Advocate or Adjudicator?

Mental Health Professionals and Refugee Status Determination

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Abstract

Ethical dilemmas often arise for mental health professionals when working with asylum seekers and refugees. This is especially true in resource poor environments such as developing countries. The unique role of the therapist in refugee status determination (RSD) is addressed, with attention to the importance of following profession-wide ethical standards of care, especially in RSD settings potentially involving conflicts of interest. Specific ethical issues are highlighted, including the power and perils of taking testimony. The challenges of cross-cultural assessment are reviewed, including the potential misuse of diagnostic test results and the complexities involved in providing psychological evidence of torture. Finally, an international board is proposed to monitor the work of therapists in specific legal contexts such as RSD.

Authors’ Note: The following article is intended to be a useful road map for mental health professionals (MHPs) as well as for those with whom they work such as lawyers, and immigration officials. However, it is important to note that significant differences in the asylum application process and consequently, in the role of MHPs, exist from one country to another. This is perhaps most true when comparing MHPs working in industrialized nations with those working in Least Developed Countries (LDCs). For example, where trained professionals are numerous, tasks are often divided such that a treating professional would not also be conducting a psychological assessment and vice versa. However, in LDCs, which host the majority of the world’s refugees and asylum applicants, MHPs are often faced with the challenge of performing multiple, at times contradictory, roles. The authors of this article are particularly interested in feedback from readers who have experienced such differences in roles from one country to another. Please write to: CourtneyMitchell13@gmail.com with any comments or suggestions on this or other topics related to this article.
Asylum seekers constitute a culturally diverse population of migrants who experience unique stressors arising from the process of their forced migration. Consequently, mental health professionals (MHPs) must be conversant with a complex range of migration issues in order to provide effective support. This paper examines the pitfalls inherent in such work and proposes solutions designed to enhance the quality of mental health services available to forced migrants, specifically during the process of applying for asylum.

Asylum seekers by definition have fled their country of origin, usually under duress, and are in the process of requesting recognition as refugees. Refugee status affords legal protection and other forms of assistance. According to the 1951 United Nation’s Convention Relating to the Status of Refugees, in order to be recognized as a refugee, a person living outside their country of origin must have a well-founded fear of persecution for reasons of political opinion, race, nationality, religion, or membership in a particular social group.

According to the United Nations High Commissioner for Refugees (UNHCR) there are 9.2 million officially recognized refugees worldwide, and 25 million internally displaced persons (IDPs; UNHCR, 2006). IDPs are defined as persons who have not crossed an international border. However, these statistics do not include the uncounted additional asylum seekers, some of whom have applied for asylum and are awaiting a decision, and others whose claims have been rejected. Historically, recognition rates in countries such as Egypt are notoriously low, with far more rejections than acceptances. UNHCR Cairo records indicate that the recognition rate in Egypt was only 31 percent in
2000. This rose to 42 percent in 2001, but dropped again during the first half of 2002 to 24 percent, the lowest rate in five years (as cited in Kagan, 2002).

For some forced migrants, securing legal status as a refugee literally means the difference between life and death. Consequently, it is critical to ensure that asylum seekers have access to a fair and professionally administered asylum application process. Various immigration authorities, including mental health professionals, are ethically obligated to ensure that this occurs.

The Role of the Mental Health Professional in RSD

MHPs can play a pivotal role in assisting applicants in navigating the RSD process. Therapists who work with asylum seekers often must collaborate with multiple authorities including the UNHCR, national immigration personnel, nongovernmental organizations (NGOs), private attorneys and others. The composition of those involved in RSD often varies, depending on the country where an individual is applying for asylum. In the United States, asylum is granted through the immigration courts and asylum seekers are often detained until their status is determined. In Turkey, the Turkish government will only process European asylum seekers, leaving the vast majority, the non-Europeans, to apply directly to the UNHCR for protection. These persons often live in poor conditions with no assistance with housing, health care, education, social security, or employment needs while awaiting a decision on their status (Steel & Silove, 2000).

It is not uncommon for the UNHCR to act on behalf of national governments in determining refugee status. This is the case in Egypt and Turkey, where refugee status determination is conducted on an individual basis. In other countries, such as Nepal and
Tanzania, the UNHCR is granted permission by the national authorities to provide prima facie recognition status temporarily for all asylum seekers from a particular geographic area or background, thus postponing the cumbersome process of individual status determination. Regardless of the body responsible for status determination, individual RSD is a lengthy process that may take months or even years to complete.

