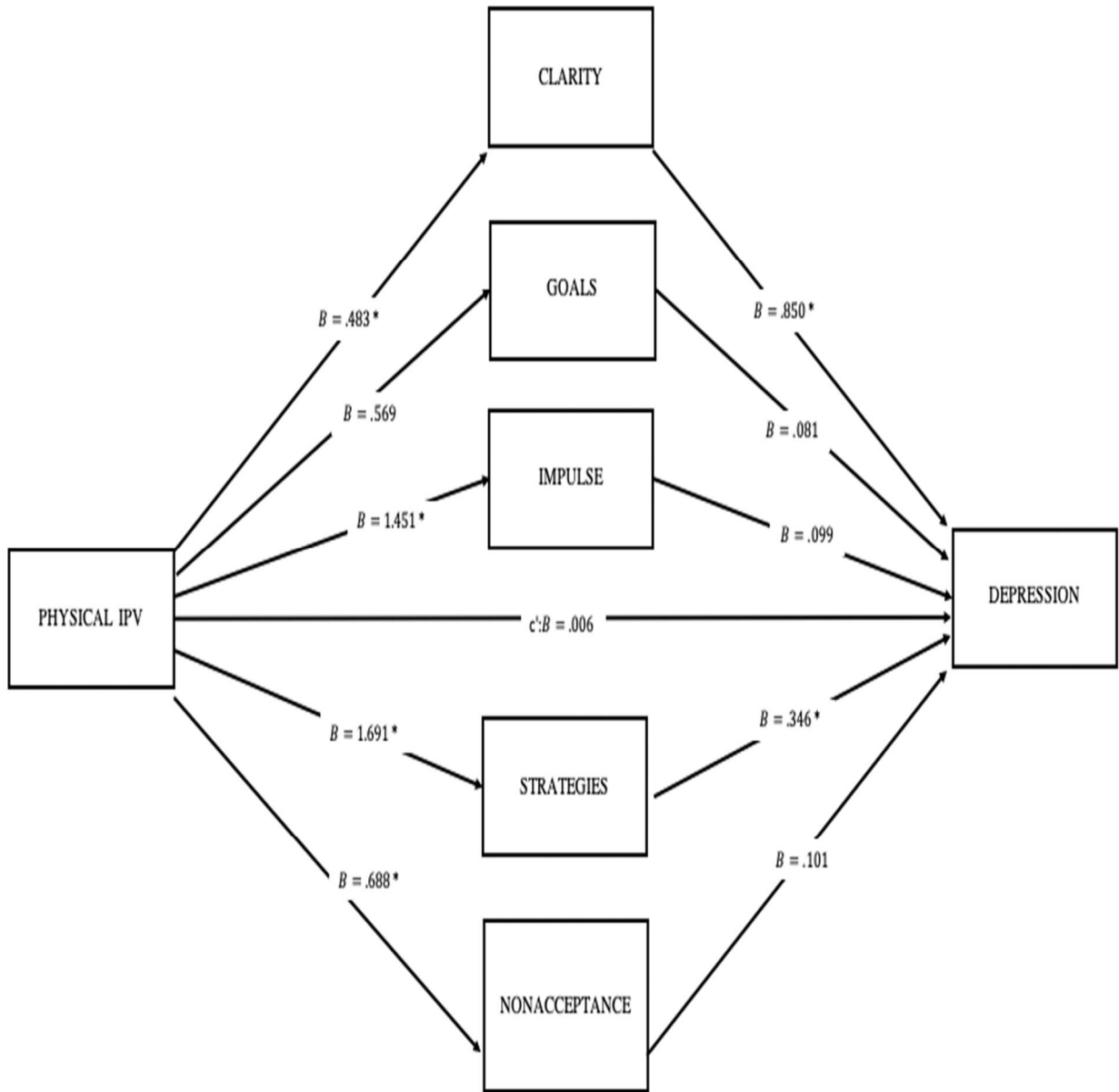
Figure 2
Statistical Diagram of Model 1. The association between Psychological IPV, five domains of the difficulty in Emotion Dysregulation, and depression among Hispanic female college students.



