

NDVFRI

National Domestic Violence Fatality Review Initiative



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NDVFRI STAFF

Director

Dr. Neil Websdale
(928) 523-9205

Program Coordinator

Tim Schrader
(928) 523-2355

Editorial Staff

Kristin Braley
Dana Oden-Stiglitz

Inside This Issue:

Editor's Introduction	1
Barbara Hart	3
Yvonne Luna	14

Editor's Introduction

During 2010, NDVFRI staff provided on-site technical assistance in a number of states including Texas, Arkansas, North Dakota, Missouri, Maryland, Arizona, North Carolina, Georgia, Florida, and Nevada. I contributed to the Family Violence Prevention Fund Workshop on Risk, held in San

Francisco in June 2010 and Matthew Dale presented a workshop on fatality review at the NOVA conference in Salt Lake City in August 2010. I also made presentations at the OVW New Grantee Orientation and the Aequitas domestic violence homicide training, both in Washington D.C. in December 2010

and at the National Council of Juvenile and Family Court Judges conference for new OVW grantees in Miami, also in December 2010. Matthew Dale and I took part in a short film on domestic violence fatality review (DVFR) produced by Motofilms and supported by OVW. The film focused on the Montana Fatality Review Commission.

NDVFRI hosted a successful national conference in Phoenix, Arizona in August 2010. Nearly 400 attendees experienced a mixture of keynote addresses, interactive panels, and mock review exercises. Presenters included Evan Stark, Jackie Campbell, David Adams, Connie Sponsler-Garcia, and OVW Director Judge Susan Carbon. The large attendance at the conference reflects a growing interest in fatality review. More than 40 states have developed fatality review initiatives. In more sparsely populated states such as Montana, New Mexico, Iowa, and Oklahoma, teams operate over the entire state, sometimes working with local communities where deaths occur. More populated states have larger numbers of teams. Florida now has 20 teams, New York at least 10, and California at least 20. In the space of 20 years, anywhere from 150-175 permanent teams have sprung up in communities all over this country.

These teams form part of that panoply of emerging coordinated community responses to domestic violence. The proliferation of teams in the US and their increasingly diverse membership expanded the formal and informal social networks enlisted to prevent domestic violence related killings. In the short space of 20 years (1990-2010), some review teams began to gather information from the relatives, co-workers, friends and neighbors of those who died or those who killed. Based on systematic research findings and anecdotal insights into the social networks of victims, some teams began to learn from pastors, school personnel, animal control officers, and others about the difficulties and compromises victims faced. Reaching into the everyday lives of citizens

and tapping into some of the capillaries of community organization reflected a growing recognition of the limitations of criminal justice intervention in these complex cases.

Most teams review intimate partner homicides involving the killing of wives and female partners. However, a few teams also examine other deaths such as female perpetrated killings; suicides; sexual competitor killings; deaths indirectly traceable to domestic violence such as those of homeless women, sex workers or prostitutes, drug-addicted women and those with HIV-AIDS; filicides; near deaths; contract killings; bystander deaths; and suspicious deaths, accidents, disappearances and others. Ideally, DVFR reconstructs the case through a close analysis of the lives of victims, perpetrators and others. Knowing about these lives involves bringing those people to the table that knew the parties, either in professional or non-professional capacities.

A potentially wide array of people typically become involved in fatality review work. These people include prosecutors, defense attorneys, shelter/ domestic violence center staff, a broad range of advocates for victims, survivors of domestic violence, surviving family members of those killed, school personnel, medical examiners and public health workers, housing authority staff, members of faith communities, batterer intervention program staff, friends, neighbors and co-workers of victims/perpetrators, child protection workers, representatives from probation and parole services, mental health professionals, researchers, police, court personnel and so on. The information and insights produced by such networks are considerable.

Notwithstanding the importance of the information and insights generated through the fatality review process, it is also the case that this kind of teamwork entails considerable community work and democratic dialogue. Teams therefore contribute to and often reinvigorate community life, build community connections and encourage democratic discussions about how to provide for those in vulnerable situations.

Two important articles grace the pages of this edition of the NDVFRI Bulletin. Both contributions grew out of special foci at our national conference: battered women’s suicides and the plight of immigrant battered women. The first article addresses battered women’s suicide and suggests fatality review teams analyze these deaths. The author, Barbara Hart J.D., artfully combines academic research, the stories of battered women who took their own lives, and data on women’s suicide gleaned from the criminal justice system. Barbara concludes with a set of practical recommendations for policy and practice. The second contribution, written by Dr. Yvonne Luna, explores the plight of battered immigrant women

and the ways of overcoming the barriers and obstacles they face. Yvonne suggests a number of improvements in the way we protect and serve immigrant battered women and also provides a useful list of additional resources.

We hope you will find these articles useful. If you have any interesting developments in your communities that you’d like to share, please email them to me at Neil.Websdale@nau.edu

Neil Websdale

Director, NDVFRI

Battered Women- Suicide

Barbara Hart

Battered Women - Suicide

Suicide and suicide attempts by battered women occur below the radar of most professionals working to end violence against women. Incidence data are sketchy. Risk markers are weak. Screening tools are nascent. Intervention strategies are vague. Evidence-based practice is non-existent. Even anecdotal wisdom is sparse.

Few battered women have shared their thinking and experience related to suicide. Whereas composites of the stories of battered women have guided practice and policy in the past, stories about the lived experience of battered women contemplating suicide have not often been volunteered by survivors or invited by the field.

This article first offers a brief overview of the knowledge gleaned from research and practice on suicide and suicide attempts by battered women. It captures several stories of battered women who died by suicide, concluding with recommendations for research

and practice to prevent suicide and suicide attempts by battered women.