The diversity of refugee status determination procedures poses a series of challenges for MHPs. For example, MHPs may be asked to perform multiple tasks simultaneously, particularly in resource poor environments where the majority of the world’s refugees and asylum applicants reside (UNHCR, 2002, 2006). Asylum seekers may initially be referred to MHPs for crisis intervention, especially if persons are experiencing suicidal or homicidal ideations, or are exhibiting symptoms of psychosis. A therapist may also be asked to transcribe an applicant’s testimony and accompany clients to an immigration hearing, or to conduct a psychological evaluation and write associated affidavits (as an adjunct to materials compiled by a client’s lawyer) for forwarding to UNHCR or National immigration courts. In addition, it is not uncommon for a MHP to be asked to evaluate a client’s reported cognitive deficits such as memory difficulties, or to assist an applicant in recalling some painful aspects of their personal history in preparation for an RSD interview. MHPs are also often the persons asylum seekers turn to in coping with rejection of an asylum request.

In some cases, the MPH may be expected to indirectly assess an applicant’s credibility during a psychological assessment. As a component, the therapist may also be asked to evaluate the consistency of an applicant’s case history as it relates to psychological symptoms of distress. In some case, supporting evidence submitted by a
MHP to an immigration authority may make the difference between recognition or rejection of an asylum claim.

Many refugees are survivors of torture (Barclay, 1998; Gerrity, Keane, Tuma, 2001). This can pose an additional challenge to MHPs who take an active role in the RSD process. As has been highlighted in the Istanbul Protocol (2002):

> Psychological evaluations can provide critical evidence of abuse among torture victims for several reasons: torture often causes devastating psychological symptoms, torture methods are often designed to leave no physical lesions and physical methods of torture may result in physical findings that either resolve or lack specificity…The overall goal of a psychological evaluation is to assess the degree of consistency between an individual’s account of torture and the psychological findings observed during the course of the evaluation. (p. 47).

Given the variety of responsibilities that MHPs may be asked to assume, a basic knowledge of the following is essential: (1) general ethical codes of conduct and specific ethical guidelines, (2) specific guidelines for conducting psychological affidavits, (3) existing assessment measures including appropriate use and potential misuse of such assessment tools, (4) sensitivity to and awareness of ethnocultural factors in diagnosis, etiology, expression and treatment of psychiatric disorders, particularly Post Traumatic Stress Disorder (PTSD), (5) means of investigation and documentation of the physical and psychological consequences of torture, (6) knowledge of current research in the field of traumatic stress, (7) communication barriers inherent in collaborative work with
interpreters, and (8) the importance of ongoing training, consultation, and adequate supervision in clinical practice.

Existing Guidelines and Relevant Codes of Ethics

Despite the education and training requirements and ethical rules of conduct in a specific country where a therapist practices, the MHP must be cognizant of the overarching spectrum of issues and regulations involved in the assessment and treatment of asylum-seekers that transcend national boundaries. While some countries have local codes of conduct for professionals in the mental health field, other countries have yet to establish or enforce ethical standards of care. Where ethical standards for MHPs are lacking, therapists can refer to well-established ethical codes of conduct that are versatile enough to be utilized internationally, such as the American Psychological Association’s Ethical Principles of Psychologists and Codes of Conduct (2002), and the American Psychiatric Association’s Principles of Medical Ethics Especially Applicable for Psychiatry (2006). If work with asylum-seekers involves documenting torture, the MHP may refer to the guidelines regarding collecting physical and psychological evidence of torture as outlined in the Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2004). Other documents including the accompanying document to the Istanbul Protocol: The International Guidelines for the Investigation and Documentation of Torture (Human Rights Foundation of Turkey, 2004), and Examining Asylum Seekers by Physicians for Human Rights (2001) address how to gather psychological evidence of torture, obtain written reports and oral testimony, and assist child survivors of torture.

