Psychiatry Research xxx (xxxx) xxxx

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Short communication

PTSD in asylum-seekers: Manifestations and relevance to the asylum process

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A B S T R A C T

Post-Traumatic Stress Disorder (PTSD) is common among asylum-seekers and manifests with symptoms uniquely problematic to the United States asylum-seeking process. Chiefly, hyper-vigilance, avoidance behavior, dissociative amnesia and a tendency towards non-linear narratives hinder the articulation of an effective asylum claim. Moreover, the format and environmental circumstances of the asylum-seeking process further heighten these difficulties.

1. Epidemiology and symptoms

Post-Traumatic Stress Disorder (PTSD) is a complex syndrome of somatic, cognitive, affective and behavioral symptoms that results from the psychological trauma of direct or indirect violence or threats to life (Van der Kolk et al., 1996). Survivors of sexual violence, physical assaults, and kidnappings are among those at risk for PTSD, as well as individuals with direct exposure to death, widespread violence, or war zones. Refugees and asylum-seekers, who flee these very circumstances, unsurprisingly exhibit a high rate of PTSD. *Refugees,* by the definition established in the 1951 United Nations Refugee Convention, are individuals who have fled their home country and are unable or unwilling to return due to fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group. In the United States, an *asylum-seeker* is an individual applying for the right to remain in the country based on the same fears outlined above, or a limited number of other factors. Estimates of PTSD prevalence in refugee populations vary widely, reflecting the heterogeneity of these groups and the challenges of cross-cultural psychiatry. Data from metanalyses suggest an approximate 9% prevalence among refugees living in Western nations (Fazel et al., 2005), although this number may be much higher. Other studies put the rate of PTSD in refugees and asylum-seekers between 32% and 46% (Richter et al., 2018).

Clinical manifestations of PTSD include recurrent, intrusive, and distressing memories, dreams and flashbacks of the initial traumatic event. Internal or external reminders of the trauma can provoke intense psychological or physiological reactions (often in the form of a *fight-or-flight* response). Consequently, individuals develop compensatory avoidance behavior both internally (attempting to minimize thoughts, memories or feelings related to the trauma) and externally (avoiding people, places or situations that may arouse reactions to the trauma). Other relevant cognitive effects of PTSD include difficulty or inability to remember specific details of the event (described as *dissociative amnesia*) and a distorted understanding of the causes or consequence of a traumatic event (sometimes leading individuals to inappropriately blame themselves). PTSD sufferers also operate in a state of hyperarousal and hypervigilance, becoming symptomatic from the inability to let down their guard even when the trauma has abated. These aspects of PTSD can have dire bearing on the asylum application process.

2. Challenges to memory recollection

To be granted asylum in the US, or even avoid immediate deportation after a *credible fear interview (CFI),* an asylum-seeker must make a qualifying claim in a detailed, specific and consistent manner. For most individuals requesting asylum after entering the United States legally or being apprehended at the borders, the first adjudicating step is an asylum interview or credible fear interview with a US Citizenship and Immigration Services (USCIS) asylum officer. Because of *expedited removal* laws, the stakes of a CFI are particularly high. If an officer establishes that there is a *significant possibility* that an individual will be persecuted in their home country, they can be released into custody to later plead their case in a more thorough manner before an immigration judge. Should they be deemed to not have a credible fear, they can be immediately deported.

In the frequent absence of corroborating witnesses or physical evidence, internal consistency becomes a critical component in the assessment of asylum claims. Here, the cognitive effects of PTSD become especially problematic. For many asylum-seekers, the initial CFI or asylum interview statements will later be referenced against subsequent statements or testimonies, and any aberration will be considered a strike against the claim. This again poses a challenge for the PTSD-afflicted recollection process. Compounding the above problems, statements and testimonies are elicited throughout the asylum process in often adversarial manners under challenging circumstances by personnel who are minimally trained in trauma and its sequela, be they

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https://doi.org/10.1016/j.psychres.2019.112698
Received 16 September 2019; Received in revised form 17 November 2019; Accepted 21 November 2019

USCIS asylum officers, CBP agents, or government lawyers. This is especially problematic in asylum seekers who are already excessively anxious as a result of their PTSD.

The dissociative amnesia that occurs with PTSD may prevent an asylum seeker from producing the necessary level of detail of a prior traumatic event that asylum officers or judges assume they should possess. Contrary to popular belief, the details of an especially traumatic experience may in fact not be well remembered or may even have been forgotten (Brewin, 2018). The DSM-5 PTSD diagnostic criteria include the possible inability to recall specific details of traumatic events, and this phenomenon has been well-described in the spectrum of trauma experienced from war veterans to airline disaster victims to tornado survivors to witnesses of executions (Bryant, 2013; American Psychiatric Association, 2013). Without an appreciation for the nuance of how the human brain responds to trauma, this lack of detail may be misinterpreted as fabrication in the asylum-seeking process.