Note: significant values = $<.05^*$

Figure 3

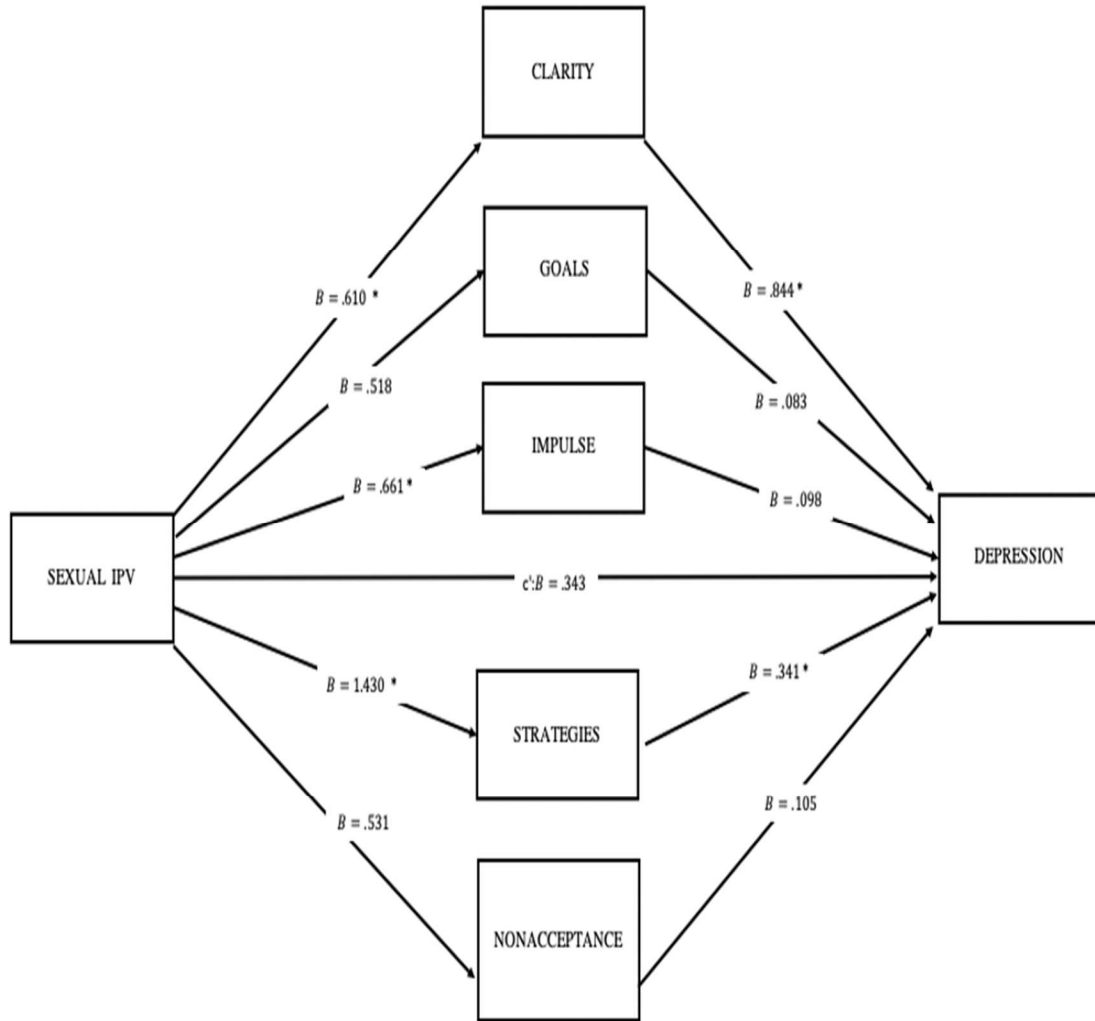
Statistical Diagram of Model 2. The association between Physical IPV, five domains of the difficulty in Emotion Dysregulation, and depression among Hispanic female college students.