Cross-cultural Challenges Inherent in Investigating Torture and PTSD

Research indicates that an estimated 5-35 percent of the world’s refugees are victims of torture (Barclay, 1998; Gerrity et al., 2001). The prevalence of PTSD and other anxiety disorders, as well as depression, is higher for torture survivors and refugees compared to the general population (Gerrity et al., 2001; Istanbul Protocol, 2004; Steel & Silove, 2000; Van der Veer, 1995). In various studies an estimated 25-33 percent of persons exposed to an extreme stressor or violent experience developed PTSD symptoms (Breslau, Davis, Andreski, & Peterson, 1991; Breslau, Kessler, Chilcoat, Schultz, Davis, et al. (1998); Kilpatrick, Saunders, Amick-McMullan, Best, Veronen, & Resnick, 1989; Kilpatrick, Edmunds, & Seymour, 1992).

However, before providing a formal diagnosis of PTSD, the MHP must remember that culture plays a role in the etiology, expression, diagnosis, and outcome of any mental health difficulty. Ethnocentric bias may limit the applicability of cross-cultural diagnostic categories of psychiatric disorders. Ethnocultural factors may influence psychological, biological, or social aspects of individual traumatic reactions.

Specifically, literature on PTSD suggests that while there may exist a universal biological basis for human reactions to trauma (DSM-IV-TR, 1994; Marsella, Friedman &
Spain, 1992), the expression of these symptoms, subjective experiences, and psychological appraisal of trauma are likely to be influenced by ethnocultural factors and religious traditions (Stamm & Friedman, 2000). In addition to cultural factors, specific needs of survivors of torture who have been exposed to prolonged and repeated trauma, collective trauma, and acute trauma must be considered before determining their treatment (Marsella et al., 1992). MHPs also need to keep in mind the sociopolitical and historical context in which the person was traumatized in order not to over pathologize individual symptomology (Friedman & Jaranson, 1994; Simpson, 1995). The reactions of the individual to trauma are often understandable in light of extraordinary circumstances (e.g., state sanctioned torture).

Trauma survivors may also experience impaired memory encoding, storage and retrieval processes that limit their ability to provide required information (Bremmer Randall, Scott, Bronen, Seibyl, Southwick et al. 1995; Davis and Follette, 2001; Kapur, 1994; Taylor, 1994; LeDoux, 1998; DSM-IV TR, 2000). In the DSM-IV-TR (2000), the American Psychiatric Association recognizes memory problems to be a possible feature of at least the following conditions: Post-Traumatic Stress Disorder, Dissociative Amnesia, Dissociative Fugue, Dissociative Disorder Not-Otherwise-Specified, and Dissociative Identity Disorder, many of which are common to trauma survivors.

In addition, other factors may limit the ability of trauma survivors to provide full detailed testimony such as organic brain injury. Specific types of psychological and neurological assessments are often requested, especially for survivors of torture, in exploring the etiology of memory problems. Such assessments can lower the burden of proof and provide crucial evidence in support of an applicant’s claim. An assessment that
highlights potential reasons for gaps in memory, or inconsistencies, may lower the burden of proof, or at least provide an opportunity for the client to be interviewed if/when their symptoms have remitted.

The Power and Perils of Testimony Taking

The process of recounting details of traumatic events or providing testimony during the asylum application process can be therapeutic or it can be further damaging to the survivor (Physicians for Human Rights, 2003; Cienfuegos & Monelli, 1983; Agger, 1994). Benefits and risks are inherent in the process of taking testimony. However, these benefits and risks may not be well understood by those giving the testimony, nor by mental health or legal professionals taking testimony.

Often, the degree to which testimony of torture is either helpful or harmful rests on the level of coercion or voluntary choice that may be involved in providing the testimony. If forced migrants feel even indirectly coerced into providing testimony, this may replicate oppressive power dynamics experienced previously. Yet the line between testimony that is “taken” (i.e. – coerced) or “given” (i.e. – voluntary) may be blurred. The purpose, utilization, level of confidentiality, and potential benefits and adverse consequences should be explained at the onset. For example, there are countless examples of humanitarian agency staff utilizing testimony without a person’s permission. Agency staff may believe they are acting in the person’s best interest when the testimony is made public, with the goal in mind to expose those responsible for acts of torture or as a fund raising and advocacy tool on the agency website. While the use of silence as a form of power by those perpetuating torture has been well documented (Agger, 1994;
Cienfuegos & Monelli, 1983; Scarry, 1985), it is critical that it be entirely the choice of the survivor whether or not to break this silence by providing that will be made public. Otherwise, asylum seekers should be assured of the confidentiality of the testimony and the limited purposes for which it will be used during RSD.

