CALIFORNIA STATE UNIVERSITY, NORTHridge

CULTURE SPECIFIC MODELS OF HEALING AMONG
UNDOCUMENTED BATTERED LATINA WOMEN: PERSPECTIVES
OF SHELTER-BASED CLINICIANS

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I hope that this study has contributed to the field of domestic violence and to enhance services for undocumented battered Latina women living in transitional domestic violence shelters.
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ABSTRACT

CULTURE SPECIFIC MODELS OF HEALING AMONG UNDOCUMENTED BATTERED LATINA WOMEN: PERSPECTIVES OF SHELTER-BASED CLINICIANS

By

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There are many studies on the concept of healing trauma and healing battered women, but there is a limited amount of literature on how undocumented battered Latina women heal. This thesis focuses on the experience of undocumented battered Latina women and their process of healing from trauma while living in a transitional domestic violence shelter. The researcher interviewed ten shelter-based clinicians, one on one, for approximately one hour. The main research questions were: 1) How do shelter clinicians define/characterize healing among undocumented battered Latina women? 2) How do shelter clinicians and workers characterize obstacles to healing among undocumented battered Latina women? (3) What are the priorities and interventions used by clinicians for each phase (beginning, middle, end) of healing? and (4) How do the clinical interventions used by shelter-based clinicians for undocumented battered Latina women differ from Herman’s (1992, 1997) traditional model of healing?

The primary themes that emerged were that healing was a process, that included healthy and [productive] reactions to stressors, and women feeling empowered/finding
their voice. Obstacles to healing were complicated by multiple marginalities due to legal issues (e.g., obtaining U-Visa/VAWA) and family/cultural concepts of bearing one's cross. To aid in the process of healing, the majority of shelter-based clinicians sought to first treat active fight, flight, or freeze trauma response. Specific clinical treatments included Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Cognitive Behavioral Therapy (CBT), Unrealistic Family System, Humanistic Therapy, Dialectical Therapy, Acetylic Approach, and Parent Interactive Therapy (PCIT). Specific interventions included psycho education, identifying support systems, relaxation techniques, and psycho education. Ideal cultural interventions included exploring what a member of this unique population has been taught socially and culturally about mental health services and provide education and advocacy regarding the rights they have even if there are undocumented. Overall, the suggested modification to Herman's (1992,1997) model included detailed culturally sensitive interventions for six trauma responses during each stage (beginning, middle, and end) of healing.

A preliminary model specific to undocumented battered Latina women living in a transitional domestic violence shelter is proposed. Such a model has not been found in previous literature and may benefit transitional domestic violence shelters that focus on the healing process of undocumented Latina domestic violence survivors.
CHAPTER ONE

INTRODUCTION

Domestic violence (DV) or intimate partner violence (IPV) relates to physical, emotional, financial, sexual, or psychological abuse towards another person (Merriam-Webster dictionary). According to Ammons (1998), a congressional report indicated that the most dangerous place in the U.S. for women is their home. Batterers use power and control tactics against women. These tactics included “intimidation, isolation, using children, coercion and threats, minimizing, denying, blaming, and gender inequalities,” (The National Coalition against Domestic Violence, 2007). According to statistics from the National Coalition against Women (2007), 1.3 million women are victims of DV. They also report that 85% of the victims of DV are women. DV costs the U.S. more than 5.8 billion a year (The National Coalition against Domestic Violence, 2007). A large part of these expenses come from medical and mental health services provided to the victims. In addition to financial costs, both the women and their children incur emotional and psychological costs.

Levendosky and Graham-Berman (2001) found that women who experience DV face many trauma symptoms, which may include depression, anxiety, child maltreatment, low self-esteem and self worth, hyper vigilance, and dissociation. According to Groves, from The National Child Traumatic Stress Network, three to ten million children witness and are victims of DV in the U.S. Various studies, (Martin, 2002; McFarlane, Groff, O’Brien, & Watson, 2003; Edleson, 1999), have found that children are also victims of DV and suffer many long term and short-term consequences. According to these various studies, (Martin, 2002; McFarlane, Groff, O’Brien, & Watson, 2003; Edleson, 1999),
children and adolescents who are victims or exposed to DV may experience anxiety, depression, difficulty concentrating, impulsive behavior, aggression, nightmares, and anti-social behavior. Women and men who have been abused as children or witnessed violence within the family are at a higher risk of becoming victims or perpetrators of violence as adults. Although DV affects all social economic backgrounds and ethnicities, some studies have found some groups of people are at a higher risk than others.

A study by Ingram (2007), found that Latino families (those who identified themselves as Hispanic in the study) are at a higher risk of experiencing DV. Ingram (2007) also found that many Latina women who live in a DV home are afraid to leave the abuser because they are not financially independent, don’t have a safe location to go to, are ashamed, and/or are afraid that their children will be taken away by Child Protective Services (CPS). Latina women are also at higher risk of DV if they live under patriarchal and male dominant traditional gender roles, which place machismo and familism ideology over women, (Kasturirangan & William, 2003; Raj & Silverman, 2002). Mattson and Ruiz (2005) argue that this reinforces the batterer’s power and control over the victim. Undocumented Latina women are at a higher risk than documented Latina women because of their immigration status. In this chapter, I will give an overview of three main themes in the literature, which include risk factors of undocumented Latina battered women, how trauma affects the body and mind, protective factors, and lastly, DV shelter experience.

**Risk Factors Unique to Undocumented Latina Women**

According to recent 2007 statistics collected by Wisconsin Coalition Against Domestic Violence Compilation of Statistics Packet (1993,1996, 2002), 34% of
undocumented Latina women experience DV, higher than the national average, which according to the National Coalition of Domestic Violence, as of 2007, is 25%. In addition, in a study by Adams and Campbell (2005) it was found that undocumented immigrant women are at higher risk of victimization by their abuser because they are not familiar with the legal and protective system in the U.S. Other risk factors included not having a family support system (since they are not in their country of origin), lack of language familiarity to seek help, dependence on the batterer for documentation to change immigrant status, financial strains, and lack of knowledge of U.S laws. Below the researcher will talk about three categories of risk factors: traditional cultural values, power and control tactics, and misinformation about possible support systems.

**Traditional Cultural Values.** According to Raj and Silverman (2002), undocumented Latina women are likely to stay in abusive relationships because of the culture that promotes patriarchal gender roles. These roles include women sacrificing everything for the family, religious beliefs that may reinforce them to stay and be silent, and stigma from the Latino community. According to Kasturirangan and William (2003), in the Latino community there are three cultural ideologies that a batterer can potentially use to justify DV, which are machismo, marianismo, and familism. In addition, Kasturirangan and William (2003), argue that machismo teaches males that they are the only ones who make decisions in the family, financially provide for the family, preserve the family’s reputation, and are emotionally strong during hardships. Thus, women in a traditional Latino family are also responsible for keeping the family together, are expected to be obedient and passive, and not exert any authority towards the male. The cultural belief of marianismo encourages women to model themselves after the Virgin
Mary, the mother of Jesus. This belief obligates women to be pure, passive, and submissive and maintain their family honor. Lastly, familism pushes women to sacrifice their personal dreams, goals, and any individual gains for that of the benefit of the family. Thus, women whose family, husband’s or boyfriend’s family, or themselves follow traditional patriarchal gender roles are at higher risk for abuse. Another risk factor that is unique to undocumented Latina women is their batterers’ power and control tactics.

**Power and Control Tactics.** Undocumented battered Latina women are also at higher risk of DV because batterers can victimize them in more ways than documented Latina women. As mentioned earlier, many undocumented battered women are unaware of U.S laws that protect them. In addition, there are limited amounts of social services that are available for the undocumented. Moreover, there are many non-cultural sensitive services, language barriers, fear of deportation, and having little to no family support in the U.S. that puts undocumented Latina women at risk. Raj and Silverman (2002) suggest that, “immigrant women’s culture, context, and legal status can (a) increase vulnerability to abuse, (b) be used by batterers to control and abuse immigrant women, and (c) create barriers to women seeking and receiving help,” (p.368). These barriers can lead to an increase in the power and control that the batterer has over the woman.

In the cycle of power and control (Domestic Violence Abuse Intervention Project, 1984), perpetrators use the power that they have over the victim by (a) threatening to deport the victim if they leave or tell anyone about the abuse, (b) threatening to not submit the proper paperwork for legal residency, (c) using intimidation by removing or destroy important documentation such as passports, (d) isolating the victim from any family member in the U.S, (e) denying them the right to talk to family members out of
the country and also not allowing them to learn English, and (f) using sexual abuse by raping her and/or stating in legal documents that she is a sex worker.

Unfortunately if the victim is undocumented, the batterer also uses the victim’s immigration status as a form of control and power, which places undocumented women at higher risk of remaining in the abusive relationship. The batterer uses various methods including, “using coercion and threats, intimidation, emotional abuse, economic abuse, isolation, minimizing, denying, and blaming, using children, and using the male privilege,” (Domestic Violence Abuse Intervention Project, 1984).

**Misinformed about Possible Support Systems.** Reinforcing the risk for victimization, is the risk factor of being misinformed about the possibility for assistance. Menjivar and Salcido (2002) interviewed various immigrant battered Latina women who stated that they would not call the police in the United States because in their country of origin, El Salvador and Mexico, the police would not take the case seriously and would not arrest the abuser. Mattson and Ruiz (2005) found that batterers deliberately misinformed undocumented battered women so that they don’t seek help. In addition, undocumented Latina women believe they will be deported if they call the police for help or tell anyone about the abuse. Thus, all of these risk factors can traumatize a woman who has experienced DV. Trauma is defined as an occurrence that causes feelings of emotional grief, suffering, and devastation that can cause long-term mental and physical effects, (http://www.joyfulheartfoundation.org/whatistrauma.htm, 2011). Trauma impacts individuals by deregulating their emotions, thoughts, and body. The researcher will provide a general overview of how DV victims are impacted by their trauma.

**Effects of Trauma in the Body and Mind**
Witnessing or experiencing violence is a traumatic event for many individuals. However, experiencing violence from someone that you love, your spouse, or intimate partner can be even more traumatic and painful. Herman (1992, 1997) argues that if the aggressor, “is a husband or lover, the traumatized person [DV victim] is the most vulnerable of all, since the person to whom she might ordinarily turn for safety and protection is precisely the source of danger,” (p.63).

Van der Kolk, for 43 years has been a teacher, researcher, and clinician in the subjects of posttraumatic stress and the impact of trauma on the entire person. Van der Kolk, has held important positions in the International Society for Trauma Stress Studies, Boston University Medical School, and the Trauma Center at Justice Resources Institute (http://www.traumacenter.org/about/about_bessel.php, 2007). According to Van der Kolk (2007):

“What people do not realize is that trauma is not the story of something awful that happened in the past, but the residue of imprints left behind in people’s sensory and hormonal systems. Traumatized people often are terrified of the sensation in their own bodies. Most trauma-sensitive people need some form of body oriented psychotherapy or bodywork to regain a sense of safety in their bodies,” (p.12).

Herman (1992, 1997) adds, “Survivors feel unsafe in their bodies. Their emotions and their thinking feel out of control,” (p.160). Moreover, Herman states that, “the survivor of a recent acute trauma is usually extremely frightened and flooded with intrusive symptoms, such as nightmares and flashbacks,” (p.218). Although trauma affects victims
and survivors of DV, there are protective factors that help them prevail through their trauma.

**Protective Factors**

According to Bucky, Geffner, and Suzuki (2008), protective factors assist an individual to adapt to a hardship and help control the feelings of stress, tension, or anxiety that arise from the adversity. Protective factors such as social support, religious faith, support and guidance from a caring adult, and confronting traditional gender roles helps victims of DV reduce mental health symptoms such as depression, social isolation, feeling of shame and guilt and substance abuse. In addition, it provides them the will and power to leave an abusive relationship, (Azhar-Millar, Lawrence, Molina, & Rivera, 2009; Bucky, Geffner, & Suzuki, 2008; Horne, Klesges, Levitt, & Wang, 2009). Below I will describe three main protective factors that the literature on DV found particularly helpful: religion, family/friend social support, and shelter services.

**Religion as a Protective Factor.** As mentioned, previously, the cultural value of marianismo and familism can make women feel they must sacrifice for their family and suffer silently. A document on the U.S. Conference of Catholic Bishops states, “that violence against women, inside or outside the home, is *never* justified” and “no person is expected to stay in an abusive marriage,” (http://www.usccb.org/issues-and-action/marriage-and-family/marriage/domestic-violence/when-i-call-for-help.cfm). Furthermore, Reverend Fortune and Rabbi Enger (2005), report that there are religious scriptures that clearly do not support abuse or violence in the home, support helping victims of abuse, and preach about women resisting against male domination, (Daniel, 13). There are also scriptures that identify violence against a woman as a sin, (Luke 17:
The authors believe that scriptures can provide strength for a survivor. Furthermore, the authors believe that having religious leaders learn about DV can help prevent religion from becoming a barrier for leaving an abusive relationship.

Horne, et. al., (2009) found that religion can be used as a coping mechanism for women who leave or plan on leaving a violent relationship as it creates strength, relief, and hope through prayer. In a study conducted by these authors, they found that 70% of Christian women reported that their Christian beliefs and faith helped them find the strength to leave and gave them hope for the future. In a questionnaire by Brabeck and Guzman (2008), seventy-five Mexican women used religion and spiritual beliefs as a form of coping skills. The same authors report that women who joined spiritual or religious support groups, had a relationship with God, and used spiritual figures that overcame hardship, such as the Virgin Mary, helped them rise above their trauma. Brabeck and Guzman (2008) found that religion provided women with strength, hope, and determination for the future. Having a strong support system of any kind was also found to be a protective factor.

**Family/Friend Social Support.** Brabeck and Guzman (2008) report that Latina women are more likely to seek help from family or friends instead of formal help such as police, doctor, etc. In addition, Hamby (2009), reports that social support assists women through the process of leaving an abusive relationship. Moreover, Hamby (2009), reports that 90% of women who seek help from family members (or other individuals they are close to) provide them emotional support, physical safety, and recognize and support their decision to leave the abusive partner. There are also studies that support DV shelters as a protective factor.
**Seeking Support in DV Shelters.** When women have no family to go to in order to escape their batterers, women may go to DV shelters to live and keep their children and themselves safe, (Few, 2005). These shelter programs vary in the services they can offer women and children. Hamby (2009) reports that women, who are low income, use shelters more compared to higher income women, as they provide protection and a place to live. In a 2000 California statewide DV shelters survey, it was found that 40% of 33,000 DV shelter residents were Latina women. In the same survey, it was found that the percentage of undocumented women who were residents in the DV shelters ranged from 2% to 35%, and even 50%, depending on the location of the DV shelters. The report suggests that the percentage of undocumented women might be unreported or underreported due to the undocumented women’s fear of receiving services because of their status as immigrants, (Bugarin, 2002). Not only do DV shelters provide protection from the batterers and a place to call home, but they also provide beneficial services to help women and their children to recover from what they have lost. 

DV shelters can help women regain self-esteem and self worth, and often provide programs to help empower women and promote independence, (Bennett, Howard, Riger, Schewe, & Wasco, 2004). Success rates for transitional DV shelters vary according to the program in the DV shelter. Some programs in DV shelters focus on the women’s own objectives and achievements to help guide women to make their own decisions, (Kasturirangan and Williams, 2008).

The remainder of this chapter will examine the DV shelter experience and evidence of its effectiveness. For instance, Bennett, et. al.(2004), studied fifty-four DV programs in Chicago, Illinois that served 31% of Latina women and found that the effects
of DV counseling programs are small, but significant. Some of the key themes that emerged were:

(a) “Domestic violence victims gain important information about violence and increase their support during their participation in domestic violence counseling, advocacy, and domestic violence hotline services;
(b) domestic violence victims perceive an improvement in their decision-making ability during their participation in domestic violence counseling and advocacy programs;
(c) domestic violence victims increase their self efficacy and coping skills while participating in domestic violence counseling programs;
(d) domestic violence victims feel safe while in shelter,” (p. 826).