Research-Generated Knowledge

Research on suicide or suicide attempts by battered women offers preliminary insight into the significant risk that intimate partner violence poses for suicide and attempted suicide by battered women. It also offers threshold information about the protective factors available to battered women that mediate against suicide attempts and the coping strategies employed by battered women to manage or escape the violence and potentially thereby averting suicide.

A meta-analysis of 40 studies of the mental health impact of domestic violence found that partner violence has a substantial effect on mental health, producing elevated rates of depression, suicide attempts, anxiety, and posttraumatic stress disorder.¹

A clinical study of women seeking emergency department services at a large urban hospital in Sweden found that battered women were significantly more likely to attempt suicide than non-battered women.² Medical records of the battered women attempting

suicide and both a control and a comparison group were reviewed over a period of 16 years (10 years before the battering that brought them to the hospital and 6 years afterwards). Only suicide attempts resulting in inpatient care were examined. Upwards of one-fifth of the battered women in the sample attempted suicide (an attempt rate 8 times greater than in both the control group of non-battered women and the comparison group from a contemporaneous study of suicide-attempts). The majority of the battered women who attempted suicide did so 1-2 times. The reasons identified for the attempts included: conflict with a spouse/partner (33%) and separation from a spouse/partner (10%); however, none of the women indicated that violence or coercive controls occurred immediately before or precipitated the attempt. Most women attempted suicide between the ages of 30 - 39. The method used was overwhelmingly the consumption of drugs (89%). Fully 59% of the battered women attempting suicide were classified as addicted, alcoholic, or problem consumers of drugs or alcohol (a rate significantly higher than among battered women not attempting or completing suicide). However, only 27% of those making a single suicide attempt were problem consumers. Many of the battering partners were described as alcohol abusers. The findings generated were solely based on medical records; particulars of the experience of the sample were not captured in interviews. None of the study participants completed suicide during the study.

The study team observed that repeated battering and a lack of a social support network, often combined with drug and alcohol problems, provoke suicide attempts. Finally, they concluded that suicide attempts by battered women are methods of help-seeking and not intended to be fatal.

Research of the medical records and histories in the emergency service of a large hospital in Connecticut revealed that 20% of

battered women made multiple suicide attempts compared to 8% of non-battered women.³ In contrast to the study in Sweden, battered women attempting suicide were most likely to do so the same day as they went to the hospital for an abuse-related injury (36.5%). Thus, the single best predictor of possible suicide attempts by battered women was violence inflicted by their partners, particularly that which caused injury in proximity to the attempt. As well, within the six months prior to the suicide attempt, almost 30% of the battered women visited the hospital due to an abuse-related injury. Additionally, pregnancy was found to be a risk factor for attempted suicide for battered women; about 20% of battered women attempted suicide while pregnant, a rate 4 times greater than non-battered women. The implications of culture or race were also noted; half of the African American women attempting suicide had been battered, while less than 25% of the white women making attempts were battered. Marital status emerged as a potential risk marker for suicide attempts by battered women; 70% of those attempting suicide were single, divorced or separated.

A critical finding of this study was related to the response of medical personnel; battered women who attempted suicide were *less* likely than non-battered women attempting suicide to receive referrals of any kind for follow-up services. They were more likely to be sent home than offered voluntary in-patient mental health services. Researchers concluded that mental health workers considered suicide attempts by battered women to be transitory events, arising out of the abuse and the distress it causes rather than deriving from psychiatric illness, and thus not appropriate or susceptible to mental health interventions.

There is other evidence that separation and divorce may be risk markers for suicide and suicide attempts. A review of the suicide literature over the last 40 years suggests that separation from an intimate partner may be the context in which suicide and suicide attempts

primarily occur.⁴ Yet, the current research does not squarely address the immediate or acute phase of separation vs. the long-term separation or divorce; however, there is some evidence that more suicide-related behavior occurs during the first period of separation from an intimate partner.

Less investigated were risk markers of suicide attempts and completions based in entrapment (the real or perceived impossibility of safely leaving a relationship/ marriage), despair (feeling that there is no way out of the violence or abusive relationship other than death), or hopelessness (concluding that none of the advocacy, services, social supports, resources, or treatment options will put an end to the violence and emotional abuse). Research outside of the U.S. has identified these risk markers.⁵

A World Health Organization multinational study (10 countries) confirmed that women who are physically or sexually abused by their husbands or intimate partners were more likely to attempt or complete suicide.⁶ Women in these countries living in rural areas were more likely to suicide, seemingly based on lower levels of education, greater social isolation and limited access to healthcare. The difference in urban and rural rates (if any or under which circumstances) of attempted or completed suicide by battered women in the U.S. has yet to be investigated. The best source on completed suicides is *The National Death Reporting System* at the U.S. Centers for Disease Control, now including multi-source data from 19 participating states.⁷ While not explicitly addressing intimate partner violence, the data are instructive. Females complete suicide at 1/3 the rate of men. Intimate partner *problems* (not necessarily violence) were cited as the precipitating event in 26.4% of female suicides. The suicide rates by race or ethnicity were highest among American Indians/Native Alaskans followed closely by non-Hispanic whites. The lowest rates of female suicides were among African Americans and Latinas.⁸

As to precipitating factors for women, the two most commonly referenced were crises in the 2 weeks preceding the suicide (30%) or intimate-partner *problems* (26.4%). Married persons were the most likely to complete suicides (38.7%). Women suiciding were most likely to use poisons (40.8%) and firearms (31.9%). Suicide is the 16th leading cause of death for women in the U.S.⁹ Beyond the research that has explored the demographics, context and precipitating events of suicide attempts in battered women, other investigations have looked at the coping strategies of battered women and the personal or circumstantial factors that may serve as protective buffers against suicide attempts or completion by battered women.

