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Article

***725 SYMPTOMS OF TRAUMA AMONG POLITICAL ASYLUM APPLICANTS: DON'T BE FOOLED**
[FNd1][FNd1]

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I. What is Post-Traumatic Stress Disorder?

Since 1981, mental health clinicians have recognized Post-Traumatic Stress Disorder (PTSD) as a psychiatric disorder that comprises a constellation of symptoms directly resulting from trauma. [FN1][FN1] PTSD is diagnosed by psychiatrists, psychologists, psychiatric social workers, marriage and family therapists, and other mental health clinicians who have spent sufficient time with the trauma survivor to elicit the symptoms. There are also many standardized interviews and survey instruments, used commonly in research settings, that can also generate this diagnosis. [FN2][FN2]

PTSD occurs only in trauma survivors, and, by definition, the trauma must be perceived as life threatening, and in many cases actually is life threatening. Typical examples include torture, physical and sexual assaults, natural disasters, and motor vehicle accidents. As a result of the trauma(s), the survivor suffers from symptoms such as unwanted memories, intrusive thoughts, nightmares, or flashbacks of the event.

Because these reminders of the original trauma are often quite disturbing, PTSD sufferers go to great lengths to avoid triggering any sort of reminder, and will therefore, by definition, shun places, *726 activities, or people who remind them of what happened. For example, a victim of an armed robbery may never again walk along the same street (i.e., avoidance of the place). A survivor of a highway car accident may completely avoid freeway driving (i.e., avoidance of the activity). A survivor of sexual abuse at the hands of the police may avoid police, or anyone dressed similarly (i.e., avoidance of people). They also often avoid even talking about the traumatic experience because of the unpleasant memories and feelings evoked. In addition to memories, flashbacks, nightmares, and anything that can trigger reminders of the trauma, PTSD sufferers may become emotionally numb. Rather than bursting into uncontrollable tears at the thought of the trauma, the PTSD sufferer can appear “out of touch” with feelings, feeling neither pleasure nor pain. This inability to feel pain may initially be adaptive in the face of overwhelming trauma, but this restricted emotional range ultimately limits the person's ability to form normal relationships, which depend upon the experience and expression of emotion. This numbness can often take the form of a foreshortened sense of the future. Those with PTSD often have difficulty anticipating being alive for long, or planning very far ahead beyond their immediate survival needs.

Another symptom of PTSD is hypervigilance. Sufferers of PTSD may compulsively check doors, windows, locks, and scan the room or sidewalk frequently to see who is around them. One PTSD patient's auditory vigil-

ance rendered him capable of hearing doors opening and closing down the hall, sounds of which I was only dimly aware and to which I had attributed no significance. For him, however, the sound of a door opening had at one point in his life reportedly signified the possible arrival of armed militiaman at his home. Always on a heightened state of alert, PTSD sufferers can be easy to startle. Noises in the average range (a hand suddenly clapping, or a door slamming) can be quite alarming and frightening.

II. Psychiatric Studies of Asylum Seekers: Emerging Trends

An emerging literature of stress among asylum seekers is beginning to elucidate the extent of their psychiatric symptoms, particularly PTSD. While several studies have enumerated the types of traumas (e.g., rape, torture, etc) reported by asylum seekers, these research efforts are not reviewed here because the information is derived by self-reports from the asylum seekers themselves and generally cannot be verified independently. However, psychiatric *727 diagnoses are determined by expert clinician interviewers and specific survey instruments, so these findings are reviewed.

For example, in one Australian study, [FN3][FN3] forty consecutive asylum-seekers attending a community resource center in Sydney were interviewed using structured instruments and questionnaires. Of thirty subjects reporting a traumatic event such as witnessing killings, being assaulted, or suffering torture and captivity, fourteen subjects (47 percent) were diagnosed with PTSD. In a British study of twenty-seven asylum seekers, the average score on a seventeen item scale PTSD severity scale (with items scored from zero, which represents no symptoms, to three, which represents symptoms five or more times a week) was thirty-three (out of fifty-one), which indicates fairly severe symptoms. [FN4][FN4] In a study of 134 consecutive asylum seekers who sought mental health services at a program caring for survivors of torture and refugee trauma, PTSD and depressive disorders, as identified in a chart review, were the most common diagnoses, with frequencies of 82 percent and 96 percent respectively. [FN5][FN5] A Dutch study found that 76 percent of male asylum seekers from Asian and African countries suffered from PTSD, and that the diagnosis was associated with more frequent medical consultations. Meanwhile, asylum seekers who had received therapy for their PTSD symptoms used fewer medical consultations compared to those who had not received treatment. [FN6][FN6]

