

THE ASSESSMENT OF ASYLUM SEEKING IMMIGRANTS TO THE UNITED STATES:
AN EXPLORATORY STUDY OF PSYCHOLOGISTS' EXPERIENCES

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ABSTRACT

The use of psychological assessments as evidence has become a frequent part of the asylum determination process in the United States. This exploratory, qualitative study focused on the personal and professional experiences of psychologists who provide these assessments. First the political, legal, and social situation of asylum seekers to the United is discussed. Then the mental health challenges that asylum seekers commonly experience are reviewed. Finally, parameters of the assessment process and common challenges are highlighted. Six psychologists with experience assessing asylum seekers were asked about their experiences providing these assessments and training for the work, and their responses were analyzed qualitatively for common categories and themes. Several major categories of experiences arose in participants' answers. They discussed a) the location of assessment experiences, b) experiences working with interpreters, c) assessing for trauma and PTSD, d) the use of psychological measures, e) writing the assessments, f) experiences with the asylum system and process, g) adapting to cultural differences, h) personal and professional impact of this work, i) professional dilemmas, j) methods of self-care and coping, and k) training experiences. Across these categories, the tension between social advocacy and clinical integrity, and the cultural challenges to usual professional praxis arose as salient themes. Finally, the limitations and implications of the current study are addressed.

Keywords: asylum seekers, psychological assessment, social advocacy, cultural considerations

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Chapter I

Introduction and Overview

The first known use of a psychological assessment in an asylum determination case occurred in 1985 (Aron, 1992). Since then, this practice has become a frequent part of the asylum determination process by providing evidence to support asylum claims. It also serves to identify clinical issues and sometimes provide access to mental health treatment. Also, more research has focused on the psychological needs of asylum seekers and the distinct characteristics of migration trauma. Asylum seekers rest at the complex intersection of legal and healthcare systems and are often impacted by sweeping historical and political processes. For American psychologists, work with asylum seekers can exemplify the challenges of working within a politicized and legal context and the difficulties of providing culturally competent services.

This exploratory study will focus on the personal and professional experiences of psychologists who provide assessments for asylum seekers to the United States. The literature review first will provide an overview of the political, legal, and social situation of asylum seekers to the United States. Then it will discuss research about the mental health challenges asylum seekers face. Next it will describe aspects of how psychologists assess asylum seekers and similar immigrant populations and outline common challenges that they face in doing this. Finally, the literature review will identify the study's focus on the personal and professional experiences of psychologists who assess asylum seekers as an area that requires further exploration. The current study uses a qualitative research method in order to explore the general areas of personal experiences, professional

experiences, and training. From these data, the current study identifies and describes major categories and themes of psychologists' experiences and highlight implications for future research, clinical practice, and training.

Chapter II

Review of the Literature

Asylum Seekers and the Process of Asylum

Mass migration in the face of oppression and war has occurred throughout human history. An ancient example would be the Biblical account of the Israelites migration out of Egypt, and a contemporary example would involve the mass migration of civilians in response to the Syrian Civil War. Modern norms and conventions for the treatment of refugees can be traced to the aftermath of World War II (Coffey, 2001). The Universal Declaration of Human Rights in 1948 recognized each nation's obligation to consider sanctuary for those fleeing persecution, and this led to the United Nations Convention Relating to the Status of Refugees in 1952. According to recent estimates from the United Nations High Commission for Refugees, Asia hosted over a third of the world's refugees, Africa has hosted a quarter, Europe has hosted nearly a quarter, and North America has hosted less than 6% (Tribe, 2005).

The terms refugee and asylum seeker may seem interchangeable, but there are key differences. The 1951 United Nations Refugee Convention, defined a refugee as someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country" (United Nations High Commission for Refugees, 2012a). Refugees leave their countries involuntarily and often in the context of war, substantial political upheaval, and other traumatic events (American Psychological

Association, Presidential Task on Immigration, 2012). Asylum seekers are a subset of the refugee population. An asylum seeker is any person who claims to be a refugee without a governing body performing an evaluation on this claim before or during migration (United Nations High Commission for Refugees, 2012b). If people apply for entry and are granted it before they arrive in a host country, they are considered refugees. If they arrive without applying beforehand, they are considered asylum seekers. Asylum systems at the national level decide which claimants qualify for protection and residency as asylum seekers. Those not judged to have an asylum claim, in other words to not need protection, are returned to their countries of origin.

Despite these international commitments, there was no statutory basis for granting asylum to people who apply from within the United States until the 1980 Refugee Act (Bhargava Ray, 2013; Coffey, 2001). The Refugee Act codified four principal areas. First, it incorporated the international definition of refugee. Second, it included the obligation to not return refugees to territories where their life or freedom would be threatened. Third, it allowed the president to set a numerical cap for refugee admissions. Fourth, it created a uniform procedure for applying for asylum. Generally, refugees apply for a legal entry visa before entering the United States. Historically, though, qualifying as a refugee has not been sufficient for gaining a legal entry visa, and most asylum seekers cannot use traditional migration procedures, due to barriers such as lack of resources or societal upheaval (Bhargava Ray, 2013). Due to this, the asylum process does not penalize an asylum seeker's application due to illegal entry. Beyond asylum, lower types of relief exist for asylum seekers. They can also receive withholding of removal and

deferral of removal (Freed, 2005). These allow asylum seekers to remain within a host country but do not have the full protection afforded by asylum.

The plight of asylum seekers has reflected two competing pressures on migration and national immigration systems (Silove, Steel, & Watters, 2000). People migrate to flee political persecution but also to escape poverty and limited social opportunities. Asylum systems must distinguish between the two groups, but doing so can be difficult in practice. Such factors as civil war, economic underdevelopment, internecine conflict, and poverty are interrelated. In the determination process, the burden of proof rests on the asylum seeker. Language and cultural barriers, lack of legal knowledge, and the reality that oppressive regimes tend not to document persecution complicate this. The perception that criminals may exploit the asylum system has further complicated how asylum claims become determined. If too hard a stance is taken toward this possibility, legitimate refugee claims may be denied.