**DV Shelter Experience: Types of Resources Provided**

There are several services that DV shelters provide to help women and children emotionally, cognitively, and psychologically. This includes advocacy, individual and group psychological intervention (by age), family interventions, reaffirming, recognizing, and validating behaviors/feelings after leaving a DV home, (Bennett, et. al. 2004; Hughes, 1982; Adams, Faul, Gallagher, Graham, Rudolph, Terranca, Trangsrud, & Wettersten, 2004; Johnson & Zlotnick, 2009). In addition, DV shelters help the child to assimilate back into school while at the shelter. Overall, DV shelters can also provide several programs such as parenting classes, childcare, adult classes, and legal aid. Below I will discuss legal aid, which is especially relevant for undocumented battered Latina women. Then I will proceed to describe the effectiveness of shelters on psychological well-being, relationships with children, and intimate relationships.
**DV Shelters as Legal Support.** DV shelters assist women with obtaining a restraining order, applying for child custody, child support, and immigration status, (Bennett, et. al., 2004). DV shelters provide undocumented battered women with information on their options when applying for legal status such as Violence Against Women Act (VAWA) and U-Visa. According to Raj and Silverman (2002), VAWA can help undocumented battered women receive residency. According to Conyers (2007), VAWA was, “the first federal law addressing domestic violence crimes to provide a federal role in the prosecution of these crimes and the treatment and protection of victims,” (p. 457). In addition, “under VAWA, battered immigrants whose abusive citizen and permanent resident spouses or parents used their immigration status as a means of afflicting abuse could attain lawful immigrant status without the approval or sponsorship of their abusive spouses,” (p. 458). Another path to legal status for undocumented battered women is through the U-Visa.

According to Ivie and Nanasi (2009), the U-Visa passed by Congress in 2000 branched from the Victims of Trafficking and Violence Protection Act of 2000. U-Visa, “provides an avenue to legal status for immigrant crime victims who 1) have suffered substantial physical or mental abuse as a result of victimization; 2) possess information regarding the activity; and 3) offer a source of help in the investigation or prosecution,” (p.11). Furthermore, through the U-Visa victims are able to obtain short-term legal status. After 3 years, they may receive permanent resident status.

**Effectiveness of Shelters.** Overall, many researchers have found DV shelters to be effective in various ways. Hunt, Murdaugh, Santana, and Sowell (2004) surveyed three hundred and nine Latina women during a six month period. They included questions regarding rate of physical violence and sexual violence, barriers for seeking help, and
services that help battered women. They discovered that the services that Latina women found helpful and important for their recovery and coping after a violent relationship included knowing their rights, legal services, court support, English classes, sense of safety, transportation, education to become self sufficient, and having someone to talk to.

Bracbeck and Guzman (2009) found that women rated DV shelters as very helpful because, it provided valuable resources that included legal, medical, and psychological help. Johnson (2009) also found that women who looked for help and used the services in DV shelters were more likely to not be victimized once they were out of the DV shelter.

Bennett et. al., (2004) also state that DV shelters provide a significant service for women who have been battered as they “offer safe refugee for women and their children, provide time for women to think about their options and to begin to rebuild their lives with social, legal, and medical assistance if needed,” (p. 817). Hughes (1982) further argues that counseling for women, the relationship they have with their children’s schools, and other interventions provided by DV shelter staff helps prevent a generational cycle of violence. A study by Jarvis and Novaco (2006), found that living in a DV shelter helps promote healthy intimate relationships for the future.

Battered women in DV shelters found strength in having support from various sources such as family, friends, other battered women, DV shelter staff, and advocates. In a study by Jarvis and Novaco (2006), in which 30% of DV shelter residents were Latina, 94% of women who left the DV shelter had a new intimate relationship that was non-violent. Both of these results can be considered a huge success for DV shelter staff. Overall, having DV shelter advocates motivate, encourage, and recognize them while in the shelter helped them feel supported, (Adams, et. al., 2004).
Effects on Psychological Well-being from Advocacy, Therapy, and Other Services. Sedlak (1998) found that formally battered women who resided in DV shelters for two weeks began to have a decrease in depressive symptoms and an increase in optimistic feelings. Bennett, et. al.(2004) also found that reduction of symptoms such as anxiety and depression were found once the women lived at the DV shelter at least two weeks. Herman (1992, 1997) reports that women “may look and act like a ‘strong survivor’ in a shelter environment where her experience is validated and her strengths are recognized and encouraged,” (p. 134).

A study on Latina immigrant women by Azhar-Miller, et. al. (2009), found that support groups were a positive experience for battered women. The authors found that these women gained positive attributes, such as being able to talk about their experiences more freely, be understood, have her feelings and experiences validated, and decrease negative feelings about themselves such as being at fault for the abuse and embarrassment.

Bennett et. al., (2004) partnered with Illinois Department of Human Services to conduct an evaluation of eighty-seven state funded DV and sexual assault agencies in the state. The data for the evaluation was collected through women who participated in at least one of the state funded agencies. Five percent of the participants were Latina women. Bennett et al., (2004) found that counseling and support groups for women enhanced confidence, boldness, locus of control, coping skills, and reduced symptoms of anxiety, depression, and hostility. In addition, Bennett, et. al. (2004), argue that living in a DV shelter and being provided with advocacy can benefit the women more than therapy. Not only do DV shelters provide services to reduce trauma symptoms and
increase mental health, but also enhance women’s relationship with their children. Although DV shelters provide many services for battered women and their children, there are limitations to these services.

**Limitations to Shelters.** Moe (2009) found that there are restrictions for women when they are seeking a DV shelter and the living experience at a DV shelter can be difficult. In fact, as mentioned earlier statistics suggest that Latinas are less likely to seek help from friends, family, and social services agencies than Non-Hispanic White women, (Ingram, 2009). Moe (2009) explains that DV shelters can be congested, do not accept older children such as teenagers, and cannot always accept bigger families. Women living in DV shelters have a difficult time coping with being watched and monitored by shelter staff. Moe (2009) found that although women were in a DV shelter for safety, the batterer continued to harass, stalk, and create fear when fighting for child custody and/or during child visitation exchanges. Women also need to be prepared to leave the DV shelter at any time if the batterer found their location or DV shelter rules were broken.

Given these limitations and unique risk factors for undocumented Latina women, the researcher is interested in documenting the healing process for undocumented Latina women as they face potential challenges to their healing. First, the researcher will discuss the definitions and models of healing. The researcher will then introduce an overview of six trauma responses, the concept of readiness to heal and Herman (1992, 1997) healing/recovery model, and other models found in the literature.
CHAPTER TWO
LITERATURE REVIEW

As noted previously, undocumented Latina women are at a higher risk of DV than documented battered women, (Raj & Silverman, 2002). While there is a lot of research on healing or recovery from trauma among DV victims, there is little to no research on the unique population of documented and undocumented battered Latina women in transitional DV shelters. My study will focus on undocumented Latina battered women living in a transitional DV shelter; it is one of the most common places where DV victims seek safety from their abuser, (Few, 2005).

First, I will discuss the definitions and models of healing and six trauma responses for individuals who have experienced DV. I will then introduce the concept of readiness to heal and the different stages of healing/recovery from trauma based research by Smith (2003), VanLerberghe (2010), Herman (1992, 1997), and Allen and Wozniak (2011). At the conclusion of this review I will begin to develop a model of healing unique to the experience of undocumented Latina battered women.

Conceptualization of Healing

Definitions of Healing. Some studies that examine healing have been done with Caucasian women in the field of humanistic psychology. According to Dossey (2003), healing is defined as, “physical, mental, social, and spiritual processes of recovery, repair, renewal, and transformation that increase wholeness, and often (though not invariably), order and coherence. Healing is an emergent process of the whole system and may or may not involve curing.” (p. A11). Allen and Wozniak (2011) believe, “that healing from relationship violence is a social, spiritual, cultural, and psychological process,” (p. 37).
For these authors healing after being harmed by another includes many numerous steps and the person as a whole being goes through the process.

According to Allen and Wozniak (2011), healing among women (race was not identified) who experienced DV consists of reclaiming a sense of safety, regaining control of their life, building themselves back after being pushed down, recognizing that they lived through a trauma, and reconnecting with family, friends, and community support. Healing can appear different for each individual that has experienced DV. For the purpose of this study the researcher will focus on the six trauma responses as a way of measuring healing.

**Overview of Six Main Trauma Responses**

Those who have experienced trauma go through many natural trauma responses, but for this study the researcher will focus on six of these trauma responses which include (1) social isolation, (2) depression, (3) anxiety/tension, (4) low self-esteem/helplessness, (5) dissociation, and (6) active fight, flight, or freeze. The six trauma responses are based on literature found on the psychological and emotional effects of DV (Herman, 1992, 1997; Levendosky et al., 2002; www.ptsd.va.gov/public/pages/common-reactions-after-trauma.asp, 2009). These responses don’t occur in any order and individuals can experience these trauma responses at the same time.

The first trauma response is social isolation. Herman (1992, 1997) defines social isolation as, “a sense of alienation, of disconnection, pervades every relationship, from the most intimate familial bonds to the most abstract affiliations of community and religion,” (p.52). An individual who experiences social isolation has a very difficult time connecting or having relationships with others. Banks, McMumm and Shankar (2001)
define, “individuals that live alone, have few friends, and have limited contact with people as being socially isolated,” (p.377). In addition, Herman (1992, 1997) argues that social isolation occurs because the person “feel[ing] utterly abandoned [and] utterly alone,” (p. 52). In other words, they feel alone in the world and can’t bond or have interpersonal relationships.

The second trauma response is depression. The National Institute of Mental Health describes depressive symptoms as, “persistent sad, anxious, or empty feelings; feelings of hopelessness or pessimism; feelings of guilt, worthlessness, or helplessness, thought of suicide, suicide attempts, etc.,” (p. 4). Life seems to be much more difficult and there is a sense of hopelessness and negative image of one self. Thus, many of the characteristics of depression can make it difficult to function in daily life.

This leads us to the third trauma response, low self-esteem/helplessness. Bem, Nolen-Hoeksema, and Smith (2001) state that individuals, who are hopeless, discouraged, and doubtful about their future, usually have a negative undertone or bias about themselves, the future, and what they can achieve.

The fourth trauma response that the researcher focused on for this study is anxiety/tension. Bem, Nolen-Hoeksema, and Smith (2001) define anxiety as an, “unpleasant emotion characterized by such terms as worry, apprehension, ‘tension’ and fear,” (p.380). A survivor has a difficult time with daily activities, people, and making decisions because there is a constant sense of doubt and preoccupation with negative outcomes.

The fifth trauma response in the healing model is dissociation. Kendall and Stein (2004) state that for survivors of abuse to protect themselves from the overpowering
emotions that occur after trauma, they use dissociation as a coping mechanism. Herman (1992, 1997) defines dissociation as an emotional, sensory, or mental disconnection. In addition, Herman (1992, 1997) states, “dissociation offers a means of mental escape at the moment when no other escape is possible,” (p.239). Survivors used dissociation when they were in danger to feel a sense of safety or escape; it was a natural reaction to a traumatic experience. Perry (2002) describes common dissociation responses, such as, “distraction, avoidance, numbing, daydreaming, fatigue, fantasy, de-realization, depersonalization, and in the extreme, fainting or catatonia,” (p. 8).

The last trauma response is active fight, flight, or freeze. Kendall and Stein (2004) state that our bodies prepare us to handle danger by responding, “in one or more of the following behaviors: withdrawal (flight); immobility (freezing); aggression (fight),” (p.81). All of these require active energy. If we do not “safely release the energy in our nervous system, the arousal stays in the body can lead to Post-traumatic Stress Disorder (PTSD)…with this undischarged energy our system becomes more sensitized,” (Cori, 2008, p. 15). Levine (2008) states that if an individual who had to use fight, flight, or freeze to respond to a trauma and has not given the body the message that he/she is no longer in danger, the body will continue to respond as if it is still experiencing a threat. In addition, Cori (2008) reports that we cannot shake off or discharge our response to fight, flight, or freeze as easily as animals.

In previous research there have only been a few studies that center on a healing model specifically for undocumented Latina women in DV shelters. Herman (1992,1997) states “Because trauma affects every aspects of human functioning from the biological to the social, treatment must be comprehensive…. At each stage of recovery,
comprehensive treatment must address the characteristic biological, psychological, and social components of the disorder,” (p.156).

**Readiness to Heal**

VanLerberghe (2010) states that in order for a battered woman to start to heal she must acknowledge the pain, have a willingness to heal, surrender or relinquish control over her life situation(s); be open minded; request help; suspend her rational mind; have clarity; have realization of truth; have the ability to forgive, accept herself, and have a spiritual connection. Once the battered woman has established a foundation to begin to heal, Smith (2003) argues that there are specific steps to take to heal.

Smith (2003) argues that in order for a battered woman to heal, she must deal “with the multiple losses she sustained in the relationship and free herself from guilt,” (p.547). Smith (2003) also argues that there is six segments that battered women need to pursue to heal. They consist of,”(a) letting go of the past, (b) finding their voice, (c) becoming self-reliant, (d) rediscovering oneself, (e) forgiveness of self/others, and (g) finding a purpose,” (p.562). Smith (2003) claims that battered women need to practice these six steps to gain a sense of recovery and healing from their traumatic experience.

In one of the only case studies of undocumented Central American women, Booker (2002) found that Latina undocumented women survivors can begin to heal/recover from their traumatic experience in support groups that provide them the opportunity to talk about their trauma. Being in a support group is a major milestone, because it signifies that they have accepted the fact that the trauma happened. The group setting provided Latina undocumented women who were survivors of DV the feelings of
support, validation, the chance to regain their voice, and a space to feel their shared experience as survivors.

Next, I will review a model of recovery and healing from Herman (1992, 1997) that is widely cited by trauma and DV professionals such as Bessel Van Der Kolk and Lenore Walker. This model has also been supported by organizations that focus on helping victims of sexual assault, DV, child abuse, and (PTSD) such as Joyful Heart Foundation, founded by actress Mariska Hargitay who plays Detective Olivia Benson on Law & Order: Special Victims Unit, and the U.S. Department of Veterans Affairs.

**Herman’s (1992, 1997) Three Stages of Recovery and Other Trauma Models**

Herman, has a large body of literature on trauma, is a clinical professor of psychiatry at Harvard Medical School, and the co-founder of the Victims of Violence Program at The Cambridge Hospital in Massachusetts. She has lectured on sexual violence and DV and has received many distinguished awards such as, “the 1996 Lifetime Achievement Award from the International Society for Traumatic Stress Studies. In 2007, she was named a Distinguished Life Fellow of the American Psychiatric Association,” (Beyond Reconciliation- Judith Lewis Herman-Biography, 2012). Her work is based on her research of psychology of “women, child abuse, domestic violence, and post-traumatic disorders,” (Regents of the University of California, 2000). In her book *Trauma and Recovery* (1992, 1997), she argues that there are three stages of recovery from trauma, which include (1) safety, (2) remembrance and mourning, and lastly, (3) reconciliation and commonality. For this study the researcher will use Herman’s (1992, 1997) recovery from trauma as healing from trauma. Below you will
find her description of these stages. The researcher will also describe other authors’ descriptions that are consistent or expand her conceptualization of healing.

In the first stage, Herman (1992, 1997) explains that an individual must first have a sense of safety (physically, emotionally, and psychologically) before continuing to the next stages. Herman (1992, 1997) found that a battered woman establishes a sense of safety from:

“The full range of therapeutic interventions brought to bear in her treatment, including biological interventions (medication), cognitive and behavioral interventions (education on traumatic syndromes, journal-keeping, and homework tasks), interpersonal interventions (building a therapeutic alliance), and social interventions (family support and a protective court order),” (p.169).

Previous literature mentioned earlier in this chapter by Allen and Wozniak (2011) has similar ideals of healing/recovery for battered women. Thus, a key component to healing for victims of DV is that women must regain their identity and all that they have lost when in the relationship. This includes regaining their self-esteem, their individualism, and ability to make their own choices, and the role in their nuclear and extended family. This leads us to the second stage, which is remembrance and mourning.

Herman (1992, 1997) argues that for a survivor to move on to remembrance and mourning they must begin to verbalize and write about the trauma that they experienced, also known as the trauma narrative process. During this stage the survivor receives acknowledgment and validation that their trauma experienced occurred and that their abuse and suffering was real. In addition, Herman (1992, 1997) notes that a survivor needs to mourn after the trauma in order to decrease the trauma’s negative effects. The
survivor needs to mourn the loss that came from the trauma, which for many, signifies the mourning of losing a husband, a marriage, a nuclear family system and losing trust and a sense of safety with someone they love or loved and who was a part of their life for many years. A survivor needs support from others to mourn their loss or they are at risk of uncontrollable pain and acute depression. Herman’s (1992, 1997) last step for recovery from trauma is reconciliation and commonality.