Research exploring the reasons that some low-income African American battered women attempt suicide and others do not was recently undertaken at an urban public hospital in the South.¹⁰ Given the backdrop of both higher rates of partner violence and homicide and the uncertainty of the prevalence of suicide for African American women, who are disproportionately poor, young, urban, single heads of households,¹¹ caring for more children and living with scarce economic resources and often dependent on the batterer,¹² this study examined the use and effectiveness of coping methods, both positive (e.g. help-seeking, adaptive living skills, ability to access and use material resources, viability and use of social support systems, as well as, efficacy in dealing with the partner violence) and negative (e.g. alcohol or drug use and abuse). There were two phases to the inquiry. The quantitative portion revealed that controls (battered women who were non-attempters) used higher levels of positive coping strategies and few maladaptive strategies as compared to battered women attempting suicide. Battered women who accommodated the demands of the abuser and approached problems from a stance of helplessness were at greater risk for suicide attempts. Those with good problem-solving skills, strong social supports and operating from a stance of greater empowerment were

less likely to attempt suicide.

The qualitative portion demonstrated that battered women participants who did not attempt suicide were more likely to engage in safety planning, self-preservation, or development of separation strategies to leave batterers. They spoke about expanding and utilizing new positive coping strategies. Attempters reported utilizing some positive coping strategies, particularly through engagement in therapy and nurturing their children. Both those attempting suicide and those who did not coped with partner violence through their religious beliefs and support system as well as community resources. The study team recommended that professionals working with battered women should assess their coping skills and provide opportunities to hone and upgrade positive coping skills in all battered women, and most especially with those who are at elevated risk of suicide.

Similar to the evaluation of coping strategies of battered women, a survey of women receiving health services investigated the role of protective factors (e.g. social support, education, employment, self-esteem, health and absence of economic hardship) in mitigating adverse mental health consequences to intimate partner abuse.¹³ The study revealed that protective factors provide a buffer against anxiety and depression for battered women. The more factors, the stronger the buffer and the greater the resilience. However, severely abused women were less likely to experience the mental health benefits apparently deriving from protective factors. Severe abuse seems to both block the power of protective factors and, over time, erode these buffers against depression and anxiety.

Knowledge from Stories of Suiciding Battered Women

In several states, Domestic Violence Fatality Review (DVFR) teams have begun to examine suicides by battered women. As

battered women are perhaps more likely to suicide than to be killed by their intimate partners, a number of the teams have determined that it is critical to review cases where battered women have killed themselves. It has not been easy to find cases to review, and it has been difficult to obtain information about the precipitating circumstances of these suicides. Nonetheless, the following stories of battered women who have completed suicides have been reviewed and offer important lessons for practitioners and policymakers.

“Laura.” Laura, 52 years-old at the time of her death, left a note at the local domestic violence shelter several weeks before her suicide:

A Message from Laura...

When Memories of Abuse Return

It never really goes away. We hope, we deny, and sometimes we even move past it for a while. The memories often linger just under the surface; then, with a jolt of recognition, they’re back as if they’d never left. Get over it, move on, and get past it. All so much easier said than done. Even when the abuser moves on to make a better life for himself, there’s the residual damage to the victim. Many of those that have been abused cloak their fears with their own set of behavior issues. All in the name of denial that someone we love could create such a climate of fear...

Yes, we try to move on. Try to let go. But it rarely covers the many facets abuse entails. Perspective generally serves to un-cloud the issue, though it may not be as long lived as one

might hope. As with most things time can lessen the impact, but not always. What you might consider as past may come back and revisit until time and distance provide a chance to put it away again. It can be unwelcome and intrusive but there's always a chance we'll gain more insight and peace within ourselves as the days go by.

The domestic violence program had no contact with Laura after she left the note. In the investigation that followed her death, family and friends suggested that perhaps she did not commit suicide; instead they believed that her boyfriend might have killed her. There was no documented history of abuse by the boyfriend against the deceased. After an extensive investigation, the boyfriend was cleared.

Lessons to be considered from the story of Laura: 1. Symbolic gestures by battered women that at least partially contain messages of hopelessness, entrapment and despair should be seen as risk markers of suicide. 2. Domestic violence advocacy programs should engage in outreach, advocacy and social support with women to whom they provide service if it appears that they are at risk of suicide or homicide.

"Anne." Anne killed herself with a firearm she had purchased to protect herself and her child from her husband, from whom she was separated. She was a professional woman who was highly respected in the community. The newspaper article did not identify that she was a victim of partner violence or that she purchased the gun for protection. The privacy of the family was cited for giving no particulars about the events prior to the suicide.

Lessons to be applied from the story of Anne: 1. Gun possession by battered women

may be a risk marker for suicide; and, although not the facts in this story, gun possession either by a battered woman or her partner elevates the risk of femicide of the battered woman. 2. Professional women are battered and may be at risk for suicide.

"Nicole." Nicole was 34 years old at the time of her suicide. Early in her marriage to her severely battering and sexually abusive husband, he began a course of violence and sexual coercion that continued and escalated throughout the 12 years of the marriage. He threatened suicide and repeatedly threatened to kill her if she left him. In the beginning, he would force her to consume alcohol, and she began to drink to medicate against the fear and pain caused by the violence and threats. Nicole suffered emotional breakdowns periodically. He masturbated to pornography in the "family areas" of the home, and their baby daughter appeared to have been sexually molested by him. The batterer isolated Nicole and engaged in surveillance to keep her from contacting friends and family. He had affairs and accused her of the same. His accusations were without merit. He abused family pets. He threatened to kill her family members. He was arrested and charged with assault on Nicole and her brother. He was prosecuted for terroristic threats against a third party. He was also charged and convicted of numerous crimes related to possessing and selling methamphetamines, financial fraud, and many moving vehicle violations, including a hit and run. While in jail he had family and friends watch her and report back to him. From jail, he made many threatening calls and sent letters asserting his entitlement to her. She sought assistance from the local domestic violence program. They helped her with a civil protection order and a divorce. The husband continued to violate the order. The husband also violated bail conditions and sentencing directives with impunity. Nicole was told by her husband's probation officer that he was a drug informant, so the criminal legal system was not going

enforce the law or court orders against him. She moved in with her parents, living with them for the last year of her life. She discontinued advocacy services with the domestic violence program. The husband threatened to take custody of their children when he got out of jail, despite the award of sole custody to Nicole. She shot herself the day before her husband was due for release from jail.