In response to the above pressures and a perception of uncontrolled migration, many regions that traditionally accept asylum seekers, such as North America, Europe, and Australia, adopted policies of deterrence in the 1990's and 2000's (Silove, Steel, & Watters, 2000). Some nations mandated confinement in detention centers during the asylum determination process or the creation of temporary forms of asylum, in which a recipient eventually must return to his or her original country. Even in circumstances when asylum has been granted, some nations stipulated enforced dispersal within the community, and asylum recipients could lose government entitlements if they declined to move to a designated area. These policies intended to limit the incentive to seek asylum and passively manage the flow of migration. This also demonstrated the paradoxical

response that host countries can have toward asylum seekers. Asylum seekers can elicit sympathy and compassion for being displaced by war and oppression, and yet, host countries also can view them as intruders. Specific to the United States, Coffey (2001) noted longstanding ambivalence between the country's legacy of compassion toward immigration and recurring fears of dwindling resources and cultural change.

The granting of asylum has remained discretionary and often considered a privilege instead of a right (Coffey, 2001). Administrative rights within the process have been set through case law, and this created a patchwork of administrative rights within a context of presumptive privilege. Asylum seekers have the right to due process and a fair hearing, and there are administrative safeguards to protect this (Coffey, 2001). Asylum seekers have the right to counsel and to submit evidence on their behalf. However, documented evidence of persecution may not exist, and if it did, asylum seekers often did not have the ability to collect it before or after migration. An applicant's testimony can be the only available evidence at times (Goodman, 2013). Due to this limitation, the court ideally gives an asylum seeker's testimony the benefit of the doubt, as long as it remains coherent, plausible, and does not run counter to generally known facts. Asylum hearings have broad evidentiary standards and can include things like hearsay as evidence. In general, though, the need to procure some form of corroborating evidence has become a norm, and virtually all successful asylum claims are accompanied by it.

The Mental Health of Asylum Seekers

The mental health and wellness of asylum seekers and refugees have been explored through empirical research and scholarship on professional practice. Keller et al.

(2003) investigated depression, anxiety, and history of traumatic experiences among detained asylum seekers in New York, New Jersey, and Pennsylvania. They used the Hopkins Symptom Checklist-25 (HSCL-25) and the Post-Traumatic Stress Disorder (PTSD) subscale of the Harvard Trauma Questionnaire (HTQ). The HSCL-25 is a symptom inventory that measures symptoms of depression and anxiety (Harvard Program in Refugee Trauma, 2011a). The HTQ inquires about traumatic events and symptoms commonly associated with traumatic experiences (Harvard Program in Refugee Trauma, 2011b). The researchers interviewed 70 participants (56 male, 14 female), from Africa (54), Eastern Europe (7) the Middle East (2), and South American (3). The participants had a mean age of 28 years (SD 7.3, range=15-26). A follow-up interview was conducted with 61 participants, at a median time of 101 days after the initial interview. The median length of detention at the initial interview was 5 months (range=1-54). Those who had been granted asylum status at the follow-up interview had been in detention for a median of 7 months (range=2-42).

Keller et al. (2003) discovered that detainees had experienced a multitude of traumatic events before seeking asylum, and they reported extensive symptoms of anxiety, depression, and PTSD. Fifty-two participants reported being tortured. Forty-seven reported imprisonment in their countries of origin. Forty-one described the murder of a family member or friend. Eighteen reported sexual assaults. In regard to anxiety, 77% of participants endorsed clinically significant symptoms. For depression, 86% reported clinically significant symptoms. In regard to PTSD, 26% reported symptoms that met criteria for a diagnosis. Among the participants, 26% described having thoughts of suicide during detention, with two reporting suicide attempts while in detention.

When factoring length of detention as a mediating variable, the study suggested that detention exacerbated symptom of depression, anxiety, and PTSD among the participants (Keller et al., 2003). The Spearman correlations between length of time in detention and initial levels of anxiety ($r=0.34$), depression ($r=0.28$), and PTSD ($r=0.28$) were all statistically significant. Participants who were still detained at the follow-up interview tended to have increased scores on the measures for anxiety, depression, and PTSD. Conversely, those who had been released from detention tended to have lower scores.

This study was limited in a number of ways (Keller et al., 2003). It did not use a comparison group of non-detained asylum seekers or refugees. The sample was also not random, as the participants were recruited from a small pool of referral sources. Despite being informed that the study would not impact their asylum claims, participants may have increased self-reports of clinical symptoms in order to bolster their applications. As most released asylum seekers had also been granted asylum, receiving asylum confounded the impact of the end of detention on symptoms. Finally, the effect of prolonged detention on symptoms could not be disentangled from the natural effect of untreated mental health symptoms becoming worse over time.

In another study of mental health issues among asylum seekers, Drozdek, Noor, Lutt, and Foy (2003) explored the associations between medical utilization, symptoms of PTSD, and treatment for PTSD among asylum seekers in the Netherlands. For the current study, Drozdek, Noor, Lutt, and Foy's relevance involved the evaluation of PTSD among asylum seekers. The study participants were 74 male asylum seekers with a mean age of 33 ($SD=8.4$, range=20-55), who had originated from Iran, Afghanistan, the Democratic

Republic of Congo, and Angola. The researchers administered a structured questionnaire to obtain demographic and social information, the Harvard Trauma Questionnaire (HTQ) to assess for PTSD, and the Hopkins Symptom Checklist-38 (HSCL-38), a 38-item version of the Hopkins Symptom Checklist-25, to evaluate for depression and anxiety. In regard to PTSD, 74% of the participants met diagnostic criteria as assessed by the HTQ. Across the participants, mean scores for anxiety, depression, and dissociation as evaluated by the HSCL-38 were high. Participants reported experiencing an average of 11.8 traumatic events, and they reported witnessing or hearing about someone else experiencing a traumatic event an average of 8.0 times. Participants who met criteria for PTSD also reported experiencing more personal traumatic events. This study was limited by the reliance on self-report measures and the use of a non-random sample.

