TRAUMA & IMMIGRATION LAW

JOE VAIL CONFERENCE
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PRIVATE PRACTICE: PSYCHOTHERAPY
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‘It Is Just Too Much To Feel’

- Anything that is too much for the person to manage emotionally
- One experience may be overwhelming to one person but not to another
- Common traumatic experiences include but are not limited to:
  - Sexual/physical abuse
  - Rape
  - Neglect
  - Being overly criticized or blamed
  - Witness to abuse
  - Torture/imprisonment
  - Poverty/hunger
  - War
  - Early loss of a parent
  - Loss of a child or sibling
  - Being overly-controlled/Monitored
  - Disability or chronic illness of parent/sibling
  - Chronic/Terminal illness
  - Accidents: auto, manufacturing, etc.
  - Natural disasters
  - Political terrorism
TRAUMATIC HISTORIES DO NOT ALWAYS SHOW
They Often Hide Behind Other Problems:

- Eating Disorders
- Mood Swings
- Staring off into space
- Chronic body problems with: pain, reproductive problems, asthma,
- Obsessive thoughts
- Sexual compulsion, affairs, seeking prostitutes

Repeated bad relationships
Disrupted sleep/waking cycles
Self-destructive behaviors

Nightmares
Regressive behavior
Disorientation
Depression
Substance abuse
Panic, anxiety, & constant worry
Hearing Voices

Inability to concentrate or organizing thoughts
Migraines, Excessive doctor visits
IT IS NOT

“WHAT IS WRONG WITH THEM”

IT IS

“WHAT HAPPENED TO THEM”
Diagnostic Categories
Associated With Trauma

- Post Traumatic Stress Disorder
- Major Depression
- Dissociative Disorders
- Bipolar Disorder
- Anxiety Disorders
- Phobias
- Substance Abuse and other Compulsive Behaviors
- Eating Disorders
- Somatization Disorders
- Personality Disorders
Depression

• 48% of men and 49% of women with lifetime history of PTSD also had a lifetime history of major depression (vs. 12% men and 19% of women without PTSD).

• A lifetime history of PTSD was associated with a 21% and 23% rate of dysthymia for men and women (vs. 4% and 7% for men & women without PTSD)

• Breslau, et al (1998) found 37% of young adults with a history of PTSD also had a history of major depression (compared to 11% of those without a PTSD history)

• Women are more at higher risk for PTSD
Co-morbidity cont:

Longitudinal data on Depression and PTSD Co-Morbidity

I. Shalev, et al. (l998)
   - Studied persons admitted for hospital treatment due to traumatic injury
   - Found major depression in over 40% of those with PTSD at one month, and again at four months after injury.
   - The combination of PTSD and depression at one month predicted PTSD at four months, better than either PTSD or depression alone

II. Blanchard, et al. (l998)
   - Concluded that a co-syndrome model better fits the data better than a one syndrome model.

Both groups conclude that the combination of PTSD and depression predicted higher stress, poorer role function, higher likelihood of PTSD at 6 months after initial assessment
The biology of PTSD and depression overlap:

- Both involve increased corticotrophin-releasing factor (CRF) activity

- Both entail deregulation of the stress-response systems:
  1) Hypothalamic CRF plays a major role in HPA axis activity in the brain by stimulating release of ACTH from the pituitary.
  2) ACTH release stimulates the release of cortisol from the adrenal cortex.

Brain Chemistry Related To Trauma
Feelings And Behaviors

CHRONIC STIMULATION CHANGES THE BRAIN

Shrinks the hippocampus (memory storage and consolidation)
Shrinks portions of the amygdala
Orbitofrontal cortex shrinks in traumatized children
Some shrinkage of the corpus callosum (bridge between two sides of the brain)

Serotonin = Despair
Cortisol = Avoidant Behavior

Norepinephrine stimulates FIGHT FLIGHT FEAR
Norepinephrine = Motivation
AND
Startle Responses
Nightmares
Explosive Outbursts
PTSD Symptom Clusters

RE-EXPERIENCING
- Intrusive thoughts/memories
- Ruminating about the past
- Intrusive images, sounds, smells
- Repetitive patterns of thinking of self
- Repetitive patterns of relating to others
- Being or feeling hurt by others
- Sense that life never gets better
- Avoidance
- Clinging
- Fighting

