Being Undocumented & Intimate Partner Violence (IPV): Multiple Vulnerabilities Through the Lens of Feminist Intersectionality

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KEYWORDS: ABUSED IMMIGRANT WOMEN; DOMESTIC VIOLENCE; IMMIGRANTS; IMMIGRATION DOMESTIC VIOLENCE LAWS; IMMIGRATION LAWS; INTERSECTIONALITY; INTERPERSONAL VIOLENCE; INTIMATE PARTNER VIOLENCE; UNDOCUMENTED; VIOLENCE AGAINST WOMEN; VAWA.

The 3.2 million undocumented women living in the U.S. today are among the most socially, economically and legally marginalized in our society, and subsequently the most vulnerable to Intimate Partner Violence (IPV). Intersecting factors of gender, ethnicity, and legal status expose undocumented women to multiplicative vulnerabilities and negative health effects. Isolation, fear of deportation, and limited access to social services both perpetuate IPV and prevent women from seeking help. While the Violence Against Women Act (VAWA) legal reforms help abused immigrant women seek citizenship and safety, many barriers (emotional, financial, and logistical) still remain. Furthermore, the perpetual stress of being undocumented places women at increased biological risk for negative health effects. Clinician interventions include patient education, documentation, advocacy and further research.

One in 10 women in the United States (U.S.) is an immigrant (Glass et al., 2011). Out of the total foreign-born population in the U.S., 26% are undocumented; almost half of those undocumented individuals—about 41%—are women (Passel, Capps & Fix, 2004). All told, there are about 3.2 million undocumented women living in the U.S.

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today (ibid). Their documentation status, coupled with their race, ethnicity and gender, makes them particularly vulnerable to violence.

The population of undocumented immigrants living in the U.S. constitutes a significant and growing public health sector. Pushed and pulled by a combination of political and economic forces such as poverty, economic opportunities, political instability, and the loss or gain of family ties, increasingly significant numbers of people are entering the U.S. illegally each year (Erez, Adelman & Gregory, 2009). This population is both underserved in health care and at risk for Intimate Partner Violence (IPV) (Berk et al., 2001; Bustamante et al., 2010; Glass et al., 2011).

The U.S. is not the only nation receiving an influx of immigrants, both with and without legal documentation. While the U.S., as of 2010, has the largest quantity of international migrants in the world, it does not have one of the highest percentage of international migrants in total population; New Zealand, Canada, Israel, and Australia are among the many nations with more international migrants as a percentage of their population than the U.S. (Migration Policy Institute, 2012). Determining how many of those migrants are undocumented can be difficult as countries around the world publish international migration data based on varying definitions. Nonetheless, it is safe to say that the U.S. is not the only country where illegal immigration is an issue; South Africa, Continental Europe, and Mexico all host numbers of undocumented immigrants estimated to be in the several millions (Papademetriou, 2005). Although this paper focuses on the policies and social paradigms of undocumented women in the U.S., the vulnerabilities faced by undocumented immigrant women and other legally disenfranchised women are globally relevant.

Violence against women is one of the most common victimizations experienced by immigrants (Erez, Adelman & Gregory, 2009; Raj & Silverman, 2002), regardless of documentation status. Research indicates that the incidence of domestic violence in immigrant women, both documented and undocumented, far outstrips that experienced by the general U.S. population. While the lifetime prevalence of domestic violence in the general U.S. population is estimated at 22-25% (Tjaden & Thoennes, 2000; Breiding, Black & Ryan, 2008), one survey of Latina immigrants found a lifetime prevalence for intimate partner violence more than twice that high (Moynihan, Gaboury & Onken, 2008). IPV against immigrant women has reached what some researchers are calling “epidemic proportions” (Raj & Silverman, 2002, p.367). The same trend is visible in other countries although not in all settings (Hyman et al., 2006; Schei et al., 2012).

IPV is a global health and social problem. It occurs in all countries and across economic, social, religious, and cultural groups
Significant negative economic as well as negative health consequences to individuals, families, communities and societies have been documented as resulting from IPV (WHO, 2005). The high rate of IPV seen in immigrant populations is not a function of culture, so much as it is a function of socioeconomic marginalization. Thus, while IPV may appear more prevalent in immigrant populations for ‘culturally innate’ reasons, research shows that differences in IPV by race and ethnicity often decrease or disappear when socioeconomic status is included in the analysis (Glass et al., 2011; Menjívar & Salcido, 2002). While this sort of analysis has not been frequently conducted in samples of immigrant women, as a highly marginalized population, immigrant women are exposed to far more factors contributing to IPV than non-immigrant women (Amanor-Boadu et al., In press).