Herman (1992, 1997) argues that during reconciliation and commonality the survivor is able to begin to connect with others and starts to form trusting relationships. In addition, they must begin to build a new life and identity, begin to take herself out of the victim role, and lastly join or form a support system with individuals that have experienced the same type of trauma and are going through the same type of recovery process. The survivor needs this in order to continue to get their life back to a sense of normality. The survivor also needs to venture out into the community and start building a new social circle.

In addition, Herman (1992, 1997) states that to recover from trauma/healing the survivor needs to feel empowered; she must be the one in control. When a survivor is given an empowering environment where she feels, “validated and her strengths are recognized and encouraged,” (p.133) she is able to reach a new sense of empowerment and look like a powerful and able survivor.

Before I proceed to develop a preliminary model of healing from DV, readers need to know how women who have experienced DV respond. This is vital in order to learn how to help this population and develop a model that tackles their trauma responses when going through the healing process.
Model of Healing for Undocumented Battered Latina Women

The researcher only found one study that focused on undocumented battered Latina women not living in a DV shelter. In one of the only case studies of undocumented Central American women, Booker (2002) found that undocumented battered Latina women can begin to heal in support groups that provide them the opportunity to talk about their trauma in their own language. The group setting provided undocumented battered Latina women the feelings of support, validation, the chance to regain their voice, and a space to feel their shared experience as survivors. Although the group included one ethnic group, the model lacked detailed interventions that were used for this specific group. This lack of information prevents shelter-based clinicians and DV shelter staff from facilitating the healing process of undocumented battered Latina women.

Since there is no model that focuses on the complexity of the healing process for the undocumented survivor of DV there is a need for a model of healing that addresses the six trauma responses, the stages of healing, as well as previous research. The researcher will develop this model with the input from transitional DV shelter-based clinicians. The intent is to share this model with other transitional DV shelters that have undocumented battered Latina women who experience unique barriers to healing. At this time there is no research on the healing process of undocumented battered Latina women living in a transitional DV shelter. This is a critical area of research given that undocumented Latina women are at higher risk of being in a DV relationship.
CHAPTER THREE

METHODOLOGY

Setting and Participants

The data for this study consisted of one-on-one, tape-recorded interviews, with eight DV transitional shelter-based clinicians. The shelter-based clinicians provide mental health services in a transitional DV shelter for women and children. It is important to note that the women who come to this transitional DV shelter have spouses or boyfriends that can be undocumented, residents, or U.S. citizens. The work experience, socio-economic status, and spoken language of the women who enter this transitional DV shelter can also vary. In the experience of the researcher the majority of the women that come to this transitional DV shelter are Spanish-speaking dominant and are low income.

The researcher used snowball sampling. The researcher approached ten shelter-based clinicians working at the transitional DV shelter. The shelter-based clinicians’ years of experience working with DV survivors ranged from three years to ten years (See Table 1). Initially, ten shelter-based clinicians were interviewed, but only eight were able to complete the full interview. One of the shelter-based clinicians found that her limited schedule did not allow her to complete the interview. The other shelter-based clinician’s data was lost due to a discharged battery in the tape-recorder.

The interviews took place in a room provided by the transitional DV shelter to accommodate the participants’ schedules. In addition, some interviews took place off-site at local coffee shops on evenings and weekends when the transitional DV shelter’s room was not available.
The transitional DV shelter is located in Los Angeles County in an urban city. One unique characteristic of this transitional DV shelter is that its private funds allow them the ability to provide services for both undocumented and documented women and children who have experienced DV. The transitional DV shelter can house twelve families for one to one and a half years. The transitional DV shelter has an administrative office, a mental health building, a childcare facility, a preschool, an elementary school, an adult education school, and a park. All buildings are located in the same facility and in short walking distance of the clients’ apartments. The shelter can only provide services to families, women and children, who have experienced DV.

Table 1

Participants Characteristics (Pseudonyms)

<table>
<thead>
<tr>
<th>Participants</th>
<th>Years of Experience</th>
<th>Completed Interview</th>
<th>Not Completed Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veronica</td>
<td>Four</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>Seven</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Camry</td>
<td>Four and a half</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ginger</td>
<td>No data</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Linda</td>
<td>Three</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Daniel</td>
<td>No data</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Paris</td>
<td>Ten</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hamlet</td>
<td>Eight</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pamela</td>
<td>Four</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Suzie</td>
<td>Ten</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Procedure and Measures

The shelter-based clinicians were tape-recorded during the interview. The researcher introduced the study to each shelter-based clinician and asked fifteen questions. It took approximately one hour to complete the interview. The fifteen questions were organized into five major sections. The sections were: 1) descriptions of healing unique to undocumented battered Latina women, 2) obstacles to healing unique to undocumented battered Latina women, 3) ideal cultural interventions, 4) recommended treatments for each trauma response, and 5) shelter-based clinicians’ responses/reactions of Herman’s (1992, 1997) model of healing and recovery. Upon completion of the interviews, the interviews were transcribed by the researcher.

Data Analysis

The data was coded by looking for key themes in response to the research questions: 1) How do shelter-based clinicians define/characterize healing among undocumented battered Latina women? 2) How do shelter-based clinicians and workers characterize obstacles to healing among undocumented battered Latina women? (3) What are the priorities and interventions used by clinicians for each phase (beginning, middle, end) of healing? and (4) How do the clinical interventions used by shelter-based clinicians for undocumented battered Latina women differ from Herman’s (1992, 1997) traditional model of healing?

Thus, as the researcher reviewed the transcripts she underlined responses that were relevant to the research questions. The researcher did this twice to ensure that there was no missing data. The researcher not only looked at the direct response to the questions (e.g., definitions of healing), but also looked at the transcripts for responses
where the concepts (e.g., definitions of healing) may have emerged. The categories the researcher coded included (1) definitions of healing, (2) barriers that affect the healing process, (3) treating specific trauma responses, (4) specific interventions, treatment, ideal cultural interventions, and (5) responses to Herman (1992,1997) model of healing and recovery. Once the data was coded, the researcher cut and pasted all the codes and started to look for key themes that emerged.

Data collected was used to develop both a preliminary developed model and a final healing model from the shelter-based clinicians’ contributions. The researcher provided shelter-based clinicians with a sample chart of a preliminary developed model (see Table 2) and asked them to contribute to the model. The researcher created this model based on her own work with undocumented battered Latina women and her review of the literature.

The model was shown to each shelter-based clinician so that they could provide any input that was overlooked by the researcher. The researcher reviewed the model with the shelter-based clinicians individually for approximately fifteen minutes. All eight shelter-based clinicians contributed to the modification of the model. The changes made included adding specific interventions that shelter-based clinicians and DV shelter staff can perform with this unique population. For instance, one shelter-based clinician added “recognizing support systems before transition outside of shelter,” to the question: “If you were to categorize the interventions that you use with undocumented battered Latina women with Herman’s (1992,1997) three stages of healing, where would you place them in each stage?” The outcomes of their contributions will be seen in chapter four.
### Table 2

**Researcher’s Initial Healing Model for Undocumented Battered Latina Women Living in a DV Shelter**

<table>
<thead>
<tr>
<th>6 Top Trauma Responses</th>
<th>Interventions Recommended during Stage #1 (Safety)</th>
<th>Interventions Recommend during Stage #2 (Remembrance and Mourning)</th>
<th>Interventions Recommended Stage #3 (Commonality and Reconciliation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Isolation</td>
<td>Introduce client to school her first or second day of arrival to shelter; encourage other clients to welcome new client; encourage client to ask for basic directions to the store and social services office to the current clients that have been in the shelter; start group therapy</td>
<td>Provide an opportunity for client and staff to work together as a group; school and shelter outing; continue with group therapy</td>
<td>Continue with group therapy; support groups; an opportunity to join or participate in community based programs</td>
</tr>
<tr>
<td>Depression</td>
<td>Psycho education about traumas’ impact on daily function; provide tools to create structure around daily living and self: A Window between World (AWBW) art expression</td>
<td>(AWBW); honoring their experience and loss; psycho education; client is in trauma informed therapy and has started working on her trauma narrative with clinician</td>
<td>(AWBW); honoring their history and focusing on the future; exit planning for graduating the program; psycho education</td>
</tr>
<tr>
<td>Anxiety/ Tension</td>
<td>Introduce healthy coping skills such as exercise, journaling, etc. create experience to notice state of relaxation vs. state of tension to</td>
<td>The root of anxiety and tension is being addressed in more depth through therapy and staff helps her use the coping skills introduced</td>
<td>The feeling of anxiety and tension has reduced and client has the tools to regulate feelings. uses a combination of coping skills and therapy to</td>
</tr>
<tr>
<td>Low Self Esteem/Helplessness</td>
<td>Psycho education about her trauma response; case manager provide client with basic tools so client can do her own advocacy; Staffing focus on her accomplishments; body/self image and empowerment series</td>
<td>Provide leadership opportunities to give client confidence in her ability to be independent and in control of her case; focus on her and her family’s accomplishments; job training/volunteer opportunities</td>
<td>Staff provides client with positive feedback and affirmation of her leadership, initiative, and abilities. Staff asks client to reflect on their own accomplishments</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Psycho education about her trauma impacting body and mind; provide tools to help them become present; connection with body and mind through yoga and other exercise</td>
<td>Psycho education; (AWBW); yoga; trauma informed therapy; client is sharing stories in a safe environment</td>
<td>Psycho education; (AWBW); yoga; uses healthy coping skills to bring to present state</td>
</tr>
<tr>
<td>Active Fight, Flight, or Freeze</td>
<td>Client has a restraining order; safety planning; client recognizes triggers; Is provided tools and support to make her feel safe; client is introduced to individual therapy</td>
<td>Psycho education; recognizes trauma triggers and is starting to manage them with support from staff; recognizes she is safe; staff provide support to decrease sense of urgency</td>
<td>Group sharing of trauma experience; client knows pain is only temporary; &quot;new normal&quot; state of calm</td>
</tr>
</tbody>
</table>
CHAPTER FOUR

RESULTS

The research questions in this study were: 1) How do shelter-based clinicians define/characterize healing among undocumented battered Latina women? 2) How do shelter-based clinicians and workers characterize obstacles to healing among undocumented battered Latina women? (3) What are the priorities and interventions used by clinicians for each phase (beginning, middle, end) of healing? and (4) How do the clinical interventions used by shelter-based clinicians for undocumented battered Latina women differ from Judith Herman’s traditional model of healing?

The researcher conducted semi-structured interviews with eight shelter-based clinicians. The researcher originally interviewed ten shelter-based clinicians, but two shelter-based clinicians were not able to complete the interview. The researcher coded the data by looking for key themes in response to the interview questions that coincided with how shelter-based clinicians define/characterize healing and obstacles to healing among undocumented battered Latina women. The researcher will discuss each theme and provide representative quotes from the interviews. Based on all of the interviews responses, a healing model for undocumented battered Latina women will be presented.

Clinicians’ Concepts of Healing

The researcher asked the shelter-based clinicians two questions to get a better understanding of the definition of healing for this population. The first question was 1) “How do you as a shelter-based clinician define/characterize healing among undocumented battered Latina women?” and the second question was, 2)” What is unique about the experience of undocumented battered Latina women (biological, psychological,
and social)?” Three themes emerged when shelter-based clinicians answered the first question: a) healing as a process, b) healthy and [productive] reactions to stressors, and c) empowered/found voice.

The first theme that emerged among six out of the eight shelter-based clinicians (75%) was that healing was a process. One shelter-based clinician noted, “I don’t think there is an actual moment when they heal. I think it’s an ongoing process,” and another added, [it could take years]. One shelter-based clinician stated that due to the complexity of prior trauma (e.g. experience as children, immigration, etc.), the process could be ongoing. Among 75% of the shelter-based clinicians, another common theme was that healing meant having healthy and productive reactions to stressor. This included the idea that the DV client has learned how to cope with triggers. One shelter-based clinician stated, “Being able to know what triggers are and what they need to do when they are triggered. Know how to cope.” In addition, one shelter-based clinician stated that a woman who has healed can “Manag[e] their stress, handle their stress in a healthy way, and now they have the tools that they need to navigate these stressors that are going to be part of life.”

The final theme that emerged among four out of the eight shelter-based clinicians (50%) was that healing meant a client was empowered. One shelter-based clinician noted, “A woman who can be assertive using her voice, being able to set limits, have their own voice and assertive with themselves.” Another shelter-based clinician stated that healed undocumented battered Latina women, “take more action for their family and themselves, control their lives and not depend on others.” In sum, the interviews with shelter-based
clinicians emphasized the many layers of the healing process for undocumented battered Latina women.

**Unique Experiences of Clients**

To continue to answer the first research question and get a better understanding of this population healing process, the researcher asked shelter-based clinicians another relevant question. The second related question was, “What is unique about the experience of undocumented battered Latina woman?” This question resulted in unique responses from the question on defining healing. A total of three themes emerged: 1) legal barriers, 2) limited resources and employment, and 3) marginality/disempowerment due to status.

All eight clinicians (100%) mentioned legal barriers as unique to the experience of undocumented battered Latina women. It included fear of deportation and a higher risk of staying in the home due to threats. One shelter-based clinician stated that, “Being an undocumented immigrant is definitely another layer to [their unique experience] because they deal with real immigrant issues that add to their DV issues at home. Which …can definitely create barriers to employment, barriers to leave their batterers.” The second theme that emerged among five out of eight (63%) shelter-based clinicians was limited resources and access to employment due undocumented status. One shelter-based clinician stated that undocumented battered Latina women, “feel that they are still trapped and there aren’t any resources for them, there are no ways to be independent and find work.” The third theme among two out of eight shelter-based clinicians (25%) was marginality/disempowerment due to status. This includes the perception of self, feeling of disempowerment, and low self esteem all due to their status in the U.S. One shelter-based clinician mentioned, “People will look at you differently and you tend to fall into this
marginalized space compared to population that is mostly educated White in the United States.”

One shelter-based clinician stated that what is unique about the healing process of undocumented battered Latina women are the overwhelming barriers and trauma they come with. She noted that undocumented battered Latina women, “bring not only issues of DV, but also issues that come with being an undocumented immigrant [which] is definitely another layer, because they deal with real immigrant issues.” In addition, another shelter-based clinician stated that being in the U.S. and being undocumented psychologically makes the individual feel disempowered, powerless, and less deserving for assistance.

After learning about the healing process for this unique population and their experiences as undocumented, the researcher proceeded to ask questions about obstacles to healing among undocumented battered Latina women.

**Obstacles to Healing Among Undocumented Battered Latina Women**

To answer the second research question, “What are the obstacles of healing for undocumented Latina battered women?” the researcher asked the shelter-based clinicians two relevant questions. During the interview process the researcher decided to remove one of the questions [i.e., “How do you as a shelter-based clinician or shelter worker describe/characterize obstacles to healing among undocumented battered women?”] which the shelter-based clinicians found repetitive. When the researcher analyzed the interview transcripts, three themes emerged regarding obstacles to healing: 1) general challenges of being single caretakers, 2) family/cultural concepts of bearing one’s cross (suffering), and 3) stress of fulfilling particular criteria to apply and qualify for U-Visa/
VAWA. The first theme included general barriers that women encounter due to their status as, “newly single, undocumented women.” Six out of eight (75%) of the shelter-based clinicians mentioned this theme. One shelter-based clinician said that for undocumented battered Latina women, “extra worry about how they are going to support themselves, the process they are going through… lot of the times this gets in the way of the trauma because they are worried about finding a job.”

The second theme was family/cultural concepts of bearing one’s cross (suffering). This includes messages from family or cultural beliefs regarding DV including bearing the cross for the family. As mentioned in chapter one, bearing one’s cross for many women include sacrificing their personal dreams, goals, and any individual gains for that of the benefit of the family, (Kasturirangan & William, 2003). Two out of eight (25%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated that for some Latino families, “domestic violence is seen as normal due to machismo. …they might encounter messages such as it’s your cross to bear, think about the children, and the idea that the family needs to stay together as a nuclear family.”