Note: significant values = $<.05^*$

Figure 4

Statistical Diagram of Model 3. The association between Sexual IPV, five domains of the difficulty in Emotion Dysregulation, and depression among Hispanic female college students



Note: significant values = $<.05^*$

Childhood Maltreatment as a covariate

A series of subsequent regression analyses controlling for childhood maltreatment as a covariate were conducted. The number of bootstrap samples was 5,000. For models 1 and 2, psychological and physical IPV victimization, respectively, only partial associations between the

variables were found between IPV (psychological and physical victimization), difficulty regulating behavior when distressed (impulse), lack of emotional clarity and lack of access to emotion regulation strategies. For these models, high levels of IPV victimization predicted higher levels of difficulty regulating behavior when distressed (Impulse), whereas high levels of lack of emotional clarity and lack of access to emotion regulation strategies predicted higher levels of symptoms of depression. In the case of model 3, significant results were found, where sexual IPV victimization predicted lack of clarity, which in turn predicted depression symptoms. (Path *a*, $B = .366$, $p < .05$, $SE = .183$, $CI = .007-.725$); (Path *b*, $B = .793$, $SE = .096$, $95\% CI = .605-.981$); and sexual IPV victimization predicted lack of access to emotion regulation strategies (Path *a*, $B = .815$, $SE = .423$, $p < .054$, $CI = -.015-1.644$); (Path *b*, $B = .313$, $SE = .068$, $p < .05$, $CI = .179-.447$). Thus, the indirect effect of sexual IPV victimization on depression through lack of clarity was significant (Total indirect effect; $B = .291$; $SE = .158$; $CI = .005-.622$); and the indirect effect of sexual IPV victimization through lack of access to emotion regulation strategies was significant as well (Total indirect effect, $B = .255$, $SE = .149$, $CI = .002-.587$), even after controlling for CM covariate, Sexual IPV victimization predicted lack of emotional clarity and lack of access to emotion regulation strategies, respectively, which in turn predicted the symptoms of depression. Below table 4 illustrates the significant indirect effects found after controlling for childhood maltreatment (CM).

Table 4

Significant indirect effects with Childhood Maltreatment (CM) as a covariate in the association between Sexual Intimate Partner Violence (IPV) Victimization based on development of emotion dysregulation symptoms as per DERS subscales and depression among young adult females in the Rio Grande Valley.

Pathways	Indirect Effect (B)	Indirect Effect 95% CI
IPV Types → DERS Subscales → Depression		
1 Sexual IPV → Lack of emotional clarity → Depression	.29	.005-.62
2 Sexual IPV → Lack of access to E.R. strategies → Depression	.26	.002-.59

Note: E.R.= Emotion (dys)regulation

Concurrently, the childhood maltreatment (CM) covariate, although not of primary interest in this study, surfaced as a predictor for the five emotion dysregulation subscales (Model 1 psychological IPV: Lack of emotional clarity $B = .039$, $SE = .005$, $p < .05$; Difficulty regulating behavior when distressed (Impulse) $B = .043$, $SE = .008$, $p < .05$; Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) $B = .054$, $SE = .007$, $p < .05$; Lack of access to emotion regulation strategies for feeling better when distressed $B = .096$, $SE = .012$, $p < .05$; Willingness to accept certain emotional responses (Non-acceptance) $B = .055$, $SE = .008$, $p < .05$), (Model 2 Physical IPV: Lack of emotional clarity $B = .038$, $SE = .005$, $p < .05$; Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) $B = .043$, $SE = .008$, $p < .05$; Difficulty regulating behavior when distressed (Impulse) $B = .051$, $SE = .007$, $p < .05$; Lack of access to emotion regulation strategies for feeling better when distressed $B = .094$, $SE = .012$, $p < .05$; Willingness to accept certain emotional responses (Non-acceptance) $B = .054$, $SE = .008$, $p < .05$), (Model 3 Sexual IPV Lack of emotional clarity: $B = .037$, $SE = .005$,