Immigrant women without documentation are at an even higher risk for violence than those with legal status. Those without documents—people known derisively in the U.S. by hate-speech labels like ‘illegals’—are among the most socially, economically and legally marginalized in U.S. society, and subsequently the most vulnerable. Their lack of documentation defines their experience and is a pivotal factor in their risk for IPV. More than cultural issues or language barriers, an individual’s immigration status is emerging as “the most significant factor in determining how, or even if, domestic violence is addressed when it occurs in immigrant families” (Earner, 2010, p.288).

An Unseen Class
Despite growing evidence that immigrant women are at increased risk for victimization, until very recently there have been few efforts to address IPV in U.S. immigrant communities in the areas of policy, research, and practice (Raj & Silverman, 2002). Even less research has been done on the healthcare deficits of undocumented immigrant women, particularly abused undocumented women. They are, by nature, an unseen class—from a logistical perspective, studying a population that necessarily flies under the radar isn’t easy. Even without those difficulties, though, it has already been observed that minority women have often been overlooked in research addressing nursing and IPV; the scholarship in the U.S. that has guided the development of nursing care with abused women has seldom included the experiences of racial and ethnic minority women (Glass et al., 2011). When attention has been given in research, advocacy, and services to IPV in immigrant populations, the diversity within immigrant groups is often overlooked, particularly differences in class, the lowest of which being the
undocumented (Glass et al., 2011). As in most scholarship, there is an entire segment of immigrant population (such as undocumented workers) that may be discounted as if nonexistent (Glass et al., 2011).

Despite the lack of substantial research on undocumented abused women, the theory of feminist intersectionality (Kelly, 2009; Glass et al., 2011) is particularly applicable to them. This theoretical framework is used in this paper to examine the impact of immigration status on IPV.

**FEMINIST THEORY OF INTERSECTIONALITY**

The theory of feminist intersectionality, originally generated by black feminist writers in the 1980s (Collins, 1986; hooks, 1984; Sokoloff, 2005), recognizes that “oppressed groups and individuals live at the margins of society with inequitable access to resources resulting in societal inequities and social injustice. The negative effects on health from belonging to more than one oppressed group are multiplicative and unique” (Kelly, Gonzalez-Guarda & Taylor, 2011, p.76). This theory of intersecting, oppressive factors yielding multiplicative, negative effects has been used by an expanding circle of researchers and applied to theories addressing both the impacts of immigration status and the epidemiology of IPV.

An ethnogender perspective or intersectionality approach to studying IPV in populations of immigrant women— for a moment, setting aside the issue of documentation status— gives equal importance to both gender inequality and racial/ethnicity discrimination, or ‘dual subordination’ (Glass et al., 2011; Kelly, 2009). Intersectionality theory asserts that the intersection of gender, race, and ethnicity, as well as the cultural differences and alienation experienced by immigrants, compound each other and become important criteria for the social construction of identity and marginalization (Glass et al., 2011). Regardless of the class to which the woman belongs in her home country, she faces subordination not only as a woman, but also as a minority woman in a foreign land. Socialization into the often rigid gender norms of one’s home country, combined with the lack of institutional support in a foreign land due to alien status, exposes immigrant women to dual marginalization (Glass et al., 2011). The effect of these multiple forms of marginalization is not additive, but multiplicative, with each added factor exacerbating the others.

Analytically, immigration status can be separated out as yet another category of intersectionality (Erez, Adelman & Gregory, 2009). This third factor places undocumented immigrant women in a category of triple marginalization. “Immigrant,” Erez says, is “a separate and multiplicative aspect of identity, violence, and oppression” (ibid, p.33);
thus, being undocumented puts women in a position of still more vulnerability. Rather than considering immigration status as a variable or static category within race, we consider immigration as part of the multiple grounds of identity shaping the woman’s experience of domestic violence. The combined factors of gender, race/ethnicity, and lack of legal documentation compound and increase the woman’s disenfranchisement.

