PSYCHIATRIC EVALUATION OF ASYLUM SEEKERS

Alisa R. Gutman, MD, PhD
Clinical Assistant Professor, Perelman School of Medicine, University of Pennsylvania
Medical Director, Philadelphia Human Rights Clinic

Jennifer McQuaid, PhD
Assistant Clinical Professor, Yale Center for Asylum Medicine, Yale University
Affiliate Scholar, Global Mental Health Institute, Columbia University
What will we talk about?

- Role of the Psychiatric Evaluation/What does it contribute?
- Pearls of Psychiatric/Psychological Evaluations
- Narratives and Lessons Learned
70.8 million forcibly displaced people worldwide

Internally Displaced People
41.3 million

Refugees
25.9 million
20.4 million under UNHCR’s mandate
5.5 million Palestinian refugees under UNRWA’s mandate

Asylum-seekers
3.5 million

Where the world’s displaced people are being hosted

80%

About 80 per cent of refugees live in countries neighbouring their countries of origin

57% of UNHCR refugees came from three countries

341,800 new asylum seekers
The greatest number of new asylum applications in 2018 was from Venezuelans

Top refugee-hosting countries

Germany 1.1m
Sudan 1.1m
Uganda 1.2m
Pakistan 1.4m
Turkey 3.7m

UNHCR has data on
3.9 million stateless people
but there are thought to be millions more

92,400 refugees resettled

37,000 people a day forced to flee their homes because of conflict and persecution

UNHCR has 16,803 personnel
UNHCR employs 16,803 people worldwide (as of 31 May 2019)

134 countries
We work in 134 countries (as of 31 May 2019)

We are funded almost entirely by voluntary contributions, with 86 per cent from governments and the European Union and 10 per cent from private donors
Clinical Evaluation of Asylum Seeker

- Documents emotional and physical harm & suffering related to persecution
- Speaks to the ways in which clinical issues may impact asylum seeker’s testimony
- Documents ongoing effects of persecution
Mental Health Evaluations Are Crucial For...

- Corroborating allegations of past persecution and severity of suffering
- Establishing “a well-founded fear” of future persecution
- Explaining behavior that makes the applicant appear not credible
  - e.g. late disclosure of sexual abuse or assault, getting irritable when Judge or attorneys ask too many questions
- Justifying exceptions to deadlines
  - e.g. missing filing deadline due to ongoing fears of attack
The Clinical Interview: LOGISTICS

Interpretation
- Arranged by lawyer or clinic; ideally not a family or community member
- Word-for-word translation, not "gist.
- Set up room for success - interpreter present but not in direct eye contact

Time Frame
- Duration: 2-3 hours; sometimes more; sometimes 2 separate sessions.
- Discuss turnaround time needed for report writing with lawyer
- May need to look at collateral information

Rapport with Applicant
- Informed Consent
- Describe goals and process; "shared work together.
- Predict frame and pacing to provide control; encourage client to self-advocate
The Interview

**Barriers to Interview**

**Sociocultural:**
- Interviewer Age
- Interviewer Gender
- Language
- Culture

**Environmental:**
- Setting,
- Comfort Level,
- Physical distractions,
- Privacy

**Physical:**
- Pain
- Discomfort
- Fatigue
- Sensory Deficits

**Relational Triggers of past,**
- Perceptions of the power differential,
- Power and Control
The Interview

Trauma Can create Psychological Barriers that surface in the Interview

- Shame when recounting narrative
- Disruptions in memory and concentration
- Hopelessness (What’s the point?)
- Re-experiencing while recounting narrative
- Distrust
- Detachment from emotional responses
The Interview

Barriers to Communication from Interviewer

Fear of what we might hear

Fear of not knowing how to respond

Idealization of trauma survivor followed by disillusionment

Our moral judgments (e.g. disapproval of client’s choices)

Fear of losing composure
Conceptualizing the Effects of Persecution:

3 Stages of MIGRATION

- PREMIGRATION
- MIGRATION
- Post-MIGRATION
Interview Content

Premigration

❖ Pre-trauma History: social, educational, health, and employment
❖ History of torture and ill-treatment, including escape/release
❖ Immediate consequences: injuries, infections, medical care, reporting, emotional reactions
❖ Decision and means of fleeing country
Decision and means of fleeing country
Issues of safety and security
Physical challenges
Trafficking in persons or drugs
Forced labor in exchange for passage
Separation from traveling group along the way
Post-Migration
The trauma of displacement

- Immigration status/asylum process
- Role transition: Loss of ties to one’s land & identity
- Basic needs unmet
- Separation from family and cultural supports
- Continued persecution of family and friends
- Ongoing lack of safety and security
- Current Functioning
- Mental Status Exam and Diagnostic Interview
- Long-term impact of trauma
Concluding the Interview

Information gathering

- Ask if there is anything else the client wants to tell you
- Clarify apparent inconsistencies within the interview or between interview and written statement