NUMBING
- Restricting activities to avoid memories
- Dissociation from feelings
- Lack of empathy
- Being shut down
- Distant from others
- Loss of interest in life
- Depression
- Unresponsiveness
- Withholding

HYPERAROUSAL
- Anger outbursts
- Crying spells
- Over reactivity
- Irritability and agitation
- Emotional impulsiveness
- Wanting to fight
- Feeling out of control
- Being controlling of self or others
- Worried all the time
- Not sleeping
Bereavement As a Stressor

REFUGEES & ASYLLEES ARE BEREAVED

- Joylessness and sadness come from irreplaceable loss
- Accompanying this may be anxiety, anger, guilt, fatigue, mood changes, somatic complaints, and changes in vegetative habits
- Bereavement is intensified by fears of abandonment, an inability to escape and feelings of hopelessness and helplessness.
- Aggravated by secondary losses with dislocation, loss of safety and security
- Intensive grief of over 6 months increases likelihood of pathology
- Manifested by behavioral changes
- Grief management tools may include anti-depressants, sleep sedatives, nutrition, hydration, self-care, exercise, and sleep
- Repeated listening to the story of loss may be necessary
- Help the person normalize and understand what grief is and what to expect
THE RIGHT MEDICATION HELPS

- Reduces nightmares and flashbacks
- Calms the body down and reduces anxiety
- Improves impulse control
- Decreases depression
- Reduces confusion and dissociation
- Reduce anger and aggression
- Improves ability to be with people
- Improves sleep

• Recommendations for medication must be made in context of culture
• Recommendations are often understood better when “the doctor” prescribes rather than the non-MD and can be done in primary care setting
• Instructions for the use of medication in refugee and immigrant populations must be made very clear
• Issues of consistency, termination of meds, etc. are often confusing and difficult to understand.
Memory

Types of Memory

EXPLICIT/CONSCIOUS DECLARATIVE MEMORY
To remember is to be conscious of some past experience, and to be able to language it into a story.

IMPLICIT NON-DECLARATIVE MEMORY
Memories of threatening situations, created through “fear conditioning” because of association with pain, terror, and/or fear of death.

Implicit Non Declarative Memory does not depend on conscious awareness and the stimulus does not have to be consciously perceived in order to elicit the conditioned emotional responses. (LeDoux, 1998)
I. **Cortical**
- The Cortex is associated with human consciousness
- Establishes declarative memory and stores details of events as facts
- Hippocampus is locus of declarative memory
- Chronic stress decreases the volume of the hippocampus thus inhibiting declarative memory

II. **Amygdala**
- Brain structure next to the Hippocampus
- Locus of non-declarative emotional memory
- Traumatic and dangerous situations, those that evoke fear, encoded in the amygdale
- Emotional memory encodes unconscious emotional associations and experiences that impact both behavior and retrieval
- Amygdala traumatic memory can continue to replay

**Refugees and asylees have problems with recalling accurate memories**
1. Continuously/clearly remembered with corroboration
2. Delayed/fragmentary memory with corroboration
3. Continuously/clearly remembered without corroboration
4. Delayed/fragmentary memory without corroboration
5. Exaggerated/distorted memory
6. False memory – patient constructed
7. False memory – therapist/outsider suggested
The Trauma Triangle

Victim

Perpetrator

Witness/Rescuer
International Trauma with Migration Complicates the Trauma Response:

Mass Violence and Humanitarian Crises Disrupts Human Beings’ Needs For:

- Effective social & political vehicles to provide and maintain justice
- The ability to perform one’s role in the family and community
- Freedom to create meaning in life via religion, politics and culture
- Safety and Security

Social/Familial Connections
Traumatic Brain Injury/Head Trauma (TBI)

Traumatic brain injury/head trauma is common in refugees, victims of torture and domestic Violence

- TBI dramatically increases risk for both PTSD and Depression

- Often do not exhibit gross neurological signs

- PTSD and Depression symptoms may cloud the underlying disruption of brain systems

- TBI symptoms can persist for years

- Most frequent symptoms include
  - headaches
  - dizziness
  - problems with concentration and memory

- At increased risk for slow mental processing speed and impairments in attention and executive functions such as multi-tasking, dividing or sustaining attention, maintaining motivational tone and engagement in environment

- Behaviors such as apathy, impulse problems, distractibility, poorly regulated emotions, increased irritability and behavioral outbursts are also associated with TBI
PTSD (also anxiety and depression) are the most common mental disorders identified across cultures with prevalence rates between 9 and 37% (Prevalence varies by latency of time and severity of trauma)

- Post conflict populations rates of PTSD ranging from 16 to 37%, but significantly higher in torture survivors (DeJong et al., 2001).