A woman’s legal status within a country is part of the interactive and dynamic processes that, along with race, gender and class, inform her experiences of and responses to domestic violence. Recognizing the intersections of these different aspects of marginalization and the multiplicative, amplifying effects that they exert is crucial in understanding a women’s experience of IPV and the forces working against her. As Glass and colleagues (2011) assert, “any effort to help immigrant women will be futile unless this intersectionality is well understood” (p.209).

Multiple Barriers to Help-Seeking

Extricating oneself from an abusive relationship is an incredibly complex and difficult proposition for any woman, one with emotional, financial, logistical, health, and security-related barriers; leaving is neither a simple nor a safe choice for many (Kelly, Gonzalez-Guarda & Taylor, 2011). It is important to note that in addition to all the existing barriers to accessing services that are experienced by all victims of abuse, the plight of abuse victims is greatly exacerbated if they are immigrants, and even more so if they have arrived in the U.S. illegally (Moynihan et al., 2008). Immigrant women with documentation are often economically, socially, and psychologically dependent on their spouses and his family; this increases their risk of experiencing IPV, a risk that is further compounded by their equally restricted access to needed resources for increasing safety while in the relationship and when leaving the abusive partner (Glass et al., 2011). Living as an immigrant without legal documentation dramatically exacerbates both that dependence on the partner and the extremely limited access to safety-securing resources.

Many immigrant women, both with and without legal status in their country of residence, have left their entire social support system behind in their country of origin, furthering their emotional, social, and psychological reliance on their partners. Abusers actively exploit this reliance and use it to further isolate women. The abuser’s coercive control, the woman’s limited language skills, and lack of knowledge of legal rights and services available for IPV, survivors all serve to deepen the isolation of immigrant women (Glass et al., 2011). Isolation techniques include restricting their contact with family both in the U.S. and in their country of origin, as well as prohibiting friendships with
‘Americans’ (Raj & Silverman, 2002). Many abusers will increase immigrant women’s insecurities about their ability to function in U.S. society without their spouses by demeaning women based on their limited English and their lower levels of acculturation, education, or work skills (Raj & Silverman, 2002).

Further exacerbating the barriers faced by abused immigrant women, both documented and undocumented women may lack information that legal recourse for intimate partner violence exists. Studies consistently report that immigrant and refugee women of all legal statuses who are abused are often completely unaware of the domestic violence services in their communities, or that laws exist that may protect them from abuse, especially as there frequently are few or no laws against IPV in their countries of origin (Raj & Silverman, 2002; Moynihan et al., 2008). Husbands/partners are likely to be themselves ignorant of the domestic violence laws in the U.S., and if they are aware of such legislation, give women incorrect information about it (Moynihan et al., 2008). Finally, even if women are aware of the illegality of intimate partner violence in the U.S., many women (regardless of documentation status) do not seek help because of shame, stigma attached to abuse, fear of the abuser, and/or cultural expectations of maintaining familial harmony (Glass et al., 2011).

Research conclusively demonstrates that abused immigrant women with and without documentation are less likely than nonimmigrant abused women to seek both informal (e.g., social support) and formal (e.g., medical and legal services) help for IPV (Raj & Silverman, 2002; Wood, 2004; Menjívar & Salcido, 2002; Bustamante et al., 2010; Berk & Schur, 2001). Even when women do overcome some of the barriers described above, help seeking continues to be limited by the systemic biases and discrimination often faced by these individuals, which are embedded in and exacerbated by the challenges they face as refugee and immigrant women (Moynihan et al., 2008).

For immigrant women who are undocumented and/or legally dependent on their partner for residence, all of these isolating factors are greatly exacerbated by the constant fear of deportation. Immigration status places women on a social hierarchy that directly affects their vulnerability to abuse: for undocumented immigrant women, deportation is a constant threat that batterers can use against them (Raj & Silverman, 2002; Moynihan et al., 2008). What’s more, for many undocumented women, the threat of deportation is not only for themselves, but for undocumented family members who the abuser may also threaten to report to immigration authorities.

The threat of deportation is not an idle one. Abusive partners have been known to keep, destroy, or threaten to destroy partners’ immigration documentation, placing immigrant women at risk for
removal (Raj & Silverman, 2002). Abusive partners have also been reported to actually start deportation proceedings themselves, sometimes accusing a woman of marriage fraud to escape prosecution for abuse or gain an advantage in divorce or custody proceedings (Raj & Silverman, 2002). Some women have been taken back to their country of origin by batterers “under the pretext of a family trip” and left there without resources or support to return (Raj & Silverman, 2002, p.381). Importantly, fear of being returned to the country from which they fled is a powerful force in not seeking or even exploring avenues for help (Moynihan et al., 2008).

