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Young, Janine
Gartland, Matthew
Ijadi-Maghsoodi, Roya

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Asylum Medicine

A Clinician's Guide

Katherine C. McKenzie
Editor

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Editor
Katherine C. McKenzie
Yale Center for Asylum Medicine
Yale School of Medicine
Yale University
New Haven, CT
USA

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Introduction to Asylum Medicine

Since the mid-2010s, the number of displaced persons worldwide has continued to increase, reaching record levels annually. At the end of 2019, there were almost 80 million refugees around the world. Over four million of those were asylum seekers. Asylum seekers have experienced violence and persecution before leaving their home countries in search for safety elsewhere, and their journey to a safe place can be fraught with further trauma. For those seeking asylum, the prospect of having to return to their home country may result in continued danger or death. Whether fleeing persecution or episodes of torture, asylum seekers often leave their homes under duress without government or family support.

Healthcare professionals can provide unique expertise and support as asylum seekers navigate the US immigration judicial system. Trained clinicians use their skills to gather evidence of physical or psychological scars of torture and persecution. They review the alleged history of persecution and then describe and characterize the scars and functional sequalae in order to provide their expert opinion on the likelihood that it resulted from the reported trauma. While clinicians are not required to determine the veracity of the asylum seeker's claims, nor whether they meet the legal standards to be granted asylum, they are able to contribute to the case with an medical opinion.

It is essential that clinicians remain objective in order to support the credibility of the medical-legal affidavits used in asylum cases. The medical-legal collaboration that supports asylum seekers is a source of professional satisfaction and intellectual interest to attorneys, human rights professionals, and clinicians alike as they together build an accurate case to present in immigration court.

For millennia, humans have offered asylum to those in danger. For much of the past, this often occurred when individuals presented to religious institutions upon entering a city. After the refugee crisis of World War II, many nationstates jointly agreed that those who are in danger because of their religious beliefs, ethnic identity, political beliefs, or other fundamental characteristics should be allowed to seek safety in a different country where they could build a life free of persecution.

Sanctuary ring on the door of Notre-Dame in Paris.

During the Middle Ages, those who touched this ring indicated their desire for asylum (Used with permission by H2OLife/Shutterstock.com)

In this book, leaders in the field of asylum medicine provide background on the legal and clinical foundations for clinicians. Best practices for assessing different groups of asylum seekers are reviewed.

History reveals that people have carried out inhumane practices against others for millennia. The recognition of universal human rights in the modern era has been foundational for informing the obligation that humans have to protect the rights of others, including the freedom to seek asylum when persecuted. Unfortunately, governments often act against this, but individuals can continue to demonstrate unequivocally their commitment to the principle of asylum.

In this book, practical information for performing evaluations of asylum seekers is provided. Practices in the field include referring to asylum seekers as "clients," rather than "patients," in recognition of the non-caregiving role of medical forensic evaluators. The terms "affidavit" and "declaration" are used interchangeably, while recognizing that they are legally distinct.

The work of evaluating asylum seekers continues to grow, and the involvement of trained and dedicated forensic clinicians is essential in meeting this need. We envision a day when, as Aeschylus wrote, we will "tame the savageness of man, and make gentle our life on this earth," when human rights are universally respected and when people can live free from persecution. Until then, the support of clinicians in asylum medicine has never been more important.

Department of Medicine
Yale School of Medicine,
New Haven, CT, USA

Katherine C. McKenzie
katherine.mckenzie@yale.edu

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Contributors

Jon Bauer Asylum and Human Rights Clinic, University of Connecticut School of Law, Hartford, CT, USA

Alison Beckman The Center for Victims of Torture, St. Paul, MN, USA

S. Megan Berthold University of Connecticut School of Social Work, Hartford, CT, USA

Hope Ferdowsian Department of Medicine, University of New Mexico School of Medicine, Albuquerque, NM, USA

Samara Fox Department of Psychiatry, Beth Israel Deaconess Medical Center, Boston, MA, USA

Matthew G. Gartland Division of Pediatric Global Health and Center for Global Health, Massachusetts General Hospital, Boston, MA, USA

Department of Medicine, Brigham and Women's Hospital, Boston, MA, USA

Department of Medicine, Harvard Medical School, Boston, MA, USA

Valeria Gomez University of Connecticut School of Law, Hartford, CT, USA

Kathryn Hampton Asylum Program, Physicians for Human Rights, New York, NY, USA

Leora Hudak The Center for Victims of Torture, St. Paul, MN, USA

Adaobi Iheduru The Center for Victims of Torture, Clarkston, GA, USA

Roya Ijadi-Maghsoodi Division of Population Behavioral Health, UCLA Jane and Terry Semel Institute for Neuroscience and Human Behavior, Los Angeles, CA, USA

VA Health Service Research & Development (HSR&D) Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIIP), VA Greater Los Angeles Healthcare System, Los Angeles, CA, USA

Jennifer McQuaid Yale Center for Asylum Medicine, Yale School of Medicine, New Haven, CT, USA

James S. Miller Department of Medicine, Massachusetts General Hospital, Boston, MA, USA

Ranit Mishori, MD, MHS, FAAFP Department of Family Medicine, Georgetown University School of Medicine and Physicians for Human Rights, Washington, DC, USA

Anjali Niyogi Tulane University School of Medicine, New Orleans, LA, USA

Deborah Ottenheimer, MD, FACOG Department of Women's Health, Gotham Health | Morrisania, New York, NY, USA

Elsa Raker Asylum Program, Physicians for Human Rights, New York, NY, USA

Olivia Shadid Department of Psychiatry and Behavioral Sciences, University of New Mexico School of Medicine, Albuquerque, NM, USA

Shawn Singh Sidhu Department of Psychiatry, University of California San Diego School of Medicine, San Diego, CA, USA

Homer Venters New York University College of Global Public Health, New York, NY, USA

Janine Young Department of General Pediatrics, Denver Health and Hospitals, Denver, CO, USA

Division of General Pediatrics, University of Colorado School of Medicine, Denver, CO, USA

Amy Zeidan Department of Emergency Medicine, Emory University School of Medicine, Georgia Human Rights Clinic, Atlanta, GA, USA

Chapter 1
Overview and Historical Background of U.S. Asylum Law

Jon Bauer

Chantal fled the Democratic Republic of Congo (DRC) after being arrested, interrogated, and tortured by Congolese security forces. She applied for asylum in the United States in 2001, and after a long legal battle, was finally granted asylum in 2008. A court opinion summarizes her story:

Chantal testified that she married Charles, a Rwandan citizen. . . . Though the couple separated in 1994, they both remained in Kinshasa in the DRC and stayed in contact because they had a child together. In 1997, Charles began work as a chauffeur and bodyguard for then-president Laurent Kabila. Because he was on duty on the day Kabila was assassinated . . . Charles was suspected of involvement in the assassination. He fled to Rwanda and called Chantal to inform her of his location. In February 2001, a group of military soldiers entered Chantal's house to search for Charles, demanded that she reveal information about him and about the assassination, and looted the house. In mid-March 2001, the military soldiers returned to Chantal's home. When Chantal refused to reveal Charles's location, they arrested her.

Chantal was detained for one week in a dark cell in which soldiers tied her hands behind her back, cut her hair, shined bright lights in her eyes, and hit her whenever she provided unsatisfactory answers to their repeated demands for information about Charles' location. Eventually, a human rights organization . . . was able to secure her release. . . . In June 2001, however, when she was returning from work, Chantal was again captured by soldiers who forced her into a military truck and brought her to a military camp called Kokolo. For two weeks, Chantal was kept in a dirty, mosquito-infested cell, with no furniture or toilets, fed minimally, and beaten with whips. The soldiers subjected her to repeated, two-hour long interrogations about [the assassination and Charles' whereabouts]. . . .

After Chantal refused to perform sexual favors for a soldier in return for her release from prison, the soldier fondled her, struggled with her as she resisted, and urinated on her. His attempt to rape her was unsuccessful, but he returned another day, repeated his offer, and on her refusal, did, in fact, rape her. When she developed a fever . . . Chantal was transferred from her cell to the military camp hospital where one of the nurses recognized Chantal from church and helped her to escape. Chantal then went into hiding with an aunt. [A friend who worked for the government helped her secure] a false passport and visa, and

J. Bauer (✉)
Asylum and Human Rights Clinic, University of Connecticut School of Law, Hartford, CT, USA
e-mail: Jon.Bauer@uconn.edu

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Chantal left the DRC at the end of July 2001. When Chantal spoke with her family by telephone, they informed her that the military continued to look for her at her house. [1]

In the second decade of the twenty-first century, at least 100 million people were forced to migrate as a result of persecution or conflict. At the start of 2020, the forcibly displaced population stood at about 80 million people, more than 1% of the world's population. A little more than half were internally displaced persons (IDPs), who fled to a different part of their home country, while the rest were refugees or asylum seekers – persons who had to flee their country of nationality and seek safety in a foreign land. Approximately 85% of the world's refugees are hosted by developing countries. Only a small proportion journey to developed nations like the United States, Canada, and countries of the European Union to seek asylum [2].

The human rights violations that impel people to flee are varied. Some, like Chantal, whose story is told above, face punishment for their actual or perceived opposition to repressive governments. Others are singled out for harm because of their religious beliefs, race, ethnicity, or sexual orientation. Women frequently face gender-specific harms such as forced marriage, sexual assault and rape, intimate partner violence, honor killings, or female genital cutting, and cannot obtain protection from the authorities in their home country due to discriminatory laws or social attitudes [3]. Many migrants from Central America are fleeing violence from gangs that act as de facto governments and brutally punish anyone who resists their authority [4].

Persons who are physically in the United States or present themselves at the border have the right to seek asylum. They may be allowed to remain in the U.S. if they can show that they suffered persecution or have a well-founded fear of being persecuted in their home country [5]. The U.S. received approximately 300,000 asylum applications in 2019 [2]. Many are unsuccessful; the "grant rate" for asylum claims in the U.S. immigration courts dropped from 56% in 2014 to 28% in 2020 [6, 7]. But those who are granted asylum – in recent decades, 20,000 to 40,000 people each year [8] – gain safety from persecution and a path to permanent residence and U.S. citizenship [9].

Physicians and other health professionals are uniquely positioned to help asylum seekers. A medical or psychological examination can contribute to a successful asylum claim by documenting the effects of persecution or torture [10]. One study found that applicants with an evaluation from a health professional were granted asylum 89% of the time, as compared with an overall average rate of 37.5% [11]. Other factors, such as effectiveness of legal representation, also help to drive favorable outcomes [12] and may correlate with the decision to have a medical evaluation done as part of the supporting evidence. Nonetheless, there can be little doubt that medical or psychological evidence plays an important role in many successful asylum claims. In Chantal's case, for example, reports from a doctor who conducted a physical evaluation and a licensed clinical social worker who performed a psychological assessment documented physical scars and symptoms of post-traumatic stress disorder that were consistent with Chantal's account of the torture and sexual assault she suffered in military detention. This evidence helped to convince an immigration judge that Chantal was telling the truth.

Conducting medical or psychological evaluations of asylum seekers presents an opportunity for health professionals to engage with human rights issues, collaborate with lawyers and nonprofit organizations, and help the legal system reach more informed decisions. To the extent that it impacts the outcome of an asylum case, it can be lifesaving. An evaluator also can provide a crucial service to someone who suffered persecution and the trauma of having to flee their home by diagnosing conditions that can benefit from treatment, identifying medical or mental health needs, and providing appropriate referrals for specialized care.

This chapter will briefly trace the history of the international treaties and U.S. legal provisions that protect individuals who, if deported, would be in danger of persecution or torture. It will then provide an overview of the U.S. legal standards for asylum, highlighting along the way how medical or psychological evidence may be relevant to an asylum application.

Foundations and Historical Development of the Contemporary U.S. Asylum System

The concept of providing refuge to those fleeing persecution has existed for millennia. Rulers since ancient times have asserted their authority to refuse to return refugees from other lands despite demands for their extradition [13]. The three Abrahamic religions, as well as other religions, emphasize in their sacred texts the obligation to welcome foreigners in need of protection and provide them with places of refuge [14].

A tradition of providing a haven for the persecuted also has deep roots in American history. The Plymouth and Massachusetts colonies were founded by Puritans fleeing religious intolerance in England. The Maryland and Pennsylvania colonies began as havens for Catholics and Quakers. In 1776, Thomas Paine's revolutionary war pamphlet, *Common Sense*, described the new United States as an "asylum for mankind" ready to "receive the fugitive" from "[e]very spot of the old world . . . overrun with oppression." [15] Through most of the nineteenth century, there were virtually no restrictions on immigration, and many who came to this country were fleeing political repression as well as seeking economic opportunity. Beginning with the Chinese Exclusion Act in the 1880s, however, the United States began to place restrictions on immigration, often targeting disfavored racial or ethnic groups for exclusion [16].

The modern concept of a refugee and provisions for refugee protection under international law began to take shape in the 1920s, when a series of international agreements made provisions for identity and travel documents for populations displaced by the collapse of the Austro-Hungarian, Russian, and Ottoman Empires, and the League of Nations established an office of High Commissioner for Refugees to coordinate protection and assistance [17]. These ad hoc and limited arrangements, however, did little to protect Jews and others fleeing Nazi Germany in the 1930s.

The U.S., in the meantime, took a sharply restrictionist turn. An unprecedented wave of immigration in the last decade of the nineteenth century and the start of the twentieth brought in tens of millions of people, mostly from Southern and Eastern Europe. Prejudice against Jews, Italians, and other groups, coupled with the rise of eugenics and widespread fear of foreign subversion after the Bolshevik revolution, led Congress to radically reduce immigration in 1924. The law set a strict overall annual cap on immigration and national limits based on the ethnic origins of the U.S. population in 1890, before the new wave of immigrants started coming, with the purpose and effect of ensuring that immigration would largely be limited to those from Western Europe. Asian immigration was banned entirely. Senator David Reed, one of 1924 law's coauthors, spoke candidly about its implications: "We no longer are to be a haven, a refuge for the oppressed the whole world over. We found that we could not be, and now we definitely abandon that theory." In the 1930s, refugees from the Nazis were turned away by the U.S. because the small annual quotas from the countries they came from had already been filled – including the famous case of the St. Louis, a boat filled with over 900 Jewish refugees that was pushed back from the Florida coast and had to return to Europe, where many of its passengers later died in extermination camps [18].

After World War II, as the magnitude of Nazi atrocities became known and the world faced a new flood of refugees from the war and from the Communist takeover of Eastern Europe, the international community began to recognize that legal guarantees were needed to protect refugees. The Universal Declaration of Human Rights, issued by the new United Nations in 1948, declared that "[e]veryone has the right to seek and enjoy in other countries asylum from persecution." [19] In 1951, many countries entered into a treaty, the U.N. Convention Relating to the Status of Refugees, which obliged states not to expel or return any refugee to a place where they would face persecution. The term "refugee" was given an internationally accepted definition: A person who is outside their country of nationality who has a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion." [20] The Convention initially applied only to persons made refugees by events in Europe prior to 1951, but that restriction was lifted by a 1967 U.N. Protocol that extended the Convention's coverage to all refugees [21].

During the decades after World War II, the United States took in a large number of refugees. It did not join the Refugee Convention, however, and instead let refugees in through ad hoc legislation and executive actions. Most of those the U.S. accepted were people displaced by the war in Europe or escaping Communist regimes [22]. The U.S. finally ratified the U.N. treaties in 1968, but it took until 1980, when Congress enacted the Refugee Act, for those international obligations to become part of U.S. law. The Refugee Act, in addition to creating a framework for refugee resettlement, adopted a definition of "refugee" modeled on the U.N. Convention. It also established a procedure to allow any noncitizen present or arriving in the U.S. to apply for asylum if they fear persecution in their home country [23].

The Process for Admitting Refugees and Considering the Claims of Asylum Seekers

The Refugee Act set up two distinct mechanisms for taking in people who meet the refugee definition: resettlement and asylum. The refugee resettlement program admits a limited number of refugees from abroad and allows them to enter the U.S. with legal status. They typically go through years of vetting before being accepted, often while living in refugee camps or other unstable settings [14]. Refugee admissions are limited to a maximum number set each year by the President in consultation with Congress. In the last year of the Obama Administration, the annual cap was set at 110,000 [24]; by the end of the Trump Administration, it had fallen to a record low of 15,000 [25]. The Biden Administration has pledged to restore a robust resettlement program; but even under the best of circumstances, only a tiny fraction of the world's refugees can gain admittance.

In contrast, any person who is in the United States or who arrives at the U.S. border has the right to apply for asylum. An asylum seeker may initially enter the U.S. with a tourist, student, or other form of visa, or may arrive with no legal status. Some asylum seekers are detained while attempting to enter without authorization or after being apprehended inside by the U.S. by immigration agents. Many such applicants face the formidable challenge of having to pursue their asylum claims while in detention [26].

Persons who arrived on a visa or who entered unlawfully but were never apprehended by the immigration authorities may file what is called an "affirmative" asylum application. Affirmative asylum applicants receive an interview with an asylum officer employed by the U.S. Citizenship and Immigration Services (part of the Department of Homeland Security). The applicant may submit written evidence in advance of the interview, and can bring a lawyer, if they have one. The asylum officer may either grant asylum, or if the officer is not convinced that the person qualifies, refer the case to the Immigration Court for removal proceedings, where the applicant receives another opportunity to present their asylum claim to an immigration judge. Other asylum seekers, who have been put into removal proceedings without first having applied affirmatively, may file a "defensive" asylum application – as a defense against removal – in the Immigration Court. Immigration Court hearings are adversarial in form; an attorney for the Department of Homeland Security serves as the prosecutor, and the asylum applicant may also be represented by a lawyer [8, 27]. Unlike criminal defendants, however, individuals seeking asylum have no right to counsel at government expense [28]. An immigration judge from the U.S. Justice Department presides at a hearing that typically lasts 3 hours and then issues a decision based on the testimony and written evidence – which may include reports from medical or other experts – submitted in advance of the hearing. An immigration judge's decision may be appealed to the Board of Immigration Appeals, an administrative review board in the Justice Department, and beyond that to a federal appeals court.

Those granted asylum (known as "asylees"), like refugees admitted through the resettlement program, gain the right to remain in this country lawfully, authorization to work, access to public benefits, and the ability to bring in a spouse and/or minor children from abroad. A year after the asylum grant, an asylee can apply for permanent resident status (a "green card"), and 4 years after obtaining that status they can apply for U.S. citizenship [9].

The Standard for Being Granted Asylum

To be granted asylum, an individual must show that they meet the refugee definition by establishing that they have suffered persecution, or have a well-founded fear of being persecuted, on account of their race, religion, nationality, political opinion, or membership in a particular social group. The burden of proof is on the person seeking asylum. If the judge or asylum officer finds that the applicant's testimony is not credible, asylum will be denied. Asylum seekers are also expected to present corroboration of their claims where available [29]. Medical evidence confirming the presence of physical scars or psychological symptoms consistent with a person's account of the harm they suffered can help to meet the burden of proof and support the credibility of the person's claims.

To meet the "refugee" definition and qualify for asylum, an applicant must establish that they suffered past persecution and/or have reasonable grounds to fear future persecution [30]. Persecution, although not precisely defined in the law, means more than discrimination, harassment, or minor mistreatment. The harm that the applicant underwent or would face must be very serious in nature. Harms that have been found to constitute persecution include torture, rape, repeated physical abuse, prolonged imprisonment, severe mental or emotional abuse, concrete and menacing death threats, and extreme economic punishments [31]. To qualify as persecution, it must be inflicted either by a government or by persons the government is unwilling or unable to control [32]. Thus, violence from private actors, such as abusive domestic partners, homophobic mobs, or criminal gangs, can amount to persecution if the police or other officials are unable or unwilling to protect the victims.

The asylum applicant must also show that race, religion, nationality, political opinion, or social group membership "was or will be at least one central reason for persecuting the applicant." [33] Many asylum claims founder on this element (often referred to as the "nexus" requirement). In Chantal's case, for example, an immigration judge initially denied her asylum application because he believed the Congolese military imprisoned and tortured her not because it viewed her as a political opponent, but because they wanted to extract information about a crime – the murder of the country's president. A court of appeals reversed that decision, finding that it could reasonably be inferred that Chantal was targeted and harmed at least in part because she was suspected of holding antigovernment views [1].

One of the grounds for asylum, "membership in a particular social group," is not well defined in the law, and its scope and meaning are frequently contested. To

qualify, the members of the group must share a characteristic that is immutable or fundamental to their identity; the group must be "particular" (meaning that it has well-defined boundaries); and the group must be "socially distinct" (meaning that the society in question views it as a group) [34]. The "particular social group" category has been found, at least in certain circumstances, to include persecution based on sexual orientation or gender identity [35]; gender-based harms such as domestic violence or female genital mutilation [36]; family ties [37]; and retaliation for opposing a gang (which also may constitute persecution based on political opinion) [38].

Asylum eligibility can be based either on past persecution or a well-founded fear of future persecution. The concept of "well-founded fear" has both a subjective and an objective component – the applicant must genuinely fear persecution, and that fear must be objectively reasonable. A mental health evaluation can sometimes be used to show an applicant's fear is genuine and not feigned. To establish that a fear is "well founded," there must be a "reasonable possibility" of persecution, which can be as little as a one-in-ten chance [39]. This may be shown through evidence such as threats made against the applicant, harm suffered by family members or associates, or country reports showing that similarly situated people frequently face persecution.

If the applicant has already been persecuted in their home country based on a protected ground, there is a legal presumption that they have a well-founded fear of persecution upon return. However, that presumption can be overcome, and asylum may be denied, if an immigration judge or asylum officer finds there has been a fundamental change in circumstances (e.g., the fall of a dictatorial regime) that eliminates the risk of future persecution. Asylum may also be denied if it is found that the person could avoid the risk of being persecuted by relocating to a different part of their home country, and it would be reasonable to expect them to do so [40].

Even in cases where there is no longer any risk of future persecution, there are some situations where asylum may be granted based on past persecution alone. This is often referred to as "humanitarian asylum." Humanitarian asylum may be granted where an applicant was persecuted in the past based on a protected ground, and either (a) the person suffered an atrocious form of persecution that has had severe and long-lasting effects (e.g., debilitating physical injuries or PTSD), or (b) the person would face "other serious harm" if returned to their home country. Other serious harm may include not having access to needed medical treatment or a foreseeable deterioration of mental health if the person is deported [41]. Medical and psychological evidence often plays a role in humanitarian asylum claims. For example, one decision by the Board of Immigration Appeals granted asylum on humanitarian grounds because medical evidence showed that a mother and daughter from Somalia were subjected to a form of female genital cutting that had caused continuing physical pain, difficulty urinating, and interference with menstruation [42].

Even if a person can establish that they meet the refugee definition, various bars to asylum may apply. The statute prohibits granting asylum to an individual who participated in the persecution of others, committed a serious nonpolitical crime outside the U.S., was convicted of a particularly serious crime (broadly defined) in

the U.S., poses a national security threat or has ties to terrorism (also broadly defined), or was firmly resettled in another country after leaving the country of persecution [43]. A bar Congress added to the asylum statute in 1996 generally prohibits filing an application more than 1 year after arriving in the U.S. There is an exception for "extraordinary" circumstances, which may include "[s]erious illness or mental or physical disability, including any effects of persecution or violent harm suffered in the past." [44] A medical or psychological evaluation can play a crucial role in showing that an applicant qualifies for an exception to the 1-year deadline. For example, in one case handled by this chapter's author's legal clinic, a 22-year-old woman was granted asylum even though she filed her application 8 years after her arrival in the U.S. because a mental health evaluation showed she suffered from PTSD symptoms arising from beatings, rape, and other harms inflicted on her in her childhood that had made it difficult for her to recount her story and take the steps necessary to file for asylum.

Anyone who meets the refugee definition and does not fall under a mandatory bar is eligible for asylum, but under the Refugee Act, a grant of asylum is discretionary. Asylum may be denied as a matter of discretion where the applicant engaged in serious blameworthy behavior. The immigration judge or asylum officer must weigh any negative considerations against factors that cut in favor of a grant of asylum, including the risk of persecution, positive attributes of the applicant, and humanitarian factors, which may include health considerations [45].

Withholding of Removal and Relief Under the Convention Against Torture

In addition to providing for grants of asylum, the Refugee Act authorizes an alternative form of relief known as "withholding of removal," which prohibits the deportation of an individual to a country where they are likely to face persecution on account of their race, religion, nationality, membership in a particular social group, or political opinion [46]. Unlike asylum, withholding of removal does not provide a path to permanent residence, citizenship, and family reunification; it provides only relief from removal and a right to work authorization [47]. It is an important alternative form of relief for some asylum applicants, however, because it has less extensive bars than asylum. Persons disqualified from asylum because they failed to apply within a year after entry or because they were firmly resettled in a third country before coming the U.S. remain eligible for withholding of removal. The criminal bars to withholding are also somewhat narrower than those for asylum, and there are no discretionary denials.

Relief under the Convention Against Torture is another important alternative form of protection for asylum seekers. Under the U.N. Convention Against Torture (CAT), which the U.S. ratified in 1990, nations are prohibited from deporting an individual to any country where they would face torture inflicted by public officials

or inflicted by private parties with the acquiescence of government authorities. The CAT defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person" for virtually any purpose, including punishment, coercion, obtaining information, or discrimination of any kind [48]. Relief under the CAT does not require showing that the torture was motivated by any of the five grounds listed in the refugee definition. In Chantal's case, for example, when an immigration judge initially ruled that her torture by the Congolese authorities was not based on political opinion or social group membership, he nonetheless found that she would face torture if removed to the DRC, and granted protection under the CAT [1]. In addition, unlike asylum and withholding of removal, there are no bars to CAT relief. Even persons convicted of serious crimes or with terrorist connections cannot be removed to a country where they would face torture.

As with asylum, evaluations by health professionals can play an important evidentiary role in claims for withholding of removal or CAT relief by documenting scars, functional sequelae, or psychological symptoms that are consistent with the applicant's account of the mistreatment they suffered [49]. Medical evidence can also help to show that a person experienced severe pain or suffering that rises to the level of torture. A federal appeals court, for example, reversed an immigration judge's denial of CAT relief to a young man who was assaulted and then threatened with a gun pointed at his head by a gang in El Salvador. It found that a report submitted by a licensed clinical social worker, who had diagnosed the applicant with PTSD as a result of these incidents, constituted adequate proof that he had suffered torture [50]. Health professionals who perform forensic evaluations can also provide a valuable service by referring persons who have suffered torture to providers who can provide ongoing care, such as community health centers and programs dedicated to serving torture survivors [51].

Barriers to Asylum Access

The U.N. refugee treaties prohibit countries from turning back refugees once they arrive, but do not require them to take in refugees in the first place. Fearing mass arrivals, Western countries that have traditionally been destinations for asylum seekers, including the U.S., the E.U., and Australia, have long employed strategies aimed at preventing refugees from reaching their territory. People from countries that generate large numbers of asylum seekers find it nearly impossible to obtain visas. Since the 1980s, the Coast Guard has been intercepting small boats carrying Haitians to prevent them from landing on the U.S. shores. The U.S. government pressures Mexico and Central American nations to turn back asylum seekers before they reach the border [52]. Under a policy known as "metering," persons attempting to present themselves at the southern U.S. border to seek asylum are often forced to wait weeks or months in Mexico before being given an appointment to present their claim at a border crossing [53]. Since 1996, a procedure known as "expedited removal" has been employed to quickly deport new arrivals unless they pass a

screening interview assessing whether they have a "credible fear" of persecution – a process with few procedural protections that often results in errors [54]. Asylum seekers subjected to this process, including families with children, are kept in detention, sometimes for long periods [55].

Policies aimed at deterring asylum seekers predate the Trump Administration, but escalated sharply during its term. Under a "zero tolerance" policy instituted in 2018, adults who crossed the border without documents to seek asylum were criminally prosecuted for illegal entry before being deported, while their children were taken away and sent to shelters for unaccompanied minors. This resulted in thousands of parents being forcibly separated from their children. In June 2018, a federal judge ruled that the family separation policy "shocks the conscience" and violated the Constitution, and ordered an end to it, but efforts to reunite the separated families are still ongoing years later [56].

Another program, misleadingly entitled "Migrant Protection Protocols" (MPP) but more descriptively known as "Remain in Mexico," was instituted in January 2019. Under it, tens of thousands of people who arrived in the U.S. via the southern border were sent back to Mexico to wait for months before receiving a hearing in front of an immigration judge at a "tent court" near the border. While waiting, many were robbed, assaulted, raped, or kidnapped [57]. The Trump Administration also negotiated so-called "safe third-country" agreements with El Salvador, Honduras, and Guatemala, authorizing the U.S. to send back asylum seekers of other nationalities to those countries to have their asylum claims heard there – even though, in reality, those three nations are rife with danger and lack functioning asylum systems [58]. Finally, starting in March 2020, using the Covid-19 pandemic as a pretext, the Trump Administration, claiming emergency public health powers, shut down asylum entirely at the southern border by authorizing the Border Patrol to immediately expel migrants, regardless of whether they wish to apply for asylum, with no hearing at all [59].

In its final years, the Trump Administration issued a flurry of regulations that reinterpreted the law to make it more difficult for individuals to be granted asylum. Many of these rules appear to violate both the U.S. law and the U.N. Refugee Convention, and have been challenged in the courts. One rule would bar anyone who enters the U.S. via the southern border from being granted asylum if, after leaving their home country, they passed through any other country on their way to the U.S. in which they failed to seek asylum [60]. Another set of rules would redefine the protected grounds of "political opinion" and "membership in particular social group" in ways that would ensure that asylum claims based on gang and domestic violence would nearly always fail, and also would vastly expand the circumstances resulting in denial of asylum on discretionary grounds [61]. The Biden Administration has pledged to rescind many of the Trump policies, but unravelling them will take considerable time and effort [62].

Physicians and other health professionals can engage in human rights advocacy, both individually and through organizations such as Physicians for Human Rights and HealthRight International, to urge legislators and policymakers to adopt just and humane policies toward those in need of refuge. When the Refugee Act was

under consideration in Congress, President Carter's Secretary of Health, Education and Welfare, Joseph Califano, gave eloquent Congressional testimony expressing why it is so important for this country to have a fair and generous asylum policy:

> [W]hat we choose to do about . . . refugees . . . reveal[s] to the world – and more importantly, to ourselves – whether we truly live by our ideals, or simply carve them on our monuments. ... When we help refugees seeking escape from ... persecution, the gift is not so much to them as to ourselves.... Today the refugees ... are seeking the same thing our parents and grandparents and ancestors were seeking: The clear air of liberty. ... And just as our parents and grandparents enriched the United States, these new refugees are enriching this Nation [63].

Medical professionals, both by conducting forensic evaluations in individual asylum cases and engaging in collective mobilization to protect the rights of asylum seekers, can help to make that vision a reality.

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Chapter 2
Preparing for Asylum Evaluations

Jennifer McQuaid and James S. Miller

Introduction

Appropriate training for clinicians with interest in the field of asylum medicine is essential before they begin to perform asylum evaluations. In addition, clinicians must prepare for each evaluation in advance of the appointment. Training and preparation help clinicians achieve and maintain the highest quality of work. An asylum evaluation is similar to other medical or mental health evaluations performed in primary care or clinic settings. It requires the quick establishment of a working relationship in which the client feels secure sharing their clinical history. The approach and skillset employed will be informed by the clinician's expertise – a combination of training, experience, and individual style of expressing empathy. An asylum evaluation differs, however, in its focus on the examination and documentation of signs and symptoms related to persecution and torture. Clinicians performing these examinations serve as independent forensic evaluators rather than treating clinicians. The optimal outcome is a detailed, objective assessment report describing the effects of persecution on the client's physical state, emotional well-being, or both.

Asylum evaluations are typically conducted within a short time frame. One or two meetings with the client suffices for conducting a thorough evaluation. Usually, the clinician will not have a further role in treating the client and does not establish

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J. McQuaid (✉)
Yale Center for Asylum Medicine, Yale School of Medicine, New Haven, CT, USA
e-mail: jennifer.mcquaid@yale.edu

J. S. Miller
Department of Medicine, Massachusetts General Hospital, Boston, MA, USA
e-mail: jsmiller@post.harvard.edu

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a traditional clinician–patient relationship. The clinician analyzes their findings, documents their findings in the form of an affidavit, and submits it to the legal team. The compressed timeframe of clinician–client interaction makes preparation invaluable.

Initial Training and Observation

Most prospective evaluators should attend a formal training session before starting to perform asylum evaluations. Clinics run by medical schools and/or psychology doctoral programs often partner with human rights organizations to train clinicians to conduct asylum evaluations. Such training sessions usually present the legal basis for asylum, the details of conducting medical and psychological evaluations, and the way to draft affidavits. Trainees may be given a manual and templates for affidavits to guide them as they begin. Trainees will be introduced to the *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (IP) [1]. An official document of the United Nations, it provides the international standard for forensic evaluations of survivors of torture, persecution, and ill treatment [2]. Before or after the training, new evaluators should review the IP in greater detail, focusing on their particular area of work.

Asylum training sessions are often attended by clinicians and students from a range of different backgrounds: physicians, social workers, nurses, psychologists, as well as students in these respective fields. In addition to the formal curriculum, training sessions provide opportunities to network and establish formal and informal mentoring relationships.

After attending an asylum evaluation training session, clinicians are encouraged to observe or assist with several evaluations performed by an experienced evaluator until they feel confident performing these exams independently. The exact number will depend on each individual clinician's prior experience and comfort. It can be helpful to observe more than one experienced evaluator to get a sense of different practices and styles. New evaluators can also assist in preparing the initial affidavit and reviewing the final affidavit to build skills in writing the affidavit as well as in conducting the evaluation session.

While such preparation requires a significant investment of time, this investment in training—and the evaluation work itself—both strengthens clinical abilities and provides professional and personal rewards. A recent study of clinicians involved in asylum work documented that their experiences lead to increased professional and research opportunities, a deeper understanding of global mental health issues and the effects of trauma, and the satisfaction that a clinician feels from using training to provide a valuable service for survivors of human rights violations [3]. Medical trainees describe their experiences with asylum seekers as pivotal moments in their training that lead to increased empathy and confidence in discussing physical and emotional hardships with patients [4].

Preparation Prior to Each Evaluation

Interaction with the Attorney Before Committing to Complete an Evaluation

Working with attorneys representing asylum seekers is usually an unfamiliar experience for clinicians. When first interacting with attorneys, the goal is to understand the client's basic information and the attorney's reason for seeking a clinician's expertise. Given the significant time required to perform a forensic evaluation and write an affidavit, forensic medical or psychiatric evaluations should be arranged only after the attorney has reviewed the client's case in detail. This enables the attorney to clarify their reason for requesting a forensic evaluation and the questions to be answered.

Sometimes a referral is made through a human rights organization such as Physicians for Human Rights (PHR), HealthRight International or other nonprofit legal agencies that work with asylum seekers. Below are two examples of case summaries in which the attorneys are seeking a forensic evaluation. The case summaries provided below were created by the authors to represent examples of typical cases managed by Physicians for Human Rights (Case 1) and New Haven Legal Assistance Association (Case 2). They do not include identifying data from a specific individual.

> Case 1. [New York, New York] A 23-year-old female from [West African country], represented by an attorney from [New York-based nonprofit]. The client is applying for Asylum, Cancellation of Removal, CAT Withholding, Withholding of Removal, and seeking a psychological evaluation (female evaluator preferred). The client speaks French, is not in detention, and is requesting oral testimony at this time (telephonic okay). The attorney is requesting a completed affidavit by 1/25/2021. The client's family arranged a marriage for her with a much older Muslim man. The client wanted to continue school and practice Christianity. She refused the marriage, eschewed Islam, and expressed her belief that she should be allowed to become a teacher. As a result, her family physically and verbally abused her for many years. The client missed her 1-year-filing deadline. She suffers from depression (possibly postpartum).

This first case summary, format of referral courtesy of Physicians for Human Rights, New York, NY, describes the type of persecution this client experienced, the cultural background of the client, the language she speaks, and the date by which the affidavit is to be completed. It also mentions the client's failure to meet the 1-year filing deadline, and potential diagnostic considerations. Most importantly, it clarifies that the evaluation sought is a psychological exam.

> Case 2. [New Haven, CT] JSR is a middle-aged man from [Central American country] who is currently detained. He is facing removal based on a criminal conviction that is currently being challenged in his home state. JSR has lived in the United States for over two decades and would face persecution on account of his sexual orientation should he be returned to [Central American country]. He fled his home country over 20 years ago due to violence he suffered at the hands of homophobic individuals. From this violence, JSR has scars on his legs and arms. JSR's attorney is requesting a written report with accompanying photographs of the injuries, and will need them within 1 week of the evaluation, as immigration courts expedite hearings for individual who are detained, often allowing them mere weeks

to prepare their cases. She has also asked that the physicians who perform the evaluation also be available for telephonic cross-examination, should the government wish to ask questions about their report or the evaluation itself.

This second example, format of referral courtesy of New Haven Legal Assistance Association, New Haven, CT, highlights that the client is currently detained, some information on injuries, and that the attorney is requesting a physical evaluation. Specific logistics of detained evaluations will be discussed in more detail later in this chapter.

Usually, such case summaries will contain some but not all of the information a clinician may require before agreeing to accept a case. Broadly speaking, the goals for the initial interaction with the attorney are to understand the reasons for the evaluation, to ensure a match between the clinician's expertise and the needs of the case, to confirm the required time frame, and to understand any unusual aspects of the case. Below is a suggested checklist for this initial interaction with the client's attorney.

The following are questions to ask the attorney before accepting the case. These will help the clinician decide whether they are able to perform the evaluation.

1. On what grounds is the client applying for asylum?
2. What are the questions the legal team is hoping the forensic evaluation can address?
3. Does the client have a preferred gender of the evaluator?
4. Has the attorney already documented the client history and helped the client complete a declaration? (If not, it is often best to defer the evaluation until the attorney has gathered more information.)
5. Did the client file within the required 1-year asylum filing deadline?
6. What is the timeline or deadline for this evaluation?
7. Is testimony in court requested?
   (a) If testimony is requested, is telephonic testimony acceptable? Does the attorney already know the date of the hearing?
   (b) If testimony is requested, will the legal team help the evaluator prepare for testimony?
8. Have any prior forensic evaluations been performed? If so, why is a second evaluation sought?
9. Is the client able to travel to evaluator's location, or will the evaluator be required to travel?
10. Is the client available on the days or times that the evaluator can offer?
11. Will the applicant undergo additional evaluations (medical, neurological)?
12. Is the legal team incorporating a country conditions expert?

Asking the attorney these questions will help to ensure that the clinician will be able to complete the evaluation appropriately if they choose to accept it. This initial conversation also provides a fuller understanding of the client's asylum case and reason for a medical or psychiatric evaluation.

Using Case 1 as an example, an initial conversation with the attorney could clarify that they are seeking expert opinion to document the effects of interpersonal

family violence on the client, the ongoing impact of that violence on the client's daily life, and an understanding of why the client did not meet the 1-year filing deadline. Clients have 1 year after arrival to file for asylum. Sometimes, there are medical or psychiatric reasons that may have made a client unable to meet this deadline. Thus, attorneys sometimes specifically request an evaluation to clarify the reason a client has missed this deadline.

Based on this initial conversation, the evaluator can use this information to decide whether to perform a particular evaluation.

Logistical Arrangements Prior to an Evaluation

Once a clinician agrees to perform an asylum evaluation, there are practical "housekeeping" elements to address before meeting the client. Some of the details will depend on whether the evaluator is performing the evaluation independently or as part of an asylum clinic that may have particular protocols. If English is not the client's preferred language, one of the most important components of preparation is arranging for a qualified interpreter. In some settings, hospital interpreters may be available. If not, attorneys are generally responsible for providing interpretation services. The ideal interpreter is (1) independent from the applicant (not part of their family or community), (2) capable of direct, not "gist" translation, and (3) comfortable with content related to persecution or violence. Clinicians should also ask the attorney whether the client has a preference for the interpreter's gender, and attempt to honor the client's preference, particularly for cases in which client has a history of sexual violence.

Appendix A provides a sample checklist of logistical issues to review with the attorney. Appendix B details a sample script for explaining some of these issues in nonmedical language.

Additional Issues to Address with the Attorney Prior to the Evaluation

Issues that may warrant additional preparation and discussion with the attorney include substance use, suicidal thoughts or attempts, and situations of child abuse or neglect. An objective evaluator cannot perform a psychiatric evaluation without addressing these sensitive topics. For medical/physical evaluations, clinicians may have different practices about the extent to which they assess the client's psychiatric history and substance use history. Attorneys may have concerns about the impact of these findings. For this reason, clear communication ahead of time is essential. Additionally, it may be helpful to seek advice from another experienced asylum evaluator, as the unique circumstances of a particular case may warrant a different approach than the general advice discussed here.

Substance Use

Attorneys often express concern about the documentation of substance use in asylum affidavits, particularly when the client has a history of illicit substance use or a substance use disorder. As noted above, it is important to speak with the attorney prior to a psychiatric evaluation to convey that the evaluation will include discussion of substance use. During these preparatory conversations, the clinician can also discuss ways in which substance use disorders among survivors of trauma can be contextualized in the affidavit. In some situations, in which the client has a significant history of illicit substance use or a substance use disorder, the attorney may opt not to pursue a psychiatric evaluation.

Suicidal Thoughts or Attempts

Attorneys may also express concern if an evaluator enquires about or documents a client's history of suicidal ideation or suicide attempts. Given the elevated risk of suicide in this population, as well as the potential for re-traumatization during a forensic evaluation, asylum evaluators should inquire about self-harm and safety concerns in every evaluation. As noted above, this should be discussed with the attorney in advance. Evaluators can explain that symptoms of self-harm and suicidal ideation are common in survivors of torture and persecution, that understanding these symptoms is critical to accurate psychiatric diagnosis, and that these symptoms would be contextualized in an affidavit.

Child Abuse and/or Neglect

During asylum evaluations, clinicians sometimes learn of situations of child abuse or neglectful parenting. It is important to remember that clinicians are always mandated reporters, and to remind attorneys of this responsibility prior to performing an evaluation. In cases where clinicians are asked to sign an engagement letter detailing confidentiality between the evaluator and a legal provider, the specific language of this letter should allow for "confidentiality to the extent permitted by the law" or similar phrasing. Evaluators should also discuss mandated reporting responsibilities at the beginning of the actual evaluation session with the client.

Reviewing the Client Declaration

Reviewing the client's declaration, or self-statement, before the evaluation allows the evaluator to conduct a more effective in-person evaluation with the client. Initiating the evaluation with background knowledge of the case increases the

clinician's ability to be attuned and responsive to the client, listen empathically, focus questions, and assess if the client's verbal narrative corresponds with the affidavit. However, knowledge gained during preparation ahead of time should not replace portions of the clinical interview. The final affidavit should reflect information gathered and/or independently confirmed during time spent with the client.

Background Country and Situational Context

Asylum work provides a unique opportunity to work in a global health context, while remaining within the borders of the United States. This opportunity poses unique challenges. Evaluators should attempt to gain a general understanding of the client's country of origin and the place— both literally and culturally—occupied by their ethnic and cultural group within their home country. It is also helpful to have a baseline understanding of the social and familial costs that might have come with the course of actions chosen by the client, the type of persecution inflicted, as well as its prevalence and cultural meaning. While it is not the clinician's role to advise the court on the country and political context of the client's case, this preparation will improve rapport between evaluator and client and allow the evaluator to focus the evaluation and obtain all necessary information.

Preparing for the Evaluation Session

General Preparation

Most evaluators schedule 2–3 hours for a medical (physical) or psychiatric evaluation, and at least 3 hours for a combined medical and psychiatric evaluation. Prior to the evaluation, it can be helpful to prepare an outline of the session introduction, and to have a note template and resources accessible during the interview. In addition, for psychiatric evaluations, it may be helpful to bring printouts of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM–5) criteria for common or anticipated potential diagnoses, as well as any standardized assessments which the evaluator plans to use.

Elements of the session introduction might include the purpose of the evaluation, expectations for and limits of confidentiality, the option for breaks during the evaluation, the evaluator's role as an expert witness rather than a treating clinician, the role of any learners or scribes who are present for the evaluation, and obtaining consent from the client for the evaluation. Some evaluators or asylum clinics also routinely request clients' consent for anonymized use of clinical images or other elements of the affidavit for research, education, and advocacy efforts.

Specific Elements for Medical (Physical) Evaluations

Based on the affidavit or discussion with the attorney, sometimes the evaluator becomes aware of specific mechanisms of injury prior to the evaluation. Evaluators should review the *Istanbul Protocol* [1] as well as other resources, such as a dermatologic atlas, to learn about the appropriate physical examination and potential physical findings for those particular torture methods or other mechanisms of injury. Since forensic medical evaluations often take place years after the injuries or torture experienced by the client, it is also important to understand the types of injury or torture which are not expected to result in persistent scarring or other physical findings, so that the evaluator can explain this in the affidavit. Finally, if the affidavit describes rape or other sexual trauma, the evaluator should consider in advance whether a genital examination is warranted. Given the sensitivity of this examination and the potential for re-traumatization, a genital exam is generally recommended only if the client reports visible scars or other physical evidence of injury to their genitals, or if the client describes ongoing symptoms suggestive of persistent physical injury (e.g., symptoms potentially consistent with a fistula). In some cases (e.g., female genital mutilation), evaluators should consider the option of referral to a gynecologist with forensic experience.

In addition to the notes template described above and a copy of the client affidavit, evaluators may wish to bring the following materials for a medical evaluation:

- Clinical examination equipment (stethoscope, reflex hammer, tuning fork, penlight, tape measure, otoscope/ophthalmoscope).
- Camera to document dermatologic findings or physical evidence of other injuries (if possible, a dedicated camera rather than a cellphone camera to ensure client privacy).
- White exam table paper (or other large sheets of white paper) for use as the background of photographs.
- Medical record release form (to allow the evaluator to request or access relevant medical records if applicable).
- Drinking water.
- Tissues.

Specific Elements for Psychiatric Evaluations

Preparing a timeline of the client's history can be particularly helpful for psychiatric evaluations. Using paper and pen to draw a timeline enables the evaluator to bring it into the exam room. Building a timeline allows clinicians to summarize what they know prior to the evaluation, what gaps remain, and what information will be most helpful to understand during the actual evaluation. When clinicians are with the applicant, they can then build out the timeline while listening to the applicant's history—adding in the physical details, emotional experiences, and cognitive appraisals resulting from their persecution or torture.

Details that might be useful in a timeline:

- *Dates of birth, education, relationships, geographic relocations, deaths, marriages, milestones of pride and achievement, involvement with support social or religious groups*. Discussing positive moments and the details of everyday life can be especially helpful in building rapport. It also helps the evaluator gain context on the effects of persecution and the ways in which the applicant's life changed post-persecution.
- *The specific events of persecution that form the basis of the asylum claim*. By putting these on the timeline, the applicant's reasons for applying for humanitarian relief become clearer. Often, this clarifies what the evaluator needs to understand about the case (e.g., how was that persecution experienced? When? Where? With whom? By whom? Why? For how long?).
- *Secondary stressors or life changes that occurred because of the persecutory events*. Frequently, the index trauma is only the beginning of a period of distress. By noting additional events that may be linked to the client's persecution or torture, evaluators may gain further understanding of the subsequent physical and emotional impact on the client's life. Such linked events might include loss of physical home, loss of relationships, separation from family of origin, separation from children, the beginning of significant health concerns, and economic struggles.
- *Described periods of physical pain and emotional distress*. Sometimes, clients themselves describe these times in their affidavits. Use the timeline to note clients' descriptions and consider them as a signal to the evaluator of a time period into which the evaluator should delve deeply.
- *Notable indicators of changes in well-being*. These may include medical or psychiatric hospitalizations, court involvement, law involvement, family court/child protective service engagement, periods of unemployment, or efforts to seek protection from police or other officials.
- *Areas of confusion*. What remains unclear? Where is more information needed?

Preparing the client's timeline often drives the generation of ideas about the psychological distress experienced as a result of persecution. Clinicians can then use their hypotheses to guide questioning, while being open and responsive to the information heard in the exam room.

Asylum seekers frequently demonstrate symptoms of post-traumatic stress disorder, depression, anxiety, complicated grief, and insomnia. Survivors of chronic trauma may also have difficulties with emotional regulation and navigating interpersonal relationships. Clinicians should prepare to assess this range of possible mental health sequelae.

In addition to reviewing the materials covered in the training and the *Istanbul Protocol* [1], close familiarity with the *Diagnostic and Statistical Manual* (DSM-5) criteria is helpful. The integration of standardized assessments into the evaluation is also encouraged—not as the sole means of diagnosis, but as a way of structuring the work. While there are always pros and cons to including standardized checklists, they are worth considering for several reasons: (1) if used as a clinician's guide,

assessments can help organize the flow of the evaluation; (2) if the client is able to work with a Likert Scale, assessments encourage them to consider a range of suffering, not a dichotomous either/or response; and (3) the structured questioning can help contain the traumatic narrative, thereby reducing the likelihood of flooding that can occur during open-ended recounting of these traumatic events.

Increasingly, assessment measures are being normed on refugee populations. Table 2.1 includes measures frequently used in refugee and asylum work. Evaluators can think of a structured assessment as a starting point, a place from which questioning expands. Different cultures express suffering, pain, joy, and pleasure differently. It is helpful to become familiar with culturally specific idioms of distress that clients might express during the evaluation. In some cultures, depression might be expressed through somatic symptoms, while in others, it might be expressed through tearfulness, hopelessness, and ruminative guilt. Advanced preparation enables evaluators to feel confident in the initial framework, so they can listen carefully for the expression of and shifts in emotion.

Table 2.1 Structured assessments and measures frequently incorporated into psychiatric asylum evaluations

Diagnostic classification	Assessment measure	Reference
Post-traumatic stress symptoms and complex post-traumatic stress symptoms	Dissociative Subtype of PTSD Scale (DSPS) Harvard Trauma Questionnaire (HTQ) Impact of Event Scale Revised (IES-R) International Trauma Questionnaire (ITQ) National Center for PTSD Clinician Administered PTSD Scale (CAPS) Posttraumatic Stress Diagnostic Scale (PDS) PTSD Checklist PCL-5 Trauma Symptom Checklist-40 (TSC-40)	[5] [6] [7] [8] [9] [10] [11] [12]
Depression and anxiety	Beck Depression Inventory II (BDI-II) Hamilton Rating Scale for Depression (HAM-D) Hopkins Symptom Checklist (HSCL-90) Patient Health Questionnaire (PHQ-9) Quick Inventory of Depressive Symptomatology (QIDS)	[13] [14] [15] [16] [17]
Grief and bereavement	Inventory of Complicated Grief (ICG) International Prolonged Grief Disorder Scale Traumatic Grief Inventory Self-Report Version (TGI-SR)	[18] [19] [20]
Post-traumatic growth	Posttraumatic Growth Inventory (PTGI)	[21]

Special Elements of Preparation for Detained Evaluations

Conducting an evaluation for a client currently in Immigration and Customs Enforcement (ICE) detention requires additional elements of preparation and coordination with the attorney. The client's attorney must submit a request to ICE for permission for the evaluation. Evaluators should not travel to the detention site without confirmation that ICE has approved the evaluation, and even with confirmation entrance to the facility is not always guaranteed. Since scheduled detention regimens may delay the client's arrival to or interrupt the evaluation, evaluators should allow additional time for detained evaluations (in addition to the required travel time). The client's attorney should also provide information on what materials can be brought into the detention facility. Generally, clinical exam equipment and note templates can be brought in, while cell phones and cameras are often not allowed. Thus, for medical (physical) evaluations, evaluators must rely on detailed notes and/or body diagrams. Since Internet access will not be available, evaluators should make sure to bring in any materials they may need (e.g., DSM-5 criteria or standardized assessments).

Typically, the rooms available for the evaluation are not fully private (e.g., the door will have a window or a surveillance camera will be present), which may limit certain elements of the physical exam. If the affidavit describes injuries to their breasts, genitalia, or other areas that are difficult to examine without having the client undress, the evaluator should inform the attorney that examination of these injuries will likely not be possible. Finally, the evaluator should be prepared for a markedly different environment than a medical clinic or law office—an environment that feels less private, more sterile or cold, and less comfortable for the client and evaluator—and consider how to address these circumstances with the client and build rapport. Clinicians who perform these evaluations must be flexible and attempt to optimize what are often less than ideal circumstances. Preparing in advance for potential challenges will help the clinician conduct the best possible evaluation in a difficult setting.

Preparing to Involve Trainees and Interpreters in an Evaluation

Preparing to Involve Trainees

Individual evaluators and asylum clinics often involve trainees, including medical students, resident physicians, other health professions students, as well as peer colleagues in their asylum evaluations. Involving trainees can have a range of benefits, both for the learner and the evaluator. For learners, participating in asylum evaluations allows them to build experience not only in asylum evaluation but also broader skills such as trauma-informed care, psychiatric diagnosis, physical exam skills, and communication skills. For evaluators, a trainee can scribe and write an initial draft of the evaluation. This allows the evaluator to focus more on the client during

the interview and decreases the time spent documenting. On a broader level, involving learners may also build capacity by increasing the number of trained evaluators in the future.

Different evaluators and asylum clinics have a range of practices around the expectations for trainees prior to their first evaluation. For example, asylum clinics may require attendance at a training session prior to their first evaluation. Many asylum clinics also ask learners to read the Istanbul Protocol [1], with particular attention to Chaps. 5 and 6 which describe the approach to physical and psychological evaluations; some asylum clinics have additional orientation materials that they ask learners to review as well. Finally, the learner should read the client's affidavit, and ideally be involved in any pre-evaluation discussions with the attorney.

In addition, many evaluators meet with the trainee before the evaluation. These meetings focus on reviewing expectations, gauging comfort and experience level, discussing the specific case, answering any questions, and deciding on a plan for respective roles in the actual evaluation session. Initially, trainees generally observe and take notes, and then prepare an initial draft of the affidavit. As a trainee gains experience with asylum evaluations, they begin to conduct much of the interview, with the primary evaluator taking notes and asking clarifying questions. However, the primary evaluator must be present for the entire interview, will sign the affidavit, and will provide testimony if requested. Evaluators may also wish to schedule a post-evaluation meeting with the learner, either immediately after the evaluation or at a later time, to provide feedback and address the potential for secondary trauma.

Preparing to Involve Interpreters

Broadly speaking, the role of an interpreter is no different than for a clinical encounter. However, evaluators may encounter a few unique elements during asylum evaluations that merit preparation. First, particularly for rare languages, an interpreter arranged by the attorney may not be a certified medical interpreter. Thus, just prior to the evaluation, the evaluator should meet with the interpreter to discuss their background and experience. If the interpreter is not a certified medical interpreter, it can be helpful to emphasize the importance of full interpretation rather than paraphrasing so that the evaluator can understand the client's exact words as much as possible. When possible, it is also helpful to provide translated copies of any standardized assessments that will be used. Second, particularly for cases involving rare languages, the interpreter and the client may be from the same community and have a preexisting relationship. If this occurs, it is important to ask the interpreter and the client about this, and to consider whether it may affect the evaluation. Third, the length of the evaluation session and the potentially traumatizing nature of the discussion may be unusual for the interpreter. In the pre-meeting with the interpreter, the evaluator can clarify that, during the evaluation, the interpreter can let the evaluator know at any time if they need a break, either to use the bathroom or because of

emotional distress. After the evaluation, the clinician should allow time for a short discussion with the interpreter to address the potential for secondary trauma.

Conclusion

Thorough preparation will enhance asylum evaluations for clinicians, trainees, and clients. While elements of preparation can seem daunting, many of the practical considerations can be addressed in a phone call with the attorney. As with any skill, preparation for evaluations becomes more efficient with practice. Finally, remember that evaluators have already spent years building the core skills in physical and psychiatric evaluation that are most critical for this work.