Ideally, testimony is given to a trusted person in a safe setting, and can be a tool for healing (Cienfuegos & Monelli, 1983). Agger (1994) has noted that testimony as an interview technique can help women who have experienced violence to alleviate the pain associated with remembering the events. Results of research with former Chilean prisoners indicated that the process of giving testimony was effective in providing symptom relief (Cienfuegos & Monelli, 1983). Testimony can empower the sufferer by validating their experience and providing a reference for personal memories. In addition, with the person’s permission, testimony can even be utilized as a tool to raise awareness, and become an historical document for future generations to use as indictment against offenders, thus orienting the victims’ desire for revenge in a constructive direction. The process of providing testimony can also serve to acknowledge that private suffering was caused by social conditions, and may speak to the need for socially oriented reparations.

However, despite the potential benefits, often the survivor experiences a deep sense of personal conflict between wanting to forget the trauma and wanting to break the silence (Agger, 1994). A number of studies have indicated that intense re-exposure, including recounting the details of traumatic events, can result in adverse outcomes, and negatively impacting future functioning (US Department of Defense, 2002; Chemtob, Tomas, Law & Cremeniter, 1997; Deahl, Gillham, Thomas, Searle, & Srinivasan, 1994). Considering the potential harmful effects of testimony taking, it is essential that the
provision of psychosocial support and follow up be integrated into existing organizations whose primary function is to gather testimonial evidence (Physicians for Human Rights, 2003). Re-experiencing an event such as torture may be detrimental especially if follow up psychosocial assistance is not offered as an option prior to requesting a survivor to recount potentially painful details (Physicians for Human Rights, 2003).

A survivor of violence may also understandably want to put the past behind them. They may not desire the label of “a trauma survivor,” or may fear risk of further marginalization or violence associated with providing testimony. Such reactions may be useful coping mechanisms, enabling survivors to continue to maintain at least minimal functioning. However, when a person has decided to engage in the process of requesting asylum they are faced with the associated requirement of providing testimony. It is important for the therapist to keep in mind certain elements that may limit the potentially damaging aspects of the asylum application process and enhance recovery. The MPH should encourage ownership of the testimony document and limit any sense of coercion, including dispelling myths regarding unrealistic expectations of associated services or “rewards”. To promote empowerment, the MPH must ensure informed consent and walk clients through the process of a cost-benefit analysis of the potential pros and cons involved in applying for refugee status, including likely outcomes such as percentage of those with similar claims recognized in the last year.

Credibility Issues

Testimony recorded during the process of RSD is unique in comparison to other environments in that there is a component of judgment. Asylum applicants’ claims are
not only scrutinized concerning whether the applicant’s experiences fit within the criteria for the definition of a refugee under the 1951 Convention, but also whether the events they describe are believable. Credibility, in the context of refugee status determination, means that the reviewer of the application believes the applicant’s testimony, or at least finds the testimony to be consistent with internal and external reference points. While adverse credibility findings are not the only reason for rejection of claims, in some locations, such as Cairo in the first half of 2002, rejections due to judgments of adverse credibility comprised as much as 75 percent of the total rejections (Kagan, 2002).

When an authority such as UNHCR or a national immigration body doubts a survivor’s description of their experience, this disbelief may generate further emotional and psychological distress in the asylum seeker. Despite the numerous factors involved in determining whether or not a person meets the criteria for a refugee, applicants often view the granting of refugee status as a confirmation that they have been believed, and view a rejection as an indication that the authorities doubt their word (Fiske & Kenny, 2004). This often leads to a high level of frustration and disappointment, further compounded by being denied access not only to legal protection, but also to a broad range of social services that often accompany the granting of refugee status.

Assessments of credibility, as well as many other elements of the asylum application process, are based on the assumption that applicants are able to recall and accurately describe detailed experiences. However, some applicants simply cannot accurately recount their experiences in specific terms. This is particularly true of those suffering from mental health difficulties such as PTSD or depression, both of which may
involve associated memory loss. These asylum applicants may be especially vulnerable to adverse credibility findings resulting in a rejection of their claim.