$p < .05$; Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) $B = .042$, $SE = .008$, $p < .05$; Difficulty regulating behavior when distressed (Impulse) $B = .054$, $SE = .007$, $p < .05$; Lack of access to emotion regulation strategies for feeling better when distressed $B = .094$, $SE = .012$, $p < .05$; Willingness to accept certain emotional responses (Non-acceptance) $B = .054$, $SE = .008$, $p < .05$), and for the symptoms of depression variable in the three models (Model 1 Psychological IPV: $B = .074$, $SE = .012$, $p < .05$; Model 2 Physical IPV: $B = .077$, $SE = .012$, $p < .05$; Model 3 Sexual IPV $B = .075$, $SE = .012$, $p < .05$) Therefore, childhood maltreatment (CM), explained part of the variability in the outcome, with greater childhood maltreatment scores being associated with higher levels of emotion dysregulation, which in turn accounted for higher levels of depression. Table 5 below shows the non-significant indirect effects in the association among IPV types, emotion dysregulation, and depression variables with childhood maltreatment as a covariate.

Table 5

Non-Significant indirect effects with Childhood Maltreatment (CM) as a covariate in the association between Psychological, Physical, and Sexual Intimate Partner Violence (IPV) Victimization based on development of emotion dysregulation symptoms as per DERS subscales and depression among young adult females in the Rio Grande Valley.

Pathways	Indirect Effect (B)	Indirect Effect 95% CI
IPV Types → DERS Subscales → Depression		
1 Psychological IPV → Lack of clarity → Depression	.02	-.22-.26
2 Psychological IPV → Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) → Depression	.02	-.05-.09
3 Psychological IPV → Difficulty regulating behavior when distressed (Impulse) → Depression	.02	-.077-.13
4 Psychological IPV → Lack of access to E. R. strategies → Depression	.18	-.03-.45
5 Psychological IPV → Willingness to accept certain emotional responses (Non-Acceptance) → Depression	.02	-.04-.10
IPV Types → DERS Subscales → Depression		
6 Physical IPV → Lack of Clarity → Depression	.13	-.21-.48
7 Physical IPV → Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) → Depression	.02	-.06-.14
8 Physical IPV → Difficulty regulating behavior when distressed (Impulse) → Depression	.05	-.12-.26
9 Physical IPV → Lack of access to E. R. strategies → Depression	.28	-.04-.65
10 Physical IPV → Willingness to accept certain emotional responses (Non-Acceptance) → Depression	.02	-.06-.14
IPV Types IPV Types → DERS Subscales → Depression		
11 Sexual IPV → Difficulty engaging in goal-directed cognition and behavior when distressed (Goals) → Depression	.03	-.04-.13
12 Sexual IPV → Difficulty regulating behavior when distressed (Impulse) → Depression	.01	-.06-.10
13 Sexual IPV → Willingness to accept certain emotional responses (Non-Acceptance) → Depression	.02	-.06-.11

Note: E.R.= Emotion (dys)regulation

CHAPTER V

DISCUSSION

The present study examined the mediating role of the five facets of emotion dysregulation in the association between three types of face-to-face IPV victimization, namely, psychological, physical, and sexual, and symptoms of depression among a large sample of emerging adult Hispanic women. Consistent with past research, this study indicated that there was a positive association between exposure to psychological, physical and sexual IPV and symptoms of depression (Ahmadabadi, 2020; White, 2015), in that increase in IPV types is associated with increase in symptoms of depression. There is a growing number of emerging adult Hispanic women that were victims of at least one type of IPV (United States Department of Justice, 2016; Bryant-Davies et al., 2009; Luo et al., 2020; Stockman et al, 2015). It is plausible that factors such as the cultural background of the victims (Oxtoby, 2012), religious beliefs, rigid social systems, the presence of substance abuse (Devries, 2014), and the media contribute to IPV victimization among emerging Hispanic adult women. The Rio Grande Valley, where the respondents reside, is an area rich in long-lasting Mexican American traditions, and its population is predominantly Hispanic. This study, in concordance with previous research which posits that psychological IPV was the most prevalent form of violence experienced by the victims (NCADV, 2020), indicated that 24.9% of the participants reported this type of violence (CDC, 2010).