Appendix A

Evaluation Logistics Checklist

1. Request a copy of the client's declaration, even if it has not been finalized.
2. Discuss the need for an interpreter and if so, necessary arrangements.
3. Review logistics for the day of the evaluation (date, time, and location of evaluation meeting, transport for client, expected length of session).
4. Obtain verbal or signed consent for the evaluation (depending on the evaluator's preference and/or institutional requirements).
5. If a prior evaluation was conducted, consider the pros and cons of reading that evaluation.
6. If client has a history of medical and/or psychiatric care, obtain clinical records if possible.
7. If client is detained, obtain clinical records from detention, if possible.
8. Encourage the attorney to prepare the client by discussing the following:

   (a) Purpose of evaluation and how it will be used.
   (b) Importance of honest and accurate reporting (not underreporting or overreporting symptoms).
   (c) Nature of a forensic evaluation (length of session as well as explaining that the session is a forensic evaluation rather than clinical care).
   (d) Expectation that the evaluator will address difficult topics (history of trauma, its effects, history of loss, psychiatric symptoms, positive and negative coping strategies, substance use, suicidal thoughts or attempts, history of self-harm, exposure to violence, and parenting and discipline styles).
   (e) While a forensic evaluation is not a clinical encounter, the evaluator nonetheless maintains their role as a mandated reporter.

Appendix B

Sample Script

Conversation with the Attorney About Preparing Their Client for the Evaluation

"I'm looking forward to meeting your client on Monday—thank you for arranging for interpretation and obtaining consents. I have read through the client declaration you sent me, and the paperwork—thank you for sharing this information, as this is very helpful to me in preparing for the evaluation.

"Before the first session, please explain to your client that the goal of the medical or psychological evaluation is to help understand their story and experiences. These evaluations can feel frightening and stressful, particularly if your client comes from a culture that doesn't seek out medical care in a preventive way or sees mental distress as shameful or a sign of weakness. Without information about what to expect, asylum applicants can feel even more stressed. Please convey that I will listen to their story as a clinician, and frame my own report in a way that clarifies and connects the dots in their history. For a psychiatric evaluation, I will try to understand the effects of their persecution/what happened to them on their body, mind and heart, their feelings and thoughts, as well as their sense of self and place in the world, their feelings and thoughts, as well as their sense of self and place in the world. I will have lots of questions for them, and those questions will guide the evaluation. So, they do not have to prepare anything or feel stressed about "how" or "what" to say. I will lead the evaluation.

"It is important that the applicant try their best to be honest about their feelings and the reactions they have had to their history. They do not have to try to show that they are doing well, with no stress or problems—and they also should not overreport their symptoms. Honesty is really the best way to go. I will cover much of this when I meet them, but if you can start to lay the groundwork, it will help them understand what to expect. This understanding will help decrease their anxiety."

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Chapter 3
Physical Evaluation of Asylum Seekers

Amy Zeidan and Hope Ferdowsian

Introduction

The primary purpose of a physical examination of an asylum seeker is to objectively identify and document physical evidence of prior torture or ill-treatment. For many asylum seekers, physical and psychological sequalae of torture may be the only evidence that exists. As a result, a physical examination can be a critical factor in support of an individual's asylum claim.

The following sections provide an overview of the physical examination within the context of a trauma-informed framework. While a physical examination can reveal key findings and support an individual's case for asylum, the examination can also be a significant source of re-traumatization for the client. Alternatively, a trauma-informed evaluation can serve as a source of empowerment and resilience for survivors of torture and ill treatment. Therefore, it is important that clinicians adopt this approach when preparing, interviewing, and examining individuals.

A Trauma-Informed Framework

A trauma-informed approach recognizes that trauma is pervasive and that it can have ongoing adverse effects on an individual's level of function and health status.

A. Zeidan (✉)
Department of Emergency Medicine, Emory University School of Medicine, Georgia Human Rights Clinic, Atlanta, GA, USA
e-mail: ajzeida@emory.edu

H. Ferdowsian
Department of Medicine, University of New Mexico School of Medicine, Albuquerque, NM, USA

Phoenix Zones Initiative, Albuquerque, NM, USA
e-mail: hferdowsian@salud.unm.edu; hrf@phoenixzonesinitiative.org

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Prior events may inform an individual's behaviors and their responses to new encounters that they may perceive as traumatic. A key objective of a trauma-informed approach is the avoidance of re-traumatization, which can be particularly challenging during physical examinations of survivors of violence since the examination focuses on reviewing and describing prior experiences [1]. Further, asylum medicine evaluations typically occur as a single encounter in which the clinician's role is as an evaluator rather than as a treating clinician. Both of these factors may limit the time and context typically required to establish trust and safety with the client. However, adopting the following key principles can minimize harm and promote resilience among asylum seekers with a history of trauma:

1. Establish a physically and emotionally safe space at the beginning of the interview.
2. Allow the individual to have autonomy and control over the examination by offering choices and alternatives to ensure comfort.
3. Create a relationship of shared decision-making whereby the individual views the encounter as cooperative.
4. Exhibit trustworthiness by setting boundaries and expectations.
5. Provide validation and empowerment throughout the interview.

Many of these principles can be established at the beginning of an interview through the process of informed consent, which can be obtained verbally or through written documentation [1]. The following interview techniques can also be utilized to support the aforementioned principles [2]:

1. Ask open-ended questions.
2. Ask simple and straightforward questions.
3. Ask nonthreatening and nonleading questions.
4. Listen actively and pause or remain silent when appropriate.
5. Maintain appropriate eye contact and remain aware of one's own body language.
6. Observe the client's body language and respond appropriately.
7. Organize the room appropriately, guided by the client's preferences.
8. Ask permission when appropriate, such as at the beginning of a physical exam.

General Approach to the Physical Evaluation

While the purpose of physical examinations of asylum seekers is to document physical evidence of trauma, many types of injuries do not leave physical scars or other forms of evidence. The appearance of scars may change depending on the acuity or chronicity of an injury and a number of other factors including the survivor's age and personal medical history; skin plasticity and pigmentation; the anatomical location of an injury, access to medical care and treatment; and the mechanisms, force, velocity, duration, and frequency of injury and restraint [3]. Mechanisms of torture are highly variable and case specific, and clinicians should use their clinical judgment and evidence-based guidance to interpret any findings [Table 3.1]. Clinicians

Table 3.1 Forms of torture and exam findings

Form of torture	Description of mechanism	Examples	Physical exam findings
Blunt force trauma [4, 5, 8, 10, 11, 14]	Traumatic injury to the body caused by forceful direct contact	Direct blows to the body using weapons (e.g., sticks, batons, or the butt of a rifle) or the perpetrators' body (e.g., punching, hitting, or kicking with heavy boots) Whipping or flogging using a cord-like object, which typically leaves stripe-like injuries Falanga: Repeated beating of the soles of the feet, causing acute swelling and pain; chronic symptoms may be worse with movement and improve with elevation. Can cause injury to the plantar fascia, and fixed dorsiflexion. Telefono: Direct forceful trauma to the ears	Contusions Abrasions Lacerations Fractures
Penetrating trauma [4, 5, 8, 11, 14]	Traumatic injury to the body caused by a foreign object piercing the skin, typically resulting in an open wound	Incision or stab wound injury from a knife, machete, bayonet, glass, or another sharp object Wound from a bullet Human bite wounds	Incision Laceration Bullet wound Findings vary depending on the type of weapon, distance from the perpetrator, depth of penetration, and velocity/speed of the object. Fractures can be associated with penetrating trauma. It is possible that the bullet or ballistic fragments may be retained; counting the number of bullet wounds for entry and exit can assist with the possibility of retained bullet(s). Bite wounds: Skin findings depend on the depth, location, and dental characteristics of the perpetrator, ranging from contusion or incision to avulsion in a semicircular pattern with small areas of incision. High rates of infection are possible depending on the depth and location of the incision.

(continued)

Table 3.1 (continued)

Form of torture	Description of mechanism	Examples	Physical exam findings
Forced/stress positioning [4, 5, 14]	Forcing the body into an uncomfortable position, placing weight on one or two muscles, often for a long period of time	Squatting position with arms restrained behind the back Standing position with arms restrained above the head	Less likely to see physical evidence; however, can cause nerve, ligamentous, joint, tendon, or muscle injury
Suspension [4, 5, 8]	Suspension in a forced position, often resulting in hyperextension or stretching	Suspension from the wrists, ankles, leg; suspension with wrists behind the back	Striae where skin is stretched Nerve (e.g., brachial plexus), ligamentous, joint, tendon, or muscle injury Shoulder dislocation, asymmetry, pain, and change in function or range of motion
Extremity restraints [5]	Tightly tying of the hands or feet together	Use of a sharp wire or cord to restrain the extremities	Ligature marks on the wrists and feet Sensory or motor damage
Crush injury [4]	Direct force and pressure placed on a body part in a squeezing or crushing mechanism	Often seen in the fingers and toes Crushing or ligation injury to the scrotum	Deformities or swelling of the fingers or toes, abnormalities of the nailbed, paralysis, or paresthesias
Burns [4, 5, 8, 11, 14]	Injury to the skin from heat, chemicals (e.g., acid), or electricity	Cigarette burns Branding burns Chemical/corrosive burns	Circular or ovoid scar with a hyper- or hypopigmented center Typically, the scar reflects the shape of the object and varies depending on the amount of energy applied, temperature, and length of time applied. Third-degree burns typically result in an atrophic center and hyperpigmented periphery. Scarring depends on the amount of chemical applied, mechanism of application, and location. Injury typically results in an asymmetrical scar with a depigmented center and a hyperpigmented periphery.
Electrocution [4, 5, 11, 14]	Application of electrical current throughout the body	Placement of electrodes can occur on the hands or fingers, feet or toes, teeth, mouth, nipples, or genitals. The addition of water or gel can increase the strength of the current.	Burns can be small, circular, and exhibit pigmentation changes, but are less common and depend on the amount of energy delivered. Scarring can be in linear or cluster formations. Linear scars can be seen as a result of electrode placement.

(continued)

Table 3.1 (continued)

Form of torture	Description of mechanism	Examples	Physical exam findings
Asphyxiation [14]	Suffocation or deprivation of oxygen; immersion of the head into water	Covering the head with a bag or forced aspiration of materials through the mouth and nose, replicating a suffocating sensation Direct pressure with hands or ligature around the neck Waterboarding or near drowning: Water is poured over a covered face while the body is immobilized; sometimes referred to as "submarine."	Scars around the neck Neurologic findings vary depending on the severity; can include a variety of cognitive, sensory, and memory impairments ranging from mild to severe. Examples include headaches, dizziness, and psychological sequelae.
Sexual violence	Refer to Chap. 7		
Imprisonment [4, 8]	Inhumane and extreme conditions resulting in physical and psychological trauma	Deprivation of food (or the provision of unsanitary food), light, social contact (e.g., solitary confinement), sleep; temperature extremes; overly crowded conditions	Physical exam findings are less common.

should also feel empowered to interpret unique findings using their knowledge and experience, and to seek expert consultation for unfamiliar findings.

A comprehensive physical exam should be performed to evaluate for ongoing signs and symptoms of trauma [2]. Individuals may exhibit symptoms or functional sequelae of an injury in the absence of physical signs, and these should be documented. It is also critical to note physical findings that are unrelated to prior torture. Depending upon the mechanism of torture, physical signs and symptoms may differ from the types of injuries clinicians typically encounter [3]. Notably, some mechanisms of torture have been developed to cause physical harm without leaving obvious physical exam findings.

Finally, it is important to realize that an individual's history of trauma may affect their recollection of events and their ability to discuss specific details of the trauma. If the individual suffered from injuries causing loss of consciousness, traumatic brain injury, or significant emotional disturbances, their memories and recall of general and specific details may be impaired. A sense of privacy, fear, shame, or denial may influence how trauma survivors report their experiences. Language, cultural factors, and personal history may also affect how interview questions are interpreted by the client or how an individual responds to questions during the evaluation.

Preparation for a Physical Evaluation

Clinicians who perform physical evaluations of asylum seekers should review trauma-informed principles and interview techniques prior to any evaluation. If there is an opportunity to read a client's personal statement and any medical records in advance of the evaluation, it may be helpful to prepare questions and interview templates in advance that are case specific. It is important for evaluators to be aware of and manage any emotional reactions to the client's story, and clinicians should allow 2–3 hours per evaluation.

Evaluators should also consider resources and equipment that are needed for the physical examination. For example, it may be helpful to bring a penlight, otoscope, stethoscope, Snellen eye chart, or reflex hammer, depending on the types of injuries reportedly experienced by the client. For gynecological examinations, it is important to ensure that the exam space contains an appropriate exam table and a speculum with a light source, a privacy gown and drape, and a lubricant. A ruler is useful in determining and describing the size and shape of injuries, and anatomical diagrams can be used to document findings during the course of the evaluation [Appendix 2]. A camera can be used to document photographic evidence of injuries. Clinicians should also ensure they have a secure method of recording information obtained during the evaluation, including a pen and paper or a computer.

Before the evaluation, it is essential to consider whether the client has language, gender, or cultural preferences of the interviewer or interpreter. Ideally, the client's lawyer should communicate these needs in advance of the evaluation. It is also important to consider how the evaluation space is configured and to accommodate the client's wishes or concerns. For example, clients may prefer to be near the door with adequate space between the interviewer and the client. Asking about the client's preferences prior to the interview can help ensure that they feel comfortable with the arrangement of space and that they have a sense of control within the context of the evaluation.

General Structure of the Interview

Setting Expectations and Obtaining Consent

Setting expectations at the beginning of the examination can help establish a trauma-informed framework for the evaluation. While it may take some time to discuss these items, it can signal respect and encourage collaboration throughout the remainder of the encounter.

At the beginning of the evaluation, clinicians should complete the following tasks:

1. Introduce all individuals present and explain their role in the evaluation.
2. Emphasize the clinician's role as an evaluator rather than as a treating physician.

3. Inquire about the client's comfort level with the space available.
4. Ensure that the interpretation services available are appropriate for the client's preferred language and dialect.
5. Discuss the purpose of the examination and any documentation, including the use of a camera.
6. Review the structure of the examination and the general timeframe for the evaluation.
7. Inform the client that they may take a break or stop the interview and examination at any time, and that they may decline to answer certain questions or omit any portions of the exam.
8. Discuss the limitations of confidentiality.
9. Ask the client if they have any questions or concerns, which should be addressed before obtaining verbal or written consent.
10. Obtain consent.

A script or template can assist clinicians in real time with the above items.

Regarding privacy, confidentiality, and consent, there are a few important distinctions between a typical clinical evaluation and an asylum evaluation [3]. The confines of privacy and confidentiality in the context of an asylum evaluation differ from a typical clinical encounter, in that the medical report will be made available to the client's legal team and to others involved in the legal process. Discussing these limitations with the client in advance of the interview and examination will help identify whether there are private issues that clients prefer to be omitted from a written report. Since clinicians are mandatory reporters, it is also important to explain any issues that would require immediate action and follow-up by the clinician. Factors that require immediate intervention include active suicidal or homicidal intentions and any form of abuse of a minor.

With respect to informed consent, some clinicians choose to obtain written consent whereas others prefer verbal consent. Regardless of how consent is obtained or documented, it is important to cover the key elements of informed consent, including adequate disclosure of information, establishing the competency of the client to make an informed decision, and the voluntary nature of any decision to agree to and continue with an evaluation. It is essential to acknowledge that questions asked during the interview may cause individuals to reexperience traumatic events; that clients can stop or take breaks at any point; and that they can avoid specific topics or questions that may be uncomfortable or particularly re-traumatizing.

Conducting the Interview

Generally, after setting expectations and obtaining informed consent, the clinician should inquire about relevant past medical, surgical, family, and social history, and then ask the client about their history of torture or ill-treatment. The exact structure of the interview is guided by the discretion of the clinician. For example, inquiring

about a timeline during the history can help illuminate how much time has passed since the trauma, and thus expected physical findings and symptoms.

Beginning with open-ended questions may help the client narrate their experiences. Throughout the course of the evaluation, it is important to focus on information that is medically relevant. Trauma varies from case to case and it may include a single encounter, episodic injuries, chronic trauma, or detention and imprisonment. To obtain medically relevant information, it may be helpful to ask about details including mechanisms of injury; the number of perpetrators involved; the types of weapons that were used; the direction and velocity of force involved; and any associated factors such as pain, skin changes, changes in function or sensation, treatment rendered, and the presence of ongoing symptoms. Inquiring about scars and physical findings may help with exploring details of the injury and ongoing symptoms, and it may be necessary to ask about specific forms of trauma including head trauma, asphyxiation, sexual violence, and common forms of torture [3].

It may be helpful to specifically ask about prior outpatient or emergency department visits and hospitalizations. If the individual has obtained medical care while in the US, especially for injuries or symptoms related to their history of torture or ill treatment, the clinician should work with the legal team to obtain relevant records.

Maintaining neutrality and avoiding leading questions can ensure individuals feel empowered to answer questions based on their experiences and recollection. As noted previously, an individual may not recall all of the details of their injuries due to loss of consciousness, emotional disturbances, blindfolding, varying levels of injury severity, or other factors. Informing individuals that the inability to recall all of the details of traumatic events is common and can provide reassurance.

In cases involving detention or imprisonment, clinicians should seek further details, including the length of time clients were detained; any specific torture techniques such as restraint or suspension; the availability of any medical evaluation or treatment; and other forms of physical harm such as prolonged thirst, hunger, sensory deprivation or overstimulation, forced nudity, exposure to extreme temperatures, and the physical conditions of detention or prison facilities [2].

At the end of the interview, the asylum seeker should be asked if they have any questions or additional items they would like to discuss.

Approach to and Details of the Physical Examination

After a full history is obtained, the clinician should ask permission to perform a physical examination. As part of the process of informed consent, clinicians should describe the components of the physical examination prior to beginning any inspection, auscultation, palpation, or manipulation. It is generally advisable to perform a comprehensive physical examination; however, if the individual prefers a focused examination, or the findings are minimal, a limited examination is acceptable as well.

The order of the physical examination is up to the discretion of the physician. Some clinicians prefer to examine clients from head to toe, while others prefer to

start with unaffected areas first. The history of torture or ill-treatment obtained during the course of the interview can guide the physical examination of affected areas. Nonetheless, a comprehensive examination can identify other scars or injuries and their origin [2]. Physical evaluations of asylum seekers commonly can occur months and often years after torture or ill-treatment has occurred. As a result, chronic, rather than acute, findings are more likely to be observed.

The following section describes potential common signs by anatomical location and system [2, 3]. These findings are meant to serve as a guide. Clinicians should interpret their own exam based on their clinical experiences and judgment.

Head, Eyes, Ears, Nose, and Throat (HEENT)

Evaluation of head and neck trauma is essential since this type of trauma is common among torture survivors, and individuals may suffer chronically from head and neck injuries. Head trauma can result from blunt force trauma or asphyxiation in the form of strangulation, suffocation, near drowning (e.g., water boarding), or different forms of suspension [4].

In asylum seekers who report head trauma, traumatic brain injury (TBI) can be assessed via a neurological exam and neurocognitive assessment by using established culturally and linguistically appropriate and evidence-based tools. Individuals may have experienced acute concussive symptoms or post-concussion syndrome. Inquiring about acute and chronic symptoms including loss of consciousness, emesis, dizziness, vertigo, memory changes, sleep impairment, headaches, and extremity numbness or weakness can support a diagnosis of head trauma [5, 6]. For those with ongoing head and neck injuries, the cervical spine can be examined through palpation of the spine for tenderness and step-offs, evaluation of range of motion, and neurological assessment for evidence of cervical radiculopathy [4].

Asphyxiation and strangulation injuries tend to produce acute findings; however, subtle chronic findings can be observed including dysphonia, dysphagia, scarring of the skin, and neck or throat pain. Inquiring about acute findings and documenting symptoms is helpful even if symptoms have improved or resolved. Acute symptoms may include dysphonia, dysphagia, difficulty tolerating secretions, difficulty breathing, throat pain, or neck pain. Fracture of the hyoid bone is extremely rare in torture survivors but can occur with strangulation injuries, blunt trauma, hyperextension, or cervical trauma [7]. Acute symptoms of hyoid fractures may include neck pain, dysphagia, dysphonia, stridor, or crepitus. Healing typically occurs without intervention, and chronic physical exam findings are rare [7]. The neck and hyoid bone should be palpated if the history is concerning for this type of injury; however, a normal examination does not rule out hyoid injury or strangulation.

Injuries to the face are also common and require careful examination. Clinicians should evaluate the skin of the face and scalp to identify any scars or asymmetry, and they should palpate for irregularities and evidence of tenderness. Clinicians should also examine facial movement and function including cranial nerve integrity.

Eye trauma can result in restricted extraocular movements, vision changes or loss, pain with eye movement, and evidence of trauma including conjunctival changes. Performing a visual acuity examination may be required if vision changes or vision loss are noted [2].

Examination of the ears is important for individuals who have experienced head or facial trauma. Evaluation should include examination of the tympanic membrane (TM). Although findings such as bleeding, tinnitus, and TM rupture may occur acutely, subtle chronic findings such as scarring of the TM, pain, tinnitus, hearing loss, or chronic ear infections may be observed. Telephono is a form of torture that involves blunt trauma to one or both ears and it can result in TM rupture and/or hearing loss [2, 8, 9].

Lacerations to the ears and face may leave scars, especially if repair was not provided, and these lacerations may result in changes in function or sensation, or facial asymmetry.

Evaluation of the nose, including both nares, by inspection and palpation can identify prior traumatic injuries which have resulted in signs and symptoms of pain, bony irregularities, and changes in function. These functional findings can include chronic congestion, drainage, and breathing changes [2].

Trauma to the oral cavity can result in missing teeth from trauma, extraction or tooth avulsion, intrusion, displacement, or fracture. Dental injuries can lead to ongoing pain, poor dentition, or dental infections. Evaluating for jaw alignment is important, and changes in function including pain with mastication, trismus, any history of jaw dislocation or subluxation, or temporomandibular joint syndrome may be signs of prior trauma. Burns or electrical injuries may leave evidence of scarring of the lips or oral cavity. Sexual violence may involve the oral cavity [2].

Chest, Abdomen, and Back

Inspection and palpation of the skin of the chest, abdomen, and back can identify evidence of prior trauma including scars, tenderness or discomfort, or asymmetry. If permission is given, breasts should be inspected for evidence of blunt trauma, electrocution, lacerations, or other forms of injury. Acutely, traumatic injuries to the chest can result in rib fractures, pneumothorax, hemothorax, blunt cardiac injury, or vertebral injury. These injuries are challenging to assess after acute trauma but inquiring about immediate and subacute symptoms can help guide the assessment of possible injuries. Individuals may describe chronic symptoms of shortness of breath, cough, frequent upper respiratory tract infections, chest pain, or back pain. Similarly, injuries to the abdomen resulting in organ injury may be challenging to detect on physical examination after the passage of time since the original injury. Clinicians should ask about acute symptoms of abdominal pain, change in bowel or bladder function, gross hematuria, and bruising of the chest, abdomen, or back. Chronic symptoms may include abdominal pain, back pain, dysuria, and changes in bowel function. Examination and palpation of the thoracic and lumbar spine should

be performed to evaluate for deformities or asymmetry, step-offs, or tenderness. Limited range of motion, as well as radicular symptoms, can be noted after traumatic injuries involving the upper or lower back [2].

Orthopedic

Orthopedic injuries are very common after torture, especially after blunt force injuries, forced positioning, suspension, and forced weight-bearing activities [5]. Falanga is a mechanism of torture whereby the soles of the feet are beaten repeatedly, and this form of torture may result in pain, sensory changes, deformities of the feet, or gait abnormalities [5, 10].

Individuals who suffer from orthopedic injuries may experience arthralgias, myalgias, and fractures or dislocations. Common chronic symptoms may include joint pain or swelling, restricted range of motion and decreased joint function, myalgias, muscle weakness, or joint and extremity asymmetry. The individual might not have received medical attention for an acute orthopedic injury, which may result in abnormal healing, deformities, or loss of function. Assessing for asymmetry of the extremities, and testing strength, range of motion, sensation, and gait can assist with the identification of abnormal findings. Peripheral neuropathies may be seen in conjunction with orthopedic injuries and these symptoms warrant assessment of sensation, mobility, strength, and reflexes [4].

Special attention should be also directed toward the hands, fingers, and nailbeds, particularly when crush injuries are reported or suspected. Crush injuries can result from blunt force trauma from heavy boots, the use of batons, or other devices and mechanisms [4]. Nailbed removal may also be observed and result in abnormal nailbed findings.

Genitourinary and Gynecological Trauma

The evaluation of clients with a history of sexual violence can be particularly challenging and re-traumatizing. Physical evidence is often absent, partly due to the vascularity of the genital and anorectal regions. Although physical evidence may be limited, a detailed history of the trauma, acute and chronic symptoms, and an examination can be useful.

Genitourinary, gynecological, and anorectal trauma can include blunt trauma to the clitoris, penis, foreskin, labia minora or majora, scrotum, urethra, and perianal or perirectal region, and it may also include penetration, cutting, crushing, pulling, twisting, or ligating mechanisms of injury. Weapons may include the use of animate or inanimate objects. Pain, swelling, lacerations, bleeding, and bruising can occur immediately after trauma. Exam findings may include swelling, tenderness to palpation, atrophy, change in pigmentation or hair patterns, abscess or fistula

formation, or scarring. Electrical burns of the genitourinary region may leave scarring attributable to electrode placement [5]. Chronic symptoms may include pain, discharge, sexual dysfunction, menstrual dysfunction, or urinary symptoms such as dysuria, hematuria, or incontinence. Commonly, individuals with a history of genitourinary, gynecological, or anorectal trauma experience pain or discomfort on physical examination. For individuals who have experienced pregnancy, a detailed history should be obtained, including any complications or the need for any surgical management [2].

Although genitourinary, gynecological, and anorectal exam findings may be limited, it is still helpful to perform and document a comprehensive exam. However, individuals may be very uncomfortable with this type of exam and consent should be obtained prior to the examination with the assistance of the legal team, and again during the examination. The examination can be avoided if the individual is uncomfortable, hesitant, or indicates signs of stress during the examination.

Dermatologic

Evaluation of scars is a critical component of the examination and can provide valuable evidence of a history of trauma. Scars can result from specific injuries including lacerations, incisions, abrasion, and burns. Scar appearance can change over time and it may be affected by the mechanism of injury and depth, procedural treatments such as sutures, the use of topical medications, wound infections, personal characteristics (e.g., skin plasticity, skin pigmentation, and comorbid medical conditions), and scar location [11]. It is important to conduct a comprehensive skin examination and to note scars unrelated to torture (e.g., immunization scars, surgical scars, and tattoos or other markings), as well as the presence or absence of a primary skin condition.

Scars can be assessed based on their location, size, dimensions, shape, borders and demarcation, pigmentation patterns, degrees of symmetry, texture (e.g., flat, raised, or ulcerated), and the presence of hair loss [2]. Scars can be compared with the client's surrounding skin, and it can be useful to test sensation and function of the affected area to assess for evidence of superficial nerve injury in cases of burns, lacerations, and some forms of blunt trauma or restraint. Scars may also be hypertrophic or keloid in formation. Hypertrophic scars remain within the boundaries of the original scar, and they commonly occur on the back, shoulders, or sternum. Keloid scars extend beyond the boundaries of the original scar, and they may occur on the sternum, deltoids, and earlobes [11].

It is common to see scars along the upper extremities that are consistent with defensive wound patterns [12]. The location of some scars can also support an external source of injury, especially if the scar is located in an area where a self-inflicted wound would be nearly impossible.

Finally, it can be useful to ascertain whether wound healing has occurred by primary, secondary, or tertiary intention. Primary wound healing occurs as a result

of surgical approximation (e.g., sutures) of wound margins, and the final appearance of scars may be determined by the initial injury and the timing and accuracy of wound closure. Healing by secondary intention occurs as a result of spontaneous healing and the final appearance of scars may depend on the presence of infection and any comorbidities. Tertiary wound healing, or delayed primary closure, occurs when a wound is left open to allow for drainage or control of contamination until further surgical closure is completed [2].

Diagnostic Testing

Access to additional diagnostic testing may be costly and impractical. If available, imaging studies may assist with the identification of prior injuries. Normal imaging cannot eliminate the possibility of prior trauma. If an individual received prior diagnostic testing, results can be made available to the clinician and incorporated into medicolegal documentation, if relevant [2].

Documentation of the Physical Evaluation

The primary goal of documentation of the physical evaluation is to correlate the degree of consistency between the following elements of the evaluation [3]:

1. The history of acute and chronic physical symptoms with the allegations of torture or ill treatment.
2. The physical examination findings and the allegations of torture or ill treatment.
3. Any behavioral or psychological observations obtained during the evaluation.
4. Any other screening or diagnostic test results.

Documentation of the physical examination should include the history of torture or ill-treatment with relevant medical details, acute and chronic symptoms reported by the individual, physical examination findings and related mechanisms of injury, and any conclusions that support findings that were obtained during the history and physical exam [13]. The report should focus on medically relevant information.

Each scar, including scars unrelated to trauma, should be described in detail. Descriptions should include the scar's location, size, dimensions, shape, borders and demarcation, pigmentation patterns, degrees of symmetry, texture (e.g., flat or raised), and the presence of hair loss and any relevant comparisons with the individual's surrounding skin [2]. Scars can be highlighted using an anatomical diagram, and photographic evidence can be included to support descriptions of injuries.

Each finding should be assessed based on the consistency of findings (Table 3.2). Findings can range from "not consistent," meaning the finding could not have possibly been a result of the mechanism described, to "diagnostic of," meaning there is almost no other mechanism by which the scar could have resulted [2, 14].

In some cases, the individual may have medical records related to prior treatment and care. Clinicians can consider incorporating these findings into their medicolegal documentation. Historical diagnostic tests and imaging may help elucidate chronic findings such as prior fractures or other sequalae of trauma.

The medicolegal report is typically reviewed by the legal team and submitted to a judge or asylum officer. Medical findings can be explained using medical terminology but clinicians should include language and descriptions that can be easily understood by individuals without medical training.

As previously emphasized, it is possible that individuals may not be able to recall every detail of their history of torture or ill-treatment. There are multiple factors that can contribute to discrepancies in memory recall, and details are more difficult to recall as time lapses. Inconsistencies about specific details are common and should not be immediately attributed to credibility. The clinician should explore the types of inconsistences noted, and case-specific reasons that may contribute to difficulty with recollection. If applicable, the clinician can include in the medicolegal documentation the medical rationale for recall challenges and minor inconsistencies.

Finally, it is important to note that the absence of physical examination findings is common, which may be explained in the medicolegal documentation.

The Use of Forensic Photography

Photographic evidence is not necessary but it can be a valuable addition to support physical exam findings [15]. Consent for photography is essential [2]. The clinician may want to inquire with the legal team about photographic evidence prior to the evaluation, and again during the evaluation. There may be some scars or body parts that an individual does not want photographed due to privacy concerns. These

Table 3.2 Degrees of consistency

Degree of consistency	Description
Not consistent	The lesion could not have possibly been caused by the trauma described
Consistent with	The lesion could have been caused by the trauma described, but it is nonspecific and there are many other possible causes
Highly consistent	The lesion could have been caused by the trauma described, and there are few other possible causes
Typical of	This is an appearance that is usually found with this type of trauma, but there are other possible causes
Diagnostic of	This appearance could not have been caused in almost any way other than that described

Adapted with permission from McKenzie et al. [9]. Adapted from *Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment*, UNHCR Professional Training Series No. 8/Rev. 1 (2004)

concerns can be ascertained prior to obtaining any photographs. The clinician should make every effort to avoid photos that could reveal the individual's identity, including identifying photos of the face and any scars or findings that are particularly unique. The quality of the photo is important to consider. If possible, photos should be taken in a room with appropriate lighting and against surfaces that allow for obvious identification of the scars. Including photos of different dimensions (e.g., by zooming in and out) can help highlight detailed features as well as context. Photographic evidence can be inserted into the medicolegal document along with a description of the corresponding scar in written text and through documentation on an anatomical diagram.

After photographic evidence has been collected, the clinician should explain to the individual how photos will be used and stored confidentially. Photos can be stored to maintain privacy and confidentiality on a password protected computer or locked storage cabinet. Similarly, once added to the medicolegal documentation, all documentation should be stored securely.

Conclusion

A physical evaluation of an asylum seeker can be instrumental to their legal case for asylum, and the evaluation can serve as a source of empowerment. The intersection of forensic science, medicine, and trauma-informed care allow for a robust synthesis of information gathered through the interview and the physical examination. Clinicians can hone their knowledge and skills through practice, mentorship, experience, and continuing education.

With attention to a trauma-informed approach, it is important to remember that the physical evaluation is only one component of the asylum seeker's set of experiences. At the conclusion of the visit, clinicians should discuss safety planning with the client and acknowledge that the interview and examination are invasive and that the evaluation may cause acute or chronic distress. In some cases, a referral to a mental health specialist may be indicated. Any referrals to medical or mental health clinicians can be discussed with the client and lawyer, and they should also be documented in the medicolegal report.

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Chapter 4
Forensic Psychological Evaluation of Asylum Seekers

Shawn Singh Sidhu and Olivia Shadid

Introduction

Forensic psychological evaluations of asylum seekers are a rewarding, meaningful, and effective way for healthcare providers to engage with a unique population while providing a valuable service [1, 2]. Although the task of providing such an evaluation may feel daunting to some at first, all healthcare providers have the requisite skills and talent to complete high-quality evaluations that can be of great service to immigrants who are fleeing torture and persecution. It is important to remember that mental health evaluators do not, and should not, feel the pressure to play the role of an attorney. The job of a mental health provider is to conduct a psychological assessment that is similar in many ways to the assessments they conduct on a daily basis. The primary purpose of any forensic evaluation is to provide an objective assessment of a client's presentation, which may include but is not limited to their history, physical or mental status examination, diagnostic assessment, documented symptoms, and/or any other issues pertinent to testimony or the client's present or future treatment needs. Meanwhile, the development of a therapeutic or treatment relationship is contraindicated in forensic evaluations, as will be further discussed.

The majority of forensic psychological evaluations screen for mental health conditions and may comment on memory, executive functioning skills, and/or basic cognitive skills. However, in-depth batteries of neuropsychological or psychological testing would typically require an expert evaluator specialized in these topics. Moreover, most psychological evaluations for asylum seekers do not comment on competency to stand trial or capacity to make medical decisions. Should a clinical

S. S. Sidhu (✉)
Department of Psychiatry, University of California San Diego School of Medicine, San Diego, CA, USA

O. Shadid
Department of Psychiatry and Behavioral Sciences, University of New Mexico School of Medicine, Albuquerque, NM, USA

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situation arise in which the mental health professional is concerned about competency or capacity, this concern should be relayed to the client's attorney, who can arrange for a separate evaluation to be conducted.

There are a multitude of potential benefits that a mental health evaluation can provide for asylum-seeking immigrants and their attorneys. Figure 4.1 outlines the benefits of the evaluation not only in the strengthening of the case, but also for the asylum seeker personally.

The presence of an objective and independent psychological legal affidavit (the signed and dated psychological evaluation) can be supportive evidence for the asylum seeker's testimony. Without a supporting objective forensic psychological evaluation, the client is at the mercy of whether the opposing attorney and immigration judge believe their story. The asylum seeker is often at a disadvantage in this circumstance because many have little formal education or understanding of the legal system. However, as noted in a study by Lustig, asylum seekers with medical evaluations performed by a healthcare professional were granted asylum 89% of the time compared with the national average of 37.5% in 2008 [2]. Given that the denial of asylum cases nationally has been gradually increasing from 42% in 2012 to 73.7% in 2020 [3], psychological evaluations may be even more valuable now than at any other time in recent history.

Forensic medical and psychological evaluations can be helpful in assisting clients, who, if deported are at significant risk of severe consequences. According to a report from Human Rights Watch, at least 138 Salvadoran asylum seekers were killed after deportation from the United States between 2013 and 2019 [4]. The data suggest that

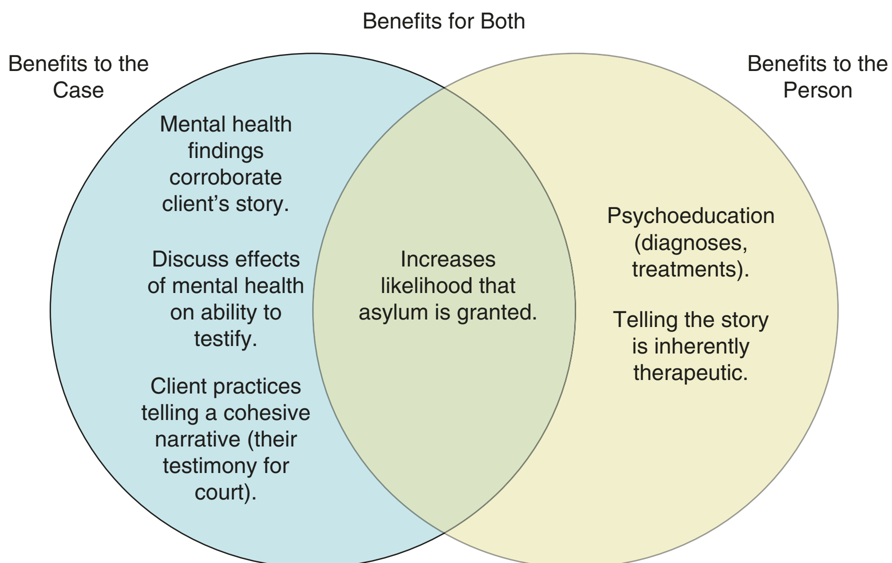

Fig. 4.1 Benefits of forensic psychological evaluations of asylum seekers. (1. Lustig et al. [1]. 2. Cortez et al. [6])

the actual figures are likely significantly higher, given the number of outcomes which are not reported. This report also documents at least 70 individual cases of deportee subjugation to sexual violence and torture by gangs. Some of these individuals were unaccounted for following their return, and the report establishes a clear link between the killing or harm experienced by deportees and the reasons they had fled El Salvador initially.

Mental Health Prevalence in Asylum-Seeking Populations

As a population, asylum seekers have a significant risk of suffering from mental health problems, particularly depression, anxiety, and post-traumatic stress disorder (PTSD) [5]. Data suggest that asylum seekers who are detained suffer from greater rates of mental illness than asylum seekers who live in the community, thus suggesting that detention itself contributes to worse mental health [7, 8]. Figure 4.2 [9] compiles data from three individual studies on the prevalence of mental health conditions in parent and child detainees. Evaluators must consider the potential effects of detention on the client's assessment, recognizing that the client's mental

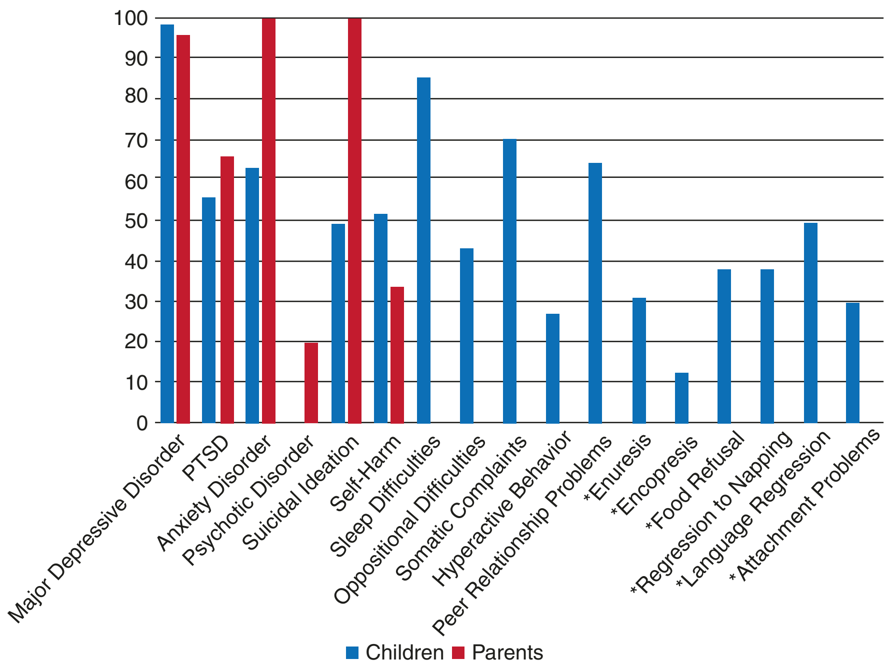

Fig. 4.2 Rates of mental illness reported across three studies of detained migrants and their parents. (Note: Adapted from von Werthern et al. [8], https://doi.org/10.1186/s12888-018-1945-y under Creative Commons Attribution 4.0 International License (http://creativecommons.org/licenses/by/4.0/) as published in Sidhu and Vasireddy [9]. PTSD = posttraumatic stress disorder). Reprinted with permission by Elsevier

health is the result of biological diathesis, development, environment, and, importantly, migration experiences. Pre-migration traumas include experiences in the home country prompting migration, while peri-migration trauma includes assault, kidnapping, thirst, sleep deprivation, witnessing violence, near-drowning, and outdoor exposure while migrating. Post-migration trauma includes experiences in detention, the stress of resettlement, the loss of home, and separation from family [7, 9, 10].

While asylum seekers have endured traumas and inhumane treatment, their mental health is also notable for its remarkable resilience. Individuals applying for asylum demonstrate hope for a better future, affirming the belief that their life is worthwhile. Eliciting this positive side of each person's narrative, in addition to the traumatic events, can provide strength and a sense of integration during the evaluation.

Overview of the Evaluation Process

While there can be considerable variation in the asylum evaluation, a majority of cases follow a typical approach (Table 4.1). Initially, an immigration attorney requests a mental health evaluation for their client. Some immigration attorneys belong to larger national networks such as Physicians for Human Rights, while others are part local networks with established asylum clinics. Immigration attorneys in rural areas with a shortage in mental health providers may have difficulty finding an evaluator, and may have to arrange a tele-video or telephonic interview for their client. Once connected, if both the provider and attorney agree on the primary purpose of the evaluation and the parameters of the case, the attorney will then assist in arranging an evaluation for their client. This evaluation may take place in the community; within a detention center or other forensic center; or through telehealth equipment in which case the client is evaluated in a home, shelter, or refugee camp. The length of evaluations can vary considerably depending on the complexity of the case, the type of questions being asked, the preference of the mental health provider, and the amount of time available for both the client and the provider. Generally, the majority of evaluators plan to spend anywhere from 2 to 4 hours per evaluation.

Getting Started

A broad range of professionals are able to conduct mental health evaluations for asylum-seeking immigrants. In some jurisdictions, doctoral-level mental health providers such as psychiatrists and psychologists perform evaluations more commonly. However, in other settings, mental health evaluations are conducted by counselors, social workers, and therapists. Primary care physicians and advanced practitioners

Table 4.1 Forensic psychological evaluation of asylum seekers checklist

Getting started

□ Trainings.
  □ In-person.
  □ Remote.
  □ Individual mentorship.
□ Practice with training video.

Preparing for a forensic psychological evaluation of an asylum seeker
□ Discuss case with attorney, including the specific needs, circumstances, and logistics. □ Review documents provided by attorney (Declaration, I-589, Credible Fear Interview, etc.). Provide feedback to attorney regarding errors or areas of concern in documents. □ Prepare template and customize based on client's documents. □ Anticipate which diagnostic criteria and/or scales will be needed. □ Ensure access to a safe and confidential site with high-quality interpretation.
Conducting the interview
□ Introduce self. □ Confirm client's identity. □ Explain purpose: Only assessment, no treatment. □ Explain confidentiality. □ History-taking and diagnostic screening with appropriate breaks. □ Conclude by thanking client, highlighting client resilience, and explaining affidavit process.
Post-interview
□ Write affidavit. For complex cases seek additional guidance or mentorship. □ Send affidavit to attorney and request feedback. □ Make any suggested edits to affidavit and resubmit to attorney. □ Follow-up with attorney regarding case outcome. □ Customize your template to improve effectiveness based on case outcomes, feedback from either attorney or the judge, the type of case or humanitarian relief, client or population demographics, local jurisdiction, and other unique legal or mental health circumstances. □ Monitor self for secondary traumatic stress and burnout.

are able to perform these in addition to their forensic physical evaluations, although some will feel more comfortable doing so after additional training or a mental health refresher course.

Students, residents, fellows, and professionals who are not independently licensed are able to carry out mental health evaluations for asylum seekers. However, these evaluations must be supervised by a fully licensed professional, ideally with experience in conducting such evaluations, who will then cosign the affidavit of the student or professional who is not independently licensed.

For many interested mental health providers, the most difficult hurdle to providing psychological evaluations for asylum seekers may simply be an uncertainty about where to begin. Mental health providers are not typically given extensive training as part of their education about how to interface with the legal system. Books chapters, articles, and formal trainings as offered at conferences or by national organizations, and informal mentorships are each avenues for learning to conduct forensic evaluations and prepare affidavits. Practice via observing mock asylum interviews and reviewing sample affidavits further aids evaluators in feeling more comfortable in conducting evaluations aptly and independently.

Preparing for the Psychological Evaluation

Once a request is received from an immigration attorney, an asylum clinic, or an asylum network, the evaluator can begin preparing to conduct the forensic psychological evaluation. Prior to the interview, it is important to review any initial documentation, such as the client's Declaration or Statement of Facts, I-589 Application, Credible Fear Interview, medical records, or any other documents made available by the attorney. First, ensure that all documents are consistent and accurate, as some may contain anything from simple typos and clerical errors to major misunderstandings of the case. Next, review documents carefully for emotionally charged traumatic experiences that may have predisposed the client to a mental health diagnosis. Lastly, assess for any other factors that could either indicate a history of functional impairment or could cause difficulty in testimony.

The evaluator should also work with the attorney to discern whether the evaluator is a good fit for the evaluation based on their identifiable characteristics. For example, an asylum seeker from a culture with gender segregation may feel uncomfortable with a differently gendered evaluator. Similarly, if there are characteristics about the evaluator that remind the asylum seeker of an individual who traumatized them, the interview may be uncomfortable to the point of re-traumatization for the client and provide less reliable information for their case.

Conducting the Psychological Evaluation: Context, Introductions, and Confidentiality

Immigrants fleeing persecution interface with a dizzying array of authority figures throughout their journey to and through the United States. This process often begins either at the border with Immigration and Customs Enforcement or while crossing the border with Customs and Border Patrol. Asylum seekers will likely transit through several facilities (holding center, processing center, detention center) prior to meeting with a mental health evaluator as they await their hearing. Thus, even if asylum seekers are briefed by their attorney that a mental health provider will be coming to evaluate them, many may not fully understand the purpose of this evaluation or the role of the evaluator.

Given the whirlwind of procedural meetings and interactions that asylum seekers may have with a multitude of individuals, it is of the utmost importance that the evaluator introduce themselves as someone working with their attorney, clearly state their profession, and explain their role as an evaluator to the client. Once the client is comfortable with this information, notify the client that the evaluation may take several hours and that they are in control of the interview, and that they can take breaks or stop at any time. Note also that this interview is completely voluntary and their autonomy will be respected. Notify the client that they should feel free to express how they are feeling throughout the interview, or if they have questions at

any time. To further elucidate the nature of the evaluation, it is useful to state clearly that while the evaluator is a mental health professional, they will not be providing the client with specific treatment plans after the evaluation or treating any mental health problems going forward. Evaluators can ensure the client understands that the written report of the evaluation will be provided to the attorney for use in their case, rather than used in their psychiatric treatment.

Next, the limited confidentiality of the exam must be explained to the client. Forensic psychological evaluations are partially confidential. They are confidential in the sense that the evaluator is not permitted to discuss the client's case outside of the legal system without their express consent. However, within the confines of the legal system, the evaluation is not confidential as it can be viewed by the opposing attorney and the judge. Only proceed with the remainder of the evaluation if the client voices an understanding of the limits of confidentiality in a forensic evaluation, and consents to the evaluation. Should the client be a minor or an adult with a guardian, the client should assent to the evaluation and the limits of confidentiality, while their caretaker consents.

Conducting the Psychological Evaluation: Interviewing the Client

It is common for asylum seekers to exhibit a broad range of emotion while telling their story and answering very detailed and specific questions about their traumas. Some may become emotionally reactive while others may shut down completely. Tearfulness to the point of sobbing, anxiety to the point of hyperventilation and a panic attack, and reexperiencing to the point of dissociation or even psychosis are all understandable reactions. The evaluator must carefully gauge the client's readiness to continue in these circumstances. While in rare circumstances the interview may need to be discontinued and resumed at a later time, the vast majority of clients are able to continue when given a short break and control of the interview ("*Let me know when you are ready to go on*"). Such changes in affect and the topics precipitating them should be noted in the mental status exam.

As mentioned previously, forensic evaluators are not permitted to engage in a therapeutic relationship with their client in order to maintain objectivity. That said, forensic evaluators can be empathic and treat their clients humanely. Offering a tissue or a drink of water can be meaningful gestures for a client discussing their traumatic narrative. Empathic statements which neither confirm nor deny the truthfulness of the client's report can also be utilized, such as, "*I can see that this is really hard for you right now*," or "*I can see that talking about this brings up a lot of emotion for you*." In some cases, an empathic statement can even be used to generate more information for the report, such as "*My goodness, how do you make sense of all that has happened to you,*" or "*How have you been able to endure so much?*" As mental health professionals are not experts in determining the accuracy and veracity

of the client's narrative, evaluators can focus on the client's emotional experience, rather than on the event itself.

Other supportive interventions include setting norms, which can be done broadly without speaking specifically to the veracity of the client's reported history. For example, an evaluator might offer, "*No one deserves to be treated in a manner as you describe*" to a client who was sex trafficked or underwent female genital mutilation. Some evaluators will use basic grounding techniques for clients who begin to dissociate, such as helping them to feel anchored in their feet to the ground, being mindful of engaging their senses in the room, or reorienting them to what is occurring. However, other evaluators may feel this is too close to therapy and would refrain from using such techniques.

Drawing from approaches employed in psychotherapy modalities, emphasizing a client's resilience can offer strength to them in the moment as they tell their story, while also reminding them of the strength they have displayed throughout their trauma experience and migration journey.

Telephonic interviews present a potential challenge for the evaluator as it makes it more difficult to observe when the client is in distress. The evaluator can inform the client that typically mental health evaluations are done in person and the evaluator can observe when someone may be in distress and in need of a break or confused by a question. In a telephonic or tele-video setting, the client may need to be more vocal about expressing when they would like to pause the interview or when a question was unclear. If an interpreter is physically present with the client, the evaluator may ask the client for consent so that the interpreter may inform the evaluator of any distress or confusion the client exhibits [11].

Lastly, culture can play a significant role in how a client engages with an evaluator, and ultimately how a client testifies. While the mental status exam will be explored further in this chapter, it is worth noting that briefly discussing with the client at the onset of the evaluation how mental health is viewed in their culture, their comfort with the evaluator and the evaluation, and the way that individuals typically express emotions in their culture of origin. For example, a client from a culture in which the expression of negative affect is considered rude may display incongruent responses such as smiling when talking about trauma. The evaluator should not hesitate to ask the client openly about the expression of their affect. Understanding this dynamic more fully at the outset will help the evaluator to understand the context for the client's responses and reactions to questions. In another example, data suggest that people with lower levels of education, as well as people from more collectivist societies, are more likely to acquiescence bias when questioned. Awareness of this can be helpful when assessing the intent of a client's answer and when phrasing questions for clients with such backgrounds [12].

Conducting the Psychological Evaluation: Contextual History

While there are many ways to effectively conduct a psychological evaluation, one logical starting point is with the contextual history, particularly when interview time

is limited. This is an opportunity for the client to express what life was like in their country of origin for individuals who shared the same identifiable characteristics as them. Citing articles that document the level of dangerousness in any given location is not as effective in this situation as utilizing the client's own words and experiences to describe the conditions from which they fled. For example, if a client is claiming that they were tortured and persecuted on the basis of belonging to a minority political group, it would be helpful for the court to understand how the predominant political group typically treated political opposition. Was the client the only one who was treated unfairly, or was this common among their associates as well? It is important to establish at this stage whether or not the client and other members from the client's group could avail themselves of police protection or move to another neighborhood or city within the country of origin, and the reasons they may have been able to do so or not. Personal stories and detailed examples help to illustrate the circumstances for the immigration judge and frame the narrative for the remainder of the evaluation. A contextual history can also emphasize life experiences that may predispose the client to develop mental health sequelae. For example, a transgender child who was abandoned by their family, bullied by peers, rejected by romantic partners, and then subsequently targeted by gangs and mocked by police would be at risk for a multitude of negative physical and emotional outcomes associated with adverse childhood experiences and psychosocial adversity. While mental health assessments document the client's subjective experience of persecution, attorneys may also be working with country experts who provide assessments that further describe conditions for persecuted groups in the client's country of origin.

Conducting the Psychological Evaluation: Focused Trauma History

Given the importance that trauma plays in psychological evaluations of asylum seekers, it is important to conduct a focused trauma history during the evaluation. This is one of the most critical sections of the affidavit, and high-quality reports have a very developed trauma history. In many instances, the psychological evaluation elicits details or traumas that were not disclosed previously, while in other instances it provides additional detail and nuanced understanding to known traumas. While qualitative details can be helpful, quantitative details can sometimes cause a client's case to lose credibility erroneously. For example, if an evaluator documents that a client was attacked by seven individuals wearing blue, but the client reported to an immigration official that they were attacked by six individuals wearing green, this small amount of a discrepancy can cause an immigration judge to become suspicious of the client's story. This is also true for other quantitative details, such as dates and times. However, qualitative details can be important in describing how the client was harmed, and in showing how damage was done to the client. This type of detail could include, but is not limited to, the type of trauma, who the attackers were, the instruments used, the type of injuries, how the asylum seeker was injured, the type and duration of the pain, and whether or not there was any bleeding, bruising,

burning, broken bones, or other forms of physical damage. In the case of sexual trauma, it can be important to ask potentially uncomfortable questions in a gentle manner, such as whether or not there was bleeding or lacerations, the type of any penetration, any resultant difficulty urinating or defecating, or persistent scarring. Occurrence and symptoms of a potential traumatic brain injury are also necessary to include, such as blows to the head, bleeding and/or bruising to the head or face or neck, whiplash, loss of consciousness, dizziness, unsteadiness, gait abnormalities, decreased reaction time, and short- or long-term headaches or memory difficulties.

It can also be helpful to ask about short- or long-term impairments in function that have resulted from trauma-related injuries. It is essential to note whether a client or client's family member's life was threatened or if they feared for their life during an event, as threats and fear of injury are considered inherently traumatic, even without associated physical injury. Also important is to ask about what was said by perpetrators during the trauma. Using the aforementioned example, if a member from a political minority was tortured, it can be helpful to note that the client heard their torturers comment on the client's political party at the time of the trauma.

In the event that a client has endured multiple traumas, it can be helpful to ask them initially about the traumas that impacted them the most. Further, traumas experienced during migration, on apprehension, in detention, or occurring on United States soil should be clearly documented with the accompanying impacts on mental health and functioning.

Conducting the Psychological Evaluation: Social History

There are several elements of the social history which could impact the client's testimony and case. For example, level of education can have a significant impact on testimony. If a client has little formal education and the judge is asking complex questions, the likelihood of a reliable or consistent answer is low, given the client's likely level of skill in rhetoric and vocabulary. Individuals with less education may not have had formal practice in skills such as seriation or sequencing, which could make remembering certain details difficult. The client should be asked what they would want their life to look life if granted asylum in the United States and if they have a spiritual or religious practice, as these small personal details can help paint a complete and holistic picture of the client. The client's number of dependents should be accurately listed across all documentation. In some cases, elements of the social history will reinforce the that the client is part of the identifiable group that caused them to be targeted.

Conducting the Psychological Evaluation: Substance Use History

The implications of substance use in humanitarian relief cases are multiple and complex. Most evaluators will include at least a basic overview of the most

commonly used substances in their report. A judge may be less likely to grant an individual asylum if they believe that the individual is likely to develop a substance use disorder in the United States, or if they think the client's memory of trauma is compromised by substance use. If significant substance use is present, a mental health evaluator can potentially explain this as self-medication for an untreated mental health condition if one exists. In this case, the client would be less likely to continue using substances were the mental health condition adequately treated.

A history of in utero exposure to substances, however, should always be documented, as this can explain potential executive functioning difficulties in the client (see section on *Past Medical History*). Forced or injected drug use by gangs, police, or other authority figures should also be reported as this is a violation of the client's autonomy over their body and can cause considerable harm.