- Refugee Tibetan nuns: Survivors had higher rates of anxiety (54% vs. 29%) but not depression. (Holtz, 1998)

- Torture predicted significantly more PTSD, Anxiety and depression in 526 Bhutanese torture survivors in refugee camp (Shrestha et al, 1998)

- Bhutanese torture survivors had more PTSD, somatoform pain, and dissociative disorders and more lifetime affective and generalized anxiety disorders. (Van Ommeren, et al)

- Heightened arousal and avoidance of cues, sleep disturbances, hyper arousal, hyper vigilance and startle also meet criteria of Acute Stress Disorder as well as PTSD

- Life threat is associated with risk of PTSD but traumatic loss of close family specifically linked to complicated grief and depression (Momartin et al, 2003)
Why do we say: “chronic and complex?”

• Single-blow trauma (Terr, 1991) usually has an easily recognizable source, a typical social context in which it occurs, a socially sanctioned expectation of disability and recovery after injury, and an interpersonally coherent context (it makes sense that the person feels traumatized).

• People relate to this: they make sense of how a person feels if they hear about one incident.
Chronic and Complex Trauma

• Victims of chronic trauma: domestic violence, survivors of incest are deprived of a supportive social context in which they can recover. The severity of symptoms are cumulative: the more that happens the worse the outcome in most cases.

• The central role of shame and the production of affective numbness and flooding associated with chronic abuse, regularly leaves people unable to advocate for themselves (I am bad), unable to stay away from additional abusive settings ("dissociative ‘sitting duck’"), and unable to extricate themselves from ongoing abuse until life provides an opportunity: death of an abuser, leaving home to go to college, marriage, running away from home, etc.

• The accumulation of problems and difficulties creates both a chronic and complex interpersonal scene.
The Role of Gender

- UNHCR (2002) women are disproportionately affected by physical and sexual violence and unequal access to asylum across the globe.

- Women have increased susceptibility to:
  - Rape
  - Prostitution,
  - Forced marriage
  - Physical abuse
  - Exclusion from education
  - Domestic violence

- There is a complex interrelationship between health and social, political, cultural and economic situations of women.

- Women have lifetime prevalence of PTSD twice as high as men.

- Women exposed to a given trauma are four times as likely to develop PTSD (ISTSS, 2000)

- Gender differences is reported to increase if the trauma exposure occurred in childhood (Blehar et al, 2002)
DOMESTIC VIOLENCE HOMICIDE RISK
THE TOP FIVE RISK FACTORS

• 1. HAS THE ABUSER EVER USED, OR THREATENED TO USE A GUN, KNIFE, OR OTHER WEAPON AGAINST THE VICTIM?

• 2. EVER THREATENED TO KILL OR INJURE THE VICTIM?

• 3. EVER TRIED TO STRANGLE (CHOKE) THE VICTIM?

• 4. IS ABUSER VIOLENTLY OR CONSTANTLY JEALOUS?

• 5. HAS THE ABUSER EVER FORCED VICTIM TO HAVE SEX?

(Women’s Justice Center, data from USDOJ Scale)

• ALL DOMESTIC VIOLENCE VICTIMS ARE AT HEIGHTENED RISK OF HOMICIDE!!
Mental Health Evaluations Are Necessary To:

- Establish applicants credibility
- Establish requisite level of harm “persecution” ”torture”, “extreme cruelty” and/or “substantial Harm”
- Diagnose PTSD, Depression, Dissociation etc. to establish exceptional circumstances for application filed after one year deadline
- Create empathy and understanding about what happened and why the individual responded the way he or she did
- Give added attention and rationale for the case since adjudicators operate in a culture of denial and disbelief

Clinical Importance:
When done carefully and with cultural competence the psychological assessment alone can and should be a therapeutic intervention in and of itself.
1. **Why are psychological opinions favorable to the applicant?**
   Answer: We decline to provide opinion if it does not support the case.

