Cultural Consultation for Refugees

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Around the world, some 36 million people have been forcibly displaced from their homes by mass conflict or individual violence (United Nations High Commissioner for Refugees, 2013). This includes over 19 million people who are internally displaced and over 14 million others who are either stateless or have fled to neighboring countries of the global South where they are often housed in refugee camps. A minority (less than a million people a year) seeks asylum in the higher-income countries of the global North.

The United Nations 1951 Convention and 1967 Protocol Relating to the Status of Refugees (UNHCR, 2010), ratified by 145 nations, defines refugees as people who have fled their country because of a well-founded fear of persecution linked to their political beliefs, ethnicity, religion, gender, sexual orientation, or similar reasons (Hathaway, 2005; United Nations High Commissioner for Refugees, 2010). Destination countries are prohibited from sending refugees back to their home country if they would be exposed to such persecution, and may not penalize refugees for entering the destination country irregularly or without official documents (Edwards, 2011; Hathaway, 2005; United Nations High Commissioner for Refugees, 2010). Some countries, including Canada, also recognize refugees as people who, if returned to their home country, would face a danger of torture, a risk of cruel and unusual treatment, or a risk to their life that does not stem from inadequate health care or conditions such as natural catastrophes that affect the population in general (Immigration and Refugee Protection Act, 2001).

In Canada, as in many other countries, refugees fall into two groups. The first group is *resettled refugees* sponsored either by the government (Government Assisted Refugees) or by private groups such as churches (Privately Sponsored Refugees). Resettled refugees, often coming from refugee camps, have already been recognized as refugees and granted permanent resident status before arriving in Canada. The second group of refugees are individuals who come to Canada on their own without prior government authorization and make a well-founded claim for refugee status. During the claims process, they are known as *refugee claimants* or *asylum seekers*. Refugee claimants have the right to remain in

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Canada until final adjudication of the merit of their claim by an independent administrative tribunal, the Immigration and Refugee Board (IRB), including any appeal or judicial review proceedings. If the initial claim is rejected, during subsequent appeals, the person retains legal status and is known as a *rejected* or *failed claimant*. Acceptance of the claim confers secure refugee status and is the first step on the path to citizenship. If the claim is definitively rejected, the person will be ordered to leave the country (Immigration and Refugee Protection Act, 2001). If he or she does not comply with the deportation order, she loses her legal status and is known as an undocumented or nonstatus migrant.

In many countries, including Canada, it is also possible to apply for permission to remain in the country on humanitarian and compassionate (H&C) grounds. In Canada, as a result of recently adopted legislation (PCISA, 2012), most rejected claimants must now wait 1 year after definitive rejection of their claim before submitting an H&C application, during which time they will almost certainly be deported (unless they go underground). However, it remains possible to submit an H&C application immediately after final rejection of the refugee claim if it is based primarily either on a medical condition or the best interests of a child. Unlike appeal procedures, submitting an H&C application does not automatically prevent deportation but it may be possible to apply to the Federal Court for a stay of deportation while the H&C application is being examined. Humanitarian applications will not be further discussed in this chapter, because the criteria vary considerably from country to country.

Most resettled refugees have suffered years of privation and marginalization in transit countries, often in refugee camps, in addition to the traumatic events that initially led them to leave their country. Many have major physical or mental health problems due to trauma and hardship in both the home and transit countries, as well as the challenges of integrating into a new society (Fazel, Reed, Panter-Brick, & Stein, 2012; Fazel, Wheeler, & Danesh, 2005; Lie, 2002; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Steel et al., 2009; Steel, Silove, Phan, & Bauman, 2002; Turner, Bowie, Dunn, Shapo, & Yule, 2003; Vaage et al., 2010). Upon arrival in Canada, however, they have secure, permanent status and are on the road to citizenship, factors that are associated with long-term improvement of mental health (Beiser, 1999, 2009; Nickerson, Steel, Bryant, Brooks, & Silove, 2011; Porter & Haslam, 2005; Schweitzer, Melville, Steel, & Lacharez, 2006; Steel et al., 2011).

Refugee claimants, on the other hand, face the challenge of trying to prove the well-foundedness of their refugee claim before the IRB, failing which they will be forcibly sent back to their country of origin (repatriation or deportation). Thus, in addition to the trauma experienced in the country of origin, refugee claimants face insecurity and precarious status in the receiving country. In this chapter, we will focus primarily on the situation of refugee claimants. After presenting the legal definition of a refugee, there is a brief overview of premigratory, transit, and postmigratory factors that may affect refugee claimants' psychosocial status, including a more detailed discussion of two common postmigratory problems: detention and family separation. The next section examines clinical intervention with refugee claimants, particularly the assessment and treatment of posttraumatic symptoms. Finally, there is a discussion of the ways in which clinicians may act upon the social determinants of refugee claimants' health, including a detailed explanation of how to write a report in the context of refugee status proceedings.

Refugees and Refugee Claimants: Legal Principles

Clinicians generally adhere to an ethos of care which prescribes that people who are ill should receive treatment, irrespective of their migration status. Many clinicians feel that the laws and policies defining migrants' rights are not relevant to their clinical practice with this population. Yet, migratory status has a huge impact on migrants' physical and mental health because it determines access to jobs, health care, social assistance, schooling, ability to reunite with family, and, most fundamentally, secure status in the destination country.

Sovereign states generally have the power to decide who may enter and remain in their country

and on what terms and to expel those who do not comply. United Nations 1951 Convention and 1967 Protocol Relating to the Status of Refugees (UNHCR, 2010) is an exception to this rule. A person may enter and remain in a country other than her own if she would be in danger because of her ethnicity, religion, gender, sexual orientation, political opinions, or similar reasons if returned to her home country (Hathaway, 2005; Immigration and Refugee Protection Act, 2001; United Nations High Commissioner for Refugees, 2010). In Canada, a person may also be accepted as a refugee if she would be exposed to a risk of torture, cruel and unusual treatment, or an individualized threat to her life if returned to her country of origin. An individualized threat to life must go beyond the risks affecting the general population (e.g., epidemics, environmental disasters, earthquakes, famine) and excludes risks linked to lack of adequate health care (Immigration and Refugee Protection Act, 2001).

In Canada, refugee claimants present their case at a hearing before the IRB, which decides if their claim is well founded. The refugee claimant has the burden of proving three main elements. First, that she would be in danger of persecution if sent back to her country of origin and that this danger is linked to one of the grounds mentioned in the refugee definition (ethnicity, religion, gender, sexual orientation, political opinions, risk of torture, etc.). To prove this, the person must usually establish that they suffered severe mistreatment for one of these reasons in their home country, or were in imminent danger of suffering such mistreatment. Second, that the government of her country is unwilling or unable to protect her against this persecution. In some cases, this is obvious because government agents such as the military were directly responsible for the persecution. In others, the refugee claimant must prove that the police and judicial system did not offer adequate protection against her persecutors. Finally, the refugee claimant must demonstrate that she would not have been safe anywhere in her country, even if she had moved to a different region. The refugee claimant must prove all of these elements; otherwise, her claim will be rejected (Hathaway, 2005; Immigration and Refugee Protection Act, 2001). Between 2006 and 2011, on average, 41% of refugee claims were accepted annually in Canada (The Refugee Forum, 2012).

Many refugee claimants travel with false documents, for a number of reasons. In many cases it would be dangerous to apply to their government for a passport or other travel document because the government is involved or complicit in their persecution. At times, staying in the country long enough to obtain official documents would place the person in danger. Finally, many refugee claimants would be unable to obtain a visa even if they asked for one, for there is no such thing as a visa to flee persecution (Hathaway, 2005; Phillips, 2011).