The third theme that arose was the stress of fulfilling particular criteria to apply and qualify for U-Visa/ VAWA. Two out of eight (25%) shelter-based clinicians mentioned this theme. Two shelter-based clinicians mentioned that, “the immigration process can delay the healing,” and that this process, “[hinders] the healing process because they become stressed and overwhelmed.” Another shelter-based clinician stated that undocumented battered Latina women also encounter added stress when trying to become documented through the U-Visa or VAWA, which can contribute to the delay of their healing process. As mentioned in the previous chapter, the U-VISA and VAWA are
two pathways for immigrant crime victims to receive legal status. These stresses included trying to fit into a specific criteria or obtaining specific and detailed documentation from law enforcement. Unfortunately, in the experience of the shelter-based clinician, if the client gets rejected or does not qualify, they feel trapped, without resources, and they believe there is no way to be independent or find work. The shelter-based clinician added that the process of receiving documentation through the U-Visa or VAWA can be long. It can overwhelm the client and create anxiety when it is time to transition out of the DV shelter because they may leave without having the documents necessary to work and be fully independent. Before answering the third research question related to the notions of healing for undocumented battered Latina women, it is important to understand the additional unique challenges that shelter-based clinicians see in the clients at each trauma response. Hence, the following section describes the types of healing that are related to six trauma responses DV survivors’ experience.

**Unique Challenges for Each Trauma Response**

Experiencing trauma can impact the life of an individual or group of people physically, emotionally, and psychologically. The researcher chose six common trauma responses discussed in the literature of trauma and DV, (Hunt, Murdaugh, Santana, & Sowell, 2004; United States Department of Veterans affairs, 2009). Shelter-based clinicians in this study agreed that these six trauma responses are natural responses of DV based on their experience working with undocumented battered Latina women. These six trauma responses include social isolation, depression, anxiety/tension, low self-esteem/helplessness, dissociation, and active fight, flight, or freeze. Shelter-based clinicians described the unique challenges that this population may encounter with each
trauma response. The researcher asked shelter-based clinicians, “What are the obstacles/challenges when a client has social isolation, depression, anxiety/tension, low self-esteem/ helplessness, dissociation, active fight, flight, or freeze?” Readers will find the results to this question in Table 3.

Table 3

*List of Key Obstacles/Challenges for Each of the Six Trauma Responses*

<table>
<thead>
<tr>
<th>Social Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Lack of desire to connect</td>
</tr>
<tr>
<td>2) Lack of value of socializing</td>
</tr>
<tr>
<td>3) Difficult building rapport</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Lack of physical energy</td>
</tr>
<tr>
<td>2) Feelings of guilt and shame</td>
</tr>
<tr>
<td>3) Feelings of hopelessness and helplessness</td>
</tr>
<tr>
<td>4) No psychiatrist referral available</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety/Tension</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Difficult to get them focused</td>
</tr>
<tr>
<td>2) Negative thoughts such as fear and doubt, worries, and what if’s</td>
</tr>
<tr>
<td>3) Feelings of hypersensitivity and hyper vigilance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Self-Esteem/Helplessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Feelings of helplessness and negativity</td>
</tr>
<tr>
<td>2) Lack of motivation, confidence, and acknowledgement of their strengths</td>
</tr>
<tr>
<td>3) Dependent on others such as clinician or shelter staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dissociation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Bringing them back to the present and identifying what is real</td>
</tr>
<tr>
<td>2) Building awareness</td>
</tr>
<tr>
<td>3) Finding a healthy way to cope</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Active Fight, Flight, or Freeze</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) High alert, hyper arousal, hyper vigilance, negative, passive or not assertive</td>
</tr>
<tr>
<td>2) Overcoming their fear that they are crazy</td>
</tr>
</tbody>
</table>
**Social Isolation.** Three challenges emerged in the interviews regarding the difficulties that may be encountered when working with an undocumented battered Latina woman who is experiencing social isolation. The first theme was shelter-based clinicians noted a lack of desire among undocumented battered Latina women to seek support from family, shelter staff, and/or residents at the shelter. Three out of eight (38%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated that, “It’s hard sometimes to engage them in seeking support especially if their partner has socially isolated them.” In the experience of the shelter-based clinicians, for this unique population, social isolation can become a norm that is hard to change. It has become a way of life for them.

The second theme was undocumented battered Latina women can become avoidance and/or lack the value placed on socializing. Shelter-based clinicians mentioned that they have personalized their life to include being isolated as a way to cope and avoid discomfort. Three out of eight (38%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated, “They don’t think socializing will solve the problem or make it any better.” One shelter-based clinician stated that it is easier for this unique population to not socialize with others because their DV experience can come up during a conversation and others might judge them. Avoiding socializing can help them elude from bringing up this painful past.

The third theme that shelter-based clinicians discussed regarding social isolation was a lack of skill in building rapport with shelter-based clinicians and fellow transitional DV shelter residents. Two out of eight shelter-based clinicians (25%) mentioned this theme. One shelter-based clinician stated that, “When they have social
isolation it’s difficult to build rapport and to help them engage with fellow women in the complex.” The same shelter-based clinician stated that they naturally have a hard time building rapport with the DV shelter residents because they avoiding interaction and only participate in what is mandated by the DV shelter. Another shelter-based clinician stated it’s hard to build rapport with a client from this population especially in case where mental health treatment is “mandated after an incident of some sort.”

**Depression.** Four themes emerged regarding the challenges shelter-based clinicians faced when working with clients from this population who are experiencing depression. The first theme was difficulty for clients to take action physically. Three out of eight (38%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated that due to their depression women had a lack of interest and ability to practice recommended interventions. Two shelter-based clinicians stated that, “If they are too depressed [they] don’t have that energy to do things differently” and have, “feelings like they don’t want to get out of bed, everything is hard [and] everyday it’s challenging.” The second theme was having feelings of guilt and shame. Two out of eight (25%) shelter-based clinicians mentioned this theme. One shelter-based clinician mentioned that this unique population, as an attempt to avoid shame of feeling depressed, could deny feelings of suicide and depressive thoughts.

The third theme was this population having feelings of hopelessness and helplessness. Two out of eight (25%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated that, “they come in with learned hopelessness and helplessness.” When a client from this population has learned this way of thinking it’s hard to work with them because if they don’t have hope for the future, “it’s hard to help
them.” The fourth theme was no psychiatrist referral available for medication due to their status in the U.S. One out of eight shelter-based clinicians mentioned this theme. Shelter-based clinicians stated that these women are unable to obtain proper healthcare resulting in clients going to a free clinic for medication and taking the risk of being over or under medicated.

**Anxiety/ Tension.** Three themes arose regarding the challenges that may be encountered while this unique population is experiencing anxiety/tension. The first theme was difficulty to get them focused and slowing down to engage in interventions. Four out of eight (50%) shelter-based clinicians mentioned this theme. Two shelter-based clinicians stated that this unique population needs to be in a, “calm state for them to know what is going on in therapy,” and they need to get “them to slow down and do the interventions.” If an individual from this unique population is not able to focus on the interventions and therapy session, it interferes with the work the shelter-based clinicians are providing and their progress in reducing this trauma response suffers.

The second theme was this unique population experiencing negative thoughts such as fear, doubt, worries, and what if’s, due to their status in the U.S. For instance, some key concerns shelter-based clinicians mentioned were pending documentation for legalization, court dates/child custody, and safety. Three out of eight (38%) shelter-based clinicians mentioned this theme. One shelter-based clinicians stated that these thoughts greatly influence women’s treatment because they think of extreme outcomes of what if’s. They have a difficult time engaging in, “relax[ation techniques and] muscle relaxation [because] they can’t focus and because they have so much on their mind. I need to find alternatives like making predictions so they can change anxiety.”
The third theme was this unique population experiencing feelings of hypersensitivity and hyper vigilance. One out of eight (13%) shelter-based clinicians mentioned this theme. “Hyper vigilance, panic attacks, [a] higher degree of mistrust, mistrust within [themselves] as well because [they] don’t know if [they’re] going to lose control.”

**Low Self-Esteem/ Helplessness.** The researcher found three themes when asking shelter-based clinicians about the difficulties that may be encountered while an individual from this unique population is experiencing low self-esteem/helplessness. The first theme was this unique population having strong feelings of helplessness and negativity. Four out of eight (50%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated that this unique population has strong feelings of helplessness and negativity because of challenges, such as their status in the U.S., that prevent them from receiving an education or certification that can help them succeed in a career. They are stuck with a low wage job, which influence their negativity and outlook for the future. One shelter-based clinician also stated that “they are stuck; they don’t see how they can survive or plan for the future.”

The second theme was client experiencing a lack of motivation, confidence, and acknowledgement of their strengths. Three out of eight (38%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated that having little to no confidence influenced their motivation and their perception of themselves, “its hard for them to see that there are other aspects [other than being a victim or survivor of DV] of themselves that are good.” The third theme was this unique population becoming dependent on others such as shelter-based clinician or DV shelter staff. One out of eight
(13%) shelter-based clinicians mentioned this theme. This shelter-based clinician stated that they are accustomed to being dependent on the batterer in the relationship that it is only natural for them to become dependent on a shelter-based clinician or DV shelter staff.

**Dissociation.** The researcher found three themes when asking shelter-based clinicians about the difficulties that may be encountered while an individual from this unique population is experiencing dissociation. The first theme was bringing them back to the present and identifying what is real and unreal. Four out of eight (50%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated that it’s important for this unique population to be able to identify what is happening in the moment versus a dissociative moment because, “it’s very adaptive.” It’s become a normal part of their life, which can be difficult to break.

The second theme was building awareness of their dissociation. Three out of eight (38%) shelter-based clinicians mentioned this theme. One shelter-based clinician stated that building awareness that they are dissociating could be difficult because they might not know that they are dissociating, as it’s a normal reaction after being in a DV relationship. One shelter-based clinician stated that not building awareness included having a, “numbing experience, not being present, and [this experience] can affect their [everyday functioning such as] taking care of their child.” The third theme was finding a healthy way to cope that doesn’t mirror dissociation. One out of eight (13%) shelter-based clinicians mentioned this theme. This shelter-based clinician stated that it’s a, “challenge, dissociating has become a way of coping and you need to give them something to replace that.”
**Active Fight, Flight, or Freeze.** The researcher found two themes when asking shelter-based clinicians about the difficulties that may be encountered while an individual from this unique population is experiencing active fight, flight, or freeze. The first theme was the client being on high alert, hyper arousal, hyper vigilance, negative, passive or not assertive. Seven out of eight (88%) shelter-based clinicians mentioned this theme. One shelter-based clinicians stated that experiencing active fight, flight, or freeze makes them feel, “hyper vigilance and hyper aroused and their judgments is amplified.” Feeling this way can negatively influence decision-making and level of comfort because they are on alert for danger. Another shelter-based clinician stated that it’s difficult to try to help this unique population when they are experiencing active fight, flight, or freeze because they are not able to calm down. Lastly, one shelter-based clinician stated that, “they’re ready to leave, they are unsure if they should be at the shelter, anything scares them, [and] they can’t get comfortable because they don’t know what might happen next.” The second theme was overcoming their fear that they are crazy, not understanding why their mind and body are responding with active fight, flight, or freeze. One out of eight (13%) shelter-based clinicians mentioned this theme.

**Summary of Challenges for Each Trauma Response**

As noted by the shelter-based clinicians, battered women have many natural responses to their trauma experience that can affect them negatively after they are no longer living with the batterer. This includes their image of self, loss of sense of safety, the feeling of being out of control of their bodies, emotions, and mind. All these natural responses that once served them as a form of protection during the trauma now affect their daily functioning as an individual and a mother. After asking the shelter-based
clinicians about the unique challenges that this unique population can encounter when experiencing trauma responses, the researcher moved on to the third interview question. The next section will focus on the shelter-based clinicians’ order of priorities in addressing each trauma responses, recommended clinical based treatment and specific interventions for each trauma response, and specific cultural interventions for this unique population.

Priorities in Addressing Each Trauma Response

To answer the third research question about priorities and interventions for undocumented battered Latina women, researcher asked participants the following questions:

(1) When working with undocumented battered Latina women, in what order (please rate 1-first priority and 6-last priority) do you see that each trauma response needs to be tackled?

(2) What is the clinical based treatment that you use when working with undocumented battered Latina women with each trauma response?

(3) What are the specific interventions that are used with this clinical based treatment?

(4) How do they [the interventions] differ from women who are documented and/or from another ethnicity (i.e., cultural interventions)?

For the purpose of the study the researcher defined clinical-based treatments as clinical modalities that are used by clinicians to target a particular mental health disorder or diagnosis. Interventions are suggested actions within the clinical treatment or modality that should be taken to reduce the symptoms that come with the particular mental health
disorder or diagnosis. A simple medical example would be a woman who is diabetic (diagnosis) and is recommended that she take insulin (intervention) to reduce her blood sugar (symptom). Below (see Table 2) are the results to each of those questions.

Table 4

_Tally of Shelter-based Clinician Ranked Priorities Regarding Which Trauma Response to Address First in a Treatment Plan for DV_

<table>
<thead>
<tr>
<th>Trauma Response</th>
<th>Ranked 1st</th>
<th>Ranked 2nd</th>
<th>Ranked 3rd</th>
<th>Ranked 4th</th>
<th>Ranked 5th</th>
<th>Ranked 6th</th>
<th>Most common rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Isolation</td>
<td></td>
<td></td>
<td>n=2</td>
<td>n=1</td>
<td>n=5</td>
<td></td>
<td>6th</td>
</tr>
<tr>
<td>Depression</td>
<td>n=3</td>
<td>n=2</td>
<td></td>
<td>n=3</td>
<td></td>
<td></td>
<td>1st or 4th</td>
</tr>
<tr>
<td>Anxiety/Tension</td>
<td>n=1</td>
<td>n=3</td>
<td>n=3</td>
<td>n=1</td>
<td></td>
<td></td>
<td>2nd/3rd</td>
</tr>
<tr>
<td>Low Self Esteem/Helplessness</td>
<td></td>
<td></td>
<td>n=7</td>
<td>n=1</td>
<td></td>
<td></td>
<td>5th</td>
</tr>
<tr>
<td>Dissociation</td>
<td>n=1</td>
<td>n=1</td>
<td>n=3</td>
<td>n=2</td>
<td>n=1</td>
<td></td>
<td>3rd</td>
</tr>
<tr>
<td>Active fight, flight, or freeze</td>
<td>n=3</td>
<td>n=2</td>
<td>n=1</td>
<td>n=1</td>
<td>n=1</td>
<td>1st</td>
<td></td>
</tr>
</tbody>
</table>

When answering the question, “When working with undocumented battered Latina women, in what order (please rate 1-first priority and 6-last priority) do you see that each trauma response needs to be tackled?” an interesting theme emerged. Shelter-based clinicians’ noted that a client’s trauma responses could become magnified as a natural response to being in a new environment that is often out of their comfort zone. This response influences the decision about which trauma response should be tackled.
first. Three out of eight (36%) shelter-based clinicians stated that many clients’ trauma responses, such as depression, anxiety/tension, and active fight, flight, or freeze are magnified at a higher rate in response to living at a DV shelter.

Thus, although shelter-based clinicians had varied priorities, the researcher will report on where there was some agreement. Active fight, flight, or freeze was chosen as the first priority among three out of eight (36%) shelter-based clinicians. One shelter-based clinician stated that it was important to tackle this response first because:

“Chances are when they come in [a DV shelter] they are very reactive. If they can get an understanding of why they are reacting this way, it will give them a better chance to control their bodies and get a better understanding of why they are responding to certain things in a more exaggerated manner.”

In addition, three out of eight shelter-based clinicians (36%) argued that depression should be the first priority. Their reasoning was that undocumented battered Latina women are coming into the DV shelter and are required to adjust to a new environment for a couple of months or years. This affects their trauma response and they want, “to see the level and intensity of depression that might affect their parenting.” However, interestingly, three out of eight (36%) shelter-based clinicians ranked depression as fourth priority, but did not give a reason.

Furthermore, three out of eight (36%) shelter-based clinicians maintained that anxiety/tension should be the second priority. While three out of eight (36%) shelter-based clinicians contended that it should be tackled third because, “most of the anxiety is fueled by their reaction [to] dissociation and active fight, flight, or freeze. Providing them
with education of why it happens will reduce anxiety.” One shelter-based clinician stated that she would tackle anxiety/tension first because she understood that living in a location that is not one’s home, like the transitional DV shelter, could create anxiety.

Moreover, low self-esteem/helplessness was chosen by the majority of shelter-based clinicians, five out of eight (63%), as the fifth trauma response they would engage. They stated that low self-esteem is a response to depression and it is important to find what is stimulating the depression. Social isolation by the majority of the shelter-based clinicians, five out of eight (63%), declared it to be the last trauma response they would embark upon because it is, “another combination of low self-esteem because with depression you isolate yourself. Your way of coping is isolating yourself.”