Moreover, recall of details both central and peripheral to a trauma narrative may change over time. Guidance for the psychotherapists of PTSD patients advocates for a tolerance of uncertainty, "even regarding the basic facts of the story," recognizing that stories may change in their retelling, as well as with the recovery of missing pieces in the therapeutic process (Herman, 1992). This guidance stems from empirically-established evidence: A 2005 study of refugees from Bosnia and Kosovo diagnosed with PTSD (all of whom had been granted asylum in the UK) compared details of their trauma stories deemed to be central or peripheral between two controlled retellings and found a 30% discrepancy of central details (although a higher rate for peripheral details). Of note, this rate increased as the time between accounts increased, a relevant fact given the delays in the US asylum process (Herlihy and Turner, 2006).

3. Effects on thought process

In addition to difficulties with the *content* of memories of a PTSD patient seeking asylum, the *structure* of those memories may also impede the process. The traumatic experience may be cognitively organized purely on an implicit and perceptual level, rather than in the neat narrative structure expected by an asylum evaluator. Stories may be told in a fractured and disjointed manner, both logically and chronologically (Herman, 1992). Studies have shown that the trauma narratives presented by PTSD patients are consistently rated as more disorganized than both the non-trauma narratives of these same patients or the trauma narratives of individuals without PTSD (Brewin, 2014).

Internal and external avoidance behavior arising from PSTD may prevent access to the trauma story that forms the basis of an effective asylum claim. The act of recalling the trauma that compelled an individual to flee their home country produces profound distress, so when asked to explain why they felt unsafe in their country of origin, the individual may avoid relaying the most central cause altogether. Or they may present the event only at the end of the time allotted to them, either preventing its full elaboration or unintentionally diminishing its perceived importance to their asylum claim. Because the recounting of one's trauma itself induces the distressing symptoms that were to be avoided in the first place, it further diminishes the individual's capacity to effectively communicate the trauma history and asylum claim. Traumatized individuals may also misinterpret the cause or consequence of their traumatic event, so the guilt or embarrassment they associate with the trauma may make them reluctant to discuss it.

4. Environmental impediments

The environment of interviews in the asylum process can be laden with circumstances and entities reminiscent of the traumatic experiences of an asylum-seeker. A traumatized survivor of rape, political violence or gang violence may aim to avoid uniformed officers, restricted egress, the presence (real or implied) of weapons, and even pointed and adversarial questioning, which frequently appear in the asylum-seeking process (Human Rights Watch, 2014). When exposed to these or other external "triggers," the potential dissociative or hypervigilant internal response will certainly detract from the individual's capacity to provide a compelling explanation of their asylum claim.

Physicians, psychologists, social workers and other clinicians train for years to hone the delicate skill of eliciting a specific, linear narrative from their patients. This requires establishing trust and building a therapeutic alliance, creating a safe space, and teaching the skills for patients to recollect, recognize and reveal their trauma - a process that often needs time. Both medicine and the law demand a clear, detailed story as the starting point for interpretation and assessment. This process is a challenge in the best of circumstances, without the added complications of educational, cultural and linguistic disparities. With the introduction of the cognitive effects and avoidance behavior of PTSD, gathering a clinical story and providing appropriate care can confound even highly trained professionals. The emerging concept of *trauma-informed care,* a holistic set of practices to mitigate the long-term health consequences of traumatic experiences, reflect the challenges of working with traumatized populations (Raja et al., 2015). With this in mind, it should be expected that a previously traumatized asylum seeker would provide only a partial or muddied version of their asylum claim after a rushed credible fear interview conducted while detained, telephonically through an interpreter by an evaluator with minimal training in PTSD.

As a critical tempering this discussion, it should be noted that longitudinal studies show strong outcomes and an impressive adaptive ability in refugees who are able to securely resettle their lives (Beiser, 1999). Limited studies suggest a high degree of *resilience* among refugee populations once the instability of displacement has ended (Fabio et al., 2019; Siriwardhana et al., 2012). While traumatization and its sequala create unique psychiatric challenges, the traumatized are by no means "broken." A just and compassionate asylum system requires a recognition of the frequency of PTSD in asylum-seekers, an understanding of its relevance to the asylum-seeking process, and a thoughtful approach to ensuring that the right to asylum is maintained regardless of barriers created by the very trauma that asylum-seekers flee.

5. IRB

Non-applicable

Declaration of Competing Interest

I wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

No funding was received for this work.

I confirm that I have given due consideration to the protection of intellectual property associated with this work and that there are no impediments to publication, including the timing of publication, with respect to intellectual property. In so doing we confirm that we have followed the regulations of our institutions concerning intellectual property.

All those designated as authors should meet criteria for authorship.

I am the sole author of this paper.

Acknowledgements

Thanks to Dinali Fernando, Craig Katz and Walter Fendrich for editorial guidance.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.psychres.2019.112698.

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