Without any form of identification, undocumented immigrant women are often unable to secure employment and, if employed, may not be able to keep any of their wages. Some undocumented women without legal work papers are simultaneously abused and/or exploited by their employer (Moynihan et al., 2008). For those who are in the U.S. on temporary work visas, they must maintain their sponsored employment to remain in the country. Batterers have been reported to disrupt and threaten immigrant women’s jobs, not only undermining their ability to remain employed but, for some, their ability to remain in the U.S. (Raj & Silverman, 2002).

**IPV, Immigrants & the Legal System: Where the Ball Got Dropped**

The criminalization of domestic violence in the U.S. was the hard-won result of the efforts of the battered woman’s movement (Erez, Adelman & Gregory, 2009). That said, feminist criminologists, their cross-disciplinary associates, and others have been part of a growing critique of the “limits or unintended effects of the criminalization of domestic violence” (ibid, p.33). Most notably, U.S. reliance on the state for women’s safety has left immigrant women without citizenship status largely unprotected (Erez, Adelman & Gregory, 2009; Bhuyan, 2008).
Table I: Violence Against Women Act (VAWA) Legal Reform Provisions

**SELF PETITION:** Allows immigrant survivors of domestic violence and their children to obtain lawful permanent residence without the cooperation of their documented spouse/parent.

Those Eligible to File:

**Spouse:** You may file for yourself if you are, or were (within 2 years of filing), the abused spouse of a U.S. citizen or lawful permanent resident (LPR).

**Parent:** You may file for yourself if you are the parent of a child who has been abused by your U.S. citizen or LPR spouse.

**Child:** You may file for yourself if you are an abused child under 21, unmarried and have been abused by your U.S. citizen or LPR parent.

**What does a person need to prove for a VAWA self-petition?**

- Spouses must file their application within two years of a final divorce;
- The abuser is a U.S. citizen or LPR, or has lost status within the two years prior to the filing of the application;
- The petitioner resided in the United States with the citizen or LPR spouse or parent;
- The petitioner was battered or subjected to extreme cruelty during the marriage;
- The petitioner is a person of good moral character; AND
- The petitioner married her spouse in good faith.

**CANCELLATION OF REMOVAL:** VAWA cancellation of removal is available to an immigrant survivor who is already in deportation proceedings. The same three categories of people eligible for Self Petition (see above) are also eligible to file for Cancellation of Removal.

**What does a person need to prove a VAWA cancellation of removal?**

- Has lived in the United States continuously for 3 years immediately preceding filing the application for cancellation of removal;
- Was subjected to battering or extreme cruelty by her spouse while in the United States and is determined to be of “good moral character.”
- Is currently deportable. She will not be eligible for cancellation if she is deportable for marriage fraud, certain criminal convictions or because she is a threat to U.S. national security, AND

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Furthermore, U.S. immigration law endangers abused immigrant women by giving near total control over the women’s legal status to the sponsoring spouse, “replicating the doctrine of coverture... [which], in effect, identifies the married couple as a single legal entity, within which the husband has control over the property and body of the wife and their children” (Erez, Adelman & Gregory, 2009, p.36). Women who immigrate as wives of U.S. citizens, legal permanent residents (LPRs), diplomats, students, or workers are legally dependent on others to sponsor, pursue, and complete their visa petitions. This legal dependency intensifies gendered inequality, creates new ways for men to abuse and control their intimate partners, and entraps abused women (ibid). The Violence Against Women Act (VAWA) legal reforms instituted in 1994 served to relieve some of the legal and economic dependencies imposed on abused and undocumented immigrant women, but not all.