Under international law, states are not allowed to penalize refugees for entering the country with false documents (Edwards, 2011; Hathaway, 2005; Phillips, 2011; United Nations High Commissioner for Refugees, 2010). Since the 1990s, however, governments in destination countries in the global North have increasingly adopted policies such as detention and visas designed to limit the flow of refugee claimants, as well as a discourse portraying them as "illegal" and potentially dangerous intruders, "bogus" refugees bent on taking advantage of the local population (Crépeau, Nakache, & Atak, 2007; Hathaway, 2005; Hyndman & Mountz, 2008). This discourse tends to reinforce implicit xenophobic stereotypes and may contribute to hostility toward refugee claimants in destination countries (Rousseau, Hassan, Moreau, & Thombs, 2011).

The Refugee Experience: Premigration, Transit, and Postmigration Stressors

Every year, thousands of people seek asylum in Canada (The Refugee Forum, 2012). Many have experienced traumatic events such as torture, sexual or physical assault, spousal violence, armed conflict, arbitrary imprisonment, murder of loved ones, or other forms of violence, often in the context of mass conflict or state failure. During their journey in search of a safe country, they often experience considerable hardship. When they finally arrive in the destination country, refugee claimants face not only the integration challenges

common to all new immigrants, but also specific challenges such as living in constant fear of deportation should they fail to convince immigration authorities that they are entitled to protection as refugees. Postmigration stresses experienced during the asylum-seeking process, such as fear of deportation, may exacerbate consequences of premigratory traumas. To fully understand refugee claimants' experience, therefore, it is crucial to examine the potentially traumatic events and stressors that they have faced in their country of origin, in transit, and since their arrival in the destination country.

In many cases, multiple traumatic events may have disrupted the person's daily life over an extended period. A recent meta-analysis of 181 surveys involving over 80,000 adult refugees and other persons affected by mass conflict showed that cumulative exposure to trauma was a strong predictor of PTSD and depression, particularly the latter outcome (Steel et al., 2009). Populations granted secure, permanent status in another country had lower PTSD rates than persons who were internally displaced or living in camps, suggesting that a positive post trauma environment can help mitigate the impact of trauma and foster recovery. This is consistent with another meta-analysis on refugee mental health showing that favorable post-displacement conditions such as access to employment and adequate housing significantly reduced the negative impact of trauma exposure (Porter & Haslam, 2005). Longitudinal Canadian studies have shown that most adults and children with secure refugee status adapt well despite high levels of premigratory trauma exposure (Beiser, 1999; Rousseau & Drapeau, 2003). However, negative postmigration conditions may adversely affect refugee claimants' mental health. Some postmigratory stressors, such as language difficulties (Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008), cultural differences (McKeary & Newbold, 2010), lack of recognition of qualifications, loss of social support (Schweitzer et al., 2006), discrimination (Rousseau, Hassan, et al., 2011), or a combination of such factors (Kirmayer, Narasiah, et al., 2011), also affect many other newly arrived migrants. However, refugee claimants often face additional difficulties that may aggravate the negative impact of past trauma, including detention (Cleveland, Dionne-Boivin, & Rousseau, 2013; Cleveland & Rousseau, in press; Ichikawa, Nakahara, & Wakai, 2006; Keller et al., 2003; Kronick, Rousseau, & Cleveland, 2011; Lorek et al., 2009; Mares, Newman, Dudley, & Gale, 2002; Momartin et al., 2006; Newman, Dudley, & Steel, 2008; Robjant, Hassan, & Katona, 2009; Robjant, Robbins, & Senior, 2009; Silove, Austin, & Steel, 2007; Steel et al., 2006; Steel, Momartin, et al., 2004); lengthy refugee claim proceedings and protracted precarious status (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Momartin et al., 2006; Steel et al., 2006, 2011); limited access to health and social services (Arya, McMurray, & Rashid, 2012; Taylor, 2009); limited job access due to the temporary nature of refugee claimant work permits; or a combination of these factors (Laban et al, 2005; Nickerson, Bryant, Steel, Brooks, & Silove, 2010; Nickerson, Steel, et al., 2011; Porter & Haslam, 2005; Ryan, Benson, & Dooley, 2008; Ryan, Kelly, & Kelly, 2009; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Steel et al., 2009; Steel, Silove, Bird, McGorry, & Mohan, 1999).

When refugee claimants flee their country, they generally leave behind close family members, including spouse and children, and must often wait for years before being reunited, given the lengthy delays involved in the refugee status and family reunification proceedings (Nickerson et al., 2010; Rousseau, Mekki-Berrada, & Moreau, 2001; Rousseau, Rufagari, Bagilishya, & Measham, 2004). In addition to the pain of separation, refugee claimants may fear for the safety of family members left behind. This fear of future harm to family may aggravate posttraumatic stress and depression symptoms, as may fear of future harm to self such as deportation (Nickerson et al., 2010).

In short, refugee claimants are simultaneously faced with the task of rebuilding their lives in an unfamiliar environment, while having to deal with past trauma and multiple ongoing stressors, including separation from family; anxiety about family back home; limited access to employment, social assistance, and health care; and fear of deportation should their claim be rejected.

Table 12.1 provides an overview of the factors affecting refugee claimants' health and

Table 12.1 Factors affecting refugee mental health and well-being

Premigration factors	Potentially traumatic events (PTEs) in home country • Single or multiple • Discrete event or continuing situation Living conditions • Socioeconomic circumstances • Family situation • Situation of membership group (ethnic, religious, etc.) Personal history • Vulnerability factors • Protective (resiliency) factors
Transit factors	Direct trip to destination country vs. stays in transit locations *If transit through other locations* • Refugee camps (internal or in transit country) • Stays in transit countries – Clandestine (nonstatus) or with status – Economic situation, access to care, etc. – Detention linked to migratory status Travel with official documents or false documents *If obtained from a smuggler* • Cost and impact on the person's finances Exposure to PTEs during transit • Exploitation by smugglers • Poverty • Protracted experience of marginalization, helplessness, being stuck (e.g., refugee camp) • Physical injuries or mental stress linked to clandestine entry (e.g., exposure to the elements, hunger, confinement) Strengths acquired during transit
Postmigration factors	Obstacles upon arriving in destination country • Interviews by immigration officers • Detention • Challenges to admissibility Ongoing threat: fears for the future, feeling of not being safe • Protracted uncertainty about legal status • Anxiety about testifying at refugee status hearing • Fear of being sent back to country of origin • Fears about safety of family members back home • Fear that their membership group (ethnic, religious, political, or other) is under threat in country of origin Current living conditions • Loss of social identity (role as provider, community member, member of extended family, social recognition of competence, etc.) • Limited access to employment, health care, social services, education, etc. • Separation from family • Poverty • Limited social support • Marginalization or discrimination linked to migratory status, ethnicity, language, etc. • Settlement challenges: finding a place to live, a job, adapting to a different culture, learning a language, etc.

well-being during the different phases of migration. Many of these factors apply to any migration situation but have specific features for refugee claimants. We will discuss two postmigration stressors mentioned in Table 12.1 in greater detail—detention and family separation—because these are especially challenging aspects of the refugee's predicament.

Detention

In Canada, about 5–10% of refugee claimants are detained upon arrival, most often pending identity checks (Nakache, 2011). Detention is generally unrelated to any criminal wrongdoing, and detained claimants are very rarely even suspected of being a security risk (Nakache, 2011). Yet nearly a third of detained refugee claimants are held in high-security provincial jails with the criminal population, while the others are placed in Immigration Holding Centres that are operated as prisons, with razor-wire fences, centrally controlled locked doors, and constant surveillance by cameras and uniformed guards, as documented by recent studies (Cleveland et al., 2013; Cleveland & Rousseau, in press). Men and women are held in separate wings, with a special section for children detained with their mothers. All aspects of daily life are controlled by rigid rules, and failure to respect rules may be punished by solitary confinement. There are virtually no activities except watching television. Basic medical care is provided, but no counselling or mental health support. Suicidal detainees are either placed under 24/7 individual surveillance, usually in solitary confinement, or transferred to a provincial jail. All detained refugee claimants except pregnant women and minors are handcuffed, and sometimes shackled, during transportation, notably when in need of specialized medical care at a hospital. Detained claimants may be chained during medical procedures. For example, a claimant recounted being handcuffed to the dentist's chair during surgery for an abscessed tooth (Cleveland et al., 2013). If hospitalized, detainees, including women who have just given birth, are almost always chained to their beds as well as being under guard. Some claimants forego medical treatment rather than enduring the shame of being seen in public handcuffed like a criminal (Cleveland et al., 2013).