Lessons to be applied from the story of Nicole: 1. Battered women who live under a “reign of terror and violence” for many years, who have sought assistance to protect themselves from on-going and escalating violence and have attempted to end relationships with severely violent and possessive batterers who assert they are entitled to control over and relationship with their battered partners – i.e. battered women who have tried all that the law, community and informal support systems can offer to no avail – may kill themselves if they cannot find ways to escape the entrapment, fear, despair and severe violence inflicted by the batterer. 2. Legal systems and personnel that collude with batterers should be called to account and compelled to comply with their responsibilities under law, and, at a minimum, pay significant penalties if they fail to enforce the law to contain battering husbands and protect battered women and their families.

“**Kate.**” Kate was 48 years old, a high school graduate with 2 years of college. She was a factory worker making a good income. A passenger in a truck her husband was driving at a high speed, she apparently jumped out, hit a guardrail, was dragged by the truck for ¼ mile and then was run over by the truck, dying of the injuries that resulted. The husband was intoxicated, according to witnesses. Little is known about Kate. However, Kate had attempted suicide previously by trying to jump out of the husband’s moving truck after he told her he was seriously involved with another woman. During the marriage, the husband’s

alcoholism became acute. He defrauded Kate and damaged their credit. The week before the suicide the husband asked Kate for a divorce. Kate’s husband was married three times before marrying Kate; he was married twice to his first wife who obtained a restraining order against him, citing injurious violence and excessive alcohol consumption. Kate told a co-worker that she feared her husband was going to kill her and that he had tormented her throughout the marriage. After her death, Kate’s co-workers advised law enforcement that they did not believe she had committed suicide. The husband plead to a “hit and run with a death involved” and a “DUI.” Kate’s death certificate stated that she had died by suicide.

Lessons to be considered from the story of Kate: 1. Perhaps this suicide could only have been averted by family and friends. However, Kate apparently did not disclose her prior suicide attempt to anyone, and, likewise, the husband seemed to have kept it a secret. 2. The amount of distress and discord in this marriage was significant, and it may have masked any display of Kate’s feelings of imminent loss and abandonment that she may have felt when her husband announced that he was ending the marriage. 3. Many battered women have no contact with law enforcement, domestic violence programs or human service agencies. If suicide is to be prevented, other institutions or support networks must identify partner violence and suicidality and offer assistance to battered women by way of education about and counseling on domestic violence. In this instance, the Employee Assistance Program at work, adult children, and/or co-workers might have intervened had they been more knowledgeable about domestic violence and the risk markers of homicide and suicide.

“**Marsha.**” In December 2009, a 48 year-old battered woman in a city in the western U.S. committed suicide by an overdose of Rx medications. There was an extensive documented history of domestic violence, in

which the suspect in all incidents was her boyfriend/ex-boyfriend. Over a 10 year period, there were 26 calls for service involving the deceased. There were 7 written police reports for domestic battery, one of which resulted in an arrest; 6 calls for service for a suicidal subject (the battered woman); 12 calls for service that were the result of domestic disputes, out of which the male was arrested during *one* of those incidents; 2 calls for service for violation of protection order, one of which resulted in an arrest. In the beginning of 2009, she was granted an extended protection order against the batterer, and she later dissolved that order in August of 2009. The last report of domestic battery by the batterer occurred on November 27, 2009, resulting in no arrest. As a result of the police report, a victim advocate was assigned to the woman's case immediately, but the advocate was unable to make contact with her. She was found deceased in her apartment on December 2, 2009, just 5 days later and after confiding in a friend about the extensive harassment and abuse from the boyfriend and how she "just couldn't take it anymore."

Lessons to be applied from the story of Marsha: 1. Outreach immediately after each contact with the police should be made by a victim specialist in the police department or prosecutor's office, with follow-up services and advocacy provided by the local DV and human services programs upon the request of the victim. 2. Repeat calls about the violent assaults against an intimate partner should be handled as "high risk," and the police department's "threat containment" section should develop individualized containment (for the batterer) and safety (for the victim) strategies tailored to deter the repeat abuse by the batterer. 3. The failure of the police department and the prosecutor to appropriately investigate, charge and pursue prosecution and detention of repeat offenders is a significant risk marker for suicide and suicide attempts by battered women. 4. Despair and hopelessness are engendered in battered women living in communities where criminal justice response is

weak, uneven, unpredictable and indifferent to the safety and health of battered women.

"Jenna." In September 2006 a battered woman, 39 years of age, committed suicide with a handgun. She had separated from her battering husband 3 months before her death; however he was stalking her at work (elementary school), by cell phone and internet postings, and at home, according to her teen daughter. Her sister stated that Jenna seemed accident prone, and bruised easily. Her daughter said Jenna was exhausted all the time. Friends stated that after the separation Jenna had become withdrawn, e.g., not returning their phone calls, no longer visiting with her mother in a nursing home, not participating in holiday celebrations, dropping out of graduate school, and quitting as deaconess of her church. None of them had been in contact with her for two weeks before the suicide. The daughter had asked her to get help, but Jenna reported that nothing she had tried in the past had worked. A search of the criminal history and protection order dockets revealed no contact with law enforcement or the courts.