2. **Are volunteer mental health clinicians biased in favor of applicants?**
   Answer: Mental health assessments are part of role and training. Professional ethics mandate we interpret findings honestly and the training materials through human rights organizations (PHR, Health Right etc.) specifically mandate never to inflate symptoms in order to support the case. Credibility as professionals is as significant as that of the asylee.

3. **Why do evaluators submit opinions in favor of claims that have many inconsistencies?**
   Answer: Traumatic Memory is frequently retrieved in inconsistent ways: often out of sequence and confusing, as trauma memory is housed in a different part of the brain than non trauma memory. Length of time between remembering and telling the story impacts consistency as does fear of divulging the full story to authorities. The evaluator often can uncover these issues.
FACT FINDER’S QUESTIONS…

4. **Do mental health clinicians consider consistency to be important part of evaluating the credibility of the person’s story?**
   Answer: Yes, but certain inconsistencies have reasonable explanations relative to trauma: the intrusive and avoidant nature of traumatic memory especially in the presence of the court representative in authority, cultural and language issues that make it difficult for the asylum applicant to understand the questions, shame that is the natural internalized experience of many trauma survivors, possible cognitive impairment by birth or by head injury etc. The experienced clinician can differentiate these inconsistencies with co-occurring clinical findings, and if not, do not submit a report.

5. **Why does the psych report repeat the person’s trauma story and not just focus on symptoms?**
   Answer: It is often redundant, but the evaluator needs to observe the way the person behaves as they tell the story, observing signs as well as reported symptoms. An evaluator asks questions regarding the person’s experience of the incident(s) not just the facts, often uncovering more details, as well as explaining the symptoms. Our relationship, defined as an evaluator imparts a certain level of trust, which may clarify and evoke memories that help the case and credibility.
FACT FINDER’S QUESTIONS…

6. **Are there standards for these evaluations?**
   Answer: There are guidelines and training for professionals on how to properly examine asylum seekers. Examiners have different professional training and have to deal with language, cultural and socio-economic and educational issues that impact the quality and extent of the assessment. One expert may be better for one case than another. Brain injured applicants need a different professional than a victim of gender violence. Many professionals willing to volunteer have had no professional standard training. Ask them. Give them an example of a good eval.

7. **How do clinicians know if an applicant is malingering or deceiving?**
   Answer: Deception is a general term, and malingering is a false production or exaggeration of symptoms, a psychiatric construct. Malingering is not easy to go unrecognized by an experienced clinician. We look at “internal consistency” of symptoms: some symptoms typically co-occur, and they are reported with commonly observed behavioral and emotional responses. We watch for behavioral signs that fit the experience being described. Clinicians should understand the many signs of the most common defenses in the face of traumatic life: Dissociation symptoms. Ask clinicians about their training etc.
8. **Why don’t evaluators use objective psychological tests that produce certain results that can be verified?**

Answer: Using standardized tests are not valid cross culturally and are not translated into various languages. The few evaluation scales that have been adjusted for culture and language may be too overwhelming for any one person and make them worse. We are mandated by ethics to be careful in evaluating as to not exacerbate the symptoms.

9. **Why do mental health reports seem to have similar conclusions?**

Answer: We are evaluating for symptoms of traumatic stress reactions that corroborate the story of the individual’s experience. There is standard language in writing about sets of symptoms as there is in general medicine: ie. Writing about diabetes, blood pressure etc.

10. **How do you know if the mental health evaluation is a good one?**

Answer: The clinical conclusions should: follow from the data in the report, explain the basis for the opinion, connect symptoms with observations, explain the number and length of interviews, use of interpreters, records reviewed (affidavits etc.), address issues of consistency, gives psychological rationale, and connects symptoms to diagnosis by explaining it in the narrative.
Psychological Assessments in Immigration Court

(Physicians for Human Rights)