Conducting the Psychological Evaluation: Past Mental Health History

A fairly standard past mental health history is warranted in a forensic psychological evaluation for asylum seekers. This should include prior counseling, inpatient hospitalizations, substance use treatment, suicidal and/or homicidal ideation, self-harm, auditory or visual hallucinations or delusions, a history of violence, and psychotropic medication trials. It would be relevant to include any treatment that the individual received while in detention or in the community while awaiting their immigration hearing. If the individual required treatment and this was neglected, that would also be noteworthy. If the client has a history of psychiatric struggles, consider noting that high-quality psychiatric care, such as is available in the United States, would likely be beneficial to the patient's mental health and functioning. If the client reports acute psychiatric symptoms, such as suicidal ideation with a plan and intent, or if the client is observed to be experiencing hallucinations and delusions to the extent that it impacts their safety, this should be reported to the attorney and/or detention center immediately. If the client presents with subacute symptoms, such as passive suicidal ideation or the inability to perform basic activities of daily living, authorities should be made aware that these symptoms are to be followed closely.

Conducting the Psychological Evaluation: Past Medical History

A basic medical history should be included in the psychological evaluation. Developmental issues, such as in utero substance exposure or other insults to the brain, should be listed. A history of traumatic brain injury or concussion is especially important in this section, as is the documentation of any significant injury or

impairments in functioning from past torture or persecution. Seizures must always be ruled out in a mental health evaluation. Current medications should be noted, as well as a basic review of systems including cardiovascular, respiratory, endocrine, and gastrointestinal health. If the individual required treatment and this was neglected, that would also be noteworthy.

Conducting the Psychological Evaluation: Physical Exam

Many mental health providers do not have the same level of comfort and experience as medical doctors in providing physical exams. Moreover, the intimate nature of psychological evaluations would make genital exams, breast exams, or evaluation of any private region unethical. Despite these limitations, some mental health evaluators choose to document scars or physical exams and the mechanism by which the patient reports that such injuries were obtained. By doing so, the provider is not stepping outside of their area of expertise, but are rather merely reporting what the client has stated. For example, if a client was struck on the forehead and has a scar, the evaluator can document a "*hypopigmented lesion on upper right temporal legion which client states is from being struck with the butt of a rifle*." Similarly, regarding functional impairment, the evaluator could document that "*the client reports that they are unable to sit for long periods of time after being struck in the knee with the butt of a rifle, which could impact testimony*." Scars in more private areas of the body can be described verbally by the client, and this verbal description can be included in the report. Body diagrams can be a helpful tool to document scars, and are available in Appendix 2.

Conducting the Psychological Evaluation: Targeted Diagnostic Screening

A thorough diagnostic mental health screening is arguably the most important portion of the entire psychological interview of asylum seekers. The presence of a mental health diagnosis can be a way of demonstrating objective harm experienced by the client at the hands of the alleged perpetrators. At the same time, a mental health diagnosis can also explain why the client's presentation in court might vary based on their experiences.

While a thorough diagnostic interview based on criteria outlined in the *Diagnostic and Statistical Manual, Fifth Edition* (DSM–5) [13] remains the gold standard, there are a number of tools that can provide numerical scores for diagnoses (Table 4.2). The value of psychological scales, screening tools, and questionnaires (Table 4.2) is their role in adding an objective measure to the report, which can lend credibility in some jurisdictions. They are also very helpful to less

Table 4.2 Psychological scales, screening tools, and questionnaires

Trauma disorders	PTSD Checklist (PCL-5) Life Events Checklist (LEC-5)
Depressive disorders	Patient Health Questionnaire (PHQ-9) Hamilton Depression Rating Scale (HAM-D)
Bipolar affective disorders	Young Mania Rating Scale (YMRS) Mood Disorder Questionnaire (MDQ)
Anxiety disorders	Hamilton Depression Rating Scale (HAM-A): adults Screen for Child Anxiety Related Disorders (SCARED): children

experienced evaluators who are not as well-versed with DSM–5 criteria, as most scales aim to capture DSM–5 criteria using standardized methodology. However, many of these scales are not validated across cultures, and some can add significantly to the time required to complete the evaluation. In addition, the use of scales can create ethical dilemmas for evaluators. For example, if a client meets all DSM–5 criteria for PTSD but they do not meet the cutoff score on a scale, then the court would receive conflicting information, which could be interpreted as lack of credible testimony.

Some immigration judges and government attorneys may become suspicious if clients have too many psychiatric diagnoses, as this may prompt the perception that clients are endorsing a "pan-positive" review of systems. Thus, it is important to include the diagnoses that cause the greatest impairment while omitting others if full criteria are not met. In the rare case of individuals who meet full criteria for a multitude of psychiatric diagnoses, the reason for these diagnoses, severity, and complexity of the case should be clearly explained in the affidavit.

When screening for mental health disorders, it is critically important to provide additional detail beyond the initial question. For example, stating "*Client screens positive for PTSD*" provides far less detail and evidence than "*Criterion B2: client describes recurrent distressing dreams of the event in which they will dream that they are being physically attacked and awaken in a cold sweat, with the feeling that they were being restrained again and not remember where they are*." Symptoms for every mental health condition should be listed criterion by criterion.

The most common diagnoses in asylum seekers are post-traumatic stress disorder (PTSD), major depressive disorder, and/or an anxiety or adjustment disorder. Less common diagnoses include a psychotic disorder, bipolar disorder, cognitive disorder, or a developmental disorder/intellectual disability.

The core features of post-traumatic stress disorder include symptom clusters in reexperiencing, avoidance, arousal, and negative cognition and mood. For children, recurrence symptoms may be more likely to manifest in play, such as imagining facing monsters or acting out the trauma repeatedly.

Major depressive disorder is diagnosed in the context of at least 2 weeks of decreased mood and/or loss of interest or pleasure nearly every day, with at least five accompanying symptoms. Meanwhile, the client should be assessed for bipolar disorder and experiences of mania. Key features of mania include discrete periods of time wherein a person had a decreased need for sleep for several days to many

months, elevated or irritated mood, grandiosity, and increased goal-directed activity and recklessness, outside of the context of substance use.

In some asylum-seeking samples, anxiety is documented in a high percentage of individuals [5, 7, 9], especially in the context of their immigration cases. Anxiety secondary to post-traumatic stress disorder or an adjustment disorder should be effectively ruled out before diagnosing an additional anxiety disorder.

Assessing psychosis in the context of an asylum evaluation can be complex and requires astute clinical skills. Hallucinations and delusions are much more likely to result from trauma and mood disorders than from a primary psychotic disorder such as schizophrenia or schizoaffective disorder. Moreover, many psychotic symptoms may be culturally normative or mood congruent, and such symptoms are more common in younger children. Paranoid delusions are much more common in immigrant populations than the general public, which is understandable given migration traumas and difficulties in assimilation. When present, these should be separated from severe PTSD symptoms such as fear of being re-traumatized. Substance-induced psychosis should be ruled out as well. The presence of multiple simultaneous voices, negative symptoms, disorganized speech, disorganized thought, or disorganized behavior are concerning for a primary psychotic disorder (such as schizophrenia or schizoaffective disorder). PTSD-induced dissociation can also mimic psychosis; however, in PTSD, the dissociation is not permanent and waxes and wanes with trauma symptoms whereas in a primary psychotic disorder these symptoms are typically chronic and fixed.

The Mental Status Exam

In addition to psychiatric scales and the physical exam, the mental status exam is the portion of the assessment wherein the clinician documents objective findings of the client's presentation, thus providing insight into the client's emotional and cognitive state (Fig. 4.3). Aspects of the mental status exam may reflect both a client's history, as well as their current functioning. The client may present a more pronounced affect with tearfulness or distress while in the safe space of an empathic psychological evaluation than may manifest in the courtroom. Thus, it can be helpful to have documentation of this affect in the legal record.

If the client is wearing an item of jewelry or has a tattoo that aligns them with certain social groups, these might be noted. Gender presentation may be noted as well, particularly if the client claims persecution based on gender identity.

Behavior is important to describe, particularly gestures of distress such as when a client holds their head in their hands, fidgets, looks at the ground, takes deep breaths and sighs, requires multiple breaks, clenches their fists, sweats, talks in either a loud or soft manner that demonstrates activation of fight-or-flight reflexes, and the nature of eye contact. Affect may shift throughout the interview and such alterations may be instrumental in acquiring a more nuanced, dynamic formulation of the client. For example, a client may be relatively comfortable relaying their

MENTAL STATUS EXAM

Client Name: ______________________ Date: __________

APPEARANCE

Grooming	◻ Neat	◻ Disheveled	◻ Inappropriate	◻ Bizarre	◻ Other
Complexion	◻ Dark	◻ Tan	◻ Fair	◻ Suntanned	◻ Other
Adornment	◻ Tattoos	◻ Jewelry	◻ Piercings	◻ Other	
Comments:					

ATTITUDE

◻ Cooperation	◻ Friendly	◻ Apathetic	◻ Withdrawn	◻ Hostile	◻ Other
Comments:					

BEHAVIOR

Eye Contact	◻ Normal	◻ Intense	◻ Avoidant	◻ Intermittent	◻ Other
Motor Activity	◻ Normal	◻ Restless	◻ Tics	◻ Slowed	◻ Other
Comments:					

SPEECH

Comment on volume, rate, prosady, and latency.
Comments:

THOUGHT

Process	◻ Linear	◻ Perseverative	◻ Tangential	◻ Diaorganized	◻ Other
Content	◻ Suicidality	◻ Homicidality	◻ Delusions	◻ Hallucinations	◻ Other
Comments:					

EMOTIONS

Mood	*Use patient's own words (e.g. "pretty down")*				
Affect	◻ Full	◻ Flat	◻ Inappropriate	◻ Labile	◻ Other
Comments:					

COGNITION

Orientation	◻ Normal	◻ Person	◻ Situation	◻ Place	◻ Time
Memory	◻ Normal	◻ Short-term	◻ Long-term	◻ Other	
Attention	◻ Normal	◻ Distracted	◻ Other		
Insight	◻ Good	◻ Fair	◻ Poor	◻ Limited	◻ Impaired
Judgement	◻ Good	◻ Fair	◻ Poor	◻ Limited	◻ Impaired
Comments:					

Fig. 4.3 Mental status exam form

trauma if they have received mental health care, have had time to process and recover, are feeling safer since immigrating, or if they possess significant resilience. However, when asked what would happen if they were returned to the country where they suffered the persecution or torture, the client may abruptly begin to cry or become disconnected and dissociate, especially if the client feels overwhelmed

by the potential suffering they could endure upon forced deportation. Alternatively, a client may display a brightened affect when discussing their children and their improved welfare since immigrating. When assessing cognition, such as attention, memory, orientation, insight, and judgment, it is important to factor in educational history and culture.

The following is a completely fictional sample mental status examination:

> *Alejandra is a 28-year-old transgender woman appearing older than stated age. She wears a rosary necklace which she clutches during the interview, particularly during times of stress. Her hair is pulled back into a bun and dyed purple. She is well groomed and is wearing pink lip gloss, wearing standard issue detention center uniform. Alejandra is highly cooperative and engaged with the interview. She has good eye contact, but will lower her eyes as expected when talking about her traumas. She was observed being tearful throughout several portions of the interview, ranging from brief tearfulness to outright sobbing. During some portions of the interview, she laid her head down to rest, while at other times she stared blankly off into the distance when discussing difficult elements. Her speech is very soft and slow, almost a whisper. Her motor exam is significant for psychomotor retardation or slowing. Her mood is, 'I feel like I lost a piece of soul that I never got back after I was attacked.' Affect tearful, dysphoric, and anxious. Thought process is linear, logical, and congruent with her affect. Thought content is without any hallucinations, delusions, suicidal ideation, or homicidal ideation. Insight and judgment appear good based on interview.*

General Tips for Writing an Effective Psychological Affidavit for Asylum Seekers

The contents of the affidavit are ultimately the only information from the mental health evaluation that will be available for use in the client's case; thus, what is written is crucial.

When documenting the client's contextual history, trauma narrative, and psychiatric symptoms, the clinician should focus on the client's subjective experiences, rather than quantitative details. This is particularly important as mental health clinicians are not experts in determining what events have or have not occurred, though they are experts in describing a person's emotional experience and impact of events on a person's mental health. Words such as "torture," persecution," and "competency" should also be avoided, as these are legal determinations. Meanwhile, psychiatric terminology may be employed when making an official diagnosis or explaining medical phenomena, but consider also explaining such terms in lay language, as most judges and attorneys are not familiar with the technical language of psychiatry and medicine.

A few disclaimers can be helpful to explain this history to the reader of the report. For example, given the limitation in time, the focused trauma history may describe some reported traumas in detail but may not be a comprehensive list of every trauma experienced by the client. This is helpful in the event that the client shares different traumas with immigration authorities than they do with the

psychological evaluator. Moreover, a history of one significant lifetime trauma is all that is required for a diagnosis of Post-Traumatic Stress Disorder (PTSD). It is also helpful to note that quotations are paraphrased and not exact quotes in the event that the client had used slightly different quotations in other immigration documents.

Tips for Writing an Effective Psychological Affidavit for Asylum Seekers: Assessment

The assessment and discussion sections of the affidavit are most likely to be of direct benefit and utility to the attorney and the client. Since they are relevant both to corroborating harm reported and to diagnostic consideration, it would be reasonable to begin with an assessment of consistency. The purpose of the consistency assessment is to state whether the evaluator found the client's reported history to be consistent with a history of traumatization. An assessment of whether the psychological findings the client reported are typical reactions to extreme stress may also be documented in this section. The evaluator may also use qualities of the interview in their assessment of consistency. For example, the evaluator may find that the emotional responses the client exhibited during the interview are consistent with the experiences the client reported. This section can also offer an opportunity to note whether the evaluator feels the client endorses symptoms indiscriminately or if they endorse some, rather than all, symptoms when they are queried.

Tips for Writing an Effective Psychological Affidavit for Asylum Seekers: Diagnosis

Following the assessment, the evaluator should include whether the client meets criteria for any diagnoses described in the DSM-5. These should be clearly labeled with the accompanying ICD-10 F-Codes (e.g., "*Post-Traumatic Stress Disorder – F 43.10*"). The evaluator may also include "rule-outs," that is, diagnoses for which the client meets most, but not all, of the criteria or that would require longitudinal assessment or collateral information to diagnose with more precision. As the term "rule out" can be confusing outside of the medical community, the evaluator may employ terms such as "provisional" or "probable" as alternatives. If the client meets criteria for multiple diagnoses, it can be helpful to list them in order of most to least impairing, in order to emphasize any severity of the primary diagnosis. For clients who previously met full DSM-5 criteria that have since resolved, the terminology "history of" can still be a helpful objective measure of harm suffered.

Tips for Writing an Effective Psychological Affidavit for Asylum Seekers: Discussion

In the discussion section, the evaluator can offer the attorney and judge information on the client's ability to testify, particularly noting findings or framings that may lead to impairment in this ability. Aspects that can affect ability to testify range from the effects of psychiatric or physical symptoms to cognitive or educational status to cultural factors to qualities of resilience.

If the client is found to have suffered from trauma, the evaluator can discuss how impaired memory is not only a symptom of trauma disorders, but also consistent with neurobiological understandings of the neurotoxic effects of chronic stress, via cortisol elevation, on the hippocampus, the brain's memory center [14]. Similarly, impaired concentration, memory, and cognition are also associated with depressive disorders, anxiety disorders, and sleep disorders. Multiple cognitive domains including memory and executive functioning may also be affected by any traumatic brain injuries suffered by the client. If there is concern for baseline neurocognitive deficits, such as in a client with intellectual disability or a dementia, this should also be noted as a possible impairment in ability to testify.

Clients suffering from a trauma disorder may also have difficulty testifying should they experience "intrusion symptoms" such as flashbacks, distressing memories, or dissociation while testifying. This risk can be mitigated by acknowledging triggers of intrusion symptoms and minimizing their presence in the courtroom. Clients may have physical conditions, whether from the traumas or as general medical conditions, that may impair their ability to testify. Examples of these include a client who was physically assaulted and who has difficulty sitting secondary to back pain or a client with severe headaches who may require access to a medication to mitigate the pain and allow improved ability to focus. Adverse childhood experiences affecting the development of lifelong medical and psychiatric difficulties should be noted as they too can influence testimony.

If a client is a child, it can be useful to describe what developmental stage they are in, noting the competencies they have attained and those that they have not yet likely mastered. For example, a child in the stage of "Concrete Operations" may not be able to sequence and consistently tell stories chronologically. A client at this stage would also have difficulty understanding and communicating abstract topics. If a client, whether child or adult, has not completed a high school diploma, it is important to note this, as the client may have difficulty with both vocabulary and rhetorical skills possessed by those who have completed higher years of formal schooling. Adults with developmental or intellectual disorders may present in a manner more typical of a child or adolescent.

Other aspects of the client's evaluation may be useful to discuss, in order to provide the attorney and judge with a stronger sense of the client's presentation and biopsychosocial formulation. An evaluator may discuss how the affect displayed by the client during testimony may appear incongruent with the topics they are discussing; for example, if a client laughs or has a flat affect when discussing trauma. The evaluator can comment about how this incongruence may be a coping mechanism in the

face of extreme stress or may be culturally normative, should the client be a part of a culture where crying in public is discouraged or considered impolite. Additionally, the evaluator may discuss the mental health impacts of detention and family separation on a client to lend insight to their presentation, ongoing stressors, and psychiatric risk factors [9, 10]. Finally, when working with children who have been traumatized, the evaluator can discuss findings in the literature that suggest the parents of such children may have also been traumatized themselves or may experience significant guilt related to their child's trauma, thus leading to inaccuracies regarding how the child is coping with trauma [15].

Tips for Writing an Effective Psychological Affidavit for Asylum Seekers: Conclusion and Signature

The affidavit should conclude by restating the mental health diagnoses and explaining that there are highly effective, evidence-based treatments available for the client within the United States for said diagnoses. The evaluator should note whether the availability of such treatments may be limited in the client's country of origin, which could lead to psychiatric decompensation. It is often imperative to discuss that risk of decompensation could be expected to increase should the client be forcibly returned to the place of their traumas and risk mitigated by placement in an environment that is safe and allows for rehabilitation and healing. Lastly, the evaluator will write that they swear by penalty of perjury that all information contained in the affidavit ("herein") is truthful to the knowledge of the evaluator, and sign, and date the affidavit for submission.

Follow-Up

Once drafted, the affidavit should be sent to the client's attorney for review. The attorney may ask clarifying questions or comment on potential considerations unique to the courts in which the client's case will be heard. The evaluator may choose to edit the affidavit to more clearly document their findings or to communicate to the particular court, but they are under no obligation to incorporate attorney feedback. The evaluator must remain objective; the attorney is the client's advocate but the role of the clinician is to provide objective evidence. If a dispute arises, it is best to discuss with the attorney and clarify, although this may not always be possible. Following this revision process, the evaluator will finalize, sign, and date the affidavit. In the majority of cases, this will conclude the asylum evaluation process. However, in some cases attorneys may contact the evaluator for additional items. For example, the judge and or government attorney may have additional questions which could be addressed by the evaluator in the form of an informal consultation with the attorney representing the client, an additional interview with the client, additional psychological or cognitive testing, an appeal or continuation of the

hearing with new questions or changes in the client's condition over time, or very rarely with a request to testify in court to answer such questions.

Immigration attorneys are often busy and represent several cases simultaneously in numerous stages of adjudication, and thus they may not always have time to communicate case outcomes to mental health evaluators. Thus, mental health providers may need to reinitiate contact with attorneys to inquire about case outcomes for their own learning. As they develop their own style and receive feedback from clients, attorneys, and case outcomes, evaluators are encouraged to update and revise their interview and affidavit templates.

Conclusion

Conducting forensic psychological evaluations can be a meaningful and rewarding experience for mental health providers, and can significantly improve the likelihood of receiving asylum or other forms of humanitarian relief for immigrants fleeing torture and persecution. Prior to evaluating the client, the clinician should carefully review all legal documents and arrange for a safe interview space and high-quality interpretation. The evaluator should conduct the interview empathically by conveying that the client is in control and allowing for appropriate breaks, meanwhile obtaining a detailed trauma history, contextual history, and mental health review of systems. The mental status exam should be used as a tool to convey the experience of being in the room with the client. The interview should conclude with a thorough and nuanced assessment and discussion, in which the diagnosis, consistency with trauma, and factors affecting testimony are described completely for legal authorities. The affidavit concludes when the evaluator states that they swear the aforementioned is truthful to the best of the examiner's knowledge, and the document is signed, dated, and submitted.

Finally, as they are at risk for vicarious trauma, evaluators should monitor their own counter-transferences and responses to hearing, engaging with, and carrying the stories of often severely traumatized individuals. Evaluators may find solace and integration by appropriately debriefing with colleagues and by consciously noting not only the traumatic experiences of clients, but also their remarkable resilience despite their traumas [16].

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Chapter 5
Evaluating Pediatric Asylum Seekers

Matthew G. Gartland, Roya Ijadi-Maghsoodi, and Janine Young

Introduction

This chapter addresses unique aspects of the forensic medical evaluation (FME) of asylum seeking children (ages 0–18 years). These evaluations build on the principles of adult FMEs, but there are a number of important differences, including the need for a varied approach to children across the developmental spectrum. Existing training modules, manuals, and guidelines for FMEs provide instructions for the investigation of torture and other forms of persecution but they provide minimal pediatric-specific content [1–3]. Instead, pediatric asylum providers commonly draw on experience and training from other fields such as child abuse medicine,

M. G. Gartland
Division of Pediatric Global Health and Center for Global Health, Massachusetts General Hospital, Boston, MA, USA

Department of Medicine, Brigham and Women's Hospital, Boston, MA, USA

Department of Medicine, Harvard Medical School, Boston, MA, USA
e-mail: mgartland1@partners.org

R. Ijadi-Maghsoodi
Division of Population Behavioral Health, UCLA Jane and Terry Semel Institute for Neuroscience and Human Behavior, Los Angeles, CA, USA

VA Health Service Research & Development (HSR&D) Center for the Study of Healthcare Innovation, Implementation & Policy (CSHIIP), VA Greater Los Angeles Healthcare System, Los Angeles, CA, USA
e-mail: rijadimaghsoodi@mednet.ucla.edu

J. Young (✉)
Department of General Pediatrics, Denver Health and Hospitals, Denver, CO, USA

Division of General Pediatrics, University of Colorado School of Medicine, Denver, CO, USA
e-mail: janine.young@dhha.org

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child and adolescent psychiatry, and domestic medical screening examinations of refugees and asylees [4].

In this chapter, we review essential aspects of prior trauma relevant to asylum determinations; common and unique forms of trauma experienced by children; key differences in the manifestations of pediatric trauma-related distress; and technical aspects of preparing for and performing pediatric medical, psychological, and specialized assessments. Our objective is to provide developmental and age-specific guidance for pediatric asylum evaluators.

Legal Status Types

Asylum is one of several humanitarian legal designations available to children seeking legal immigration status [5]. These designations are discussed in greater detail in Chap. 1, but there are several elements that apply uniquely to children. A child may be the primary applicant for immigration status or a derivative on the application of a legal guardian.

Most FMEs involve assessing physical and psychological sequelae of past persecution. However, an FME of a child at risk for female genital mutilation/cutting (FGM/C) may be needed to document *lack of* prior harm, such as in the case of girls who have not had FGM/C but are at significant risk of FGM/C if returned to a country where FGM/C is still practiced (see section "Female Genital Mutilation/Cutting" and Chap. 7) [6]. Similarly, mental health evaluations may be requested to discuss harm to a girl who, if deported, would be subjected to forced underage marriage. Such an evaluation would focus on potential future harm to both her physical and mental health if she were returned to her home country, and would include data on increased maternal morbidity and mortality if pregnancy occurs during adolescence.

Special Immigrant Juvenile (SIJ) classification is the only legal status with specific age-based criteria for eligibility. An applicant must be under the age of 21 and unmarried. The child must demonstrate abuse, abandonment, or neglect by one or both of their parents, and that it is not in the child's best interest to return to their country of origin. If a child is granted SIJ status, they are limited in their ability to petition for lawful permanent residence for either parent.

Children may be eligible for Victims of Trafficking (T visa) and Victims of Criminal Activity (U visa) status with the same eligibility criteria as adults. The Violence Against Women Act (VAWA) may apply to children of a US citizen or legal permanent resident who have been abused.

It is important for all medical providers to be aware of these options for legal relief, as medical providers are in the unique position in their practices to elicit histories that may indicate legal status options for children and families. Legal status affords multiple protections for children and families including potential access to health insurance. In such cases, it is essential for providers to refer children and families to legal aid programs to determine whether relief is possible.

Common Types of Trauma

Pediatric asylum seekers may flee severe forms of abuse. Exposure to trauma is frequently complex, involving multiple forms of abuse that may have been recurrent over time. They can be exposed to a variety of traumatic events in their country of origin as well as during and post-migration. In a 2014–2018 report by Physician's for Human Rights, 183 children's findings were summarized; more than 78% reported experiencing direct physical violence, 71% experienced threats of violence or death, 59% witnessed violence, and 18% experienced sexual violence, almost half committed by a family member [7]. Children from El Salvador, Guatemala, and Honduras ($n = 163$) were particularly vulnerable to gang-related violence, including forced gang membership and sexual assault.

It can be particularly challenging to elicit history about sexual abuse in an FME because of the difficulty survivors of sexual trauma have in disclosing this history [8]. Sexual abuse increases the risk of developing post-traumatic stress, anxiety disorders, and depression; therefore, screening for sexual abuse is important in all evaluations, and conducting a thorough mental health evaluation is essential in cases of sexual abuse [9].

Exposure to trauma is often compounded by underlying poverty, crime, community violence, and deprivation of food, education, and medical treatment [10–12]. During migration, children may be separated from caregivers, suffer from intimidation or coercion, experience physical and/or sexual assault, endure dangerous transit and harsh living conditions (including lack of food, water, or shelter), and can be traumatized from detention and shelter conditions [13–15]. These experiences may not be the focus of a child's legal claim to asylum, but their effect on the child's physical and psychological well-being is important to understand and document in a forensic evaluation.

After migration, children may experience acculturation stress and difficulty adapting to a new school and language, may be placed with new caregivers with limited parenting experience or lack of understanding of their experience, may be reunited with caregivers who they have not seen in some time or with whom they have had disrupted attachment, may experience stress and traumatization navigating the legal system and asylum process, and may experience racism/discrimination [16, 17]. Some pediatric asylum seekers are victims of human trafficking, including sexual exploitation and forced labor, before, during, or after migration to the US [18].

While each child presents with a unique trauma narrative, a pediatric evaluator should have a broad awareness of common types of harm suffered by children. In addition, evaluation preparation includes researching particular types of abuse and country conditions. This knowledge informs the structure of an interview and helps an evaluator screen for sensitive forms of abuse such as sexual and gender-based violence and identify previously unrecognized or undisclosed trauma.

Family Detention and Separation

Family detention and separation in the United States (US) is a relatively new and damaging form of trauma, common particularly for Central American migrants arriving at the US–Mexico border [19–21]. Ample evidence demonstrates the fundamental harm and lifelong consequences of separation to a child's well-being and development [20, 22–24]. Reports from government agencies and independent organizations have documented highly traumatic environments including unsanitary conditions, inadequate food, medical care, and bedding, and chronic sleep deprivation [7, 25–27]. In such cases, it is essential for mental health providers to perform forensic evaluations to document the undue psychological trauma these children have endured. If children and families with a history of separation by the US government are identified, they should have access to designated federal funds to cover ongoing mental healthcare [28].

Unaccompanied Children

Evaluators may encounter unaccompanied children, legally referred to as "unaccompanied alien children," a designation given to children under 18 at time of US entry who arrive without a parent or legal guardian. Fiscal year (FY) 2018 data from Office of Refugee Resettlement (ORR) showed that of 49,100 children arriving, the majority were over 14 years old and over 70% were male, with most arrivals from Guatemala, followed by Honduras, and El Salvador [29]. These children are in the legal custody and care of ORR, and stay in an ORR shelter until a parent, legal guardian, or other sponsor is identified to assume guardianship; they reach their 18th birthday and are sent to an adult immigration detention center; or they are deported. The average length of stay in ORR shelters for FY 2019 was 66 days, but in some cases it has been over 12 months [29]. The trauma experienced in many of these children's home countries, en route, and in the US cannot be overstated. It is essential for evaluators to elicit a thorough trauma history and obtain medical and mental health treatment records for their affidavit. These can be requested from the ORR, available at https://www.acf.hhs.gov/orr/resource/requests-for-uac-case-file-information.

Female Genital Mutilation/Cutting

Over 30 countries continue to practice FGM/C in children, usually from infancy through 15 years of age, depending on region of the world (see Figs. 5.1 and 5.2). Worldwide, it is estimated that over 250 million females have undergone FGM/C. It is primarily practiced on children, usually performed by designated laypeople, without anesthetic, and is associated with significant morbidity and mortality, including an association with HIV, hepatitis B, and hepatitis C infections. Evaluators may be asked to examine children who have had FGM/C performed or who have normal

Fig. 5.1 FGM/C prevalence. (Countries with unknown prevalence include Colombia, Bahrain, India, the United Arab Emirates, Oman, Malaysia, and Russia. South Sudan is not noted on this map) [30–33]. (United Nations Populations Fund. *Demographics Perspectives on Female Genital Mutilation.* 2015)

physical findings but are at risk of FGM/C if deported. Of note, if FGM/C was performed at a young age, the child may not recall the event; lack of recall should not be used to support or refute whether or not FGM/C occurred. Similarly, it is possible that parents are not aware that FGM/C was performed. In such cases, physical findings may be the only evidence available of prior FGM/C [6].

Unique Aspects of Forensic Medical Evaluations of Children and Adolescents

Preparing for the Pediatric Forensic Medical Evaluation

Preparation for the FME involves consideration of the unique needs of pediatric patients. Medical providers may be involved with the Physicians for Human Rights Asylum Network, medical student and resident-run clinics, and clinics that perform domestic medical examinations of newly arriving refugees and asylees [34–38]. In

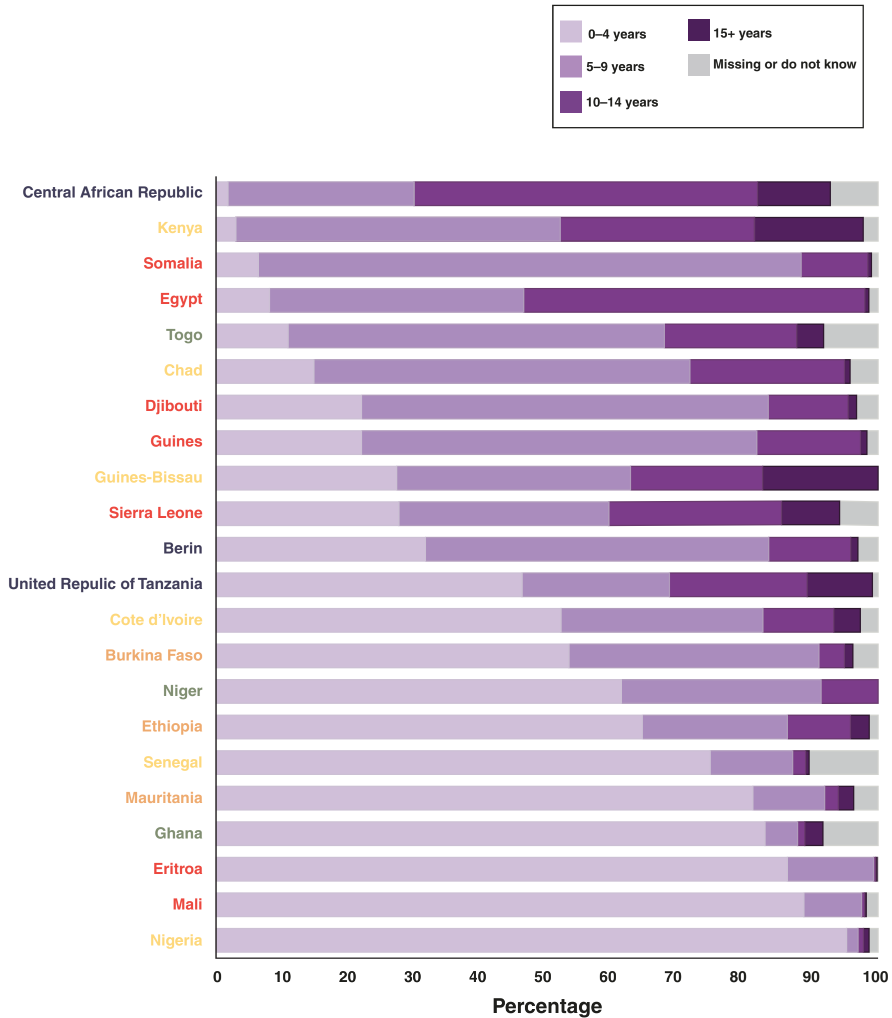

Fig. 5.2 Maternal reported age of girls who have had FGM/C, by country [31, 73]. Reproduced with permission from Pediatrics 2020 Aug; 146(2)

almost all cases, organizational policies focus on the needs of adults and therefore must be adapted to children and families.

Pediatric FMEs can be performed by a range of medical providers, including pediatricians, pediatric gynecologists, adolescent medicine physicians, child abuse pediatricians, family medicine physicians, child psychiatrists, child psychologists, physician assistants, social workers, and nurse practitioners trained in pediatrics. It is recommended that pediatric evaluators receive additional training and mentorship from experienced providers; this training should include observation of multiple cases before performing an evaluation independently.

Prior to the evaluation, it is essential not only to review legal documents and medical records, but also to assemble collateral information, when applicable, from family members, the child's medical and mental health providers, or teachers, to gather information about the child's history as well as observations of a child's behavior. Caregivers can be asked about demeanor, possible developmental regressions, changes in sleep, social withdrawal, or other behavioral changes. This requires written permission from the child's guardian. Arranging a pre-evaluation visit or allowing for multiple visits may be helpful in complex cases. Evaluators should arrange to use a certified medical interpreter in the child's primary language as the gold standard. Use of family or community members is highly discouraged.

The evaluator should counsel on the anticipated scope of the evaluation and physical examination and receive consent from the legal guardian and assent of the child (if developmentally appropriate) before proceeding with the evaluation.

A Trauma-Informed Approach to Interviewing Children

Given the high prevalence of trauma in pediatric asylum seekers, it is important to be aware of the risk of re-traumatization during an interview and to use a trauma-informed approach [39–41]. Prioritization of the child's well-being while seeking the information necessary for an effective assessment is essential. This approach recognizes the importance of safety (physical and psychological); trustworthiness and transparency; collaboration and mutuality; empowerment; voice and choice; and cultural, historical, and gender issues [42].

First, evaluations should occur in settings that are age appropriate and feel safe and comfortable to children. In some settings, such as detention centers and shelters, the evaluator may have little control over the environment. Regardless, there are factors that may help children feel more at ease and decrease the risk of re-traumatization; this could involve allowing the child to have easy access to the door, asking where the child wants to sit in the room, sitting at the same level, and allowing the child to have control over the interview as much as possible. Offering tissues, water, and age-appropriate activities such as paper and pencils to draw with can be helpful.

Developing rapport and setting the stage for evaluation expectations is important to minimize anxiety and risk of re-traumatization and to prepare the child for questions that may be emotionally difficult. Evaluators should clearly explain who they are, their role in the process, and what the interview will consist of in a transparent manner. It is important to explain to the child and caregiver that the evaluation is a forensic evaluation and not a medical visit. Certified medical interpreters or anyone else in the room should be introduced. Evaluators also should explain what types of questions will be asked and the limits of confidentiality with the interview. In addition to issues of mandatory reporting as discussed below, evaluators should make clear that findings from the evaluation will be shared in a document with the child's lawyer who will submit this to the immigration office or court. Evaluators should

offer opportunities for breaks and for children to check in with their caregiver. For young children, starting with playing a game or drawing can help establish rapport.

Interviews with children are more effective when the atmosphere is supportive and interviewers are perceived as curious [43]. Evaluators should use a warm, non-judgmental approach for the interview and avoid rapid questions that may seem threatening or similar to a forced exposure. Structured interview guides and developmental-specific approaches are also helpful [44, 45].

It is often useful to normalize and validate any distressing or embarrassing feelings that may arise during the course of the interview, and to explain why questions are being asked. In all cases, it is important to explain that the child has the power and control to stop the interview at any point, and to take a break. Further, it is critical to take an approach of cultural humility, and use self-evaluation to recognize the potential power dynamics during the interview, interviewer biases, and the evaluator's own privilege and background [46, 47].

Clinics should make accommodations for caregivers, allowing them to accompany children to the clinic and to participate in elements of the evaluation, as appropriate. For example, in the evaluation of a young child, the caregiver is likely a primary source for history and observations about the child's behavior, while in the evaluation of an adolescent, some history may be obtained from caregivers and the remainder of the history and physical evaluation may take place with only the adolescent present. Children and adolescents should be interviewed separately from their caregivers as well, and older children and adolescents should be given the option to have the entire evaluation done without a guardian present. Sources of obtained history should be documented in the affidavit.

Finally, it is helpful to conclude the evaluation using a strengths-based and affirming approach, such as asking the children their goals or future plans. The evaluator can note and highlight protective factors, strengths, and resilience of the child. Pediatric asylum seekers often demonstrate internal resilience factors such as problem-solving and self-efficacy, and are able to utilize external supports, including support from caregivers, school teachers, and other adults, to thrive [48].

Conducting the Psychological Assessment

The overall goal of the psychological assessment is to obtain facts about the trauma, torture, or persecution endured and assess how consistent the psychological evaluation findings are with the account of abuse. In addition, the psychological evaluation can provide details or elicit additional trauma history not obtained in prior attorney interviews. It can illuminate insight into a child's behavior, including during the credible fear interview or interactions with the attorney, such as an incongruent affect, trouble remembering details, or avoidance of providing details about trauma.

The psychological evaluation can be emotionally taxing. After first establishing rapport, it is helpful to start by obtaining a pre-trauma history (including details such as developmental history, family history, and cultural and religious

background), which provides information about the child's environment and allows the interviewer to assess mental health symptoms prior to the traumatic events. Easing into this portion of the interview by first gathering background information and establishing rapport may allow children to feel more comfortable talking about distressing situations. Obtaining a psychiatric and medical history also provides information on functioning prior to experiencing trauma.

When gathering details of traumatic events/torture, the evaluator should attend to the emotions and behaviors of the child and signs that a break is needed. The evaluator should also document changes in functioning and behavior that occurred after the events. While asking about psychological symptoms, the evaluator should assess for symptoms of PTSD, depression, anxiety, and other disorders, if indicated.

Throughout the evaluation, notes should be taken regarding the child's demeanor, including documenting periods of tearfulness, needs for breaks, and affect. Stressors during flight and after arrival to the US (such as time spent in detention or a shelter, separation from family members, bullying at school, living with a new family) are helpful to document, in addition to allowing for an understanding of psychosocial functioning in the US.

When this portion of the interview is concluded, the evaluator should ask if the child has any questions. Providing psychoeducation about PTSD, normalizing physiologic symptoms and feelings that may arise in the interview, and explaining that the child may continue to feel more emotions after the interview may be helpful. The evaluator can help the child use coping and relaxation skills such as deep breathing exercises. If safety concerns arise, a plan should be made with the child and caregiver and linkage to ongoing mental health care should be arranged.

The most common mental health disorders that pediatric asylum seekers experience include major depressive disorder, post-traumatic stress disorder (PTSD), and anxiety disorders. Although reported prevalence varies, one systematic review examining 47 studies of pediatric asylum seekers and refugees in Europe found that the point prevalence (reported as interquartile ranges) ranged 19–52.7% for PTSD, 10.3–32.8% for depression, and 8.7–31.6% for anxiety disorders [49]. Additionally, studies demonstrate that unaccompanied refugee minors separated from both parents report higher numbers of traumatic events compared to accompanied refugee minors, with significantly higher scores of PTSD and depression [50].

Although not all children meet diagnostic criteria as outlined in the *Diagnostic and Statistical Manual for Mental Health Disorders*, Fifth Edition (DSM–V) for depression, PTSD, or anxiety disorders during the FME, they will often display symptoms of these disorders [51]. In addition, children may show symptoms of separation anxiety, adjustment disorders, social withdrawal, aggression, impulsivity or outbursts, sleep disturbances, and somatic symptoms as a result of their traumatic experiences [17]. For children who have endured the loss of a caregiver or loved one in a traumatic way, they may demonstrate signs of traumatic grief, or trauma-related symptoms in addition to grief symptoms [52].

Children often display symptoms consistent with traumatic stress, even if they do not meet the full DSM-V criteria for PTSD. These symptoms can differ from adults and often have varying presentations depending on a child's developmental level

(Table 5.1). For diagnosing children with PSTD, the child must experience symptoms of PTSD within four clusters—intrusion or reexperiencing of the trauma, avoidance, negative changes in cognitions and mood, and arousal. The DSM-V also has separate criteria for PTSD for children under 6 years of age [51].

Of note, during the interview, children may make efforts to avoid reminders of trauma. This may manifest as reluctance to volunteer information about the trauma, inability to recall aspects of the trauma, and attempts to avoid distressing feelings or emotions about the events, which can appear as a restricted affect. These responses should be documented in the affidavit. Of note, sometimes children may become overwhelmed in the interview, which can include episodes of crying or incongruent reactions such as laughing. Sometimes children may dissociate under frightening situations, and appear as if they are staring off into space or daydreaming [53]. If a child becomes overwhelmed or there is concern about dissociation, the evaluator should help the child feel supported and grounded. The child can be invited to take a few deep breaths or stretch, water or tissues can be offered, or they can be given an opportunity for a hug or comfort from a caregiver. A distracting exercise such as listening to music or coloring may provide some relief too. If they appear to be dissociating, bringing the child back to the present moment with an exercise such as asking the child to name five things of a certain color in the room may help. Finally,

Table 5.1 Signs and symptoms of traumatic stress in children and adolescents[a] [45, 70]

Age	Potential symptoms and signs of traumatic stress
Young children	Reexperiencing of traumatic experiences through repetitive play Frightening dreams (may not be trauma specific) Avoidance of people, places, conversations, situations, or physical reminders of trauma Constricted play or decreased interest in activities Behavioral changes (e.g., aggressive behavior, outbursts) Developmental regression (e.g., speech, toileting) Sleep disturbances Appears “numb” or underreacts to situations Restlessness/has trouble sitting still Trouble separating from their caregiver, such as during the forensic medical evaluation
Elementary age children	Behavioral changes, including sadness, irritability, and withdrawal Academic and peer difficulties Separation anxiety from parent/caregiver Fears unrelated to the trauma
Adolescents	Conduct problems Risky behaviors Relationship changes with peers, teachers, and family members Isolation Feelings of guilt or responsibility for what has happened Self-harm Sense of a shortened future Changed outlook on the world

[a]Adapted with permission from the National Child Traumatic Stress Network [71]

it is essential to remain calm and attuned to the child's needs, acknowledge how hard the evaluation is, and praise their participation and efforts.

It is also important to note that parents/caregivers may also deny trauma exposure in their child. They may not be aware of their child's traumatic events, especially if the child is an unaccompanied minor and the caregiver was not present in the country of origin or during the journey to the US.

Conducting the Medical Assessment

As with other components of the evaluation, the medical assessment of a child incorporates information from collateral sources. The evaluator gathers a complete past medical history covering elements related and unrelated to the reported abuse. For example, history of an unrelated injury, such as a remote humerus fracture, can help explain physical findings unrelated to abuse and establish credibility of the child's report of persecution-related injuries. Past medical history can also demonstrate a child's ongoing medical needs, which may be important for legal considerations such as neglect or medical hardship.

In addition to a thorough past medical history, the evaluator should gather details about specific injuries reported by the child and/or caregiver. In this step, the evaluator elicits a more detailed narrative of abuse by focusing on mechanisms of physical injury, resulting scars, and persistent physical symptoms such as an antalgic gait or other disability. While children and caregivers may be able to relate a general description of the trauma, they may have difficulty describing details of past injuries, particularly remote trauma occurring at a young age. It is important to represent accurately how the child relates the events in the affidavit, including if a child does not have specific memories.

The evaluator should next take a focused history of persistent physical injuries or symptoms, such as pain with movement of injured joints or symptoms of a traumatic brain injury. This history includes the impact of injuries on growth and development, as well as any functional disability resulting from trauma-related injuries. A general review of systems may reveal additional undisclosed symptoms resulting from trauma.

The physical examination comprises a general head-to-toe as well as a focused examination of scars and any areas of the body that have sustained injuries. Given the immense range of injuries, the evaluator must develop a broad expertise in taking history on mechanisms of injury, understanding scar formation and healing, and describing physical examination findings. The evaluator will draw on this expertise to formulate and document an impression of the consistency of examination findings with the reported abuse.

A discussion of the physical examination of common injuries is discussed in Chap. 3, including many injuries common in pediatric asylum seekers such as blunt and sharp trauma, musculoskeletal injuries, and burns. Reviewed, below, are several pediatric-specific injuries, though injuries may be remote and may have subtle

findings. While pathognomonic signs of intentional harm may be less common, an assessment to identify a pattern of traumatic injury is important to corroborate a child's narrative of reported abuse.

Fractures and Head Injuries

Certain types of long bone fractures are more suggestive of non-accidental trauma, including metaphyseal fractures, spiral/oblique fractures, and multiple fractures [54, 55]. Unfortunately, contemporaneous imaging is not available in most cases and uncomplicated fractures are typically fully healed within 3 months and completely remodeled within 1 year [55]. Premature arrest of bone growth can occur in injuries involving the growth plate resulting in limb-length differences. Poorly healed or unrepaired fractures can result in deformity, non-union, or overlying skin and soft tissue changes [56]. Physical disability resulting from injuries is especially important to document as it can be used as the basis for demonstrating additional persecution of the child.

Children with head trauma may have skull fractures or intracranial hemorrhage such as subdural or subarachnoid bleeding. Again, a lack of timely imaging may limit assessment of these injuries as there may be no permanent signs of prior injury for many types of injury or torture [57]. The evaluator may consider using symptom-screening tools for persistent mild traumatic brain injury symptoms, including cognitive dysfunction [58]. Neuropsychological testing can be helpful in complex cases involving cognitive impairment, however screening tools and neuropsychological testing may be difficult to obtain and are not validated in many languages.

Neglect

Neglect is a common form of abuse and may result in worsening of acute or chronic medical conditions; however, neglect may be difficult to distinguish from the impact of poverty.

Sexual Abuse

Sexual abuse may not leave physical evidence because anogenital tissues heal quickly after many types of sexual trauma [59, 60]. The evaluator must use their discretion to determine whether examination of the genitalia and anus is warranted and consider a range of factors including the age and emotional stability of the child, suspected presence of scars or lesions, and whether privacy can be assured during the evaluation. It is important to balance the documentation of physical findings with the well-being of the child. An evaluator may elect not to perform a genital

exam in order to prioritize the well-being of the child even when the child relates a history of sexual abuse. In these cases, it is important for the examiner to document clinical judgment regarding why a genital examination has been deferred. If there is concern for morbidity from the abuse, consultation with a child abuse pediatrician should occur.

It is important to have the requisite knowledge of genital anatomy, ability to identify normal anatomy and variants, and the vocabulary to describe findings with accurate and precise language. The evaluator may consult reference materials on child sexual abuse for detailed guidance on the genital examination of a child who reports sexual abuse [61]. It may be necessary to involve a child abuse pediatrician, gynecologist, or other expert provider.

It is recommended to follow standard of care, using a chaperone and gowns and drapes to allow for privacy, and to adhere to principles of trauma-informed care including allowing the child control in the examination [54, 62]. It is important to explain to the guardian and child, as appropriate, reasons for the exam as well as approach, for example, that the child will be draped on the examination table, in a frog-leg position, with pants and underwear removed.

A child or caregiver may feel more comfortable with a same-gender evaluator and should be given this option prior to the evaluation, if available. The examination of the external genitalia and anus does not require the use of instruments such as a speculum in most cases. If an internal examination is needed, expert consultation is strongly recommended. Photographs of exam findings are not required. A thorough description and diagram or drawing is sufficient for documenting findings.

Female Genital Mutilation/Cutting—Pediatric Considerations

It is important for the examiner to have significant experience performing standard external genital examinations on girls at well-child examinations or as part of fellowship training in child abuse pediatrics so that they are comfortable with normal findings and variation of normal findings. Without this experience, misdiagnosis of FGM/C is possible, with peri-clitoral and peri-vaginal adhesions mimicking findings of FGM/C (see Figs. 5.3 and 5.4). Findings may be subtle and missed. In all cases, prepuce, clitoris, labia minora and majora should be identified, and findings documented [6]. Using diagrams with specific findings documented in the chart and on the forensic examination affidavit (see Fig. 5.5) is recommended.

Unfortunately, there are few medical providers with expertise in the diagnosis of pediatric FGM/C, and more subtle findings may be easily missed [63] (see Fig. 5.6). If there are concerns for FGM/C and no obvious findings on examination, it is essential to identify a clinician well-versed in identifying FGM/C findings [63]. End FGM/C Now (https://endfgmnetwork.org/members/) has a list of providers with experience diagnosing and managing FGM/C in the US.

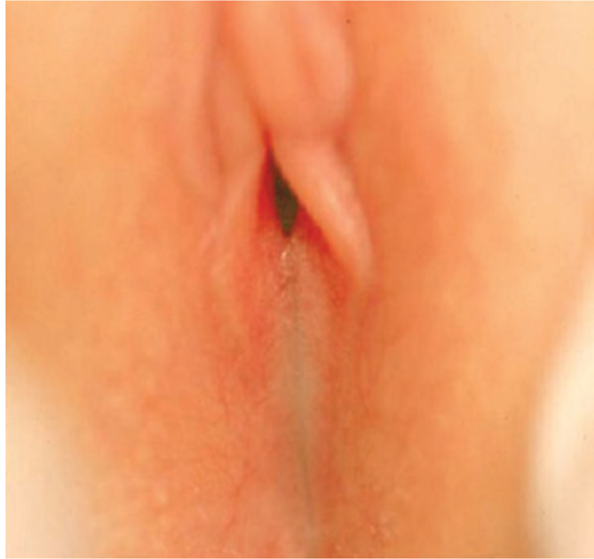

Fig. 5.3 Labial adhesions. (Reprinted with permission from American Academy of Pediatrics [72])

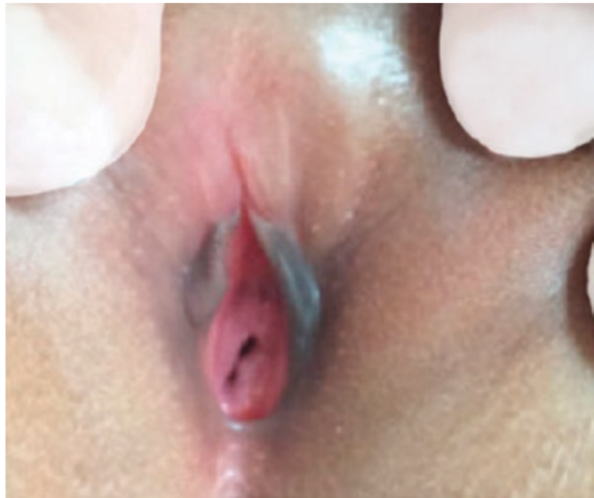

Fig. 5.4 Peri-clitoral adhesions. (Young et al. [73])

Unknown Date of Birth

In resource-limited settings of developing countries, many children never receive birth certificates and families do not know their date of birth. An asylum-seeking child may arrive with an assigned date of birth of January 1st and a birth year. Forensic evaluations as well as physical examinations and developmental assessments are challenging in these situations. Evaluators may be asked to help estimate the child or young adult's age, which may have significant legal implications, including whether the patient is truly a minor and subject to protections afforded to

minors, and whether demeanor and behaviors are developmentally appropriate for a child who is being assessed.

If there is uncertainty about a child's age, it is essential to review these concerns with the child's attorney. Evaluation may include a developmental assessment performed by a trained developmental pediatrician, physical exam assessment of the presence or absence of pubertal changes and predicted weight and height attainment, though in some cases Tanner staging and growth may be delayed if the child has significant malnutrition. Dental films and bone age are not recommended, as data are not validated across immigrant populations and malnutrition negatively impacts appropriate interpretation [65–67].

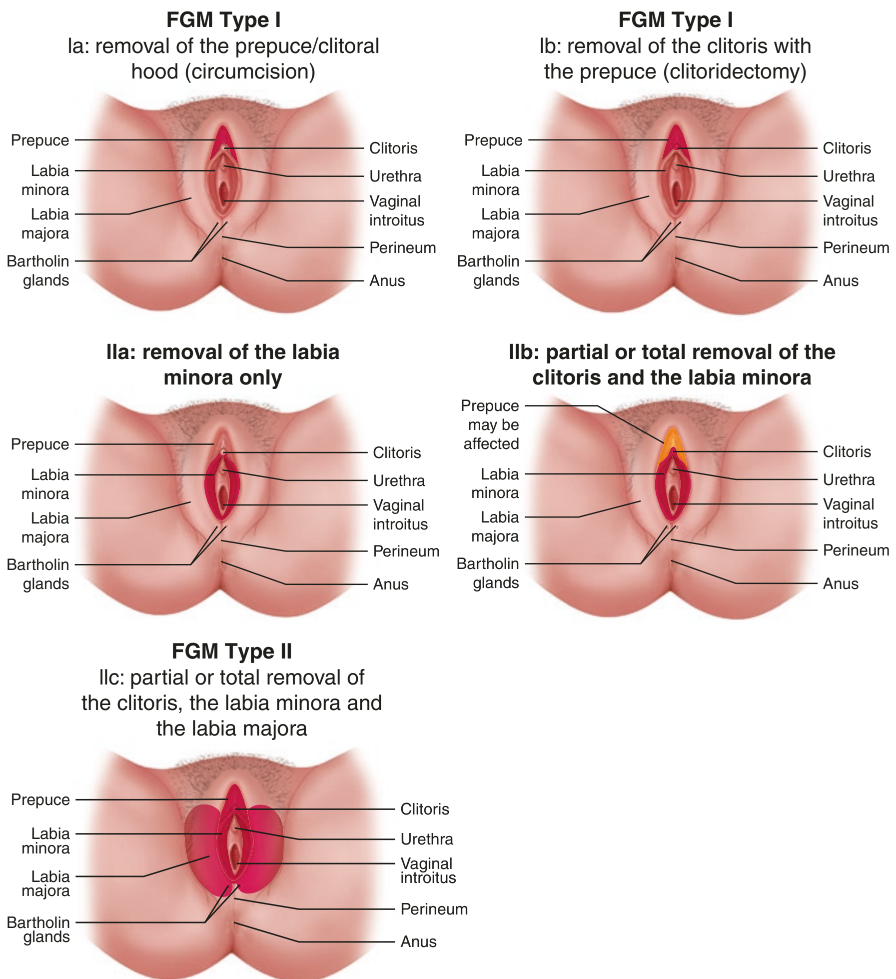

Fig. 5.5 A visual reference for FGM/C [64]. Reprinted with permission from Wolters Kluwer

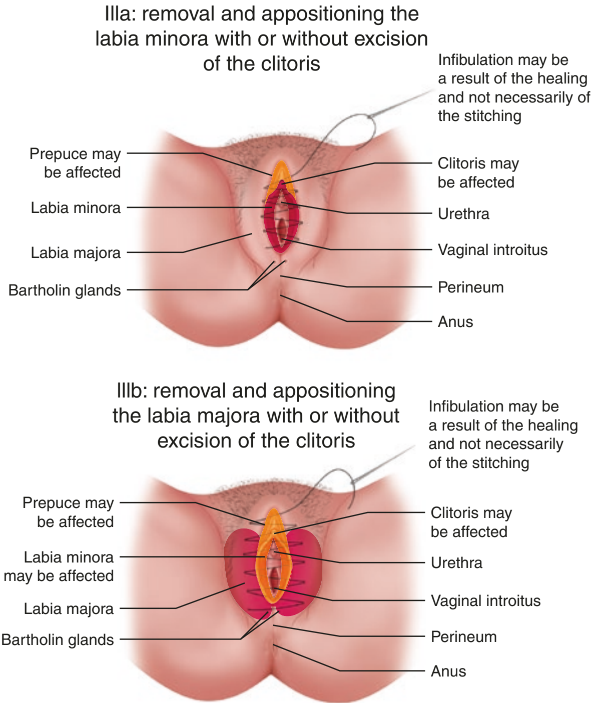

Fig. 5.5 (continued)

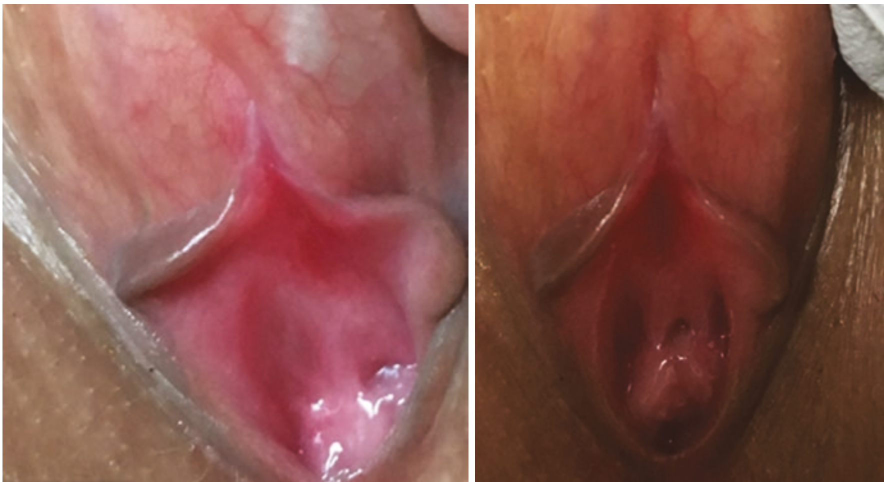

Fig. 5.6 Type Ib FGM/C in a 2 year old girl. (Photo credits: J Young)

Pediatric Considerations in Affidavit Preparation

When writing the affidavit, the evaluator should list all people present for the evaluation and clearly cite history from collateral sources including caregivers, teachers, pediatricians, or medical records. Pediatric affidavits may also need to contain more detail regarding varied pediatric response to trauma by age.