**Recommended Clinical-based Treatments**

Below is a description of the recommended clinical-based treatments for each of the trauma responses. The researcher did not provide the shelter-based clinicians with a list of clinical-based treatments. The shelter-based clinicians provided the researcher with their personal expertise regarding which clinical-based treatment worked best with each trauma response. The full list of recommended clinical-based treatments for each trauma response can be found in Table 4.

**Recommended Clinical-based Treatment(s) for Social Isolation.** Six out of eight (75%) shelter-based clinicians responded that Cognitive Behavioral Therapy (CBT) would be the best treatment for social isolation. Two (25%) of the aforementioned shelter-based clinicians also stated that using only one model is unrealistic because clients differ in treatment. Two out of eight (25%) shelter-based clinicians would use
other models such as family system and cognitive approach at the end of the treatment. One of those 25% shelter-based clinicians stated the CBT would work best because:

“It’s easier for them to check off how many times they were able to make a connection with someone. When you think about the Latino community many times there seems to be a concrete focus so it works out a lot better.”

The other shelter-based clinician, who stated that using only one model would be unrealistic, disagreed with the CBT approach and stated that it would not work for this population because, “it’s to obstruct, a more directive approach would be more appropriate.”

**Recommended Clinical-based Treatment(s) for Depression.** Seven out of eight (88%) shelter-based clinicians stated that CBT would work best with this population. Of those seven shelter-based clinicians who would used CBT one (14%) would add a humanistic approach to the CBT, “because with humanistic its very warm and caring, but also with cognitive behavioral therapy you are really able to have some concrete things they can do that they can track,” and one (14%) would add dialectal therapy in addition to CBT. One shelter-based clinician would not use only CBT, but would, “need to explore where it is coming from [symptoms of depression]. “I use the acetylic approach and I would do family therapy if that’s what is causing it.”

**Recommended Clinical-based treatment(s) for Anxiety/Tension.** Eight of eight shelter-based clinicians (100%) recommended Trauma Focused Cognitive Behavioral Therapy (TF-CBT). Of those eight, one (13%) who recommended TF-CBT would add additional models or treatment such as psychodynamic, which helps clients’ explore their childhood and its connections to their underlying issues of anxiety. One of those eight
(13%) who recommended TF-CBT would add parenting classes and Parent and Child Interactive Therapy (PCIT). The shelter-based clinician believed that much of their anxiety for the women might come with their interactions with their children. One of eight (13%) who recommended TF-CBT would also, “focus more on the relaxation and what would someone see in the situation, would they also be scared, if domestic violence didn’t happen to you would it still be a fear.” Lastly, one of the shelter-based clinician believed that you couldn’t be specific when it came to models.

**Recommended Clinical-based Treatment(s) for Low Self-esteem/Helplessness.** Four out of eight shelter clinicians (50%) recommended TF-CBT. Of those four that recommended this model one (25%) recommended that they would also use Child parent psycho (CPP) therapy (work done with Latina community and DV). One out of eight (13%) recommended PCIT and praising the client for what they have accomplished as a parent. One out of eight (13%) recommended Psycho dynamic and humanistic approach because, “with self esteem you want to see what is fueling those messages and you want to use a loving space to let them know they are valued and it is about them.” Two out of eight (25%) could not recommend a specific model.

**Recommended Clinical-based Treatment(s) for Dissociation.** Seven out of eight (88%) shelter-based clinicians recommended TF –CBT, of those seven who recommended TF-CBT, one (14%) stated they would recommend it because it helps track, “yourself and really thinking about ways you are dissociating.” One out of eight (13%) could not choose a specific model.

**Recommended Clinical-based Treatment(s) for Active Fight, Flight, or Freeze.** Seven out of eight (88%) shelter-based clinicians recommended TF–CBT. Of
those seven shelter-based clinicians, one (14%) stated they recommend it because it is, “easier to track, more structured and it’s easier to identify and decrease symptoms.” One out of eight (13%) stated that they couldn’t be specific because it would depend on the clients.

Table 5

*Suggested Clinical-based Treatments for Six Trauma Responses*

<table>
<thead>
<tr>
<th>Clinical-based Treatment</th>
<th>Social Isolation</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Low self-esteem</th>
<th>Dissociation</th>
<th>Active fight, flight, or freeze</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavioral</td>
<td>n=6</td>
<td>n=7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma-focused CBT</td>
<td>n=8</td>
<td>n=4</td>
<td>n=7</td>
<td>n=7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psycho-dynamic</td>
<td>n=1</td>
<td>n=1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humanistic Family System</td>
<td>n=1</td>
<td>n=1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Model</td>
<td>n=2</td>
<td>n=1</td>
<td>n=1</td>
<td>n=1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Unrealistic
Dialectical  n=1
Therapy
Acetylic  n=1
Approach
Child parent  n=1
Psycho
Parent  n=1  n=1
Interactive
Therapy/
Parenting

Note: The shelter-based clinicians identified these treatments without the researcher prompting

Once the shelter-based clinicians were able to define what healing was among undocumented battered Latina women, the unique experiences and challenges of undocumented battered Latina women, and recommended clinical-based treatments, the interview protocol shifted to a focus on their specific interventions.

Specific Interventions for the Main Stages of Healing

The researcher showed shelter-based clinicians Herman’s (1992, 1997) model and described her three stages on healing and recovery. Based on those stages, the researcher asked shelter-based clinicians to give her the interventions that they use with this unique population and how they would use them in each stage. In addition, the researcher asked the shelter-based clinicians to add these interventions to the researcher’s development
model of healing for undocumented battered Latina women living in a transitional DV shelter (See Table 2). The recommended interventions were presented to the shelter-based clinicians when asking them to categorize their interventions with those of Herman’s (1992, 1997) model. The researcher interpreted Herman’s (1992, 1997) model and initiated a model specifically for undocumented battered Latina women living in a transitional DV shelter. The researcher believed that this method would help the shelter-based clinicians categorize their recommended interventions more efficiently. In addition, the researcher believed that it would help support her recommended interventions.

The revised model was developed after conducting and analyzing the interviews. The researcher’s and shelter-based clinicians’ recommended interventions are underlined to let the readers see which group added to the developed model. Table 6 shows the shelter-based clinicians contribution to the model and the researcher recommended interventions.

Table 6

Researcher’s Revised Healing Model for Undocumented Battered Latina Women with Shelter-based Clinicians’ Recommended Interventions (which are underlined)

<table>
<thead>
<tr>
<th>6 Top Trauma Responses</th>
<th>Interventions Recommended during Stage #1 (Safety)</th>
<th>Interventions Recommend during Stage #2 (Remembrance and Mourning)</th>
<th>Interventions Recommended Stage #3 (Commonality and Reconciliation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Isolation</td>
<td>Introduce client to school her first or second day of arrival to shelter; encourage clients to welcome</td>
<td>Provide an opportunity for client and staff to work together as a group with firm and</td>
<td>Continue with group therapy; support groups; an opportunity to join or participate in</td>
</tr>
</tbody>
</table>

51
<p>| Depression | Psycho education about traumas’ impact on daily function; provide tools to create structure around daily living and self: A Window between World (AWBW) art expression; yoga, meditation and guided imagery; encourage client to be physically active 10 to 15 minutes a day or every other day; identify and create strong support systems; provide the shelters success rate to initiate hope and normalize fear of the future. | Increase knowledge of familiar patterns of depression; connect childhood experience impacting current life; (AWBW); honoring their experience and loss; Psycho education; client is in trauma informed therapy and has started working on her trauma narrative with clinician; psychiatric evaluation if appropriate; create new rituals (i.e., Holidays); accept losses without predicting what triggers might bring out symptoms and what coping skills practiced to cope with them; (AWBW); honoring their history and focusing on the future; exit planning for graduating the program; psycho education; review progress made; continue working on strategies learned to continue progress; resource planning; highlight strengths and accomplishments. | Community based programs |</p>
<table>
<thead>
<tr>
<th>Anxiety/ Tension</th>
<th>unknown,</th>
<th>avoidance</th>
<th>The root of anxiety and tension is being addressed in more depth through therapy and staff helps her use the coping skills introduced.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Create awareness of what and how you are triggered (5 senses); introduce healthy coping skills such as exercise, journaling, mediation; living in the present, etc; create experience to notice state of relaxation vs. state of tension to improve clear headiness; connect to resources (i.e. legal resources)</td>
<td></td>
<td>The feeling of anxiety and tension has reduced and client has the tools to regulate feelings; the client uses a combination of coping skills and therapy to regulate the feelings of anxiety/ tension; able to catch thoughts contributing to anxiety and change them.</td>
</tr>
<tr>
<td>Low Self Esteem/ Helplessness</td>
<td>Positive qualities journaling; volunteer salon makeover visits; (AWBW); psycho education about her trauma response; case manager provide client with basic tools so client can do her own advocacy; staffing meeting with clients focus on her accomplishments; body/self image and empowerment classes</td>
<td>Provide leadership opportunities to give client confidence on her ability to be independent and in control of her case; focus on her and her family’s accomplishments; job training/volunteer opportunities; client continue treatment with self esteem; staff praises client’s different accomplishments to increase confidence.</td>
<td>Shelter staff and outside agencies provides client with positive feedback and affirmation of her leadership, initiative, and abilities. Staff asks client to reflect on their own accomplishments</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Psycho education about her trauma impacting body and mind; provide tools to help them become present; connection with body and mind through yoga, and</td>
<td>Psycho education; build and share dissociation (AWBW); yoga; meditation; trauma informed therapy; client is sharing stories in a safe</td>
<td>Psycho education; (AWBW); yoga; uses healthy coping skills to bring to present state; meditation and mindfulness exercises</td>
</tr>
<tr>
<td>Active Fight, Flight, and Freeze</td>
<td>other exercise such as meditation and mindfulness exercises</td>
<td>environment; help client be aware of present, increase self-awareness and confidence with coping</td>
<td>Predict future triggers and identify healthy coping skills to manage the trauma response; group sharing of trauma experience; client knows pain is only temporary; &quot;new normal&quot; state of calm</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Psycho education about shelter experience which includes clear and structured expectations and rules; client has a restraining order; safety planning; client recognizes triggers; meditation and grounding exercises; client is provided tools and support to make her feel safe; client is introduced to individual therapy</td>
<td>Psycho education; mindful meditation and self regulate techniques; client recognizes trauma triggers and is starting to manage them with support from staff; recognizes she is safe; staff provide support to decrease sense of urgency</td>
<td>Note. The shelter-based clinicians’ suggested interventions are underlined</td>
<td>The researcher added all of the interventions that the eight shelter-based clinicians recommended for each trauma responses during each stage. As seen above the shelter-based clinicians made many helpful comments, but also agreed with the researchers suggested interventions.</td>
</tr>
<tr>
<td>During the first stage (safety) of social isolation, shelter-based clinicians recommended that DV shelter staff identify assigned captain/case manager to the client, assign the client a mentor to guide them through the program, connect client to community resources and activities such as parks, and have clear and specific agreements of transitional DV shelter living and time frame of their stay. In the second stage</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(remembrance and mourning) of social isolation the shelter-based clinicians recommended that the client be encouraged to participate in outside community activities, the client be provided resources and the client’s case manager advocate for her needs including legal services, DPSS, DCFS, etc. In addition, the shelter-based clinicians recommended that there be clear boundaries between DV shelter staff and clients.

During the first stage (safety) of depression, shelter-based clinicians recommended additional mindfulness exercises such as yoga, meditation, and guided imagery. They also recommended that clients be encouraged to be physically active ten to fifteen minutes a day or every other day. In addition, they recommended that the client be helped in identifying and creating strong support systems. Lastly, it was recommended that the client be provided the transitional DV shelter’s success rate to initiate hope and normalize fear of the unknown. In the second stage (remembrance and mourning) of depression, shelter-based clinicians recommended providing the client with increased knowledge of familiar patterns of depression and help them connect with how their childhood experience is impacting their current life. Another recommendation was psychiatric evaluation if appropriate depending on the seriousness of the depression. Lastly, shelter-based clinicians recommended helping the client create new rituals (i.e., Holidays) and accept their losses without avoidance. In the third stage (commonality and reconciliation) of depression shelter-based clinicians added helping the client predict what triggers might bring out symptoms and what are the coping skills she needs to practice to cope with these triggers. In addition, they added reviewing the clients progress made since starting treatment, continue working on strategies learned to continue
progress, and highlight the clients strengthens and accomplishments. Lastly, they recommended the shelter-based clinicians help the client with resource planning.

During the first stage (safety) of anxiety/tension, shelter-based clinicians recommended that a shelter-based clinician help the client create awareness of what and how she can become triggered (5 senses) and help her practice living in the present with meditation practices. Lastly, it was recommended that the client be connected to important resources such as legal resources. In the third stage (commonalty and reconciliation) of anxiety/tension shelter-based clinicians added that during this stage it was important for them to help the client be able to catch thoughts contributing to anxiety and change them.

During the first stage (safety) of low self-esteem, shelter-based clinicians recommended that the client practice writing down their positive qualities in a journal, attend volunteer salon makeover visits, and participate in AWBW. In the second stage (remembrance and mourning) of low self-esteem shelter-based clinicians recommended that the client continue treatment with self-esteem and DV shelter staff praises client’s different accomplishments to increase confidence. In the third stage (commonalty and reconciliation) of low self-esteem shelter-based clinicians recommended that outside agencies provide that client with positive feedback and affirmation of her leadership, initiative, and abilities.

During the first stage (safety) of dissociation shelter-based clinicians recommended helping the client connect with body and mind through exercise such as meditation and mindfulness exercises. In the second stage (remembrance and mourning) of dissociation, shelter-based clinicians recommended helping the client build and share
dissociation, practice meditation, help client be aware of present and increase their self-awareness and confident with coping. In the third stage (commonality and reconciliation) of dissociation they recommended practicing meditation and mindfulness exercises.

During the first stage (safety) of active fight, flight, or freeze, shelter-based clinicians recommended that the client be given psycho education about the transitional DV shelter experience, which includes clear and structured expectations and rules. In addition, they recommend meditation and grounding exercises. In the second stage (remembrance and mourning) of active fight, flight, or freeze they added mindfulness, meditation, and self-regulating techniques. In the third stage (commonality and reconciliation) of active fight, flight, or freeze, shelter-based clinicians added helping the client predict future triggers and identify healthy coping skills to manage the trauma response.

Readers are able to see that the shelter-based clinicians did not add their recommended interventions during stage three of social isolation and stage two of anxiety and tension. The researcher believes that her personal experience working with this unique population in a transitional DV setting is the reason why the shelter-based clinicians agreed with her recommended interventions for this developed model.

**Cultural Interventions to Assist Undocumented Battered Latina Women**

Readers have been exposed to many recommended interventions for each trauma response from shelter-based clinicians that work with undocumented battered Latina women living in a transitional DV shelter. Many of the shelter-based clinicians who work with the population and other cultural groups are aware that there is a need for some specific cultural interventions, accommodations, and cultural sensitivity. Readers will
find these interventions and accommodations below. The questions the researcher asked were, “What are the specific interventions that are used with this clinical-based treatment?” and “How do they differ from women who are documented and/or from another ethnicity (i.e., cultural interventions)?”

Shelter-based clinicians who work with undocumented battered Latina women may use many of the same interventions with other populations that are documented or are of another ethnicity. However, all of the shelter-based clinicians (100%) that the researcher interviewed believed that many interventions need to be culturally sensitive to work effectively. The researcher chose specific interventions that the shelter-based clinicians stated needed a culturally specific or culturally sensitive component. The three main themes that emerged included: (a) language based mental health agencies that cater to the specific language of the population, (b) knowledge of specific cultural beliefs regarding family, religion, mental health services, and worldview, and (c) sensitivity to their acculturation process, if applicable.