In the present study, mediation analyses indicated that exposure to IPV types through two facets of emotion dysregulation—lack of emotional clarity and lack of access to emotion regulation strategies for feeling better when distressed—was associated with greater depression symptomatology, and that even if the participants suffered childhood maltreatment, sexual IPV victimization was associated with depression through the aforementioned emotion dysregulation facets.

A large body of research has linked emotion dysregulation with IPV. Specifically, the majority of those studies focused on the relations among different IPV types and perpetration (McGinn, 2020; Lee et al., 2020). Considering possible gender differences in emotion regulation processes would help to elucidate the link between IPV female victimization, emotional dysregulation and depression (McRae et al., 2008), as it has been proposed that men and women's thought processes differ (Jäncke, 2018). The present study found that specific subscales of emotion dysregulation, namely, lack of emotional clarity and the lack of access to emotion regulation strategies for feeling better when distressed fully mediated the association between the three types of IPV victimization and depression among Hispanic undergraduate females. In other words, the study indicated that the psychological, physical and/or sexual IPV suffered by Hispanic women predicted lack of emotional clarity and lack of access to emotion regulation strategies, two facets of emotion dysregulation, and they consequently, predicted increase in depression, suggesting that emotion dysregulation had to be present for a victim to score higher on depression. High scores on the emotion regulation subscale lack of emotional clarity, might prevent the IPV victims from making sense of their emotions and feelings. When experiencing lack of clarity, victims are confused about their feelings and fail to comprehend and discern their own emotional experiences. On the contrary, those with higher emotional clarity reported more

self-efficacy in affect regulation (Lischetzke et al., 2017). The causal mechanisms that are involved in the development of emotion dysregulation following IPV are beyond the scope of this study, nonetheless, research proved that the influence exerted by IPV perpetrators result in feelings of powerlessness in victims (Filson et al., 2010). Thus, an IPV victim with deficits in clarity of emotions may not be able to identify her emotions appropriately or be unable to recognize what caused them (Mowrer, 2007). Consequently, the victims of IPV experiencing deficits in clarity might not have the capacity to comprehend their emotions, product of the violence exerted upon them. They might internalize the abuse, not taking into consideration the possibility to seek help, or even blaming themselves for undergoing violence. On the same note, it has been proposed that as women analyze their emotions, they are likely to make attributions to internal features of themselves rather than to situational factors, and this might reduce their tendencies to take action to change situations that contribute to distress (Nolen-Hoeksema, 2012). These theories align with the findings of this study, where the victims of physical and sexual IPV consequently developed deficits in emotional clarity. In addition, these deficits were considered transdiagnostic factors involved in depression (Lischetzke, 2017). Thus, this facet of emotion dysregulation possibly caused the victims experiencing feelings of hopelessness, failure, and sadness, among other symptoms of depression. In addition, it was found that the limited access to effective emotion regulation strategies played a salient role in the association between the three types of IPV and depression. Research states that as a way to cope with difficult or adverse situations, individuals unconsciously use emotion regulation strategies many times throughout each day (Rolston & Richardson, 2020). The findings of the present study indicate that the psychological, physical, and sexual IPV experienced by the victims hindered their ability to make use of effective strategies that could facilitate the reinstatement of their well-being and