A common issue is memory and recall and the child's ability to accurately relate remote events and symptoms. The evaluator should address why a child may not recall or choose to share specific events and discuss the impact of developmental stage, the passage of time, psychiatric diagnoses, guilt, shame, and trauma on memory. The evaluator can guide the adjudicator on appropriate accommodations, and can provide information about a child's reactive response to difficult questioning, such as their body language, demeanor, tone of voice, or consistency in retelling a story. Such reactions can be misperceived to indicate a lack of credibility or believability, but in fact may be related to their trauma history, developmental stage, language barriers, or cultural expectations.

Linkage to Ongoing Care

Medical and mental health forensic examinations are performed with the specific purpose of documenting signs and symptoms of prior physical and/or psychological abuse, neglect, abandonment, or future risk of such abuse from occurring if deported. These findings are written in a formal affidavit for use by the child's immigration attorney. In all cases, it is essential for forensic examiners to develop a system to assure that children are linked to timely, ongoing care for primary, subspecialty, and mental healthcare.

Review of ongoing care for immigrant children is beyond the scope of this text, however, evidence-based guidelines may be referenced through the Centers for Disease Control (CareRef, https://careref.web.health.state.mn.us/ and CDC Domestic Refugee Screening Guidelines, https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html).

Mandatory Reporting

Mandatory reporting laws exist in all 50 states requiring professionals who work with children to report suspected abuse and neglect to child protective services or other designated authorities [68]. The reporting laws may override the ethical duty for healthcare providers to protect confidential patient information; however, the issue becomes more complicated in relation to attorney–client privilege and whether healthcare providers performing forensic evaluations at the request of an attorney fall within the scope of attorney–client privilege [54]. This legal question

is only addressed directly in several states and remains unclarified by legal precedent in many places [69]. An evaluator's decision should consider foremost the protection of the child and they should consult with the attorney throughout the process of deciding to report. Information on specific state laws are provided by the Children's Bureau: www.childwelfare.gov/systemwide/laws_policies/search/index.cfm.

Conclusion

In this chapter, we have reviewed pediatric-specific legal considerations; common types of trauma; unique circumstances, including unaccompanied minors and family detention; and technical aspects of pediatric medical, psychological, and specialized assessments, including the evaluation of female genital mutilation/cutting. Our objective has been to provide developmental and age-specific guidance with a trauma-informed approach for pediatric asylum evaluators.

We would like to acknowledge all youth and families with whom we have worked, the staff and volunteers of the Denver Health Human Rights and Refugee Clinics, the Massachusetts General Hospital Asylum Clinic, the Los Angeles Human Rights Initiative–Asylum Clinic, and the UCLA Psychiatry Asylum Clinic, and representing attorneys.

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Chapter 6
Asylum Evaluation in Detention Settings

Homer Venters

Introduction

Health risks created by detention and incarceration include risk of exposure to solitary confinement and resulting mental health deterioration, risk of physical injury and sexual abuse, as well as risk of inadequate medical care [1–4]. These health-related conditions of confinement can add complexity to a medical forensic exam, as the trauma of experiences before arrival in detention are compounded. The elements of conducting an asylum evaluation are well documented [5]. Aside from the routine preparation required by the evaluator, conducting an evaluation in a detention setting requires understanding of the type of detention, the logistics of the evaluation, and remedies for any barriers that are encountered. It also requires clarity about the role of the evaluator in addressing any concerns with conditions of confinement or potential release. Every evaluation in a detention brings unique set of challenges, but the potential to advocate on behalf of people who are detained while they seek refuge from persecution presents a rewarding and impactful role.

Logistical Preparation

Before conducting an asylum evaluation in a detention setting, the evaluator will need to gather information about the type of detention setting and potential limitations that may be encountered. If the clinician has not worked in or conducted asylum evaluations in a detention setting, it is worthwhile to speak with another evaluator with this experience. One of the jarring features of working in detention settings is that rules of conduct and security presented as firm and mandatory are

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H. Venters (✉)
New York University College of Global Public Health, New York, NY, USA

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often enforced unpredictably and with seeming arbitrariness. Seeking clarity about what writing tools, measurement instruments, audio and photographic equipment, and personal property the evaluator is allowed to bring into the facility, along with expectations about the amount of time and confidentiality of the settings for the evaluation, are important. For example, security staff may attempt to keep a door open to the evaluation space, allowing them to overhear conversations, or even stay in the evaluation space while the interview and exam are being conducted. They may also attempt to keep the person being evaluated in handcuffs, leg chains, or other restrains that would impede the evaluation. Evaluators may be in the facility alone and need to understand how to advocate for the full measure of conditions they expect and whom to contact when these conditions are not met. There is pressure to accede to the demands of the security staff in these scenarios and discussing expectations with the attorney of record and client is useful. It is helpful for the evaluator to note times of entry into the facility, when the evaluation starts, and the timing of any interruptions.

The Impact of Confinement

Being detained can have a significant impact on the health and well-being of any person, but it can be especially harmful to a person seeking asylum. Two primary mechanisms often exist to exacerbate the physical and psychological health of a detained asylum seeker. The first involves triggering of prior trauma caused by past abuse at the hands of state actors and other law enforcement or security agents. The second involves new harm inflicted on the detained person in the form of abuse or neglect in detention. Both mechanisms can impact the physical and psychological state of the person being assessed, and merit consideration.

The nature of the asylum process results in identification of people who often suffered traumatic abuse at the hands of law enforcement or security sources in their countries of origin. These experiences may range from witnessing abuse to personally experiencing torture and other forms of physical, sexual, and psychological abuse, as well as threats of the same [6]. The United States maintains the world's largest network of immigration detention settings, and utilizes this system to often detain people seeking asylum. Immigration detention facilities fall under the authority of the Department of Homeland Security's Immigration and Customs Enforcement (ICE) but the system is comprised of a patchwork of approximately 200 facilities throughout the US. Some of these facilities are local county jails that have entered into financial contracts with ICE to hold people detained by ICE. Other facilities are stand-alone detention centers, which may be administrated by for-profit detention corporations. Finally, some facilities are run by ICE or other federal law enforcement agencies, including Customs and Border Patrol, which may detain people initially before transfer into ICE detention [7].

As a result of the wide spectrum of American immigration detention facilities, a person detained by ICE may be shuttled through multiple jurisdictions and facilities

in a matter of days or weeks, and exposed to multiple sets of rules and conditions, many of which may not be explained or presented to the detained person in a manner or language they understand. Treatment and conditions in these settings can act as potent triggers for memories and past experiences of abuse, especially when that treatment occurred at the hands of state actors including police and other security forces. Some individuals seeking asylum may be aware of this triggering, but some may not, especially if their primary focus is on survival and navigating the day-to-day challenges of being detained in a strange setting. This triggering of past traumatic experiences in detention is common and may not be apparent to the asylum evaluator. After the general evaluation, it is worthwhile to have a group of additional questions about the time in detention that include focus on whether any of the experiences there have provoked memories from the past experiences (Table 6.1). These questions can start as open-ended prompts with more detailed follow-up.

Vignette 1: An evaluator was asked to conduct an asylum evaluation on behalf of a woman being detained by ICE in a rural county jail, located several hours outside a large city. The background given to the evaluator included that the woman had suffered long-term physical and sexual abuse at the hands of security forces in another country. These experiences involved being taken by security forces to a barracks outside her hometown and held and repeatedly abused over many months. Upon arriving to the detention facility, the evaluator was told that the evaluation would need to be conducted with the woman in handcuffs because she posed a "security risk." Further conversation revealed that the woman had been placed into punitive segregation/solitary confinement 2 weeks earlier for refusing to follow verbal commands of officers. The person being evaluated reports that she was detained by ICE when she went to a convenience store outside her apartment, was apprehended for shoplifting food for her family, and then transferred by police to ICE, who then transported her several hours away to the current jail.

The second element of detention that is harmful to health and relevant to the asylum evaluator is the creation of new health risks and harms in detention. These harms range from medical neglect to outright physical, sexual, and psychological abuse. People may have their medical care interrupted when detained, especially in the case of care for chronic medical problems, substance use treatment, and mental health services. These areas of healthcare have been repeatedly documented as limited and often deficient in ICE detention [1]. Some of them, including access to evidence-based treatment for opiate use disorder, are often completely unavailable [8]. Aside

Table 6.1 Open-ended questions relating to detention experiences

Has anything here in detention caused you to relive or reexperience some of the experiences we discussed in the past?
Have you had any problems getting care in detention for your physical or mental health?
Has being in detention interrupted any care or worsened your health as compared to before you were detained?
Have you been injured or had any new health problems in detention?
Have you experienced any physical, verbal, or sexual harassment, or been treated poorly here in detention?
Do you feel that you have been punished in any way for participating in this evaluation today?

from the scope and competence of clinical services provided in detention settings, care can also be deficient due to a lack of language services.

> Vignette 2: During an asylum evaluation, the evaluator learns that the person seeking asylum had been receiving methadone before being detained by ICE. He reports that he had been employed and managing his life well but that since arriving in detention, he had been told that ICE does not offer this treatment and he had been told to go "cold turkey." He went through opiate withdrawal with only some antihistamines given to him. He now reports being very worried that he will relapse and suffer an overdose because although he can't receive methadone in detention, opiate pills are freely available on the illicit market.

Asking questions about the conditions and impact of detention on a person's health raises the issue of whether the evaluator will use this information to advocate for any actions beyond the asylum evaluation. This poses a challenge, given the prolific harms caused by detention and the readily observable deficiencies in care. The evaluator has a range of options, including counseling the person being evaluated about how to pursue grievances or access to care, writing a separate letter or communication to detention officials relating concerns about health status or care, and advocating with the legal team for release of the asylum seeker on medical grounds. It is important for the evaluator to discuss this range of involvement with the client's attorney before the evaluation. The clinician should also be clear with asylum seeker, in order to minimize misunderstandings about what the evaluator can or will provide.

Another important consideration for asylum evaluations in detention involves ensuring the informed consent of the person seeking asylum, and that they understand the limits and potential implications of participating in the evaluation. While most people will generally understand that the information they provide, and the physical examination and assessment of the evaluator, will be utilized in their asylum case, it is also important to relate that immigration courts may not be the only ones to review the report, and that other immigration officials, including those in enforcement and removal, may also review the report and attempt to use it to discredit them or use discrepancies between the report and other information as a reason to prolong detention. There is also a real concern that if conditions of confinement are discussed and reported, either in the asylum evaluation report or separately, that the person may experience retaliation by detention and immigration staff [9]. This retaliation may involve their asylum case, other immigration proceedings, or may involve their treatment in the detention setting by security or health staff. Discussing these potential issues with the attorney in the case and the person being evaluated is important.

Summary

Conducting evaluations in a detention setting can be a rewarding endeavor, but the evaluator must prepare for the additional elements that the setting may bring to the evaluation. The encounter will likely take more time, due to the necessity of waiting

for entry and access to the person being evaluated. The evaluation may also require that the evaluator assert that the agreed-upon conditions of the evaluation are met, or call the case attorney for assistance. The clinician will also benefit from dedicating time after the evaluation to process the secondary or vicarious trauma from the experience. Finally, the logistics and unique elements of conducting the evaluation in a detention setting may obscure (and even increase) the secondary trauma.

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Chapter 7
Evaluating Survivors of Sexual and Gender-Based Violence

Deborah Ottenheimer and Ranit Mishori

Introduction

Sexual and gender-based violence (SGBV) is a ubiquitous phenomenon [1] affecting people around the world, primarily women and girls [2]. A lifecycle of violence has been described affecting women living in almost every nation and belonging to every ethnicity [3, 4]. While the specific forms of violence may vary, the constant threat can be pervasive. In 1948, the Universal Declaration of Human Rights (UDHR) was adopted by the United Nations highlighting equality and special protections for women and girls; however, in the ensuing decades, increasing evidence showed that women and girls faced unique barriers to equality and specific forms of abuse which were not fully enumerated in the UDHR. As a result, in 1979 the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was adopted by the United Nations (UN) with 189 signatories as of 2015 [5]. It is noteworthy that the United States has signed, but never ratified CEDAW.

The UN defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" [6].

The World Health Organization (WHO) describes SGBV as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work [7]. Multiple human rights violations fall under these

D. Ottenheimer (✉)
Department of Women's Health, Gotham Health | Morrisania, New York, NY, USA
e-mail: deb@ottenheimerhealth.com

R. Mishori
Department of Family Medicine, Georgetown University School of Medicine and Physicians for Human Rights, Washington, DC, USA

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definitions and the spectrum includes a wide array of acts ranging in severity from verbal harassment, to daily physical or sexual abuse, to female genital mutilation/cutting (FGM/C), to rape, honor killing, and femicide [8] (Table 7.1).

When evaluating a survivor for SGBV, it is important to note that such violence is not limited to penetration of sexual organs or the physical invasion of bodily cavities. Additionally, survivors usually report having experienced more than one form of SGBV. Most experience multiple forms simultaneously or sequentially across time.

Settings with increased risks of SGVB include areas with a high prevalence of poverty, conflict and post-conflict zones, natural disaster zones, refugee camps, and

Table 7.1 Types of sexual and gender-based violence [9] (Adapted from United Nations. International protocol on the documentation and investigation of sexual violence in conflict best practice on the documentation of sexual violence as a crime or violation of international law. 2017, March. https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/06/report/international-protocolon-the-documentation-and-investigation-of-sexual-violence-in-conflict/International_Protocol_2017_2nd_Edition.pdf.)

Type	Description
Intimate partner violence (IPV)	Any physical, sexual, or psychological abuse perpetrated by an intimate partner
Rape (completed, attempted, or threatened)	Included vaginal and anal penetration by a body part or an object, or oral penetration by a sexual organ, by the perpetrator or the victim Threats and attempts of any form of rape or threats and attempts of other sexual assault
Genital mutilation or cutting	Cutting or mutilation of the vulva, labia, clitoris Forced elongation of the labia Mutilation of breast and nipples Male genital mutilation or amputation, or other types of violence directed at sexual organs
Sexual slavery	Sexual slavery, including conjugal slavery or concubinage
Sexual torture	Sexual torture, including electrocuting genitals or pinching nipples, or being forced to watch a partner or child be sexually abused
Forced prostitution	Forced prostitution
Reproductive coercion	Reproductive coercion can include forced pregnancy, forced abortion, and forced sterilization [10] Forced pregnancy may occur in the setting of intimate partner violence, forcible withholding of contraception, and/or in situations of genocide coupled intentional "repopulation" via rape of the conquered/minority women and girls Forced abortion may be part of a violent relationship, or it may be part of a broader, systematic strategy of reproductive control over women and girls who have been trafficked into the sex trade Forced sterilization is a worldwide practice, usually perpetrated upon minority women, disabled women, and women with certain diseases like HIV
Dowry deaths [11]	Killing or suicide of married women due to continuous harassment and torture by their husbands and in-laws over a dispute about their dowry
Honor killing [12]	The killing of a family member (usually girl or woman) due to the belief that the victim has brought shame or dishonor to the family
Human trafficking [13]	The use of force, fraud, or coercion to obtain some type of labor or commercial sex act, though the use of use violence, manipulation, or false promises of well-paying jobs or romantic relationships to lure victims into trafficking situations

Table 7.1 (Continued)

Type	Description
Child Marriage [14, 15]	Any marriage occurring in which either party is under the age of 18 It is a practice affecting both boys and girls, however, the vast majority of affected individuals are girls While child marriage is illegal in many parts of the world, 33,000 child marriages a day continue to take place because of lack of legal enforcement and/or parental consent exceptions Girls most vulnerable to this practice are poor and/or live in rural areas, and it has been shown to increase during humanitarian crises Girls who are married as children are more likely to be deprived of education, to experience childbirth complications, and to experience intimate partner abuse
Virginity testing [16]	An inspection of the female genitalia (specifically the hymen) meant to determine whether a woman or girl has had vaginal intercourse The examination has no scientific merit or clinical indication The practice is a human rights violation is associated with both immediate and long-term consequences

areas dominated by gangs and gang violence. [15] At the time of this writing, the worldwide COVID-19 epidemic is raging, and there is abundant evidence that because of enforced social isolation, coupled with long-standing structural inequalities, SGVB is on the rise [17].

Prevalence

According to a 2020 Report of the United Nations Secretary-General [2], "Data on violence against women and girls indicate that it affects women in all countries and across all socioeconomic groups, locations and education levels." Data from many sources indicate that the most dangerous place for women and girls is in their home [15, 18, 19]. Physical violence may begin as early as infancy, when cultural preferences for male children can result in the withholding of food and education, as well as domestic servitude and corporal punishment. The cycle of violence continues for girls and women as they enter into relationships with male partners. A 2013 report from the World Health Organization reports on data from 106 countries and concludes that approximately 30% of women will experience violence by a partner in their lifetime [20].

SGBV also affects the LGBTQ community, with some important differences, which will be discussed at length in Chap. 8 of this book. For the remainder of this chapter, we will use the terms "women" and "girls" to refer largely to cis-gendered individuals who identify as female.

The Impact of Sexual and Gender-Based Violence

SGBV often has long-lasting physical, psychological, social, behavioral, and spiritual impact on survivors. The physical and psychological effects may include (but are not limited to) those outlined in Tables 7.2 and 7.3 (Adapted from United Nations.

Table 7.2 Some physical effects of SGBV

All genders	Physical injury (internal/ external)	*Sexually transmitted infections*: GC, CT, HIV, Hep C, etc.	Permanent physical disability	Sexual dysfunction	Malnutrition due to food restriction
Women/ girls	Vulvar, pelvic, rectal injuries	*Pregnancy related*: Unplanned pregnancy complications Complications from unsafe abortion Complications from miscarriage Infertility			
Men/ boys	Testicular, penile, rectal injury	Atrophy of organs due to ligation			

Table 7.3 Some psychological effects of SGBV

Acute stress disorder	High-risk sexual behavior	Sleeping disorders
Anger	Low self-esteem	Suicidal thoughts/behavior
Anxiety	Post-traumatic stress disorder	Substance abuse
Chronic fatigue syndrome	Poor impulse control	
Depression	Personality disorders	
Dissociation	Self-blame	
Fear	Sexual dysfunction	
Flat affect/emotional numbing	Shame	

International protocol on the documentation and investigation of sexual violence in conflict best practice on the documentation of sexual violence as a crime or violation of international law. 2017, March. https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/06/report/international-protocol-on-the-documentation-andinvestigation-of-sexual-violence-in-conflict/International_Protocol_2017_2nd_Edition.pdf.)

US Asylum Law and SGBV

The granting of asylum in the United States on the basis of sexual and gender-based violence is a relatively new phenomenon. Case precedent was first established in 1996 with the Matter of Kasinga [21], and grew steadily until 2016. Nevertheless, it is still very difficult to win asylum on the grounds of IPV or SGBV, and the legal landscape often changes. The grounds for asylum on the basis of SGBV was further eroded by the 2020 Department of Justice guidance: *Procedures for Asylum and Withholding of Removal; Credible Fear and Reasonable Fear Review* [22] in which many of these grounds for relief were explicitly revoked. While these developments are discouraging, they also make the role of the clinician–evaluator even more important in the asylum process [23], and particularly so in sexual and gender-based violence cases.

One of the barriers faced by asylum seekers is documentation of efforts to seek protection through law enforcement or government agencies. This absence of reporting is often seen by the United States asylum adjudicators as evidence that either the abuse did not occur or that it was not severe. There are many reasons for underreporting of SGBV, including fear of reprisal, dependence on the abuser, shame, and stigma. Widespread underreporting makes the documentation of scars/ injuries, and long-term sequalae much more critical.

The Evaluation

The evaluation of a survivor of SGBV should follow trauma-informed care [24, 25] guidelines. Special consideration should be given to having a gender-congruent clinician and interpreter. All consent procedures should be strictly followed before and during the evaluation.

History Taking

When interviewing the client, begin with a routine medical, gynecological, surgical, and social history. When inquiring about incidents of SGBV, the evaluator should ask specific questions about the physical acts endured by the client. These include (but are not restricted to) the survivors' body parts involved (e.g., genital, anal, oral); the perpetrator's body parts involved in the incident (e.g., penis, fingers); use of foreign objects; the number of perpetrators; use of ligatures or strangulation [26] (can be common with IPV and SGBV); and co-occurring violent acts (e.g., kicking, beating, stomping, pushing). Inquire about any resulting pregnancy or pregnancy loss from the assault, or subsequent sexually transmitted infections (STIs). Document details of symptoms that immediately followed the assault, as well as those which became chronic conditions, such as genital bleeding, discharge, itching, sores, pain, urinary symptoms, anal pain, urinary or fecal incontinence, abdominal pain, etc.

In addition to an assessment of the physical and psychological scars inflicted by the abuser(s) on the client, it is vital to elucidate the cultural context in which the abuse(s) occur. It is incumbent on the evaluator, in cooperation with the attorney, to educate the adjudicator on in-country conditions as they relate to the experiences of the client. With respect to SGBV, clients should be asked about traditional family structure in which they lived, including patrilocal living arrangements, permitted daily activities, ability to leave the home/family compound alone, and polygamous households. History regarding restriction of educational opportunities, arranged and/or forced marriage, child marriage, dowry/ bride price, female genital cutting, and cultural tolerance of intimate partner violence should also be obtained from the client. The credibility of the client's experience of any of these harmful practices should be supported with scholarly sources on and expert analyses of the prevailing conditions in the client's home country whenever possible.

Physical Examination

There is a traditional division of the physical forensic evaluation into "medical" and "gynecological" spheres, which is a false dichotomy. When a forensic evaluator performs a physical evaluation, we do not serve our clients if we do not do a full exam of her entire body, including the genitals, when relevant. Furthermore, recognizing that forensic evaluations are often re-traumatizing [27–29], it is incumbent to minimize this exposure as much as possible. As such, we encourage "gynecological" evaluators to perform "head to toe" examination of all client, if they feel comfortable doing so, thus eliminating the need for an additional physical evaluation.

Importantly, when it comes to evidence of rape or sexual assault, there is often no remaining sign of genital injury, especially if the incident is not acute. Always ask yourself if a genital examination is necessary. If it is not necessary to further the forensic evaluation, genital exams should not be performed. Of particular concern is the sometimes "expected" examination of the hymen. In some settings, clinicians refer to changes in the hymen to confirm a history of consensual or nonconsensual sexual intercourse. However, an examination of the hymen is not an accurate or reliable test of a previous history of sexual activity, including sexual assault [30].

As described elsewhere in this book, documentation of injuries should be precise and in accord with the guidance offered by the Istanbul Protocol [31]. Photographs should be taken whenever possible after the provision of consent. However, genital injuries/scars should not be photographed. Photographing the genitals for the purpose of the asylum application may be traumatic and humiliating. Furthermore, it is critical to recall that the adjudicator will have the affidavit in front of him/her while they are speaking with the applicant: The inclusion of genital photographs would be highly inappropriate. Instead, the use of illustrations from a variety of sources (e.g., the WHO FGM/C typology or obstetrics and gynecology texts) is preferred (Appendix 2 also includes body diagrams).

The use of a chaperone during evaluations that include genital exams is not universal. On one hand, a chaperone's presence may offer a sense of safety to the client. On the other hand, it introduces yet another individual into the exam room at a time when the client may feel particularly vulnerable and possibly ashamed. The use of a chaperone should be discussed with clients and their attorneys in advance, with an assessment the client's preferences and emotional needs prior to the evaluation.

The Affidavit

In addressing SGBV cases, the task before the forensic examiner is somewhat different than those presented by cases which are centered on a basis of political opinion, nationality, or religion [32] because of the complexity and duration of abuse, as well as the cultural context in which the abuse took place. As with other asylum

applications, evaluators must consider the nature of injury inflicted, the severity of the harm, patterns of abuse by a perpetrator, and the existence of permanent or serious mental or physical health sequalae. Each of these should be addressed in the affidavit as it relates to the individual applicant's experience.

In writing this type of affidavit, it is reasonable to assume that the adjudicator is not familiar with the cultural/national behavioral norms experienced by the applicant. Describing the cultural setting for the adjudicator is important because they may not believe that behavior/abuse so different from what they consider "typical" is common or plausible.

Finally, the organization of the affidavit is particularly important in SGBV cases. Because women seeking asylum have often experienced a lifetime of overlapping types of violence in a variety of settings [33], it can be more difficult to describe and document a linear trajectory of persecution and abuse. However, it is incumbent on the clinician evaluator to make clear the co-occurring and extended nature of abuse often suffered by asylum seeking women. This may be best accomplished by dividing the affidavit into sections, with headers indicating each abuse type. This helps to give structure to a possibly complex narrative, and also serves to highlight the types of violence experienced by the applicant.

Special Consideration: Female Genital Mutilation/Cutting

Anecdotal information suggests that hundreds of women every year seek asylum in the US based on FGM/C status [34]. The practice has very specific and unique features that require specialized knowledge both of the sociocultural aspects of the practice, as well as the anatomical and morphological features of the external female genitalia, pre- and post-FGM/C. For this reason, we are providing a separate section dedicated to this type of evaluation.

Background

The practice of FGM/C affects an estimated 200 million women and girls worldwide. Accurate, up-to-date statistics are difficult to obtain because, while widely practiced, most nations have legislation banning the practice, thus making data collection difficult. It is estimated that more than 500,000 women and girls currently residing in the United States are at risk of or have undergone FGM/C [35]. FGM/C has been recognized as a human rights violation under several UN declarations and conventions including the Convention for the Elimination of Discrimination against Women [6], in which FGM/C is considered to be an extreme form of discrimination against women; is both physical and psychological abuse; the Convention on the Rights of the Child [36] (as FGM/C is usually carried out on minors); and the

UDHR [37] as a violation of the "rights to health, security and physical integrity of the person, the right to be free from torture and cruel, inhumane or degrading treatment." Furthermore, FGM/C is associated with child marriage and other harmful traditional practices in many regions [38].

The WHO has described four classes of FGM/C with several subcategories [37]. While there is ongoing discussion about the adequacy of the current classification, it is currently the authoritative standard and should be used in the affidavit to

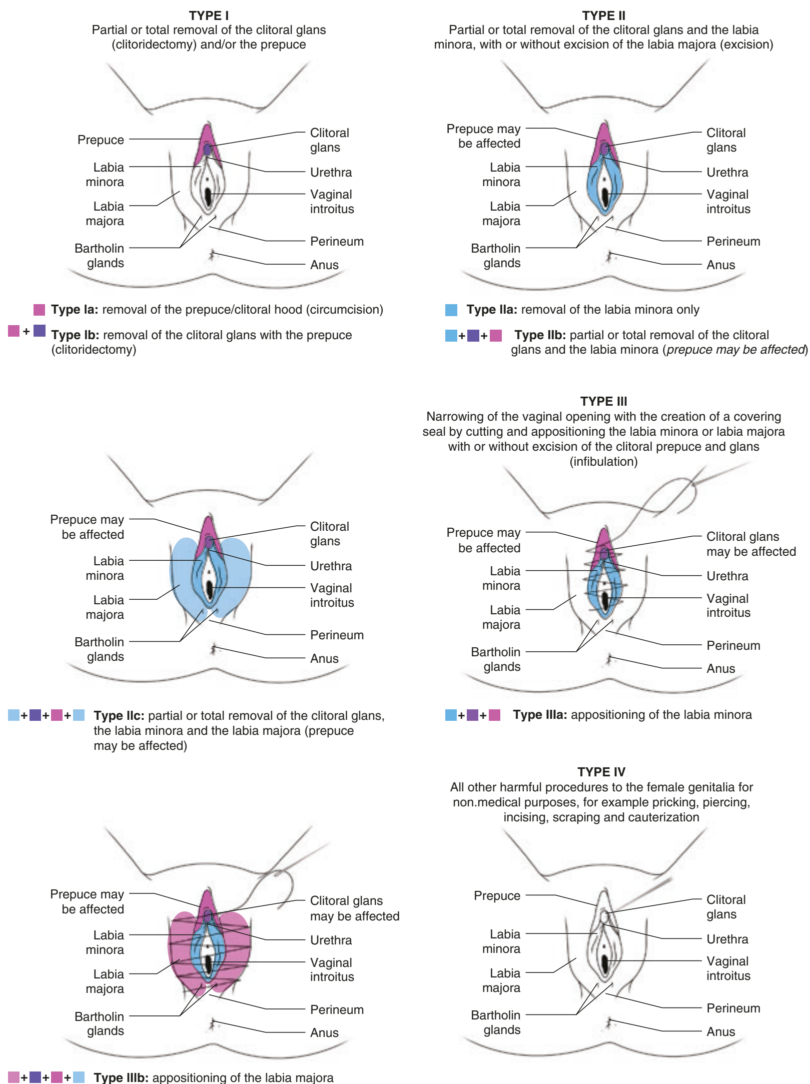

Fig. 7.1 World Health Organization FGM/C classes (Reprinted with permission from [37])

describe and categorize the parts of the external genitalia which have been removed (Fig. 7.1).

History Taking

When obtaining history about FGM/C, it is important to document not only the physical and psychological impact of the practice, but also the social history and details of the specific circumstances surrounding the cutting. A full description of

Table 7.4 Possible acute health consequences of female genital mutilation or cutting

Pain
Tissue swelling
Urinary retention
Genitourinary infection (local or disseminated)
Impaired wound healing
Hemorrhage
Shock (due to sepsis or hemorrhage)
Human immunodeficiency virus infection
Tetanus
Psychological trauma
Fractured pelvis, clavicle, or femur due to restraints
Death

Table 7.5 Possible chronic health consequences of FGM/C

Manifestation	Higher risk of
Genital	Chronic genital infections, including bacterial vaginosis
Human immunodeficiency virus infection	Due to genital trauma during intercourse
Infertility	Due to recurrent/chronic ascending genital infections
Menstrual	Dysmenorrhea, difficulty passing menses
Obstetric	Cesarean delivery, higher risk of hemorrhage, episiotomy or prolonged labor, obstetric tears and lacerations, instrumental delivery, labor dystocias, stillbirths, early neonatal deaths, prolonged hospital stay, infant resuscitation at delivery, obstetric fistula
Pain	Chronic vulvar, clitoral, vaginal, or pelvic pain
Psychological	Post-traumatic stress disorder, anxiety, depression
Sexual function	Dyspareunia, decreased sexual satisfaction, reduced sexual desire and arousal, decreased lubrication, anorgasmia
Skin	Scarring, keloids, cysts
Urinary	Recurrent urinary tract infections; painful urination due to obstruction

Table 7.6 FGM/C evaluation recommended history elements [40]

History element	Specific questions	Reasons
Ethnic, tribal, and religious history	Ask about ethnic/tribal and religious affiliation of the client, her spouse, parents, grandparents	Ethnic, tribal, and religious variations exist, and are reflected in different FGM/C prevalence rates. The client data can be compared to published statistics Family members' affiliations may be an important element in discussions about fear of the practice being forced on daughters The role of patrilocal marriage traditions should be ascertained as well. Anecdotally, we have seen cases when even if a girl's parents did not believe in the practice, she was forced to undergo the practice in deference to the groom's parents' demands
Geographic location	Ask about place of birth (country, village/town, region) and residence prior to migration	Regional variations exist in FGM/C prevalence. The client's personal information can be presented in the context of published regional statistics Bear in mind that the geographic distribution of ethnic/tribal groups does not always fall neatly within national borders. A high prevalence ethnic group may reside in a low prevalence nation
FGM/C status of other female family members	Inquire about the FGM/C status of sisters, mother, grandmothers, daughters	This information may help establish the community social norms about FGM/C as well as the potential threat of FGM/C if the asylee is, as yet, uncut
The procedure	Obtain detailed information about the practice the client has undergone: At what age? How do they know about the details? (What do they personally recall versus what a family member told them happened) Who did it (grandparent, midwife, medical professional) The social situation surrounding it Where was it done (village, hospital, house) Was it done in a group? If so, did anyone die? Was there kidnapping/trickery involved? Was it done with parental consent or against their wishes? What tools were used?	Such details offer more data that can be described in context with common practices published in the literature Such details can also offer additional hints to facilitate further probing about acute and chronic complications Type IV FGM/C may not be visible on physical examination, but is still considered a human rights violation Labial minora elongation (LME) is practiced in some countries (Rwanda, Uganda, Mozambique) and is considered a form of FGM/C in some contexts

Table 7.6 (continued)

History element	Specific questions	Reasons
	Memories of restraints (ropes or held down) What kinds of hygiene measures were taken? What was done immediately after the procedure for hemostasis, pain control Ask about other genital modification practices such as use of caustic substances, pricking, nicking, and labial elongation practices	
Acute complications	Ask the client to recall any acute reactions or complications suffered during or immediately after the procedure, including bleeding, pain at the wound, pain with urination, infections, musculoskeletal injuries, fear, anxiety Inquire about how those were addressed (use of local remedies, need to see physician, hospitalizations)	This information may establish the severity of the event (especially if linking it with allegations of torture) The history of intense fear, anxiety, and panic at being removed from loved ones or being injured by one's loved ones, held down against one's will, and injured painfully contribute significantly to the chronic psychological effects, such as PTSD
Chronic complications	Inquire about long-term physical and mental health complications the client associates with undergoing FGM/C Inquire about difficulty with routine reproductive health activities such as use of tampons, undergoing preventive health exams, and pap smears	Those may include chronic pelvic pain, sexual dysfunction (vaginismus, low/no sexual satisfaction, inability to achieve an orgasm), chronic urinary problems, scars/keloids, PTSD, anxiety and depression, permanent avoidance of marriage or intimacy, which may result in rejection and anger by a husband if married, or if single, ostracization by family and social group, as being single is not acceptable This information may help establish lasting physical and mental health effects of the practice
Issues related to pregnancy and delivery	Assess whether the client had any pregnancy-related complications potentially related to FGM/C during the prenatal, perinatal, and postnatal periods Inquire about a history of undergoing defibulation and when Inquire about a history of reinfibulation and if done, at whose request it was carried out.	For example: whether a cesarean or an episiotomy was required; whether the birth attendant attributed the need for the intervention to the FGM/C specifically; or whether they recall a significant tear/laceration requiring lengthy repair, which may be from FGM/C There are some (low quality) studies and case reports about an association between FGM/C and stillbirth, C-section, need for assisted delivery

(continued)

Table 7.6 (continued)

History element	Specific questions	Reasons
Other human rights violations	Assess whether the client has experienced other forms of sexual and gender-based violence, such as child marriage, forced marriage, rape, IPV, sexual assault	Some studies suggest that FGM/C co-occurs with other forms of gender-based violence Such information may help establish the need for protection under the "specific social group" criteria
Status of daughters	Inquire about the asylum-seeker's daughters' FGM/C status, and, if not cut, assess their risk of being cut if forced to return to the family's country of origin	This may help establish fear of future persecution and may offer an opportunity to also assess the risk to daughters of "vacation cutting" and associated legal issues
Activism	Ask about any political, social, advocacy, anti-FGM/C activities the client may have been involved with	This may help bolster claims of persecution due to political activities
Status of friends/family	Ask about deaths or significant morbidity/chronic complications witnessed directly after FGM/C or in childbirth due to FGM/C	May bolster claims of harm from the practice

the particular sequalae affecting a particular client is critical to the evaluation, as it speaks to the issue of "ongoing harm" as a result of an abuse.

Tables 7.4 and 7.5 describe some common acute and chronic manifestations of FGM/C [39].

Table 7.6 includes recommended elements of the history when evaluating a client seeking asylum based on FGM/C [40].

It is also important to ask about second cuttings. If the initial cutting is deemed to be unsatisfactory or insufficient, girls may be subjected to a second procedure: This may occur days or years after the initial event. For women and girls who have undergone FGM/C Type III (infibulation), a second procedure may be required to enlarge the vaginal opening in order to allow for sexual intercourse. This is often done by the same practitioners who perform FGM/C is often performed without anesthesia. Finally, some traditions require that women be re-infibulated after childbirth.

Lifelong psychological effects [41, 42] may also be experienced by FGM/C--affected women. Importantly, the degree of psychological distress is not related to the severity of the cutting itself, and some women do not express psychological harm at all. Feelings of betrayal, shame, humiliation, and distrust may manifest shortly after the procedure. Longer-term consequences may include anxiety, depression, and post-traumatic stress disorder. In addition to the psychological effects of their own FGM/C experience, asylum applicants may also experience trauma and distress after witnessing the FGM/C procedure and complications endured by others, including sisters, cousins, and friends.

While the majority of asylum seekers evaluated for FGM/C will be adult women, it is important to recognize that this is, in fact, a pediatric phenomenon [43]. The vast majority of individuals who will undergo the procedure are under the age of 15.

Those asylees who have female children often request protection, in part, to prevent their daughters from being forced to undergo the procedure over parental objection. Whenever possible, it is important to evaluate the children in order to attest to the fact that their genitals are (or are not) altered. If the child/children are prepubertal and you are not familiar with pediatric gynecologic exams/anatomy, it is best to request assistance from a local expert in the field.

Conclusion

Significant levels of inequality persist globally, resulting in many women and girls experiencing multiple and intersecting forms of discrimination, vulnerability, marginalization, and violence throughout their life course. Clinicians who conduct medicolegal evaluations are uniquely positioned to provide evidence of many elements of an applicant's story as well as supporting documentation. Medicolegal affidavits are also an opportunity to educate the immigration judge or asylum officer specifically about the effects of the abuse a particular asylee has suffered, as well as about the more general in-country conditions faced by women and girls from the same region.

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Chapter 8
Evaluating LGBTQ Asylum Seekers

Samara Fox

Introduction

While lesbian, gay, bisexual, transgender, and queer (LGBTQ)[1] individuals comprise a relatively small proportion of most global populations, they consistently experience discrimination and persecution, and are thus well represented among populations of asylum seekers. Consensual same-sex sexual activity is criminalized in 70 countries around the world [1] and in many more it remains fundamentally dangerous to live as a sexual or gender minority. One recent estimate calculated that 83% of all sexual minorities across the globe conceal their sexual orientation [2]. Since the 1990s, sexual orientation and gender identity have become increasingly common bases for asylum claims [3–5]. While awareness of the particular challenges faced by LGBTQ asylum seekers is increasing [6], these vulnerable populations can still experience a myriad of challenges after arriving in a host country. Some of these challenges may come in the form of stereotypes and assumptions held by the very healthcare and legal professionals who intend to help them. This chapter will review best practices for the evaluation of LGBTQ asylum seekers.

[1] The acronym LGBTQ refers to lesbian, gay, bisexual, transgender, and queer-identified individuals. This is an umbrella term popular in Western countries that will be used throughout this chapter to refer to all sexual and gender minorities. The terms LGBTQIA (I for intersex and A for asexual) and LGBTQ+, are also commonly used umbrella terms. As will be explained in section "Terminology and Identity", there are many other terms used across the globe for different sexual and gender identities, as well as different acronyms used by humanitarian and activist groups, and social science scholars.

S. Fox (✉)
Department of Psychiatry, Beth Israel Deaconess Medical Center, Boston, MA, USA
e-mail: sfox1@bidmc.harvard.edu

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Terminology and Identity

When evaluating asylum seekers making claims on the basis of sexual orientation and/or gender identity, it is important to be aware that some individuals may not necessarily use an identity label that is familiar to the healthcare provider. While the terms lesbian, gay, bisexual, transgender, and queer have spread from Western countries to many other parts of the globe and tend to dominate international human rights discourse [7], there is an enormous variety of sexual and gender identities in the world [8]. For example, in Haiti, some men who would likely self-identify as gay in the United States or Canada use the acronym MSM (men who have sex with men) for themselves. While the term was originally used as a behavior descriptor in the field of HIV epidemiology, in Haiti it has become an expression of self-, or at least behavior-identification [9]. In India and Pakistan, the terms "hijra," "kinnar" and "khawaja sira," which have longstanding caste-based connotations, are often used as both othering labels as well as proud self-descriptors for individuals who are assigned as male at birth but who have a feminine gender presentation [10]. While a Western healthcare practitioner may view such an individual as a transgender woman, they are officially recognized as a "third gender" on the Indian subcontinent and many identify as neither male nor female [10].

Overall, it is also important to be aware that even terms that are already familiar to a clinician may have a different meaning to an asylum seeker. Most often, a transgender person is someone whose gender identity differs from their sex assigned at birth. These individuals identify as either male or female and will only use the term transgender as a modifying adjective (transgender man or transgender woman). However, some asylum seekers who still identify with their birth sex but do not comply with gendered societal expectations regarding their appearance may also refer to themselves as transgender [11]. Similarly, in some countries where terms such as gay or lesbian are especially taboo, individuals may refer to themselves as bisexual even though they lack an interest in the opposite sex [11]. This may be because the term is less stigmatized, or because they have engaged in sexual behavior with the opposite sex and choose a label that is based on their history of sexual behavior rather than their sexual attraction. Even within the world of international human rights activism there are differences in terminology. Some organizations prefer the umbrella acronyms SOGIE (sexual orientation and gender identity and expression) or SGMs (sexual and gender minorities) to LGBTQ. The nomenclature to describe various particular gender identities continues to evolve.

In light of this wide variation in terminology, practitioners should always ask an asylum seeker what words they use to identify themselves, should explore their exact meaning, and should use them while in conversation with the asylum seeker. When documenting the forensic evaluation, practitioners should provide an explanation for the identity term used by the asylum seeker if they think the term may be unclear to an aslym officer or judge. Similarly, practitioners should ask what pronouns asylum seekers use to refer to themselves (masculine pronouns, feminine pronouns, or other pronouns) and not make assumptions regarding the genders of

their romantic or sexual partners. Some asylum seekers may never have been asked what identity labels or pronouns they use, and may even be confused by the question. However, asking about preferred terminology and pronouns is not only an important basic courtesy for many LGBTQ individuals, but it also fosters trust during an evaluation that can cover emotionally difficult and personal disclosures, and provides for consistency in the documentation of an asylum seeker's application.

LGBTQ Asylum Narratives

An LGBTQ asylum case generally relies upon the applicant's ability to persuade an adjudicator that they are a member of a "particular social group." This phrase was intentionally used as a catch-all category in the 1951 United Nations Convention relating to the Status of Refugees and the 1967 Protocol Relating to the Status of Refugees so that the courts of signatory countries could have the flexibility to recognize new vulnerable groups in need of protection [5, 12]. Since the late 1980s and early 1990s, an increasing number of countries began to recognize sexual and gender minorities as being eligible for protection under the classification of "particular social group" [3–5]. In deciding whether an applicant fits into the social group of a particular sexual or gender minority, adjudicators may rely on their own culturally bound stereotypes regarding the expected appearance, life history, and identity narrative of an LGBTQ person [13]. For example, an immigration official may expect a lesbian to wear masculine clothing, or expect a gay man to have effeminate mannerisms or particular speech patterns [13, 14]. Immigration officials are generally trained to avoid such stereotyping [6]. However, a grant of asylum depends upon a highly subjective determination of an applicant's "credibility" and therefore these stereotypes can still exert a subtle influence. Forensic evaluators may possess such stereotypes as well, and it is important to be mindful of how they may bias an evaluation.

Adjudicators and forensic evaluators may assume LGBTQ applicants have had an awareness of their sexual orientation or gender identity from a young age, that they have acted on their attraction or identity, and that their orientation or identity has been consistent over time [15]. There is also a prevalent belief that applicants have uncomplicated binary identities. For example, transgender and other gender-nonconforming individuals are often expected to feel as if they were "born in the wrong body" and to desire a complete transformation, both physically and socially, into the "opposite" sex from which they were born [16]. In reality, transitioning is an ongoing process for many, and as a concept can vary from for different transgender and other gender-nonconforming people. While applicants who are bisexual or pansexual can win asylum claims, they can be viewed with skepticism by immigration officials [17]. While it is in violation of existing asylum law precedent, some adjudicators have even explicitly denied asylum for a bisexual applicant, reasoning that they could choose to have exclusively heterosexual relationships [17]. There is often another expectation that applicants are open about their identities with family

members and friends and that they often socialize with other LGBTQ people [18]. These presumptions often persist despite the very real risks of being out in an applicant's home country and in the immigrant communities of prospective host countries, the existence of internalized homophobia and transphobia, and natural variations in an individual's preference for socializing with a larger sexual orientation or gender identity-based community [18]. Some asylum seekers may have an awareness of certain stereotypes because they also exist in their home countries. They may also be pressured by their attorneys or fellow refugees to conform to these stereotypes in a misguided effort to improve their chances obtaining asylum. Despite many of these unwarranted notions, it is important to note that a valid asylum claim can be made even if an applicant is merely "perceived" to be a member of a particular social group and is persecuted based on that perception [19]. Thus, some asylum seekers may not actually identify as being LGBTQ, but may still be persecuted because of their behavior of having sex with someone of the same sex, because their gender presentation is perceived by others to be a marker of sexual orientation (as is often the case for gender-nonconforming individuals), or because they are associated with other people who are known to be sexual or gender minorities.

Overall, given the complexities reviewed above, it is important for forensic evaluators who include any component of an applicant's life narrative in their affidavit to record it specifically and accurately. An evaluator may ask probing questions about an applicant's sexual, romantic, and gender-identity history, but should ask respectfully and avoid the use of leading questions or identity labels that telegraph the examiner's culturally bound expectations. In particular, examiners should not assume that an applicant has only been sexually or romantically involved with one particular gender, or that an applicant identifies as exclusively male or female.

Physical Exam

One recent study of LGB asylum seekers found that sexual violence was the most common form of persecution they experienced (65.5%), followed by beatings (59%) [20]. LGBTQ asylum seekers frequently also experience medical abuse and extended periods of detention at the hands of law enforcement [21]. Given the high rates of physical and sexual abuse that LGBTQ asylum seekers have experienced, the physical exam component of a forensic exam should be approached with particular sensitivity. Prior to the evaluation, it is helpful to ask if the applicant has a preference for the gender of the person who will be conducting their physical exam. If an examination of any gendered anatomy is necessary, such a breasts or genitals, a respectful forensic examiner also will ask what terminology transgender and other gender-variant examinees prefer to use for their own anatomy [22]. Using preferred terminology is useful in reducing gender-related dysphoria for individuals who are uncomfortable with their own gendered anatomy. For example, a nonbinary or transgender male may prefer that a practitioner use the term chest when examining breast

tissue [22]. Based on their own cultural background, some asylum seekers may be confused by this question, but others will appreciate the awareness and sensitivity it demonstrates.

Unfortunately, in a number of countries where sexual intercourse between cisgender males is prohibited, forensic clinicians there perform forcible digital rectal exams to “determine” if an individual has had ongoing receptive anal intercourse [23]. Such practitioners claim that they can detect decreased anal sphincter tone on exam, and that this decreased tone is an indicator of repeated anal intercourse [23]. Even if such an exam were done with the consent of the examinee, there is no scientific evidence that it is a reliable indicator of an individuals’ sexual practices, and should never be performed by a forensic evaluator [23]. If an applicant has experienced an acute sexual assault that included forcible anal penetration, a standard sexual assault exam of the anal verge for signs for trauma such as hematomas and lacerations would be appropriate [24]. A digital rectal exam would only be appropriate if there was a recent sexual assault which included the insertion of a foreign object into the anal canal [25]. Since most asylum examinations occur months or years after the persecution, rectal and vaginal exams are rarely necessary.

In addition to documentation of sequelae of assault, a physical exam of an LGBTQ asylum seeker may also be useful in providing documentation of any gender-affirming interventions. This could include documentation of surgical scarring and physical appearance consistent with gender-affirming surgeries such as top surgery (the removal of breast tissue to create a male-appearing chest), augmentation mammoplasty, orchiectomy, phalloplasty, and vaginoplasty [26]. This could also include documentation of other self-initiated interventions such as binding (using a piece of tight fabric used to flatten breast tissue to create a more male-appearing chest), facial hair removal, packing (the use of a penile prosthesis in undergarments to create the outward appearance of male genitalia), and tucking (moving the penis and scrotum posteriorly and/or moving testicles into the inguinal canal to create the outward appearance of female genitalia) [26]. Finally, if not documented by another practitioner who is prescribing gender-affirming hormones, a forensic examiner may describe physical exam findings consistent with their use (e.g., characteristic patterns of hair growth, skin texture, and fat deposition) and/or laboratory tests of hormone levels [27, 28]. Documentation of the initiation of gender-affirming care may be particularly important for applicants who are attempting to obtain an exception to an asylum application deadline. For example, in the United States, asylum seekers are required to apply within 1 year of arrival [29]. However, this requirement may be waived if an applicant can demonstrate “changed circumstances” that occurred after the 1-year deadline [29]. Such circumstances can include a change in gender identity or expression that would now place an applicant at risk of persecution if they were returned to their home country [29]. Overall, given the sensitive nature of examining gendered anatomy, practitioners should obtain explicit consent for such exams, and discuss in advance with the asylum seeker, and potentially their attorney, if the exam is truly necessary for completing a dispositive forensic evaluation.

While the focus of this chapter is on LGBTQ asylum seekers, people with differences of sexual development (also referred to as intersex people, or in medical literature as people with disorders of sexual development (DSD)) are also frequently persecuted. This may be the result of a stigma against the atypical sex characteristics themselves, because intersex individuals are perceived to be LGBTQ, or because they also identify as a sexual or gender minority [30]. In addition to the same types of persecution that LGBTQ people experience, those with difference of sexual development may also be subjected to "corrective" surgical procedures [31]. When evaluating an asylum seeker with a difference of sexual development, it is only necessary to examine genitalia or document secondary sex characteristics if they are directly related to the applicant's persecution narrative, or to document evidence of a prior surgery or genital mutilation. When conducting such an exam, it is important to employ the same sensitive approach described above for LGBTQ applicants, including using the asylum seeker's preferred terminology for their anatomy.

Mental Health Exam

As mentioned above, LGBTQ asylum seekers experience particularly high rates of sexual trauma. They also frequently experience patterns of persecution that are associated with long-term mental health sequelae. One study that compared LGB asylum seekers with non-LGB asylum seekers of the same country of origin and gender found that LGB asylum seekers were significantly more likely to have experienced sexual violence, as well as childhood persecution and persecution from family members [20]. This same study also found a relationship between a history of sexual violence and screening positive for PTSD on the Harvard Trauma Questionnaire. Existing psychological literature has shown a strong relationship between childhood trauma and mental health morbidity as an adult [32], and research on LGBTQ populations in particular has shown a relationship between family rejection and mental health morbidity [33]. Other forms of persecution that may lead to psychological traumatization include the ongoing threat of execution or honor killings, forced marriage (particularly lesbian and bisexual asylum seekers) [34], as well as blackmail and extortion [35]. LGBTQ asylum seekers also experience high rates of social isolation in their host countries, which can further exacerbate mental illness [36].

Given the patterns of persecution and ongoing stigma that LGBTQ asylum seekers often experience, rates of mental health morbidity are very high. One chart review of 50 LGB survivors of torture found that 70% were diagnosed with PTSD, 28% with generalized anxiety disorder, and 76% with depression [37]. Similarly, a survey of more than 300 LGBTQ asylum seekers in North American found that 80.2% screened positive for mental distress requiring referral to a mental health professional [36]. Because of these high rates of mental health morbidity and the sensitive nature of the trauma experienced, it is important to obtain a thorough persecution history from LGBTQ asylum seekers, compare that history to the one described in any written affidavit provided at the time of evaluation, and to use

culturally appropriate and validated mental health screeners. Some examples include the Harvard Trauma Questionnaire (HTQ) [38], the Refugee Health Screener (RHS-15) [39], and the Hopkins Symptom Checklist (HSCL-25) [40].

Conclusion

Until acceptance grows substantially for the millions of LGBTQ individuals living in countries around the world, those experiencing persecution on the basis of their sexual orientation or gender identity will continue to seek humanitarian protection in substantial numbers. Clinicians evaluating these individuals should be comfortable using appropriate terminology and conducting an interview that covers an asylum seeker's sexual orientation, gender identity, life history, and any relevant gender-affirming medical care. If a physical exam is part of the evaluation, clinicians should perform a relevant, focused, and sensitive exam on transgender and other gender-variant individuals. For those interested in learning more about LGBTQ human rights and health, the appendix lists in-depth resources. These resources include overviews of anti-LGBTQ laws, guides to sexual orientation and gender identity terminology, summaries of best practices when interacting with LGBTQ asylum seekers, and several suggestions for those interested in learning more about LGBTQ-specific healthcare.

Appendix: Additional Resources

Topic	Source	URL
Anti-LGBTQ laws	Human Rights Watch	http://internap.hrw.org/features/features/lgbt_laws/
	International Lesbian, Gay, Bisexual, Trans, and Intersex Society	https://ilga.org/downloads/ILGA_World_State_Sponsored_Homophobia_report_global_legislation_overview_update_December_2020.pdf
SOGIE terminology	Organization for Refuge, Asylum & Migration	https://oramrefugee.org/wp-content/uploads/2019/12/Glossary-PDF.pdf
	Heartland Alliance	http://www.rainbowwelcome.org/uploads/pdfs/Rainbow%20Response_Heartland%20Alliance%20Field%20Manual.pdf
	National LGBT Health Education Center – Fenway Institute	https://www.lgbthealtheducation.org/publication/glosario-de-terminos-lgbt-para-equipos-de-atencion-a-la-salud/
SGM refugee best practices	Organization for Refuge, Asylum & Migration	https://oramrefugee.org/wp-content/uploads/2019/12/Sample-Training-Slides-English.pdf
	Immigration Equality	https://www.immigrationequality.org/get-legal-help/our-legal-resources/immigration-equality-asylum-manual/working-with-lgbth-asylum-seekers/#.XnY1lxd7nVo

Topic	Source	URL
LGBTQ and gender-affirming care	UCSF Transgender Care & Treatment Guidelines	https://transcare.ucsf.edu/guidelines
	National LGBT Health Education Center – Fenway Institute	https://www.lgbthealtheducation.org/publication/textbook/
	Lesbian, Gay, Bisexual, and Transgender Healthcare – Clinical Guidebook	https://www.springer.com/gp/book/9783319197517

LGBTQ Lesbian, Gay, Bisexual Transgender, Queer, *SOGIE* Sexual Orientation and Gender Identity and Expression, *SGM* Sexual and Gender Minorities

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Chapter 9
Performing Remote Asylum Evaluations

Elsa Raker and Anjali Niyogi

Introduction

In cases where an evaluator and asylum seeker are unable to be in the same physical location, a remote forensic evaluation is often an acceptable alternative to foregoing the evaluation altogether.