Lessons to be applied from the story of Jenna: 1. Withdrawal or self-isolation is a risk marker for suicide. Significant changes in the social behavior/connectedness of battered women may reflect sharply increased distress or despair. When battered women isolate themselves, withdraw from close friends or family, sharply reduce community engagement, or discontinue activities that had brought them personal gratification and growth, they may be contemplating suicide. 2. Hopelessness is a risk marker for suicide. When battered women conclude that their help-seeking and other safety strategies will not end the violence of intimate partners and that, despite their best efforts, all the strategies they have employed do not bring an end to the violence or relief from fear, they may conclude that suicide offers respite. 3. To date, research has not sufficiently examined the potency of withdrawal and hopelessness as risk markers

for suicide.

Knowledge Gleaned from Criminal Justice System Data Collection

Police departments in the U.S. have begun to explore the nexus between domestic violence and suicidal behavior in battered women.

Hawai’I County, HI (177,835 residents) For several years, a police advocate has cross-referenced police and EMT reports on suicide attempts and suicide of both men and women with criminal justice databases on domestic violence. She advises supervisory police staff about the nexus between domestic violence and suicide attempts/completions discovered. Responding officers are informed about the co-occurrence of partner assault and suicidal behavior. In August 2010 in Hawai’I County, 3 women attempted suicide – one immediately following a child custody hearing. Six women threatened suicide when police responded to domestic violence calls. The coroner found that one woman suicided by hanging herself. Two women were reported missing by their husbands and were found dead, apparently by suicide. In reviewing these data, the police advocate reflected, “Coercive controls by batterers foster a deep sense of entrapment in battered women. This experience of entrapment is compounded by poorly trained police, judicial system personnel, and the domestic violence advocacy staff here on this island... . Women who have been trafficked in from other countries under the guise of marriage with the 2 year conditional visa have attempted to take their lives.”¹⁴

Reno, NV. (220,500) Starting in January 2010, the Reno Police Department (RPD) began reviewing all reported attempted suicides, completed suicides, homicides, and deaths in the city of Reno. RPD staff cross-check them for any documented domestic violence, stalking, and/or harassment history, as well as calls for service. In addition, the staff reviews cases of individuals who mention a

significant other or spouse within the attempted suicide/suicide/death report. The reports contain a detailed examination of the complex characteristics and risk factors for homicide and suicide. This information is kept separate from all other information regarding domestic violence incidents, victims, and offenders. Also included within the case management system are data that cannot otherwise be extracted from the RPD Automated Reporting System. These include, but are not limited to, alcohol/drug use, children present, domestic violence history, prosecution/charge details, risk factors, specific descriptions of offender actions, relationship of victim/offender, direct contacts with offender/victim (if the case is assigned to a detective), etc. The goal is to identify repeat suspects and victims to better assess the history of violence and the risks posed by the predominant aggressor, rather than only detailing the new incident. Law enforcement personnel are alerted to any documented domestic, suicidal, harassment, or stalking history of a victim and offender. By examining the history of contact with justice and human services systems and not approaching a case as an isolated incident, RPD is able to engage in more thorough and thoughtful approaches to domestic violence intervention.

RPD contends that early intervention in these incidents is important for prevention of future incidents, or even death. If data (current and historical) is compiled in a consistent and detailed manner, staff believes there is great potential to save lives. To facilitate secondary prevention work, professionals within and outside the RPD are developing specialized programs within the department to respond to intimate partner violence, suicide, mental health and substance abuse.

Evidence-Based Recommendations for Policy and Practice

Research, stories of battered women, and criminal justice data systems offer preliminary guidance on policy and practice

enhancements to prevent suicide and suicide attempts by battered women.

1. Professionals serving battered women, family and friends supporting battered women, and advocates working in domestic violence programs should initiate conversations about suicidal ideation with battered women. Screening for suicidal thinking, planning, and attempts is a first step. However, the shame and stigma of acknowledging suicide consideration, coupled with the fear that thinking about suicide portends mental illness and that the listener will blame her for contemplating suicide or for the despair and hopelessness she is experiencing or her belief that nothing can be done to stop the violence and end the entrapment, are likely to make these conversations very difficult for both the helper and the battered woman to begin.
2. First responders in police departments, emergency rooms and domestic violence hotlines should be coached on approaches to opening up conversations about suicide. Supervisors should include suicide as one of the elements to be addressed in oversight of direct service staff.
3. Conversations about suicidal ideation and attempts can be time-consuming and repetitive. Battered women who do choose to talk about suicidal ideation and behaviors may exhaust professionals and support networks. Battered women may feel hopeless about achieving safety and stability and eliminating the circumstances that propel them into suicidal behaviors. Thus, back-up systems of support and intervention must be considered and employed with the informed consent of battered women.
4. Allies of battered women should

explore the coping strategies that battered women are employing.

Attention should be paid to enhancing positive coping strategies – to include assessing risk, planning for safety, acquiring essential resources, obtaining essential healthcare, enhancing support networks, accessing effective legal protections, enhancing self-confidence, crafting strategies for leaving the abuser and avoiding unsafe contact, and managing all the loss and pain of ending the relationship with a batterer. Attention should likewise be paid to identifying and eliminating the coping strategies that undercut a survivor's efforts to be safe, secure, healthy and otherwise resilient. Allies should help battered women identify and expand those protective factors that facilitate resilience and buffer against suicidal ideation and attempts.

5. Police departments, in addition to implementing systems for batterer containment and accountability, might retain victim specialists, employ case management systems and institute databases that will enable them to better assess the risks both of injurious violence and of suicide, make appropriate referrals to community agencies, engage in outreach and follow-up with battered women,¹⁵ and educate the community and friends of battered women about legal, human services and resource options.
6. Practitioners should devise and share emerging promising practices for prevention and intervention in suicidal ideation and behavior of battered women. Practitioners might invite evaluation of the strategies they institute to serve battered women contemplating suicide.
7. Scholars should expand inquiry about suicidal ideation, attempts and

completed suicide by battered women to further understand the reasons for suicidal behavior, any elevated risks associated with various demographic characteristics of victims, common precipitating events, positive and counterproductive coping strategies utilized by battered women and the protective factors that mitigate against battered women's suicidal ideation, attempts and completion.

