PSYCHIATRIC EVALUATION OF ASYLUM SEEKERS

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

What will we talk about?

- *Role of the Psychiatric Evaluation*
- *Pearls of Psychiatric Evaluations*
- *Narratives and Lessons Learned*

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Roles in the Asylum Process

- The role of the **mental health care provider** is to document objective evidence of the psychological effects of torture or other forms of abuse on the individual.
- The role of the **attorney** is to prove that the asylum seeker has a “well founded fear of persecution” and meets all other requirements for a grant of asylum.
- The **Immigration Judge** is charged with making the legal determination of past persecution, and/or “well-founded fear” of future persecution.

Documentation of Trauma

- U.S. immigration system requires assurance that claims of persecution are credible in order to obtain residency in the U.S.
- Challenges to documentation
  - *Torture survivors leave their home nation with little personal documentation and rarely possess a legal record of torture*
  - *Complicity among health professionals in persecution limits the degree of medical care pursued by torture survivors*
- Human body and mind can be a form of documentation
  - *Characteristic scars and disabilities*
  - *PTSD and other psychiatric sequelae*

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

- Interpreter often present, lawyer or clinic should arrange, should NOT be a friend or relative of the client
  - *Give instructions to interpreter: speak in first person, word-for-word unless noted, sit in triangle to the side, evaluator and client should be speaking directly to each other not to interpreter*
- Extensive: two to three hours, depends on type of case
- Rapport with client:
  - *Informed consent*
  - *Give the client as much control as possible and help her to anticipate what will happen next*

Barriers to Interview

- Environmental
  - *Setting, comfort level, differences in power and control, triggers*
- Physical
  - *Pain, discomfort, fatigue, sensory deficits*
- Sociocultural
  - *Cultural, language, interviewer age, gender*

Psychological Barriers Trauma Often Leads to…

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

Barriers to Communication From Interviewer

- Fear of what we might have to hear
- Fear of not knowing how to respond
- Fear of losing composure
- Our own moral judgments (e.g. disapproval of client's choices)
- Idealization of trauma survivor followed by disillusionment

Interview Content

- 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, resettlement
- Current Functioning
- Mental Status Exam and Diagnostic Interview
- Long-term impact of trauma

Resettlement

- Trauma of displacement
- Immigration status/asylum process
- Adjustment (loss of ties to one's land and identity)
- Basic needs unmet
- Separation from family and cultural supports
- Continued persecution of family and friends
- Lack of safety and security

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

Common Types of Torture

- **Physical**: beating, whipping, stabbing, drowning, suffocation, stress, positions, electrocution, burns , abusive conditions of detention (including lack of food, water, sanitation and medical care, sensory overload or deprivation)
- **Sexual Violence**: rape, sodomy, all other sexual assault
- **Psychological**: killing or disappearance of family, mock execution, threats, humiliation (nakedness, forced to sing or bark like a dog, violation of cultural taboos), being forced to harm or renounce others
- We break our cases into these three large (often overlapping) categories

Reactions to Torture Are Highly Variable

- Severity and duration
- Physical impact
- Presence of humiliation
- Political involvement
- Individual factors (age, history of trauma, pre-morbid adjustment)
- Response from family and community

Psychiatric Sequelae of Mass Conflict

Meta-analysis: 81,866 persons, 40 source countries

Torture endemic in countries affected by pervasive conflict: 21%

Dose response effect of potentially traumatic events

PTSD

- Rates of PTSD ranged between 13-25%
- Torture accounted for 23.6% of intersurvey variance
- Society-wide index of terror showed association between general state of political violence in country and mental health

Depression

- *Torture accounted for 23.6% of intersurvey variance*
- *# Potentially traumatic events accounted for 22% of variance*

Steel Z, **Chey** T, **Silove** D, Marnane C, Bryant RA, van Ommeren M. **JAMA**. 2009 Aug 5;302(5):537-49.

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)*

Frequently, trauma victims will exhibit some constellation of symptoms, whether or not they meet diagnostic criteria

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*

Example: PTSD Criteria

While most victims of torture do not develop PTSD, it is a very serious and under-recognized result of trauma. Its diagnostic criteria include:

- *Intrusion Symptoms (re-experiencing)*
- *Avoidance (of internal and external reminders)*
- *Negative cognitions/mood (includes dissociative amnesia, negative emotional state and numbing/detachment)*
- *Hyperarousal Symptoms*
- *Duration (>1 month)*
- *Impairment ("clinically significant distress or impairment in social, occupational, or other functioning")*

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

Avoiding Re-traumatization

- Apologize for asking intrusive questions and for interrupting or redirecting
- Review goals and rational as often as necessary
- Allow time to build rapport and trust, schedule a second meeting if necessary
- Invite questions and be transparent
- Normalize reactions
- Stops when the client asks you to or when you have “enough”

Vicarious/Secondary Traumatization

- Can occur in those who work with survivors of trauma
- Can be a normative reaction to hearing vivid distressing narratives
- Manifests in distress and symptoms of PTSD (e.g. nightmares, irritability, anger) or feelings of demoralization and depression
- Can make you feel like victim or perpetrator

Vicarious/Secondary Traumatization

How do I manage?

- Clarify the limits of your role with clients, refer for other services
- Clarify what you CAN do for the client
- Tolerate feelings of guilt and helplessness
- Recognize countertransference, fantasies of rescue and omnipotence
- Seek supervision and support from colleagues

Vicarious Resilience

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

- Not all asylum applicants have suffered torture, but generally reason for a physical exam is that they have suffered some form of violence that has left permanent signs of damage
- Psychological responses to trauma are varied and often change over time; many victims will have symptoms, but fewer will fit a formal psychiatric diagnosis
- The evaluator's job: deem consistency of physical and psychological sequelae with client's history

QUESTIONS ABOUT PSYCHIATRIC EVALUATIONS?

19 y/o East African Woman

- Older sisters ran away from home, her father reacted by forcing FGM on her and her younger sisters
- She was accidentally seen by an Al-Shabaab 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."

42 y/o West African Woman

- Came to U.S. to escape persecution as a Christian, her father was killed, she and her sister fled but her sister was left behind
- Sought refuge at a police station, terrible outcome
- First attorney in the U.S. was unethical, she was arrested for irregularities in her immigration case

Consider that trauma does not end in flight, and ask rather than presume what an individual believes is a traumatic event.

60 y/o Indonesian Woman

- Moved with her husband to Indonesia, evangelical Christians who eventually set up their own church, she was threatened by a group of Muslim men
- At start of exam, appeared psychotic, husband stated that she became like this when reminded of trauma
- Given space in the interview, it was clear that she is bright and articulate

Consider cultural elements of presentation, use collateral information as able.

Victim vs. Survivor

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.