Remote evaluations may be necessary due to circumstances created by government policies resulting in obstacles or deterrents to seeking asylum. For example, in 2019, the United States (US) implemented the Migrant Protection Protocols (MPP) or "Remain in Mexico" policy. The policy allowed the US border officers to return non-Mexican asylum seekers to Mexico to wait while their US asylum cases were adjudicated in the US immigration courts. Due to the backup of immigration courts, asylum seekers were forced to remain in dangerous conditions in Mexico for months before crossing northward to attend their immigration hearing. At its peak, well over 65,000 asylum seekers were stranded just south of the Mexico–US border [1]. Whereas before MPP was instituted, asylum seekers who needed a forensic evaluation for their asylum case might have been able to present to a US clinician's office for an in-person evaluation, MPP created a need for a system in which asylum seekers forced to be in Mexico could still access forensic asylum evaluations. Dangerous situations in Mexico highlighted another reason for remote evaluations. As of February 19, 2021, there were over 1500 public reports of kidnapping, torture, rape, murder, and other atrocities committed against those in waiting [2]. In December 2019, a program to provide remote forensic asylum evaluations was launched in Matamoros, Mexico [3].

E. Raker (✉)
Asylum Program, Physicians for Human Rights, New York, NY, USA
e-mail: eraker@phr.org

A. Niyogi
Tulane University School of Medicine, New Orleans, LA, USA
e-mail: aniyogi@tulane.edu

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Asylum seekers in immigration detention have also utilized remote evaluations, particularly in cases where Immigration and Customs Enforcement (ICE) does not allow an in-person visit with the evaluator or where the evaluator is not able to travel to the client. For the thousands of asylum seekers in ICE custody across detention centers, jails, and prisons in the US, remote asylum evaluations are often the only option.

At the start of the COVID-19 pandemic, communities across the United States sought to “flatten the curve” of the virus by reducing the spread in order to save lives and decrease the burden on the health system through practices of social distancing, wearing face masks, and undertaking all health visits that could reasonably be carried out remotely through telehealth platforms. The pandemic interfered with most options for performing in-person evaluations, and left providers of forensic asylum evaluations with two options: suspend forensic evaluations until the pandemic allowed for in-person evaluations to resume or provide them remotely.

From March 15, 2020, until March 12, 2021, most asylum seekers, attorneys, and clinician evaluators who made requests for forensic evaluations to the Asylum Program at Physicians for Human Rights opted to pursue a remote option rather than waiting for social-distancing restrictions to live. In that time, the program placed 562 client cases for remote evaluations [4].

This chapter, drawing heavily from experiences providing remote evaluations during the COVID-19 pandemic, provides commentary about the impact of remote evaluations, the technology required, logistical challenges, similarities with telehealth, and training resources available to evaluators.

Scholarship on Remote Asylum Evaluations

As remote forensic evaluations have much in common with telehealth and telemental health visits, it is useful to reflect on some of the findings of recent scholarship on telehealth. The COVID-19 pandemic forced many providers to adapt to remote alternatives for in-person patient visits across health disciplines, and these adaptations have led to the creation of reputable resources for providers conducting visits remotely [5]. Research suggests that providers have confidence about the reliability of telehealth visits. For example, practitioners have found that “teledermatology is a useful alternative […] and has generally been accepted by patients and practitioners alike” [6]. This finding provides confidence that the remote evaluation of scars and lesions from traumatic injuries and torture is also possible.

Likewise, the finding that “phone interviews are a reliable method of interviewing for use in assessing patients for posttraumatic stress disorder and major depressive disorder” [7] supports the principle that psychological evaluators can adequately diagnose PTSD in an asylum seeker through a remote psychological evaluation. A review of 452 published research articles on telepsychiatry found similar treatment outcomes to in-person visits and satisfaction among patients and providers [8].

A recent study on remote evaluations of asylum seekers also reports on the satisfaction of providers. The 2019 study compared 10 telephonic asylum affidavits with 20 affidavits from in-person evaluations and found that "Providers agreed that despite limitations, the ability to diagnose and advocate for asylum seekers is equivalent regardless of format" [9]. The study's overall finding identified that "telephonic psychiatric evaluations produce comparable results to in-person evaluations with the benefit of reaching a hard-to-reach population." An April 2020 review of the Mount Sinai Human Rights Program's Remote Evaluation Network finds "that concerted coordination of forensic mental health evaluations by telephone or video improves access to forensic evaluations and provides a feasible alternative for asylum seekers unable to obtain in person evaluations" [10]. Eric Stone, a California-based licensed clinical social worker who has conducted at least 20 asylum evaluations, echoes this finding, stating that "Online eval[uation]s are equally as effective as in-person. In fact, I think the clients are slightly less anxious online because they are in their own homes and not traveling to an 'examination' which tends to create a buildup of anxiety" [5].

Among asylum medicine scholars, the consensus seems to be that the capacity of medical experts to determine their own ability to make a diagnosis and assess signs and symptoms of an asylum seeker's trauma through a forensic evaluation remains the same with remote evaluations as in-person evaluations. By March 12, 2021, at least 282 individual asylum evaluators with Physicians for Human Rights' (PHR) Asylum Network had volunteered to undertake remote evaluations, demonstrating their confidence in a remote modality [4]. At least 20 medical school asylum clinics including those at Cornell, Harvard, Brown, UCLA, Emory, Columbia, Baylor, and others also adapted to remote programming during the COVID-19 pandemic, reflecting a similar confidence [4].

Of course, as is the case with in-person evaluations, an opposing attorney might try to discredit the evaluator's affidavit. However, if the evaluator is able to provide an affidavit of the same quality as an affidavit following an in-person evaluation, the evaluator should feel confident in their ability to defend their findings if asked to provide testimony as part of the asylum seeker's proceedings. The clinician should be open about the remote nature of the evaluation, any difficulties that were encountered, and how those difficulties were addressed [11].

Most of the outcomes of cases where an asylum seeker received a remote evaluation will likely not be available for some years as the backlog in immigration courts has become even more pronounced due to the COVID-19 pandemic. Nevertheless, it is still important to create systems to track case outcomes. This programmatic data may be used in the future as a metric to assess the impact of remote evaluations and can be compared with case outcomes for in-person evaluations. Some asylum adjudicators give us hope that the affidavits from remote evaluations will be viewed favorably. Susan Roy, a former immigration judge, stated her belief that "Online evaluations, if they're conducted with the same sort of protection of privacy and objective measures, would be given the same weight as in-person evaluations by immigration judges" [12].

Technology, Confidentiality, and Consent

During a remote asylum evaluation, a telehealth platform or other technology is used to connect the asylum seeker to the evaluator. Thus, the more comfortable an asylum seeker is with telehealth, the more likely the evaluation to be successful. The more comfortable an evaluator is with telehealth, the better. The client's age and mental health status should be taken into consideration when deciding if they are a good fit for a remote evaluation, as well as their consent to do the evaluation remotely and their ability to undertake it. The determination of whether a remote evaluation is likely to be successful can be made through communications with the attorney and client, and through accessing prior health records and prior evaluations.

Health Insurance Portability and Accountability Act (HIPAA) Compliance

In-person asylum evaluations are undertaken to document torture and ill-treatment and the content of the evaluation is recorded in an affidavit and presented to immigration authorities and therefore does not generally fall under HIPAA requirements. The same is applicable to remote evaluations. However, some evaluators still prefer to use a HIPAA-compliant platform to conduct the remote evaluation, such as a HIPAA-compliant Zoom account, doxy.me, or Simple Practice [12]. Other evaluators may be able to use any number of other platforms such as non-HIPAA-compliant Zoom accounts, Blue Jeans, Facebook, FaceTime, Google Hangouts, WhatsApp, Skype, or a telephone. Public facing platforms such as Facebook live and TikTok are not appropriate for remote evaluations [11].

Choosing the Technology

Though the evaluator may prefer a HIPAA-compliant telehealth platform, the platform can also be chosen through consensus between the asylum seeker and evaluator. Ideally, the platform should be one that the asylum seeker and evaluator are comfortable with and experienced using, or a platform that someone in the same physical space as the asylum seeker is comfortable using and can help to configure.

Consent and Data Security

Though HIPAA compliance is not essential for asylum evaluations, the evaluator still has an ethical duty to maintain confidentiality, protect client data, and obtain consent from the asylum seeker undergoing the remote evaluation.

Since no remote platform is 100% secure, it is the evaluator's responsibility to inform the asylum seeker of the data security risks involved in conducting the evaluation remotely [12].

Location

In addition to obtaining consent, the asylum seeker (or their attorney) should be asked if they have access to a remote platform and a private space where they can share confidential information with the volunteer for the duration of the evaluation. In cases where the asylum seeker does not have access to a private space, the evaluator should seek to postpone the evaluation until such space can be found. Note that a "private space" can also mean the client's car, a public park where they are out of earshot, or other such places, though an office, exam room, or residence is ideal.

Technology and Detention

For asylum seekers in detention, ICE might be more likely to acquiesce to a request for a confidential phone for a forensic evaluation than a remote video platform. While a tele-

phone encounter might be adequate for a psychological evaluation, it is not conducive for a physical evaluation.

Tools for Masking an Evaluator's Telephone Number

Other technical tools include Doximity, which hides the evaluator's phone number while conducting a telephonic evaluation. Evaluators can also dial *67 before dialing the asylum seeker's number, which makes the evaluator's phone number appear as "Unknown." Alternatively, evaluators have used the iPlum app, which is HIPAA-compatible, for a similar purpose [12].

For information about online instruments, the evaluator can contact a scientific assessment company to ask about online tools. Pearson Clinical Assessment group, the Global Institute of Forensic Research (GIFR), and Multi-Health Systems Inc. (MHS) all offer a wide variety [12].

Malingering

Test of Memory Malingering (TOMM) is an online tool to assess malingering. The likelihood of malingering should not differ between a telephone or a video appointment [12]

Logistics

A conversation with the asylum seeker's legal counsel prior to the remote evaluation is just as important when a remote evaluation occurs as when the exam is in person. This conversation should include all topics covered in a pre-evaluation conversation with an attorney in an in-person evaluation scenario, including discussion of the key details of the client's case. The evaluator and attorney should also discuss:

- Emergency plans (in case the client expresses being in danger or wanting to cause harm to self or others)
- An alternative plan in the case the technology fails
- How to obtain the client's consent
- The technological platform to be used
- The space where the client will be for the duration of the 2–3 hour evaluation
- Remote interpretation

Since the experience of a remote asylum evaluation is probably unfamiliar to the client and the interpreter, some evaluators prefer to set up a test run with both parties prior to the evaluation to confirm that the technology will function. Interpreters can also be contacted separately to prepare them for the remote evaluation in advance.

During the remote evaluation, the evaluator's goal is to replicate the experience of an in-person evaluation as much as possible, while being candid with the client about the potential limitations of and possibilities of re-traumatization when discussing intimate details over a remote platform. To achieve the goal of mitigating limitations, the evaluator can minimize distractions when possible, point the camera to their eye level, and discuss potential technological difficulties with the client. The clinician can let the client know they will take notes during the encounter and might

look away from the screen, but that this does not mean they are not listening to the client [12].

Remote Evaluation Types

This section explains major considerations for each type of evaluation (physical, psychological, and gynecological). Neuropsychiatric and competency evaluations are not addressed here.

Psychological:

Though the clinician might prefer to conduct the psychological evaluation via video platform to make it easier to establish rapport and to assess physical and visual cues, psychological evaluations can also be adequately conducted using a telephone. In fact, a phone might be preferable in situations where the Internet connection is not strong enough to sustain a natural conversation over a video platform [12]. As mentioned, the evaluator should speak with the client's attorney prior to the evaluation, in part to decide which platform is most suitable for the remote evaluation. For clients in detention, the *de facto* option might be to use a telephone, due to lack of access to video capabilities. It is also acceptable to begin the evaluation via video to establish rapport and assess visual cues and then change to phone in cases where the internet signal is weak.

Physical:

There is very limited scholarship on conducting physical evaluations remotely. A remote physical evaluation of scars, burns, or other findings on the body is only suitable if these marks are in a place on the body that the client is comfortable revealing on camera. Scars that are on breasts, genitalia, or other private parts of the body should never be evaluated over video. For clients who are comfortable with a video evaluation and have good connectivity, it is recommended that the evaluator ask the client to have a mobile device on hand. The evaluator can then guide the client to show the parts of the body that may have scars or other anomalies. This method requires that the client have good lighting and/or a flashlight on hand. The client should also have a ruler, coin, or other standard-sized object available to hold next to the scar so the evaluator can document the size of the mark.

Another option for viewing scars or other anomalies on the body is to ask the client to show the scar on camera to the evaluator, who can take a screenshot of the scar. The client can then take a higher-quality photo and send it to the evaluator. For clients in detention who might not have access to a video platform, sending a high-quality photograph may be the only option, and if possible, the scar should be verified by the client's attorney or other witness. Another suitable alternative to a remote physical evaluation is a medical record review, if the client can provide medical records [11].

Gynecological:

Gynecological evaluations are the most difficult type of evaluation to conduct under circumstances that prevent the evaluator and client from being in the same physical location. As mentioned, evaluators should never ask an asylum seeker to reveal their genitalia over a video platform. Instead, a two-part evaluation is recommended.

After the client has confirmed their consent to speak with a gynecologist over a phone or video platform, part one of the gynecological evaluation is undertaken by the evaluator.

This includes taking an in-depth client history, with particular attention to queries about physical sequelae of their genital trauma. For example, if the client is being evaluated for female genital mutilation/cutting (FGM/C), this could include questions about sexual function, birth complications, urinary symptoms, etc.

Part two of the gynecological evaluation should include a brief in-person physical evaluation of genital trauma. If this in-person exam is not possible, the evaluator can still write an affidavit using part one of the evaluation, explain the constraints of the evaluation, and express a medical need for any deportation proceedings to be stalled until after the evaluator has had a chance to document any genital trauma in person. Again, a medical record review as an alternative to an in-person assessment can be also acceptable [11].

Case Study: Measuring Scars with Coins

During the COVID-19 pandemic, a female asylum seeker from Central America was evaluated over a video platform to document psychological trauma related to her account of sexual and domestic abuse. The client was comfortable with the evaluator taking her medical history through a remote platform. The evaluator was forthright about limitations caused by the remote platform at the beginning of the affidavit:

> The interview was conducted remotely by video via WhatsApp. Consent for the video encounter was obtained in advance by [Client's Name]'s attorney. The interview lasted approximately 2.5 hours and was conducted in Spanish, with the help of an interpreter who provided simultaneous translation by video.
>
> Of note, forensic medical evaluations are generally done in person, not by video. Remote forensic evaluation practices have adapted as a result of the COVID 19 crisis and the need for social distancing. […]
>
> [B]ecause of the limitations presented by the video venue, I was not able to do a full physical evaluation as I usually do; I was restricted to visualizing only the scars that [Client's name] was willing and able to show me via video. […]
>
> [Client's name] was able to cooperate fully with the entire evaluations and manage the technical aspects of the video encounter.

The evaluator completed the client's history taking remotely and administered assessment tools to document whether the client had anxiety, depression, and/or PTSD. The affidavit then moved on to the physical portion of the evaluation, also conducted remotely. The affidavit states:

> Right upper thigh: [Client's name] placed a quarter coin at the center of a cluster of 2–3 millimeter hyperpigmented (darker) circular markings. [Client's name] attributes these to injuries sustained when she was beaten with a cord that had a connector at the end; she explained that the connector was hard and made small punctures where it landed on her skin. The size and random distribution of these scars is consistent with this type of injury. […]
>
> Of note, a genital exam was not done. In addition to the potential trauma of such an exam to [Client's name], there is almost no possibility of identifying physical evidence of her years of sexual abuse as a child [13].

Challenges of Conducting Remote Asylum Evaluations

Remote evaluations present a host of challenges, including technical problems with remote platforms and internet connectivity, difficulty building rapport with the client, assessing mental health status, and logistical issues. Because of the need to develop more creative strategies around logistics for remote evaluations, here are two particularly challenging scenarios that were addressed in 2020. Additionally, below is a case study of remote evaluations conducted in Matamoros, Mexico, that demonstrates how asylum seekers, attorneys, evaluators, and civil society groups navigated the difficult context.

Scenario 1 Five-year-old client living with his grandmother who requested psychological evaluation and physical evaluation of a scar on his ankle during the COVID-19 pandemic.

> Due to his age, it was anticipated that a telehealth evaluation would be formidable. Nevertheless, the mental health evaluator met with the client and his grandmother remotely to assess his amenability for a remote option. When it was found that it was difficult to build rapport with him, the psychological evaluation was postponed until a time when the evaluator could see him in person. However, the physician evaluator was able to conduct the physical evaluation of the client with the assistance of his grandmother, who helped him show his scar to the evaluator over the video platform. The evaluator also conducted a remote interview with the child's grandmother for more information about the history and cause of injury.

Scenario 2 Adult client with poor Internet connection and no access to a phone who requested a physical evaluation of a scar on his back and a psychological evaluation during the COVID-19 pandemic.

> In this situation, an attempt was made to find an appropriate space for the client to perform the evaluation that could accommodate the technological needs. The client's attorney invited the client to use her private office for the evaluation and configured a confidential Zoom line for him so he could show his scar to the evaluator and complete the psychological evaluation.

Case Study: Asylum Seekers Encamped in Matamoros

An encampment in Matamoros, Mexico, grew rapidly after June 2019, when the Trump administration enacted the Migrant Protection Protocols (MPP) or "Remain in Mexico" policy. It created a particular set of obstacles for asylum seekers accessing remote evaluations.

Kidnappings and armed assaults against migrants and asylum seekers in Matamoros are frequent and compound the pre-existing trauma many asylum seekers already carry. By February 19, 2021, Human Rights First had documented over 1500 cases of murder, kidnapping, rape, or other violent attacks on migrants and asylum seekers along the US–Mexico border [2]. Since volunteers started conducting remote asylum evaluations in Matamoros during a pilot program launched in December 2019, there have been many challenges:

- It is difficult for asylum seekers to find safe and secure places to participate in evaluations.
- It is challenging for asylum seekers living in makeshift camps or shelters to establish secure Internet or phone connectivity for the evaluation.
- Evaluators face challenges to establishing rapport with asylum seekers when they need to address not only the ongoing trauma suffered by asylum seekers from their journey to Matamoros and their country of origin, but also trauma from the current danger they are in while living in the camp.
- Because living conditions can be so unstable, it can be difficult to locate asylum seekers at the time of their scheduled evaluation.

In these situations, it is important to collaborate with entities trusted by the community. In Matamoros, a network of partners worked together to overcome some of the obstacles faced by asylum seekers. Due to the increased security concerns, maintaining anonymity and securing a protected space was of the utmost importance. To mitigate this challenge, evaluators worked with the Resource Center of Matamoros (RCM), which provided a safe space with network connectivity for the evaluations. Project Lifeline coordinated the project locally, assisting with scheduling and secure interpretation to assure that privacy and security were handled with care. To prepare evaluators to conduct remote evaluations in these circumstances, Physicians for Human Rights provided guidance prior to the evaluations about what evaluators could expect.

Conclusion

As evidenced by the COVID-19 pandemic, policies such as MPP, and the cases of immigrants in detention centers, prisons, and jails in the US, creative solutions are needed to ensure asylum seekers have access to forensic asylum evaluations. Remote evaluations are one such solution. Evaluators and attorneys are normalizing remote evaluation programming while asylum seekers still hope to achieve protection from persecution and torture and move forward with their lives in the United States, despite all obstacles. Of course, evaluators hope that asylum adjudicators share their confidence in the ability of health experts conducting evaluations to determine whether they are able to make a quality assessment of the asylum seeker's trauma remotely.

Evaluators can find more resources on telehealth through the American Psychological Association [14].

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Chapter 10
Best Practices for Writing Affidavits and Preparing for Testimony

Valeria Gomez and S. Megan Berthold

After engaging in a medical, psychological, or psychiatric evaluation of an asylum seeker, an evaluator will share the findings in the form of evidence with the client's attorney. Generally, this will take the form of a written affidavit or oral testimony in a hearing setting. Understanding how an evaluator's findings and conclusions will be used is vital and influences how this evidence is presented in an affidavit, declaration, or testimony.

As explained in the previous chapter on asylum law, in most immigration cases, the applicants for immigration relief bear the "burden of proof," that is, the burden of showing that they have met all of the requirements necessary for immigration relief. To do so, applicants for immigration relief must corroborate the elements of the claim they are presenting as much as possible. Additionally, those seeking immigration relief must show that they are credible. To understand how the client will be using the evaluators' testimony, it is important to clarify what the client will be seeking to establish in the asylum interview or immigration court.

Cases Where Evaluations May Be Useful

While each case poses singular evidentiary concerns, certain elements of an asylum claim may be especially amenable to being proven through a medical, psychological, or psychiatric evaluation. Additionally, because asylum seekers may be eligible for and pursuing various forms of immigration relief concurrently with an asylum

V. Gomez (✉)
University of Connecticut School of Law, Hartford, CT, USA
e-mail: valeria.gomez@uconn.edu

S. M. Berthold
University of Connecticut School of Social Work, Hartford, CT, USA
e-mail: megan.berthold@uconn.edu

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application, an asylum seeker may use an evaluation to support a variety of immigration applications.

Asylum

To succeed on an asylum claim, asylum seekers must establish credibility and corroborate the key elements of their story. The Immigration and Nationality Act sets forth the facts that asylum seekers must meet to establish credibility and to adequately corroborate alleged facts [1]. A medical or psychological evaluation may help with both evidentiary requirements.

Corroborating Incidents of Past Trauma

Many asylum seekers have suffered serious incidents of violence, abuse, and other torment in ways that are relevant to their asylum case. Medical and psychological evaluations, in keeping with internationally recognized standards of the Istanbul Protocol [2], can help corroborate these incidents. Medical evaluations may support that marks, scars, bruises, or other physical sequelae are consistent with past physical or sexual violence that the applicant may testify to have suffered. For individuals who have survived traumatic events, psychological evaluations may reveal diagnoses or sequalae indicative of having survived trauma. In cases where there has been traumatic brain injury, a neuropsychological evaluation may be valuable.

Establishing Genuine Subjective Fear of Return

In order to establish a well-founded fear of persecution in the asylum seeker's country of origin, the applicant must establish that the fear of persecution is both subjective, that is, that the applicant actually has a genuine fear of persecution if returned to the country of origin, and objective, meaning that the fear of persecution is reasonable and sufficiently likely given the facts and evidence presented. It can be assumed that an asylum seeker's subjective fear of returning is to be understood by the fact that they have requested asylum. Nevertheless, the burden of proving this subjective fear rests with the applicant, and certain events in the applicant's story may, at first glance, cast doubt upon whether the asylum seeker's fear of persecution is genuine. For example, an asylum seeker may have previously escaped the country of origin and returned despite serious, credible threats to safety. (This is common, for example, when the return is precipitated by

feelings of religious or familial obligation, such as when loved ones are ill or have died.)

Especially in such cases where the authenticity of an applicant's fear may become an issue of contention, a psychological evaluation may help document indications that an asylum seeker genuinely fears harm if returned to their country of origin. An evaluator may note in the affidavit any symptoms or behavior that could reflect that the person is experiencing fear of being harmed if returned to their home country.

Credibility

For an asylum seeker's application to be successful, the adjudicator must find them to be credible. The Immigration and Nationality Act gives adjudicators broad discretion in their credibility assessments, explicitly authorizing them to consider, among other things, an applicant's demeanor, candor, or responsiveness, and the inherent plausibility of the applicant's account. Consistency is a key factor for adjudicators' determinations. Asylum adjudicators may consider the internal consistency of an applicant's testimony; the consistency between an applicant's current testimony and any prior statements (without regard to whether prior statements were made under oath); the consistency of the applicant's statements with other evidence the applicant has presented (including witness statements, expert testimony, or documentary evidence); and any inaccuracies or falsehoods – without regard to whether the inaccuracy or falsehood relates directly to the asylum claim or any materially relevant factor [3]. Regardless of how strong an asylum seeker's evidence is, it will not matter if the adjudicator determines that the asylum seeker's inconsistencies or demeanor renders them not credible.

Psychological evaluations in particular can be crucial for helping an asylum seeker overcome behavior that, left unexplained, could lead to a negative credibility finding. Where an applicant may be unable to describe specific details, recount events sequentially, or recall events without variability, a psychological evaluation may help explain how these occurrences are consistent with having survived trauma [4] and explain the effects of trauma and stress on memory. Similarly, if an applicant's demeanor is flat, dissociative, or seemingly out of character with the tenor of the testimony, a psychological evaluation could identify these testimonial characteristics as consistent with conditions such as post-traumatic stress disorder, major depressive disorder, dissociative disorders, or other conditions that could result from surviving traumatic events. While evaluators should resist making conclusory statements about the credibility of an asylum seeker, given that "credibility" is a legal finding that only an adjudicator can make, evaluators may weigh in on the believability of an asylum-seeker by explaining why their assessment does not support malingering [5–7].

Establishing Facts Relevant to Eligibility for Humanitarian Asylum

Asylum seekers who have established that they have survived persecution on account of a protected ground, but who cannot establish a well-founded fear of future persecution, may still receive a grant of asylum under the theory of humanitarian asylum. Humanitarian asylum is a valuable tool for those who have suffered persecution in the past, but who may no longer be able to prove that they would suffer the same kind of harm if they returned in the future. This arises, for example, if an asylum seeker's persecutor dies or loses power or influence, or if conditions in the asylum seeker's home country improve for those similarly situated to the asylum seeker.

To be granted humanitarian asylum based on past persecution alone, an applicant must establish at least one of two things: (a) compelling reasons for being unwilling or unable to return to the country of origin, arising out of the severity of the past persecution; or (b) that there is a reasonable possibility that the applicant may suffer other serious harm upon removal to that country [8]. In essence, humanitarian asylum recognizes that certain asylum seekers have suffered so immensely in the past that returning them to the place of persecution would be inhumane.

An asylum seeker can qualify for humanitarian asylum if the harm they suffered on account of a protected ground was especially atrocious. In assessing humanitarian asylum claims, adjudicators look for indications of extraordinary suffering [9] and may require a demonstration that the suffering resulted in long-lasting physical or mental effects for the asylum seeker [10]. Physical and psychological evaluations can be vital evidence to describe the evidence of past abuse or torture (such as scars, broken bones, or post-traumatic stress disorder), opine on the likelihood that the sequalae of harm could have been caused by the events described by the asylum seeker, and speak to any long-standing health effects caused by the harm.

An evaluator can also speak to other harm that an asylum seeker may face if returned to their country. While it is not within the evaluator's area of expertise to opine as to whether the applicants should be returned to their home countries as a matter of law, a medical or psychological evaluation may assist an asylum seeker in showing eligibility for humanitarian asylum by detailing the medical or psychological consequences that returning home could have on the applicant. For example, if the applicant's present condition requires continued medical attention or medication, an evaluator may make a note of this and detail the harm to the applicant's well-being that can arise if a treatment plan is interrupted or stopped. (Note, however, that an adjudicator would consider it beyond the evaluator's area of expertise to comment on the availability of the necessary treatment in the applicant's home country. Such an assessment would be best left for an expert on conditions in the applicant's home country.) Similarly, if a mental health evaluator predicts that a return to a person's home country would create a significant possibility of severe depression, suicidal behavior, dissociation, or exacerbation of an anxiety disorder, a

detailed explanation of the evaluator's prediction may help bolster the asylum seeker's request for humanitarian asylum.

Meeting the "Extraordinary Circumstance" Exception to the 1-Year Deadline

As previously noted, to be eligible for asylum, a person must file an asylum application within 1 year of entering the United States. Failing to meet that deadline renders the applicant statutorily ineligible for asylum [11]. Missing the 1-year filing deadline will not bar an applicant from asylum, however, if the applicant can prove that circumstances have materially changed, such that the person developed a well-founded fear while already in the United States, or if the applicant can prove that extraordinary circumstances prevented the applicant from filing an asylum application within 1 year of arrival. In both instances, the applicant's failure to file for asylum within a year of arrival in the United States will not render them ineligible for asylum, so long as the applicant subsequently files the application within a reasonable time.

Changes in circumstances can manifest in a variety of ways. Applicants may have experienced personal life events that have created risks of persecution that did not exist before. A person may have determined or publicly revealed that they are not heterosexual or cis-gendered; converted to a new religion, or rejected or denounced a religious faith or method of practice; or engaged in new, dangerous forms of political speech or advocacy.

An extraordinary circumstance is one that reasonably precludes the applicant from filing an asylum application within a year.[1] Federal regulations provide certain non-exclusive examples of the types of situations that may constitute extraordinary circumstances. Of relevant interest, some of those named exceptions include serious illness or mental or physical disability during the 1-year period after the asylum seeker's arrival in the United States, including any effects of persecution or violent harm suffered in the past, and legal disability, which can include any relevant mental impairment or other incompetency. Another exception, though not one explicitly mentioned in the federal regulations, could include situations of trafficking or domestic violence that significantly threatened the applicant's freedom or safety.

An evaluation could help identify, diagnose, or describe any medical or mental circumstances that have prevented the individual from being able to file an application within a year of arrival. Further, the evaluation could explain in simple terms how such a circumstance could affect the afflicted individual in such a manner that meeting a legal deadline would have been exceedingly difficult or impossible. It is not uncommon, for example, for an applicant coping with untreated post-traumatic

[1]As in most situations in the legal arena, ignorance of the law is not considered an excuse for not meeting deadlines or complying with the law.

stress disorder to avoid anything that may remind them of the survived past persecution and, consequently, to find themselves unable to speak about their past to an attorney or unable to write about their experiences in the asylum application form. In this circumstance, an evaluation and affidavit could be helpful to diagnose post-traumatic stress disorder, describe the symptoms and behavior that the applicant is exhibiting, and explain how these affect their ability to function in everyday life and to engage in the legal asylum process.

Custody Redetermination Requests, Habeas Corpus Petitions, and Other Issues Related to Release from Immigration Detention

In recent years, the federal government has resorted to detaining asylum-seeking adults and children, keeping them in detention centers or "family residential centers" (i.e., family detention centers) until they are able to have a day in immigration court to present their claims [12, 13]. Representation in these circumstances presents special challenges for attorneys and evaluators, and raises significant access to justice, health, and wellness concerns. Inadequate medical care that detained immigrants often receive while incarcerated in immigration detention centers has been widely documented [14]. For particularly medically vulnerable asylum seekers, medical, psychological, or psychiatric evaluations of detained individuals may be conducted to support petitions aimed at releasing these individuals from their carceral settings. In most cases, these requests for release will take the form of a custody redetermination request (i.e., a bond request or hearing) before ICE or an immigration judge, or a habeas petition in a federal district court.

Custody Redeterminations

In a custody redetermination (bond) hearing before an immigration judge, the immigration judge has broad discretion to determine whether, and under what conditions, the detainee may be released. An immigration judge generally weighs a number of factors, including the likelihood that the release would pose a danger to property or to the community, the likelihood that the detainee will comply with their obligations to appear at subsequent immigration court or ICE appointments, and other issues, such as the roots that the detainee may have in their communities, the impact of the detainee's absence to members of the community, and special humanitarian concerns [15, 16]. A medical, psychological, or psychiatric evaluation of a detained asylum seeker may support an asylum seeker's request to be released from immigration detention when the expert's affidavit concludes that continued detention would endanger the detainee's health.

Habeas Corpus

Habeas corpus is a legal recourse available to people in government custody, through which these individuals petition a court to assess the circumstances of their detention and determine whether the detention is unlawful. Notably, while a bond hearing happens in immigration court, a venue that lies within the Department of Justice and is thus susceptible to the policy concerns of the administration in power, a petition for habeas corpus is decided by an appointed judge in federal district court, within the judicial branch of government. The right to habeas corpus stems from the Suspension Clause of the United States Constitution [17] and federal statute [18]. Federal district court judges can grant habeas corpus to people that are held in the custody of the federal government in violation of the Constitution, laws, or treaties of the United States.

In the immigration context, an asylum seeker may bring a petition for habeas corpus to challenge the length or conditions of immigration detention. Attorneys may file petitions for habeas corpus to challenge the length of time that a noncitizen can be held in detention after they have been ordered removed by an immigration judge, or to challenge the conditions of detention for medically vulnerable noncitizens, such as detained children with suicidal ideations [19], women with high-risk pregnancies, or individuals in need of emergency medical care or with particular vulnerability to a pandemic [20]. In these cases, an evaluation or professional opinion may be sought to support the detained person's argument that continued detention would constitute excessive punishment and be unconstitutional. An evaluation can identify an unrecognized or untreated disease or condition; challenge the efficacy, propriety, or quality of health care available in detention; or otherwise support the idea that continued detention or isolation poses a serious risk to a detained person's life.

How Asylum and Immigration-Related Forensic Evaluations Differ from Clinical Examinations for Care Purposes

Psychological evaluations conducted for asylum and immigration-related purposes (and their associated affidavits) often differ in some key respects from those conducted for treatment or other legal purposes. They typically are narrower in scope and focus strictly on the key legal issues where the evaluator has been asked for their assessment. Determining which facts are legally as well as psychologically or medically relevant is important [5]. In addition, the evaluator may have more time constraints compared to when they assess a client who is under their clinical care. This too would affect the scope of what they are able to address in their forensic assessment and affidavit.

Before the evaluator meets with the asylum seeker, they should find out how much time they will have to conduct their evaluation, as this will help them to

determine what they will be able to cover. If the person is detained or otherwise in custody, the attorney who has asked them to conduct the evaluation will need to ascertain what the limits and protocols are for the evaluator and confirm that the detention facility will grant the evaluator access to meet with the person. Some facilities will only allow evaluators to meet at certain times and have strict time constraints. Some will limit the evaluator to only one session, while others will allow for a second or even third session. This information will help the evaluator to prepare a plan to that allows sufficient time to address the most crucial issues.

Best practices in many clinical care contexts require a medical or psychological evaluator to perform a comprehensive holistic assessment of the individual across their lifespan and to provide extensive details in a report. It is important to address the implications of these practices when training and orienting clinicians who are new to conducting forensic evaluations in the context of asylum and related immigration cases. Sometimes, it may be appropriate to leave details more general or vague to avoid an inconsistency that is immaterial to the main conclusions in the evaluation [5]. For example, rather than providing details of the persecution or other life experiences, such as the exact number of times that the person was beaten, it is typically recommended to summarize by saying that the event happened multiple times, or more than once. The person may not remember all the details or exactly the same details when on the stand testifying. Instead of including exact dates and times, evaluators should consider framing those details in the affidavit and testimony by anchoring the person's experience to aspects they are likely to remember such as, "It was dark – in the evening," "It was the day that we buried my mother," or "It was the day my son graduated from primary school." Some asylum applicants will not use the Gregorian calendar commonly used in the West. The Ethiopian calendar, for example, is composed of 13 months – 12 months with 30 days and 1 month that includes just 5 days (or 6, if it is a leap year). The impact of severe trauma, including head or brain injury, may impact the person's ability to store memory, resulting in an impaired ability to recount a detailed narrative of their experiences.

In the context of asylum and other immigration proceedings, a psychological evaluator typically would not include a comprehensive psychosocial history as they might in many psychological reports. Instead, the evaluator should focus on the key legal issues that they have been asked to weigh in on and provide evidence to support their clinical impressions. The evaluator is encouraged to discuss with the asylum seeker's attorney any suggestions they have for issues to assess that may be legally relevant to the case. Some common areas for focus include:

- Does the person present as someone who has gone through the persecution experiences that they report?
- What is the impact of such experiences on their life?
- Do they have any physical or mental health condition(s)? If so, what is the history of the health condition(s) and is it (are they) related, at least in part, to the qualifying persecution?

- What is the evaluator's professional opinion on the likely impact on the person's psychological state if they are ordered deported?

While it is important for the evaluator to understand how the qualifying persecution experience(s) fit(s) into the person's life (in terms of any prior trauma and the impact of that on the person's mental or physical health and functioning), an evaluator would generally not have time to gather as extensive a history as is common in other types of evaluations. It may be valuable to include a brief summary of the person's earlier life prior to the qualifying persecution experiences. The key purpose of this is to establish a baseline of their functional and mental health and document any change (if relevant) after they were persecuted, and how this evolved over time in the case of repeated or long-term persecution) [4]. For example, a young woman may have been a strong student, socially active and outgoing, and a leader of her church youth group, but since she and her family were attacked and tortured by the police for their political activism, she has been withdrawn, rarely leaves the house except to go to school, is failing two of her classes, and has stopped her involvement with church youth group. It would be informative to discuss the reason(s) for any changes (e.g., she is fearful of seeing the police or being attacked on the street again; cannot concentrate in class or on her assignments; is ashamed that friends may learn that she was raped and ostracize her).

Collaborating with Attorneys

The most effective asylum evaluations are invariably those that are tailored to meet the asylum seeker's legal needs. As such, collaboration with attorneys is crucial for ensuring that the evaluation effectively addresses matters that will be addressed in the adjudicatory hearing.

Preliminary Considerations

It is helpful, and in some courtrooms necessary, for the forensic psychological or medical evaluator to be licensed if they are to testify as an expert witness in asylum or other legal proceedings. An essential first step for evaluators seeking to perform a forensic evaluation out of the state where they are licensed is to investigate the licensing laws in the state where they are conducting the evaluation. Some states have laws that allow a professional licensed in another state to perform an evaluation, but do not allow them to provide therapy or treatment, and may require that the clinician inform the person that they are evaluating in writing that they are not licensed in that state.

Clinicians who are experienced in conducting assessments in their clinical practice or in their professional offices for forensic purposes generally have confidential

meeting spaces for these purposes. We have found that some detention facilities do not provide evaluators with confidential meeting spaces unless the attorney representing the detained person negotiates for this in advance. This may be due, in part, to a lack of appropriate spaces in the facility, competing demands for confidential meeting spaces, or to a lack of understanding by facility personnel for the need for confidential meeting spaces. Evaluators may be provided with inadequate and non-private meeting spaces. Not only do these configurations preclude the possibility for confidential conversation, but they also violate the rights of detainees, and serve to inhibit the person being evaluated from disclosing sensitive topics that may leave them feeling vulnerable or unsafe – often the very topics that the evaluator needs to hear. Even when provided with a space that is soundproof and confidential, there is an often window in the door through which correctional staff and other detainees can look in, which can result in a sense of intrusion and disruption. Sometimes it is the evaluator who is more disturbed by this, as the detained person may have come to expect this in a facility where privacy is scarce. Regardless, these circumstances should be anticipated for and mitigated as much as possible.

Deadlines

To the extent that deadlines are calculable, it is helpful to determine when the client will need to have a final version of an affidavit to submit to the asylum office or immigration court. Deadlines – and the amount of certainty with which one can determine them – can vary depending on the venue in which the asylum claim will be heard, the procedural posture of the client's case, and the extent to which the attorney may need to review the findings to develop the legal theory.

Generally, deadlines associated with filing evidence are most easily determinable when the hearing is in immigration court, where hearing dates are often set several months, if not years, in advance. In these instances, an immigration judge will often set a deadline for when evidence and a list of potential witnesses must be filed. Litigation schedules for detained asylum seekers may have a shorter turnaround time than for those that are not detained, because, to avoid prolonged detentions, immigration judges tend to schedule merits hearings for asylum seekers within a few months of the initial hearing.

For those requesting asylum before the asylum office, scheduling can be less predictable, as scheduling priorities are subject to change. Currently, asylum offices employ a first-in–last-out scheduling policy, prioritizing interviews for those who have most recently filed their asylum applications [21]. While exact scheduling patterns vary by asylum office, it is not uncommon for an asylum interview to be scheduled within a month of when the asylum seeker files their asylum application. An asylum seeker filing shortly after arrival in the United States, where the proximity of the 1-year deadline is not a pressing concern, may have months to prepare evidence, which may include an affidavit from a physical or psychological evaluator. On the other hand, asylum seekers who must rush to file asylum applications

with the asylum office before the 1-year deadline may find that they only have 45 days or less to compile and submit all corroborating evidence to the asylum office. This rushed circumstance is common, particularly for those who delay finding legal representation because they need time to save money for legal fees or wait for an attorney to have availability. As a general matter, evaluators should determine not only whether the attorney knows of any already existing deadlines, but also what the likelihood is that a filing deadline could be suddenly imposed.

After ascertaining an approximate deadline, an evaluator should ensure that the deadlines leave sufficient time to meet with the client as many times as necessary. Clinicians must also consider the length of time it will take to write an initial draft of the evaluation and the amount of time it may take to discuss and implement any revisions suggested by the attorney.

Known Information on Medical and Social Background

An evaluator can find it challenging or impossible to conduct a thorough forensic evaluation when there is limited access and time for the evaluation. The evaluator may also be constrained when they have little or no access to relevant collateral information regarding the person's health, mental health, psychosocial history, and other pertinent matters. In general, evaluators should request access to pertinent collateral information. Such information may serve as important documentation of the person's persecution and its impact on their lives, as well as help the evaluator better understand the person's clinical condition and functioning over time (including any changes that may have occurred at the time of or after the persecution).

Sometimes collateral information may not be readily available due to a number of factors: a detention center or other facility may not make the information available, even if the person consents; individuals with relevant collateral information may be unavailable (e.g., deceased or in a different country) or unreachable (e.g., in hiding in the home country or with no known address or way to call or otherwise contact them); or the information may be unavailable, destroyed, or misplaced (e.g., documents left behind in the home country when the person escaped; documents burned in a fire when the person's home was attacked during persecution or after they fled; disorganized official records in the person's home country; or missing birth certificates, if the person is from a region where home births are common and official birth certificates are not often issued).

Occasionally it is possible to obtain relevant independent observations from the person's roommate or cell mate (e.g., regarding sleep disturbances, behavior, or other observations). A case example that illustrates this involves a client who was tortured. The evaluator was able to interview a sibling who had moved to the United States a few years prior to the person's torture. The sibling had returned to the home country for a visit shortly after the torture occurred and was able to report significant changes in the mental health of the person, changes that persisted after the person fled to the United States and began to live with the sibling. They told the

evaluator that they did not know what had caused the dramatic changes until a couple of years later, when they learned that their sibling had been tortured.

Personal Declaration or Affidavit, If Available

As explained previously, an integral part of an asylum seeker's evidence is the personal declaration or affidavit – sworn testimony that spells out, in a detailed, narrative form, the events that led to the asylum seeker's escape, or the basis for their fear of persecution in their country of origin. At the time an evaluation is requested, an attorney may already have a working or final draft of the asylum seeker's personal declaration. Reviewing the client's declaration before the evaluation may make the evaluation and revision process more efficient, preparing the evaluator to be vigilant with respect to the types of medical and psychological sequelae that may be present and to tailor examination questions appropriately.

An effective personal declaration will tell the relevant story in the asylum seeker's voice, while setting forth the story in a way that highlights the facts the asylum seeker must establish to show eligibility for asylum. Accordingly, reviewing the asylum seeker's declaration will provide give the evaluator with a clear picture of the kinds of events that could benefit from corroboration through a medical or psychological evaluation.

Having a copy of the declaration, especially one that is in near-final form, will also ensure that the evaluator's summary of facts shared by the asylum seeker does not conflict with the sworn testimony that the asylum seeker submits in support of the asylum application. Because any factual inconsistency – even an immaterial one – can lead an adjudicator to deny an asylum application for lack of credibility, consistency in details such as order of events, dates, and numbers is paramount to the success of an asylum seeker's claim. If during the evaluation, the asylum seeker deviates from the descriptions set out in the declaration, the evaluator may bring this to the attention of the attorney to determine whether the attorney misunderstood the client's story, whether the asylum seeker (or interpreter) misspoke during the evaluation, or whether the asylum seeker is having trouble remembering details and should be screened for conditions that might affect memory. The declaration may also prove useful during the evaluation drafting process, as the evaluator summarizes statements shared during the evaluation (to the extent they are consistent with the declaration).

Case Theory

As noted above, asylum seekers may use medical or psychological evaluations, and their associated affidavits, to corroborate several elements of their asylum claims. Knowledge of the attorney's case theory can help an evaluator understand the

evaluation's role in the legal case, which in turn can help the evaluator ascertain what to look for or assess in the evaluation. For example, if the attorney shares with a psychological evaluator that the asylum seeker will be pursuing humanitarian asylum and will try to show that the effects of past persecution are such that the asylum seeker will need ongoing treatment that is unavailable in the asylum seeker's home country, the evaluator can anticipate detailing what they recommend as further treatment and explain how foregoing further care would harm the asylum seeker's mental health. If the lawyer shares that a medical evaluation will be used to corroborate an asylum seeker's account of past torture, a medical evaluator can prepare for the evaluation by reviewing the asylum seeker's personal declaration to familiarize themselves with the ways that the asylum seeker's torture could manifest on the body or on the asylum seeker's health.

Scope of Testimony and How Testimony Will Be Used

In addition to determining how an evaluator's affidavit or live expert witness testimony will form a part of the case theory, an evaluator should learn how the testimony will be used in litigation, the venue in which the case will be presented, and the scope of the testimony (i.e., whether the expert will be expected to present live testimony and be cross-examined during a trial or hearing). If the evaluator is not willing to testify in court as to the methods and findings of the evaluation, they should express this when initially approached by the attorney so that the attorney can determine whether the evaluator will be the right expert witness for the case.

One issue to consider is that the venue where an asylum seeker's claim is ultimately decided can change from what is initially anticipated. For example, live witness testimony is rarely expected in adjudicatory interviews before the asylum office, so an expert witness hired to provide an affidavit for an asylum seeker presenting their case before the asylum office might reasonably assume that no court appearances or live testimony will be necessary. If the asylum officer does not approve the asylum seeker's application, however, and the asylum seeker is not otherwise in lawful immigration status, the asylum seeker's case will be referred to an immigration judge, where the asylum seeker would have another opportunity to pursue the asylum claim in an adversarial setting. As such, the evaluator should ask whether the affidavit initially produced as evidence for the asylum office could also be used as support for the claim in immigration court, should the case be referred. If so, the evaluator should also ask whether they would be expected to be called as an expert witness, subject to direct examination by the asylum seeker's attorney and cross-examination by an opposing government trial attorney and the immigration judge. Similarly, if an affidavit is used to support a request for bond, an evaluator should determine whether the affidavit will also be used as corroborating evidence for the asylum claim.

Another key question is whether the attorney anticipates that the affidavit could be used in federal court litigation, where the evaluator's oral or written testimony

may be compelled by a federal judge. Because immigration court is an administrative hearing that is not subject to the Federal Rules of Civil Procedure, an evaluator who has agreed to prepare an affidavit for an asylum seeker has the authority to decline live testimony in immigration court. While immigration judges technically have the authority to subpoena certain witnesses, they rarely execute this authority and are unlikely to compel an evaluator to show up in person to be subject to cross-examination (though some immigration judges may refuse to admit an expert affidavit into evidence if the expert is not available for cross-examination). In federal district court, the venue where petitions for habeas corpus are heard, however, opposing parties have a right to engage in discovery, a formalized fact-finding process that entitles parties to request information and evidence from other opposing parties and their witnesses. Parties in federal district court generally have more latitude to request a judge to compel a witness to testify in court or in a deposition. For expert witnesses who submit written testimony in the form of an affidavit, parties have the right to propound interrogatory requests (compelled fact-finding requests in the form of a set of questions that must be answered in writing under oath) [22].[2] Given that an asylum seeker denied bond by an immigration judge might attempt to secure a release from detention through a habeas corpus proceeding, evaluators would be wise to ascertain whether affidavits they submit for a custody redetermination hearing in immigration court would be reused in federal district court if the asylum seeker were to pursue a habeas corpus claim at a later date.

Evaluation Revisions

After an evaluator submits an initial draft of the affidavit to the asylum seeker's attorney, the evaluator should expect to receive feedback from the attorney, and more likely than not, a request that certain changes be made to the evaluation. How and when to acquiesce to these requests can pose difficult professional and ethical determinations for an evaluator. An evaluator's role in the litigation is to provide objective evidence about the asylum seeker's physical or mental state. Further, evaluations are generally submitted in the form of a sworn affidavit or declaration under penalty of perjury. Evaluators must only submit testimony that they believe to be true, or else risk committing perjury, and they must maintain an objective tone and purpose in their evaluations. Showing clear bias in favor of the asylum seeker or reaching dubiously favorable findings and conclusions is not only ethically questionable, but it may also render the evaluation less reliable as evidence, defeating the purpose of the endeavor.

[2] The relevant federal statute states: "On application for a writ of habeas corpus, evidence may be taken orally or by deposition, or, in the discretion of the judge, by affidavit. If affidavits are admitted any party shall have the right to propound written interrogatories to the affiants, or to file answering affidavits."

Even so, an attorney may request revisions to the evaluation for any number of legitimate reasons. An attorney may request that an evaluator remove legal conclusions or predictive findings that are not within the scope of the evaluator's expertise and are likely to provoke an adjudicator or draw an objection from opposing government attorneys. For example, if a psychological evaluator states that the asylum seeker is credible and predicts that returning the asylum seeker to her home country would lead to persecution, the attorney would be wise to request a revision, given that credibility is a legal standard and likelihood of future harm is a factual finding that only an immigration judge has the authority to make. Instead, an asylum attorney may ask the evaluator to omit the prediction of future harm and to rephrase the credibility statement into a statement that details why the evaluator has determined that the client is not malingering. An attorney may request other revisions, including:

- *Further explanation, justification or support of conclusions or findings*. An attorney may request that an evaluator provide additional clarification or more support for an important finding, particularly if the justification would be persuasive to corroborating a key element of the asylum claim. Similarly, an attorney may suggest wording or style changes, especially to avoid the use of words with particular legal definitions or to better fit the preferences of a particular immigration judge.
- *Fixing inconsistencies*. As explained above, an adjudicator may rely on any inconsistencies, however minor, to reach a negative credibility finding, including inconsistencies between the story recounted in an asylum seeker's testimony and in the factual summary contained in the evaluator's affidavit. An evaluator should determine how crucial the exact details are to the overall conclusions of an evaluation. Omitting an inconsistent detail in the factual summary that would not affect the overall conclusions or tarnish the integrity of the evaluation (like a date that varies by just a few days) may preserve the asylum seeker's credibility in court.
- *Maintaining an objective tone*. An affidavit that reads as overly supportive of the asylum seeker's claim or lacking objectivity may be counterproductive, as an adjudicator may give a biased evaluation little probative weight. As such, an attorney may make suggestions as to tone. For example, an attorney may request that an evaluator delete statements that a person is deserving of asylum or pleas for the grant of the asylum seeker's case.

Evaluators should be mindful, however, that the decision as to whether to revise the affidavit lies with them. Evaluators should resist revising an affidavit in a way that would insert misstatements, findings or diagnoses that are not warranted, or factual recollections that clients themselves did not provide. For example, an attorney attempting to justify missing a 1-year filing deadline may press a psychological evaluator to make a finding of post-traumatic stress disorder and to explain the effects that trauma can have on the ability to file an asylum application within a year of arriving in the United States. However, if the evaluator assessed for post-traumatic stress disorder and did not find that the diagnosis was warranted, the evaluator would be violating their ethical and legal duties by making a diagnosis that the

evaluator knows is not warranted. Additionally, blindly accepting all attorney revisions may ultimately lead to the evaluation being unpersuasive, especially if upon cross-examination, the evaluator admits to having added a diagnosis or changed a conclusion at the request of an attorney. If there is reason to believe that the evaluator overlooked something important in the evaluation process, one solution could be for the evaluator to perform another evaluation before determining whether subsequent revisions are warranted.

Best Practices for Testifying in Court

One overarching best practice for testifying in court (and for conducting the evaluation and writing an affidavit) is to remain as objective as possible, without becoming defensive. Any clinical impressions or conclusions that the evaluator/witness make should be backed up with supporting evidence [4, 23]. Care should be taken not to overstate or understate findings or conclusions, and the witness should be prepared to note any limitations or uncertainty in their findings if they are questioned about them on cross-examination. Remember that an expert witness who has been qualified as such by the judge is allowed to offer their professional opinion within the scope of their training and expertise.

It is vital for the witness to listen carefully to the questions they are asked and answer truthfully. In general, witnesses should answer concisely, including with a simple yes or no when possible. When a yes or no response is inappropriate or cannot provide an accurate answer to the question asked, the witness can and should qualify their responses. The asylum seeker's attorney can ask follow-up questions to obtain further details if needed.

As appropriate, an evaluator may clarify why it was determined that a client's reaction to a situation or their condition is different from what may be observed in others or is generally observed. For example, one of the authors of this chapter was asked on the stand once why she had stated in her affidavit that she believed that the teenaged person she evaluated was fearful of being tortured again or killed if they returned to their country of origin, especially given that they had returned once after their initial departure following their torture. The expert testified that the teenager had reported that they had returned only because they heard that their mother was dying, and it was important in their culture to pay their last respects, be with their parent at their death, and ensure a proper burial. The teenager shared that they would never have been able to forgive themselves if they had not done so. Given that they feared that the authorities were still looking for them, they remained in hiding when they went back and met their mother only for brief periods late at night and in disguise. As soon as the mother was buried, they escaped the country again. The expert also testified about the independent report they had received from the person that had hidden the teenager in their home, which corroborated the youth's account.

Witnesses should be prepared for their testimony by the attorney. An evaluator can request a "mooting," that is, a dress rehearsal of the direct examination and

cross-examination. Expert evaluators/witnesses should communicate with the attorney regarding their professional opinion of the respondent, the range of findings that they could testify to, and what their recommendations would be, if asked, in advance of the hearing. With regards to preparing for being qualified as an expert witness, some attorneys may not understand how some of an expert witness' background (e.g., the expert witness' training, credentials, and experience) is relevant to the case. As such, as part of the hearing preparation, the expert witness should highlight key relevant parts of their background for the attorney.

For example, in a cross-examination, an opposing government attorney may note that an expert witness has only ever testified on behalf of asylum seekers (and never against their interests), in an attempt to show bias. In preparation for such questioning, an expert witness might share with the asylum seeker's attorney background details that give context to a seemingly detrimental response. In this example, the expert could share that while they had only ever testified in support of asylum seeker's interests, they did so while working at a nonprofit agency whose largest funder was the US government. The expert witness could further clarify that, in fact, their salary was primarily paid by the US government, and that the expert witness's agency was audited every year to ensure that it only served those who had experienced state-sponsored torture. Other relevant background factors expert witnesses may want to highlight for the asylum seeker's attorney may include experience in training relevant federal personnel (such as training asylum officers or judges on the psychosocial effects of torture); experience in evaluating similarly situated individuals; how their professional license qualifies them to assess, diagnose, and treat individuals with a wide range of health or mental health conditions; the pertinent specialty training the expert witness has received; and the expert witness' training and supervision of other health or mental health professionals as relevant to the evaluation and testimony.

The opposing government attorney will have a copy of the expert witness' curriculum vitae (CV) and can ask follow-up questions about the expert witness' credentials and expertise. An expert witness might consider discussing with the asylum seeker's attorney in advance whether to shorten their CV to highlight what is most relevant to the testimony. Evaluators should be aware, however, that if there are other versions of their CV readily available online, and if they differ substantially from the CV presented in court, the expert may have to field questions about why they changed their CV. Expert witnesses should be ready to answer those questions.

Expert witnesses typically are asked questions covering the scope of their affidavit, although sometimes the judge will admit the affidavit into evidence without the need for live court testimony (particularly if experts have made themselves available for cross-examination and there are no questions pertaining to their findings). Questions related to the evaluation and the affidavit commonly cover such domains as the expert's training, credentials, background, and relevant expertise; number of sessions and length of time that they examined the respondent; the typical duration of an evaluation for an asylum seeker; and methodology used in evaluation. Experts can also expect to explain the context for their main findings, such as what the respondent described to the evaluator regarding the reasons for their leaving their

home country; whether the evaluator found the respondent to be malingering and the basis for said finding; the respondent's psychiatric and medical history and current diagnoses; whether the evaluator reached a conclusion regarding the factors contributing to the development of the condition(s) they diagnosed the respondent with; the evaluator's prognosis for the asylum seeker's future health, including any potential health effects that could result if the asylum seeker is deported to their home country; and recommendations for treatment, care, or stabilization.