8. Domestic Violence Fatality Review initiatives should consider cases where battered women have completed suicide to identify missed opportunities for support and intervention and to fashion recommendations for systemic reform to prevent suicide and suicide attempts by battered women.

Footnotes

¹ Golding, J.M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, 14, 99 - 132.

Rates of suicidality of battered women varied widely (4.6% to 77%) depending on the sample (e.g. highest among psychiatric patients, then shelter residents, the general population, and lowest among emergency room patients.). The method of research also produced diverse results with the highest rate derived from medical records, then interviews, and lowest from surveys. Notwithstanding the sample or method, the rate of suicidality of battered women is sharply greater than that of women in the general population.

The sample size of many of the studies was very small. Few investigators interviewed battered women attempting suicide. The findings and analyses are consequently limited. More quantitative and qualitative investigation is essential to produce a nuanced, robust picture of the experience and ideation of

battered women considering, attempting and completing suicide.

² Bergman, B. & Brismar, B. (1991). Suicide attempts by battered wives. *Acta Psychiatr Scand*, 83, 380-384. An important finding inviting more investigation was that almost 60% of the battered women seeking emergency care and 32% of those attempting suicide were born outside of Sweden. The higher rate of suicide attempts by immigrant battered women is consistent with the limited findings in studies in the United States.

³ Stark, E. & Flitcraft, A. (1996). **Women at Risk: Domestic Violence and Women's Health**. Sage Publications; Thousand Oaks, CA.

⁴ Ide, N., Wyder, M., Kolves, K. & DeLeo, D. (2010). Separation as an important risk factor for suicide: a systematic review. *Journal of Family Issues*, 31 (12), 1689-1716. Cf. NVDRS data, footnote 7.

⁵ Haarr, R. N. (2008). Local justice and victim support for battered women in Tajikistan. *International Journal of Comparative & Applied Criminal Justice*, 32, 195-220. Battered women seeking social support for ending partner violence were more likely to report suicidal thoughts and attempts than battered women who did not turn to others about the abuse. Women who told family or friends that their husbands or mothers-in-law beat them were 2.5 and 4 times, respectively, more likely to have suicidal thoughts and 7 times more likely to attempt suicide than women who did not seek help for partner or mother-in-law violence. Aliverdina, A., & Pridemore, W. A. (2009). Women's fatalistic suicide in Iran: a partial test of Durkeim in an Islamic republic. *Violence Against Women*, 15, 307-320. Provinces with stricter regulations on women's behavior have higher female suicide rates in Iran. Bagli, M., & Sev'er, A. (2003). Female and male suicides in Batman, Turkey: poverty, social

change, patriarchal oppression and gender links. *Women's Health & Urban Life*, 2, 60-84. Poverty, social disruption and patriarchal oppression are risk markers for female suicides in Turkey.

⁶ Garcia-Moreno, G., Jensen, H., Ellsberg, M., Heise, L., & Watts, C. (2005). **WHO Multi-country Study on Women's Health and Domestic Violence Against Women**. Geneva, Switzerland: World Health Organization.

⁷ Centers for Disease Control and Prevention. (2010). Surveillance for Violent Deaths: National Violent Death Reporting System, 16 States, 2007. *Surveillance Summaries*, May 14, 2010, 59, No. SS-4.

⁸ However, a small study of residents in a rural U.S. shelter found that suicidal ideation in Latina victims was significantly higher rate than other ethnic populations. More than half the Latina participants reported suicidal thoughts or suicide attempts, as compared to 35% of other study participants.

Krishnan, S., Hilbert, J., & VanLeeuwen, D. (2001). Domestic violence and help-seeking behaviors among rural women: results from a shelter-based study. *Family Community Health*, 24, 28-38.

⁹ Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2007). National Center for Injury Prevention and Control, CDC (producer). Available from URL: www.cdc.gov/injury/wisqars/index.html.

¹⁰ Reviere, S. L., Farber, E. W., Twomey, H., Okun, A., Jackson, E., Zenville, H., et al. (2007). Intimate partner violence and suicidality in low-income African American women: a multi-method assessment of coping factors. *Violence Against Women*, 13, 1113-1129.

¹¹ Rennison, C. M., & Welchans, S. (2000). *Intimate partner violence*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

¹² Sullivan, C., & Rumptz, M. (1994). Adjustment and needs of African American women who utilized a domestic violence shelter. *Violence and Victims*, 9, 275-286.

¹³ Carlson, B.E., McNutt, L., Choi, D.Y. & Rose, I.M. (2002). Intimate partner abuse and mental health: the role of social support and other protective factors. *Violence Against Women*, 8, 720.

Note, the study did not investigate the nexus between intimate partner abuse and suicide. The survey inquired about social support from the participant's intimate partner and her closest friend.

As anticipated, battered women experienced less social support from their abusive partners than other women. Yet, the finding that battered women receive equivalent social support from their closest friends was unexpected as other research* had documented the isolation and lack of social support networks available to battered women. The authors suggest that their focus on social support from two sources, rather than the broad constellation of the participants' social networks/supportive context, may explain the difference between their finding about the social connection and the more frequent finding of the social isolation of battered women. The question that this study does not answer (or confirm) is whether a robust network/context of social support is an additional protective factor for battered women against both abuse across the lifespan and adverse mental health consequences of abuse.

¹⁴ Personal communication with author. October 2010.

As a result of the work of the police advocate, the Hilo Medical Center staff now screen for domestic violence and suicide and provide survivors with brochures and articles on a broad range of DV issues, both prevention and services.

¹⁵ Research on the Triage Review Collaboration in Denver demonstrates that early follow-up with battered women, offering services and advocacy, as well as legal protections, improved both the rate of participation of battered women as witnesses in criminal proceedings and as consumers of relevant community services. Concomitantly, successful disposition of criminal cases against batterers increased significantly.