Table 7

*Ideal Cultural Interventions to Assist Undocumented Battered Latina Women Manage Six Trauma Responses*

<table>
<thead>
<tr>
<th>Each Trauma Responses</th>
<th>Specific Interventions</th>
<th>n=</th>
<th>Cultural Interventions /Responsiveness to this unique population</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Isolation</td>
<td>Identify support systems</td>
<td>4</td>
<td>Undocumented status/Fear of deportation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Group therapy</td>
<td>2</td>
<td>Language</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Connect with local support groups</td>
<td>1</td>
<td>Acculturation level</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Identify fear of</td>
<td>1</td>
<td>SES status</td>
<td>1</td>
</tr>
<tr>
<td>Trauma Response</td>
<td>Intervention</td>
<td>Shelter-based Clinicians Recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Referral to psychiatrist</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psycho education</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Journaling</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Physically active</td>
<td>2</td>
<td></td>
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<td></td>
<td>Connect with others</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Lack of support system</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explore what they have been taught socially and culturally</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase in symptoms due to status</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety/Tension</td>
<td>Relaxation techniques</td>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Psycho education</td>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Slow exposure of stressor</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Low Self Esteem/Helplessness</td>
<td>Identity times of assertiveness</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive affirmation</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grounding/Meditation/Relaxation techniques</td>
<td>4</td>
<td></td>
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<tr>
<td></td>
<td>Psycho education</td>
<td>4</td>
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<tr>
<td></td>
<td>Grounding/Meditation/Relaxation techniques</td>
<td>4</td>
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<tr>
<td></td>
<td>Psycho education</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td>Dissociation</td>
<td>Grounding/Meditation/Relaxation techniques</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Psycho education</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td>Active Fight, Flight, Freeze</td>
<td>Grounding/Meditation/Relaxation techniques</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Psycho education</td>
<td>4</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Grounding/Meditation/Relaxation techniques</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psycho education</td>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Triggers in response to the presence of law enforcement or immigration officers</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acculturation</td>
<td>2</td>
<td></td>
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</tbody>
</table>

Table 7 shows readers the specific cultural interventions that the shelter-based clinicians recommended for each trauma response. Readers are able to see how many shelter-based clinicians recommended specific interventions. In addition, readers are able to see the cultural interventions, cultural sensitivity, and responsiveness to this unique
population that needs to be taken in consideration when attempting to tackle a trauma response.

**Cultural-based Interventions for Social Isolation**

The shelter-based clinicians recommended specific cultural interventions for the trauma response of social isolation. These included 1) identifying support systems, 2) attending group therapy, 3) connecting with local support groups, and 4) identifying why they fear connecting with others. The shelter-based clinicians recommended that a shelter-based clinician and DV shelter staff who are working with this unique population need to be culturally sensitive to the following: 1) undocumented status/fear of deportation, 2) language, 3) acculturation level, 4) social economic status, 5) lack of support system. The shelter-based clinicians only mentioned this short list because they had previously mentioned barriers and challenges for this population that need to be taken in consideration when working with this group. These cultural aspects of the unique population can effect attempting to help them tackle the trauma response of social isolation and needs to be addressed during treatment. Shelter-based clinicians recommended that being culturally sensitive to what was mentioned above is important; because some of the interventions recommended could trigger an increase in social isolation if not looked at carefully. For an undocumented battered Latina woman going to a local support group that is English only and is anti-immigrant may trigger her and can make her isolate herself more due to fear.

**Culture-based Interventions for Depression**

The shelter-based clinicians recommend specific cultural interventions for depression, which included: 1) referral to psychiatrist, 2) psycho education, 3) journaling,
4) physically active. The shelter-based clinicians recommended that clinicians need to explore what this unique population have been taught both socially and culturally to see if a woman who belongs to this unique population is comfortable with the interventions that are used to tackle depression. In addition, another benefit to exploring what has been taught is to get their outlook of the trauma response, psychiatrist, and mental health services. Shelter-based clinicians recommended that those working with this unique population need to explore their lack of resources to decrease asking them to follow through on interventions that they are not capable of accessing (transportation, money for medication, etc.).

**Culture-based Interventions for Anxiety/Tension**

The shelter-based clinicians recommended specific cultural interventions for anxiety/tension, which included: 1) relaxation techniques, 2) psycho education, and 3) slow exposure of stressor. The shelter-based clinicians recommended that clinicians who are working with this unique population in the same shelter setting should be cultural sensitivity to the following: 1) increase in symptoms due to status and 2) not comfortable with relaxation techniques. The shelter-based clinicians stated that although many clinicians recommend relaxation techniques to help with the trauma response that this unique population might not be comfortable with this intervention. Some shelter-based clinicians stated that in their experience, this population felt uncomfortable practicing the techniques because it is not practiced in their country of origin. It is seen as more of a U.S. method. In addition, their immigration status will increase this trauma response because of the anxiety of awaiting documentation and the fear that comes with being undocumented.
**Culture-based Interventions for Low Self-esteem/Helplessness**

The shelter-based clinicians recommend specific cultural intervention for low self-esteem/helplessness, which included: 1) identifying times of assertiveness and 2) using positive affirmation. The shelter-based clinicians recommended that clinicians and DV shelter staff who are working with this unique population be culturally sensitivity to the following 1) cultural pressures or ideas of country of origin and 2) provide client with education in rights and advocacy. Shelter-based clinicians added that cultural pressures from their country of origin could affect the suggested interventions of identifying moments of assertiveness, because the action of assertiveness can be seen as negative or frowned upon. In addition, providing this population with their rights and helping them advocate for their services is important to decrease feelings of helplessness and feelings of having no rights due to their undocumented status.

**Culture-based Interventions for Dissociation**

The shelter-based clinicians recommended specific cultural interventions for dissociation, which included: 1) grounding/mediation/relaxation techniques and 2) psycho education. The shelter-based clinicians recommended that clinicians and DV shelter staff who are working with this unique population be culturally sensitive to the assimilation/acculturation process. Shelter-based clinicians acknowledged that an undocumented battered Latina woman’s level of assimilation/acculturation could affect the outcome of the recommended interventions. This includes not being comfortable with meditation or grounding exercises. In addition, the level of assimilation/acculturation can also effect their interpretation of psycho education and mental health services.

**Culture-based Interventions for Active Fight, Fight, or Freeze**
The shelter-based clinicians recommended specific cultural interventions for active fight, flight, or freeze, which included: 1) grounding/mediation/relaxation techniques and 2) psycho education. The shelter-based clinicians recommended that clinicians and DV shelter staff who are working with this unique population also be culturally sensitive to the following: 1) triggered by law enforcement or immigration officers and 2) acculturation. Shelter-based clinicians further stated that seeing or hearing a police car or authority that can threaten their stay in the U.S. could produce or trigger a fight, flight, or freeze reaction. Relaxation techniques and psycho education interventions may not necessarily be effective immediately because this unique population will always have this response to authority unless there are documented.

Comparison of Proposed Interventions with Herman’s (1992,1997) Model

Shelter-based clinicians were asked to compare their own clinical-based treatment experience of healing and compare it to Herman’s (1992, 1997) model of healing. To answer the final research question about whether their models of healing differ from Herman’s (1992,1997) traditional model of healing, the researcher asked participants the following questions, “How do the healing process for undocumented battered Latina women differ from Herman’s (1992,1997) traditional model of healing (trauma, safety, remembrance and mourning, and reconciliation and commonality”, (see Table 8) and “If you were to categorize the interventions that you use with undocumented battered Latina women with Judith Herman’s three stages of healing, where would you place them?”

Table 8

List of Interventions by Herman According to her Model of Healing
Stage One (Safety)

1) "Biological (medication),
2) Cognitive and behavioral (education on traumatic syndromes, journal-keeping, and homework tasks),
3) Interpersonal (building a therapeutic alliance),
4) Social (family support and a protective court order,” (Herman, 1992, 1997, p.169).

Stage Two (Remembrance and Mourning)

1) Recognizing and accepting their trauma experience and mourning what they have lost due to the trauma (losing their identity, a partner, a marriage, a nuclear family system and lost of trust and sense of safety with someone they loved).
2) Intervention: Create Trauma narrative

Stage Three (Commonalty and Reconciliation)

1) Begin to connect with others
2) Start to form trusting relationships,
3) Begin to build a new life and identity,
4) Begin to take herself out of the victim role
5) Join or form a support system with individuals that have experience the same type of trauma and are going through the same type of recovery process

The researcher found that the interventions recommended to tackle social isolation by shelter-based clinicians are similar to Herman’s (1992, 1997) three stages of healing and recovery only during the reconciliation and commonality stage, (stage three). Both the shelter-based clinicians and Herman (1992, 1997) recommended that the client connect with others and form a community. Five out of eight (63%) shelter-based clinicians recommended interventions such as recognizing support system, “look[ing] at local churches,” and participating in programs “outside the shelter.”

The interventions recommended by the shelter-based clinicians to tackle depression were also similar to all three of Herman’s (1992, 1997) stages of healing and recovery. Both Herman (1992, 1997) and the shelter-based clinicians recommended psycho education associated with each trauma response, reflecting the natural response of
depression due to their trauma experience, journal-keeping, focusing on the future, highlighting strengths and accomplishments, honoring their loss, and planning and beginning to build a new life and identity. Eight out of eight (100%) of shelter-based clinicians recommended these interventions.

The interventions recommended by the shelter-based clinicians to tackle anxiety and tension and low self esteem/helplessness are similar to Herman’s (1992, 1997) recommendations only during the safety stage. Both the shelter-based clinicians and Herman (1992, 1997) recommended psycho education of these two natural responses to trauma. Eight out of eight (100%) of shelter-based clinicians recommended interventions that provided psycho education such as “creating awareness of what can cause triggers.”

The interventions recommended by the shelter-based clinicians to tackle active fight, flight, or freeze are similar to Herman’s (1992, 1997) first stage (safety). Eight out of eight (100%) of shelter-based clinicians recommended interventions such as education on trauma responses. The shelter-based clinicians agreed with the researcher recommended intervention of starting individual therapy, which would help the individual feel safe physically, emotionally, and psychologically.

In comparing the shelter-based clinicians recommended interventions to Herman’s (1992, 1997) healing and recovery model the researcher believes that some of the stages in Herman’s (1992, 1997) model can fit with this unique population. For instance the researcher only saw Herman’s (1992, 1997) first stage (safety) frequently during each trauma response.

**Overall summary of results**
Key themes of defining healing (research question #1) included: 1) healing was a process, 2) healing meant having healthy and productive reactions to stressor, and 3) healing meant a client was empowered. A total of three themes emerged when asking clinicians about the unique experiences of this population: 1) legal barriers, 2) limited resources and employment, and 3) marginality/disempowerment due to status. Three themes emerged regarding obstacles to healing (research question #2): 1) general challenges of being single caretakers, 2) family/cultural concepts of bearing ones cross (suffering), and 3) stress of fulfilling particular criteria to apply and qualify for U-Visa/VAWA. With respect to comparing the process of healing for undocumented battered Latina women from Herman’s (1992, 1997) traditional model of healing (question #4) three themes emerged 1) their needs to be language based mental health agencies that cater to the this population, 2) knowledge of their specific cultural beliefs regarding family, religion, mental health services, and worldview, and 3) sensitivity to their acculturation process if applicable. Herman’s (1992, 1997) traditional model does not exactly fit this unique population, but can be used as a guide for helping this population heal. As mentioned above Herman’s (1992, 1997) model lacks specific interventions during each stage, Herman’s (1992, 1997) model does not take in consideration difficulties that might arise during each stage, and each stage lacks cultural sensitivity.

The researcher’s interpretation of these findings will be reviewed in the following chapter. A preliminary model for undocumented battered Latina women living in a transitional DV shelter will be presented.
CHAPTER FIVE

DISCUSSION

Shelter-based clinicians working with battered women face multiple challenges because of the natural trauma responses that affect one’s mind, body, and soul. However, the challenges become amplified among undocumented battered Latinas who are also experiencing marginalization related to race, class, and gender. Their undocumented status places them under multiple stresses because it limits their possibility to secure employment, shelter, and even mental health services. In addition, legal and traditional cultural barriers affect the healing process as women leave an abusive relationship. This thesis examines the complex experiences of undocumented battered Latina women through the eyes of expert shelter-based clinicians. The interviewees provide insights on the process of healing (e.g., obstacles and treatments) for six common trauma responses. Based on these interviews, the researcher has developed a model that offers best practices both that shelter-based clinicians and DV shelter staff can use to support the healing process of undocumented battered Latina women who are DV victims or survivors. This is the first study of its kind to obtain thorough detailed information on each trauma responses, interventions for each trauma responses, difficulties that can be encountered with each trauma responses, assessing priorities when tackling trauma responses, and identifying recommended clinical-based treatments.

As discussed in chapter one, there are limited amounts of social services that are available for the undocumented. Those that are available may not be culturally sensitive and may not offer services in their language. The lack of family support in the U.S and
inability to find work are some of the challenges undocumented battered Latina women face.

**Definitions of Healing**

In developing a model of healing, three main themes emerged when defining what healing was for this population, 1) healing is a process, 2) healthy and productive reactions to stressors, and 3) empowered/found voice. The first theme that emerged among the majority of the eight shelter-based clinicians was that healing is a process. It is significant to note that 75% of the shelter-based clinicians stated the healing from DV is a process. One reason why this is so salient to shelter-based clinicians is based on the reality of the multiple traumas that can affect the process of the healing. Shelter-based clinicians have a limited time to help survivors start to heal because DV transitional shelter programs only allow DV survivors to stay in their DV shelter from eight months to a year. Thus, it makes sense that one shelter-based clinician stated, “I don’t think there is an actual moment when they heal. I think it’s an ongoing process,” and another added, [it could take years]. Their responses are consistent with the literature on healing from trauma, (Dossey, 2003; Allen & Wozniak, 2011). Although there is no set time to calculate when this unique population has healed, the second and third themes (i.e., health reactions of stressors and feeling empowered) highlights some key factors to focus on the process of supporting undocumented battered Latina women to heal.

It is important to note that 75% of shelter-based clinicians stated the second theme, having healthy and productive reactions to stress, is a key aspect of healing. Having healthy and productive reactions to stress for this population is a major milestone, given the multiple challenges of their immigrant status. For instance, their immigration
status can cause great amounts of negative feelings such as fear, worry, and hopelessness. As mentioned in chapter one, a Latina’s undocumented status can be used by her batterer to create fear of deportation, if she seeks help. Also, as discussed in chapter one, there are limited amounts of social services that are available for the undocumented. Those that are available may not be culturally sensitive services and may not offer services in their language. Another factor that can bring a lot of negative feelings is having little to no family support in the U.S. In addition, shelter-based clinicians mentioned that because of their immigrant status is it very difficult to find legitimate work, which creates worry on how she will provide for the family.

The third theme, a woman feeling empowered and finding a voice, supports the literatures’, (Allen & Wozniak, 2011; Smith, 2003) findings in the literature that a battered woman needs to find a voice and become self-reliant to be healed from DV. This is consistent with other studies with Caucasian populations, (e.g., Smith, 2003). Shelter-based clinicians stated that an undocumented battered Latina woman that is healing from DV, “can be assertive [by] using her voice, being able to set limits, have their own voice and assertive with themselves” and “take more action for their family and themselves, control their lives and not depend on others.” Thus, empowerment is key to healing in any culture, but again, the researcher believes can be especially difficult for undocumented Latina women who are DV victims and survivors.

However, what is unique to the need for empowerment among undocumented Latinas, is legal status. The lengthy process, to obtain legal status compromises a sense of empowerment. Thus, the researcher believes that helping undocumented battered
Latina women tackle tangible barriers, such as legal documentation, is essential in the process of healing.

**Unique Experiences and Obstacles to Healing**

Legal issues were one of the key themes that emerged when shelter-based clinicians’ described what was unique in the experience of undocumented battered Latina women’s healing. These themes were: 1) legal issues and threats, 2) marginality/disempowerment due to status, 3) socio economic factors, 4) cultural/religious challenges, 5) language issues, and 6) lack of social support.

**Legal Issues and Threats.** Resoundingly, all eight clinicians (100%) mentioned legal barriers as unique to the experience of undocumented battered Latina women. This includes fear of deportation, a higher risk of staying in the home due to threats, and immigrant issues. As mentioned in chapter one, batterers whose victims are undocumented use this status to increase their power and control over them. Batterers threaten that if they talk to police or social services regarding the abuse that the victim will be deported and if they have children they will be taken away. The researcher believes that it is completely justifiable for undocumented battered Latina women to feel an extreme fear of being deported and stay in the home to protect themselves from this consequence. Undocumented battered Latina women who are not aware that there are laws in the U.S to help protect them from the abuse which can lead to legalization, are at a higher risk of victimization by their abuser, (Adams & Campbell, 2005). In addition, the undocumented population is aware that they may likely find hostility when seeking help. Another unique legal issue for this population is overwhelming stress that comes with obtaining “legalization.”
The shelter-based clinicians in this study stated that legal issues might trigger the same feelings and symptoms that they have when they arrived at the transitional DV shelter. For instance, if the undocumented Latina battered woman is able to obtain “legalization” through the U-VISA or VAWA, because she is a victim of abuse, the process can be overwhelming and stressful. Women, who apply to obtain documentation, have to fit into criteria as specified through the government and have many hoops to jump through. If and when they apply there is still a chance that they will not receive “legal” status. The waiting process to become documented through this process can take some time. Time is something that not all undocumented battered Latina women have if they are living in a transitional DV shelter because housing is only temporary. When it is time to leave the program undocumented battered Latina women are expected to find housing for herself and her children. This process can be extremely difficult, overwhelming, scary, and can create feelings of doubt and helplessness because they are unable to find a legitimate job because of their status. In addition, finding housing can become difficult because of the lack of credit.