Robjant, Robbins, and Senior (2009) examined levels of psychological distress among detained asylum seekers in the United Kingdom and compared them with levels among asylum seekers residing in the community. The study contained 146 participants: 98 male and 48 female, with a mean age of 31.86 (SD 9.7, range=15-66). Participants had migrated from 43 different countries of origin. The detained group comprised 97 participants from four immigration removal centers (IRCs). In this group, only 67 participants were asylum seekers, 21 of whom had failed claims and awaited removal. Thirty adjudicated prisoners who did not have legal immigration status comprised the rest of the group. The researchers recruited the community group from seven community centers, day centers, and drop in centers for asylum seekers and refugees, and it consisted of 49 asylum seekers, three who had failed applications.

Robjant, Robbins, and Senior (2009) administered the Hospital Anxiety and Depression Scale (HADS), the Impact of Event Scale-Revised (IES-R) (a questionnaire measuring posttraumatic intrusive thoughts, avoidance, and hyperarousal), and part one of the Post-Traumatic Diagnostic Scale (PDS), a checklist of traumatic events (National Center for PTSD, 2014). On the HADS, detained asylum seekers reported more symptoms of depression and anxiety than the community comparison group. Detained asylum-seekers had higher IES-R scores than the community group, specifically in regard to symptoms of avoidance. The researchers detected no main effect between length of time in detention and number of reported traumatic events. There was an interaction effect between length of time in detention and symptoms as measured by the HADS, specifically on the depression subscale.

The researchers noted a number of limitations to this study (Robjant, Robbins, & Senior, 2009). First, the participants were from a diverse array of cultures, which may have affected measure validity. Second, the researchers noted that the Impact of Event Scale-Revised might measure general distress rather than PTSD specifically, as it correlated highly with depression and anxiety measures. Third, the detained group comprised two subgroups, asylum seekers and adjudicated, non-legal immigrants, and these may be demographically separate populations. Fourth, the researchers operationalized length of time in detention with a one-month cutoff. Since asylum seekers can be detained for several months, a one-month cutoff may be premature. Fifth, the correlational nature of this study could not establish a causal connection between detention and mental health. Detention could be damaging to mental health. Conversely,

people with pre-existing mental health difficulties may be more likely to be detained due to a lack of community resources and support.

Steel et al. (2006) studied the long-term mental health effects of mandatory detention and subsequent temporary protection on Australian asylum seekers. In Australia, temporary protection visas were created in 1999. Holders have a time limit on residency and restricted access to healthcare, education, work, and travel. The study's sample consisted of 241 Mandaean, an ethnic group from Iraq and Iran. Sixty-two percent had been detained on arrival in Australia. Regarding residential status, 58% held temporary visas, while 42% held permanent visas. All participants were interviewed with the Harvard Trauma Questionnaire (HTQ), the Hopkins Symptom Checklist-25, and the Medical Outcomes Study-Short Form. The Medical Outcomes Study-Short Form measured physical health, mental health status, and disability. They also utilized three measures developed by the research team. The Post-Migration Living Difficulties Checklist identified ongoing stressors after migration. The Detention Experiences Checklist detailed 64 common adverse experiences in detention. The Detention Symptom Checklist, a modified version of the Harvard Trauma Questionnaire, related specifically to the detention experience.

The results suggested that both prolonged detention and temporary protection contributed substantially to ongoing depression, PTSD, and mental health-related disability (Steel et al., 2009). This relationship remained even when controlled for other risk variables, such as gender, age, extent of past trauma, length of residency, and experience of family separation. Holders of temporary visas reported more pre-migration trauma than permanent visa holders. Holders of temporary visas also reported greater

post-migration living difficulties than permanent visa holders. In regard to detention experiences, 90% of temporary visa holders and 30% of permanent visa holders had been detained upon arrival. The median time in detention was 6 months. The researchers stratified detained respondents into groups of short (0-5 months) and long-term (over 5 months) stays. Both groups reported substantial stress on all indices, but the long-term detention group tended to score higher. The long-term detention group reported more traumatic stress symptoms related to past detention, even though the mean time since detention had been 35.5 months. Holders of temporary visas had higher rates of depression, PTSD, and mental health-related disability than those with permanent visas. Those who had experienced long-term detention continued to experience greater rates of depression, PTSD, and mental health related disability.

Steel et al. (2009) acknowledged several limitations to this study. The sample was not random. Participants with more traumatic experiences may have been more likely to participate. The focus on one refugee population limited generalizability to other groups. Similarly, this study involved holders of temporary visas after the United States-led 2003 invasion of Iraq. Unique characteristics of that conflict and the participants' situation may have affected results. Finally, the measures were all self-report, and the researchers considered that temporary visa holders might report more difficulty in order to highlight their political situation.

While the previous studies described the mental health situation of asylum seekers and refugees, some literature has explored possible reasons for their compromised mental health. Perez Foster (2001) focused on distinguishing between stressors that are endemic to most immigrant experiences and those that precipitate trauma. Perez Foster described a

three-phase framework for understanding the trauma of immigration: pre-migration, transit to the new country, and resettlement (adapted from Desjarlais, Eisenberg, Good, & Kleinman, 1995). Resettlement would include possible asylum application. Pre-migration trauma can involve events like war, civil unrest, political persecution, and general socioeconomic impoverishment. Transit experiences can be traumatic if they involve short-term residency in camps or dangerous and uncertain transportation. Resettlement trauma can involve a host of experiences that stress immigrants and challenge their accepted worldviews. People can experience substandard living conditions and a general downturn in socioeconomic status in a host country. Immigrants may experience the loss of family and community social networks. Women may find work quicker after migration, which can redefine familial gender norms. Immigrants to the United States also encounter cultural mores and values that can be incongruent with ethnic traditions. Additionally, children may assimilate to the host culture quicker, creating distance from parents and disrupting family hierarchies.