(DePrince, A. "Women's Social Context and Well-Being following Police-reported Intimate Partner Abuse." Forthcoming in the *Violence Women Journal*, 2011.)

Barbara J. Hart, J.D.

**Director of Strategic Justice Initiatives
Muskie School of Public Service
P.O. Box 9300
Portland, ME 04104-9300
207/780-4804 (Office)
207/899-7771 (Cell)**

An Overview of Battered Immigrant Women's Issues

Yvonne Luna

At the New Directions in Domestic Violence Fatality Review conference a number of critical issues were raised regarding the plight of battered immigrant women. In view of those concerns and because of the attention given to immigration in the popular media, it is important to shed light on the problems associated with being an immigrant woman who experiences domestic violence. It is also imperative that fatality review teams consider the particular barriers and difficulties battered immigrant women face so that appropriate actions are taken to prevent domestic homicides.

One of the neglected dimensions of immigration in the popular press is an informed understanding about the reasons people choose to leave their home countries. This is explained through a review of the *push-pull process*.

Ernest Ravenstein, a widely regarded migration theorist, argued that migration is governed by a push-pull process. That is, unfavorable conditions push people out of their

countries of origin while favorable conditions in a host country pull them in. Most often, people are pushed out of their home countries because conditions there are politically, economically, or environmentally problematic. Many people in these situations feel threatened enough that they risk dangerous border crossings. In July 2010, 59 suspected undocumented migrants were found dead in the Arizona desert.⁵ The adverse economic conditions in Mexico have pushed many people out. With the rise of global markets created by global trade agreements like the North American Free Trade Agreement, large and/or corporate farmers have fared well to the detriment of the small farmer. Because of their ability to compete with import markets, large farmers now account for a greater proportion of Mexican domestic markets. The result is a significant increase in migration out of rural areas as livelihoods are lost and farms abandoned. According to a study conducted for the Mexican government, between 1992 and 2002, the number of agrarian households fell 75 percent from 2.3 million to 575,000.⁴ Proponents of global free trade hoped they would be absorbed into Mexican non-agrarian urban employment but there was not enough growth in that type of work. The result has been a change in the pattern of rural out-migration. In the 1980s, the number of individuals migrating

to urban Mexico was higher than those migrating to the United States (US); a pattern now reversed. It is estimated that 400,000 to 500,000 Mexicans migrate to the US annually, with a vast majority (300,000) being from rural Mexico, mostly small, marginal farmers and agricultural laborers.^{1,4}

While certain conditions push people out of their countries of origin, there are inviting circumstances in a host country, such as the promise of political freedom or economic opportunities. Since the 1970s, the US has largely become a service-sector economy; an economy where goods-production has diminished substantially. Because of this, the earnings structure is exceedingly polarized with high-paying service jobs on the one hand and low-paying service jobs on the other. The high-paying jobs require education and technical skill, like professions in electronic communications, education, or healthcare. Most of the growth, however, has been in the low-paying service sector such as hotels, restaurants, retail, and agriculture. Legal migration is severely restricted while the demand for low-paid service workers continues to increase and the availability of US workers has diminished. In 1960, half of the US population did not have a high school diploma, whereas in 2009, only 12 percent did not.⁹ Nonetheless, annual migration to the US has declined by two-thirds over the last decade because the pull factors have changed significantly, with the recession and housing-market collapse largely contributing. Although the focus here is on Mexican migration to the US, the push-pull process can be applied to all migration patterns, including internal and external migration that occurs all over the world. Given that large numbers of migrants still come to the US, it is critical to employ measures that will protect battered women from the vulnerabilities of that status.

Barriers and Obstacles Experienced by Battered Immigrant Women

There exists a considerable amount of research regarding the barriers and difficulties battered immigrant women face. These include, but are not limited to: fears of deportation and separation from children, social isolation, language barriers, legal status, economic dependence, and lack of information about rights and available services. These factors render immigrant and refugee battered women vulnerable.

Motherhood poses special considerations for all battered women. For immigrant battered women, however, there are additional concerns. Abusers often use a mother's fear of deportation to keep her from reporting violence. She may fear being separated from her children, especially if they are American-born, or she may worry about the loss of livelihood if the abusive partner is deported. This is compounded by her knowledge of, or experience with, law enforcement in territories that do not define domestic violence as a crime as well as language barriers. Motherhood is most often viewed as a cultural requisite for women from traditional patriarchal cultures and many immigrant women, therefore, have the responsibility of caring for children. Leaving may seem like an insurmountable task and sometimes it is. If she leaves the abusive partner, it may be difficult to find space in a shelter or she may not have family or friends to turn to.

Women from patriarchal and/or patrifocal (e.g., centered on the father/husband) cultures tend to be particularly vulnerable to social isolation because of the importance given to the husband's family, the negative views on separation or divorce, the pattern of custody given to fathers when custody is in dispute, discouragement of women's work outside the home, and the tendency to face ostracism when

they deviate from their traditional obligations as wives and mothers. Migration also often means that they leave their families and loved ones behind.

In addition to contributing to isolation, language barriers and lack of access to interpretation and translation services pose obstacles to obtaining assistance. This, together with social and cultural differences and lack of understanding about legal processes, put immigrant women in disadvantaged positions. Even if they have the skills to secure jobs in higher-paying fields, as few do, they may lack language skills necessary for those jobs. Some women do not have opportunities to learn the host-country language. An abuser may feel threatened by his partner's ability to speak the host language and therefore prevent her from learning the language.

An irregular (e.g., undocumented, pending, or unstable) legal status may also contribute to battered immigrant women's vulnerability and isolation. If the abusive husband has legal status, he often uses this as a way to intimidate her, make her fearful of deportation, and prevent her from reporting abuse to authorities. When both parties are undocumented, many women fear that the family's security is at risk if she calls attention to it. If she decides to leave, her legal status may be an impediment to accessing services such as cash assistance, subsidized housing, job training programs, and domestic violence and legal services. Not only is an irregular legal status detrimental, her economic position may complicate her vulnerable position.