Studies from around the world have consistently shown high levels of psychiatric symptoms among detained refugee claimants, even after short periods (Cleveland et al., 2013; Cleveland & Rousseau, in press; Ichikawa et al., 2006; Keller et al., 2003; Kronick et al., 2011; Lorek et al., 2009; Mares et al., 2002; Momartin et al., 2006; Newman et al., 2008; Robjant, Hassan, et al., 2009; Robjant, Robbins, et al., 2009; Silove et al., 2007; Steel et al., 2006; Steel, Momartin, et al., 2004). Symptoms tend to worsen over time (Keller et al., 2003; Steel et al., 2006). Depression and posttraumatic stress are the most common psychiatric problems among detained refugee claimants. In the United Kingdom, after about 30 days in detention, 76% of detained refugee claimants were clinically depressed compared to 26% of a nondetained comparison sample (Robjant, Robbins, et al., 2009). In the United States, after about 5 months in detention, 86% of refugee claimants showed clinical levels of depression, 77% clinical anxiety, and 50% clinical posttraumatic stress disorder (Keller et al., 2003). At follow-up a few months later, the mental health of those who were still detained had continued to deteriorate, whereas it had substantially improved among those who had been released and granted permanent status. In Australia, in 2010–2011, there were over 1,100 incidents of self-harm in immigration detention centers, including 6 suicides (Suicide Prevention Australia, 2011), for a population of about 6,000 people detained for a median of 10 months (Australian Department of Immigration and Citizenship, 2011).

In Canada, researchers conducted a study involving 122 adult refugee claimants detained in immigration holding centers and a comparison group of 66 never-detained refugee claimants (Cleveland et al., 2013; Cleveland & Rousseau, in press). Claimants in both groups had experienced an average of 9 serious traumatic events

such as being physically assaulted, having family or friends who were assaulted and/or murdered, and being at risk of death. After an average detention of only 31 days, over three-quarters of the detained participants scored above clinical levels for depression, about two-thirds for anxiety, and about a third for posttraumatic stress symptoms. Detained refugee claimants were almost twice as likely as their nondetained peers to report clinically significant levels of posttraumatic stress symptoms (32% for detained participants, 18% for nondetained), while clinically significant depression rates were 50% higher among detained claimants than among their nondetained peers (78% for detained participants, 52% for nondetained). This reflects a response to factors such as disempowerment, loss of agency, inability to modify or escape from a painful situation, isolation, and stigmatization.

Detention is also harmful for asylum-seeking children (Kronick et al., 2011). In the UK, after an average 43-day detention, asylum-seeking children showed symptoms such as posttraumatic stress, depression, suicidal ideation, behavioral difficulties, and developmental delay as well as weight loss, difficulty breast-feeding in infants, food refusal, and regressive behaviors (Lorek et al., 2009). An Australian study of ten asylum-seeking families (14 adults and 20 children) detained for a prolonged period found that all but one child suffered from major depressive disorder and half from PTSD (Steel, Momartin, et al., 2004). A majority of children frequently contemplated suicide, and five had self-harmed. Most of the younger children showed developmental delays as well as attachment and behavioral problems. A third of the parents had attempted suicide. In 2004, an Australian government inquiry found that a high proportion of detained asylum-seeking children had psychological problems such as developmental delays, bed-wetting, nightmares, separation anxiety, sleep disturbance, depression, and suicidal behaviors (Newman et al., 2008; Silove et al., 2007). Previously competent parents, notably women giving birth during detention, were often too depressed to adequately care for their children.

In January 2012, four asylum-seeking children won a six-figure settlement from the UK government in compensation for the negative impact of their 13-month detention (Taylor & Hattenstone, 2012). During detention, the children had developed multiple problems including hand tremors, refusal to eat, hair loss, recurrent nightmares, and severe anxiety. Eight years after release, the four children still had numerous symptoms, including insomnia, intrusive frightening memories of detention, phobic reactions, and reduced ability to concentrate and study. Their academic performance, which had been excellent before their detention, remained impaired.

Case Vignette 12-1

A family with two Canadian-born children aged 5 and 7 was detained for 5 days following rejection of their refugee claim. During the arrest, the parents were handcuffed in front of the children. The 5-year-old boy tried to escape and was physically forced into the van.

After release from detention the 7-year-old girl, who was previously healthy and doing well at school, became severely withdrawn and had difficulty speaking with adults and peers. Her academic performance declined. She also had regular nightmares and difficulty falling asleep. The 5-year-old boy developed phobias of police, dark-colored vans, and dogs and refused to go to preschool for the first 6 months after detention because he was too frightened to leave the house. He had regular temper tantrums, was unable to fall asleep without his parents present, and would not tolerate being in a room with the door closed. A year after detention, the two children were still struggling with anxiety, sleep problems and irritability, and met diagnostic criteria for PTSD.

In some cases, children may be separated from detained asylum-seeking parents, particularly when parents are held in regular jails, which do not accept young children. Forced separation is particularly likely to be harmful to children who have been exposed to violence in their home country; who leave behind relatives, friends, school, and everything with which they are familiar; and who arrive in a strange country where they may not even speak the language. Most are unlikely to have close relatives in Canada and would be placed in institutional care or in foster care with strangers, which is generally more harmful than fostering by relatives (Holtan, Rønning, Handegård, & Sourander, 2005).

Asylum-seeking Sudanese youth in the USA who were separated from their immediate family were at increased risk of PTSD, especially those placed in foster homes with strangers rather than with other Sudanese families (Geltman et al., 2005). Children separated for over a month from parents detained in US immigration prisons had high rates of sleep disturbance, aggressiveness, and withdrawal (Chaudry et al., 2010). On the other hand, when children fleeing organized violence are able to maintain secure attachments to family members, they are protected from some of the psychological consequences of trauma (Rousseau, Said, Gagne, & Bibeau, 1998).

Family Separation and Reunification

Separation of family members is a central stressor for refugees. Barudy (1989) distinguished three main stages in the family separation and reunification process: before the separation, during the separation, and the reunion itself. Each of these stages defines a new balance or imbalance in the family and determines, in part, what will become of the family. As in the case of other migrants, separations and cultural uprooting change family relationships, roles, and strategies (Williams, 1990), but for refugee families, these reorganizations take on distinctive characteristics.

Refugees repeatedly must face the question of what an extended separation means to the various members of their family. Family members who have fled abroad may be in a very difficult situation; the refugee who has found safe haven may feel guilty, powerless, and depressed about a separation over which they have little or no control (Fox, Cowell, & Johnson, 1995; Nickerson et al., 2010; Tseng, Cheng, Chen, Hwang, & Hsu, 1993). Those who remain behind may feel abandoned or even betrayed or deceived (Moreau, Rousseau, Meikki-Berrada, TCMR, & ERASME, 1999; Suarez-Orozco, Bang, & Kim, 2011). The long absence of one or more members first leads to a reconfiguration of roles within the family. Sometimes one of the parents must play the role of both mother and father; sometimes the older children must assume adult responsibilities or symbolically take the place of one of the parents (Barudy, 1989). This reorganization may also involve the use of surrogates, including members of the extended family, outsiders, and sometimes even divine figures. The temporary nature of this initial reconfiguration of roles may make the family all the more vulnerable (Williams, 1990).