The VAWA legal reforms (see Table I) include self-petition, which lets an abused spouse apply for a green card on his or her own; cancellation of removal, which lets an abused spouse who has already
been subjected to removal proceedings request to remain in the U.S.; the U-visa, which lets a victim of crime (including domestic violence) who has been helpful to its investigation or prosecution apply for a nonimmigrant visa and work permit; and access to public benefits such as food stamps (Erez, Adelman & Gregory, 2009). Obstacles to obtaining these protections remain, in particular “the complex nature of legal qualifications, including who is eligible to apply for which form of legal relief, and meeting the threshold required to demonstrate having been subjected to battery or extreme cruelty” (ibid, p.37). Add to these obstacles the post 9/11 processing delays in visa applications and the increasingly exclusionist laws that are the consequence of widespread U.S. anti-immigrant sentiment, and the resulting situation is one in which the implementation of these legal protections becomes almost prohibitively difficult.

Barriers for women’s self-petitioning under VAWA are emotional, financial, and logistical in nature (Ingram et al., 2010). In a recent qualitative study conducted by Ingram and colleagues (2010), six major aspects of preparing the VAWA self-petition were identified by petitioners as extremely difficult: 1) having to provide a personal statement of the abuse, 2) the insecurity of the process, 3) confusion regarding the self-petition process, 4) the amount of evidence required to demonstrate eligibility, 5) the length of time a self-petitioner has to wait for employment authorization and subsequent financial hardship, and 6) immigration law penalties (Ingram et al., 2010). Being forced to relive the experience through personal statements, having to come up with extensive documentation to prove the severity of their abuse, and waiting for months (or longer) without any security that the outcome of the petition would be positive were all deeply stressful for VAWA self-petitioners. Just being able to continually file the necessary paperwork presented many challenges; for women seeking refuge in temporary shelters or in other locations, the issue of having a permanent address for the duration of the petition was deeply problematic. Transience, frequently experienced by women fleeing from an abuser, makes changing immigrant status logistically impossible when a steady residence is needed for the extensive paperwork to be processed over time (Raj & Silverman, 2002).

Each year, hundreds of thousands of women enter the U.S. as a spouse of a U.S. citizen or legal permanent resident (LPR) (INS, 1997; Monger & Yankay, J., 2011), coming to the U.S. with significant disadvantages in social status and resources compared with their male partners (Raj & Silverman, 2002). In the absence of VAWA protection, control over their documentation status is solely in the hands of the spouse. If the marriage dissolves prior to the immigrant spouse obtaining permanent residency status, the immigrant spouse will remain
undocumented and can be deported as an illegal alien. Furthermore, if the U.S. citizen or LPR spouse opts not to file for permanent residency status on their spouse’s behalf, in the absence of VAWA protection, the immigrant spouse cannot attain legal immigration status, thus maintaining dependence on the batterer. Disturbingly, 72% of citizen and LPR spouses do not file immigration papers for their wives (Dutton, Orloff & Hass, 2000; Raj & Silverman, 2002).

Underlying all of these barriers is the reality that approaching the legal system for help can be incredibly daunting to the immigrant whose primary goal is to avoid contact with this system so as to avoid deportation. Women in countries in which there are no laws against IPV are often able to rely on religious, traditional, and societal institutions for protection. As these kinds of protections are rarely in place in the U.S., abused immigrant women are often at a loss as to whom they can turn to for help (Raj & Silverman, 2002). In addition, immigrant women often fear the police, given that the police in many of their countries of origin are hostile and even dangerous to women and/or perceived as corrupt forces of oppressive governments (Wessel & Campbell, 1997).

Social Services & Compounding Barriers

As the debate on immigration intensifies in the U.S., the response in the political arena has placed emphasis on passing increasingly stringent controls on access to social benefits based on immigration status—creating what Earner describes as “a sort of negative immigrant policy whose intended outcome is, presumably, to make it difficult for immigrants, specifically the undocumented, to stay and hopefully, make them go back to wherever they came from” (Earner, 2010, p.289). This kind of thinking presumes that undocumented immigrants are single people, when in fact, like most adults, they form families (Earner, 2010).

For undocumented immigrant families as a whole, the unintended consequences of limiting access to social benefits are enormous and include increasing economic hardship, inadequate food, lack of access to health care and increased stress. These are the very risk factors often identified as correlating with increases in family violence (Earner, 2010). In this way, the cycle of risk and vulnerability perpetuates: undocumented women are restricted from access to help by the very policies that simultaneously make them more likely to experience IPV. This chain of events can quickly spiral into family disintegration and negative health outcomes as curtailed access to public benefits and social services for the undocumented leads to further impoverished families without safety nets (ultimately leading to the involvement of public child welfare services).
In a recent study by the Urban Institute, it was clear that immigrant populations, despite eligibility and need, did not access services that would ameliorate problems such as lack of access to food and health care. This could effectively place children of undocumented mothers at risk and bring the attention of public child welfare services (Passel et al., 2004; Capps et al., 2002; Earner, 2010). These restrictive policies are becoming increasingly widespread as initiatives at the state level are simultaneously seeking to restrict undocumented immigrants’ access to state-funded benefits and services, including developing the type of legislation which could restrict immigrant women’s access to basic domestic violence services such as shelters and counseling (Earner, 2010).