Although crucial in the assessment of refugee status eligibility, making fair and unbiased credibility assessments is difficult. Arguably the tools to adequately assess credibility are lacking. Research indicates that police investigators, lawyers and psychologists all have significant limitations in their ability to effectively determine whether or not a person is telling the truth. This is largely because there is no standard demeanor or type of physiological behavior displayed when a person is lying (Ekman, 1996; Iacono, 2001; Vrij, Evans, Akehurst & Mann, 2004). Research conducted by Vrij and colleagues (2004), indicated that even police investigators trained in lie detection had an only 65-70 percent rate of success in determining if a suspect was lying, only slightly better than the 55 percent success rate of those not trained in lie detection (Bond, as cited in Lock, 2004). As is often the case when dealing with the complexities of human nature, the subjective perceptions of the assessor can be misleading. Thambirajah (2005) has reported that “the more confident clinicians feel about their judgments, the less likely they are to be accurate” (p. 200).

Summarizing the difficulty in determining the credibility of a refugee applicant, Kagan (2002) noted the following:

An applicant's credibility is often central to refugee status determination because refugees rarely have independent evidence with which to back up their claims. Credibility assessment is perhaps the most difficult part of refugee status determination because it requires interpreting flaws in testimony provided by nervous people speaking to a foreign institution,
often in a foreign language, and across a cultural divide. Often, the most vulnerable refugees — trauma victims, women, people lacking education, and people who have learned to fear official institutions — have the most trouble giving complete, detailed and coherent testimony (p. 28 - 29).

Despite knowledge of the limitations of current means of lie detection, some RSD staff and MHPs continue to employ imperfect and highly subjective means of credibility assessment that may have damaging implications for asylum seekers. Such behavior is inconsistent with the ethical obligation of the MHP to act in the best interest of the client and to do no harm (APA, 2002, Principle A).

While in most cases, psychological assessments strengthen an asylum seeker’s claim, there may be times when this is not the case, especially when the therapist suspects that the applicant has fabricated a claim. Often asylum applicants have valid reasons for being less than honest when providing testimony. For example, even when an applicant may have a valid claim, they may choose to present a fabricated story 1.) in order to distance themselves from the pain of actual events, 2.) because they have received advice to do so from trusted family or community member, or 3.) because they doubt that immigration authorities will believe actual events, being aware that they are often unfamiliar with their country, customs, and culture. Whatever the reason, if fabrication is suspected, the therapist must precede with caution, as symptoms of distress may potentially worsen through calling an applicant’s credibility into question. Assessments that highlight such concerns can also potentially result in harm to the client that could include denial of refugee status and even deportation to country of origin.

As recommended in the Istanbul Protocol (2004):
If the clinician conducts examinations and suspects fabrication, the clinician should refer the individual to another clinician and ask for the colleague’s opinion. The suspicion of fabrication should be documented with the opinion of two clinicians (p.52).

Attempts by the MHP to be sensitive to the pain of not being believed can help mitigate the impact of adverse credibility rulings. It is important for the therapist to remind clients that a rejection in RSD does not mean that his or her testimony was not credible, but may instead be an indication that the applicant’s experiences do not fit within the UN 1951 Convention definition of a refugee. In addition, even when the adjudicating agency may not believe the client, an affirmation that the therapist does may also aid in the promotion of recovery.

Professional Responsibilities and Considerations Prior to Conducting Psychological Assessments

Before any assessment is conducted, the purpose of the assessment must be clear to both client and the MHP. The purpose of assessments can vary within the context of refugee status determination and may include exploration and/or determination of: 1.) symptom patterns, 2.) functional impairment, 3.) risk and protective factors related to symptom course, 4.) proposed treatment plan, 4.) client’s trauma history, and lastly 5.) credibility of an applicant’s claim of torture or other forms of trauma.

During assessment and treatment, it is the MHP’s responsibility to be aware of the asylum seeker’s potential reluctance to establish trust, whether this may be attributed to their torture experiences, or to cultural factors related to talking to a therapist (Pope &
Garcia-Peltoniemi, 2001). If the MHP is employed by an RSD decision-making authority such as the UNHCR, the therapist needs to make known to the asylum applicant any potential conflict of interest such an inability to maintain confidentiality and the possibility of information divulged during sessions being used to undermine an applicant’s asylum claim. In fact, before accepting employment, a therapist should make clear to the employer that the therapist can not assume any responsibilities that conflict with their professional and ethical obligations (APA, 2002, 3.06). If the therapist foresees any possible conflicts between organizational demands and their professional ethics, ethical obligations must first be clarified with supervisors or upper level managers (APA, 2002, 1.03).