When adolescents were reunited with their parents after having been left with close relatives for a few years while their parents settled in the USA, those who had been separated from one or both parents for over 2 years had significantly higher levels of depression and anxiety than those who had not been separated (Suarez-Orozco et al., 2011). Symptom severity increased with length of separation. Family reunification was often fraught with conflict. Especially in cases of lengthy separation, many children felt estranged from their parents and were deeply distressed at the separation from their alternate caregivers. Some children showed withdrawal, lack of trust, and depressive symptoms, while others showed increased anger and aggression. The emotional scars of long-term separation typically took years to heal.

Refugees often see family reunification as an event that will bring a happy ending to a long series of losses. Although refugees may eventually mention problems ensuing from reunification, it is initially presented as a time for celebration. While the family reunion is a turning point that can lend meaning to the many losses refugees have endured in their long journey, it

also disrupts the fragile balance that has been established during the waiting period. The family reunion thus represents both renewal of highly significant family bonds and at the same time another loss of the new equilibrium, which may be difficult to cope with because it often cannot be mentioned. Once the family has been reunited, it has another crisis to face in trying to unite members who may have had very different experiences. The longer members of the family have been apart, the more difficult it may be for the family unit to regain its balance (Barudy, 1989). Roles must be redefined, taking into account the past (family history and ideas of the home culture) and the present (the realities of the host country, the cultural gaps between family members across generations). For those who have experienced trauma, this process may be particularly difficult if they need to hold on to well-defined roles in order to rebuild their identity (Rousseau et al., 2004). For further discussion of issues of reunification see Chapter 13.

Responding to Refugee Trauma and Loss: When and How?

Primary care practitioners have a key role in the recognition and management of mental health problems in immigrant and refugee patients for three main reasons (Kirmayer, Narasiah, et al., 2011). First, general practitioners are the gateway to health care for immigrants and refugees, who, as a group, underutilize mental health services in Canada. Second, immigrants and refugees report elevated rates of extreme trauma, such as torture and rape, that can have severe and long-lasting consequences for both physical and mental health and require integrated treatment approaches. Third, although a particular family member may present as the identified patient, a family perspective is essential because trauma stemming from organized violence tends to affect the whole family, especially, children, who may not display dramatic or easily recognizable symptoms. Because of the complexity of these situations and the emotional burden that they represent, the primary care practitioners can benefit from cultural consultation to help them address the entanglements of past and present contextual factors with cultural issues.

In many places, health care services for refugees are limited. In Canada, the federal government has recently made major cuts to health care for refugee claimants (Arya et al., 2012). The new Interim Federal Health Plan covers only medical acts by physicians or nurses and explicitly excludes coverage of psychotherapy or any services provided by psychologists or other non-medical health professionals. Medication coverage by the federal government is also very limited, although this may be mitigated by provincial plans. As a result, primary care practitioners will face the challenge of managing refugee claimants' mental health problems with very limited resources.

Primary care practitioners need to be aware that immigrants and refugees may have undergone premigratory trauma. A warm and empathic stance is essential to create a safe environment for disclosure (Rousseau, Measham, & Nadeau, 2012). It is important to include an interpreter when language may impede accurate and empathetic communication (see Chapter 5). The choice of interpreter (gender, ethnicity, religion) should be discussed with the patient. Interpretation over the telephone is not recommended because of the mistrust and shame often associated with a traumatic experience.

Assessment of traumatic symptoms cannot be separated from potential interventions. If a patient discloses a traumatic experience, acknowledging the pain and suffering associated with the event may be helpful. Practitioners may explain that the reaction is common in persons who have undergone trauma (normalization) and provide information. When patients face misunderstanding or incredulity elsewhere in health care, social service, or legal systems, practitioners may need to move away from offering a neutral stance and adopt a clear position of advocacy (Kirmayer, 2001; Rousseau et al., 2012). Offering empathetic reassurance that help will be provided and that the situation is likely to get better is an important first step. For refugee patients, practical family and social support is most often

provided in Canada by community organizations. Family physicians may find it helpful to establish partnerships with these organizations in order to reduce the isolation of families and to help them obtain support in the initial phases of resettlement.

Although not supported by clinical trials, National Institute of Clinical Excellence (NICE) (National Collaborating Centre for Mental Health, & Royal College of Psychiatrists' Research Unit, 2005) recommends a phased model, reflecting a pragmatic clinical approach for refugee and refugee claimants who face the possibility of being returned to a traumatic environment. Phase I is defined as the period in which safety has not yet been established, during which intervention should focus on practical family and social support. Advocacy by health professionals may be essential at this stage to help establish a sense of safety. Phase II and III should focus on patient priorities, which may include social integration and/or treatment of symptoms. Trauma-focused psychological treatment should be offered because it has been shown to be effective even years after trauma occurred (Rousseau et al., 2001).

There is some evidence that even for accepted refugees the effect of social factors like unemployment, isolation, and discrimination may overshadow the efficacy of mental health treatment in many patients (Gorst-Unworth & Goldenberg, 1998). This adds support to the idea that a multilevel response to traumatic stress is needed for refugee and immigrant populations, with interventions that include primary care, community organizations, and other social institutions (Nickerson, Bryant, Silove, & Steel, 2011; Silove, 1999).

Clinical Assessment of Trauma and Its Consequences

Exploration of trauma and its consequences is not typically recommended in the first meeting with a patient unless it is the patient's primary complaint. Otherwise, exploration of mental health issues can be delayed to subsequent interviews when a trusting relationship has been established (Weinstein, Dansky, & Iacopino, 1996). However, certain symptom presentations should alert clinicians to assess for PTSD, including unexplained physical complaints that may not be presented as PTSD (Burnett & Peel, 2001; Lustig et al., 2004), but suggest the possibility of psychological distress and PTSD as differential diagnoses (New Hampshire State, 2005). Similarly, trauma and torture can lead to a wide range of psychological pathologies that have significant comorbidity with PTSD. The most common are depression, panic disorder, and somatoform disorder (Fazel et al., 2005; Hinton et al., 2005). Other presentations, such as severe dissociation mimicking brief reactive psychosis, dissociative disorders involving amnesia and conversion symptoms (Van Ommeren et al., 2001), and psychotic depression, although less frequent, may also be related to PTSD. Key elements of the assessment include the level of psychological distress, impairment associated with the symptoms in the patient and his or her family, substance abuse, and suicidality. In children, particularly under age 8, the presence of sleep disturbance, emotional or behavioral problems should alert clinicians to the possibility of PTSD (National Collaborating Centre for Mental Health, & Royal College of Psychiatrists' Research Unit, 2005).

Interviews should be carried out in the presence of professional interpreters if the language ability of the patient is not adequate to express psychological distress and narrate their experience (Moreno & Grodin, 2002; National Collaborating Centre for Mental Health, & Royal College of Psychiatrists' Research Unit, 2005). Disclosing traumatic experience through relatives, family members or, particularly, through children can be traumatic and can discourage the patient from doing so. Efforts should be made to ensure the patient feels safe and understands that the assessment will be kept confidential. Assessment of children should be done directly in a culturally sensitive manner rather than relying solely on information from parents or guardians who may tend to minimize or ignore symptoms.

Treatment Interventions, Recovery, and Resilience

For refugees and others recovering from the impact of trauma and forced migration, intervention involves personal, family, and sociocultural collective dynamics with the aim of restoring a sense of normality by allowing life to go on (social integration) and overcoming the paralysis that terror and grief can cause (symptom reduction) (Nickerson, Bryant, Brooks, et al., 2011; Nickerson, Bryant, Silove, et al., 2011). Although they are affected by many of the same processes, social integration and symptom reduction are not given the same weight in the specific treatment interventions. The chief target of psychotherapy and medication is symptom reduction, and their effectiveness is usually measured in these terms; gains in terms of reduction of impairment and improvement in functioning are often not considered, although their relation to symptoms is not linear (Pynoos et al., 2009). Consideration of patients' own concerns and their social context, however, makes it clear that restoring the continuity of life by facilitating a person and family's social integration into the host country is just as important as symptom reduction.