Specific to asylum seekers, the detention environment can trigger disturbing memories of previous imprisonment and persecution (Perez Foster, 2001). This traumatic reaction can sometimes be misinterpreted as uncooperative behavior, and the reaction of detention guards can foster further triggering of traumatic memories. In a similar regard, Silove, Steel, and Watters (2000) identified how an interrogative approach in interviews can trigger PTSD symptoms. This might negatively impact asylum cases by fostering discrepancies within asylum seekers' stories.

Robjant, Hassan, and Katona (2009) discussed plausible ways in which the detention process can negatively impact the mental health of immigrants. They completed

a systematic review of studies that investigated the mental health impact of detention on children, adolescents, and adults who had been detained as part of their immigration. They identified ten qualitative and quantitative studies that consistently indicated an association between detention and poor mental health, namely high rates of anxiety, PTSD, depression, and thoughts of self-harm and suicide. Detention can involve a host of stressors for those who experience it, such as uncertainty about removal, social isolation, and conflicts with detention staff. In addition to characteristics of the detention environment, the qualitative studies implicated a sense of injustice and feelings of hopelessness as contributory psychological factors. In all studies, longer lengths of time in detention were associated with higher reports of symptoms.

Kaplan (2009) described the ways in which the psychosocial experiences of refugees can affect psychological wellbeing. Once settled, refugees contend with factors such as ongoing grief and guilt about being separated from family members and communities. They may experience practical hardships, such as learning a new language, adjusting to a different culture, and establishing a new life. They also possess limited social support in the face of a potentially hostile reception from the host community. Refugee experiences and trauma can also impact specific psychological domains. It can detrimentally affect cognitive functioning, information processing, and learning achievement. Early trauma experiences can negatively impact the attainment of a secure attachment style and long-term emotional regulation abilities. Beyond the level of the individual, family functioning in the form of a sense of cohesion and parental capacity can be challenged.

In summary, the research indicated a number of mental health issues associated with being a refugee or asylum seeker. Research on this population consistently reported high degrees of psychological distress in the form of depression, anxiety, symptoms of PTSD, and self-harm ideation and behavior. Asylum seekers have been exposed to a number of traumatic experiences before and during migration to the host country, and they face serious psychosocial stressors afterward. Furthermore, being in detention has been associated with higher rates of psychological distress, in comparison to asylum seekers who always lived in the community or had been released from detention.

The Psychological Assessment of Asylum Seekers

Aron (1992) and Freed (2005) noted that a psychologist's report serves several functions in the asylum process. It can prepare court officials and judges for the behaviors that a client may exhibit during testimony. It can help identify therapeutic needs and make treatment recommendations. It also potentially humanizes asylum seekers for court officials, so they can be seen as more than their legal category. Most notably, though, psychological assessments provide supportive evidence for an asylum seeker's claim by linking past traumatic events with present mental health symptoms. To do this, the clinician assesses the applicant's mental state and determines the consistency of his or her history and reported symptoms. Additionally, the evaluation can be utilized further to determine if the events of the asylum claim interfered with an asylum seeker's ability to file within the statutory deadlines, and it can explore if detention has affected the asylum seeker's mental health and asylum claim. Within the asylum process, the clinician is commissioned as an independent and objective expert, and his or her affidavit

is considered useful to the extent that the evaluation occurred in a context of clinical objectivity and professionalism.

Freed (2005) outlined an ideal process for conducting an assessment with an asylum seeker, while noting that the reality of assessment processes can vary due to contextual factors and clinical decisions. The evaluator typically receives asylum claim documents from the attorney and reviews them. The evaluator strives to work collaboratively with the attorney through all steps of the process. The evaluator then familiarizes him or herself with the culture and politics of the asylum seeker's country as much as possible. During the actual interview, the asylum seeker will be encouraged to help with this when specific knowledge is needed. The evaluator orients the asylum seeker to the purpose of the evaluation and explains the parameters of confidentiality, especially in regard to communication with attorneys and courts. The assessment will proceed flexibly. An asylum seeker's mental state is often unknown prior to the assessment, and it may also fluctuate during the process of the assessment. The evaluator will focus on the events of the asylum seeker's claim and screen for mental health symptoms that may be related to it. The assessment will also highlight concerns about future persecution in the event of denial of an asylum claim. The evaluator will also ask questions to ascertain the asylum seeker's life and functioning before the claim events. This offers a baseline comparison, and the assessor can learn about potential resources and coping mechanisms. If treatment is recommended, the asylum seeker's response to treatment can also provide some indication of the asylum seeker's capacity for integrating traumatic experiences into an overall life narrative. The evaluator will leave time at the end for questions and try to conclude the evaluation in a positive manner.

Since these assessments serve as evidence in court proceedings, Freed (2005) also provides general guidelines for how evaluators can write their assessment as a legal affidavit. Affidavits generally begin with a legal heading, a statement that affirms how the information was gathered, and a statement of the evaluator's qualifications (i.e., profession, degrees, licenses, certifications, educational institutions attended, and date of graduation). Affidavits should be written as clearly as possible with any conclusions supported by evidence gathered during the assessment. Any narrative of events must be reported as a true representation of the applicant's account. Criteria for diagnosis should be detailed and presented clearly. An evaluator should work closely with the attorney in order to minimize inconsistencies with asylum documents and prepare for possible court testimony.

Clinical and Professional Challenges with Assessing Asylum Seekers

Many aspects of asylum seekers' sociopolitical situation and distinct mental health issues can challenge the assessment process and complicate clinical practice.