safety. The participants' response to abuse might give room to overwhelming feelings of despair and sorrow that inculcated a negative self-image perception that possibly signaled the presence of symptoms of depression. Prior research sheds light on the matter postulating a sort of linkage between emotional clarity and emotion regulation strategies, in which individuals that know what they feel should have more cognitive resources available for evaluating potential regulation strategies and their effective implementation. It is worth mentioning that as the victims of IPV experience lack of access to emotion regulation strategies, they could engage in maladaptive strategies such as the use of alcohol, drugs, promiscuous sexual intercourse (Soper, 2014), rumination, non-suicidal self-injurious behavior, or suicidal ideation as a way to cope with intense emotional pain, feelings of frustration and anger. The chronic use of emotional maladaptive strategies could turn into a leading factor to symptoms of depression. In fact, past findings suggested that some emotion dysregulation's maladaptive strategies partially accounted for the depression levels in women, and that the negative affectivity experienced by them is likely to develop into depression (Nolen-Hoeksena, 2012). Thus, emotional clarity might directly affect the selection of effectual strategies and their implementation (Lischetzke et al., 2017; Thompson, 2017) in order to stop the cycle of escalating violence and/or end a toxic and abusive relationship which consequences may be as devastating as death.

Childhood Maltreatment

The association between childhood maltreatment, emotion dysregulation and depression has been largely studied. In his study, Dvir (2014) postulates that emotions have a neurological component that involves a complex interplay between cortical and limbic brain regions. Previous findings suggest that emotional regulation is developed during early years, and it is shaped by early childhood experiences and caregiver responsiveness. Thus, it was suggested that the

maltreatment experienced by victims as children interfered with the acquisition of developmentally emotional-regulation skills (Dvir, 2014). Perhaps, these deficits are carried by the victims throughout adulthood turning into a strong risk factor for IPV victimization (Charak et al., 2020). Moreover, the connection between childhood maltreatment and depression was also studied. It appears that childhood emotional abuse (CEA) not only predicted but also mediated the relationship between emotional childhood maltreatment and depression in a sample of European female college students (Christ et al., 2019). Hence, although childhood maltreatment was not a variable of interest in the present study, it is worth mentioning that when childhood maltreatment was considered as a covariate in the triad consisting of IPV -psychological, physical, and sexual- victimization, emotion dysregulation, and depression, it became a strong predictor for all the facets of emotion dysregulation and for psychopathologies like depression. Additionally, even though victims of sexual IPV experienced childhood maltreatment, sexual IPV victimization plays a significant role in the development or worsening of deficits in the emotion (dys)regulation facets lack of emotional clarity and lack of access to emotion regulation strategies for feeling better when distressed and in the symptoms of depression. Thus, emerging adult Hispanic women victims of sexual IPV that experienced childhood maltreatment are likely to undergo difficulties to comprehend their emotional experiences, feelings, and the cause of them. Simultaneously, the sexual IPV these victims suffer undermines their capacity to select effective strategies aimed at ameliorating or ending their distress. Hence, in light of these deficiencies and the sensation of powerlessness, despair, and frustration these deficits evoke in those victims, it is probable that they experience a development or increase in their levels of depression.

Limitations

The present study has a number of limitations that must be considered when interpreting the findings. First, assessment of IPV is retrospective; thus, recall and response bias may exist considering the length of time that may have elapsed between participation in the study and IPV experience. Second, the design of the study is cross-sectional and cannot establish causal effects of IPV types, emotion dysregulation and depression. Third, variables like cultural framework, religious beliefs, attitudes about *machismo*, *familismo*, motherhood, racism and discrimination were not included in the present study. Controlling for these variables that are deeply ingrained in Hispanic communities would be of great significance. Additionally, findings are based on a sample of college students who were predominantly Mexican American, which may not generalize across the entirety of the Hispanic communities of emerging adults (Cano-Gonzalez et al., 2020). Fourth, given the large number of female immigrants in the area, the incorporation of a non-convenience sample as means to compare populations could be beneficial to the nature of the study, as it would enhance generalizability.