The witness should expect tough questions from the prosecutor (the "trial attorney" in immigration court), but it bears repeating that a witness' testimony will be more effective if they avoid appearing defensive. While space constraints prohibit an exhaustive list of potentially challenging questions (which invariably are shaped by the specific case at hand), some common questions an expert witness who evaluated a respondent should be prepared to answer include:

- Have you always testified for the respondent in asylum proceedings?
- Is everything that you know about the person based solely on what they told you?
- In every case where you have testified, have you always recommended that the asylum seeker not be deported?
- Were you paid for the evaluation, for drafting the affidavit, and for appearing in court today? How much?
- Did you use (or fail to use) a particular methodology or diagnostic scale or test? Why?

Psychological evaluators who have diagnosed the asylum seeker with post-traumatic stress disorder (PTSD) should be prepared to be asked about other traumas (nonqualifying persecution) that they have experienced that may have resulted in PTSD (e.g., a soldier who saw combat):

- How do you know that their PTSD is really due to being tortured by the secret police for their political activism and not because they are a combat veteran?

Similarly, if a medical evaluator has made findings about physical scars, fractures, or other conditions that have resulted from the alleged past persecution, the expert may be asked if they have assessed the likelihood that the harm resulted from causes other than the persecution alleged.

The asylum seeker's attorney may object to any questions that they determine may be impermissible, irrelevant, or inappropriate. If an attorney objects to a question, the expert witness should refrain from answering (or stop talking, if the objection is raised mid-response) until the judge rules on the objection. Bear in mind, however, that rules of evidence are particularly relaxed in immigration court, and government trial attorneys have wide latitude in the types of questions they may ask.

When Proceedings Go Beyond the Immigration Court

It is helpful for the evaluator to know prior to conducting an evaluation what the context and scope of the legal matter at hand is, as they may alter the scope of their assessment, affidavit, and testimony in response. This matters for several reasons that should be considered in advance. Discovery and subpoenas may be more relevant in legal proceedings outside of immigration court. Unlike asylum hearings in immigration court, which are generally closed for the safety and comfort of the asylum seeker, parts of the federal district court proceedings may become public record unless placed under a protective order. In addition, the cross-examination process in federal district court may require more preparation because opposing counsel may have more time to prepare for and conduct a cross-examination, and the types of questions asked of the witness may differ as well.

Conclusion

Asylum seekers face a difficult task when they present their cases before an adjudicator. They must prove that they meet their burden of establishing the many eligibility requirements for asylum, and they must do so while presenting a believable, consistent, and chronological story, with corroboration from other forms of evidence. Many asylum seekers have had to flee without key documents, photographs, and other forms of evidence that could support their claims, and others, for safety reasons, must cut off ties with witnesses in their home countries. For this reason, affidavits and court testimony by medical and mental health professionals can be invaluable in assisting asylum seekers with the herculean task of demonstrating credibility and eligibility.

Evaluations for the purposes of establishing eligibility for asylum are different than evaluations performed for purposes of medical care. Limitations related to inflexible filing deadlines, access restrictions for detained asylum seekers, and lack of background information can complicate the evaluation process, but they also provide a singular view of the complex immigration system that asylum seekers must navigate in their attempt to secure safety and refuge. Through collaboration with attorneys, medical and mental health professionals use their expertise to help asylum seekers corroborate and explain their circumstances and can play a crucial role in supporting an asylum seekers desire for safety.

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Chapter 11
Teaching and Learning Asylum Medicine

Ranit Mishori and Deborah Ottenheimer

Introduction

Despite the documented need for medical evaluations of asylum seekers, few healthcare providers are adequately trained to perform them [1]. One notable reason is the lack of emphasis on the health of forced migrants in most health profession trainee curricula, making it difficult for clinicians to become trained in performing medical evaluations or refining their skills [2, 3]. Additionally, in areas with few asylum seekers requiring medical evaluation, it can be a challenge to provide interested healthcare workers with adequate hands-on experience.

Over the past decade, several academic medical institutions around the United States, in collaboration with human rights organizations, have developed and incorporated asylum evaluation programs at the undergraduate medical education level. Instruction around asylum medicine is very much aligned with the overall increasing educational focus on the roles that racism, the social determinants of health, social justice, and health equity play in the delivery of healthcare in the US and abroad. A 2016 survey among clinicians engaged in medico-legal evaluations noted that practitioners found the experience "very rewarding personally and professionally" [4].

Asylum medicine has the potential to address the forced migrant crisis by uniting healthcare professionals and other learners to help meet the demand for the medico-legal evaluation of asylum seekers while simultaneously improving learners' insight into global health issues, augmenting their medical skills, and highlighting interprofessional collaboration.

R. Mishori (✉)
Department of Family Medicine, Georgetown University School of Medicine and Physicians for Human Rights, Washington, DC, USA

D. Ottenheimer
Department of Women's Health, Gotham Health | Morrisania, New York, NY, USA
e-mail: deb@ottenheimerhealth.com

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The literature is growing on asylum education program descriptions, and on the benefits of engagement with asylum medicine through acquiring the skills to conduct forensic evaluations. Several small studies have looked at outcomes associated with learner engagement in asylum clinics or programs. Asgary et al. [5] noted improvements in several educational objectives for medical students such as attitudes working with torture survivors, knowledge of the outcomes of torture, and self-efficacy in clinical evaluations. The authors noted that "medical students learned necessary skills to provide services for survivors, which will also serve them in caring for other vulnerable populations." An assessment of the impact of asylum programs that are led by or engage medical students noted a trend "that underscores medical students' ability to significantly impact human rights issues" [6]. Schonholz et al. [7] assessed the experience of medical students involved in a human rights program focused on the provision of medicolegal services. The vast majority of students indicated that they "developed important, clinically applicable skills that enhanced their traditional medical education." Positive impacts are not limited to medical students. Patel et al. [8] surveyed psychiatry residents in an academic-affiliated asylum clinic and noted that the majority of residents reported the experience had a "significant impact" on their clinical practice and their own professional roles.

Educational Goals and Opportunities

There are multiple experiential and didactic opportunities for learners of all levels to obtain skills and competencies associated with asylum medicine, often absent from or de-emphasized in traditional health professions education, to hone attitudes, improve job satisfaction, and contribute to professional identity formation.

Asylum medicine encompasses the following broad areas of instruction and experiential learning: clinical skills, communication, cross-cultural and holistic practice; interprofessional collaboration; population and global health; leadership and stewardship development; and health systems function. Table 11.1 lists possible educational goals and outcomes.

Different Educational Models

The skills needed to perform asylum evaluations successfully and competently are not generally taught as part of routine undergraduate or graduate health profession education, although some residency programs around the country do require them as part of their curriculum. Increasingly, however, medical schools have begun to adopt human rights curricula, which may incorporate training in forensic evaluation. The growing interest in human rights medicine and asylum evaluation competency is evidenced by the existence of at least 35 human rights clinics housed in

Table 11.1 Recommended Asylum Medicine educational objectives

Instructional area	Educational objectives
Clinical skills and competencies	Recognize physical signs and symptoms of torture and trauma Recognize mental health sequelae of torture and trauma Identify and describe scars, with appropriate correlation to attributed causal events Conduct a focused history relevant to the identification of human rights violations Conduct a focused physical examination for human rights violations Use validated mental health screening instruments appropriately Examine, assess, describe, and document genital findings related to female genital cutting [9, 10] Become proficient in the physical and psychological assessment of victims of sexual violence Understand and summarize common manifestations of injury and illness resulting from human rights violations Practice appropriate documentation and medicolegal affidavit writing Understand diagnoses and management of conditions related to human rights violations (e.g., psychological trauma, adverse childhood experiences, somatization, etc.) Understand and practice the principles of trauma-informed care [11, 12] Practice using the Istanbul Protocol [13]
Communication skills and competencies	Develop trauma-informed interviewing skills Understand the principles of communicating through interpreters Practice working with interpreters Develop a holistic view of health that includes the Social Determinants of Health State the role of the social determinants of health for forced migrants Formulate understanding of the role of mental and behavioral health in trauma and healing Incorporate cultural humility into practice Practice working with individuals with limited linguistic skills, English fluency, and health literacy
Cross-cultural, holistic, and compassionate practice	Learn about common traditional harmful practices (FGM/C, forced marriage) Describe the role of gender norms across cultures and their relation to human rights violations Explain the role of trauma in clinical encounters Discuss ethical and cultural issues in the care of refugees and asylum seekers Understand barriers to integration and acculturation Develop nonjudgmental interviewing skills Recognize conscious and unconscious bias in approaching patients from diverse backgrounds Develop enhanced empathy and compassion Practice deep listening skills

(continued)

Table 11.1 (continued)

Instructional area	Educational objectives
Interprofessional and interdisciplinary collaboration	Practice working with legal professionals Recognize the role of medicolegal partnerships Explain the legal structures involved in obtaining asylum status, and other forms of relief Experience working with civil society and advocacy organizations Illustrate ways to address human rights violations and their sequelae through cross-sectoral collaboration among the health, legal, and social work professions
Population and Global Health	Describe populations that are at risk for human rights violations, including, but not limited to: LGBTQ+ individuals, refugees, prisoners, children and women Become familiar with different types of gender-based violence such as: female genital mutilation/cutting (FGM/C) [14], forced marriage, human trafficking, domestic violence, and honor killing. Describe human rights violations in the global context Review trends in global and regional migration Understand the connection between conflict and forced migration Understand the connection between climate change, human rights violations, and human migration Consider the role of immigration as a social determinant of health Develop an understanding of how current affairs and geopolitical trends affect the health of populations Define the connections between health and human rights and their relevance to and association with healthcare delivery Explore theoretical models of vulnerability and resilience
Leadership and stewardship (for learners involved in asylum training and asylum clinics)	Develop conference organizational skills Learn about running a small organization Develop advocacy skills Consider research gaps and carry out research projects
Health system	Understand how the health status of forced migrants is connected to their legal status Define and list community-based resources needed by asylum seekers Scope, identify, and vet local resources and create referral processes Understand the importance of follow-up care Describe barriers to integration and acculturation Explain the structure of the American medical system and barriers to care for refugees and asylum seekers

medical schools which serve as training hubs for the general medical community and advocacy agents for asylees and immigrants, as well as proponents of human rights curricula in the larger medical education context. Asylum medicine education may occur in different formats including:

1. Apprenticeship and mentorship: In-depth training under the direct supervision of an experienced forensic evaluator in a one-on-one setting with an interested medical professional or student (MD, DO, PhD, NP, MA, MSW, etc.).
2. Stand-alone asylum training: Often hosted by a human rights organization (i.e., Physicians for Human Rights, Health Right International), a medical school–based asylum program, or professional societies (i.e., the Society of Refugee Health Providers). This format provides a public training via in person or prerecorded lectures, with or without participatory breakout groups. Participants are generally enrolled in a network of trained examiners for future consultation and are often awarded a certificate of participation which augments their legal credibility as an expert evaluator.
3. Medical student-run asylum programs[1]: In addition to stand-alone trainings, these programs offer extensive opportunities to students for hands on participation in case management, ongoing medical care, research, and advocacy [15, 16].
4. Training in the context of human rights education curricula: Practical training in forensic evaluation is often included in the broader human rights curricula currently offered in some medical schools and residency programs.

Ideally, all training would incorporate components from each of these learning environments in order to provide ongoing holistic training to the largest number of medical professionals. While the conceptual portions of asylum evaluation training are generalizable, specifics may vary by region and nation and consultation with local legal experts should be engaged. Table 11.2 contains a sample agenda for a typical asylum training workshop.

Other Considerations

Assessment and Evaluation

There are currently no recognized or validated assessment tools specific to the field of asylum medicine. Educators may consider creating benchmarks and measurement instruments to assess the impact of asylum medicine educational activities. This may be particularly important if an institution or organization has a formal curriculum or a structured asylum program. Various subjective and objective indicators can be developed and adapted, relying on well-established frameworks such as Blooms Taxonomy for the acquisition of knowledge or skills [18], and the *Kirkpatrick Model* for evaluating the results of training and educational programs [19]. Areas for assessment can include, but are not limited to, measuring changes in attitudes, behaviors, and empathy scores; assessing knowledge acquisition; evaluating the development of clinical and communication skills; and analyzing professional identity formation.

[1] https://www.phrstudents.com/asylum-clinics

Table 11.2 A sample asylum training agenda

Outline of legal framework for asylum and related forms of relief	UN Declaration of Human Rights and asylum guarantee Define the five grounds for asylum Brief history of asylum in the US One-year filing deadline Describe all forms of relief: Asylum, T-visa, U-visa, Special Immigrant Juvenile (SIJS), Withholding of Removal, Convention against Torture (CAT), Violence Against Women Act (VAWA) Obligation for non-refoulment Role of medico-legal collaboration
US Case precedent for expansion of Membership in a Social Group criteria – GBV and LGBTQI/SOGI	FGM/C Severe domestic abuse Trafficking Persecution of LGBTQ+ community Impact of the matter of A-B
Physical forensic exam	Recognition of signs/symptoms of injury Description of common modes of torture and their sequalae Use of descriptive terminology set forth in the Istanbul Protocol Appropriate attribution of scar(s) to method(s) of injury as: *not consistent with/consistent with/ highly consistent with/ diagnostic of*
Psychological forensic exam	Focus on psychological sequalae of trauma (not a therapeutic encounter) Use of DSM-V criteria for diagnostic conclusions Appropriate use of standardized questionnaires: Harvard Trauma Questionnaire (HTQ-4), Hopkins Symptom Checklist (HSCL), Refugee Health Survey (RHS-15), Generalized Anxiety Disorder (GAD-7), Patient Health Questionnaire (PHQ-9) Recognition of and minimization of the possibility of re-traumatization due to the evaluation itself
Special circumstances: Wwomen, LGBTQ+, children / unaccompanied minors	Awareness of specific in country conditions, harmful practices, cultural persecution relevant to the client's circumstances Age and developmentally appropriate approach Use of the Ahola–Shidlo scale [17]: *Sexual Orientation and Gender Identity Assessment in LGBT Refugees and Asylees*
Affidavit writing	Expert credentials Format/ style – in contrast to medical charting Use of scholarly citations Wording of conclusion Collaboration with legal team
Break out groups by topic of interest for in depth discussion	Psychological Evaluation Asylum-seeking women Unaccompanied minors Political persecution / Imprisonment
Self-care	Recognition of vicarious trauma and how to address it Creation of vicarious trauma/resilience institutional protocols Recognition of one's own trauma history and triggers Support from other evaluators Support from mentors

Assessment tools may include formative or summative exams, quizzes, and tests; surveys, interviews and focus-groups; observed live clinical encounters as well as Objective Structured Clinical Examination (OSCEs); self-reflection exercises (e.g., blogging, writing, art projects).

Tracking students' specialty or other career choices may be instructive (e.g., geographical practice setting, populations served, or focus on advocacy). Several studies have described associations between experience working in global health or with vulnerable populations and students' choice to pursue careers in primary care, to work with underserved patients, and/or to work in rural area practice sites [20].

Associated Learning

Asylum medicine education can be augmented by online learning opportunities. One such option is the interactive platform called The Waiting Game (https://projects.propublica.org/asylum/), which takes learners through several journeys of asylum-seeking migrants. Another platform is a multiplayer online game called This War of Mine, which has been employed in medical education [21] to introduce first-year medical students to the complex humanitarian and human rights challenges of living in a war zone.

The expansion of andragogy into broader concepts and frameworks, in the classroom as well as in community-based instruction, may help anchor asylum medicine on a spectrum that encompasses human rights [22], social justice, and health equity.

A session about forensic photography that includes practical, hands-on instruction, as well as discussion of the ethical dimensions of photography is also recommended [23, 24].

Ethical Considerations

Any educational program about asylum medicine should include content related to best practices for avoiding re-traumatization with specific modules on child asylum seeker and examination of victims of sexual violence. Instruction about obtaining informed consent given the sensitive nature of information and associated photography is also critical. Additional topics that should be covered include the creation of protocols for medical and community-based referrals and the development of continuity of care processes that take into consideration the learners' and clients' local context and access to care.

Learners should also be advised of the potential harms of exposure to traumatizing narratives while conducting asylum evaluations. No educational program will be complete without some discussion of vicarious trauma [25] including manifestation, recognition, and means of addressing it on the individual as well as the institutional level.

Resources

The following links may be useful for educators and learners:

- Society of Asylum Medicine https://asylummedicine.com/
- Physicians for Human Rights Asylum Network and Training https://phr.org/issues/asylum-and-persecution/phr-asylum-program/
- Society of Refugee Healthcare Providers http://refugeesociety.org/
- Health Right International https://healthright.org/our-work/human-rights-clinic/
- Hastings Center for Gender and Refugee Studies https://cgrs.uchastings.edu/
- PHR Medical Student Program https://phr.org/get-involved/participate/students/
- Forensic Photography https://phr.org/what-is-forensic-photography/
- How to Obtain Meaningful Informed Consent https://phr.org/how-to-obtain-meaningful-informed-consent/
- MSF travelling exhibit about what it's like to live in a refugee camp https://www.doctorswithoutborders.org/what-we-do/news-stories/news/doctors-without-borders-brings-interactive-exhibition-global-refugee
- An interactive exploration about solitary confinement https://www.youtube.com/watch?v=odcsxUbVyZA
- The Waiting Game https://projects.propublica.org/asylum/
- This War of Mine https://store.steampowered.com/app/282070/This_War_of_Mine/

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Chapter 12
Advocacy and Asylum Medicine

Kathryn Hampton

> Medicine is a social science, and politics is nothing but medicine on a large scale. The physicians are the natural attorneys of the poor, and social problems should largely be solved by them.—Rudolf Virchow, the "father" of public health

Definition of Advocacy

Advocacy is "the act or process of supporting a cause or proposal."[1] Healthcare and human rights advocacy refers to activities undertaken to affect change by influencing decision-makers on health and human rights issues. Advocates can include individuals, organizations, or informal groups, who may attempt to influence local, regional, national, or international institutions on a particular issue. Advocacy strategies may involve researching a topic to generate evidence or analysis, holding personal meetings with decision-makers, mobilizing networks, launching awareness raising campaigns on social media or mass media, organizing public demonstrations, or supporting legal action. Change that advocates seek might range from adaptations of policies or practices, agenda-setting, introduction of new policy solutions, or accountability for harmful practices.

Advocacy is not "being a voice for the voiceless," because marginalized communities like asylum seekers and migrants have a voice, but one which is often ignored. Advocacy must be grounded in the principles of solidarity, inclusion, and

[1] "Advocacy." Merriam-Webster.com. 2021. https://www.merriam-webster.com (3 March 2021)

K. Hampton (✉)
Asylum Program, Physicians for Human Rights, New York, NY, USA
e-mail: khampton@phr.org

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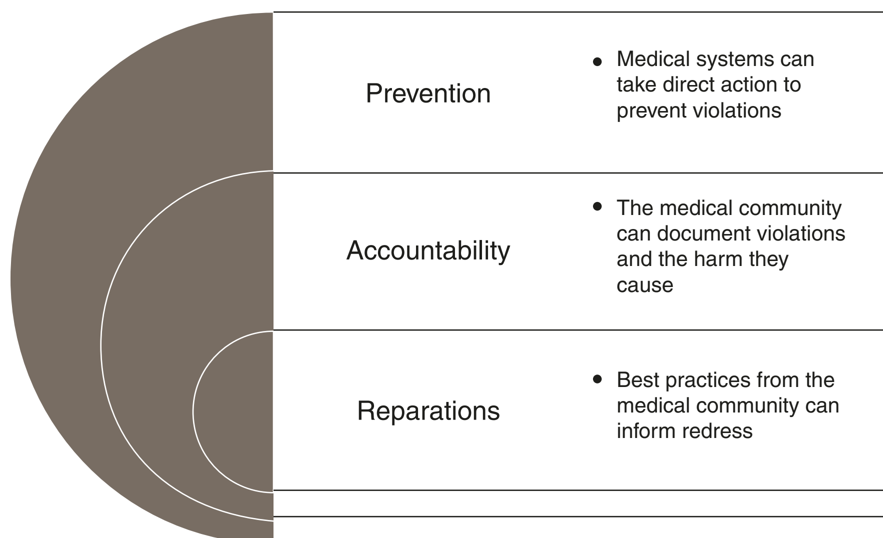
participation, while being mindful that due to pending potential risks or confidentiality issues, asylum seekers may not always be able to participate directly in advocacy. However, it is essential for advocates to continue to explore ways to ensure that advocacy is grounded and centered in communities and in lived experience of affected communities.[2] In the context of asylum medicine, advocacy seeks accountability for human rights violations, remedies for victims and survivors, and prevention of future persecution.

Policy and Health

Human rights violations are often inextricable from their health consequences. Health professionals and medical systems are regularly on the front lines of emerging violations, so understanding the role of the medical system in the response to human rights violations is critical. The many disciplines which support health systems operations—from medicine to public health to nursing to behavioral health—all lend a unique expertise to document the presence and impact of human rights violations, and also how bioethics and standards of care can inform and generate policy solutions.



[2] See, for example, "Kids in Need of Defense, the Voices that Matter Most" project, which works with Kids in Need of Defense (KIND) clients and other immigrant and refugee children to help them share their stories of resilience and hope through workshops, trainings, and public speaking and advocacy opportunities, https://supportkind.org/what-we-do/voices-that-matter-most/

The Role of Asylum Medicine Practitioners in Advocacy

Health professionals have unique stature as advocates due to their specific expertise. Clinicians, who hold a symbolic and trusted role in society, can understand and explain medical data and facts, and are often part of large professional organizations by health specialty and other expert affiliations.

Clinicians who are specialized in asylum medicine have unique credibility and expertise due to their training, knowledge, and clinical experience working with immigrants and asylum seekers, documenting torture and trauma, and analyzing forensic evidence. Moreover, direct exposure to the stories, struggles, and resilience of asylum seekers has been shown to inspire idealism and a desire to act and advocate for change among both medical students and clinicians.[3] Advocacy can also seem intimidating or challenging to health professionals, particularly if coming from clinical training and an approach of helping individual patients, rather than working towards systemic change. Advocacy requires a mindset shift from advocating for individual patients in specific cases, to advocating for systemic changes which affect social and political determinants of health at a macro level.

Policy issues which may be particularly well suited to benefit from the expertise of asylum medicine practitioners' expertise and experience:

- Policies regarding adjudication of applications for asylum and other forms of humanitarian relief (T-visa, U-visa, SIJS, VAWA, CAT withholding)
- Immigration enforcement policies in the interior of the US, such as arrests, raids, and deportations
- Immigration detention policies, including family detention and federal custody of migrant children
- Border enforcement policies, including apprehension, processing, and expulsion
- Policies or practices which implicate torture, persecution, human rights violations, and other forms of state or state-sanctioned harm

Due to the expertise of asylum medicine practitioners in documenting human rights violations, this section will focus on advocacy related to human rights violations.

[3] Mishori R, Hannaford A, Mujawar I, Ferdowsian H, Kureshi S. "Their Stories Have Changed My Life": Clinicians' Reflections on Their Experience with and Their Motivation to Conduct Asylum Evaluations. *J Immigr Minor Health*. 2016;18(1):210–218. doi:https://doi.org/10.1007/s10903-014-0144-2; See also Lubin, M and Lustig, S, "Discovering your inner advocate," Chap. 1, *Advocacy Strategies for Health and Mental Health Professionals: From Patients to Policies*, Stuart L. Lustig, ed, Springer Publishing Company, 2012.

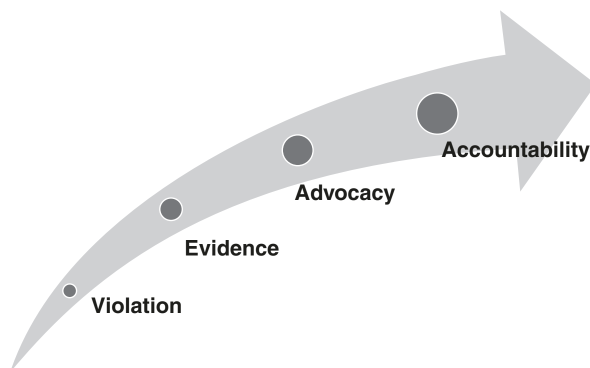
What Are the Goals and Outcomes of Advocacy?

The following are several categories of advocacy tactics[4]:

- Informational: using credible information to influence others with facts
- Symbolic: referencing powerful symbols or stories that influence through heart-felt messaging
- Leverage: mobilizing powerful actors to influence their own audiences
- Accountability: holding decision-makers to account by comparing the consistency of their actions with their own stated policies

Evidence-Based Advocacy: The Role of Medical Evidence

By definition, most perpetrators of human rights violations seek to conceal or deny violations, which is why evidence is essential to activate accountability mechanisms. Evidence does not result in accountability on its own, but relevant evidence can bring pressure to bear on perpetrators through advocacy. Accountability, which involves acknowledging the harm that was caused, sanctioning the perpetrator and providing remedies for the victim, results in increased transparency about abuses and can serve as a deterrent to future violations. Accountability for one human rights violation is rarely about only that individual case. It can have outsized impact in the future if these findings are leveraged through advocacy.



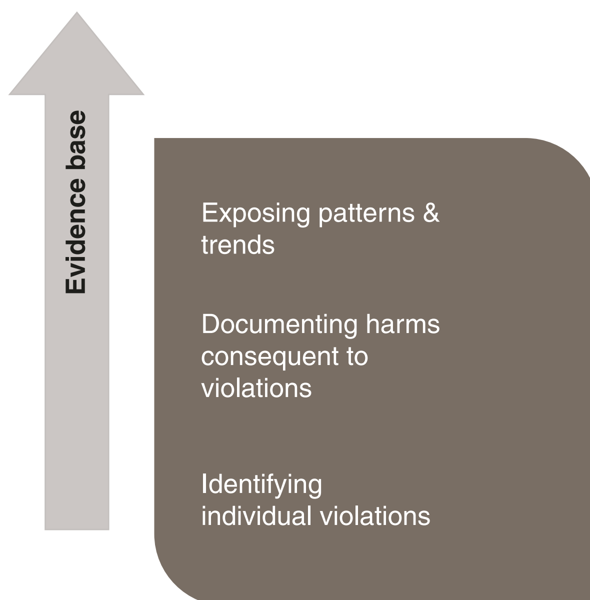
Incidents of discrimination can be invisible unless wider patterns are uncovered. For example, the possible chilling effect of anti-immigrant rhetoric on healthcare utilization, or the mental health harms caused by punitive immigration raids, can be

[4] Keck, Margaret E.; Sikkink, Kathryn (1998). *Activists beyond Borders Advocacy Networks in International Politics*. Cornell University Press. p. 16. ISBN 978-0-8014-7129-2.

studied systematically by looking at episodes over time by affected populations in order to expose statistically significant patterns. Once those previously invisible patterns are exposed, it can be possible to raise awareness and to challenge some of the underlying causes of those disparities.[5]

Medical documentation of physical and psychological effects of human rights violations underscores the longer-term impact of these violations on the victim and can illuminate the severity of the violation. The health and behavioral health consequences, which can sometimes last a lifetime, make the gravity of human rights violations more evident, and support the need for reasonable compensation, including the right of victims and affected communities to rehabilitation.

Research can also confirm the content of specific violations, such as those related to inadequate medical care or conditions of confinement. Legal professionals and human rights advocates will be limited in their ability to confirm that medical care provided to prisoners was not in accordance with medical standards of practice without medical expertise to assess the treatment which was given. For example, Physicians for Human Rights (PHR) joined the American Civil Liberties Union (ACLU) in demanding that the US Customs and Border Protection improve medical care for people forced to endure substance withdrawal at ports of entry.[6] Medical review of the treatment provided confirmed that in fact the care was inadequate and caused unnecessary pain and suffering, as well as creating significant health risks.



[5] See, for example, Separated: Family and Community in the Aftermath of an Immigration Raid. by William D Lopez · Johns Hopkins. Sept. 2019. 232p. ISBN 9781421433318.

[6] RE: U.S. Customs & Border Protection's Routine Failure to Provide Necessary Medical Care and Treatment to Individuals in Substance Withdrawal at Ports of Entry, ACLU and PHR, Sept 17, 2019, https://www.aclutx.org/sites/default/files/poe_med_care_ltr_-_aclu_and_phr.pdf

Policymakers are swayed by evidence. Some challenges in leveraging the findings of asylum medicine practitioners include (1) how to make scientific data and evidence understandable to lay people, through translating them into language that policymakers can understand; and (2) how to keep data relevant and current given the long publication cycle of peer-reviewed research, because policymakers need recent data. Asylum medicine practitioners can navigate these challenges of accessibility and timeliness by publishing articles using more accessible, easy-to-read language in news media, or putting together literature reviews which sum up the current evidence, framed in a way that is relevant for the moment when the timeframes for empirical research might be too long to respond effectively to policy developments.

The following are a few case studies which illustrate different roles of various types of evidence.

- Global standard setting in medical evidence: the Istanbul Protocol

Case Study

The United Nations (UN) *Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, otherwise known as the "Istanbul Protocol" (the IP), is familiar to asylum medicine practitioners as the global standard in medical documentation of torture.[7] Most asylum evaluations use IP taxonomy in describing their clinical impressions and conclusions, by describing the sequelae as "not consistent," "consistent," "highly consistent," or "diagnostic" of the torture which was alleged.

In a 2019 United Kingdom asylum case, *KV (Sri Lanka) v Secretary of State for the Home Department*,[8] a medical doctor assessed the scars of an asylum seeker as "highly consistent" with his account of the torture he endured that resulted in a particular burn pattern on his skin. The lower court stated that the medical expert went outside his scope of expertise to make this statement, saying that a clinician should not be able to speak to the circumstances of an injury. However, the UK Supreme Court held that in assessing not merely the mechanism of injury, but also the consistency of the physical signs and the narrated trauma, the medical expert "was giving assistance to the tribunal of significant potential value" (para 20). The UK Supreme Court therefore stated that the Istanbul Protocol should be recognized as "equally as authoritative" as the tribunal guidelines in regard to medical investigation of alleged torture (para 24), especially as the practice direction of the tribunal guidelines do not directly address the investigation of torture.

- Medical Evidence That Confirms Harms Caused by Violations

[7] UN Office of the High Commissioner for Human Rights (OHCHR), *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ("Istanbul Protocol"), 2004, HR/P/PT/8/Rev.1.

[8] *KV (Sri Lanka) v Secretary of State for the Home Department* [2019] UKSC 10, accessed at: https://www.supremecourt.uk/cases/docs/uksc-2017-0124-judgment.pdf

Case Study
In 2003, asylum medicine practitioners published a study which scientifically documented the harmful impacts of detention on individual's psychological well-being.[9] Researchers interviewed 70 detained asylum seekers to assess mental health symptoms, and conducted interviews which demonstrated that respondents who were released from detention showed improvement in symptoms, while those who were still in detention showed a worsening of symptoms. This article has been cited in in legal cases related to US immigration detention as one of the critical pieces of evidence that attorneys can use to demonstrate the harms caused by detention.

One legal case that successfully leveraged this evidence for change was *Damus v. McAleenan*, where the ACLU and others sued the Department of Homeland Security for the practice of prolonged detention of asylum seekers without considering parole requests. The US District Court for the District of Columbia required Department of Homeland Security (DHS) field offices to comply with the DHS policy that required the government to make an individualized assessment to parole asylum seekers so long as they did not pose a flight or public security risk.[10] Medical evidence that detention is associated with worsening of mental health symptoms in asylum seekers was cited to help the court understand the health impact of prolonged detention on asylum seekers.

- Generating Best Practices: Medical Evidence Fueling Policy Alternatives

Asylum medicine practitioners are also well placed to advise on policy solutions which can ensure that knowledge and best practices from health systems inform policy choices and create new alternatives to achieve a policy goal—such as border management and immigration processing—while still respecting health and human rights.

Alternatives to Immigration Detention

A number of studies in the US and in other asylum destination countries have found that community-based alternatives to detention show improved health outcomes for asylum seekers compared with those who are detained, even in some that controlled for trauma exposure and demographic factors.[11]

[9] Keller AS, Rosenfeld B, Trinh-Shevrin C, et al. Mental health of detained asylum seekers. *Lancet*. 2003;362(9397):1721–1723. doi:https://doi.org/10.1016/S0140-6736(03)14846-5

[10] *Damus v Nielsen*, No. 18–578 (JEB), 2018 WL 3232515 (D.D.C. July 2, 2018).

[11] See references in the PHR Asylum Fact Sheet, Alternatives to US Immigration Detention, October 2018, https://s3.amazonaws.com/PHR_other/factsheets/PHR_Asylum_Fact_Sheet_Alternatives_to_Detention.pdf

Sanctuary or Safe Space Hospitals

Data indicate that fear of immigration enforcement in health facilities, as well as fear of cooperation between health systems and immigration enforcement, has a detrimental effect on healthcare utilization of immigrants and asylum seekers in the US. Research has also shown that there are proactive measures that health professionals and health systems can take in order to mitigate the risks of immigrant enforcement impact on healthcare access. For example, a qualitative study conducted 38 interviews in 25 healthcare facilities in 5 states in order to gather evidence about best practices for welcoming immigrants to health facilities. This study described a range of best practices, including adopting policies and establishing task forces that limit cooperation with immigration enforcement, promoting welcoming messages for all patients, and providing training for health professionals, and supportive services and alternative payment methods for patients.[12]

1. Advocacy Towards Accountability: A Human Rights-Based Approach

Generating evidence about harms caused by human rights violations and about the effectiveness of policy alternatives is just the first step. In order to leverage that evidence for change, it must influence decision-makers, directly through formal or informal channels, and indirectly by influencing public opinion.

Health systems that are providing treatment in times of crises when human rights are being violated produce evidence about harms caused by human rights violations and about the effectiveness of policy alternatives. The question is to what extent medical systems are open to speak out about what have been called the “upstream causes” of health conditions. Which partnerships can support medical systems to be more engaged in accountability movements?

Once a violation is exposed, and accountability, transparency, and remedies for the victims have been achieved, how can this knowledge prevent these violations in the future? Policy change that supports policy solutions or alternatives can bring about lasting and systemic change.

Policies are formed at different levels, from local to national, and with different instruments or tools. These include municipal, state, and national laws passed by legislatures, executive orders from executive offices, statutes that regulate the work of administrative agencies, and internal agency guidelines.[13]

The following section describes various ways that clinicians can directly contribute to changing policies and practices.

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[12] Saadi A, Sanchez Molina U, Franco-Vasquez A, Inkelas M, Ryan GW. Assessment of Perspectives on Health Care System Efforts to Mitigate Perceived Risks Among Immigrants in the United States: A Qualitative Study. *JAMA Network Open*. 2020;3(4):e203028. Published 2020 Apr 1. doi:https://doi.org/10.1001/jamanetworkopen.2020.3028

[13] For detailed information on policy and legislative advocacy, see *Advocacy Strategies for Health and Mental Health Professionals: From Patients to Policies*, Stuart L. Lustig, ed, Springer Publishing Company, 2012: Barnes, R, Chap. 3, Overview of the Political Advocacy Process and Ptakowski, K, Chap. 4, Legislative Advocacy: Putting your house in order.

Providing Evidence to Policymakers

Briefing Congressional representatives and staff, whether testifying in a Congressional hearing or appearing in informal briefings for members of Congress or their staff, is an important way to present evidence to policymakers. Congress holds the executive branch accountable for its actions in order to receive funding, so keeping legislators informed is crucial for advocacy. Legislative staff are knowledgeable about policy development, but they need information from clinicians about subject matter expertise. Some staffers may need new data or even anecdotes from respected constituencies such as health professionals in order to generate interest in a particular issue. Although opportunities for formal testimony are rarer, presenting evidence through in-person meetings, or through letters and phone calls to elected officials, is a way to build relationships so that staffers can reach out when relevant expertise is needed. When a particular issue raises broad public support and a hearing is scheduled, legislative staff can reach out to healthcare providers for expert testimony or written statements. Hearings generally are scheduled with very short notice.

Case Study
Child psychiatrist and PHR Asylum expert Dr. Amy Cohen testified before the Senate Democratic Policy and Communications Committee about poor conditions of confinement and inadequate medical care for children in the Office of Refugee Resettlement. The hearing was attended by 16 Democratic Senators.[14] Congress used her testimony to build oversight of federal agencies holding children into appropriations bills.

Whistleblowers have consistently spoken out about issues affecting asylum seekers, from DHS medical consultants exposing family detention conditions, to a recent letter published by an asylum officer about the Migrant Protection Protocols. Whistleblower laws protect them from prosecution for disclosing confidential information for the public good. If a clinician works for the government and has witnessed or has access to information about human rights violations noted through the course of their duties, they can consult with attorneys who specialize in whistleblower protection as they contemplate a course of action.

Case Study
In July 2018, an internal medicine physician and a child psychiatrist who had served as medical consultants for DHS to evaluate medical care and conditions of confinement in family detention centers wrote to the Senate Whistleblowing Caucus in order to report their concerns about family separation and about increased use of

[14] Testimony Submitted for the Record: Senate Democratic Policy and Communications Committee Hearing on "America Speaks Out: Stop Trump's Cruel Treatment of Migrant Children at the Border," July 23, 2019, https://phr.org/our-work/resources/11003/; Udall, Heinrich to Hold Hearing on Treatment of Children at the Border, July 22, 2019, https://www.heinrich.senate.gov/press-releases/udall-heinrich-to-hold-hearing-on-treatment-of-children-at-the-border

family detention.[15] Their letter emphasized objective medical information and findings that demonstrate that family detention is not a safe place for children. Their letter was widely cited in policy debates and court cases as key evidence of the harms of detention and family separation on children.

Case Study
In September 2020, a licensed practical nurse working in an immigration detention center in Georgia spoke up about conditions in the detention center where she worked to provide healthcare. She reported that COVID mitigation measures were dangerously inadequate, putting people in detention at risk, as well as workers like herself who have underlying conditions. She further reported that numerous women in the facility underwent unnecessary gynecological procedures, including hysterectomies without adequate information or consent.[16] Her disclosure resulted in a class action lawsuit, internal agency investigations and calls from Congress, and prompted more than 57 women to come forward with their experiences of abuse.[17]

Providing Evidence to Policy Implementers

Public comments can be submitted to administrative agencies when they issue new rules which are based on their interpretation of existing law. Regulations.gov offers notices of all upcoming new regulations. When agencies such as the Department of Justice and Department of Health and Human Services publish new administrative rules, individuals can contribute public comments. In a public comment, members of the public describe their credentials and share concerns about the proposed rule, based on their expertise and experience. They can also attach links and supporting documents, which then become part of the public record. Since it is a matter of public record, private or personal details such as a personal phone number or patient information should not be included in the comment. Comments may result in amendments to the rule and can also be used as evidence by litigators to oppose implementation of the rule.

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[15] Dr. Scott Allen and Dr. Pamela McPherson, Letter to the Senate Whistleblowing Caucus, July 17, 2018, accessed at: https://www.whistleblower.org/sites/default/files/Original%20Docs%20Letter.pdf

[16] Olivares and Washington, "He Just Empties You All Out: Whistleblower Reports High Number of Hysterectomies at ICE Detention Facility, The Intercept, September 15, 2020, https://theintercept.com/2020/09/15/hysterectomies-ice-irwin-whistleblower/

[17] Press Release: Government Accountability Project and Project South Stand Behind Detained Immigrants' Class Action Lawsuit Against ICE, December 22, 2020, https://whistleblower.org/federal-whistleblowers/press-release-government-accountability-project-and-project-south-stand-behind-detained-immigrants-class-action-lawsuit-against-ice/

Case Study

More than 60,000 individual public comments were submitted opposing expansion of family detention centers for immigrants, including comments from health professionals and health advocacy groups, which pointed to medical evidence that conditions in family detention centers are inherently harmful to children.[18] Although the three existing family detention centers were not closed, there was a reduction in the overall detention population. In addition, despite being a stated goal of the administration, no new family detention centers were established.

Administrative complaints directly address the responsible executive agency in order to seek remedies for individuals or populations. Agency staff may be unaware (or may not care) that their operational policies and practices have negative health consequences, because the health aspect is not their area of expertise and they may have other priorities, such as law enforcement. Other officials, especially those who work for internal government watchdogs, such as inspectors general, may need data and evidence from credible external experts, such as asylum medicine practitioners, in order to activate internal mechanisms to address violations.

Case Study

In February 2019, the American Immigration Lawyers Association filed a complaint with the US Department of Homeland Security Office for Civil Rights and Civil Liberties (CRCL) and the Office of the Inspector General (OIG) about prolonged detention of infants with their parents. Physicians for Human Rights submitted an expert letter that cited research about the health harms that detention poses to infants and young children specifically. Within 6 days, 16 of the 17 infants were released from immigration detention.[19]

2. Providing Evidence for Lawsuits

When executive agencies ignore administrative complaints, and when there is not enough support in Congress to enact policy change, litigation is a powerful means to obtain remedies and protection for victims of human rights violations, and medical evidence is a critical element of that process. Providing affidavits, expert declarations or briefs in lawsuits is another way that health professionals can leverage evidence to have a significant impact.[20] Asylum medicine practitioners are already familiar with the process of providing individual affidavits or declarations in asylum cases, but expert declarations in other types of cases can be based on evaluation of individuals, review of medical records, or simply knowledge of existing literature or medical data. Ethical and professional standards should be followed

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[18] PHR opposes the proposed changes as announced in DHS Docket No. ICEB-2018-0002, October 30, 2018, https://phr.org/wp-content/uploads/2018/10/0000-PHR_Public-comment-for-DHS--submissionCARSMSKH.pdf

[19] Complaint Urges Immediate Release of Infants from Detention, AILA Doc. No. 19022836, February 28, 2019, https://www.aila.org/infonet/complaint-urges-immediate-release-of-infants

[20] See also Simon, B and Boardman, T, Class Action for Health professionals, Chap. 7, *Advocacy Strategies for Health and Mental Health Professionals: From Patients to Policies*, Stuart L. Lustig, ed, Springer Publishing Company, 2012.

in these circumstances. Clinicians should not provide opinions outside of their expertise, should declare conflicts of interest, should avoid using medical jargon and voicing political and ideological views, and should ask for supporting data when needed.[21] Lawsuits related to the forced separation of families at the US–Mexico border in 2018 demonstrate a particularly strong example of the impact of medical evidence.

Case Studies from Family Separation Although it was obvious that the policy caused trauma to both children and parents, the medical and mental health findings, including published research, clinician statements, and clinical evaluations of clients, quantified and described the persistent and serious nature of the effects of forced separation.

In the case *Ms. L v ICE*, attorneys cited American Academy of Pediatrics statements on the trauma caused by separation, and attached affidavits by clinicians based on medical literature ("overwhelming medical evidence") on the trauma caused by separation from primary caregivers. The result was an injunction on June 26, 2018, that required the government to halt the practice of separation, to reunite families, to facilitate contact between parents and children until reunification, and to ensure interagency record keeping of separations.

In another case, *Dora v Sessions*, a psychiatrist evaluated 29 parents who underwent credible fear interviews during the period of separation. These parents were unable to effectively tell their stories to the asylum officer due to their distress at being separated, and therefore they did not pass the credible fear interview. The psychiatrist found that the parents' extreme trauma caused by separation amounted to a mental disability which required accommodations in immigration proceedings. They stated, "Because of the disabling trauma … parents seeking asylum were confused, disoriented, unable to focus on anything other than the whereabouts and well-being of their children, and unable to adequately articulate their experiences to the interviewing officers…" The result was a settlement agreement that required the government to review all the credible fear determinations for these parents, and to ensure reasonable accommodations, such as allowing breaks during the interview and letting their child remain with them. A companion case, *MMM v Sessions*, represented separated children, and the children's credible fear determinations were also reviewed.

In the case, *Ms. JP v Sessions, the US District Court of Central California* issued a preliminary injunction on November 6, 2019. It required the government to provide mental health screenings and any recommended follow-up treatment for the separated families, as the state had acted with deliberate indifference to the trauma caused by separation. The complaint references psychological evaluations of the clients throughout and cites extensive commentary by doctors and mental health experts.

[21] Ten Guiding Principles for Writing Medical-Legal Documents, https://phr.org/wp-content/uploads/2020/06/PHR-guidelines-for-writing-medical-legal-declarations.pdf

Case Study
The government has increasingly used forced feeding as a dangerous response to hunger strikes organized to protest poor conditions in immigration detention. Forced feeding causes significant health risks, as well as being a form of cruel, inhumane, and degrading treatment.[22] In one case, a doctor reviewed almost 500 pages of medical records and asserted in an affidavit that the asylum seeker who was being forced fed received "the worst medical care I have seen in my 10 years of practice" and recommended immediate release from detention.[23] The outcome of the lawsuit was release of the asylum seeker.[24]

Case Study
During the outbreak of the COVID-19 pandemic, expert declarations and briefs to demonstrate risks to people with underlying conditions for severe illness or death due to the disease were in high demand. Medical and immigrant rights groups trained and mobilized health professionals to work with attorneys to present the latest evidence and knowledge about the disease, applied to the individual clients or detention facility, to explain public health imperatives to immigration authorities and to judges to advocate for their release.[25] Medical and legal experts worked together to leverage both innovative constitutional legal arguments, as well as new epidemiological modeling tailored to realities in detention centers, covering a wide range of expertise.[26] Ultimately, hundreds of people with underlying conditions and other risk factors were released from immigration detention and prisons during the pandemic.[27]

Dissemination

In addition to influencing government officials, policy makers, and judges, medical evidence can also be influential in swaying public opinion, humanizing marginalized groups, and galvanizing the public for social change.

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[22] Asylum, Hunger Strikes, and Force-Feeding, Physicians for Human Rights Fact Sheet, https://phr.org/wp-content/uploads/2019/03/PHR-Asylum-Force-Feeding-Fact-Sheet.pdf

[23] Revealed: man force-fed in Ice custody at risk due to "substandard care," doctor says, *The Guardian*, August 30, 2019, https://www.theguardian.com/us-news/2019/aug/30/ajay-kumar-hunger-strike-asylum-seeker-us-detention

[24] Indian hunger striker released from immigration detention in Texas, *The Guardian*, September 27, 2019, https://www.theguardian.com/us-news/2019/sep/27/indian-hunger-striker-released-immigration-detention-texas-ajay-kumar

[25] Best Practices in Writing Expert Declarations, Physicians for Human Rights, April 8, 2020, https://www.youtube.com/watch?v=Y7K5QHuR_Mk&feature=youtu.be

[26] Amicus brief for the Ninth Circuit Court of Appeals, *Kelvin Hernandez Roman v. Chad F. Wolf*, Case No. 5:20 CIV. 768, https://phr.org/wp-content/uploads/2020/05/Adelanto-ICE-Litigation-Amicus-Brief.pdf

[27] ACLU News and Commentary, How the ACLU is Responding to the Pandemic, Visualized, April 30, 2020, https://www.aclu.org/news/civil-liberties/how-the-aclu-is-responding-to-the-pandemic-visualized/

Actions to impact the wider public can include:

- Letters to the editor and opinion pieces in local and national newspapers
- Blogs or perspective pieces in online publications or professional publishing platforms
- Press releases and public statements sent to media
- Social media campaigns
- Demonstrations, rallies and marches (such as those by Doctors for Camp Closure, Free Our Children Now)
- Talks and presentations
- Online webinars
- Email campaigns
- Call-in actions
- Film and video

Evaluating Impact of Advocacy

How can advocacy initiatives and actions be evaluated to see if they are making a difference? Longtime impact may take years or even decades to achieve, and changes in public opinion can be costly to assess. In the meantime, it is possible to measure process indicators which show the issues that are attracting increased visibility or effecting change in individual decision-makers.

Examples of impact metrics for advocacy:

- Media and social media metrics (# media products, hits, readership, responses/comments, media requests)
- Actions taken by decision-makers (# court cases, # meetings, requests for further information or to testify as experts, revising proposed bills, new policies)
- Response by organizations and institutions that are part of the wider advocacy coalition (contacts, citations, invitations to meetings)
- Anecdotal assessment of usefulness of advocacy materials, resources, and recommendations
- As resources allow, public opinion polls, or surveys of policymakers

Discussion Questions and Exercises

Individual Brainstorming Exercise

What is your personal message?
Which issues are you interested in advocating for?
What is your personal experience (either research, clinical, personal exposure, or lived experience) with those issues?

Which government body is responsible for addressing that issue?
How could you reach that body?

Group Discussion Questions

How can you gain exposure to relevant policy issues? For example through:

- Asylum evaluations, including for detained clients
- Detention center visitation

Volunteering with groups that provide medical services at the border or during emergencies

- Reading legislative bills and existing operational agency standards

How can you reach elected officials with your message?

- Call attention to the issue through media and social media, with the power of your medical voice
- Use science and medicine to document human rights violations
- Use the public health "imagination" to generate policy solutions, and to scientifically evaluate the effectiveness of alternative programming
- Provide technical feedback on draft bills which reflect your medical expertise and professional ethics
- Schedule meetings with staffers
- Testify before a committee or in a hearing

How can you tailor your message to policymakers?

- Present a spectrum of options: from ideal proposals to politically feasible proposals
- Standards (legislation) versus resourcing (appropriations)
- Strategically choosing evidence/sources to back up your positions
- Joining with diverse allies to form coalitions

Further Reading

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Chapter 13
An Introduction to Secondary Trauma and Resilience for Asylum Evaluators

Adaobi Iheduru, Leora Hudak, and Alison Beckman

Introduction

Evaluators who assess individuals who have survived human rights abuses and have fled their countries to seek protection in the United States will be impacted. Clinicians may be moved by accounts of severe trauma, and their understanding of the world and human nature changed by virtue of what is learned in the evaluation process.

The authors of this chapter are psychotherapists at The Center for Victims of Torture (CVT), a torture treatment program, with headquarters in St. Paul, Minnesota. Their roles include eliciting, witnessing, documenting, and helping torture survivors after profound traumatic experiences caused by other human beings. For each of them, this work is impactful in rewarding yet complex ways. We begin with their stories.

> One day I drove my son to a soccer game and left my 13-year-old daughter at home. As I pulled away from the driveway, I did a mental checklist: Did I turn off the oven? Was her phone near her bed? Would she be able to exit the house safely if it burst into flames? I think I had this reaction from years of exposure to terrible things randomly happening to people.
>
> During a routine therapy appointment, an asylum seeker reported they were on the verge of homelessness due to unemployment. The client asserted I had the power to solve the problem because I was in an office sitting behind a desk. I went home that day feeling overwhelmed, powerless and guilty for all that I had; I was confronted by the privileges that I take for granted.
>
> Once I conducted an evaluation for a torture survivor in detention that took several logistic steps to coordinate and was emotionally intense throughout the process. For

A. Iheduru (✉)
The Center for Victims of Torture, Clarkston, GA, USA
e-mail: Aiheduru@cvt.org

L. Hudak · A. Beckman
The Center for Victims of Torture, St. Paul, MN, USA
e-mail: LHudak@cvt.org; Abeckman@cvt.org

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2 weeks after this evaluation, I had my notes, results of the instruments, and the outline open on my computer. I could not bring myself to write the evaluation; reliving the trauma presented during the evaluation felt like too much.

Over the last decade, books, articles, webinars, and in-person training have demonstrated how professionals are affected when working directly with survivors of trauma. There are now numerous descriptors, with overlapping but different meanings, to describe the phenomena. The "negative" effects include terms like secondary trauma, vicarious trauma, and compassion fatigue. The "positive" effects include the terms vicarious resilience and compassion satisfaction. Concepts used to describe strategies to protect include self-care, staff care, wellness, and well-being. Separate, but often coexisting, is burnout, which is a more general concept related to the exhaustion associated with workplace stress, but not tied specifically to working with trauma survivors.

Secondary trauma responses should be contextualized within the larger political context and immigration system. It is important to define and describe the effects of trauma exposure, address specific ways in which medical and psychological evaluations may be affected by exposure to trauma, and manage and mitigate those effects within the process of the asylum evaluation and in broader self-care practice.

The Asylum Context

The sociopolitical context of an environment can impact the satisfaction, joy, and sense of accomplishment that is derived from work. Asylum, at its most basic level, is hopeful: It creates a pathway to protection for individuals who have experienced harm. The role of evaluator is to provide evidence that supports this process of pursuing safety. The political context in the United States can often by marred by a hostile environment and intolerant rhetoric towards immigrants, particularly asylum seekers. Policies restricting immigration and complicating the asylum process can leave asylum seekers living in a state of hopelessness and uncertainty about the future.

Professionals working with the asylum-seeking population encounter clients who may be experiencing severe psychological symptoms and high levels of distress. This, in turn, can weigh heavily on clinicians, who see their clients making limited progress with their claims despite the amount of effort they devote. Some professionals have described this feeling of powerlessness as overwhelming and defeating, particularly due to the sense of responsibility that they feel for the clients they serve [1]. Individuals who choose to work with asylum seekers typically do so due to a desire to change the lives of others. When this value is threatened by the political context, this can contribute to feelings of burnout, compassion fatigue, and overall dissatisfaction with the chosen career.

The immigration process can be tumultuous, unpredictable, and filled with uncertainties. There are often new and revised policies, as well as regional and

individual factors that may impact the outcome of a client's case, regardless of the political landscape. Societal acceptance of immigrants has also varied over time, with particular populations being considered more acceptable than others, which consequently influences decision-making on cases. As such, when beginning to perform immigration evaluations, an awareness of the inherent difficulties allows for emotional preparation and framing of reasonable expectations for the evaluator.

Clinician Motivations

Motivations for pursuing a helping profession are directly tied to impact. When the work involves bearing witness to and documenting the worst actions human beings take against each other, the impact is further pronounced. Many individuals pursue the challenging line of immigration work because their life experiences and skills have led to the development of an identity and worldview that includes a desire to help others. Because of these deeply personal motivations, it is imperative that professionals working with asylum seekers routinely engage in self-reflection about their underlying motivations. This self-care practice uncovers valuable information to ensure that engagement in this line of work is grounded in a clear sense of values and purpose.

Included here are reflection questions to guide through this process:

What motivates me to do this work?
What is my core value system?
What knowledge do I have about this work?
What personal or family experiences have led me here?
*What are my various identities (*i.e., *race, ethnicity, culture, immigrant, gender identity, sexual orientation, disability status, religion, family constellation, language, etc.) and how do they influence my work?*
How are my motivating values currently being reinforced or (conversely) challenged/undermined by the work I am doing? What can I do to adjust accordingly?

The Evaluation Context

At the time an evaluation is conducted, clients are often facing instability due to their legal status. In some cases, clients are in immigration detention during the evaluation. In affirmative asylum cases, clients live outside of detention, but face barriers and restrictions that can impact overall well-being and access to basic needs. Unlike refugees, asylum seekers do not have full access to public benefits such as food stamps and housing, and there can be long waits to obtain work permission. When performing asylum evaluations, the clinician has a specific and

defined role: to assess objectively scars or other evidence of persecution and to provide written documentation to the client's attorney.

As this context takes shape, certain strengths and vulnerabilities emerge for the evaluator. During the process of conducting the evaluation, practitioners may encounter harms and frustrations in the asylum system. Evaluators learn about their client's trauma history in a short amount of time, but are not able to provide long-term support. Clients may ask for support with housing, parenting, or other basic needs that go beyond the scope of their role. Typically, when the evaluation is complete, the evaluator may not have information about the outcome of the case or ultimately know what happens to a client. These factors create a set of circumstances that might look and feel quite different from a practitioner's scope of practice in other settings, such as at a medical clinic or private practice.

Ultimately, evaluators often leave evaluations aware of the trauma history, difficulties in the asylum system, and multiple basic needs of their clients. As such, maintaining boundaries in the evaluator role is important to the integrity of the evaluation and to the client's overall well-being. Providers may hope the evaluation is supportive of the client's asylum claim, but this desire must not influence what is included in the evaluation documentation. When considering the impact of this work on evaluators, it is essential to continue to contextualize the experience. While exposure to trauma stories is one area of impact, exposure to immigration systems and processes often has an equally distressing impact.

Defining Secondary Trauma Concepts

The following is a list of the key terms related to secondary trauma with definitions and descriptors.