The Impact of Detention and the Asylum Process. As noted earlier, the assessment process can hold the potential to negatively impact the mental health of asylum seekers. The detention environment can trigger disturbing memories of previous imprisonment and persecution, which can be misinterpreted as uncooperative behavior (Perez Foster, 2001). Also, an interrogative approach during interviews can trigger PTSD symptoms (Silove, Steel, & Watters, 2000). This might negatively impact asylum cases by fostering discrepancies within asylum seekers' stories. Also, an evaluator may be seen

as an authority figure and remind the asylum seeker of a past persecutor (Freed, 2005). The administrative demand to obtain a testimonial of traumatic events may run counter to usual clinical caution when delving into traumatic material (Steel, Frommer, & Silove, 2004).

Mental health symptoms and psychological factors may also influence asylum determination. Rousseau, Crepeau, Foxen, and Houle (2002) qualitatively analyzed 40 cases by the Canadian Immigration and Refugee Board and identified five general themes. First, decision-makers frequently misinterpreted PTSD symptoms in a way that discredited claimant stories. Second, confusion about dates and time lines was often met with suspicion. Third, the typical process of disclosing trauma, that is details emerge over time, was not considered, and the omission of significant information from original statements was seen as evidence that events did not occur. Fourth, decision-makers often did not appear to understand or consider medical and psychological evidence. Fifth, decision-makers experienced vicarious traumatization from hearing claims, and this sometimes resulted in a lack of empathy and the defensive use of avoidance.

Use of Psychological Measures. Psychological measures have been used extensively in research on the mental health of asylum seekers, and theoretically they can assist in the clinical assessment process. However, researchers and clinicians have raised questions about their linguistic and cultural appropriateness. Perez Foster (2001) identified two central concerns with the use of measures. First, most measures that psychologists use have been designed, standardized, and validated from majority American populations. When used with other populations, there may be substantial

testing bias. Second, psychologists unintentionally create new measures when they translate existing ones. Even if they are translated in a fashion that maintains fidelity across languages, these translated measures still require new study for reliability and validity with the new language and population.

The Harvard Trauma Questionnaire (HTQ) and Hopkins Symptom Checklist-25 (HSCL-25) have been used commonly in research and clinical practice with asylum seekers. Jakobsen, Thoresen, and Johansen (2011) studied the usefulness of the HTQ and HSCL-25 as screening tools for PTSD and other mental health issues among asylum seekers from various countries. Sixty-four individuals from Africa, Asia, and Europe completed the HTQ and the Composite International Diagnostic Interview (CIDI), a semi-structured clinical interview. Their mean age was 33 years old, and 46% of participants were female. The HTQ was translated into five languages: Arabic, Dari, Farsi, Bosnian, and Somali. Ninety-five percent of study participants reported experiencing one or more traumatic events, and participants averaged self-reports of nine traumatic events. In regard to diagnoses, 70% of participants met criteria for some kind of mental health issue, the most prevalent being PTSD (45%) and a depressive disorder (33%). Forty-two percent of participants met criteria for more than one diagnosis. Crucially, the HTQ and HSCL-25 both showed significant differences in their estimation of PTSD when compared to results from the CIDI. These differences varied by language group, sometimes overestimating the prevalence of PTSD and sometimes underestimating it. Despite the time and cost involved, the researchers concluded that validating the measures for each language group or developing alternative methods of assessment would improve symptom identification and minimize cultural bias.

Other cultural factors can complicate the use of measures with refugee and asylum seeking populations (Kaplan, 2009). Refugees may have cognitive skills or capacities that are not recognized fully by professionals and psychological measures. They may have little experience with formal classroom environments or performance testing. Standardized testing may not be normed for people of their cultural background and may involve social conventions and norms that are unknown. Under the best of circumstances, the results of standardized testing may identify an area of need but might not guide actual interventions. Any number of causative factors, including cultural testing bias, may lie behind an identified deficit.

Diagnosis and Culture. Clinicians face an interesting challenge when using PTSD and other psychiatric diagnoses with asylum seekers. Beliefs about mental health, psychological wellbeing, and wellness differ by cultural situation, and many cultures emphasize community and family processes as well as physical, moral, or spiritual explanations (Perez Foster, 2001; Tribe, 2005). Conversely, Western beliefs tend to revolve around individual or intrapsychic processes. Perez Foster (2001) discussed that many indigenous idioms of distress emphasize somatic symptoms over psychological ones. A focus on Western nosology may diagnose culturally appropriate behaviors, affects, and belief systems as pathological, and it can ignore or de-emphasize natural avenues of resilience and personal meaning for asylum seekers.

Also, the kinds of traumatic experiences that asylum seekers report may not be conducive to Western diagnostic knowledge. Given the fact that most refugees have suffered a variety of unquestionably terrible experiences, responses that meet criteria for

PTSD may reflect normal human reactions to extreme situations (Tribe, 2005). Clinicians may be unfamiliar with clients who have psychological issues resulting from well-founded fears of persecution (Aron, 1992). Instead, they may interpret chronic fear as pathological or a loss of reality testing. Aron also noted the difficulty of differential diagnosing. For instance, issues such as communication disorders, substance abuse, or personality disorders might be better understood within the context of PTSD. Clinicians may be unfamiliar with the phenomenology of torture trauma, the most extreme form of trauma experienced by asylum seekers. Steel, Frommer, and Silove (2004) indicated a consistent pattern of sequelae from torture, which can include depression, anxiety, sleep disturbances, nightmares, impaired executive functioning, and PTSD. Finally, the absence of psychological symptoms does not indicate that an alleged event did not happen. Many individuals demonstrate resilience and an ability to cope with extreme events, and PTSD is not an inevitable outcome (Steel, Frommer, & Silove, 2004).

