

# Chapter 21

## Undocumented Immigrants: Connecting with the Disconnected

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### OBJECTIVES

At the end of this chapter, the reader will be able to

1. Describe the diverse composition of the undocumented immigrant population.
2. Discuss the scope of influence undocumented status has on quality of life.
3. Identify strategies that support therapeutic connections with undocumented persons.

### INTRODUCTION

In this chapter, I ask you to set aside everything you think you know about undocumented immigrants. Doing so will allow you a glimpse into a world that will both amaze and anger. The term itself *undocumented* puts emphasis on something lacking, something not done. An alternate perspective permits a fuller assessment of what *has* been done—what has transpired in the life of this person. It is from this richer understanding of the person's experience that insightful and effective care connections are developed. It is satisfying work and there is much work to be done. Estimates put the number of undocumented immigrants in the United States at 11 million. Zack Taylor, chairperson

of the National Association of Former Border Patrol Officers, estimates that the number is actually more like 18 million (Dinan, 2013). Such a number has both social and political implications. Political implications are not the focus of this chapter. However, after reading this chapter it is anticipated that the reader will take these additional insights forward into such discussions.

The following cases are based upon real patients, but the names are pseudonyms. My role was as the psychiatric-mental health advanced practice nurse who saw them in a community-based clinic associated with a university.

### **Talia**

This is all I knew about my 2:00 p.m. appointment: she is a 14 year old referred by a school counselor because she appears sad and is withdrawn. Talia was seated in a pillow-backed chair meant to be comfortable and homelike. Clearly, for Talia it was neither. She was tense and at the same time her eye contact was pleading. Her style of dress is what you would see on most any teenage girl: stylish jeans, fitted tee shirt, strappy sandals accented by bright purple toenails. There is nothing standard about undocumented immigrants—they come in all shapes and sizes. One year ago she was living with her father and two younger brothers in Ecuador. Her mother had immigrated to the United States a year earlier. Her father paid a “very large sum of money” to transporters who brought Talia and her 15-year-old cousin to the United States. At the border, both girls were sequestered and then taken by bus to a detention center. Several hundred children were housed at the center. They had medical examinations and were assigned a cot in a large dormitory. Talia was held at the detention center for 9 months. Her cousin was released a few months earlier. Talia remained at the center because she expressed suicidal ideation to one of the interviewers. Talia was very worried about her young brothers because her father drank heavily and often would beat the children. She had not wanted to leave her brothers. She felt helpless and hopeless. Talia’s mother lived several thousand miles from the detention center. She didn’t visit or call. Upon release from detention, Talia was transported to her mother’s home. The mother had a new boyfriend and was not pleased to have her daughter added to the household; Talia was not pleased to be added. The mother proved to be both physically and psychologically abusive—and this abuse was not something new. When Talia was 8 years old she was walking home from school when a 17-year-old village boy raped her. She was crying so hard that the boy felt bad and gave her money. Her mother told her that meant she was now a whore and she beat her. Focusing on her story, that is, focusing on what she had done versus what she had been through allowed a connection that proved to be therapeutic. In a later session with her mother, this petite, beautiful, 14-year-old undocumented immigrant looked her mother directly in the eye and said “this is American you can’t do these things to me ever again.”

**Roberto**

In the 1980s Roberto was a 17 year old living in Cuba with his family. He was a typical teenage boy with perhaps one exception: he was academically gifted. Cuban President Fidel Castro arranged scholarships for promising students to attend university in Germany. Roberto had been in university for several months when he returned to Cuba “to visit.” Much was going on in Cuba at the time. The United States and Cuba had negotiated the Mariel boatlift. Under this agreement a mass emigration of Cuban citizens occurred during April 15 through October 31, 1980. They were to be sent to the United States on a temporary basis. They would be given Social Security cards and I-94 papers. Roberto and a couple of his friends hid on one of the boats transporting criminals from Cuban jails and mental patients from institutions. It was an opportunity for freedom.

Upon arrival in the United States, Roberto and his friends were issued Social Security cards and I-94 papers just like all the other passengers. For almost a year, he made his way in a big city with the eagerness of youth. Unfortunately, he became involved in the sale of marijuana. When he was arrested, he had just enough marijuana on his person to send him to federal prison. He served his time as a model prisoner and was released a little more mature and a lot more motivated to build a good life for himself and a future family he so much wanted. That is exactly what he did. Roberto built a successful roofing company employing many workers and proudly paying his taxes as a business owner. He still had his Social Security card and I-94 paper (with no expiration date), which gave him refugee status, but he also had a criminal record from his stay in federal prison. He married and had children. In 2012, he was deported. It was a traumatic process. U.S. President Obama pulled all I-94s from the Mariel boatlift emigrants that could be located. Roberto’s brief stay in federal prison made him easy to locate. He complied with the notification to go to the Immigration Customs Enforcement (ICE) office to register. Upon entering the office, he was stripped of his personal belongings and sent to a deportation camp for 90 days. From there he was sent to another camp in Key West, Florida, and then to prison in Cuba. His prison time was “hard time” due to the seriousness of his crime: he had “taken” a Cuban government scholarship and then fled the country. During his imprisonment in Cuba, he was forced to wear steel boots as punishment for running away. When he was finally released, he was 65 pounds lighter, physically ill, and depressed. When he walked into that ICE office, he walked in with 32 years (1980–2012) of contribution to society. Newly immigrated undocumented persons have heard these stories and live in fear that it could happen to them at any time. Roberto’s child told me that immigrants fear the hospital because it can house an ICE processing center: “Entering a large building is always a risk. You never know if you will be allowed to walk out.”