Trauma-related anxiety disorders (which have been mainly studied in relation to PTSD), depression stemming from multiple losses in an exile setting, and the interaction of the two can be treated through various forms of psychotherapy, psychopharmacology, or alternative therapies including traditional treatments (Hinton, Hoffmann, Pollack, & Otto, 2009). In primary care settings, the recommendation of one type of treatment over another must be based on considerations that include the resources available and the cultural and clinical appropriateness of these resources. Acknowledging at the start that access to specialized therapeutic resources in the host country is limited can safeguard the referring clinician and the patient against unrealistic expectations. Drawing up an inventory of available resources prior to consultation is essential for a realistic treatment plan. In many settings, specialized psychotherapy for refugee trauma or torture-related issues may not be widely available, but committed community workers and primary care professionals can provide excellent therapeutic support and a forum for empathic listening that can provide relief for patients.

Trauma-focused psychotherapy helps reduce the fragmentation of memory caused by trauma by providing the patient with a coherent account. Diverse methods of psychotherapy that elicit a trauma narrative—some emphasizing structure, others the value of openness to what emerges—may be successful and can be chosen to fit the patient's expectations and the clinician's skills. In clinical practice, some patients seem to need to borrow an external structure in order to reconstruct coherence. They may prefer a culturally distant frame of reference, like cognitive behavior therapy (CBT) (Bolton et al., 2007) or narrative exposure therapy (NET) (Neuner et al., 2008), for example, or opt for a more traditional framework that emphasizes the coherence of their experience within the range of representations of their culture of origin (Peltzer, 1997). Other patients will resist such structures because they see them as representing a repetition of the constraints to which they were subjected. They need to talk at length and to be the architects of their life stories. The therapist, provided he or she does not enter into a struggle for control, can help them to avoid the vicious circle of traumatic repetition and to reintroduce key fragments of their past to help them with their posttraumatic reconstruction (Rousseau & Measham, 2007).

Unilateral imposition of either Western expertise (no matter how "cutting edge") or culturally sensitive modalities (no matter how rooted in tradition) may be experienced as coercive if the choice of the individual or family is not taken into account. Creative arts based therapies, such as art therapy, are sometimes preferred by refugee families, in part because these therapies often emphasize nonverbal therapeutic methods, thus helping people who are reluctant to engage in verbal therapy (Rousseau & Guzder, 2008). This reluctance may reflect either cultural attitudes or

the fact that verbal approaches may be seen as being disrespectful of cultural values of emotional containment or restraint. Some clinicians may regard nonverbal therapies as potentially colluding with the avoidance that is part of the psychopathology of PTSD. But avoidance is not uniformly harmful, nor is it always a sign of psychopathology. While psychotherapists in the West (and popular culture) may favor more direct working-through of trauma, focusing therapeutic work explicitly on trauma, other cultural traditions prefer to work "around" trauma, institutionalizing avoidance as a collective strategy. At one end of the spectrum stands the culture of Jewish Holocaust survivors, in which collective pressure to remember has resulted in a "duty of memory", and at the other end are cultural strategies like those adopted by Cambodian survivors of Pol Pot, who seek to set aside the past in order to move on (Kidron, 2012). The duty of memory serves collective goals of communal solidarity, moral pedagogy, and even nation building, but it is not always associated with individual healing (Semprun, 1994). The preferred strategy in some cultures is to avoid direct individual or collective references to specific trauma and instead emphasize survival and continuity through a peoples' ability to overcome adversity (Rousseau, de la Aldea, Viger Rojas, & Foxen, 2005).

In addition to emotional problems, refugees who have experienced trauma may display other stress-related symptoms, which may be very impairing (Ehntholt & Yule, 2006; Kinzie, 2007). Sleep is often a major problem for PTSD patients; nightmares being one of the most frequent and disabling symptoms. NICE recommends the short-term use of hypnotic medication for adults or, if longer-term treatment is required, the use of suitable antidepressants to reduce the risk of dependence. Trials of cognitive behavioral treatments of nightmares have very promising results, and although they have not been tested in refugee and immigrant patients, their mode of action (cognitive restructuring and replacing negative by positive appraisals) may fit well with the ways in which certain cultures normalize nightmares rather than considering them symptoms per se. Medically unexplained symptoms and various forms of chronic pain also warrant attention. The Rehabilitation and Research Centre for Torture Victims in Copenhagen (Sjölund, 2007) has produced a very useful manual to help practitioners address these symptoms which need to be taken seriously even if they are not related to clear organic pathology.

Case Vignette 12-2

Begum was a 30-year-old Bangladeshi Muslim mother who had fled her country after repeated domestic violence. After she had attempted to leave her husband, he abducted her from her family, vandalized her parent's home, and assaulted them. With the help of her parents, she left Bangladesh with her 4-year-old son. En route to Canada, she was detained in New York by the agents who had arranged her passage with her parents. She was taken to an apartment with other refugees and raped before being returned to the airport.

She applied for refugee status in Canada, but was too ashamed to recount her rape en route and the history of rape within her marriage. The refugee board rejected her claim because her testimony differed from her initial written claim, and she had dissociated during the hearing when attempting to recount her traumatic journey. Her appeal process continued for 6 years. During much of this time, she was suicidal and depressed, at times threatening to kill both her children as she felt unsafe to return to Bangladesh where her husband continued to be involved in antisocial gang activities. She was particularly terrified that she might be returned to New York, which triggered re-experiencing of her rape and helplessness. Both of her parents died in Bangladesh during this period and this further complicated her adaptation. Her depression undermined her parenting capacity and her children also suffered from depression.

(continued)

The role of the CCS consultant was to advise her primary care clinicians on the management of Begum's complicated grief, PTSD, her threats of suicide and infanticide, as well as the depression of her children during the protracted period of her unresolved status. Initially, she had been assessed by a male Euro-Canadian psychiatrist and refused to speak because cultural and gender differences precluded a sense of cultural safety. Her primary care team, comprised of a female general practitioner and social worker, worked with interpreters, her children's school, the Department of Youth Protection, and other resources to stabilize her functioning. Her functioning improved significantly after her refugee status was confirmed, but her children remained fragile and continued to have significant mental health problems.

Writing Reports for the Determination of Refugee Status

During the refugee status determination process, claimants must explain the events that have led them to seek refugee status. When they first claim refugee status at the port of entry, they will be questioned by immigration officials, primarily about identity and security issues. Under new Canadian legislation that came into force in December 2012 (PCISA, 2012), refugee claimants must complete and submit a detailed written Basis of Claim form explaining the reasons for their claim to the IRB within 15 days of arrival. Later, they will give an in-depth oral account of the events underlying their claim at a hearing before the IRB, which then determines whether the claimant meets the legal criteria for recognition as a refugee. The new law provides that most claimants will (for the first time in Canada) have access to a full appeal on the merits before the Refugee Appeal Division (RAD) of the IRB. The RAD appeal is generally based solely on the transcript and other documentary evidence already on file, so the claimant will not testify anew at this stage.