Nevertheless, the need for a psychological report and the power differential with professionals can result in an asylum seeker's distress being translated into Western psychiatric terms despite these and other challenges. Some researchers proposed ways of expanding diagnostic practice to address cultural considerations. Davidson, Murray, and Schweitzer (2010) advocated identifying patterns of distress among specific populations. In effect, this could create subtypes of PTSD associated with cultures and historical events. Also, they proposed assessing beyond the traditional focus on PTSD and identifying longer-lasting psychopathology, as these may have a greater impact on functioning, and other dimensions of refugees' lives. The ICD-10 category of Enduring Personality Change after Catastrophic Experience would be one such possibility (Beltran

& Silove, 1999). Dana (2007) stressed a more comprehensive assessment of refugees than just psychopathology. This would include domains of holistic health (i.e., adaptation, posttraumatic growth, strength, resilience, wellness, and resources for resistance) and acculturation (i.e., cultural identity, ethnic identity, racial identity, acculturation stress, coping skills and styles, and social support).

Assessing Credibility of Events. Aron (1992) discussed how assessing credibility and the veracity of asylum seekers' claims added a new dimension to clinical practice. Typically with asylum seekers, a psychologist would start by gathering a general history. Only after a certain period of this would a psychologist elicit the story of a client's claim. The psychologist would then build a clinical impression of the story's organization, the manner and ease in which it is told, points of emphasis, details and omissions, and overall coherence. This can differ radically from how governmental figures elicit a client's story. Namely, it involves a greater sensitivity to placing the client at ease and minimizing the difficulty of self-disclosure. Despite the fact that asylum seekers already have told their stories numerous times, clinicians often find that they tell the full extent of their traumatic stories for the first time in an assessment.

Herlihy, Scragg, and Turner (2002) stated that asylum seekers often give differing accounts of persecution. Asylum officials may assume that this reflects a lack of credibility, as a wealth of detail, especially peripheral ones across multiple disclosures, is a commonly held measure of credibility. However, the emotional impact of the overall memory, discussions of the event by others, and the phrasing of questions have been shown to disrupt memory for peripheral details (Lipton, 1977). Herlihy, Scragg, and

Turner explored the phenomenon of differing accounts more closely. In their study, they asked 43 refugees from Kosovo and Bosnia to recall a traumatic event from their experiences and complete a post-traumatic stress scale. The participants were then re-interviewed from three to 32 weeks later. Discrepancy rates between the two interviews were calculated for central and peripheral story details. Discrepancies between the two interviews were found for all participants, but the length of time between interviews had a significant effect on number of discrepancies, especially for peripheral details. In the group of participants who scored high for post-traumatic stress, this association was strongest. Herlihy, Scragg, and Turner hypothesized that factors such as experiencing multiple similar traumas, emotional state at the time of an interview, and reminiscence (i.e., new information becoming available over repeated recall) may be related to discrepancies. They expressed concern that a focus on discrepancies as a measure of credibility may reflect negatively on an asylum seeker's claim, especially if they show symptoms of post-traumatic stress at the time of an interview. This study's primary limitation was a small sample size.

Language Considerations. Bilingualism and language differences can affect the assessment process. Perez Foster (2001) noted that bilingualism can affect symptom expression, which would in turn complicate diagnostic practices. The use of a second language might serve a facilitative, defensive function for clients, as it can isolate the emotions associated with the trauma narrative. Searight and Searight (2009) also described clients alternating between first and second languages as a possible defense mechanism for managing emotions related to difficult interview content. Recall of

experiences may be more vivid and emotionally overwhelming in a client's first language, and a second language can utilize cognitive resources that help modulate emotions. Perez Foster also stated that anxiety or discomfort with a second language may affect a client's presentation. The fear and frustration of not being understood can paralyze clients, and people may feel less capable and intelligent when using a second language. Searight and Searight (2013) stated that language discordance has the potential to result in misdiagnosis and misattribution of symptoms and may mask cognitive pathology. Perez Foster recommended evaluating language proficiency and the client's history of learning both English and his or her original language. If possible, bilingual assessments may be optimal.

Interpreters have been a common part of assessments with asylum seekers when clinicians and clients do not speak the same language to a proficient degree. Tribe and Lane (2009) emphasized that working with interpreters requires clinicians to develop a range of new skills. They must learn a greater level of reflection on their communication style and possess more clarity and thoughtfulness about language usage. Similar to this, clinicians must learn to identify and then avoid the use of colloquialisms and metaphorical statements, as their meaning may not translate well. They must learn to make interpreters feel at ease and valued for their contributions. They must grow in their ability to work cross-culturally by identifying their assumptions and learning other culture's ideas about behavioral health and distress. They also have to consider the implications of working within a clinical triad, instead of a dyad, and make appropriate adjustments.

Searight and Armock (2013) proposed a three-phase set of guidelines for clinicians to follow when working with interpreters. First, they suggested a pre-session meeting, in which the clinician orients the interpreter to the purpose of the interview. The interpreter should be instructed to translate everything said and use first person language and pronouns. Second, they discussed clinician behavior during the interview. The clinician was encouraged to minimize eye contact with the interpreter and focus on the client. The clinician should also ask only one question at a time and speak in short sentences. Third, Searight and Armock proposed a post-interview meeting between the clinician and interpreter. They can provide feedback to each other and clarify any cultural or linguistic issues. They can also process any emotional reactions that the interpreter may be having.

In contrast to the “black box” view of interpreters, in which they are seen purely as verbatim language translators, interpreters in mental health contexts can adopt multiple roles (Searight & Armock, 2013; Searight & Searight, 2009; Tribe & Lane, 2009). Notably, they can be treatment advocates and clinical paraprofessionals. Due to these dual roles, some professional dilemmas can occur when interpreters are used in mental health settings. Interpreters may not have adequate training in client confidentiality or understand its importance. They may intervene negatively when the client is experiencing a strong emotional reaction, either by stifling it or offering a caretaking response. Similarly, they may selectively translate clients’ speech in order to protect them from shame or embarrassment. This can be noticed from nonverbal signs of shame or vague and inconsistent replies. They may be unaware of the ethical and professional standards of clinicians and lack a framework for addressing ethical dilemmas that arise. They may

also lack intentional routines of self-care and be unaware of the potential for vicarious traumatization.