Emotional containment

- Validate and normalize
- Warn about re-activation and need for self-care

Provide information

- Next steps
- Referral/resources for follow-up care

Check in with Interpreter
Working from a Time-line

Externalizes narrative
Decreases focus and eye-contact, decreases anxiety
Increases collaboration
Facilitates connecting the dots: timing of onset of dx, exacerbations, triggers
Domains to Consider

Mental Health
Effects of Persecution

Physical Effects of Persecution

Stress of Migration

Ongoing stressors in Host Country (poverty, unemployment, lack of family/social support)

Effects of Seeking Asylum:
Mental Health Effects of Living with Future in the Balance
Common Psychiatric Sequelae of Trauma

❖ Posttraumatic Stress Disorder
❖ Major Depressive Disorder
❖ Sleep Disorders, including parasomnias
❖ Anxiety Disorders
❖ Substance Abuse
❖ Sexual Dysfunction
❖ Dissociative Disorders
❖ Neurocognitive Disorders (resulting from TBI)
❖ Complicated Bereavement

*Frequently, trauma victims will exhibit some constellation of symptoms, whether or not they meet diagnostic criteria*
Reactions to Trauma Are Highly Variable

- Severity and duration
- Physical impact
- Presence of humiliation
- Political involvement
- Individual factors (age, history of trauma, premorbid adjustment)
- Response from family and community
Studies have shown rates of PTSD in asylum seekers to range from 30% in some studies to over 82% in others (Stenmark, et al., 2013; Teodorescu, et al., 2012).

Asylum seekers demonstrate higher rates of PTSD than refugees; fear of deportation and application process can elevate symptoms (Nakeyar & Frewen, 2016).

In contrast, according to Harvard Medical School’s National Comorbidity Study, the lifetime prevalence of PTSD in the general United States population was 6.8%. 
PTSD vs. Complex PTSD

Single Incident Trauma
e.g., car accidents, natural disasters, etc.
time-limited duration

Chronic trauma
e.g. domestic violence, sex trafficking, political imprisonment, etc.
repeated, over months and years

The current PTSD diagnosis often does not fully capture the severe psychological harm that occurs with prolonged, repeated trauma.

People who experience chronic trauma often report additional symptoms alongside formal PTSD symptoms, such as changes in their self-concept and the way they adapt to stressful events.

www.ptsd.va.gov
Complex PTSD

What types of trauma are associated with Complex PTSD?

During long-term traumas, the victim is generally held in a state of captivity, physically or emotionally. In these situations the victim is under the control of the perpetrator and unable to get away from the danger.

Examples of such traumatic situations include:

- Concentration camps
- Prisoner of War camps
- Prostitution brothels
- Long-term domestic violence
- Long-term child physical abuse
- Long-term child sexual abuse
- Organized child exploitation rings

www ptsd va gov
Complex PTSD/ Disorders of Extreme Stress Not Otherwise Specified (DES NOS)

Long term, prolonged (months or years), repeated trauma or total physical or emotional control by another

**I. Alterations in regulating affect and impulses**
- Chronic affect deregulation
- Difficulty modulating anger
- Self-destructive and suicidal behavior
- Difficulty modulating sexual involvement
- Impulsive and risk-taking behaviors

**II. Alterations in attention and consciousness**
- Amnesia
- Transient dissociative episodes
- Depersonalization

**III. Somatization**
- Digestive System
- Chronic Pain
- Cardiopulmonary symptoms
- Conversion symptoms
- Sexual symptoms

**IV. Alteration in self-perception**
- Chronic guilt, shame and self-blame
- Feeling of being permanently damage
- Feeling ineffective
- Feeling nobody can understand
- Minimizing the importance of traumatic event

**V. Alterations in perceptions of the perpetrator (not needed for the diagnosis)**
- Adopting distorted beliefs
- Idealization of the perpetrator
- Preoccupation with hurting the perpetrator

**VI. Alterations in relation with others**
- Inability to Trust
- Re-victimization
- Victimizing others

**VII. Alterations in systems of meaning**
- Despair, hopelessness
- Loss of previously sustained beliefs
Cultural Impact on Diagnosis

- Not everyone who is tortured develops PTSD
- Varying cultural concepts of distress
- Primary posttraumatic symptoms may be somatic and not fit well into DSM-5 PTSD criteria
- Ask...
  - *Is there a name for this problem in your country?*
  - *Do you think you’ve changed since your trauma? Do others think so? How so?*
Interpretation of Findings

As defined by Istanbul Protocol (international guidelines on documentation of torture)

- **Not Consistent**: could not have been caused by trauma described
- **Consistent**: could have been caused by trauma described, but is non-specific
- **Highly Consistent**: few other explanations besides the trauma described
- **Diagnostic**: could not have been caused in other way than that described
Standardized Assessment Tools