In general, the refugee claimant is the only witness; everything hinges on the believability of the claimant's testimony, as there are generally no witnesses to corroborate her account and little documentary evidence beyond general information on country conditions. Credibility assessment is largely based on the coherence, consistency, level of detail, and plausibility of the claimant's account (Herlihy, Scragg, & Turner, 2002; Steel, Frommer, et al., 2004). In addition, Board members are inevitably influenced by factors such as the claimant's demeanor, nonverbal signals, and expressed emotions as well as their own emotional response to the claimant's story (Macklin, 1998; Rousseau, Crépeau, Foxen, & Houle, 2002). Consistency is of paramount importance, and discrepancies between the claimant's testimony before the Board and previous oral or written accounts tend to be viewed with suspicion. Claimants are generally expected to give a reasonably coherent, linear account of their traumatic experiences, including precise dates and locations.

Consultants may be requested by the patient, a lawyer or other health care practitioners, to provide a written report on the refugee claimant's mental health and capacity to take part in the IRB hearing. When preparing this report, there are two essential questions to consider: (1) What are the precise issues of concern to the decision-maker who will read the report? and (2) What aspects of the refugee claimant's psychological state are relevant to these issues?

As already mentioned, refugee claimants must prove three main elements in order to be accepted as refugees. First, that if sent back to their country of origin, they would be in danger of severe mistreatment linked to one of the grounds mentioned in the refugee definition (ethnicity, religion, gender, sexual orientation, political opinions, risk of torture, etc.). Although in theory all that is necessary is to prove that the person would be at risk of persecution if returned to their country (future risk), in practice this almost

always implies showing that they have already suffered persecution in their home country for one of these reasons and would still be in danger if sent back. Second, refugee claimants must show that they made reasonable efforts to obtain protection in their own country, but that their government was unwilling or unable to protect them. If the government is directly responsible for the persecution (e.g., ethnic minority civilians targeted by government troops during a civil war), state protection is clearly unavailable. In other cases, the refugee claimant will have to show that he made diligent but unsuccessful efforts to seek protection from local authorities, or that he had serious reasons not to seek protection (e.g. in his country, police officers consistently beat up or ignore gay men who try to make a complaint). Finally, the refugee claimant must prove that she would still have been at risk if she had moved to a different region within her country.

These criteria are specific to refugee claim proceedings. If the report is submitted in the context of a different type of procedure, the issues to be addressed will be different. For example, in Canada a failed refugee claimant can apply for permanent residence based on humanitarian and compassionate grounds (H&C application) if she can demonstrate that her deportation would be contrary the best interests of her children or severely detrimental to her own physical or mental health. She must also show that she is well integrated into Canadian society (e.g., employed, studying or involved in volunteer work, reasonably fluent in one of the official languages). All these issues are largely irrelevant in the context of a refugee claim. The content of the report therefore will differ depending on the nature of the proceeding and the specific factors to be considered by the decision-maker. As already mentioned, only reports in the context of refugee claim proceedings will be discussed because the grounds for humanitarian applications differ considerably from one country to another, whereas the criteria for successful refugee claims are relatively uniform throughout the 145 countries that have ratified the United Nations 1951 Convention and 1967 Protocol Relating to the Status of Refugees (UNHCR, 2010).

The following comments on writing expert reports apply in cases in which the consultant has no serious reasons to suspect that the claimant is malingering or fabricating her story. When the consultant feels uneasy about writing a report, the consultant would share with the refugee claimant that the report may not be helpful to his or her case.

In the context of refugee claim proceedings, there are four main issues that mental health professionals may potentially need to address: (1) whether the person's symptoms and clinical presentation are consistent with the alleged traumatic events on which the refugee claim is based; (2) whether certain apparently unreasonable or surprising behaviors might be linked to the person's psychological difficulties. For example, shame, disempowerment, and fear of authority figures might help explain why a woman in an abusive relationship failed to seek protection from local police and later failed to tell immigration officers about the abuse; (3) whether being sent back to her country might be a threat to her life or psychological integrity (e.g., risk of decompensation or suicide); and finally, (4) whether the person's ability to adequately present their case may be diminished due to cognitive, psychological, or emotional difficulties. Such difficulties may affect the person's ability to tell her story coherently, to describe certain particularly traumatic events, to attend a hearing on a particular date, or even to understand the proceedings (Herlihy et al., 2002; Prabhu & Baranoski, 2012; Rousseau et al., 2002; Steel, Frommer, et al., 2004).

In writing the report, it is important to try to make the person come alive as a unique individual for the reader. Board members see dozens of reports from mental health professionals, most of which state that the person suffers from PTSD. Of course, this is because refugee claims are usually based on traumatic events, so PTSD is not only frequent among refugee claimants, but is also the diagnosis that is most likely to be relevant to the issue at stake, namely, whether the refugee claimant's story of traumatic persecution is credible. Unfortunately, the ubiquity of PTSD in reports submitted in support of refugee claims tends to generate the impression that the diagnosis

Table 12.2 Outline of the mental health consultant report for refugee determination

The report should generally be about 2–4 pages long and include the following information:
• Professional qualifications
• Context of consultation and nature of relationship (assessment requested by a lawyer, progress report of an ongoing therapy)
• Method of assessment
• Clinically relevant elements of the refugee claimant's story
• Clinical signs and symptoms
• Diagnosis
• Potential limitations to the person's ability to adequately present their case
• Recommendations

is overused. This impression is strengthened if, as sometimes happens, the report is simply a generic list of symptoms such as insomnia, nightmares, and loss of appetite followed by a diagnosis of PTSD, based on a single assessment interview. In this context it is all the more essential to provide a clearly individualized report.

Table 12.2 outlines the key elements of the report. The overall tone of the report should be professional and objective while conveying the suffering experienced by the patient. To be credible, it is important to speak as a professional, not as an advocate (e.g., not to write "I urge you to accept Mr. X's refugee claim"). The report should focus on issues relevant to refugee status, particularly the symptoms consistent with acts of persecution that would entitle the person to protection as a refugee. It should be presented in terms that an educated layperson will readily understand. Technical jargon may be misunderstood by the decision-maker and should be avoided except when precise technical terms are essential, such as for the diagnosis, in which case the term should be briefly explained. For example, instead of "negative affect", it is preferable to use terms such as "negative emotions" or, better yet, more vivid and specific terms such as anger, sadness, or tears.

Professional Qualifications

In legal proceedings such as the refugee claim process, opinions are generally not admissible. The sole exception to this rule is opinions expressed by qualified experts, and only to the extent that the opinion is within their field of expertise (Paciocco & Stuesser, 2008; R. v. Lavallee, 1990). Consultants' opinion will not be taken into consideration unless they establish their expertise, primarily by listing their professional title (e.g., licensed psychologist) and relevant degrees. To further establish expertise, the consultant can mention relevant experience with certain populations or disorders (e.g., experience with refugees or trauma survivors), institutional affiliation (e.g., cultural consultation service, multidisciplinary treatment team), academic position, publications, and so on.

Context of Consultation and Nature of Relationship

Indicate whether the report is based on a one-off assessment requested by a lawyer or on an ongoing therapeutic relationship. If requested by a lawyer, the report may mention the specific questions that were posed. Otherwise, simply describe the person's reasons for consultation and whether she was referred by a colleague. If the consultation was requested because of physical or mental health problems, rather than simply because of an upcoming hearing, this is worth mentioning because it may contribute to making the patient's health problems credible.

Method of Assessment

Indicate the time frame, number, and length of assessment interviews or therapy sessions. Reports based on several assessment interviews or on a reasonably long-term therapy process are more credible than those based on a single brief

interview, so it is important to emphasize that time was taken to do a full assessment if such is the case. If tests were used, briefly describe their purpose and validity, the results, and the interpretation.