The type of interpreters used in clinical assessments may affect the quality of communication and rate at which traumatic events and psychological issues are detected. Eyton et al. (2002) reviewed 319 structured medical screening interviews with Kosovo asylum seekers to Switzerland. For 18% of the interviews, relatives were used as ad hoc interpreters. Professional interpreters were used in 16% of the interviews. Finally, no interpreters were used for the remaining interviews. In those instances, screeners used a mixture of specifically designed lexicons, drawings, and gestures. In terms of communication quality, interviews were categorized with ratings of poor, fair, and good. With no interpreter, 16% of interviews were rated as good. With a relative used as an ad hoc interpreter, 28% of interviews were rated as good. With a professional translator, 94% of interviews were rated as good. The presence of a trained interpreter increased the proportion of people reporting traumatic events and psychological symptoms above when no interpreter or a relative was used.

Eyton et al. (2002) hypothesized that the use of trained interpreters assisted the expression of psychological distress, provided important verbal and cultural information, and acted as cultural mediators. The authors also hypothesized that the use of relatives as ad hoc interpreters lead asylum seekers to under-report issues in order to protect relatives from painful information or avoid stigmatization. This study was limited by a retrospective research design that used data not collected with the intention of studying the impact of interpreters.

New Professional Considerations. Mares and Jureidini (2004) drew from their experiences with an Australian Immigration Reception and Processing Centre (IRPC) and addressed the professional complications that psychologists can face when assessing asylum seekers. First, staff felt that a medical model approach to diagnosis devalued the environmental and systemic context of the detention center as a contributor to psychopathology. Second, their clinical recommendations in the assessments were enacted in no cases, which was attributed to administrative and practical barriers. This inaction on recommendations was seen as an ethical and moral dilemma for personnel. Third, it was not possible for staff to divorce political concerns and debate from the assessment process, due to the ongoing impoverished and traumatizing detention center environment. Fourth, the IRPC and by extension the assessors held the ambivalent position of being both the caregiver and jailer of asylum seekers, which represented dual roles and a conflict of interest. Fifth, clinicians had little administrative power within the system, similar to their clients. Eventually, clinicians felt that their professional expertise had been denigrated, and some felt impotence, guilt, and complicity over their failure to protect clients from detention's negative effects. Sixth, some clinicians reported vicarious traumatization, describing feelings of hopelessness, avoidance, numbing, sadness, and despair. Staff attempted to cope with these various difficulties by allocating assessments across multiple teams and clinicians, visiting the IRPC jointly with other staff members, having weekly phone conferences, and debriefing after difficult events.

Freed (2005) warned of the potential for vicarious traumatization, when the evaluator feels a level of helplessness and hopelessness similar to the applicant. This can present a dilemma for the clinician who works with asylum seekers. He or she may

respond by distancing from the applicant, which negatively affects rapport and the thoroughness of the assessment. Conversely, evaluators can respond by becoming too closely identified with the applicant. In addition to the clinician being emotionally overwhelmed, this can convey to the asylum seekers an inability to create a safe and comfortable environment for the assessment.

Since work with asylum seekers can involve social and political advocacy as well as clinical practice, Silove, Steel, and Watters (2000) discussed how psychologists could tangibly address those needs of asylum seekers. Psychologists can contribute to the general knowledge in this area and heighten awareness of the issues through research and advocacy. Silove, Steel, and Watters also believed that advocates must be pragmatic and willing to consider less than perfect alternatives to detention, such as temporary asylum. They stressed that psychological and psychiatric reports may benefit from integration with physical examinations. To this end, cross-disciplinary, interagency coalitions may be more effective than the work of individual health professionals. Finally, they thought that psychologists should work to promote leadership and political structures within the communities of asylum seekers.

Limitations of the Literature and Focus for the Current Study

The majority of the literature on asylum seekers has focused on the mental health needs of asylum seekers (Drozdek, Noor, Lutt, & Foy, 2003; Kaplan, 2009; Keller et al., 2003; Perez Foster, 2001; Robjant, Hassan, & Katona, 2009; Robjant, Robbins, & Senior, 2009; Steel et al., 2006; Silove, Steel, & Watters, 2000) and the process of and challenges to psychological assessment of an asylum seeker's claim (Aron, 1992; Dana, 2007;

Davidson, Murray, & Schweitzer, 2010; Eyton et al., 2002; Freed, 2005; Herlihy, Scragg, & Turner, 2002; Jakobsen, Thoresen, & Johansen, 2011; Kaplan, 2009; Mares & Jureidini, 2004; Perez Foster, 2001; Rousseau, Crepeau, Foxen, & Houle, 2002; Searight & Armock, 2013; Searight & Searight, 2009; Silove, Steel, & Watters, 2000; Steel, Frommer, & Silove, 2004; Tribe, 2005; Tribe & Lane, 2009). Information about psychologists' experiences when conducting these assessments have been a minimal part of the literature, beyond short anecdotes and generalized statements (Freed, 2005; Mares & Jureidini, 2004). The literature did not provide an intentional exploration of how psychologists administer these assessments, the personal and professional challenges they encounter, and aspects of psychologists' training to do this work. A qualitative exploration can provide a rich source of information about these areas and help explicate common categories of experiences.