Secondary Traumatic Stress

Definition

Originally defined by Charles Figley, Secondary Traumatic Stress (STS) is experienced by professionals who work with trauma survivors. It results from bearing witness to trauma – specifically hearing or knowing about traumatizing event(s) experienced by another. STS can be exacerbated by the professional's desire to help the traumatized or suffering person. STS is often characterized by PTSD-like symptoms such as nightmares, sleep difficulties, irritability, difficulty concentrating, and numbing [2]. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) now recognizes, "experiencing repeated or extreme exposure to

aversive details of the traumatic event(s)" as a qualifying experience for post-traumatic stress disorder (PTSD) [3].

Impact on Evaluators

The primary task of an evaluator is to gather and document the trauma story that led the individual to seek asylum. Evaluators focus on some of the worst events clients have experienced and the subsequent physical and psychological impact. A clinician may carry the most traumatic details with them after the encounter has ended. In contrast to other types of clinical interactions, often there is not an opportunity to witness healing and growth. The result is vulnerability to secondary traumatic stress. This exposure is compounded by the volume and speed at which providers are expected to provide evaluations and complete assessment reports.

In addition to past trauma, many asylum seekers struggle with a myriad of current stressors. They may be in precarious immigration detention facilities, without work permits, managing family separation, in transitional housing, or experiencing stress related to adjusting to the US. Evaluators may empathize with clients' feelings of overwhelm and helplessness. They should also be aware of the impact that exposure to postflight or resettlement trauma can have on them during the evaluation. The impact can be particularly challenging if the evaluator feels they do not have any immediate support to offer to alleviate those stressors (as is commonly the case) or if doing so goes beyond the boundaries of the evaluation relationship.

Burnout

Definition

Burnout is the response to a broad range of occupational stressors and chronic tediousness in the workplace, often characterized by feelings of emotional exhaustion or depersonalization or a sense of a lack of personal accomplishment [4]. Some authors have emphasized interpersonal stressors; work–life balance; loss of meaning in work; and lack of adequate compensation, recognition, or gratification [5].

Impact on Evaluators

Burnout is a distinct phenomenon, but it can coexist with secondary trauma. Individuals in any profession can experience burnout; it is a pressing problem in the medical community. To evaluate asylum seekers effectively, clinicians must

coordinate logistics, perform a rigorous and precise assessment, and write a detailed affidavit. Revisions and review with an attorney are often required. Many times, there is pressure to complete this under a tight timeline.

These factors could make evaluators vulnerable to burnout. Evaluators have described "churning out" an evaluation and the intricacy of the details as factors that contribute to burnout or a desire to take a break. Furthermore, many medical and mental health providers perform evaluations as part of a pro bono practice in addition to their full-time clinical employment. This work cannot be undertaken lightly as it requires significant attention to detail and is emotionally taxing. This, in addition to a regular job, can be experienced as overload and may contribute to a sense of weariness in the work, and eventually burnout.

Moral Distress

Definition

In 1984, Andrew Jameton, a bioethicist, coined the term "moral distress," which the professions of nursing and social work have since applied and adapted. The concept captures the experience of professionals who feel they know the right course of action to take, but are blocked or limited from taking that course due to external or institutional restraints. The authors state that the inability to act in the way that is perceived as moral, ethical, or right results in emotional and psychological pain [6].

Impact on Evaluators

There are many ways in which moral distress can manifest in evaluators. The immigration system, as a whole, has numerous institutional constraints. There are limited paths to immigration in the US, all of which are long and cumbersome. It can feel unfair that people who want to resettle in the United States, no matter what their reasons, are unable to do so.

The asylum system, as one part of this broader immigration system, can create specific vulnerabilities for moral distress. Asylum relies heavily on one adjudicator's subjective determination of an applicant's credibility. This subjective determination may not be based on the science on how traumatic memories are recalled or the severity of physical markers. It can be distressing to an evaluator if adjudicators do not understand that it is normal for an asylum applicant to tell the story of what happened to them in a way that is not linear, coherent, and with lapses or gaps.

Another potential area of moral distress occurs when an asylum seeker does not endorse psychological or physical symptoms necessary to result in a conclusive diagnosis to support their claim. Not all survivors of traumatic experiences meet

criteria for psychological disorders or demonstrate significant physical symptoms. While not endorsing all symptoms at the highest levels actually speaks to an applicant's credibility, it is a challenge to explain this reality to an adjudicator who is likely not trained in the wide range of individual responses to trauma. Evaluators are often caught between the demands of the system and the human being sitting in front of them, and this can be a source of stress and worry.

Complications arise if, during the evaluation process, the evaluator collects information that could be harmful to the applicant's claim. Quandaries that can emerge after interviewing the asylum seeker include:

How is it possible to know if the client is lying?
What is the best way to address inconsistencies that make sense to you as an evaluator but may not be understood in the same way by an adjudicator?
What do you do if you learn something about an applicant that you don't see as a moral problem but that is a potential bar to asylum?

The tension that exists between what is felt to be best for the client and how they may be seen by an immigration official can be especially stressful.

Vicarious Resilience

Definition

Vicarious resilience is a concept developed by Hernández, Gangsei, and Engstrom and refers to the positive growth and transformation that occurs in therapists working with trauma survivors as a result of exposure to survivors' resilience [7]. In their research with therapists working with survivors of political violence, the authors found that witnessing clients overcome adversity and demonstrate the capacity to heal had a positive effect on the therapist. The therapists' own attitudes and emotions were changed, allowing them to reassess their own problems. Ultimately, they reported they were better able to cope with their own adversity [7]. Similarly, this concept can be applied to other professionals who witness and document trauma stories, such as medical and psychological forensic evaluators.

Impact on Evaluators

A significant part of the evaluation process involves having survivors recount their stories to gain a better understanding of the nature of their experiences and for the purposes of the evaluation. It is likely that while recounting these traumatic details, survivors will share messages of hope for the future and disclose resources and skills that enabled them to survive. Evaluators can witness the courage, hope, and

strength that their clients exhibit amidst the intensity of their traumatic experiences. Witnessing survivors' resilience can be inspiring and transformative for evaluators, a reminder of the strength of the human spirit to transcend adversity. Keeping in mind the resilience of the clients we serve will inadvertently influence the way we interact with them. We are better able to recognize their strength and resilience when we begin with this frame, rather than seeing them simply as victims.

Additionally, evaluators may notice their value systems and perspectives on life have changed. By bearing witness, they may be changed in complex ways that can deepen or broaden perspectives, increase empathy, and introduce strength and power to a person's life. These experiences may result in an increased capacity to face adversity and cope with stress.

Managing and Mitigating Secondary Trauma at Each Step of the Evaluation

Too often, "self-care" is thought of as something confined to after-work hours: a checklist of tasks followed to counter experiences that occur during work hours with clients. However, there are ways the evaluator can approach the assessment and writing process that are additionally protective to their own well-being.

Understanding the Impact of the Evaluation Process

A forensic psychological evaluation requires gathering a detailed account of severe traumatic experiences. With this in mind, evaluators can anticipate ahead of time that they will be impacted by the interaction. Following are specific steps to use when conducting a psychological evaluation and ways that trauma-informed principles such as transparency, containment, pacing, and structuring safety can be incorporated throughout the assessment to mitigate impact. While this focuses specifically on the psychological evaluation, a process more familiar to the authors, much of the information is also pertinent to medical evaluators and can be adapted to the physical forensic evaluation.

Before the Evaluation

Preassessment preparation is essential and involves discussions with the attorney about details such as location of the evaluation. If it is occurring in a detention facility, clarify if the exam space is private, if a guard will be present and other details in advance. This knowledge is especially relevant if the encounter will be virtual (via a telephone or video platform). Ascertaining this information in advance allows for

the ability to anticipate what might occur during the evaluation and how the evaluator might feel.

Reviewing legal documents in advance allows for consultation with the attorney and the ability to plan for the evaluation. Some questions that may arise include:

What items might I need to focus on?
What parts of the story could be sensitive and challenging for two people new to one another?
If the client experienced interrogation, might the evaluation itself be a traumatic trigger? How will that feel in the moment?

While this review may not anticipate all details, it helps the evaluator to be aware and to prepare for the client and for themselves.

When reviewing the legal documents before the case, the evaluator noted that the client faced persecution at home due to their LGBTQIA identity. The country of origin was a place where identifying as LGBTQIA was stigmatized, illegal, and would be dangerous to the client's safety. During a pre-evaluation phone call, the attorney noted challenges when asking the client about their sexual and gender identity, sharing that the client would shut down, seemed to dodge the questions and became suspicious of the lawyer. The attorney expressed concern about the outcome of the case as a result.

Knowing this was a difficult subject, the evaluator was able to anticipate this might be a difficult moment during the evaluation. The evaluator made a plan about how to explain transparently to the client why gathering this information would be important to the evaluation and laid out steps for how the client could indicate if they wanted to stop the conversation. By taking these steps, the evaluator felt prepared for the evaluation process and anticipated their sense of calm and honesty would lead to a better outcome for all.

During the Assessment

During the assessment, a central task is to remain focused on gathering the information while balancing empathy, attunement, and a witnessing stance. During the assessment, evaluators ask a set of diagnostic questions and may administer assessment tools. Evaluators typically gather a detailed account of the trauma history connected with the individual's clinical diagnostic picture. Clinicians should be aware of what details are needed to write a thorough evaluation, as well as how to manage and respond to questions experienced as triggers, and to establish empathic ways to respond in the moment.

It is normal to feel whatever emotion or lack of emotion the client expresses during the assessment. These can be important moments of connection, but they also create vulnerability. The first step is to acknowledge that this is normal and perhaps inevitable. It can be useful to have a set of empathic responses prepared that help to contain emotion and stay focused. Without explicit containment provided by the

evaluator, stress often mounts as the assessment proceeds. When the client and evaluator reach the end of the evaluation, both may feel disorganized, overwhelmed, and exhausted (or any other emotion, for that matter). Conversely, when there are moments of stress followed by containment and release, both client and evaluator will complete the evaluation feeling impacted, but in a tolerable way.

Closing the Evaluation

When closing, take some time to wind down before ending the evaluation. It is normal at this stage of the assessment to feel overwhelmed by all the evaluator has learned, and have a desire to help. Overpromising is one of the riskiest things that evaluators can do when they are at the end of the evaluation and perhaps feeling emotionally raw themselves. Be cautious not to promise the client that your evaluation will guarantee them asylum. Expect that you may feel pulled to help or "wrap things up nicely," and be careful to refrain from any speculation on their chances or the strength of their case. As appropriate and genuine, the evaluator may find a moment to share their gratitude for the privilege of meeting with them.

Furthermore, during the assessment, an evaluator may learn of a client's needs for money, housing, food, or other basic needs. It is normal to want to assist, especially if it seems like an easy solution to an emerging problem. However, doing so would change the nature of the evaluation relationship and ultimately could compromise the integrity of the asylum process. During this stage, it is important for the evaluator to recognize their own emotions about what they just learned, examine why those reactions come up, and attend to them with supervision and consultation, rather than attempting to feel better by reassuring the client. It is justifiable to finish the evaluation feeling outraged, overwhelmed, or guilty about what you learned (or any emotion, for that matter). Resolving those feelings, however, should not be done with the client. These feelings are good indicators that external support is needed and should be sought. Below is an illustration of this process.

The client revealed several significant pressing needs during the assessment, including ongoing mental health support. The client also described a tenuous housing situation and limited access to food. They shared with the evaluator that they believe all of their problems will go away if they can get asylum. They ask the evaluator to help with that as soon as possible. In the moment, the evaluator felt compelled to offer food and help find housing and a mental health referral. However, the evaluator also recognized they wanted to help because the evaluation was overwhelming and learning the client's experience left them feeling guilty and ashamed that there was not more to offer.

The evaluator initially responded by acknowledging and validating the difficulty of the asylum process. They then reminded the client of their role to gather information and prepare written documentation as part of the asylum claim. They also told the client that within the report they will have the chance to make recommendations

for ongoing care. In this section, they would note the need for mental health services and housing/food assistance. Because the need for food and housing presented a safety concern, the evaluator also asked permission to alert the attorney. The client consented. Later, the evaluator provided the attorney with this information, as well as some referral resources.

In this interaction, the evaluator was aware of the limits and boundaries of their role with the client, while also taking seriously the needs that arose and the safety of the client. Because the evaluation is for the client's legal case, and the evaluator would not be involved in ongoing care, the decision was made to offer referrals through the attorney, who would have an ongoing relationship with the client.

The Written Assessment

The next step is to write the assessment report or declaration/affidavit. Although the in-person interaction is complete, the involvement with the traumatic content has not ended. Written assessments come with their own unique challenges. In order for the evaluation to be an effective tool in court, it should be written in a style that clearly and concisely outlines the details and diagnostic picture, but sometimes it is difficult to revisit the traumatic history and re-experience it through writing. In addition, the objective style of the written evaluation or affidavit can feel disconnected from the powerful or intense relational moments the evaluator experienced during the live evaluation.

Mitigate the difficulties in this process by outlining a template for the written assessment ahead of time. Make a plan for how to approach the written evaluation, consider whether to write a little at a time to limit exposure, or block off a period of time for writing to keep it contained. Sometimes there are external constraints such as deadlines from the attorney; learn about these as soon as possible and negotiate if needed. Whatever the strategy, considering self-care and well-being is essential and should not be considered selfish. An approach that is paced and incorporates coping strategies will increase the likelihood of a sustainable practice.

One of the authors had an experience in which she had the evaluation template open on her computer and walked past it over and over again without feeling able to start writing. In this example, the author bore witness to the client's pain as well as the tremendous strength and resiliency it took to flee and seek safety. During the live assessment, the client was open, vulnerable, expressive, and undeniably strong. Every time she began to write the evaluation, she felt these nuances of the client's humanity were missing from the assessment. How could she possibly communicate all she had seen?

After some time, the author was able to reorient to the purpose of the evaluation and the power and importance of her role. Although the format of the written evaluation felt somehow distant from all she had experienced, it was that way for a purpose – because it is the most effective tool for the case. With this in mind, and with the story of the client's strength, she was able to see this format and style as one of her most powerful tools as an advocate and clinician, and reorient to the task at hand.

Broader Self-Care Principles and Practices

Self-care is a set of external actions taken to support an individual's well-being in social, physical, emotional, relational, and spiritual domains in order to perform tasks in sustainable and effective ways. Some of those actions, as outlined above, come in the preparation for, execution of, and follow-through of the evaluation itself. Some will come in the practices, routines, and rituals one incorporates into their life. Below are strategies that can support a healthy and sustainable self-care routine.

Awareness

Improving Well-Being for Refugees in Primary Care: A Toolkit for Providers written by The Center for Victims of Torture (CVT) describes the importance of having an awareness of secondary trauma:

> The first, and often most challenging, aspect of mitigating secondary trauma for an individual is to be aware that it is happening. It is easy and often protective to try to avoid thinking about how you are doing and feeling about your work. Secondary trauma can be insidious and manifest in unexpected ways. You may have heard a number of trauma stories from clients or listened to their current stressors with relative ease only to find that you are annoyed with your partner for complaining about the hard day they had at their desk job. Or you might find yourself feeling tense and irritated for unclear reasons. You might speak more brusquely to a colleague than you normally would. Or you might find yourself declining more and more invitations to social activities. Understanding where these reactions come from is an important first step in mitigating the effects of secondary trauma. There are many different ways individuals can take steps to become aware of their reactions. One awareness tool is the Professional Quality of Life Elements Theory Measurement survey (ProQOL). Taking the survey every few months is a way to stay aware and in touch with your current work experience [8, 9].

Self-Care

Improving Well-Being for Refugees in Primary Care: A Toolkit for Providers also describes ways to mitigate secondary trauma:

> Once aware of how you are impacted by secondary trauma, the next step is to determine how to mitigate it. Often self-care strategies are presented as a somewhat exhaustive (and potentially exhausting) list of things we need to do to take care of ourselves. The standard list includes suggestions such as get eight hours of sleep, avoid caffeine, have a healthy diet, exercise multiple times a week, do yoga, meditate, take naps, avoid alcohol, do not smoke, be social, relax, do something creative, spend time outdoors, etc. Lists like this may be helpful for some but also may be overwhelming and have the potential to serve as a reminder of all of the things we are not currently doing. Consider choosing one or two strategies to focus on, rather than trying to do them all and potentially setting yourself up for disappointment or failure [8].

Self-care should not be viewed as an additional obligation. Ideally, it is not postponed until a moment of high stress, but rather should be part of a proactive plan that is personal, flexible, and changes over time with the clinician's needs. The plan should contain elements that can be implemented both during the evaluator role and outside of work. Generally, the focus should be on activities or experiences that bring joy, peace, or energy, or make the evaluator feel calm, confident, competent, or grounded.

There are pertinent cultural differences in approach to self-care that should be mentioned at this point. Various factors (including, but not limited to, race, ethnicity, culture of origin, socioeconomic status, religion/spirituality) can influence the ways in which individuals care for themselves. In various groups, self-care can be considered a luxury as individuals may be confronting other individual and systemic challenges that can make this difficult to accomplish. In addition, the activities that are typically recommended by self-care experts are often individualistic in nature and may not resonate (or be possible for a myriad of reasons) for various groups of people. Finding a community of people with whom you identify and colleagues who can offer support and empathize is also a crucial strategy for those working with asylum seekers. As such, diversity factors need to be realistically considered when developing a self-care plan.

> One asylum evaluator shared her journey with finding a self-care plan that worked for her. She stated she learned that the most effective self-care practice is one that is responsive to her needs in real time. In order to sustain her work, she has incorporated both self-care rituals and a process of assessing what she needs at a particular time. For example, she stated she knows she processes emotion through the body. Therefore, swimming is a part of her regular routine. She also knows that asylum evaluations leave her feeling alone with the weight of a client's story. Because of this, she incorporates connection with friends and family into her regular routine. If she does these things, she reports she can maintain a baseline of well-being in the work. Sometimes she reported she needs more, like when she feels the weight of the broken asylum system. At those times she needs to connect with something bigger than herself to restore hope. She prioritizes getting into the outdoors, where she finds her sense of spirituality. This approach is one that is grounded in an understanding that how an individual is impacted changes over time, and is responsive to how they are depleted, rather than being a long list of activities to complete every day.

Returning to the Beginning: Cultivating Awareness

Routine engagement in self-reflection can deepen awareness about the ways in which an evaluator is impacted in their work with asylum seekers. Awareness is a lifelong skill that needs to be cultivated over the course of a career. Just as life experiences shape clinicians in ways that lead to the decision to complete evaluations for asylum cases, evaluators are changed by the stories that they bear witness to, throughout the process.

As Laura van Dernoot Lipsky describes, evaluators should continue to ask themselves why they are doing this work. This continual process of reflection can lead to

a renewed sense of agency and help to counter the feelings of helplessness that can arise when working within such adversarial systems as immigration [10].

The following are suggested questions for ongoing self-reflection:

How has this work changed me?
How has my worldview changed, either positively or negatively?
In what ways have my daily activities changed unconsciously?
What have I learned about the world?
What have I learned about my strength and that of others?
Why do I continue to do this work?

The authors of this chapter have faced challenges in managing secondary trauma, burnout, and moral distress. It is challenging to work within systems that should provide opportunities for safety but in practice have become politicized, deterrent, and adversarial. Bearing witness to the stories about speaking out, standing up in the face of injustice, and making impossible decisions for the safety of families has changed the authors' worldviews. The authors have experienced the strength of the human spirit, have come to appreciate the beauty in small moments of connection, and have come to know their own potential for social justice. Examples of their experiences are below:

> One of the ways I have been positively impacted over the years is that I have developed a deep appreciation for small moments of human kindness, empathy, and beauty. A boy, in the lunch line at school, who puts his arm around a lost and spinning younger boy and invites him to stand with him. Reunion videos of soldiers returning home and surprising their family. A large virtual choir singing a beautiful song together. Simple examples of decency and humanity.
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> The most notable way I have been positively impacted by working with survivors of torture and war trauma is in my increased ability to find joy even in the most challenging circumstances, a lesson that I have learned directly from clients. It is only human to complain about daily frustrations but I have realized that despite all the pain in the world, there is also good. Each day, I intentionally choose to focus on the good, as much as I can.
>
> Over the years, I have worked with survivors of torture, many of whom have put their lives in danger for justice, human rights, and a better world. I began this work as a clinician because I share the same values. However, at times the problems have felt so big and insurmountable that I feel helpless to take action. In doing evaluations, I have learned that with our highly technical and specialized skill set, we can advocate for and participate in large justice processes. Through this work of evaluating asylum seekers, I learned I can be both clinician and advocate and to incorporate my clients' stories into working for a fairer and more just world.

Summary

Understanding how evaluators may be impacted while completing evaluations for asylum cases begins with understanding the context in which evaluations are conducted. The asylum legal process and attitudes toward immigration in the U.S. will shape clinicians' experiences. When entering into this work, it is important to understand the nature of the role of the evaluator and connect with their motivations.

This is a process that evaluators should return to repeatedly in order to stay grounded in their motivations and engage with a sense of empowerment and purpose.

Impact is inevitable in this work, though it is not one dimensional. Secondary traumatic stress, burnout, moral distress, and vicarious resilience are interrelated and distinct concepts. The first step to understanding impact is awareness. With awareness, evaluators can take concrete steps to care for self while centering the client's needs and well-being throughout the evaluation process. Trauma-informed approaches to evaluations are first and foremost for the client, but they also play an important role in self-care for the evaluator.

Self-care for the evaluator is not limited to the evaluation itself. Often evaluations are one part of a larger clinical practice or role. Sometimes evaluators conduct evaluations as part of volunteer activities or on a pro bono basis outside of their full-time job. With these realities, it becomes increasingly important to have a robust self-care practice in order to remain sustainable in the work over time. Returning to practices of self-awareness and self-reflection, a self-care practice should be rooted in the evaluator's identity and what is needed for long-term sustainability.

Finally, and not insignificantly, in conducting asylum evaluations clinicians have the privilege of bearing witness to stories of pain, injustice, survival, and determination. The clinician's values, worldview, and perspective will be changed, both positively and negatively. This interconnectedness–the ways in which evaluators make change in the world and are changed in the process–is one of the greatest realizations of this work.

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Appendix 1: Atlas of Scars of Torture

Alexia P. Knapp, Scott A. Norton, and Katherine C. McKenzie

Asylum evaluators often take photographs of clients to obtain objective visual record of physical findings at the time of evaluation. The appearance of many findings will likely change, evolve, or resolve over time; a photograph, on the other hand, can record the appearance of findings at the time of examination (and may be less susceptible to dispute than hand-drawn sketches or text descriptions). Best practices for photography should be attempted, but are not always possible under sometimes limited circumstances.

Physical signs of trauma can result in a broad range of findings. Furthermore, these signs can be transient (e.g., bruises or ecchymoses) to permanent (e.g., full-thickness burn scars or radiographic evidence of fractures). The Istanbul Protocol provides a uniform way to record, assess, and report injuries.

When clients present with physical evidence of alleged injuries, the clinician's role is to describe the finding and render an opinion about whether the findings are consistent with the history, timing and sequence of events, and the alleged mechanism of injury. Injury description by the asylum seeker is often limited by impaired recall, language barriers, and cultural differences. The goal of the asylum evaluator is to correlate the history described to them with the physical findings from the exam. The Istanbul Protocol (IP) characterization is subjective and based on the trained evaluator's expert opinion.

Photographs in this appendix show scars from real asylum evaluations. The images are not necessarily flawless from a photographic standpoint, but they are

A. P. Knapp
Department of Dermatology, HealthPartners Medical Group, Saint Paul, MN, USA
e-mail: alexia.p.knapp@healthpartners.com

S. A. Norton
Department of Dermatology, George Washington University, Washington, DC, USA

K. C. McKenzie
Department of Medicine, Yale School of Medicine, New Haven, CT, USA
e-mail: katherine.mckenzie@yale.edu

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authentic (and typical) pictures of injuries that might be presented to an asylum evaluator. We have intentionally chosen photos that may not be perfect to reflect scars that might be seen in common asylum evaluations. The client's account of the injury is also provided, and the evaluator renders a reasoned opinion based on the IP.

As noted in the physical exam chapter, scars should be described by noting dimensions, pigmentation, shape, and borders. In this appendix of photographs, these descriptive practices are not used.

Tips for Photographing Cutaneous Signs of Torture [1, 2]

High-quality photographs are essential for proper documentation of cutaneous signs of known, alleged, suspected, or possible torture. The following instructions can improve the quality of one's photographs.

- Use good lighting, such as a well-lit room, natural sunlight (or through a window), or by using the camera's built-in flash.
- Use a neutral, uncluttered, nonreflective background, such as a plain neutral-colored (e.g., light gray or light blue) wall or cloth sheet.
- Remove distracting objects from the patient (e.g., jewelry, hats, glasses, patient name bracelets) and from the background.
- Orient the camera and/or the patient so that the body part being photographed is vertical or horizontal in the image.
- Hold the camera steady with both hands. Consider stabilizing one's hands against a firm, immobile surface (or use a tripod). The patient (or the body part that is being photographed) should also be kept still.
- Hold the mobile device (e.g., a smart phone) or camera parallel to the skin's surface.
- On a mobile device, adjust the focus by tapping the screen in the area of interest.
- On a camera, use the macro setting, often denoted by a flower icon, for close-up photographs.
- Avoid using filters or settings such as "portrait mode" or "vignette" or "vibrant."
- Include close-up photographs of the lesion and at least one from farther away to show the anatomic location and orientation.
- Consider including additional photographs of a symmetric, uninvolved surface for comparison.
- Consider including a ruler (or tape measure) next to the lesion.
- Consider including labeling photos with the client name, time, date, place, and photographer.

Istanbul Protocol (IP) Taxonomy of Scars [3]

Not consistent with	The lesion could not have been caused by the trauma described
Consistent with	The lesion could have been caused by the trauma described, but it is nonspecific and there are many other possible causes

Highly consistent with	The lesion could have been caused by the trauma described, and there are few other possible causes
Typical of	This is an appearance that is usually found with this type of trauma, but there are other possible causes
Diagnostic of	This appearance could not have been caused in any way other than that described

Reprinted by permission from McKenzie KC, Bauer J, Reynolds PP. Asylum seekers in a time of record forced global displacement: the role of physicians. J Gen Intern Med. 2019;34:137–143.

Adapted from the Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol"). UNHCR Professional Training Series No. 8/Rev. 1, Geneva, 2004, 76. https://www.ohchr.org/Documents/Publications/training8Rev1en.pdf

Acute Skin Avulsion Due to Blast Injury

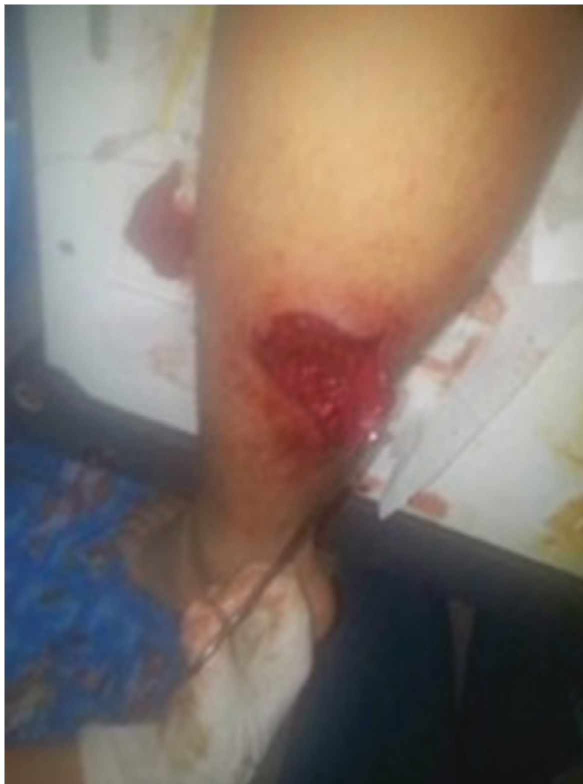
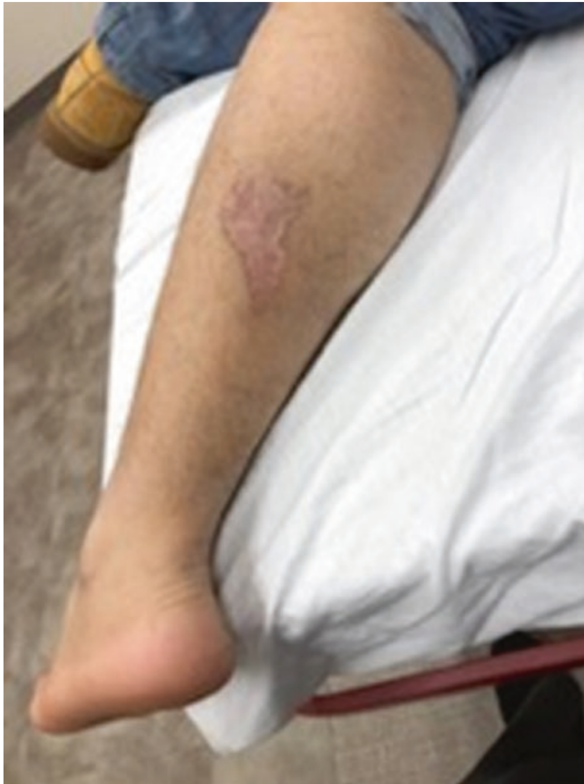


Photo of acute injury taken by client

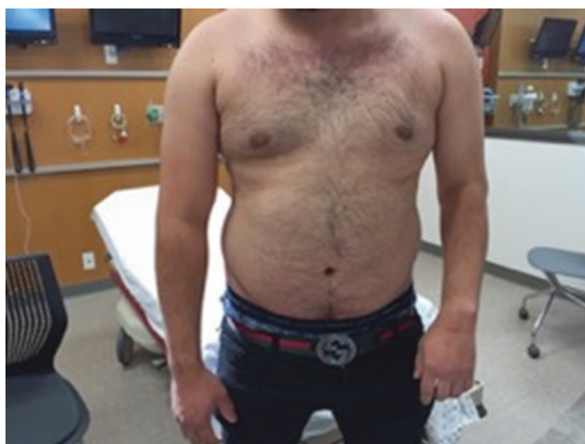
Scar Due to Blast Injury

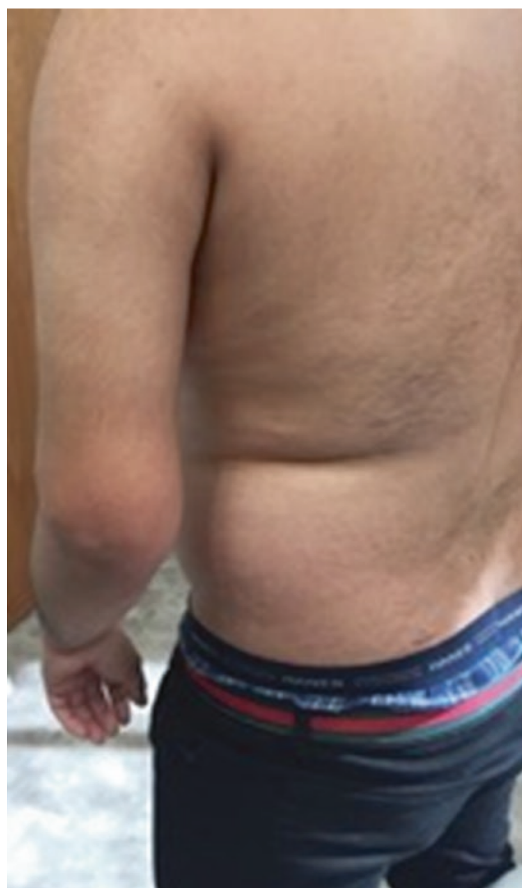


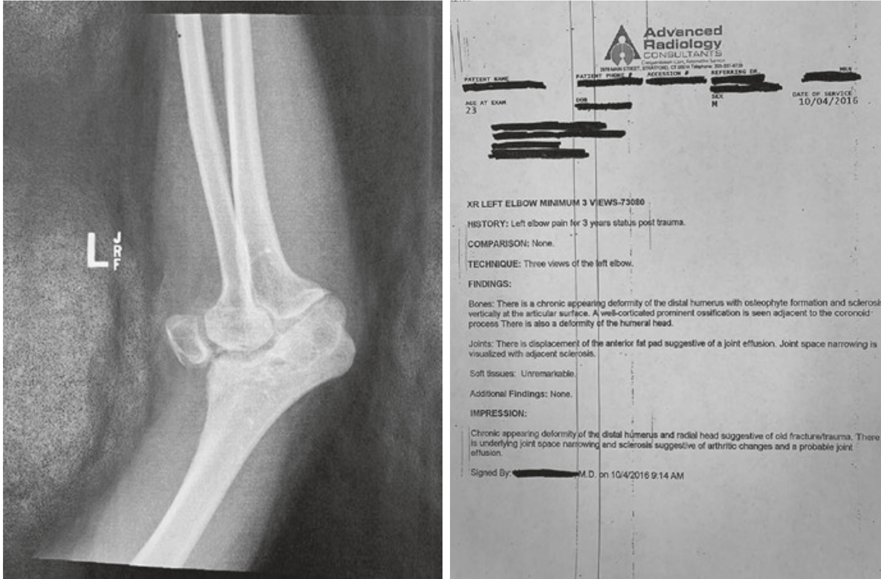
The client states that he was a 30-year-old man involved in a political protest. Police descended upon the crowd and a chaotic scene ensued. He describes that as he was running, a projectile object exploded nearby, injuring his leg. He believes it was a tear gas canister, but is not certain. Later that day, he received medical care at a clinic that included cleansing and suturing and subsequent wound care for 2 weeks. Blast injuries resulting in avulsion can result in scars with irregular borders and pigmentation. The evaluator characterized the scar as highly consistent with avulsion injury from blunt/blast trauma.

Photo taken by Katherine McKenzie

Physical Finding Due to Blunt Trauma







Advanced Radiology CONSULTANTS

PATIENT NAME PATIENT PHONE # ACCESSION # REFERRING DR. MRN

AGE AT EXAM 23 DOB SEX M DATE OF SERVICE 10/04/2016

XR LEFT ELBOW MINIMUM 3 VIEWS-73080

HISTORY: Left elbow pain for 3 years status post trauma.

COMPARISON: None.

TECHNIQUE: Three views of the left elbow.

FINDINGS:

Bones: There is a chronic appearing deformity of the distal humerus with osteophyte formation and sclerosis vertically at the articular surface. A well-corticated prominent ossification is seen adjacent to the coronoid process There is also a deformity of the humeral head.

Joints: There is displacement of the anterior fat pad suggestive of a joint effusion. Joint space narrowing is visualized with adjacent sclerosis.

Soft tissues: Unremarkable.

Additional Findings: None.

IMPRESSION:

Chronic appearing deformity of the distal humerus and radial head suggestive of old fracture/trauma. There is underlying joint space narrowing and sclerosis suggestive of arthritic changes and a probable joint effusion.

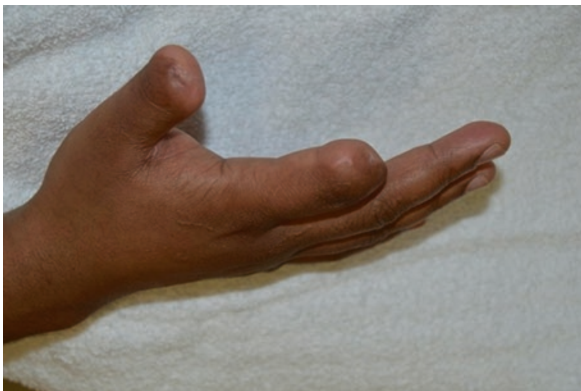
Signed By: M.D. on 10/4/2016 9:14 AM

This client states that he was attacked and beaten by a group of approximately six people. He states that he was surrounded by individuals who used their fists, hands, sticks, and metal objects to hit him. He believes his left arm was broken during this beating, but that he was unable to seek medical care for the injury. He states that since the injury healed, his arm has been permanently contracted.

It is often not possible to obtain imaging to confirm alleged fractures, but the examining team was able to do so in this case. Attached is an x-ray and reading. The evaluator characterized the physical findings as consistent with blunt trauma, which resulted in a fractured left humerus. A fracture that is not surgically repaired can result in a permanently contracted limb. There is no evidence of surgical management, and he now has a permanently contracted elbow.

Photos taken by Katherine McKenzie

Scar and Physical Findings and Surgical Scar Due to Loss of Phalanges After Explosive Trauma



This 28-year-old man recounts that as a 6-year-old child, he picked up a landmine that exploded in his hand. He lost the distal phalanges of the thumb and forefinger. He underwent prompt removal of bone fragments and avulsed tissue, followed by controlled surgical closure.

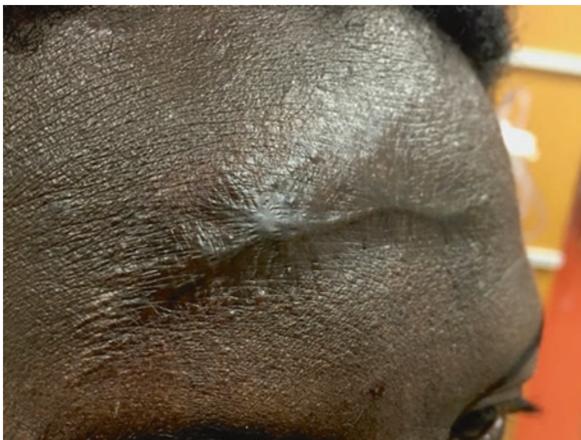
Photo taken by Scott Norton

Acute Laceration Due to Machete Blow

This 20-year-old woman was struck by a machete in a single blow, producing a linear laceration with sharp borders and even depth [3]. It is important to record the location, length, and direction of the laceration to assess whether the injury is consistent with the mechanism of action.

Photo taken by James E. Wiedeman [4]

Scar Due to Sharp Trauma

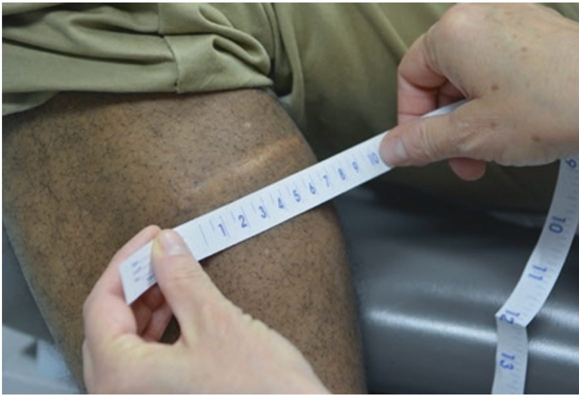


This 30-year-old man states that he sustained blunt force trauma to forehead with a bat or baton that resulted in an irregular, jagged laceration of varying depths. He

received no formal medical treatment for this injury. This image was taken 3 years after the injury and the scar is irregular, hyperpigmented, and hypertrophic. No suture marks are present. This type of injury can occur after a single forceful blow of a blunt object across a bony surface [3]. Lacerations can often result in linear scars. Blunt force trauma over a bone is more likely to result in a scar than when it occurs over a non-bony area. The evaluator characterized this scar as consistent with laceration caused by blunt force trauma over bony prominence.

Photo taken by Samara Fox

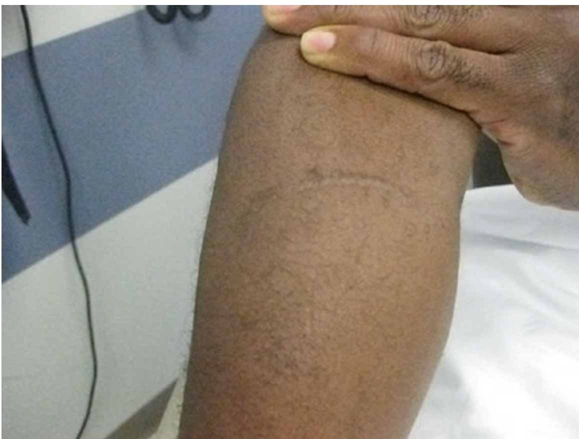
Sharp Trauma



This 30-year-old man stated that while he was detained and tortured, his leg was slashed with a bayonet approximately 18 months before this exam. He states that he did not receive any medical treatment for the wound. Sharp trauma often results in a linear scar. The evaluator characterized the scar as consistent with history of sharp trauma injury such as a bayonet and that no suture marks are evident.

Photo taken by Alison Mosier-Mills

Scar Due to Sharp Trauma



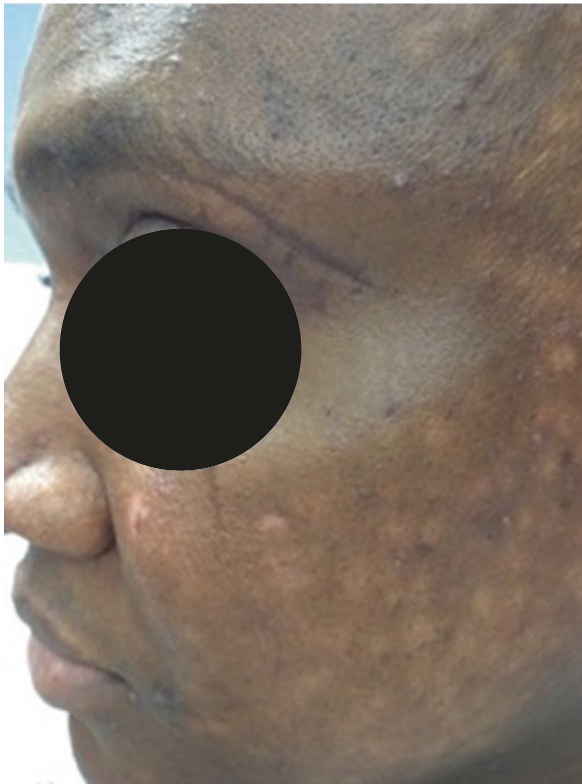
This 25-year-old man states that he was in a bar with his gay partner when a group of patrons chased the two men out of the bar. They ran to an adjacent field, where the group of men surrounded and attacked him. They beat him and one attacker used a broken beer bottle to cut the client's arm. He states that he had no formal medical treatment for the injury. His scar was examined 2 years later. Sharp trauma can often result in a linear scar. The evaluator characterized the scar as highly consistent with a laceration from a single pass of a sharp piece of glass.

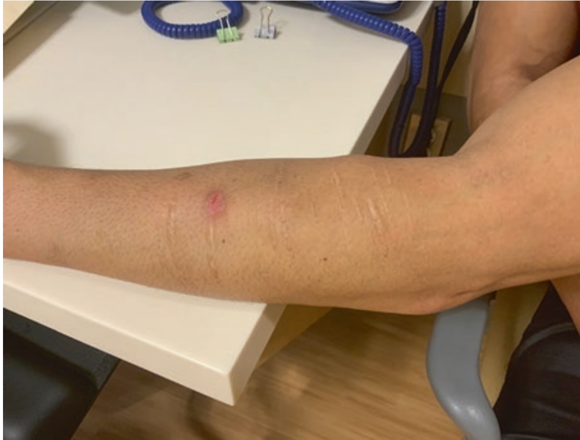
Photo taken by Alison Mosier-Mills

Scar Due to Sharp Trauma

This man states he was attacked by a group of men on the street who targeted him because he was gay. One attacker had a knife and cut him over his left eye. The man was able to obtain care on the day of the attack from a clinician who sutured the wound. The client was examined 2 years after the attack. Sharp trauma can often result in a linear scar. The evaluator characterized the scar as highly consistent with a sharp laceration that was promptly sutured.

Photo taken by Katherine C. McKenzie



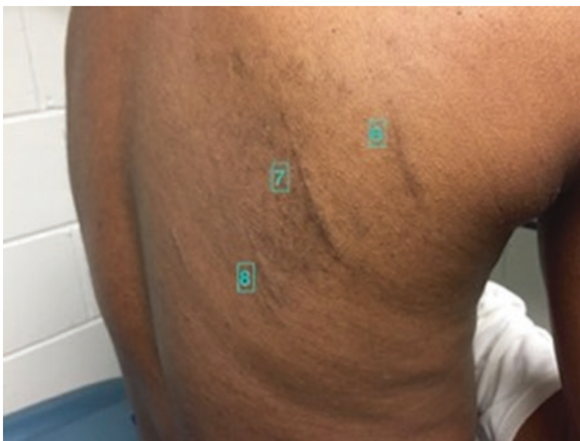


This client states he was held down by several men, one of whom cut his arm with a knife. There are 12 hypopigmented linear scars on the dorsal surface of his left forearm, ranging from 2.5 to 5 cm in length and oriented horizontally to the arm axis. (Note: the erythematous lesion near the midpoint of the forearm visible in picture is from a recent burn and is unrelated to the alleged persecution and attack. Clients will occasionally have scars not related to the persecution injury that are adjacent. It is important to note them).

He received a topical medical agent (name unknown) at a hospital, but sutures were not placed.

Photo taken by Kathleen Gang and John Andrews

Whipped with Belt

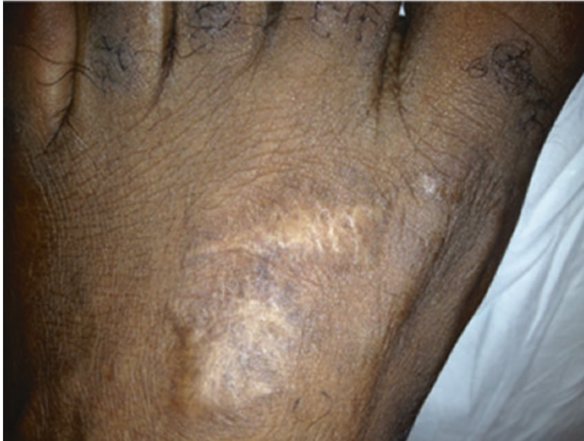


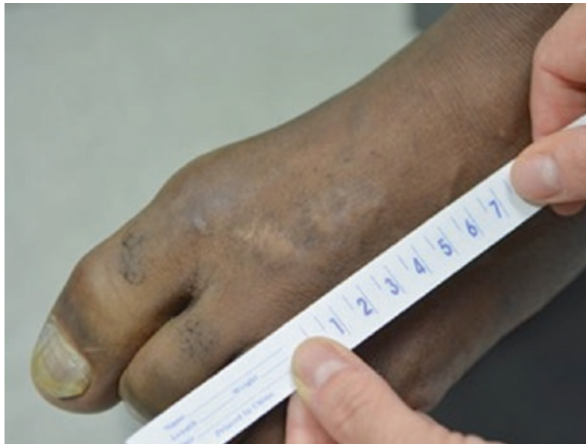
This 35-year-old man states that he was beaten with a belt while being tortured. He did not receive any medical care to treat the wounds. He was examined 2 years after the injury while in immigration detention. Whipping often can result in

approximately parallel linear scars. The evaluator characterized these scars as consistent with blunt trauma related to being whipped with a belt.

Photo taken by Ryan Handoko

Scar Due to Thermal Burn

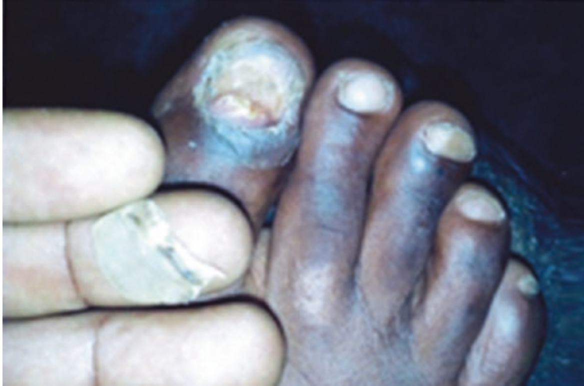




This client stated that while being tortured, a piece of plastic was heated with a lighter and the melting plastic dripped on the dorsal aspect of his foot and burned him. When he was released from detention several days after the injury, he applied topical agents but did not seek formal medical care. This image was taken approximately 16 months after the injury. Scars due to thermal burns can have irregular borders and irregular pigmentation. The evaluator characterized the scar as consistent with thermal burn related to dripping hot plastic.

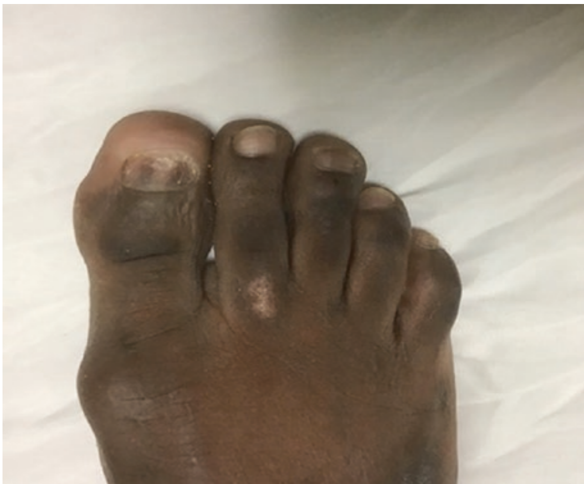
Photos taken by Katherine McKenzie

Nail Damage Due to Avulsion of the Right Great Toenail



This 29 year-old-man states that during torture, his left great toenail was forcibly removed with pliers. He received no formal medical care for the injury. The client states that he photographed the injured toe, showing the avulsed nail and exposed nail bed shortly after the injury. He provided this photograph at the time of his asylum exam.

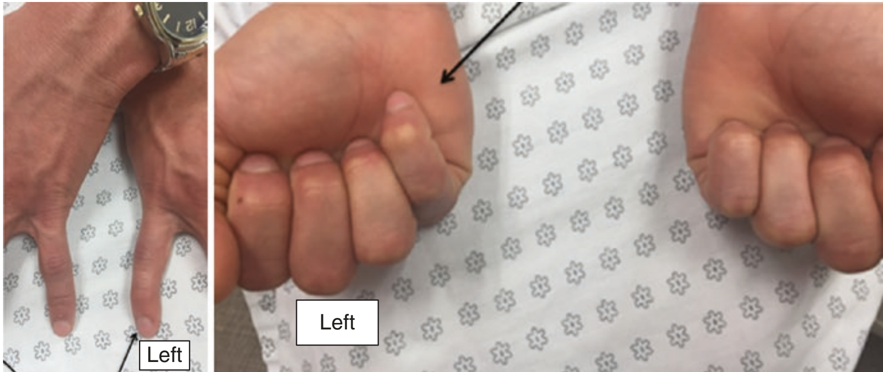
Photo taken by the client



This image was taken while the client was seeking asylum and being held in detention, approximately 6 months after the injury. There is partial regrowth of the toenail. The evaluator characterized this injury as highly consistent with forcible removal of toenail.

Image taken by Alison Mosier-Mills

Blunt Trauma



This client states that while he was tortured, his left finger was beaten with a baton. His hands are crossed in the left photo to contrast the injured finger with the uninjured finger. He believes it was broken, but he had no formal diagnosis or treatment. Since the beating, his left fifth finger has been contracted. The evaluator characterized the finding as highly consistent with fracture from blunt trauma with no surgical repair.

Photo taken by Justin Johnson

Blunt Trauma

This client states while being tortured, he was kicked with boots and beaten with a baton on his shins. He did not receive any formal medical treatment. The photograph was taken approximately 1 year later while client was in detention. Blunt trauma from beating or kicking can result in scars over bony areas, such as the tibia that are circular or oval. The evaluator characterized the scars as consistent with blunt trauma.

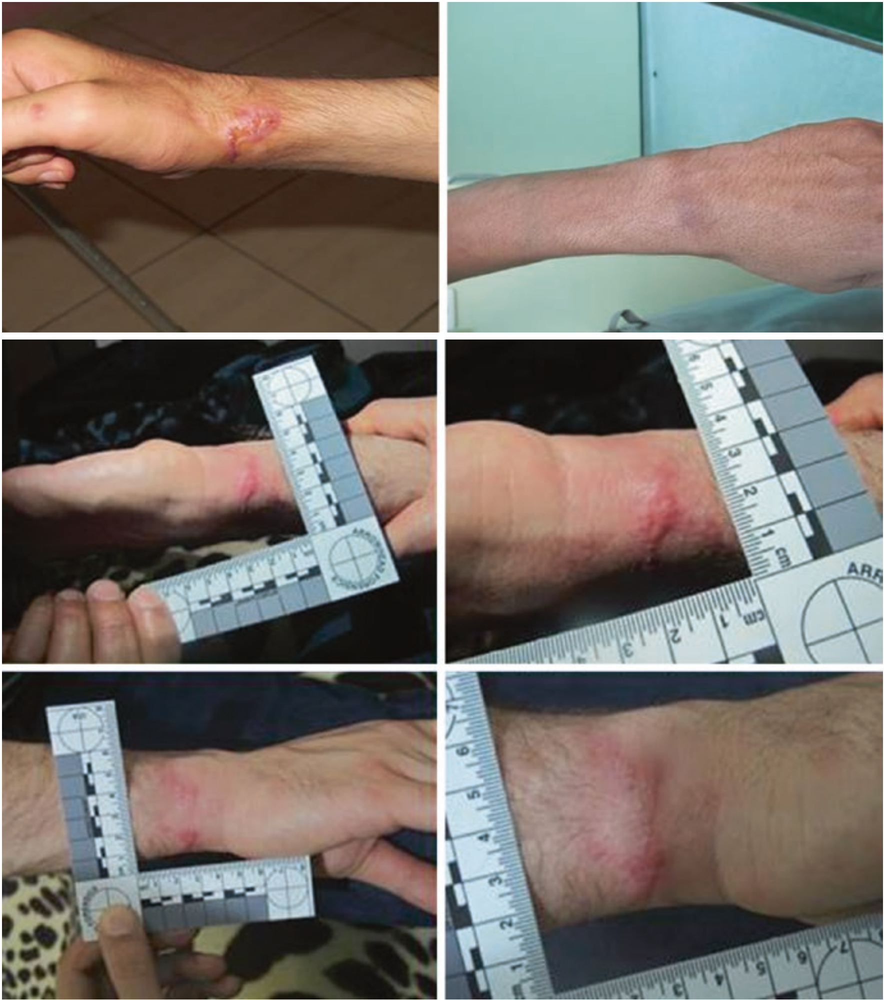
Photo taken by Ryan Handoko

Blunt Trauma

This client states she was hit in the mouth by the butt of a gun approximately 8 months before this photo was taken. She states her tooth has been displaced since the attack. The finding was characterized as highly consistent with tooth displacement due to blunt trauma.

Photo taken by Katherine McKenzie

Scars Due to Wrist Restraints [5]



These photos represent scars related to alleged wrist restraints and handcuff injuries. Scars from wrist restraints can have nonspecific borders and show hyperpigmentation.

Photo taken by Sondra Crosby

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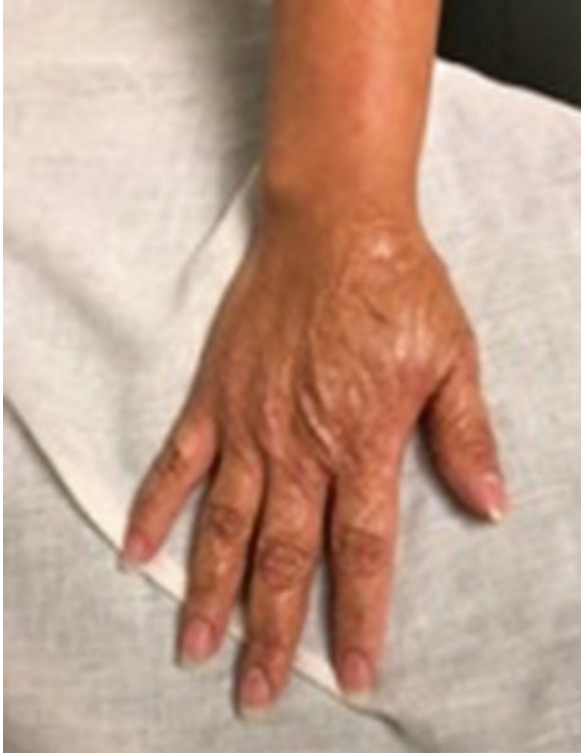
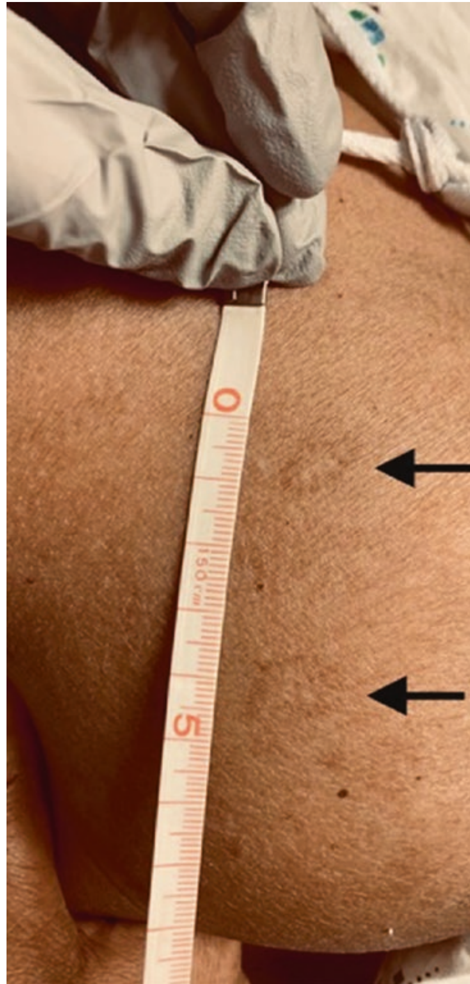
Thermal Burn



This client states that gasoline was thrown on her hand and lit with a match. The flames were extinguished quickly but the skin was burned. She received herbal treatments at home for the first 3 days. Then she was taken to a local clinic where she was treated with a topical medication for several days. She does not know the name of the medications. She did not receive surgical burn care. After the burn healed, a scar remained. The client was examined approximately 2 years after the attack. Scars from thermal burns can show hyperpigmented and thickened skin with nonspecific borders. The evaluator characterized this scar as highly consistent with thermal burn.