Clinically Relevant Elements of the Refugee Claimant's Story

References to the refugee claimant's story should be limited to essentials, including only elements that are both relevant to the refugee claim and indispensable to explain the clinical assessment of the person's psychological state. In particular, keep details such as date, time, and place to the absolute minimum needed to make the account comprehensible. This is vitally important, for three main reasons. First, the more narrative details included, the higher the risk of contradictions between the report and the refugee claimant's testimony at the IRB hearing. At the hearing, claimants are under a tremendous amount of stress and may easily get confused about certain aspects of their story, particularly dates or names. Memories will be less reliable with the passage of time. The consultant may also have misunderstood certain details, such as the name of a town or a paramilitary group. During the interview, the claimant may describe a person as her brother and later call him a cousin during the IRB hearing. Including such details increases the risk of inconsistencies that may harm the claimant's credibility. Consulting the refugee claimant's Basis of Claim narrative before writing your report may be helpful to minimize inconsistencies, although this type of detail should in any case be limited to the strictly essential.

The second reason for keeping the summary of the claimant's story to a minimum is that the consultant usually has no personal knowledge of the facts that the claimant recounts and no means to check their veracity. In any case, this fact checking is not the consultant's job. Eliciting a detailed account of the facts on which the claim is based and assessing the refugee claimant's credibility is at the heart of the IRB's jurisdiction and will be the main focus of the hearing. For the same reason, it is also crucial to always use expressions like "Mr. Y reported" or "Ms. Z said" rather than stating that an event actually occurred.

Finally, if the diagnosis appears to be based primarily on the claimant's story, and the Board does not believe the claimant, then the report is likely to be ignored. Board members frequently use this rationale to justify ignoring a clinical report: "The report was based on the refugee claimant's account, and I don't believe the refugee claimant, therefore I do not need to take the report into account." On the other hand, if the report is primarily based on specific clinical signs and symptoms, especially the consultant's own observations, it is much harder to set aside.

In the context of a therapeutic relationship, claimants may sometimes reveal important facts that they had not previously disclosed to immigration authorities or to their lawyer (e.g., sexual assault). When a claimant adds new details to her story at an advanced stage of the proceedings, there is a risk that the Board may suspect that the claimant is embellishing or making up facts to try to strengthen her claim. At the least, the claimant will need to explain the reasons for the late disclosure. Ideally, it is preferable to ask the lawyer whether the newly disclosed fact should be mentioned in the report. If the fact has little relevance to the claim, it may be as well not to include it. If, on the other hand, it is highly relevant, it is important to mention it and explain the reasons that the person did not disclose earlier (e.g., shame, fear) and did disclose to the consultant (e.g., having developed a relationship of trust). Simply stating that "rape victims often feel ashamed," for example, may not be sufficient. Board members will undoubtedly have heard such explanations before, as refugee claims are almost always based on acts of interpersonal violence.

Childhood trauma or other painful events unrelated to the refugee claim should usually be left out of the report. No matter how much a person may have suffered during their lives, this does not entitle them to refugee status unless the events fall within the scope of the legal refugee definition. On the other hand, for example, it could be relevant to mention that a woman had been a victim of incest as a child if this helps to explain why

she stayed in an abusive relationship or was too ashamed to report spousal violence. More generally, psychological problems may have affected the person's ability to seek state protection or to relocate within the country of origin.

Clinical Signs and Symptoms

A description of the relevant clinical signs and symptoms is at the heart of the consultant's expertise. Reports based solely on self-reported symptoms may be seen as less persuasive because of the perception that claimants could be making them up. It is therefore important to explain the congruence between the symptoms reported by the claimant and the signs that you personally observed, and how the overall presentation is clinically plausible. Clinical signs are particularly important because they are directly observed by the clinician and cannot be entirely disregarded by the Board even if it does not believe the claimant. Potentially relevant clinical signs include: psychomotor slowing or similar physical signs consistent with depression; inability to stay focused or to tell the story coherently because of emotional distress or problems with memory or concentration; and nonverbal expressions of emotions such as tears, choked voice, shaking, tension, agitation, and tone of voice. Linking nonverbal emotional expression to trauma may make it more credible (e.g., "As he described seeing his father being killed, tears ran down his face").

Similarly, in describing the symptoms reported by the claimant, particular attention should be paid to symptoms consistent with the alleged traumatic antecedents. This may include intrusive thoughts or images, ruminations, recurrent themes in nightmares, situations that trigger strong emotions or avoidance, suicidal ideation, and so on. A brief quote from the claimant that illustrates her pain about past trauma, current suffering, or fear of future harm may be useful to include. In the context of a hearing, the claimant may not be able to express her feelings in a way that is as vivid or personal as in a clinical setting. In any case, refugee claim hearings tend to focus more on claimants' objective actions and cognitions than on their inner world, so the consultant's report may be an occasion to highlight dimensions of the claimant's subjective experience that are relevant to the refugee claim but might not otherwise be mentioned. For example, recurrent nightmares of men hammering on the door would be highly relevant if the claim centers on an incident of arbitrary arrest and imprisonment, yet this is unlikely to come up at the hearing unless included in the report.

Faced with the difficult task of assessing a claimant's credibility, Board members often look for specific details that "ring true." For example, a young man from a persecuted religious minority recounted how, hidden in his parents' house, he had listened helplessly to his mother being insulted and threatened by police who were looking for him. In a choked voice, he reported being tormented by persistent feelings of shame at having exposed his mother to danger and having failed his duty as a man and a son to protect her. This type of snapshot of vivid, emotionally charged memories may contribute to the credibility of the claimant's account, especially when they involve feelings that most people can readily identify with.

Mentioning that the claimant is afraid of being repatriated is relevant, as this is one of the elements that must be established for the claim to be successful. However, it is rarely useful to expand on the hardships such a return may involve for the claimant and her family (e.g., disrupting children's schooling) because this has no bearing on the merit of the refugee claim, although the same information would be highly relevant to an application based on humanitarian and compassionate grounds. On the other hand, the heightened vulnerability of psychologically disturbed persons may be a relevant factor when assessing the risks they would face if returned to their country of origin. For example, a Roma woman who had suffered for years from severe depression, anxiety, and agoraphobia following an attack by skinheads was found to have compelling reasons not to return to Hungary, although the Board judged that the risks that she would face there would not amount to persecution for a less psychologically fragile person (ReX, 2008). Similarly, the claim

of an Ethiopian refugee claimant with bipolar disorder and a history of suicide attempts was accepted on the grounds that the severe stigmatization and discrimination that she would experience in Ethiopia because of her mental illness amounted to persecution likely to lead to suicide (Re X, 2007). More generally, if there are serious reasons to believe that forced repatriation is likely to cause clinical decompensation, a suicide attempt or other consequences that could put the claimant's life at risk, this should be explained.

Generally, it is important to indicate whether the clinical presentation is consistent with the alleged trauma. However, never write that the claimant's symptoms are *caused* by the traumatic events, but rather that they are *consistent* with the alleged events. Causality is impossible to prove, and in any case the consultant has no personal knowledge whether the alleged events actually occurred.

Diagnosis

When posing the diagnosis (or clinical impressions), it may be useful to very briefly summarize the main factors on which the diagnosis is based that are set out in greater detail elsewhere in the report.

Potential Limitations to the Person's Ability to Adequately Present Their Case

Refugee status hearings are extremely stressful for claimants because the outcome will determine whether they will obtain secure, permanent status and the chance to build a new life in a safe country, or be forcibly sent back to a country where they may face grave danger. To establish that their claim is well founded, refugee claimants have to describe, sometimes in considerable detail, the traumatic experiences that form the basis of their claim. They may face close, sometimes confrontational, questioning, and their credibility may be challenged. Many claimants are particularly psychologically vulnerable because of the multiple hardships they have endured.

If the claimant may be unable to adequately present her case before the IRB because of cognitive, psychological, or emotional difficulties, this should be explained in the report. However, although the consultant may recommend that the Board be particularly sensitive when questioning the claimant about certain topics, the claimant generally will have no choice but to testify about the traumatic events on which her claim is based in order to prove that it is well founded.