**Marginality/Disempowerment due to Status.** Another obstacle to healing for this population was a feeling of marginality/disempowerment due to status. This includes the perception of self, feeling disempowered, and low self esteem all due to their status in the U.S. This theme was not found in any of the literature on the obstacles or challenges for this population. Hence this is a unique contribution of this thesis. One shelter-based clinician mentioned, “People will look at you differently and you tend to fall into this marginalized space compared to other populations that are mostly educated White in the United States.” Shelter-based clinicians need to understand how this unique population
perceives their self and how this will affect their clinical-based treatment and intervention strategies.

**Socioeconomic Factors.** A majority of the shelter-based clinicians, as well as extant literature, (e.g., Raj & Silverman, 2002) describe limited resources and access to employment due to undocumented status as a major challenge. One shelter-based clinician stated that a, “lot of the time this gets in the way of the trauma because they are worried about finding a job.” One shelter-based clinician stated that undocumented battered Latina women, “feel that they are still trapped and there aren’t any resources for them, there are not many ways to be independent and find work.”

**Cultural/Religious Challenges.** Shelter-based clinicians’ findings are consistent with research, (Kasturirangan & William, 2003; Raj & Silverman, 2002) that states that some traditional cultural values such as machismo, marianismo, and familism, if used for control, can present a challenge for this unique population. The researcher believes that these beliefs can discourage empowerment for women if the belief reinforces the idea that women are obligated to be passive, submissive, and maintain the honor for the family. Two out of eight (25%) shelter-based clinicians mentioned that one of the obstacles to healing was the family/cultural concept of bearing one’s cross (suffering), which included internal message from family or culture regarding DV. The researcher found this obstacle to be very important and a cultural component that shelter-based clinicians need to be aware of and take in consideration when working with this unique population. It may be helpful for women to be informed about officials’ statements by religious officials. As noted in chapter one, a document on the U.S. Conference of Catholic Bishops states, “that violence against women, inside or outside the home, is
never justified” and “no person is expected to stay in an abusive marriage,”

Language Issues and Lack of Social Support. Adams and Campbell (2005) report that language and not having family support in the U.S. are a unique experience for this population that can prevent them from seeking help. The shelter-based clinicians also reported that language and identifying the lack of support that this population does not have in the U.S. is an important key in providing culturally sensitive services. For an undocumented battered Latina woman going to a local support group that is solely in English and might have anti-immigrant participants may do more harm to the process of healing. Such a group may not allow her to tell her story, express her feelings, will make her feel unaccepted and can make her isolate herself more due to fear. Lastly, not having a family support system during this period can exacerbate feelings of loneliness in an unknown country.

Clinical-Based Treatments: Results on Priorities When Addressing Trauma Responses

The goal of this thesis was to develop a model for undocumented battered Latina women living in a transitional DV shelter. The researcher asked shelter-based clinicians their priorities in addressing each of six trauma responses. Shelter-based clinicians reported that active fight, flight, or freeze and depression would be first priority. Anxiety, tension, and dissociation would be middle priority and low self-esteem/helplessness and social isolation as last priority.
The shelter-based clinicians believe the natural trauma responses that appear due to their reaction to being in a DV shelter should be tackled first. The majority of the shelter-based clinicians choose active fight, flight, or freeze as first priority because, “chances are when they come in [shelter] they are very reactive.” In addition, the majority of shelter-based clinicians argued that depression should be concentrated on first because they are adjusting to living in a transitional DV shelter, an unfamiliar place, and it increases “level and intensity of depression that might affect their parenting.” However, interestingly, there were several shelter-based clinicians that ranked depression as fourth priority, but did not give a reason. It is unclear why depression for some shelter-based clinicians was ranked first and fourth in priority. The researcher was surprised to find the priority in addressing depression was varied. The priority of the order in which these trauma responses should be tackled is new information that has not been found in the literature. Having a better understanding of the priority of order is vital to help this unique population who come with many barriers that increase symptoms related to their trauma responses. The researcher recommends that there needs to be further research on the order of priority for these trauma responses.

After finding the suggested order of priority that each of the six trauma responses should be engaged, the researcher wanted to obtain more information that would benefit the unique model. The researcher asked the shelter-based clinicians to recommended suggested interventions and clinical-based treatment for each response. The researcher believed that this would help expand the development of a unique model for undocumented battered Latina women.

Clinicians’ Clinical-based Treatments for a Given Trauma Response
For the purpose of the study, the researcher defined clinical-based treatments as clinical modalities that are used by clinicians to target a particular mental health disorder or diagnosis. Interventions are suggested actions within the clinical-based treatment or modality that should be taken to reduce the symptoms that come with the particular mental health disorder or diagnosis. As mentioned previously, a simple medical example would be a woman who is diabetic (diagnosis) and it is recommended that she take insulin (intervention) to reduce her blood sugar (symptom). Shelter-based clinicians in the study had detailed interventions to tackles some of the natural reaction to DV, but also helped the clients with tackling other traumas that effected their treatment. The researcher did not find any literature that suggested specific clinical-based treatments to tackle the six common trauma responses. Thus, this is another contribution of this study.

During the development of the shelter-based clinicians’ interventions recommendations they also recommended clinical- based treatments for the healing process of undocumented battered Latina women. This included CBT, TF-CBT, CPP therapy, Unrealistic Family System, Humanistic Therapy, Dialectical Therapy, Acetylic Approach, and PCIT. The researcher found that the shelter-based clinicians most commonly mentioned two clinical-based treatments through out each of the natural trauma responses, TF-CBT and CBT. A full list of which clinical based treatment was recommended for each trauma response readers can review Table 5 in chapter four.

Shelter-based clinicians responded that CBT would be the best treatment to reduce symptoms of social isolation, depression, dissociation, active fight, flight, or freeze. Shelter-based clinicians recommended TF-CBT to reduced symptoms of anxiety and low self esteem. Shelter-based clinicians stated that these models worked for this
unique population because it helps them track their progress and decreases symptoms. One shelter-based clinician stated, “When you think about the Latino community many times there seems to be a concrete focus so it works out a lot better.” The researcher concluded that these two clinical-based treatments worked with this population because it visually and mentally provided them an opportunity to see if they were progressing in their responses. In addition, it helped them follow up on the interventions recommended by the shelter-based clinicians. Lastly, the researcher believes that having a more concrete focus helps this population understand their mental health treatment more effectively. The researcher at this time is unable to talk about the detailed practices and effectiveness of each of these clinical-based treatments, as this was not discussed during the interviews.

Collectively, the shelter-based clinicians also mentioned an array of clinical-based treatments. Some of the shelter-based clinicians stated that they could borrow and use other clinical-based treatment depending on each individual’s trauma or need for treatment. The researcher believes that since the shelter-based clinicians suggested many clinical-based treatments, this may be a reason why the literature does not specify a “best” approach for trauma victim or survivor. It is evident through the shelter-based clinicians experience that several clinical-based treatments are necessary for this unique population because as mentioned earlier they come with more than DV trauma. Shelter-based clinicians need to tackle what is affecting the client and use several methods to help them through the healing process.

**Recommended Interventions**
An especially unique contribution of this study was to have shelter-based clinicians develop their interventions recommendations to facilitate the healing process. Particular recurrent interventions were mentioned repeatedly across three stages of healing (i.e., beginning, middle, end). These recurrent interventions included: 1) group therapy, 2) safe support systems, 3) psycho education about trauma impacting their daily function to normalize their responses, 4) A Window between World (AWBW) art expression, 5) psychiatric evaluation, 6) connecting to community resources, 7) relaxation and mindfulness techniques, and 8) recognizing and reducing triggers. The researcher concludes that these interventions periodically appeared because these are interventions that can help individuals’ throughout the healing process. The researcher also found that the shelter-based clinicians recommend these interventions because they reduce the symptoms that come with the six trauma responses.

Recognizing and reducing triggers and psycho education on how trauma can impact their daily function was recommended to reduce all of the six trauma responses. These recommended interventions are supported by Herman’s (1992, 1997) belief that battered women need a series of clinical-based interventions which include, “medication, cognitive and behavioral interventions (education on traumatic syndromes), interpersonal interventions (building a therapeutic alliance), and social interventions (family support and a protective court order),” (p.169).

**Recommended Ideal Cultural Interventions**

Based on her experience with this setting and client population, the researcher was not surprised to learn that [100%] of the shelter-based clinicians believed that the interventions for this unique population needed to be culturally sensitive. What prior
research does not do is give details about how to modify interventions to become culturally sensitive among this unique population. Table 9 provides a list of culturally sensitive recommendations for shelter-based clinicians to keep in mind when using interventions with this population. These recommendations are important to consider because they can affect the success of the interventions.

An example of the shelter-based clinicians’ recommended cultural interventions for depression included: 1) referral to psychiatrist, 2) psycho education, 3) journaling, and 4) being physically active. As mentioned in chapter four when working with this unique population, one must explore what the client has been taught to believe about trauma responses, psychiatrists, and mental health. If there are negative views about mental health and its treatments, the interventions recommended can be limited in effectiveness. Shelter-based clinicians would need to normalize the client’s point of view and strategies in working around their point of views respectably.

Cultural interventions to treat the trauma response of active fight, flight, or freeze included: 1) grounding/mediation/relaxation techniques and 2) psycho education. In addition, the shelter-based clinicians recommended exploring the possibility of triggers in response to law enforcement or immigration officers. Shelter-based clinicians further stated that seeing or hearing a police car or authority that can threaten their stay in the U.S. could activate a fight, flight, or freeze reaction. Relaxation techniques and psycho education interventions may not necessarily be effective immediately because this unique population will always have this response to authority unless there are documented.

Table 9

List of Culturally Sensitive Recommendations from Shelter-based Clinicians
(a) Knowledge of clients specific cultural beliefs regarding family, religion, mental health services, and worldview

(b) Be sensitive to clients adaption to U.S. culture

(c) Recognize clients triggers to law enforcement or immigration officers

(d) Recognize cultural pressures or ideals of country of origin,

(e) Difficulties in working with this population on their trauma responses include: No psychiatrist referral available for medication due to their status in the United States,

(f) Anticipate a client experiencing negative thoughts, worries, and what if’s due to their status in the U.S., pending documentation for legalization, court dates/child custody, and safety,

(g) Explore clinical treatments that work best with this unique population; it can effect treatment and needs to be taken in consideration when working with this population.

Comparison to Herman’s (1992,1997) model

For the most part shelter-based clinicians’ responses were in agreement with the phases of Herman’s (1992, 1997) model. The researcher believes that Herman’s (1992, 1997) model can work with women who have experienced DV because of the overall knowledge of trauma and what a survivor needs to recover. In this study, it was difficult for shelter-based clinicians to align themselves exactly with Herman’s (1992, 1997) three stages of healing and recovery. Some of Herman’s (1992, 1997) descriptions of each stage did not necessarily have interventions they could compare to due to their broad statements. Such statements included begin to connect with others and start to form trusting relationships, begin to build a new life and identity, and begin to take herself out of the victim role. The broad statements provided enough room for shelter-based clinicians to make their own recommended interventions based on their experience with out restrictions. Herman’s (1992,1997) work provided both the researcher and shelter-
based clinicians with an outline of a healing model. A contribution of this thesis is the cultural modifications to Herman's (1992,1997) model specific to undocumented Latinas.

**Quintana DV Model of Healing: Modifying Herman’s (1992,1997) Model**

The researcher developed a model of best practices to support the healing process of undocumented battered Latina women that is practical and can be used from the moment a client is first admitted in the transitional DV shelter. The researcher believes that, as mentioned in the interviews and literature, (Dossey, 2003; Allen & Wozniak, 2011), there is no time limit in the process of healing. The intention of this model is to provide specific cultural-based interventions and clinical models to reduce/address the six common trauma responses. In addition, cultural-based interventions are expected to attempt to tackle barriers for this population that can magnify the symptoms related to these trauma responses. The unique features of the researcher’s Preliminary Model of Healing for Undocumented Battered Latina Women is that there are recommended clinical-based treatments and culturally sensitivity components during each trauma response. In addition, there are also recommended interventions during each stage of the healing process for each of the trauma responses. The researcher recommends that this healing model be used as an outline in collaboration with shelter-based clinicians and DV shelter staff working in a transitional DV shelter setting. The researcher believes that this model would be more effective if both parties use it at the same time to help this population heal. Both the shelter-based clinicians and DV shelter staff can use their judgment when it is time for each individual to move on to the second and third stage of suggested interventions.
### Quintana DV Model of Healing for Undocumented Battered Latina Women Living in a Transitional DV Shelter

<table>
<thead>
<tr>
<th>6 Top Trauma Responses</th>
<th>Clinical Based Treatment</th>
<th>Cultural Sensitivity Component</th>
<th>Interventions Recommended during Stage #1 (Safety)</th>
<th>Interventions Recommended during Stage #2 (Remembrance and Mourning)</th>
<th>Interventions Recommended Stage #3 (Commonalty and Reconciliation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Isolation</td>
<td>Cognitive Behavioral Therapy</td>
<td>Undocumented status/Fear of deportation, Language, Acculturation level, SES level, Lack of support system</td>
<td>Introduce client to school her first or second day of arrival to shelter; encourage clients to welcome new client; encourage client to ask for basic directions to the store and social services office to the current clients that have been in the shelter; start group therapy; Identify assigned captain/case manager; assign client and mentor to guide through the program; connect client to community resources and activities such as parks; have clear and specific agreements of shelter living and time frame of stay.</td>
<td>Provide an opportunity for client and staff to work together as a group with firm and constant boundaries; school and shelter outing; continue with group therapy; encourage outside community activities.; provide resources, case manager advocates for clients needs including legal services, DPSS, DCFS, etc.</td>
<td>Continue with group therapy; support groups; an opportunity to join or participate in community based programs</td>
</tr>
<tr>
<td>Depression</td>
<td>Cognitive Behavioral Therapy</td>
<td>Explore what they have been taught socially</td>
<td>Psycho education about traumas’ impact</td>
<td>Increase knowledge of familiar</td>
<td>Predict what triggers might bring out</td>
</tr>
</tbody>
</table>

81
and culturally, Lack of resources on daily function; provide tools to create structure around daily living and self: A Window between World (AWBW) art expression; yoga, meditation and guided imagery; encourage client to be physically active 10 to 15 minutes a day or every other day; identify and create strong support systems; provide the shelters success rate to initiate hope and normalize fear of the unknown. patterns of depression; connect childhood experience impacting current life: (AWBW); honoring their experience and loss; psycho education; client is in trauma informed therapy and has started working on her trauma narrative with clinician; psychiatric evaluation if appropriate; create new rituals (i.e. Holidays); accept losses without avoidance symptoms and what coping skills practiced to cope with them: (AWBW); honoring their history and focusing on the future; exit planning for graduating the program; psycho education; review progress made; continue working on strategies learned to continue progress; resource planning; highly strengthens and accomplishments

<table>
<thead>
<tr>
<th>Anxiety/Tension</th>
<th>TF-CBT</th>
<th>Increase in symptoms due to status, Not comfortable with relaxation techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create awareness of what and how you are triggers (5 senses) Introduce healthy coping skills such as exercise, journaling, meditation; living in the present, etc; create experience to notice state of relaxation vs. state of tension to improve clear headiness; Connect to resources (i.e. legal resources) The root of anxiety and tension is being addressed in more depth through therapy and staff helps her use the coping skills introduced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The feeling of anxiety and tension has reduced and client has the tools to regulate feelings; the client uses a combination of coping skills and therapy to regulate the feelings of anxiety/ tension; able to catch thoughts contributing to anxiety and change them.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Self Esteem/ TF-CBT</th>
<th>Education in rights and Positive qualities</th>
<th>Provide leadership</th>
<th>Shelter staff and outside agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in symptoms due to status, Not comfortable with relaxation techniques</td>
<td>Create awareness of what and how you are triggers (5 senses) Introduce healthy coping skills such as exercise, journaling, meditation; living in the present, etc; create experience to notice state of relaxation vs. state of tension to improve clear headiness; Connect to resources (i.e. legal resources) The root of anxiety and tension is being addressed in more depth through therapy and staff helps her use the coping skills introduced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The feeling of anxiety and tension has reduced and client has the tools to regulate feelings; the client uses a combination of coping skills and therapy to regulate the feelings of anxiety/ tension; able to catch thoughts contributing to anxiety and change them.</td>
<td>Shelter staff and outside agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helplessness</td>
<td>advocacy, Cultural pressures or ideas of country of origin</td>
<td>journaling; volunteer salon makeover visits; (AWBW); psycho education about her trauma response; case manager provide client with basic tools so client can do her own advocacy; staffing meeting with clients focus on her accomplishment; body/self image and empowerment classes</td>
<td>opportunities to give client confidence on her ability to be independent and in control of her case; focus on her and her family’s accomplishment; job training/volunteer opportunities; client continue treatment with self esteem; staff praises client’s different accomplishment to increase confidence.</td>
</tr>
<tr>
<td>Dissociation</td>
<td>TF-CBT</td>
<td>Assimilation/Acculturation level</td>
<td>Psycho education about her trauma impacting body and mind; provide tools to help them become present; connection with body and mind through yoga, and other exercise such as matron meditation; meditation and mindfulness exercises</td>
</tr>
</tbody>
</table>
| Active Fight, Flight, and Freeze  | TF-CBT | Triggers to law enforcement or immigration, Acculturation | Psycho education about shelter experience which includes clear and structured expectations and rules; client has a restraining order; safety | Psycho education; mindful mediation and self regulate techniques; client recognizes trauma triggers and is starting to manage them | Predict future triggers and identify healthy coping skills to manage the trauma response; group sharing of trauma experience; client knows pain is only
planning; client recognizes triggers; meditation and grounding exercises; client is provided tools and support to make her feel safe; client is introduced to individual therapy with support from staff; recognizes she is safe; staff provide support to decrees sense of urgency temporary; "new normal" state of calm

Note. For the purpose of the study the researcher defined clinical based treatments as clinical modalities that are used by clinicians to target a particular mental health disorder or diagnosis. Interventions are suggested actions within the clinical treatment or modality that should be taken to reduce the symptoms that come with the particular mental health disorder or diagnosis. A simple medical example would be a woman is diabetic (diagnosis) and is recommended that she take insulin (intervention) to reduce her blood sugar (symptom).