Undocumented women fear that if they ask for help, healthcare or social service providers will turn them in for deportation; even abused immigrant women with legal status feel vulnerable to deportation for themselves or their families should they seek help (Raj & Silverman, 2002), an impression that is the result of both misinformation and an overall culture of fear. Furthermore, many states’ mandatory arrest policies in domestic violence cases result in the arrest of both the male perpetrator and female victim. Subsequently, immigrant women seeking police help for abuse may also risk their own deportation if convicted through this process.

Other service-related barriers to seeking help include lack of outreach to immigrant communities on behalf of domestic violence services, lack of accessible or culturally relevant services, and language barriers (Raj & Silverman, 2002). Some shelters have already denied immigrant women access by requiring proof of citizenship or English fluency for entry, despite the fact that this denial of services is a violation of federal law (Raj & Silverman, 2002; Ganatra, 2001).

**Biological Effects of Being Undocumented: Stress & Allostatic Load**

According to a research study done by McGuire & Georges (2003) exploring the qualitative experiences of women immigrants, most women in the study identified lack of legal documentation as “a major and overriding concern that influenced their thoughts about seeking health care and complicated their lives with fear” (p. 190). Simply living day-to-day without legal status within a country is a great source of anxiety and fear. The direct, negative health impacts of the stress of being undocumented are twofold. First, undocumented women are much less likely to seek any kind of healthcare, both because of cost and because of fear of being reported. As a source of prolonged stress, lack of documentation can exacerbate health risks because of other variables such as affordability, accessibility, acceptability, knowledge, cultural views and practices, and willingness to seek care. Second, in keeping
with the recent research on the concept of allostatic load, the stress itself of being undocumented—a “major and overriding” source of concern and fear—takes a very real, direct physical toll (McGuire & Georges, 2003, pg. 190). This concept of allostatic load has been used in nursing and other disciplines since the 1990’s to examine the direct effects of stress on the human body. The frequent activation of the body’s stress response, while essential for managing acute threats, can physically damage the body if hyperarousal becomes chronic. The accumulation of biological risk associated with persistent hyperarousal is applicable to the lives of many immigrants, even those with documentation; this state of hyperarousal is deeply intensified by being ‘an illegal’ (McGuire & Georges, 2003).

When discussing the biological impact of distress, it is important to note how crucial the element of time can be, in the sense that undocumented women who might suffer from chronic conditions like anemia or type-2 diabetes, or preliminary, early, or curable stages of cancers such as cervical dysplasia carry elevated risk if they do not or are unable to access available health services for early detection (Coker et al., 2003; McGuire & Georges, 2003). The longer women endure these stressors, and the fewer levels of prevention they have access to, the more at risk for serious negative health effects they become. Even further compounding these risks is the loss of future Social Security benefits and better economic security, given the well-acknowledged association between poverty and health risk (McGuire & Georges, 2003).

The level of stress that undocumented immigrants live with should not be underestimated. For these women, their documentation status dominates their entire lives. Being undocumented “renders the immigrant a ‘persona non grata,’ one who has no official right to exist within the political-legal-geographic boundaries of the country in which they live” (McGuire & Georges, 2003, p.191). Understandably, the greatest hope of the undocumented women studied by McGuire & Georges was that they would “someday qualify to legalize their status either through an amnesty program as occurred last in 1986, or through grown citizen children (a very long wait)” (ibid, p.191).