Some studies demonstrate how labor force participation increases personal freedom and chances to escape abusive situations. Other studies document how abusers control women's economic activities, from determining where she will work and how often she will work, to seizing control of wages. Because of her economic status, and other factors discussed here, including isolation and

language barriers, battered immigrant women are at particular risk of poverty. With little means to support herself and her children, she may choose to remain in an abusive situation or return if she has left.

Although a number of barriers and obstacles have been addressed here, it is important to note that they are only highlighted. For additional information, please see the references and resources listed below. Having touched on the barriers and obstacles, possible solutions are considered.

Overcoming the Barriers and Obstacles

The US government, in an effort to provide greater protections, has responded to the peculiar needs of battered immigrant women. The 1994 Violence Against Women Act, reauthorized in 2000 and 2005, includes special provisions for battered immigrant women, known as the Battered Immigrant Women Protection Act. This Act provides that spouses and children of US citizens or lawful permanent residents may self-petition for legal permanent residency. There are several stipulations, however, that may prove difficult for many women. For additional information, see [The Immigration Policy Center](#).

Some women seek legal status vis-à-vis their spouses' employment-based temporary nonimmigrant visa. In a majority of cases under this program, immigrant women are not provided legal work authorization. This manifests her dependency on her lawfully-present spouse for financial support and for completing the immigration-sponsorship process. Oftentimes, abusive spouses revoke sponsorship in an effort to prevent wives from obtaining legal residency. Efforts to detect sponsorship breakdown due to violence are encouraged. In addition, there could be provisions in place that would require a sponsor to provide "good reason" for revoking sponsorship, or allow women to self-petition, as described above.

In addition to policy efforts, other improvements should be considered:

- Immigrant victims of crime qualify for U-Visas, but only 10,000 are issued every fiscal year. This is available to those who assist in the detection, investigation, or prosecution of specified criminal activities including domestic violence, sexual assault, and human trafficking ([US Immigration Support](#) offers more information). Part of the application process requires that the form (I-918) be certified by a federal, state or local law enforcement agent. Without this certification, the petition cannot be submitted. Law enforcement officials should understand that they are not granting lawful status to undocumented immigrants nor are they determining victims' eligibility for U-Visas. In addition, the certifying agent will not be held liable if the victim is found ineligible. For more information see [Law Enforcement's Role in U-Visa Certification](#).
- More and better interpretation and translation resources in compliance with Title VI of the Civil Rights Act are needed to address language barriers at all points of contact. In addition, measures should be taken to ensure the cultural competence and sensitivity of interpreters and translators.
- Accessible and affordable legal services for battered immigrant women are severely lacking, especially considering the complexity of US immigration law. Service providers should be knowledgeable and able to present options to battered immigrant women that ensure safety without jeopardizing immigration status or risking deportation. Perhaps a "fast track" process in legal aid agencies would better serve battered immigrant women. Finally, immigration legal aid attorneys should be available to immigrant women facing possible deportation due to sponsorship breakdown.
- An information packet should be given to battered immigrant women by service

providers. It is essential that it contain key phone numbers and legal information in a variety of languages in a user-friendly format, such as the one provided by the [Arizona Coalition Against Domestic Violence](#).

- Better collaboration, networking, and information-sharing within and between service providers is also imperative.

Some of these suggestions are offered in the [Washington State Domestic Violence Fatality Review 2008 report](#). In their reviews, they also found a need for: culturally-competent service providers; community organizations in immigrant neighborhoods who can provide domestic violence awareness, information on legal rights and access to legal services; educating battered immigrant women on how to document abuse; state and local bar associations providing affordable continuing legal education on immigration options and other legal concerns for battered immigrant women.

Additional Resources:

[Advanced Special Immigration Survivors Technical Assistance \(ASISTA\)](#)

[Asian & Pacific Islander Institute on Domestic Violence](#)

[Family Violence Prevention Fund](#)

[Legal Momentum](#)

[National Domestic Violence Hotline](#)

[National Immigration Project of the National Lawyers Guild](#)

[National Network to End Violence Against Immigrant Women](#)

[The National Women's Health Information Center](#)

Footnotes

¹El Nasser, Haya. 2010. "Fewer illegal immigrants entering USA," *USA Today*, September 2. "Fast Facts." 2010. US Department of Education, Institute of Education Sciences, National Center for Education Statistics. <<http://nces.ed.gov/fastfacts/display.asp?id=27>>.

²Han, Ju & Hui Judy. 2009, October. *Safety for Immigrant, Refugee and Non-Status Women: A Literature Review*. Ending Violence Association: Canada.

³Menjivar, Cecilia, and Salcido, Olivia. 2002. "Immigrant Women and Domestic Violence: Common Experiences in Different Countries." *Gender & Society* 16(6): 898-920.

⁴Mohanty, Mritiunjoy. "Small Farmers and the Doha Round: Lessons from Mexico's NAFTA Experience." June 24, 2008. <www.stwr.org>.

⁵"Record Migrant Deaths on Arizona Desert Border." 2010. *BBC News: US & Canada*, August 3.

⁶Stark, Evan. 2007. *Coercive Control: How Men Entrap Women in Personal Life*. Oxford University Press: New York.

⁷Waslin, Michele. 2008. "Why Don't They Just Get In Line? The Real Story of Getting a 'Green Card' and Coming to the U.S. Legally." *Immigration Policy Center*, March 8.

Dr. Luna is an Assistant Professor of Sociology at Northern Arizona University in Flagstaff, Arizona. She acknowledges Firoza Chic Dabby, Director of the Asian and Pacific Islander Institute on Domestic Violence, for her suggestions and comments about this article.