**Maria/Hector**

In some ways Maria was one of the lucky ones. She felt blessed to have been chosen by lottery to enter the United States. She joined a large group of family members and friends who had immigrated to United States years before. They were all undocumented. Maria was grateful to have family and friends in the United States because she had had to leave her children, aged 5 and 10 years, in Honduras. Her plan was to work hard, save money, and have her children join her. She wanted to provide a better life for her children in America. As the only documented person in the group, Maria was often called on to handle all matters of business for the others. It was Maria who convinced her uncle Hector to come to the clinic. He had become increasingly withdrawn. He rarely left the home. His sleep and appetite were poor. He felt emasculated, as he could not be a man to his full potential. In his view, he was a financial failure. He was “tired of sneaking around and looking over my shoulder ... I’m an empty, weak man with no rights.” Maria warned me that Hector would be resistant to taking psychiatric medicine. That, to him, would confirm that he was indeed “loco.” I prescribed a tea infusion of telio leaf—an herb Hector knew well for his “weakness.” We discussed exercise: “Back home I was the dancer.” I prescribed salsa dancing. Subsequently, Hector was comfortable taking S-Adenosylmethionine (SAM-e), which he could buy himself at a local store. I wish I could say Maria did as well. It would be years before she would also be challenged with depression. By the time she was able to bring her children to the United States, they wouldn’t come. During the 10 years she struggled, her children had grown—the eldest was planning to marry. Maria then came to realize that she had given up years with her children that could never be recouped. She was angry that she, the only fully documented member, had “been so foolish with my time.” She wasn’t at all sure that she was one of the lucky ones.

**Lester**

Twenty-five years ago Lester, age 50, came to the United States. He is a talented woodworker who, despite his undocumented status, has been steadily employed throughout these years. He married, had a child, and later divorced. Two years ago Lester sustained a serious back injury at work. Even after more than 20 years in the United States, he was fearful of seeking medical care. Desperate for food, he went to a free pantry and met a social worker who was from Colombia, his native country. She convinced him to come to the clinic for reiki treatments. Reiki, an energy medicine technique, is frequently used in Colombia. This familiar practice served as entry to an otherwise intimidating environment.

**Grace**

Grace was not a patient. She worked at the clinic as a phlebotomist. One day she and I were talking about colleges because her daughter, a senior in high school, was working

on applications. I mentioned that I did my undergrad at University of Arizona and I went on to say how much I loved Arizona. I asked her if she had ever been there. She said: “Oh yes, I will never forget Arizona.” She then lifted her skirt to show me her legs. Angry looking scars covered her thighs, and her lower legs looked like the complex fine lines you’d see on a subway map. “The cactus in the desert was very difficult,” she explained. At age 17, Grace came into the country alone, literally crawling across the desert and hiding among the tumbleweeds and, of course, the cactus. Exhausted and in pain, she fell asleep in the sandy soil. In the morning, she prayed—not a plea for help but a prayer of gratitude. She continued: “The desert in the spring has the most beautiful wild flowers. The cactus flower is a wonder to behold—I knew my life had just begun.”

## NURSING OPPORTUNITY

There is no group of healthcare professionals better positioned to significantly impact the health of undocumented immigrants than nurses. The core of nursing is and always has been the nurse–patient relationship. The challenge with undocumented persons is that they are essentially disconnected from the society in which they live. They move about the community in fear and distrust—always on guard. Stories of being apprehended, detained, and deported are circulated in the communities. Hearing these stories reinforces the distrust. Detention camps are real. The stories of deportation are real. ICE offices housed in various buildings are a reality. Skillfully building connections is the requisite first step in getting this population engaged in health care.