Photo taken by Faiza Yasin

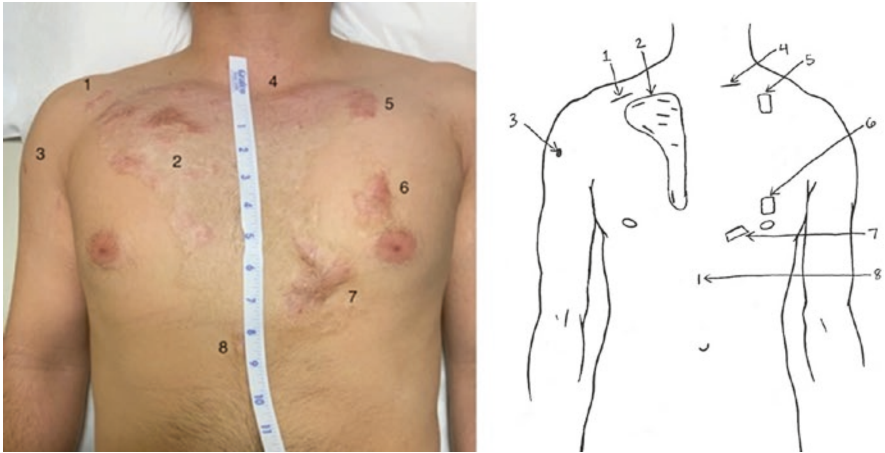
Thermal Burn



This client states she was attacked by three men, who held her on the ground, and burned her breast with a cigarette or cigarillo, despite her struggles. At home, she treated the burn with a topical cream but is not certain about its ingredients. She did not receive formal medical treatment. She interpreted the attack as a sexual assault because the injury was in a private area of her body. She was examined approximately 9 months after the attack. Scars due to cigarette or cigar burns can be circular with discrete borders and irregular pigmentation. If the client struggles, the scars may be less distinct and not perfectly circular. The evaluator characterized the scar as consistent with thermal burn due to a cigarette or cigarillo.

Photo taken by Chaney Kalinich

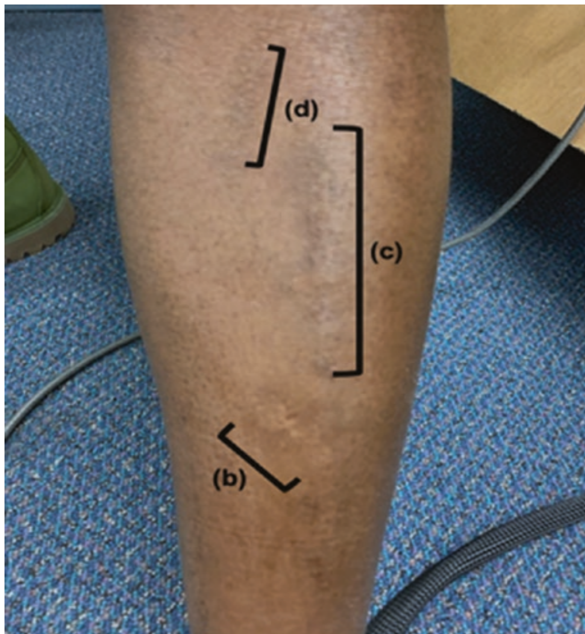
Struck Repeatedly with an Electrical Cord with Exposed and Live Wire



This client states that while being tortured, he was struck repeatedly with an exposed electric wire. He believes the wire was live; therefore, his injury consists of both blunt trauma and electrical burns. Scars dues to blunt trauma and electrical trauma can be raised with irregular borders and irregular pigmentation. The evaluator characterized the scars as consistent with blunt trauma and electrical burns.

Photo taken by Arianna Kahler-Quesada and Rachel Levinson

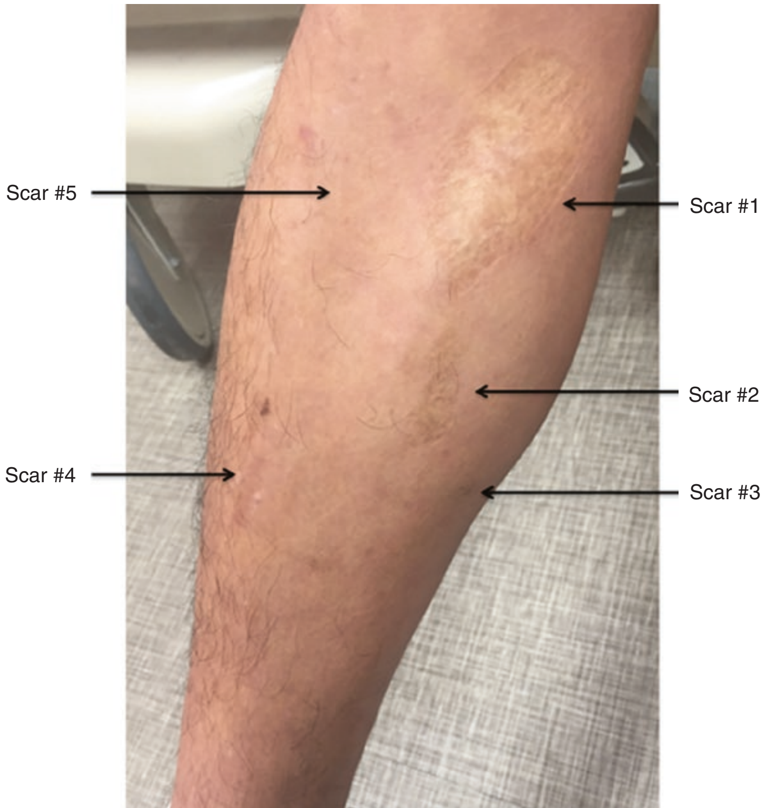
Blunt Trauma When Struck with Baton



This client states that he was beaten repeatedly on his leg with batons. Blunt trauma is more likely to leave scars when the trauma occurs over a bony area. The photo was taken approximately 1 year after the injury. The evaluator characterized the scars as consistent with blunt trauma.

Photo taken by Sumaiya Sayeed

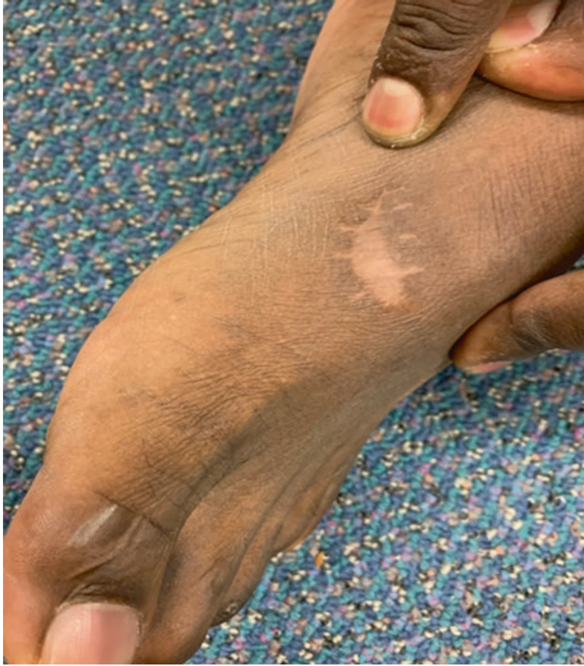
Blunt Trauma



This client states he was kicked repeatedly by several men wearing steel-tipped boots. He did not receive any formal medical treatment. He applied an ointment to the open areas until they healed. The examiner assessed that these scars were consistent with blunt trauma related to being kicked over a bony area (the tibia).

Photo taken by Justin Johnson.

Sharp Trauma Related to Cut by Glass and Delayed Suturing



This client states that he was abducted by government forces from his home. When he was being forced into the truck that would transport him to a detention facility, he cut his foot on a piece of broken glass on the floor of the truck. While in detention, the injury began to heal by secondary intention. After release, he obtained medical care and the wound was sutured. The client was evaluated approximately 1.5 years after the injury. The scar appears flat, widened ("fish-mouthed"), and hypopigmented. Transverse "track" scars are from the sutures. The evaluator characterized the findings as highly consistent with sharp trauma from a glass fragment with delayed suturing.

Photo taken by Sumaiya Sayeed

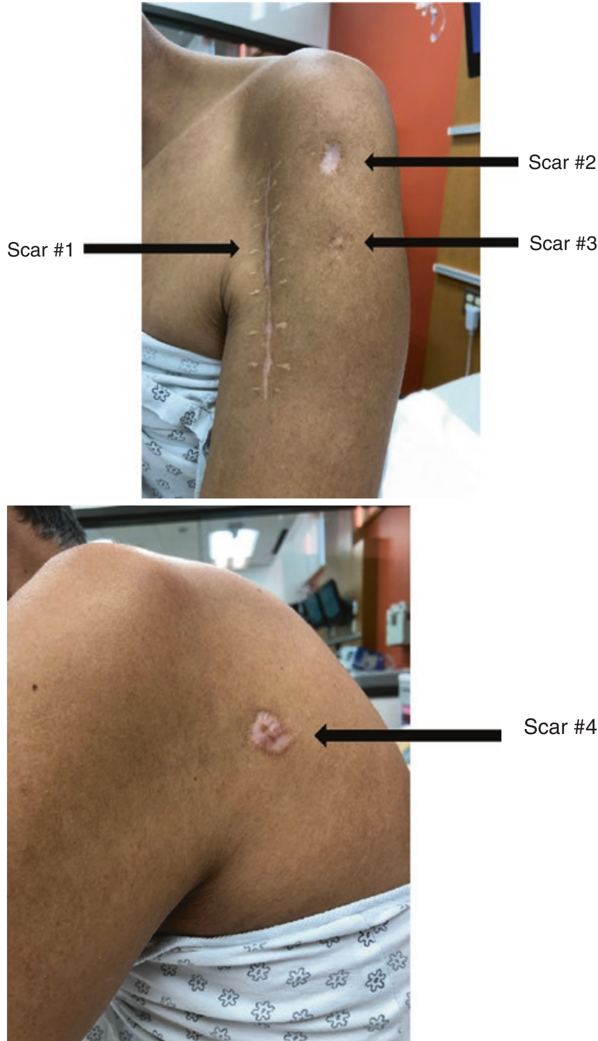
Blunt Trauma

Blunt trauma occurs over a bony area and is more likely to leave a scar. The photo was taken approximately 1 year after the injury. A 1.2 cm jagged, depressed, hyperpigmented scar (0.6 cm on upper edge, 0.5 cm on diagonal edge, 0.2 cm width) above the outer edge of the left eye. There was no history of damage to the ocular globe.

The client states that this scar results from being kicked and punched, and that the injury was bandaged but not sutured. The evaluator characterized the scar as consistent with blunt trauma causing a laceration that was not sutured.

Photo taken by Tracy Rabin

Scars Due to Bullet Wounds



Left Upper Arm, Anterior (Front) and Posterior (Back) View
This client was seen over a year after his attack. This client states he was attacked by a man who shot him with an assault rifle while he ran away. The client states he was able to seek medical and surgical care after the attack. He states that one bullet fractured his left humerus and was surgically repaired.

Scar # (1) Along the proximal left upper arm, there is a 10.0 cm linear scar, with distinct borders. It is hypopigmented. This linear scar is highly consistent with a

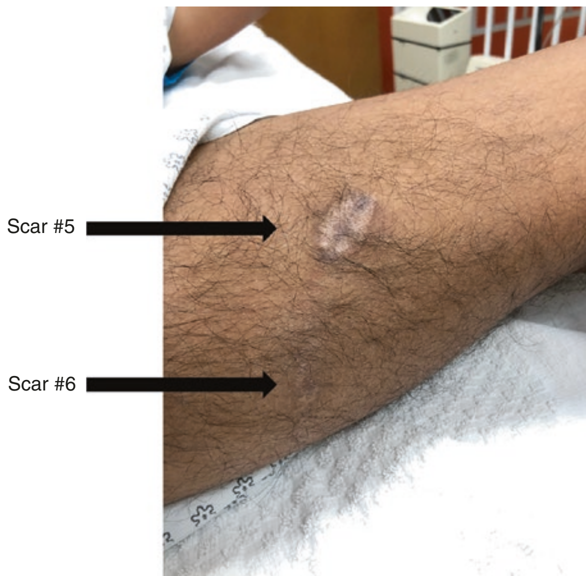
surgical incision required to repair a fractured humerus. There are also nine linear scars that transect the long linear scar that are highly consistent with surgical sutures.

Scar # (2) A 1-cm-wide circular appearing, hypopigmented scar on the left upper arm. The client does not remember if this is entry or exit wound. This scar is consistent with an injury from a gunshot wound.

Scar # (3) A 1-cm-wide circular appearing, irregularly pigment scar, on the left upper arm. The client described this scar as unrelated to injury described and is a result of a vaccine.

Scar # (4) A 2.0 cm approximately circular in shape, irregularly pigmented scar on the posterior side of left upper back consistent with gunshot wound. The client does not remember if this is entry or exit wound. This scar is consistent with an injury by a gunshot wound.

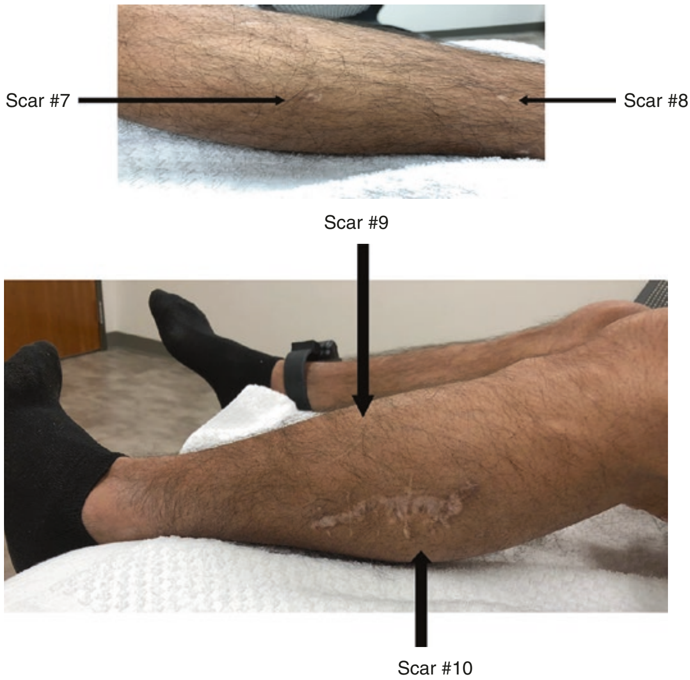
Scars 2 and 4 are highly consistent with entrance and/or exit wounds from a bullet from an assault rifle. It is likely that the bullet that entered the arm fractured the humerus. Given the size of the surgical scar, it is likely that scar 1 represents surgical repair of the severely fractured humerus. The history of the need for metal plates as well as the large surgical scar is highly consistent with a severe injury from an assault rifle instead of a handgun.



Scar # (5) A 3.5-cm-wide, oval-shaped, irregularly pigmented scar.

Scar # (6) A 1.0-cm-wide, faint scar, medially located to scar #5.

These scars are consistent with entry and exit wounds from a gunshot from an assault rifle.



Scar # (7) – A 0.75-cm-wide, circular, irregularly pigmented scar on medial aspect of the left lower leg. This scar is consistent with entry wound from a gunshot.

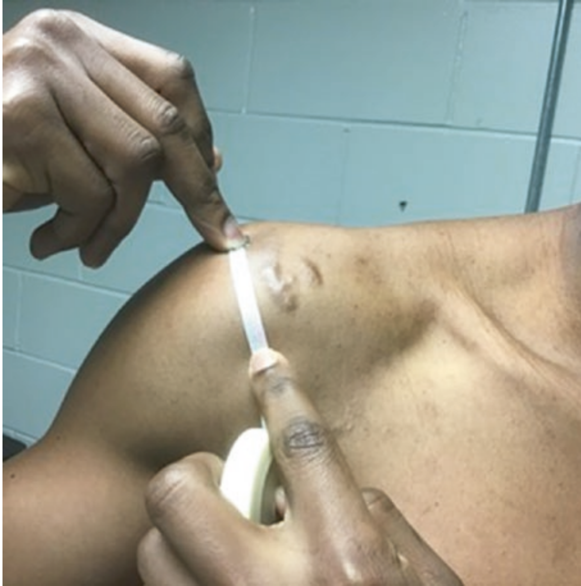
Scar # (8) – A circular, hypopigmented scar. The client states this scar is unrelated to the injuries from the attack.

Scar # (9) – A faint linear, hypopigmented scar on lateral aspect of the left lower leg, more ventral to scar #10. The client states this scar is unrelated to the injuries from the attack.

Scar # (10) – A 11.5 cm scar in length and 2.0 cm at its widest dimension. It is smooth, irregularly pigmented, irregularly linear. There are approximately three clear sutures scar lines. This scar is highly consistent with an exit wound from a gunshot using an assault rifle and the subsequent surgical repair of the wound.

Photo taken by Karen Wang

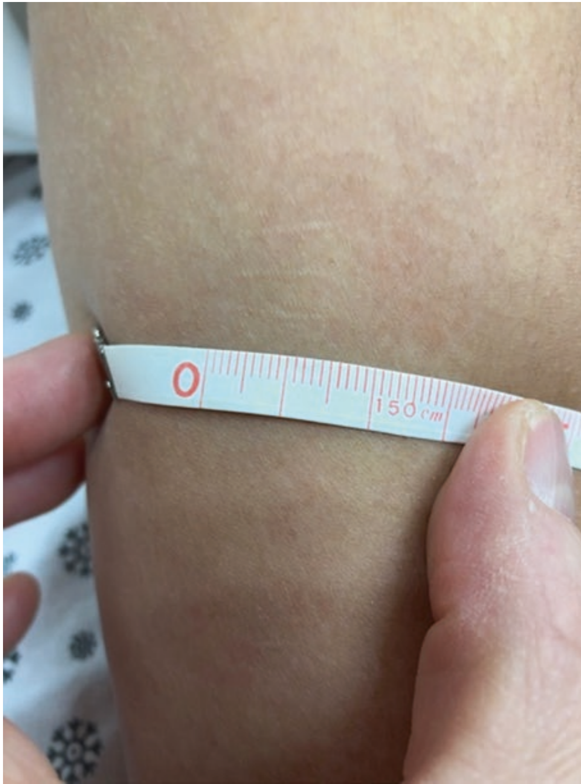
Two Separate Bullets That Grazed the Skin (Not Entrance and Exit Wounds)



This client states that he was shot by two bullets from the same weapon. He states the bullets grazed his skin but did not enter. He received no surgical treatment, and this photo was taken approximately 6 months after the attack. The evaluator characterized the scars as consistent with avulsive injuries from superficial bullet wounds.

Photo taken by Alison Mosier-Mills

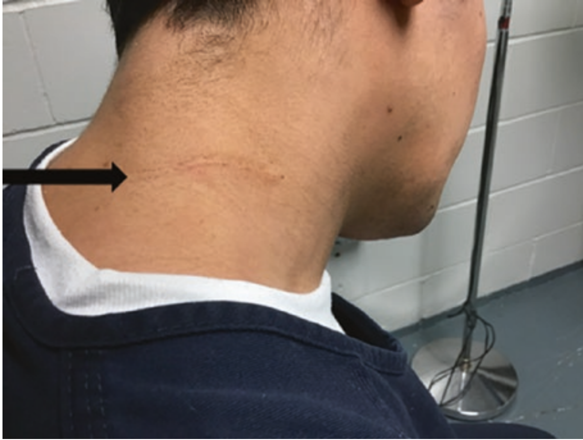
Sharp Trauma with Barber-Type Straight Razor



This client states her husband slashed her skin superficially with a barber-type straight razor. She received no medical treatment. She was evaluated approximately 2 years after the injury. There are three parallel linear faintly hypopigmented scars of the same length and caliber. The lacerations appear superficial and there is no evidence of suturing. Scars due to sharp trauma can be linear with regular pigmentation. The evaluator characterized these scars as highly consistent with sharp trauma from a razor.

Photo taken by Katherine McKenzie

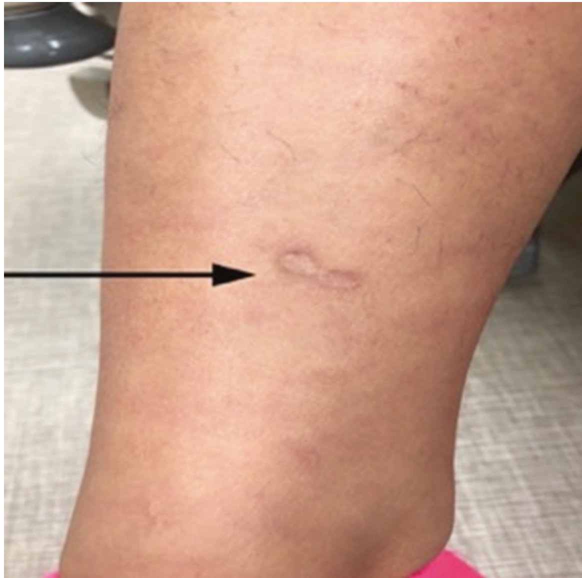
Sharp Trauma with Knife



This client states that his skin was slashed superficially with a knife when he was being tortured. He had no formal medical treatment for the injury. He was seen in a detention facility approximately 8 months after the injury. Sharp trauma can result in a linear scar. The evaluator characterized this scar as highly consistent with sharp trauma due to a knife injury.

Photo taken by Katherine C. McKenzie

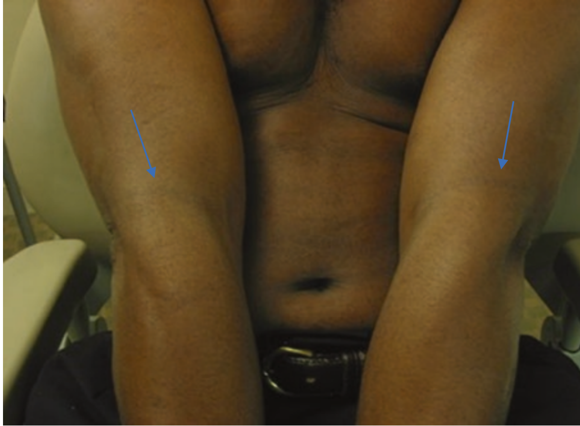
Woman Burned by Her Husband with a Cigarette



This client states that her husband burned her with a cigarette. The scar is noted to be a dumbbell-shaped flat scar (2 cm long, 0.5 cm wide) with well-demarcated borders, hyperpigmented edges, and a hypopigmented center on the right anterior shin. She was evaluated approximately 2.5 years after the injury. The evaluator characterized these lesions as consistent with thermal burn scars from a lit cigarette.

Photo taken by Arianna Quesada-Kahler

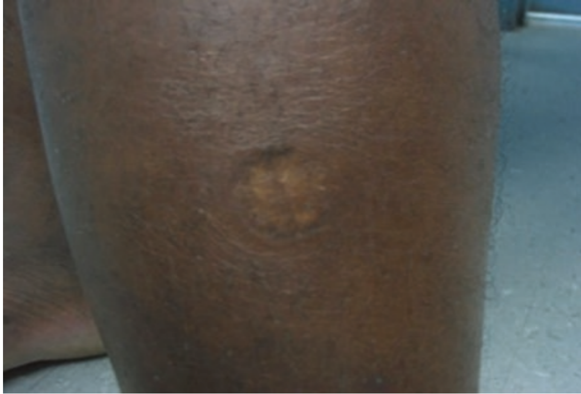
Blunt Trauma/Rope Restraint [7]



This man states that he was tied tightly with a thin rope such that his elbows nearly touched behind his back. The men who were holding him captive then poured water on the rope to cause the fibers to shrink. This tightened the rope further, thereby cutting into his arms, which then bled. He experienced shortness of breath which eased later when the ropes were cut. His arms were so weak afterward that he had difficulty holding a spoon for a number of months.

The scars encircling the arms above the elbow may be considered diagnostic of restraint scars due to a rope. The scars are symmetric and show a regular pattern. Also of note, the applicant's report of dyspnea when restrained is compatible with his description of having his arms tightly bound behind his back. This position limits full expansion of the thorax during inspiration, causing dyspnea. The mechanical restraints encircling the limbs may have also stretched, compressed, or otherwise damaged nerves of the brachial plexus, causing temporary neurologic deficits of the upper limbs. Used with permission by Elsevier. Excerpts and images shared by HealthRight International.

Thermal Burn [7]

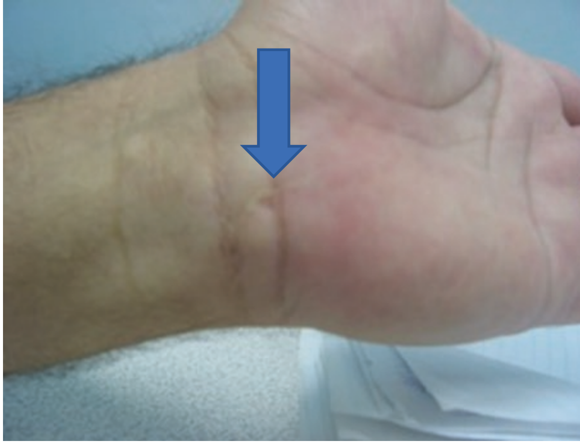


This man reported that he was tortured by the military. He recounts that on numerous occasions, he was restrained and then burned on his lower legs with the flat tips of metal rods that had been heated in a fire. The burned areas formed blisters which he lanced and drained.

This scar is round, reflecting the fact the shape of the end of the metal rods. In addition, there was a unique scar on the left lower leg. A full thickness burn injury is suggested by hypopigmentation and depression. In the center are two wide, hyperpigmented intersecting lines at a 90° angle which may be due to the conformation of the tip of a heated metal rod.

The evaluator characterized this scar as diagnostic of a burn using a heated metal rod with a circular end. Used with permission by Elsevier. Excerpts and images shared by HealthRight International.

Sharp Trauma [7]



Scar on inner wrist outlines shape of the tip of a knife.

This man states he was attacked by a man wielding a knife. The applicant describes that to protect himself from the blow, he extended his left hand in a defensive posture. The knife penetrated his leather jacket and cut him, with the knife tip jabbing into his left wrist. The injury was superficial and he did not suffer nerve or arterial damage. He did not seek medical attention and the wound healed slowly over approximately 25 days.

Close examination of the ventral aspect of the wrist reveals a small triangular scar which reflects injury from the tip of a knife. It is a small depressed scar, consistent with the tip of a knife digging into the skin, as opposed to a long linear laceration from, a slashing wound. In addition, the distinctive location of the scar, on the ventral surface of the wrist, is consistent with the client's description and demonstration of a defensive posture taken during a frontal attack. Used with permission by Elsevier. Excerpts and images shared by HealthRight International.

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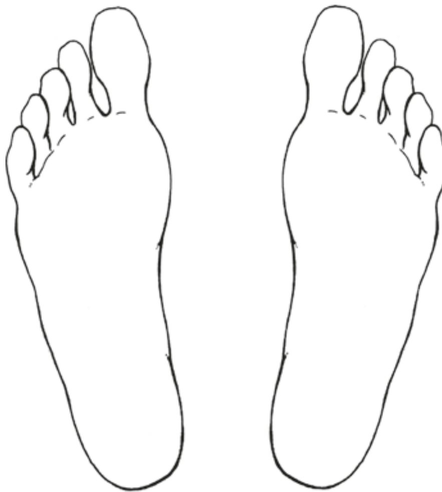
Appendix 2: Body Diagrams

Anne Marie Boustani

(Body diagrams used with permission from the Society of Asylum Medicine. May be used without attribution by asylum medicine providers for forensic evaluations.)

Feet- Left and Right Plantar Surfaces



Name ____________________

Date ____________________

A. M. Boustani
Department of Radiology and Biomedical Imaging, Yale School of Medicine, New Haven, CT, USA
e-mail: Annemarie.boustani@yale.edu

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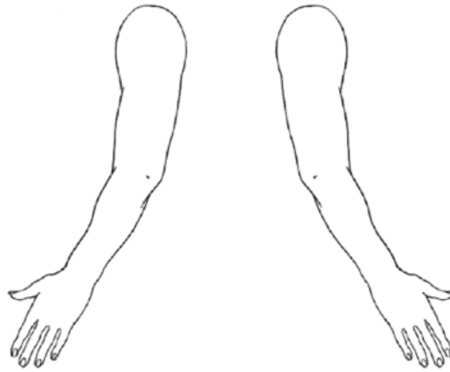
Full body. Female–Lateral view



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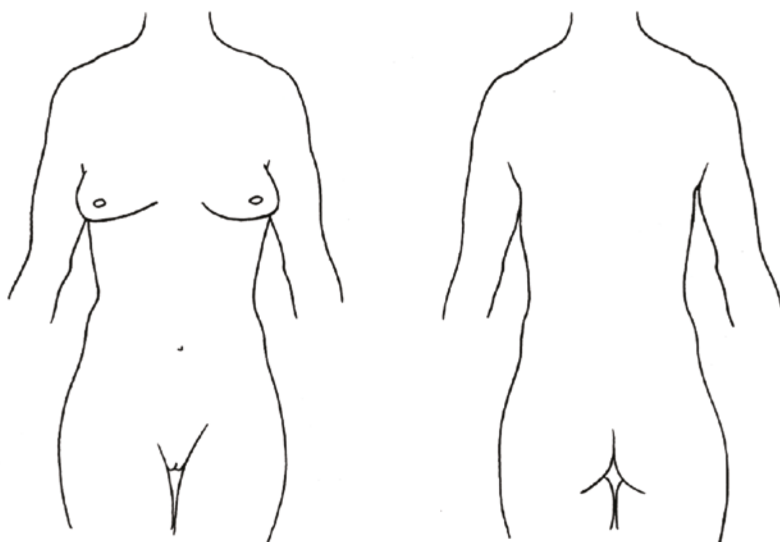
Thoracic Abdominal Female–Anterior Posterior views



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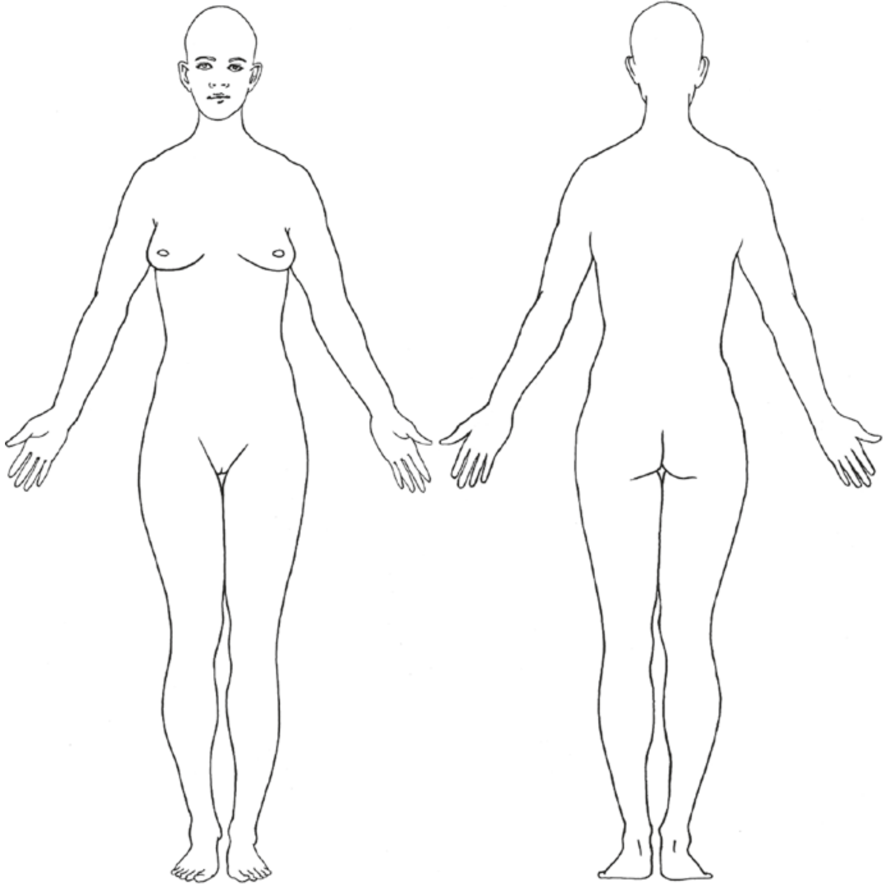
Ful body Female–Anterior and Posterior views (Ventral and Dorsal)



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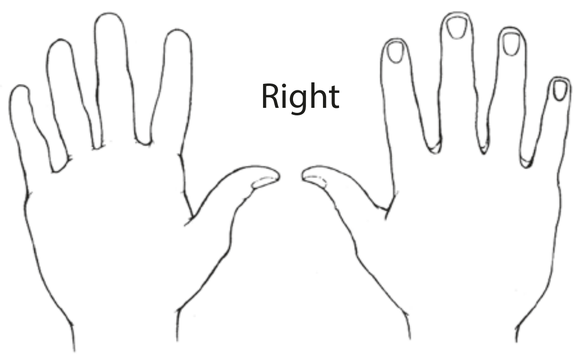

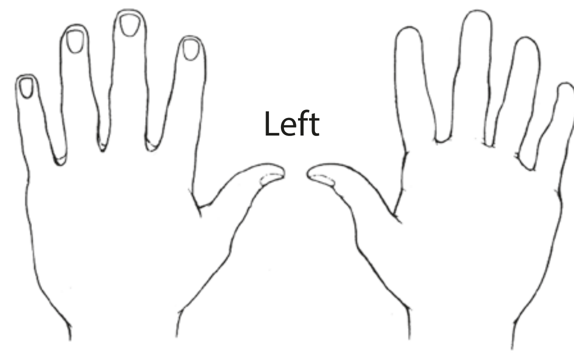

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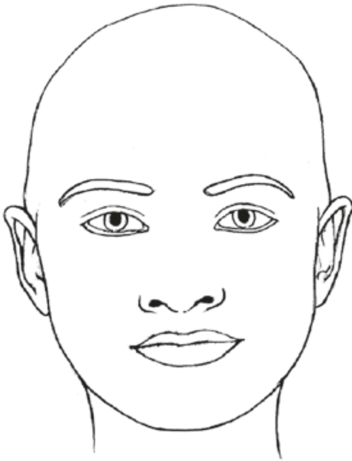
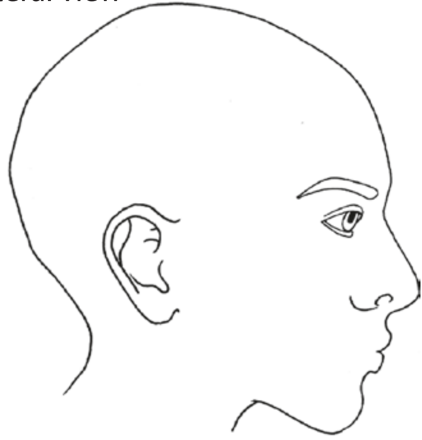
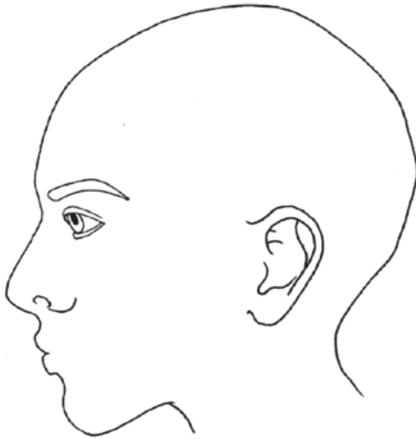
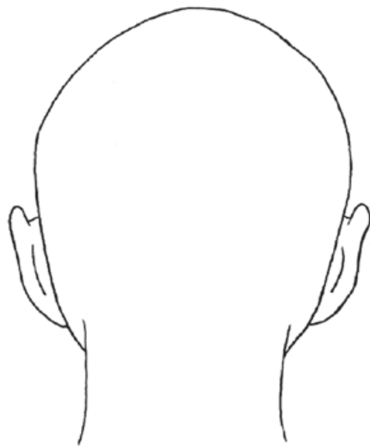
Head–Lateral view









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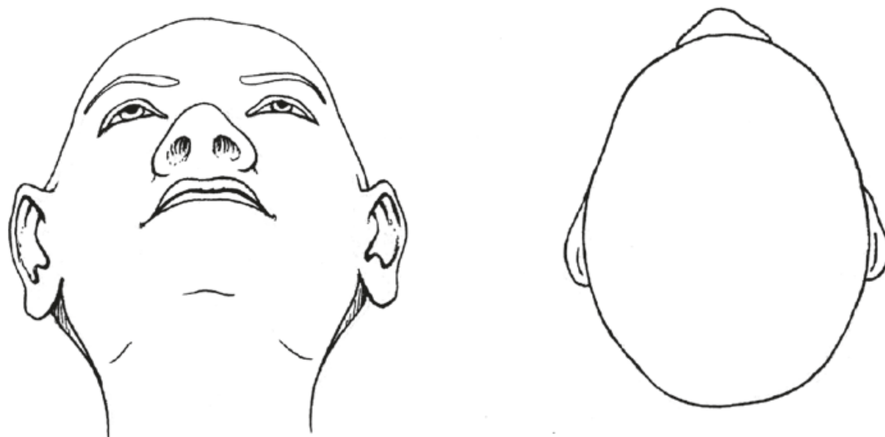
Head– Superior and Inferior view of neck



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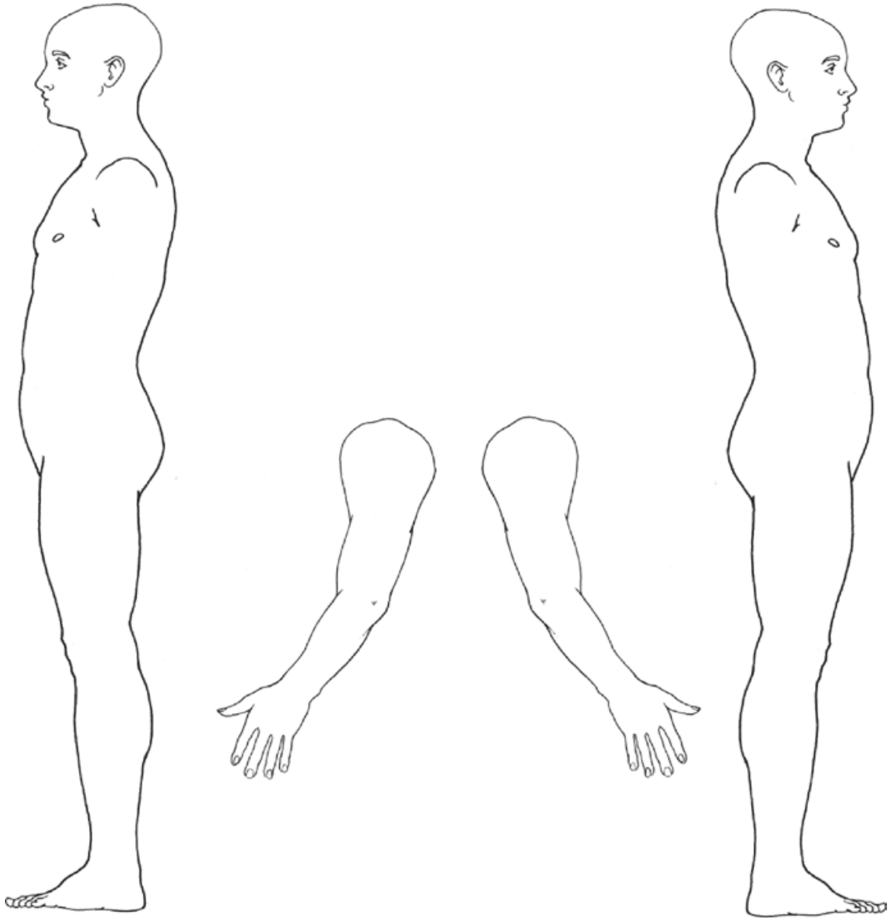
Full body Male–Lateral view



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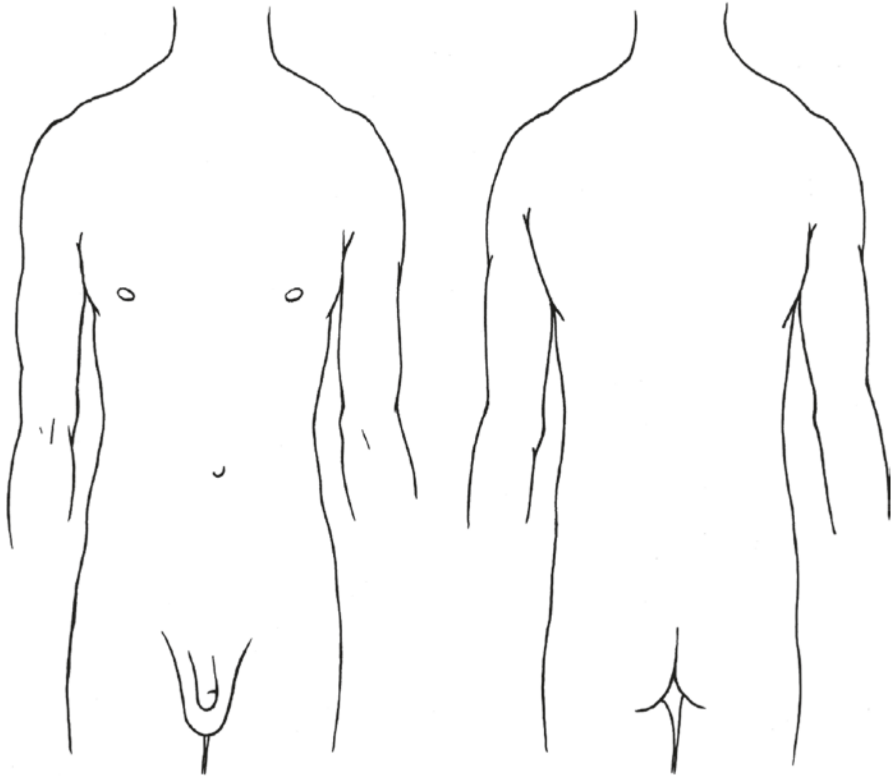
Thoracic Abdominal Male–Anterior Posterior views



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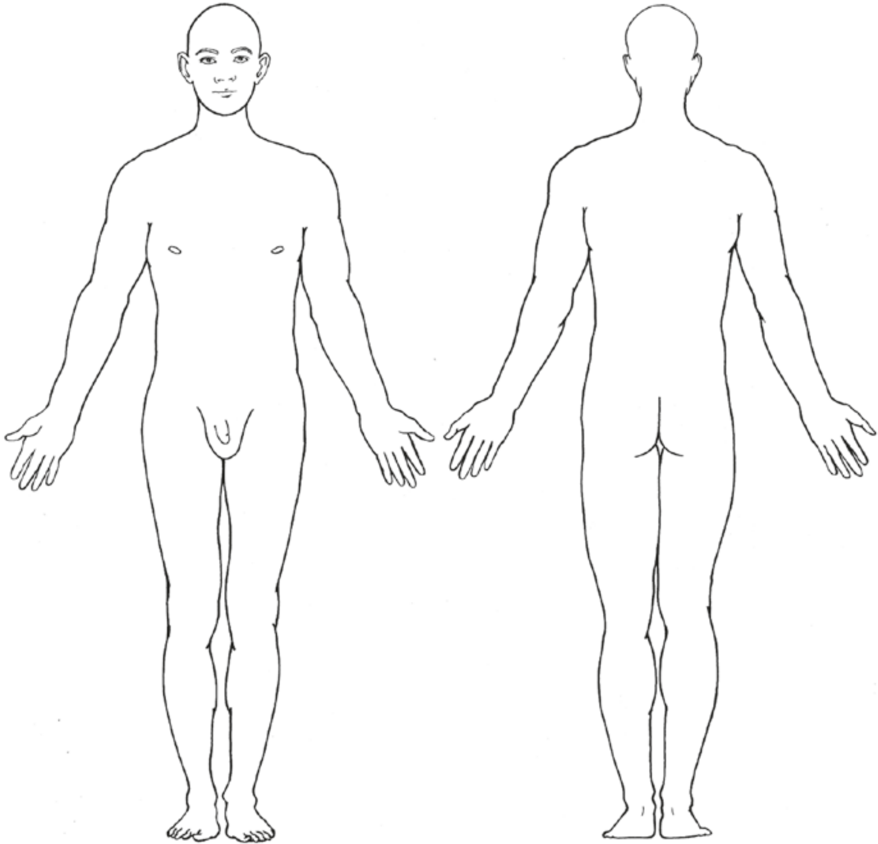
Full Body, Male–Anterior and Posterior views (Ventral and Dorsal)



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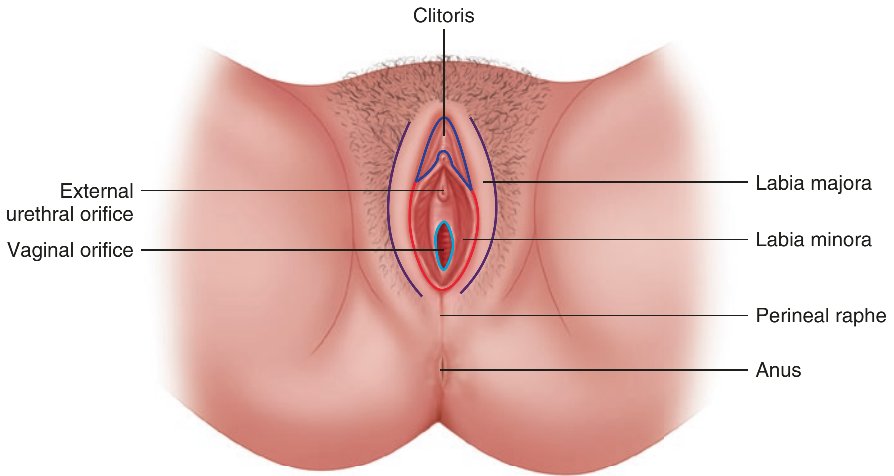
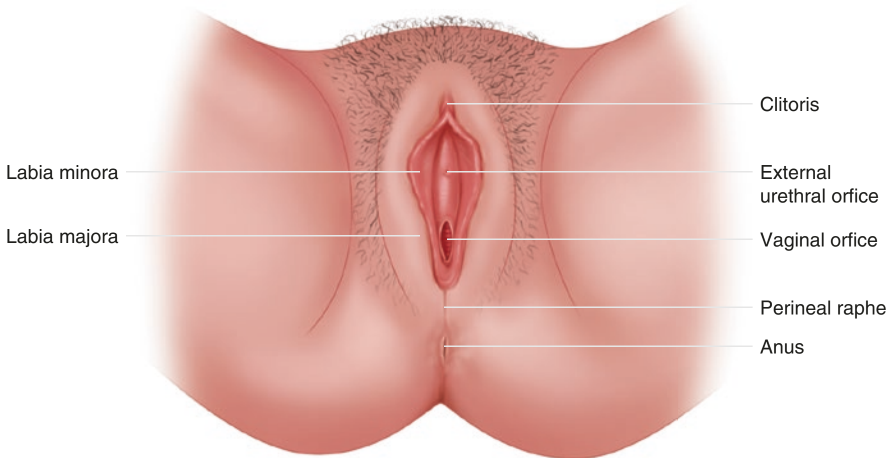
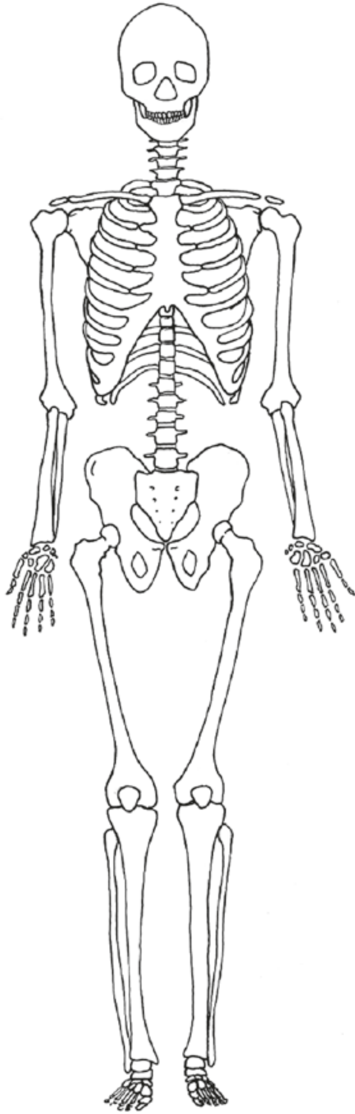
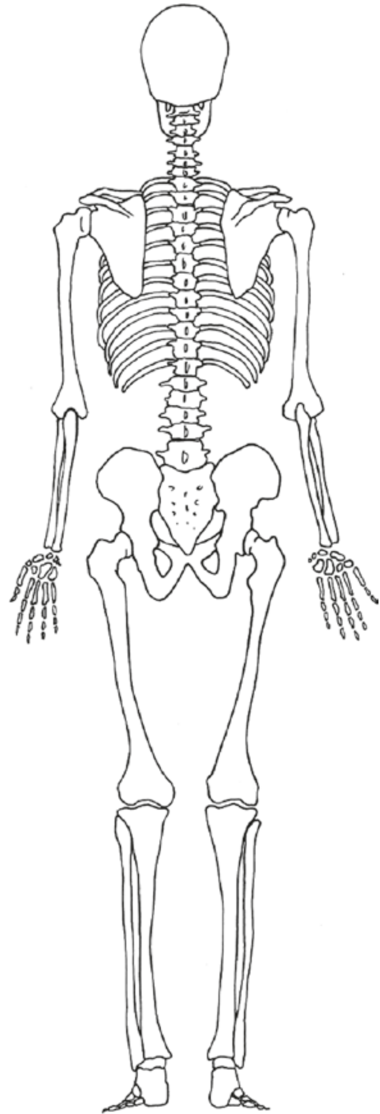


Female perineum



Skeleton–Anterior and Posterior views





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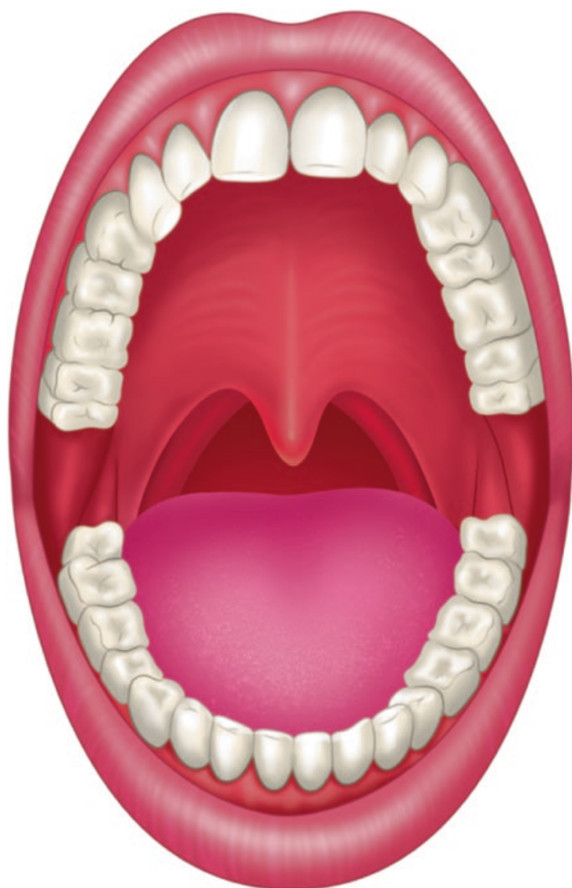
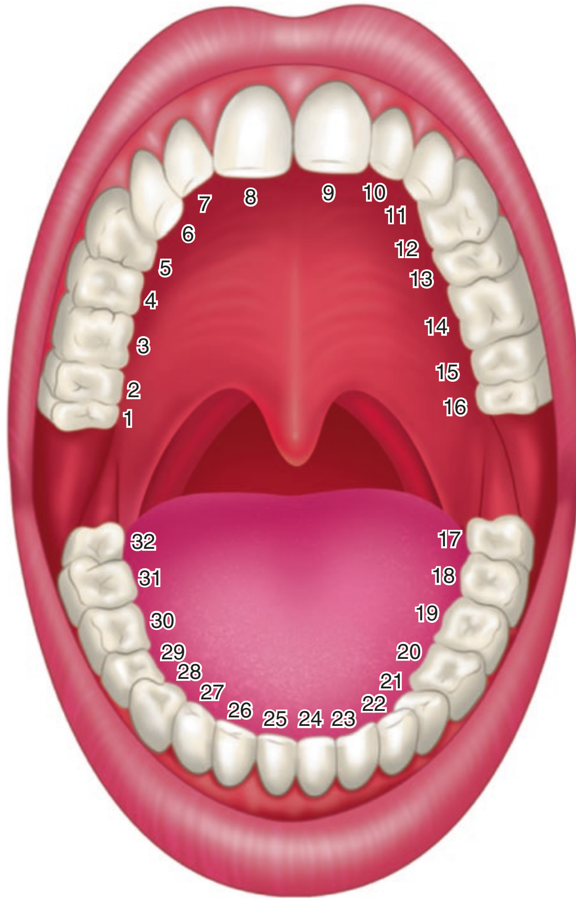
Teeth



Teeth with numbers



Appendix 3: Resources

The Istanbul Protocol: https://www.ohchr.org/documents/publications/training8rev1en.pdf

Universal Declaration of Human Rights: https://www.un.org/en/about-us/universal-declaration-of-human-rights

UNHCR Global Trends: https://www.unhcr.org/search?comid=56b079c44&&cid=49aea93aba&tags=globaltrends

US Department of Homeland Security Yearbook of Immigration Statistics: https://www.dhs.gov/immigration-statistics/yearbook

TRAC Immigration Statistics: https://trac.syr.edu/phptools/reports/reports.php?layer=immigration&report_type=report

Care of Girls and Women Living with Female Genital Mutilation: A Clinical Handbook: https://apps.who.int/iris/rest/bitstreams/1136324/retrieve

AAP Immigrant Toolkit: https://www.aap.org/en/search/?k=immigrant%20health%20toolkit

ORR Unaccompanied Children's Program: https://www.acf.hhs.gov/orr/programs/uc

Sample Psychological Evaluation Training Video: https://www.youtube.com/watch?v=AxGr_AFrPxc

Immigration Equality Asylum Manual: https://immigrationequality.org/asylum/asylum-manual/

Society of Asylum Medicine: https://asylummedicine.com/

Physicians for Human Rights Asylum Program: https://phr.org/issues/asylum-and-persecution/phr-asylum-program/

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HealthRight International Human Rights Clinic: https://healthright.org/our-work/human-rights-clinic/

Society of Refugee Healthcare Providers: https://refugeesociety.org/

Center for Gender and Refugee Studies: https://cgrs.uchastings.edu/

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