I. Case Information
   • Client demographics, Date/Location of Evaluation, Interpreter(s) used, etc.

II. Clinician’s Examiners Qualifications
   • Credentials, years of experience, professional affiliations, attach CV

III. Pre-Trauma History
   • Family, employment, education, medical, and psychiatric history

IV. Current Psychological Compliant
   • How events have effected the person, how are events viewed in their culture

V. Abuse Torture History
   • Amount of details needed varies. Consult legal team to assess its exact needs.

VI. Post Torture History
   • How does person view themselves, is person treated differently by community

VII. Symptom Questions
   • Alteration in Memory, Depression, Anxiety, Dissociation, PTSD, Impact on Identity

VIII. Mental Status
   • Mood, Affect, Thought content & process, general appearance, motor activity

IX. Clinical Impressions and Observations
   • Tie together symptoms and diagnoses

X. Recommendations
   • Recommendations for asylum, medication, medical exams, psycho-therapy

For full assessment template email rosaliehyde@hgtraumainstitute.org
Vicarious Trauma Definition

• “Vicarious traumatization is the transformation of the helper’s inner experience as a result of empathic engagement with survivor clients and their trauma material. Simply put, when we open our hearts to hear someone’s story of devastation or betrayal, our cherished beliefs are challenged and we are changed.” (Pearlman and Saakvitne, 1996)
Signs and Symptoms of VT

- Signs and Symptoms of Vicarious Traumatization

  - General Changes:
    - Social Withdrawal
    - Increased sensitivity to violence
    - Cynicism
    - Generalized despair and hopelessness
    - Nightmares
    - No time or energy for oneself
    - Disconnection from loved ones

  - Specific Changes:
    - Disrupted frame of reference
    - Changes in identity, worldview and spirituality
    - Diminished self-capacities
    - Impaired ego resources
    - Disrupted psychological needs and cognitive schemas
    - Alterations in sensory experiences (intrusive imagery, dissociation)
WHAT TO DO ABOUT VT

CARING FOR YOURSELF IN THE FACE OF DIFFICULT WORK

- Our work can be overwhelming. Our challenge is to maintain our resilience so that we can keep doing the work with care, energy, and compassion.
- 10 things to do for each day
  1. Get enough sleep.
  2. Get enough to eat.
  3. Do some light exercise.
  4. Vary the work that you do.
  5. Do something pleasurable.
  6. Focus on what you did well.
  7. Learn from your mistakes.
  8. Share a private joke.
  9. Pray, meditate or relax.
  10. Support a colleague

SWITCHING ON AND OFF

- It is your empathy for others helps you do this work. It is vital to take good care of your thoughts and feelings by monitoring how you use them. Resilient workers know how to turn their feelings off when they go on duty, but on again when they go off duty. This is not denial; it is a coping strategy. It is a way they get maximum protection while working (switched off) and maximum support while resting (switched on).
- How to become better at switching on and off
  1. Switching is a conscious process. Talk to yourself as you switch.
  2. Use images that make you feel safe and protected (switch off) or connected and cared for (switch on) to help you switch.
  3. Find rituals that help you switch as you start and stop work.
  4. Breathe slowly and deeply to calm yourself when starting a tough job.
WHAT HELPS?

MAKES IT BETTER

- REGULAR SCHEDULED CONTACT
- FIND/CREATE A PEER CONSULTATION GROUP/MENTOR
- PEOPLE NEED TO KNOW THEY NEED SUPPORT And ATTENTION.
- BALANCE OF WORK AND PLAY: THE BIOLOGY OF PLEASURE CHANGES THE BIOLOGY OF STRESS
- SELF CARE IN EVERY AREA OF ONE’S LIFE:
  - Physical, Emotional and Spiritual
  - Regularly scheduled contact with friends and family that provide PLEASURE
  - PLEASURE fights Vicarious Trauma and Pain: psycho- biologically

OBSTACLES

- TIME
- DISCOUNTING OUR OWN NEEDS
- BECOMING OVERBURDENED/TOO MANY CASES
- NO ENERGY
- GRANDIOSITY/ I CAN TAKE IT MENTALITY
- UNREALISTIC EXPECTATIONS
- PROFESSIONAL CULTURE OF BLAME AND UNDERLYING SHAME
- (What does it say about me if I need this support? “LAWYERS ARE NOT SOFT AND PSYCHOLOGICAL”)
WHAT HELPS OTHERS and FOSTERS JUSTICE?

GOOD WORK

EMPATHY ———— SELF-CARE
References

• All photos credited to publications from United Nations High Commission for Refugees.


References cont.