Among 70 detained asylum seekers who were given self-report measures, at baseline, fifty-four (77 percent) participants had clinically significant symptoms of anxiety, sixty (86 percent) of depression, and thirty-five (50 percent) of post-traumatic stress disorder; all symptoms were significantly correlated with length of detention ($p=0.004$, 0.017 , and 0.019 , respectively). At follow-up, participants who had been released had marked reductions in all psychological symptoms, but those still detained were more distressed *728 than at baseline, which suggests that detention of asylum seekers exacerbates psychological symptoms. [FN7][FN7]

Less is known about psychiatric symptoms in asylum seekers who are children, but another Dutch study found that, based on data derived from initial intakes, PTSD and anxiety disorders were presumed present among 84 percent of the 129 child and adolescent asylum seekers evaluated by a multidisciplinary team in a specialized psychiatric clinic. [FN8][FN8] Depressive disorders were prevalent among 36 percent of the sample. For both diagnoses, unaccompanied minors seeking asylum were at significantly greater risk than were youngsters with families.

There are several obstacles to studying the unique effects of torture and maltreatment among political asylum seekers, not the least of which include distinguishing these effects from the emotional impact of migration itself, or the impact of detention, when applicable, as illustrated above. Although the exact origin of stress

symptoms may be difficult to pinpoint, in an Australian study of post-traumatic stress among 196 Tamil refugees, asylum seekers and immigrants, [FN9][FN9] pre- and post-migration stress each accounted for 20 percent and 14 percent respectively of the variance in post-traumatic stress symptoms among the sample. In other words, migration and post-settlement stress are traumatic, but most of the symptoms are attributable to traumas reported in conjunction with alleged political persecution. Furthermore, symptoms of PTSD and other diagnoses, though by no means universal, are common among applicants for political asylum.

III. Credibility in the Courtroom: How Not to Be Led Astray by Symptoms of Trauma

Unfortunately for survivors of trauma who are also seeking political asylum, telling and retelling the events of the past can be ***729** extremely painful. Just recounting the story is enough to trigger uncontrollable tears, panic attacks, or flashbacks of the event. Thus, many asylum seekers may never actually recount all the details, particularly those that are shameful in their society, such as details of sexual violations. Or they may tell incomplete versions, or versions that vary over time such that an affidavit prepared with the help of an attorney may differ from the story recounted to a mental health professional, or an adjudicator. These inconsistencies can be indicative of a trauma story that is too painful to share in its entirety, but may be misinterpreted erroneously by adjudicators during an asylum hearing as a lack of credibility on the part of its victim.

In addition to the intentional filtering of information in affidavits to protect themselves from painful memories and shame, asylum seekers who have been traumatized may unintentionally omit key aspects of the story due to memory problems. Memory problems which can affect credibility in the courtroom occur with PTSD, specifically with “dissociation,” a psychiatric term used to describe a kind of numbing that occurs at the time of the trauma itself. Someone who is dissociating may feel as though she is not in her body, but looking down on it while it is being raped or beaten, or he may feel that the assault is happening to someone else instead. From the standpoint of adaptation, dissociation permits a person to endure a trauma that would otherwise be too horrific. Dissociation is like emotional and physical anesthesia. However, despite its initially adaptive quality, a significant longterm problem with dissociation is that it makes it extremely difficult for people to make sense of what happened to them, in part because they simply do not remember the details. The who/what/where/when/how of the details of the trauma are often lost to them. Ironically, the dissociation caused by the trauma can adversely affect asylum applicants' credibility as they attempt, with difficulty, to describe the trauma. Immigration Judges and Asylum Officers are understandably suspicious of factual accounts with conflicting, inaccurate, or missing data, but need to take into account the possibility that the very experience itself of severe trauma could be interfering with its description in an affidavit, an interview, or a courtroom.