Some recommended interventions are clinically based only (psycho education) and other interventions are DV shelter staff based (welcome client to shelter school) interventions. Below the researcher will provide readers with one fictional example of how this model would be effective for the population of undocumented Latinas in a transitional DV shelter.

Application of Quintana DV Model of Healing to a Fictitious Client's Case

Ana is an undocumented Mexican immigrant who has been in the U.S. for five years. She knows little English and has three children. She only has a sister who lives in Southern California. During her first four months at the transitional DV shelter she had experienced all six trauma responses. DV shelter staff introduced Ana to the other DV shelter residents and assigning her a mentor to help guide her through the program to help her feel comfortable knowing that she had a support system with in the residents. The group therapy provided her with the feeling that she was not alone in her experience.
These steps helped Ana start to break away from continuing the cycle of isolating herself and she was able to begin developing trust.

Ana was experiencing a great amount of anxiety/tension, dissociation, and active fight flight or freeze during the first months of her stay. Ana had to see her batterer when she exchanged the children for weekend visitations and was fighting to continue to have full custody of her children. DV shelter staff helped Ana obtain a restraining order against the batterer and developed a safety plan when dropping off and picking up the children from a police station. The shelter-based clinicians provided Ana with psycho education on triggers, helped her develop healthy coping skills, and introduced her to mindfulness experience that she could use while experiencing these triggers.

DV shelter staff and a pro-bono attorney helped advocate and help support Ana with fighting for custody of her children. These interventions reduced Ana’s anxiety/tensions and active fight, flight, or freeze trauma responses. Although she now had tools and had custody of her children she was experiencing low self-esteem/helplessness and depression due her constant self criticism that developed when she was with her batterer; not having a real home, her undocumented status preventing her from obtaining work, and doubt of her future with her children exacerbated her self criticism.

DV shelter staff helped Ana apply for U-Visa to help her receive “legalization” to help reduce the feelings of helplessness for future employment. DV shelter staff focused on Ana’s accomplishments when meeting with her and she attended self-image and empowerment classes to continue to build her self-esteem. Ana was provided leadership opportunities to help her build her self confidence, and both DV shelter staff and shelter-
based clinicians provided Ana with positive feedback on her continued accomplishment and growth in the program. Shelter-based clinicians provided Ana with psycho education on how her depression was impacting her daily life and provided her with tools to help reduce depressive symptoms such as physically activity and helped her identify and create a strong support system both within the transitional DV shelter and outside. DV shelter staff provided Ana with the success of other residents that had graduated the program and normalize the scary feeling of the unknown. DV shelter staff also had a weekly art expression class to help her express what words could not. After Ana obtained her own therapy and her symptoms had reduced, her exit date to leave the DV program was coming to a close.

At this time, some of Ana’s symptoms increased once again and shelter-based clinicians and DV shelter staff worked to help her control her symptoms. Shelter-based clinicians helping Ana predict what triggers might bring out her symptoms and went over the coping skills she had practiced to help her cope. DV shelter staff helped Ana with exit planning for graduating the program which included helping her in finding affordable housing and a job, DV shelter staff reviewed her progress made in the program, highlighted her strengthens and accomplishments, and continued working on strategies learned to continue her progress. After receiving all of these interventions both from the shelter-based clinicians and DV shelter staff, Ana graduated the program and moved into an apartment with her children. Her symptoms had reduced and she was able to control them more effectively then when she entered the transitional DV shelter a year ago.

Ana’s example is only a fictional example of how this model would be effective; there are limits to it working precisely as Ana’s story as everyone’s experience is
different. However, policy and treatment implications need to be applied for this model to be more effective.

**Policy Implications**

The researcher believes that more campaigning for government funded aid for DV victim/survivor such as the U-Visa and VAWA to obtain “legalization” is necessary. The researcher believes that more promotion in the Latino communities will help them see that there is a way of changing their status and obtaining future resources and employment. Promotion can occur in community centers, schools, churches, and other safe havens. The increased advertising of the available aid that is accessible for this population will help eliminate the feeling of helplessness and fear of not reporting incidents of violence. The researcher also recommends that more resources are necessary to help this unique population to decrease the worry around being able to provide for their family when they graduate a DV program and do not have the “legal” status to work. The researcher recommends that further housing opportunities or programs for undocumented battered Latina women who are in transition to becoming documented is necessary to reduce stress and challenges that come with their status. Based on the shelter-based clinicians’ insights and the researcher’s interpretation less stress will help this unique population through the healing process. Otherwise, their healing may actually become impeded.

**Treatment Implications**

Future shelter-based clinicians need to be aware that specific trauma responses such as depression and active fight, flight, or freeze needs to be addressed first. This is important to help stabilize the client in her new setting before attempting to tackle the
remaining natural trauma responses. This specific awareness is important to help modify
future treatments to provide best practice for this population. If trauma responses that
effect the stabilization of a client are not tackled at the beginning of treatment the
interventions recommended for other trauma responses may not be as effective.

The researcher recommends that obstacles such as traditional cultural values and
family beliefs of what is expected from a woman needs to be addressed during the first
meeting with the client. This will provide the client with an understanding of what has
been taught and how it might affect interventions recommended by shelter-based
clinicians. Each client from this population is unique and the perception of themselves
due to their status will be different.

Although shelter-based clinicians need to explore how their cultural beliefs and
acculturation level might impact their treatment plan and rapport, this study
revealed possible areas of concern regarding cultural treatments. For instance, one
shelter-based clinician in the study shared that some of her clients’ confused dissociation
as a natural response to their spiritual practices with curanderos. According to Crowe,
Tafur, and Torres (2009), “Curanderismo is a term referring to the Spanish word curar,
meaning ‘to heal’, and is used to describe the practice of traditional healing in Latin
American (Hispanic) cultures,” (p.82). According to the authors curandero or curandera
is a healer who in consider to be respected the same as a traditional medical doctor.
Curandero or curandera, like medical doctors, have different specialties and, “work on
many realms including the physical, mental, emotional and spiritual in order to diagnose
and cure illness,” (p.84). Curandero or curandera use different methods that come from
the earth such as herbs to cure illness. The belief in this practices could impact a shelter-
based clinicians attempt to help the client from practicing interventions to help her control or decrease dissociation.

Based on the results of this study, we can conclude that this unique population is complex and therefore shelter-based clinician treatment and interventions must be flexible and sensitive to the needs of the population. Shelter-based clinicians must be willing to be patience and find out the needs, worldview, and what their clients have been taught both by their family and their culture in providing effective service. Shelter-based clinicians need to have an understanding that with cultural sensitivity their services to help this population heal will be effective. While Herman’s (1992, 1997) model was developed for a general trauma population, this study has provided invaluable insights into the undocumented Latina DV population. The researcher’s Quintana DV Model of Healing for Undocumented Battered Latina Women Living in a Transitional DV Shelter (Table 10) is included in the chapter for shelter-based clinicians and other DV shelter staff to use to support the healing process of this unique population with the researcher’s permission.

Overall, clinicians must ensure they address risk factors such as a) language, b) awareness that the client may not have a strong support system in the U.S., c) lack of resources, and d) fear due to status in the U.S. They must explore/assess what they have been taught socially and culturally and how it might effect treatment and also accommodating their treatment based on a woman's level of comfort for relaxation techniques. Lastly, providing them with valuable resources in the community, case manager advocates (including legal services, DPSS, and DCFS), educating them about their rights, and connecting them to support groups that have the same status is essential.

Limitations
The researcher’s developing model, interventions, and clinical treatment recommended in the model will not necessary “fit” each DV case. Each DV case can be complex and very different. The model is to be used as a guide to be used by shelter-based clinicians and DV shelter staff as a unit. This model is limited to only undocumented battered Latina women who are living in a transitional DV shelter.

This research was done with a small sample of eight shelter-based clinicians in one transitional DV shelter setting. The researcher lost data because of a discharged battery in the tape recorder and a participant in the study not having enough time to complete the study. The researcher believes that this lost data limits the study. The two clinicians’ contribution to the study would have positively impacted the study because at least one had ten years of experience. The researcher met with some shelter-based clinicians off site of the DV transitional shelter at a local coffee shop. The researcher found that tape recording the interview in this setting was more difficult for the researcher to transcribe the data because of the amount of surrounding sound. Thus, further research needs to be done in a quiet setting with a larger body of shelter-based clinicians. Lastly, future studies should test this model and should also be tested in multiple DV transitional shelters with a larger number of interviews.

**Conclusion**

Undocumented Latina women face multiple barriers and fears due to their status. Undocumented Latina victims/ survivors of DV undergo more pain and terror in their own U.S. homes. While there is a lot of research on healing or recovery from trauma among DV victims, there is little to no research on the unique population of undocumented battered Latina women living in transitional DV shelters. This study
provided a great contribution to documenting and understanding the experience of undocumented battered Latina women and their process of healing from trauma while living in a transitional DV shelter. Through, an in-dept study of the healing process and recommended treatments and interventions, the researcher developed a sorely needed preliminary model specific to undocumented battered Latina women living in a transitional DV shelter. Such a model has not been found in previous literature and will greatly benefit transitional DV shelters that focus on the healing process of undocumented Latina domestic violence survivors.
REFERENCES


The effects of domestic violence on women and their children. *Journal of Family Violence*, 16(2), 171-192.


APPENDIX A: INTERVIEW QUESTIONS

Interview Protocol
(Sample Questions)

Mission Statement:

The mission of this interview is to collect research from expert shelter clinicians and shelter works on the healing process, obstacles of healing, ideal cultural-interventions, and treating trauma responses when working with undocumented battered Latina women. The researcher will also ask the interviewee to compare Judith Herman’s healing model with their work with undocumented battered Latina women. The goal is for the researcher and interviewee to develop a new model that is specific to undocumented battered Latina women with Judith Herman’s three phases of healing and recovery from trauma.

Descriptions of Healing unique to Undocumented Battered Latina Women

[Thank you for coming. Your insights are extremely valuable to me. I am interested in learning the healing process of the undocumented battered Latina women you work with]

1. How do you as a shelter clinician or shelter worker define/characterize healing among undocumented battered Latina women?
2. What is unique about the experience of undocumented battered Latina women (biological, psychological, and social)?

Obstacles to Healing unique to Undocumented Battered Latina Women

3. How do you as a shelter clinician or shelter worker describe/characterize obstacles to healing among undocumented battered Latina women?
4. What are specific issues that prevent them from healing that are unique to their status in the United States?
Ideal Cultural-Interventions

5. What are the ideal interventions that you use to help undocumented battered Latina women manage their trauma responses during the beginning, middle, and end of their healing process?

**How would you treat X Trauma Response**

[Thank you. Now I would like to ask you about the 6 response to trauma and healing as being whatever helps them "resolve" those 6 responses]

6. When working with undocumented Latina battered women, in what order (please rate 1- first priority and 6-last priority) do you see that each trauma response needs to be tackled?

<table>
<thead>
<tr>
<th>Trauma Responses</th>
<th>This trauma response was our first priority</th>
<th>This trauma response was our second priority</th>
<th>This trauma response was our third priority</th>
<th>This trauma response was our fourth priority</th>
<th>This trauma response was our fifth priority</th>
<th>This trauma response was our last priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Isolation</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Anxiety/ Tension</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Low Self Esteem/Helplessness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
Dissociation

Active Fight, Flight, Freeze

7. Social isolation

a) B1) What is the clinical based treatment(s) that you use when working with undocumented battered Latina women with SOCIAL ISOLATION?

B2) What are the specific interventions that are used with this clinical based treatment?

B3) How do they differ from women who are documented and/or from another ethnicity (i.e., cultural interventions)?

8. Depression

A.

B1

B2.

B3.

9. Anxiety

A.

B1

B2.

B3
10. *Low self-esteem/helplessness*
   
   \textit{A.}
   
   \textit{B1}
   
   \textit{B2.}
   
   \textit{B3.}

11. *Dissociation*

   \textit{A.}
   
   \textit{B1}
   
   \textit{B2.}
   
   \textit{B3.}

12. *Active flight/freeze*

   \textit{A.}
   
   \textit{B1}
   
   \textit{B2.}
   
   \textit{B3.}

**Response to Judith Herman model (+/-)**

[Thank you. I would like to ask you about Judith Herman’s healing model that I found during my research]

13. Judith Herman defines healing and recovering from trauma in three phases, a. Safety,
   
   b. Remembrance and mourning and c. Reconciliation and commonality.
   
   \textit{A. Safety}
Herman defines safety as an individual feeling a sense of safety both physical, emotionally, and psychology. Herman states that battered women need several interventions “including biological (medication), cognitive and behavioral (education on traumatic syndromes, journal-keeping, and homework tasks), interpersonal (building a therapeutic alliance), and social (family support and a protective court order), (P.169),” to reach a sense of safety.

B. Remembrance and mourning

Herman identifies remembrance and mourning as an individual recognizing and accepting their trauma experience and mourning what they have lost due to the trauma. What the individual may mourn includes losing their identity, a partner, a marriage, a nuclear family system and lost of trust and sense of safety with someone they loved. An individual honors their trauma experience through working on a trauma narrative.

C. Reconciliation and commonality

Herman argues that reconciliation and commonality is reconciling with… and starting to form a sense of community with others. Herman believes that during this phases the survivor is able to begin to connect with others and start to form trusting relationships, begin to build a new life and identity, begin to take herself out of the victim role, and lastly join or form a support system with individuals that have experience the same type of trauma and are going through the same type of recovery process. Herman claims that during this phase an individual’s needs a sense of community in order to help them get their life back to a sense of normality. It helps if the individual ventures out into the community and start to build a new social circle or community.
How do the notions of healing for undocumented battered Latina women differ from Judith Herman’s traditional model of healing (Readiness to heal + recovering from trauma, safety, remembrance and mourning and reconciliation and commonality)?

14. If you were to categorize the interventions that you use with undocumented battered Latina women with Judith Herman’s three stages of healing, where would you place them?

**Conclusion**

15) Is there anything that you would like to add or comment that you believe would benefit this study?

*Thank you for your time and participation in this study*