- Controversial due to lack of normative data in these populations
- Useful as a supplement to a clinical interview
- PTSD Checklist (PCL-5), Quick Inventory of Depressive Symptomatology (QIDS, available in 30+ languages free online), National Center for PTSD’s Clinician-Administered PTSD Scale, Harvard Trauma Questionnaire (screening instrument, *normed in refugee populations)
- Cognitive screening can be helpful and important, MoCA or MMSE
<table>
<thead>
<tr>
<th>What is it?</th>
<th>How do I manage it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Secondary trauma can occur in those who work with survivors of trauma</td>
<td>❖ Clarify the limits of your role with clients, refer for other services</td>
</tr>
<tr>
<td>➢ Manifests in distress and symptoms of PTSD (e.g. nightmares, irritability, anger) or feelings of demoralization and depression</td>
<td>❖ Clarify what you CAN do for the client</td>
</tr>
<tr>
<td>➢ Can make you feel like victim or perpetrator</td>
<td>❖ Tolerate feelings of guilt and helplessness</td>
</tr>
<tr>
<td></td>
<td>❖ Recognize countertransference, fantasies of rescue and omnipotence</td>
</tr>
<tr>
<td></td>
<td>❖ Seek supervision and support from colleagues</td>
</tr>
</tbody>
</table>
A positive effect through interaction with clients’ stories of resilience:

❖ Witnessing and reflecting on human beings’ remarkable capacity to heal
❖ Reassessing the significance of one’s own problems
❖ Developing hope and commitment
❖ Articulating personal and professional positions regarding political violence
Psychiatric Evaluations

Summary

<table>
<thead>
<tr>
<th>Variation</th>
<th>Psychological responses to trauma are varied and often change over time; many victims will have symptoms, but fewer will fit a formal psychiatric diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistency</td>
<td>The evaluator’s job: deem consistency of physical and psychological sequelae with client’s history</td>
</tr>
<tr>
<td>Document</td>
<td>Document your clinical findings in an affidavit for the court using your existing skill set with additional attention to trauma/flight/recovery</td>
</tr>
</tbody>
</table>
Older sisters ran away from home, her father reacted by forcing FGM on her and her younger sisters.

She was accidentally seen by a man, when her father refused to approve marriage he was beaten and killed.

She fled through several countries, eventually arriving in the U.S. where she was detained.

Consider self care in this work, find colleagues for consultation and support.
35 y/o Russian Man

- Came to escape persecution as a gay man living in Russia
- Described incidents in which he was attacked, threatened

Consider how countertransference can be diagnostic, use these findings to explain potential behavior the court.

“It is possible that these issues regarding disclosure of his sexuality and his underlying hostility when asked questions about his sexuality could surface under the stress of a court hearing.”
A young, college-educated political activist who was jailed on multiple occasions during protests and abused when in prison. Came to U.S. to escape persecution for political opinion.

Presented as stoic, sometimes without affect, highly focused on building a new life. Reported pain and PTSD symptoms when in prison that remitted upon arrival. Holds strongly to his belief that he participated in “the birth of his nation as a democracy,” and has no regrets.

Consider speaking about the Posttraumatic Growth and strengths of the applicant, as well as the idea that symptoms can be (1) highly circumscribed and finite, (2) Acute Stress Disorder might apply, and, most importantly (3) that many survivors of political violence may find strength in the very act at the core of their persecution.

My words in documenting, “Applicant considers his actions to have been meaningful and holds strongly to the belief that he was in the right. In my expert opinion, this attribution schema – or way of making sense – of his deleterious experiences, serves as a protective factor. His ability to see himself as an agent of change and author of his own destiny fuels his ability to thrive.”
45 y/o Nigerian Woman

- Survivor of sex-trafficking from Nigeria – Sicily – US.
- Dx of Complex PTSD with significant increase in re-experiencing sx in recent months.
- Reported having a panic attack upon leaving my office.

❖ “It felt so good to talk to you and to have you listen. I felt like I poured everything out and the weight started coming off, but then, when I left, I had too much anxiety and pain. I couldn’t tolerate anything. I got a headache. My heart was beating very fast and I started having flashbacks. I went to Rite Aid (pharmacy) to get something for my head.”

Consider the effects of the asylum process on the applicant. How can we, as evaluators, use this information to suggest what might occur to applicant during her hearing?
We who have been subjected to torture and extreme trauma are often given the label of “victim.” This label focuses attention on the atrocities we have suffered, the shattering of our lives, and the fear and uncertainty with which we must live. But there is strength in us too, a resilience attested to by our very survival. We have lived through something unspeakable. We may greet each day with fear and uncertainty, but we also meet it with a strength that empowers us to reclaim our dignity, our hope, and our trust in humanity, and to adapt to a new life.

Sister Dianna Ortiz, The Survivors Perspective, 2001
HUMAN RESILIENCE IS PROFOUND.