Implications

To the best of this author's knowledge, the present study is one of the first in examining IPV victimization in the emerging adult Hispanic college female population of the Rio Grande Valley, a region located in the south east area of the state of Texas, United States. As previous studies suggested, the Hispanic population is growing rapidly, and Hispanic college attendance is increasing (Luo et al., 2020). In light of the alarming rates of IPV victimization affecting ethnic minorities such as Hispanic adult females (Bryant-Davis et al., 2009), addressing this detrimental type of violence is important in order to fill the existing gap in research regarding nontraditional

and minority college females. Awareness and understanding of the deficits in the emotion regulation domain these IPV victims develop could facilitate the design of intervention and prevention policies intended to engage males, boys, and families to promote gender equality and nonviolence, programs created to enhance socioeconomic power of women (World Health Organization, 2009) , an effective use of the media to educate and assist victims and their families, university and college programs aimed at assisting the victims, and the implementation and affordability of therapies such as the Emotion Regulation Group Therapy (ERGT), Mindfulness-Based Cognitive Therapy (MBCT), and Schema Therapy (ST), aimed at assisting not only the aforementioned minority group, but other existing and potential victims. Further research controlling for gender differences and cultural background of minority groups in emotion dysregulation is strongly recommended.

Conclusion

It was observed that 54% of Hispanic emerging female adults studied experienced one or more IPV types. As a consequence of enduring psychological IPV, the victims presented limited access to effective strategies to regulate their emotions. Furthermore, victims that went through physical and/or sexual IPV simultaneously developed deficits in the emotional clarity and deficits access to effective emotion regulation strategies facets. Consequently, the aforementioned states caused the victims to endure depressive symptoms. Whenever childhood maltreatment was considered as a pre-existing condition in the participants, it was observed that this type of abuse evoked all the facets of emotion regulation deficits and the symptoms of depression, resulting these deficits into possible risk factors leading to IPV victimization in the emerging adult females from the Rio Grande Valley. Furthermore, it is worth considering that the Sexual IPV experienced by victims of childhood maltreatment led to the development or

increment of deficits in two facets of emotion (dys)regulation, lack of clarity and lack of access to effective strategies to regulate their emotions, which consequently led to depression.

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APPENDIX A

Appendix A

The Rio Grande Valley area

The Rio Grande Valley (informally called The Valley), is a region in Deep South Texas, which includes Cameron, Hidalgo, Starr, and Willacy counties. To the east this region is bordered by the Gulf Coast of Texas. To the south it is bordered by the Rio Grande River and the state of Tamaulipas, Mexico. To the north and west it is bordered by the Texas counties of Kennedy, Brooks, Jim Hogg, and Zapata. As of January 1, 2012, the U.S. Census Bureau estimated the population of the Rio Grande Valley at 1,305,782. The RGV is not only one of the fastest growing regions in the US, but also one of the poorest. The region frequently leads the nation in unemployment and poverty and ranks near the bottom nationally in per capita income (Ryavob, 2017).

Located in the southernmost tip of Texas, the Rio Grande Valley is a distinct region from other parts of the state. With the exception of Willacy, all counties in this region border Mexico. For this reason, many traditions from Mexico have been mixed with American customs.