When this stress is combined with the equally all-consuming stress of living in an abusive relationship, the potential for serious negative health consequences rises dramatically. Viewed through the lens of intersectionality, an undocumented abused woman’s risk for severe negative health effects via allostatic load are further amplified: she is dealing with the stress of abuse, the stress of the constant threat of deportation, and the stress inherent in being socially subjugated by merit of gender, race and nationality. Each of these factors interact and compound each other to add to health-crippling stress; again, the effect of the intersection of these factors is multiplicative, rather than additive.
Implications for Health Care Providers & Social Service Providers

Domestic violence is, at its core, a health issue. Healthcare and social service providers need to be deeply engaged with this issue and aware of the many factors compounding it. One of the biggest barriers to help is lack of awareness and education on potential legal protections available to women (namely, VAWA). Well-informed clinicians and social service providers can provide that education. Clinicians can also play a key role in providing one of the biggest requirements for VAWA petitions: the documentation of abuse. For undocumented immigrant women not eligible for legal protections such as VAWA, providers need to understand the vulnerable position these women are in and try to reach out to them regardless of citizenship status.

Undocumented immigrant women and children are in danger of being abused, have little or no protection from their abuser, and have little or no ability to seek help (Moynihan et al., 2008). As Moynihan et al. (2008) asserts, this is an area for intervention. The comprehensive skills of the nurse, particularly forensically trained nurses, for example, “can pave the way for services to this population....These skills include comprehensive assessment, advocacy, and multi-disciplinary collaboration, bringing comprehensive assessment skills and the broad knowledge of the legal policy, system, and community support services for support, advocacy intervention, and rescue” (p.123). In addition, public/community healthcare workers and clinicians providing care for undocumented immigrant women in a whole variety of settings (e.g. nurse home visitation for at risk pregnant women, prenatal care, family planning clinics, well child clinics) can also provide assessment for IPV and ‘intersectionality informed’ care to abused immigrant women. Below I have outlined several areas of intervention.

Patient Education: A major constraining factor preventing abused immigrant women from accessing help is the “lack of awareness of available IPV services, lack of culturally or linguistically competent IPV services, and lack of awareness of IPV as a legal issue for which they can receive assistance” (Raj & Silverman, 2002, p.385). For example, few women are aware of the existence of VAWA. Education has always been a primary healthcare concern; when victims of IPV lack awareness of their options, as is often the case, patient education is more important than ever. If and when these women enter the health care system, school system, or any other place where healthcare or social service providers practice, all efforts should be made to build awareness and assist women and children in accessing services. Access to the opportunity of provider-patient interaction—and, especially for the undocumented, to medical care at all—is very dependent on the ability of abused immigrant women to seek treatment (which is often compromised by the abuser’s
unwillingness to let the victim, or her children, see a medical provider) (Moynihan et al., 2008). Every effort should be made to encourage potential patients to seek treatment. For example, school nurses can assist in identifying children who are undocumented and in harm's way and increase the opportunities for advocacy and intervention (Moynihan et al., 2008). It’s important that any opportunity to reach out to a woman, once she is within an arena where assistance is possible, not be missed (Moynihan et al., 2008).

Documentation: The biggest and most difficult hurdle for many women in petitioning for VAWA protection is getting a good, clear paper trail of their abuse. Of critical importance is the documentation of battering or other ‘extreme cruelty’ perpetrated on the abused women. This is an excellent area for clinicians, who are able to identify and assess this form of victimization, to make a critical contribution (Moynihan et al., 2008). Obtaining the necessary evidence to demonstrate eligibility for VAWA is both overwhelming and difficult, and has been identified as one of the major obstacles to VAWA (Ingram et al., 2010). As Bhuyan (2008) noted, “proving you are a good (enough) victim” is a central and problematic part of the VAWA self-petitioning process (p. 162). The easier and less painful we can make this process, the better. Documentation of the abuse that has occurred should record what the victim says in quotation marks, specifying dates of particular episodes of violence, and recording any evidence of violence (e.g. describing “old” bruises or bruises in various stages of healing or a entering on a body map notation of injuries and what date they occurred) (Laughon et al., 2011). These medical records are admissible as evidence in legal proceedings, including VAWA hearings.