Numbness associated with PTSD on an ongoing basis, rather than at the time of the trauma, may adversely affect the credibility of asylum seekers in the courtroom in a different way. Many adjudicators understandably expect that survivors of trauma, particularly in its more horrific forms such as torture, will have such ***730** overwhelmingly strong feelings about what they have endured that they will weep when recounting traumatic memories. In fact, their deadpan narratives are typical of the emotional numbing that often follows severe trauma. Many PTSD patients cannot access these feelings when describing the trauma. They may or may not cry when talking about other emotional topics.

Asylum seekers, by definition, come from other countries, and therefore other cultures. Cultural factors may strongly influence the types of information asylum seekers are comfortable sharing, as well as the pace of disclosure. In many cultures, victims of sexual abuse, rape, or sexual torture experience an overwhelming amount

of shame. Because in many cultures it is important to not lose face, these painful experiences would be difficult to share with loved ones, let alone with strangers in a public setting, especially government officials who might evoke memories of the perpetrators in cases where applicants have been terrorized by the agents of the state. Many asylum applicants offer only the sketchiest of details about these horrors, even though a more complete rendition could be helpful to their cases. For example, one study of British asylum seekers from multiple countries found that those who experienced sexual violence reported more difficulty disclosing personal information during asylum interviews than those who had not experienced sexual violence. [FN10][FN10] Survivors of sexual violence also reported greater dissociation as well, although they experienced more difficulty in reporting sexual violations independently of this increased dissociation. Thus, whereas adjudicators may attribute the timing of traumatic disclosures to an applicants' attempts to favorably (i.e., fraudulently) alter the outcome of their cases, the timing often reflects their great difficulty reporting these types of symptoms any earlier.

Eye contact is another culturally variable pattern of behavior. To quote from a primer on career advice for those seeking to adapt to British culture, "In many countries looking directly at a person's eyes while speaking is disrespectful. However in British culture having shifty eyes or not looking at the person you are speaking to is taken to show that you have something to hide or are not speaking the truth." [FN11][FN11] *731 Lewdness or aggression is associated with prolonged eye contact in many cultures, though not in the U.S. However, newly arrived asylum seekers may not have sufficiently assimilated to western culture to look directly at the person to whom they are speaking, particularly if that person is an Asylum Officer or Immigration judge by whom they may feel very intimidated. Thus, in U.S. culture, ironically, some asylum seekers may arouse suspicion by the aversion of gaze that to them is innately ingrained as a sign of respect or deference.

In the companion paper by Musalo et al., [FN12][FN12] the case of the Guatemalan domestic violence victim whose PTSD was not recognized as a valid diagnosis because she was able to pay her bills on time, nor was the case of the Kenyan woman whose PTSD supposedly could not have contributed to her delay in filing for asylum because she was still able to attend church. Both cases demonstrate a fundamental misunderstanding of what PTSD is and is not. Traumatized people often avoid people, places, and activities that are unwelcome reminders of the original traumatic event or events. In other words there is specificity to the avoidance, and also to the associated disability. By and large, such people may function quite well so long as they are not reminded of the original event. A common example of this phenomenon is the Vietnam veteran who appears to function indistinguishably well from his civilian colleagues, until he is within hearing distance of a car backfiring, at which point, based upon an increased startle response, he may leap under a piece of furniture for cover, as if he were being fired upon anew in the battle field. At that moment, it is as if he is suffering from the flashbacks and memories that are the hallmark of PTSD. Veterans such as he know to avoid fireworks celebrations or any other situation where sudden, loud noises are likely to hurl them back into the horrors of their pasts. However PTSD would not prevent them from paying their bills on time, or attending church because there is nothing about those activities that reminds them of the traumas they endured.