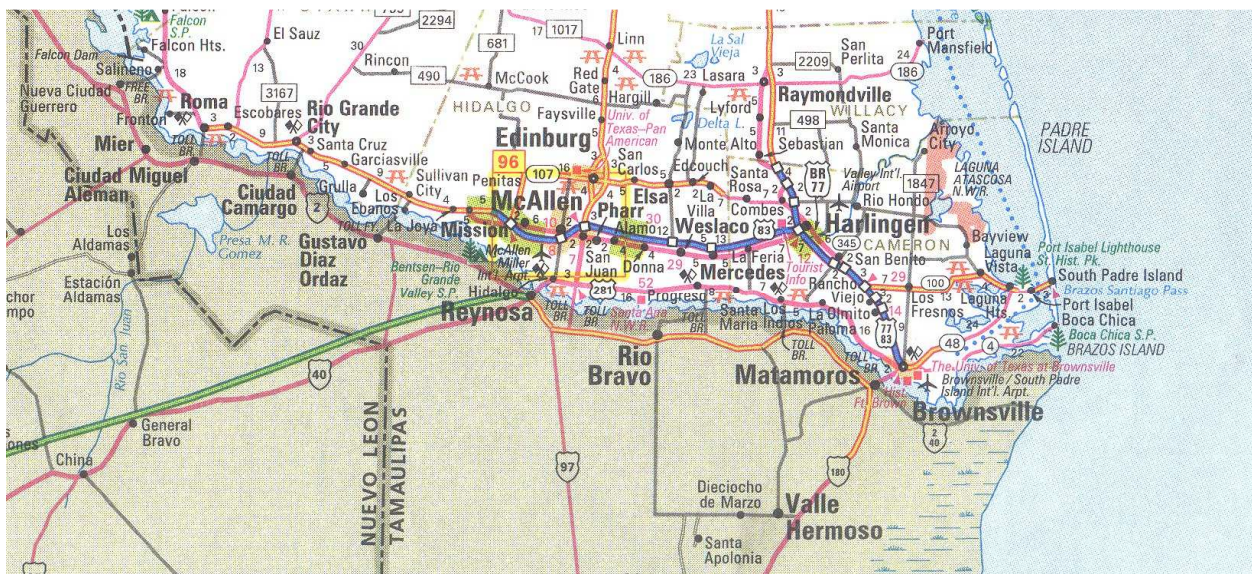
The warm weather attracts large number of retirees from the Northern United States and Canada during the winter months. Its abundance of great shopping opportunities attracts Mexican nationals throughout the year.

The two major languages spoken in the Valley are Spanish and English. 80% to 90% of the Valley's population is Mexican American.

Also, there are usually many Mexican visitors in the Valley, so it is not uncommon to meet people who speak little to no English. Most Valley natives are bilingual and can quickly switch from English to Spanish, sometimes in the same sentence. Since this is a border area, there is a strong blending of American and Mexican cultures in this region. It is quite common to encounter people speaking 'Spanglish.'

The valley is historically reliant on agribusiness and tourism. The region is the center of citrus production and the most important area of vegetable production in the State of Texas. Over the last several decades, the emergence of maquiladoras (factories or fabrication plants) has caused a surge of industrial development along the border, while international bridges have allowed Mexican nationals to shop, sell, and do business in the border cities along the Rio Grande. (Wikitravel)

Figure 5
Map of the Rio Grande Valley area



BIOGRAPHICAL SKETCH

M. Gabriela Copeiro De Lestarpe is a proud wife and mother of four and resides in McAllen, Texas. She earned her Master of Arts (MA) degree in Clinical Psychology from the University of Texas Rio Grande Valley in December 2020. Previously, Copeiro De Lestarpe earned her Cum Laude Bachelor of Arts (BA) in Clinical Psychology from the same institution. She attended the South Texas College (STC) in McAllen and earned her Associated Degree (AD) in Clinical Psychology with honors. She is part of Dr. Ruby Charak's Psychology Research lab (STEER) at UTRGV. Her research is focused on Intimate Partner Violence (IPV), emotion dysregulation across different populations such as females, males, juveniles, and childhood maltreatment. Copeiro De Lestarpe works with first time offenders at the Mario E. Ramirez, Jr. Juvenile court of Texas, where she completed her internship as an undergraduate. She currently is a certified volunteer there. She gained experience working at the Baptist Children and Family Services (BCFS) HHS organization, providing mentoring and guidance to unaccompanied minors. Copeiro De Lestarpe worked as a research assistant for the Dean of the Education and P-16 Integration Department at the University of Texas Rio Grande Valley. She has served youth and children in a variety of programs across Argentina, Mexico and the U.S. She completed her graduate internship at the Pina & Acosta Psychological Associates Agency in Mission, Texas under the supervision of Dr. Ruben Pina, PhD. Copeiro De Lestarpe holds a lifetime PSI-CHI, The International Honor Society membership and is pursuing a PhD in Clinical Psychology. M. Gabriela Copeiro De Lestarpe's email: gabrielacopeirolong@gmail.com & gabycope1@live.com