It is crucial to ensure that informed consent of asylum seekers is obtained (APA, 2002, 3.10) before proceeding with any assessments, evaluations, or other potentially psychologically invasive or damaging procedures. Informed consent can only be given by asylum seekers who have been fully informed of the implications of agreeing to undergo a psychological evaluation. Informed consent is also a prerequisite before giving any form of testimony or participating in any psychological research (APA, 2002, 9.03).

Clusters of symptoms and psychological reactions to trauma in general, and torture specifically, are best evaluated through a variety of “phenomenological or descriptive methods” (Istanbul Protocol, 2004, p.45). This is especially true considering the multitude of factors involved in the development of and recovery from PTSD, or other mental health challenges. The following elements can help shed light on symptom expression: 1.) age, 2.) developmental history, 3.) prior life experience, 4.) culture, 5)
trauma attributions, 6.) social support, 7.) religious/spiritual belief system, 8.) internal coping resources, and 9.) social and political circumstances (Rothschild, 2000).

It is important to understand appropriate use of any assessment or evaluation measures. Professionals who administer and interpret test results have significant responsibilities, such as those outlined in various guidelines including *The American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct* (2002), *The American Association for Counseling and Development’s (AACD) Joint Committee on Testing Practices: Test Taker’s Rights and Responsibilities* (1998), *The Association for Assessment in Counseling and Education (AACE), Rights and Responsibilities of Test Takers: Guidelines and Expectations* (2000), and *The Association for Assessment in Counseling’s Standards for Multicultural Assessment* (2003). Clients who are administered psychological tests have a right to be tested with culturally valid and reliable measures, administered in appropriate environments, and have their test results interpreted by trained and ethical professionals. Furthermore, clients must provide consent before being tested, be given clear and precise explanations of test results, and be provided the opportunity to discuss their concerns about the testing process. It is the responsibility of the individual who administers a test to inform test takers of these rights and responsibilities (AACD, 1998; AACE, 2000).

Increasingly MHPs are working with persons from cultural backgrounds that differ significantly from their own (Williams, 1986). Mental health assessment of diverse refugee groups can present a number of unique challenges (Goodwin, 2002). Consequently, test administrators must, prior to selecting an assessment instrument, verify that the test is appropriate for use with the specific population including possessing
validity, reliability, and appropriate norms groups (Chang, 2001; Association for Assessment in Counseling, 2003; Thambirajah, 2005).

There are a variety of assessment methods and procedures that may be utilized when conducting psychological assessments. However, psychological assessment of culturally diverse or minority groups is a contentious issue within current psychological discourse (Williams & Westermeyer, 1986). In addition, many assessment measures may not be appropriate for use with populations that differ significantly from those for whom the test was originally intended (Chang, 2001; Rudner, 1994; Association for Assessment in Counseling, 2003). Even with standardized trauma symptom questionnaires, such as the Trauma Symptom Inventory (TSI) (Briere, 1995), differences have been found in scores based on ethnicity and gender even with groups within the United States (Piedmont, 2001). Questions concerning the validity of these assessment tools for use with diverse groups in the U.S. certainly calls into question the ethics of use of such instruments in international context.

Consequently, the use of psychological tests in the evaluation of torture victims should be limited at best (Istanbul Protocol, 2004). Furthermore, some refugees may be less inclined to trust a therapist who uses unfamiliar or potentially intimidating psychological tests (Williams & Westermeyer, 1986). A diverse array of cultural, social, economic, and political factors must be considered in determining if any assessment battery is appropriate for a given population. In order to avoid some of the difficulties inherent in over-reliance on tests whose validity and reliability measures are not well established, it is advisable that assessment data come from multiple sources such as: 1.)
interviews, 2.) mental status exams, 3.) information from significant others, and 4.) behavioral observations (Williams & Westermeyer, 1986).

Despite the limitations, the use of various assessment tools during a psychological evaluation can still offer a range of useful information for MHPs who may be asked to provide psychological evidence of an asylum seeker’s claim of torture or other forms of trauma. However, it is important that the results of the psychological assessment be interpreted in combination with other sources of information. Even when an asylum seeker’s symptoms fit neatly into prescribed DSM-IV diagnostic categories, this alone can not be taken as evidence of torture having taken place. As in the case of PTSD, the nature of the initial traumatic stressor may remain elusive. At the same time, if an asylum applicant is asymptomatic, or sub-threshold, this cannot be assumed to indicate that torture has not occurred, nor that a claim is fraudulent. Many persons who have been exposed to torture or other forms of violence will not go on to develop a diagnosable mental illness (Istanbul Protocol, 2004).