Advocacy & Policy: VAWA is up for reauthorization this year. Despite all of it’s logistical shortcomings, VAWA is still an excellent protection and far better than nothing at all. All health practitioners in the U.S. can and should be involved in advocating for it’s renewal whenever it comes up. Further recommendations for policy should include not only the renewal of VAWA, but the serious reevaluation of some of the elements of the VAWA process already addressed in this paper that hinder the acquisition of VAWA protection. For all policy makers in every country, certain realities of IPV need to be considered in the implementation of legal provisions like VAWA which are meant to protect abused women; transience, security, clarity, time, children, and limiting the amount of repeated trauma that abused immigrant women experience should all be taken into account. Beyond VAWA, there is a great need for advocacy on behalf of these vulnerable individuals in U.S. society. The testimony of professionals who are privy to a unique and powerful perspective regarding the public health crises of the undocumented, such as healthcare workers, could greatly contribute to
improving legal protections. From their position as routine witnesses to the unnecessary hardships suffered by undocumented women, healthcare workers can consistently and persistently direct their support for an amnesty to their legislators in Congress. Furthermore, agency policy can be shaped by advocating for outreach to immigrant women irrespective of documentation (McGuire & Georges, 2003, p.192).

**Awareness:** There is a great deal of ignorance and even more misconceptions in U.S. society about undocumented immigrants, who they are, and the obstacles they face. Spreading awareness about this population, among coworkers as well as in the community at large, should be a priority for the thoughtful individual engaged with this issue. It is critical that we understand this population’s abundance of health-related vulnerabilities. It is also important to be aware of some of the traumatic experiences many undocumented immigrants have already faced. While undocumented immigrants come from many parts of the world, a large proportion of them come into the U.S. via our southern border with Mexico—a border that has been identified as “the most violent border in the world between two countries not at war with one another” (McGuire & Georges, 2003, p.192). It is rare that an individual who has crossed into the U.S. illegally via this pathway has not experienced some kind of trauma; the increased militarization and rampant human rights violations contribute to a growing public health problem, and the potential that undocumented immigrants will demonstrate symptoms of post-traumatic stress as a result of their crossing is high. Talking about the issue with coworkers and the IPV advocacy community is very important.

**Research:** Data regarding the health care needs of the undocumented immigrant populations in America has been difficult to uncover and may not have been collected on a regular basis, for obvious reasons. More research is necessary to determine the best possible interventions. For example, we know that cultural competency on the part of IPV outreach is an issue; however, culturally appropriate interventions have not been designed and widely tested. More exploration of this topic is greatly needed. Furthermore, more research on the topic of how documentation status affects overall health is needed to better design policies and interventions for this population. Through the voices of undocumented women, we are beginning to see specialized knowledge with implications for women’s and family health and social justice. In nursing, this knowledge is “highly politically charged, still incomplete, falls largely outside current dominant discourses in women’s health and research directions, and presents key dilemmas, challenges, and newer foci for nursing practice, praxis, and research” (McGuire & Georges, 2003, p.192). A fuller exploration of the influence of lack of legal documentation status on health is urgently needed.
CONCLUSIONS

Despite the logistical difficulties present in studying undocumented abused women, the body of research which demonstrates that they are particularly vulnerable to IPV is both consistent and growing (Moynihan et al., 2008). Even those immigrant women with legal documentation status have fewer resources, stay longer in the abusive relationship, and sustain more severe physical and emotional abuse than non-immigrant women. They may also often regard domestic violence as 'normal,' suffer more intense isolation, and experience obstacles to accessing services that are exacerbated by language difficulties, cultural norms, and traditional gender roles, and by severe economic deprivation (Moynihan et al., 2008). The lack of awareness among populations of immigrant and refugee women of domestic violence services in their communities is widely reported in studies (Moynihan et al., 2008). All of these factors are further exacerbated when abused immigrant women are also undocumented. The intersection of illegality with immigrant status and gender render women exponentially more vulnerable.

Skilled clinicians can open the door to assistance through their assessments. Reaching out to this population is not easy; fear of deportation and mistrust of the system, coupled with cultural impediments, exacerbate the difficulties faced by this under-recognized population. These dynamics considerations compound the typical disincentives that are faced by abused women (Moynihan et al., 2008). Clinicians may have access to rare opportunities to overcome these barriers to help-seeking for undocumented abused women. Victims of domestic violence, as we know, often accommodate to the situation because the act of help seeking is in itself stressful and often dangerous (Moynihan et al., 2008). Undocumented women and children face particularly severe risks when seeking relief. It is here that the individual who has informed his or her practice by including information regarding these issues can make the difference. Understanding the danger of immigration-related abuse is critical to our ability to offer what can be and often is life-saving help to immigrant women and their children (Moynihan et al., 2008).

REFERENCES