A quick anatomy lesson may further clarify the specificity of the symptom. At a neuroanatomical level, the part of this veteran's brain (the amygdala) which instantly responds to perceptions of danger by *732 triggering the body's fight or flight response (i.e., hyperarousal) has hijacked his behavior and induced a series of physiologic reactions (rapid heart rate, palpitations, sweating, increased blood flow to large muscle groups) which are entirely appropriate for dealing with actual threats to one's survival. For a person suffering from PTSD, it takes much longer than normal for the part of his brain (the hippocampus) that rationally assesses the situation and synthesizes data about the environment to override the amygdala and restore a feeling of personal safety. For example, if we hear a car backfire nearby, our amygdala instantly raises our level of alertness, but if similar loud

noises have not, in the past, been associated with dire consequences, the hippocampus almost immediately takes over and reminds us that we are on a street where cars may backfire fairly commonly, with no real danger. This process happens very quickly for most of us, but the hippocampus of someone who has been shot while hearing similar sounds would take much longer to restore equanimity. Again, however, these neurological structures which regulate our response to the environment are not functioning abnormally except when the environment contains a perceived threat. Paying bills, which has no relation to this Guatemalan domestic violence victim's trauma, would not induce traumatic symptoms; however, completing an asylum application based on the domestic violence she suffered would induce these traumatic symptoms. The veteran in our example, similarly, would have no difficulty paying bills or going to church, despite suffering from PTSD.

Asylum Officers and Immigration Judges are faced with the daunting task of weeding out fraudulent claims from the truthful ones. In fact, among data collected during a recent study of stress and burnout among Immigration Judges, [FN13][FN13] concern about fraud was a recurrent theme, [FN14][FN14] and the incentive is clearly high for asylum seekers to not only invent aspects of their story, but potentially to create medical or psychiatric symptom profiles consistent with their claims. Mental health professionals have no truth serum that can definitively determine which asylum seekers are truthful in their claims. However, there is a well-described clinical syndrome known *733 as Malingering that is relatively easy for clinicians to detect. [FN15][FN15] The malingering patient is one who derives an obvious benefit from being perceived as ill by others, even though he or she is not. These benefits may include access to pain medications, paid sick days at work, disability payments, or, in the case of an asylum seeker, a potential grant of asylum, or eligibility to apply for relief despite the passage of more than one year since entry into the U.S. Certain characteristics render malingerers easily identifiable. They are often well-versed in the details of the physical or mental condition which they are feigning, which for PTSD are readily available on the internet. They have often read the diagnostic criteria, and list as many symptoms as they can remember, even without prompting. They are also quick to deny the absence of symptoms, all in an effort to be a more convincing patient. By contrast, during the past decade of assessing asylum seekers, while I have encountered some asylum seekers who did not exhibit outward signs of trauma that I could document (either because they may have not been traumatized by their experiences, or were traumatized and recovered, or they may have been lying about what actually happened), I have never encountered a malingering asylum seeker. Some asylum seekers had very little idea what a psychiatrist does, or why their attorneys had referred them to me for evaluation. Others who understood my role nevertheless only revealed their symptoms when probed. Had I not asked about them, I would never have known about them. Furthermore, many were only too glad to deny symptoms, or to let me know the many things in their lives that they perceived as going well. By contrast, malingerers tend to list all the symptoms of the disorder from which they are claiming to suffer, in order to appear to be more convincingly ill. In short, while I cannot vouchsafe the veracity of their asylum claims, nor opine about the political conditions in their countries of origin, the psychiatric symptoms I elicited, in those cases when present, seemed genuine.

IV. Summary

In summary, trauma is a common response to events perceived *734 as life threatening, with associated neurobiological abnormalities. PTSD often is prevalent among asylum seekers. Symptoms include nightmares, flashbacks, intrusive memories, avoidance of triggers, numbing, hyperarousal, hypervigilance, and dissociation. Unfortunately for asylum applicants, their credibility in the courtroom may be undermined unless Immigration Judges and Asylum Officers are aware that trauma compromises consistent memories of the event, that avoidance of trigger-related stress or cultural factors such as shame may decrease their willingness or ability to dis-

close what has happened to them, and that PTSD symptoms do not affect daily activities in which memories of the trauma are not evoked. Eye contact is variable among cultures and may be diminished or absent in asylum applicants. Malingering (faking of illness) is usually easy to detect by psychiatric clinicians, but seldom occurs in this population. Adjudicators who keep in mind these signs of trauma will be less likely to wrongly conclude that an applicant lacks credibility when in fact he or she is suffering from a psychiatric disorder directly attributable to the trauma(s) in question.

[FNd1]. This article is a companion piece with Karen Musalo and Marcelle Rice's article.

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