Recommendations

Although numerous ethical codes exist for MHPs, many of which provide guidelines for assessing and treating general mental health needs, including those of asylum seekers, there is no uniform international code of conduct for MHPs who work with asylum seekers within a legal framework. Establishing a professional governing body to oversee international mental health practice within the legal framework surrounding the RSD process, would protect asylum seekers by setting minimum standards of ethical practice. First, a governing body could establish guidelines regarding
possibilities and limitations for MHPs asked to assess credibility in the RSD process. Second, it could introduce comprehensive international humanitarian and professional ethical codes of conduct to protect the rights of asylum seekers. A governing board could also ideally aim to hold MHPs who engage in unethical and unprofessional conduct accountable. Such an organization might also serve as a conduit for information sharing, guidance and consultation for MHPs who participate in any aspect of the refugee status determination and perhaps even the resettlement process. UNHCR should assume a primary role in providing organizational support, at both the ideological and infrastructure levels, in collaboration with professional associations such as the APA.

Whether such a body could perform an international peer review function and enforce it, is debatable. However, such institutions do exist in other professions. Such an institution would be one step in the right direction of ensuring consistency in practice and a minimum quality standard for MHPs working within a legal context with unique and diverse populations of asylum seekers worldwide.
Appendix: A Case Study on the Misuse of Personality Tests in Credibility Determination

The inappropriate use of personality tests with trauma survivors may not be uncommon, despite the fact that “…little published data exist on the use of psychological testing (projective and objective personality tests) in the assessment of torture survivors…” (Istanbul Protocol, 2004, p. 51). One of the authors of this article recently observed an example of the misuse of personality tests to determine the credibility of asylum applicants in Cairo, Egypt, despite the fact that it is clearly stated in the Istanbul Protocol (2004), “…psychological tests of personality lack cross-cultural validity” (p.51).

A psychologist working with a RSD agency described to the author that the Eysenck Personality Questionnaire–Revised (EPQ-R) was being used to determine the credibility of asylum seekers’ claims. The EPQ-R (Eysenck & Eysenck, 1991), along with scales measuring the three personality dimensions of extraversion, neuroticism and psychoticism, also includes a lie scale. The lie scale component of the EPI-R is intended to measure the extent to which answers on the EPI may be falsified. Yet, such results can not be generalized to indicate whether or not a refugee applicant’s testimony has actually been falsified. In addition, cultural factors may play a role in high rates of response bias on the EPI, especially within cultural groups that favor collectivism and preference for increased uncertainty avoidance (Smith, 2004).

Disregarding the inappropriate use of the EPQ-R, the test was administered to a young client during a RSD interview. The psychologist apparently interviewed the client briefly and administered components of the EPI including the “lie scale.” According to his legal advisor, the client had not given informed consent before having the test administered, nor did he understand in advance the purpose of the questions.
The psychologist subsequently interpreted the client’s EPI-R lie scale results, according to a file note (Yuksel, personal correspondence, May, 2006), as support for the idea that the client had falsified his asylum claim. Concerned that these events demonstrated a lack of ethics and a lack of knowledge of appropriate test interpretation on the part of the psychologist, the author felt ethically bound to file a complaint with the agency with which the psychologist was employed.

The author was subsequently told by the agency that the results of this client’s EPI-R lie scale would not be used against this client in determining refugee status. However, even after this exchange, additional staff members at the agency have confirmed that such measures are still being employed, and notes in clients’ files regarding credibility are still being made by this particular psychologist, based on the Eysenck and similar assessment measures during the process of RSD determination and associated with resettlement referrals (Yuksel, personal correspondence, July, 2006). Unfortunately, no national or international governing body exists to monitor such ethical violations.

It is tempting to think that there may be an ultimate lie detector. However, even the control question test (CQT), which combines a collection of interview techniques with measurement of physiological recordings, known as the most common form of polygraph test, is notoriously unreliable (Iacono, 2001). Polygraph results are not admissible in US courts due to inaccuracy, the ease with which results can be faked, and the frequency of false positives. Recent research into the use of brain scan imaging in detection of deception is also still unable to provide an accurate means of lie detection (Rosenfield, 2001).
References