The IRB has adopted the Guideline on Procedures with Respect to Vulnerable Persons Appearing Before the Immigration and Refugee Board of Canada (Guideline 8) to encourage decision-makers to make procedural accommodations if required to ensure that vulnerable refugee claimants are not disadvantaged in the presentation of their case (Cleveland, 2008; Immigration and Refugee Board of Canada, 2006). The focus is more on ensuring fairness than on minimizing distress, although decision-makers are also encouraged to "prevent vulnerable persons from becoming traumatized or re-traumatized" by IRB proceedings. Procedural accommodations include expediting or postponing a hearing, allowing the presence of a support person, keeping questions about certain particularly painful areas to a minimum, and so on.

Some claimants may have cognitive or psychological problems that impair their ability to understand the nature of the proceedings, such as an intellectual handicap, dementia, traumatic brain injury, or certain psychotic conditions. In such cases, the Board will appoint a designated representative who will find a lawyer and provide support to the claimant during the proceedings. Designated representatives are also automatically appointed to assist unaccompanied minors.

Other claimants may have difficulty telling their story coherently and convincingly due to psychological difficulties, sometimes compounded by sociocultural factors such as illiteracy, language difficulties, or traditional gender roles (Cleveland, 2008; Herlihy et al., 2002; Prabhu & Baranoski, 2012; Rousseau et al., 2002; Steel, Frommer, et al., 2004). The consequences can be extremely grave; if the Board member does not believe the claimant's story, the claim will be rejected. Board members often rely

on narrative characteristics such as coherence, consistency, and emotional congruence to assess credibility, yet these same characteristics may be detrimentally affected by psychological or emotional problems. Therefore, if there are serious reasons to believe that a claimant may have difficulty presenting her case, it is important to mention this in the report and to explain the basis for these difficulties. Board members are generally aware that psychological problems may negatively impact claimants' ability to testify. The issue is to establish why this particular person is especially likely to have difficulties. This should be based on observations during the consultation (e.g., confusion, incoherence, numbing, intense emotions, dissociation), the clinical history, and psychological state. Behavior that the consultant has personally observed may be very persuasive; for example, claimants who are distressed to the point of incoherence when describing certain events systematically avoid certain topics, or display frequent or severe attention or concentration problems. However, the consultant should avoid making specific statements about how the patient will behave at the IRB hearing because it is difficult to predict how claimants will respond in this high-stress context. Some claimants may be very emotional, others may freeze, while still others may marshal all their inner resources and be very functional.

Board members' assessment of a claimant's credibility is likely to be influenced by the degree of congruence between the emotions expressed by the claimant and the content of her narrative. If the claimant displays flat affect, numbing, or excessive detachment, therefore, it is particularly important to explain that this may be a largely involuntary coping mechanism to ward off unbearable emotional pain. Lack of apparent emotion due to avoidance, dissociation, depression, or rigid self-control may easily be mistaken for untruthfulness.

Recommendations

If the claimant's ability to understand the IRB proceedings is impaired, recommend that a designated representative be appointed. If the claimant may have serious difficulty telling her story at the hearing, the consultant can recommend procedural accommodations such as expediting or postponing the hearing, minimizing questions about certain traumatic events, and so on. It is preferable to check with the claimant's lawyer before finalizing such recommendations to make certain that they are feasible and likely to be helpful.

To illustrate writing an effective report, Box 12.1 presents examples of incorrect and correct styles.

Box 12.1: Examples of Refugee Claimant Report Writing

Example A: INCORRECT
X was raped on September 3, 2010 in her home in YZ. The rape was perpetrated by M21 paramilitaries who were targeting her husband for his political opposition to the ruling regime. Five men, armed with rifles, broke into her house around 1:30 AM, while she and her husband were asleep. One man guarded the door, while two men dragged her husband to another room, tied him up, and hit him with the butt of a gun. The other two men forced X to undress and then one of them raped her.

X presents with primarily flat affect, although she briefly displays aversive negative arousal. She is currently suffering from insomnia, nightmares, anxiety, and feelings of hopelessness caused by her rape.

Example B: CORRECT
X initially appears tense and somewhat withdrawn. She reports having been raped in 2010 when several men broke into her home at night, apparently targeting her husband for his political opposition to the ruling regime. She first recounts the incident in a detached tone with little visible emotion. However, when she describes being rejected by her husband following the rape, she breaks down and weeps uncontrollably. She says "I have told my story so many times, I am tired of crying. I don't want to cry any more," but remains tearful for much of the rest of the interview.

(continued)

Box 12.1 (continued)
X reports that she sleeps very poorly. She often imagines men breaking into her room and becomes terrified, and cannot sleep at all without having a light on. She also reports frequent nightmares with themes of intrusion (e.g., men breaking down her door) and helplessness (e.g., being unable to flee). X says that at times when she is walking on the street and notices a man walking behind her, she panics and speeds up, fearing attack. She is particularly afraid of men who show signs of drunkenness because this reminds her of her rapist. According to X, all these symptoms (sleep problems, nightmares, fear of men) started after the rape. When asked how she sees her future, she replies in a despairing tone "The future is dark, it is like the past." Yet, she also expresses hope that she will find safety, saying that she has come to Canada because women are protected here.

There are several problems with Example A. There is far too much factual detail about the alleged rape, increasing the risk of inconsistencies between the report and the claimant's testimony at the hearing, which could seriously harm her credibility. Claimants may easily misremember details such as the date, time, sequence of events, precise identity, and even the number of attackers, either when recounting the story to you or to the Board. On the other hand, there is too little detail about clinical observations—the emotions, signs, and reported symptoms that are within the clinician's field of expertise and contribute to making this woman's story come alive. The clinical part of the report is generic and contains jargon terms such as "flat affect" and "aversive arousal" that may be meaningless to the Board member. Events are described as if the clinician could attest that they actually occurred, and the alleged rape is presented as the cause of the woman's symptoms. Example B avoids these errors, presenting a much more individualized picture that weaves together the claimant's symptoms, emotional presentation, and the core traumatic event.

Conclusion

Cultural consultation for refugees is challenging because clinicians must often go beyond their usual clinical role and take a position of advocacy that actively acknowledges and engages with the predicament of forced migration. Caring for refugees and their families involves medical and mental health interventions to mitigate the consequences of past violence and loss as well as current adversities. At the same time, consultants need to take on the role of advocate to contribute to illness prevention and mental health promotion by addressing the social determinants of health which include precarious migratory status, harsh practices of detention, prolonged uncertainty about the future, and obstacles to family reunification. Many of these issues are important for the long-term well-being and social integration of all refugees, including those who are not symptomatic or who do not request services.

Recent years have seen increasing ambivalence in most high-income countries toward refugees and refugee claimants, with considerable erosion of the international commitment to providing safe haven for the most vulnerable human beings. Clinicians who try to address these issues may be criticized by some individuals or institutions as taking an ideological position. Guidelines for medical training in Canada recognize that clinicians must be able to play the role of advocate both to provide care and work toward prevent and health promotion (Kirmayer, Fung, et al., 2012). In refugee health, there is simply no way to avoid the complex issues at the intersection of human rights, ethics, and politics.

In caring for refugee claimants, clinicians typically focus on helping the person to heal from past traumatic experiences and deal with the challenges of resettlement and adaptation to the host society. Helping to change the external circumstances that negatively impact the client has not traditionally been seen as an integral part of the mental health practitioner's role. Yet, the ongoing threat of possible deportation and a variety of other real-life stressors play a major role in maintaining and exacerbating psychological

problems among refugee claimants and other migrants without secure status. Providing a report or letter concerning their mental or physical health in the context of the refugee claim process is only one of the ways in which clinicians can play a key role in improving the health of people who are seeking refugee status. In order to prevent further harm, health professionals also need to join forces in order to advocate for protection of refugees and their access to the same rights and services as Canadian citizens.

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