Nurses are rightfully concerned about immigrants being able to access health screenings and receiving care for chronic health conditions like hypertension, diabetes, and asthma. Community nurses are frustrated in their attempts to reach this population. One nurse who works on a mobile health van in a city heavily populated with undocumented immigrants put it this way: “We literally take the care to their doorstep yet they won’t come—they wait until there is a health crisis and often then it is too late.” Assessing the problem, I see a constant. That constant is fear and distrust. But what is it that allows the fear and distrust to persist? We cannot deny the reality of detention camps and deportation, but we can create another reality just as real. Nurses can create new stories—stories of safe interaction: stories of a nurse who asked: “What has it been like for you?” stories of a nurse who didn’t interrogate to fill in blanks on a form but rather a nurse who listened. In homeopathy we see the Law of Similars. Simply put, the law posits that what caused the illness can cure the illness. When nurses listen to the stories of Talia, Roberto, Lester, and all of the other undocumented immigrants, we are establishing caring connections—we are creating new stories to flood the community. And as we listen, we see life through their lens, which gives us a richer understanding of their problems. Solutions are always most effective when we thoroughly understand the

problem. I have found that using treatment approaches that are familiar to this population is very well received. Lester was comfortable with reiki and prayer, which set in motion a care connection that allowed additional healthcare interventions. Hector drank a telio tea infusion, which led to an agreement to take SAM-e (Papakostas, Mischoulon, Shyu, Alpert, & Fava, 2010).

### Treatments

You cannot attend a nursing conference or pick up a journal without seeing emphasis on evidence-based practice. You may be concerned that immigrants from some less-developed countries will be more receptive to herbs or folk remedies than to FDA-approved pharmaceuticals. How will building care connections with immigrants mesh with an evidence-based standard of practice? The truth is that the timing couldn't be more perfect. American healthcare consumers have been demanding more complementary and alternative medicine (CAM) for several decades. The use of CAM is increasing yearly and research has responded to this trend. Changes in nursing education will play a major role in bringing CAM into everyday practice. As doctor of nursing practice (DNP) programs flourish, graduates will be positioned to translate research into practice. Nurse practice councils and committees in hospitals will update practice guidelines and nursing literature will bring evidence-based nutraceuticals and herbals to nurses practicing in a variety of settings. Already there is sufficient evidence to support the use of a wide range of natural modalities. As you listen to your patients from these "underdeveloped" countries you will learn about natural treatments. When you go to the literature, you may be surprised to find evidence to support the use of the herb or flower your patient cited (Blumenthal, Goldberg, & Brinckman, 2000; DeStefano, 2001; Lange, 1999; & Rotblatt & Ziment, 2002). Many undocumented immigrants, fearful of going to medical facilities, are purchasing herbs and medicines from sources that may or may not be safe. If the story gets into these communities that we are knowledgeable about these natural practices, it could encourage them to consult with us.

- *Epsom salts* are known in almost every country. Many people will tell of seeing their grandparents soaking their feet in a basin of water and Epsom salts. I keep a large container in my office and a supply of Ziploc bags. Epsom salts is magnesium sulfate and we know that magnesium is nature's tranquilizer. A soak in a bathtub is most effective but a foot basin will do. Its gentle chelating properties soothe sore muscles. Lavender-scented Epsom salts are useful for calming anxiety. Instruct that they are not to be taken orally.
- *Kava* (*Piper methysticum*) has been studied in numerous clinical trials (Pittler & Ernst, 2003; Stevinson, Huntley, & Ernst, 2002). Kava is an anodyne and an antianxiety

agent. It should not be used in conjunction with hepatotoxic medications (like acetaminophen) or alcohol. Kava is less popular in the United States than in most countries, in large part due to a manufacturing contamination that was widely publicized in the 1990s in the United States. It is not intended for long-term use but can be very effective for acute stress episodes.

- *L-theanine* is very effective for anxiety and can be used long term (Kimura, Ozeki, Juneja, & Ohira, 2007). It is an amino acid that supports production of inhibitory neurotransmitters. The fact that it is inexpensive and can be purchased at many local stores makes it less intimidating than benzodiazepines. It increases alpha waves in the brain producing a state of *relaxed alertness*—a mode of action that is especially appealing to an undocumented immigrant.
- *CoQ10* (coenzyme Q10) can be an important adjunct for patients who have agreed to take a statin for hyperlipidemia. When patients experience muscle pain after taking a prescription, they can become fearful and distrustful. Statins deplete CoQ10 causing myalgia. There are two forms: ubiquinon and ubiquinol, which is the reduced form and therefore immediately bioavailable.
- *Reiki* is one type of energy healing. Many nurses are familiar with therapeutic touch, originally introduced to nursing by Dolores Krieger in the 1970s. Reiki is known and practiced worldwide. Reiki can be a power connector.
- *Pranic Healing* is familiar to many immigrants. I have a vibrantly colored poster of chakras hanging in my clinic office. While a clinic can offer a full range of primary health care, it is important to start with the patient's priority. I recall the first day Felix came to the clinic. In response to: "How can we help you?" Felix, with tears in his eyes, asked: "Can you, will you please clean my chakras?" A connection was made and a story begun.

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