Qualitative Research

A qualitative study design was used to provide a fuller description of psychologists' experiences providing assessments to asylum seekers to the United States. According to Morse and Richards (2002), qualitative research designs can be well-suited for certain research purposes. First, they can increase understanding in areas where distinct research questions have been overlooked or incompletely formulated. Furthermore, data can be collected in a way that helps formulate new research questions. Second, qualitative research designs can help researchers make sense of complex situations in a manner that does not involve reductionism or remove key contextual information. Third, they can focus on how participants perceive and understand an

experience or phenomenon. Fourth, they can help construct a theoretical framework that reflects the data more than prior assumptions or previous research findings. Fifth, qualitative research designs can help understand experiences in a deeper and fuller sense by identifying core categories and themes.

A qualitative design was chosen for the current study for a number of reasons. The literature on the assessment of asylum seekers did not provide much information on psychologists' personal and professional experiences aside from generalized statements and brief, anecdotal accounts (Freed, 2005; Mares & Jureidini, 2004). From this paucity of information, distinct research questions or hypotheses were difficult to form. A qualitative research design could explore the experience in a general sense and identify important areas and questions for further study. Also, a qualitative research design would focus on the perceptions, interpretations, and distinct contexts of psychologists' experiences. It would provide a sense of their understanding of matters instead of relying on a priori assumptions. A qualitative research design could build a framework of categories and themes from the participants' descriptions.

Chapter III

Methodology

Participants

Participants for this study were six psychologists who have conducted psychological assessments with adults seeking asylum to the United States. To be eligible for the study, a participant had to a) be a licensed or supervised doctoral-level psychologist, b) have conducted at least two assessments with asylum seekers over his or her career, and c) have conducted at least one of these assessments since 2003. The mean age of participants was 48. Three participants were women, and three were men. All six participants identified their ethnicity and race as white. The mean age since licensure for participants was 13.5 years, with a range of zero to twenty-seven years. One participant had yet to complete licensure and performed assessments under the supervision of a licensed, doctoral-level psychologist. Five participants held doctoral degrees in Clinical Psychology, and one participant held a doctoral degree in Counseling Psychology. Participants estimated conducting a mean number of 31 assessments over their careers, with a range of three to one hundred assessments. The modal year of participants' most recent assessment was 2013.

Measures

The study utilized a demographic questionnaire and semi-structured interview to gather data from participants. The Demographic Questionnaire (Appendix C) was administered at the beginning of the interview. This questionnaire requested information

from the participant regarding a) age, b) gender, c) racial and ethnic background, d) professional degrees and years obtained, e) years in practice since licensure, f) number of psychological assessments with asylum seekers conducted in his or her career, and g) year of most recent assessment.

The Semi-Structured Interview (Appendix D) gathered data related to the purpose of this study. This measure consisted of a series of open-ended and closed-ended questions and prompts related to three primary areas: a) the participant's experiences conducting assessments with asylum seekers, b) their professional training to conduct these assessments, and c) a general, open-ended question to close the interview. The questionnaire prompts were used when the open-ended question yielded insufficient information.

Procedure

Participants were recruited through a) email advertisements (Appendix A) to two agencies that connect asylum seekers with psychologists, b) email advertisements (Appendix A) to two state psychological associations, and c) word of mouth from participants. Sixteen individuals responded to recruitment efforts. The researcher provided them with information about the purpose and procedures of the study, confirmed their eligibility for the study, and arranged either an interview in person or through Skype, a video conferencing computer program. After receiving a copy of the study's oral consent form (Appendix B), two individuals declined to participate. Five individuals did not respond to further communication. One individual did not wish to be recorded. Three individuals were deemed to not meet the study's eligibility criteria. They

were provided with an explanation of ineligibility and thanked for their time and interest. Participants were not offered financial compensation for participation.

All participants chose to be interviewed through Skype. The researcher asked each participant to find a setting that ensured comfort and privacy for interviewing. Before each interview, participants read an oral consent form (Appendix B) that described the parameters of the study. At the beginning of the interview, participants read two statements at the end of the oral consent form that gave their consents for participation and audio recording. The researcher used an oral consent form to protect participant confidentiality by limiting the storage of identifying information. Participants were given a copy of the oral consent form for their records.

All participants were interviewed using the Demographic Questionnaire (Appendix C) and the Semi-Structured Interview (Appendix D), both developed by the researcher. The participant interviews lasted an average of 47 minutes, with a range from 35 minutes to 65 minutes.

Treatment of Data

All data were managed and stored in accordance with the rules and regulations of Rutgers' Institutional Review Board.

Demographic Questionnaire. Responses to the demographic questionnaire were used to categorize participants based on age, gender, racial and ethnic background, professional degrees and years obtained, years in practice since licensure, number of psychological assessments with asylum seekers conducted in his or her career, and year

of most recent assessment. All participants were assigned a non-sequential, three digit case number prior to the interview. All interviews were recorded for review and transcription. No identifying information, beyond the case number, was attached to recordings, measures, or transcriptions.

Interview Data. The researcher stored audio recordings of each interview on a password protected flash drive. No identifying information, beyond the case number, was attached to recordings or transcriptions. After transcription, the audio recordings were deleted. Any record of contact information was not kept as part of the research record, and the researcher destroyed any written communications with participants, such as email conversations. All remaining study data will be kept for five years after completion of the study.

Data Analysis

Data were analyzed using a modified version of Strauss and Corbin's (1990) grounded theory methodology. Grounded theory examines issues of process and dynamism (Morse & Richards, 2002). This examination assumed that theory could be induced and constructed from the interplay between analysis and data (Morse & Richards, 2002). The goal of this data analysis was to identify the categories, relationships, and knowledge that informed the participants' experiences in providing assessments to asylum seekers.

Data analysis occurred in three phases: open coding, axial coding and selective coding (Strauss & Corbin, 1990). In open coding, the data were scrutinized for

similarities and differences. The researcher extracted general categories and coding labels from the transcripts. Then data across transcripts were collapsed into these general categories. The researcher then identified related categories and collated them into larger group categories. In axial coding, the researcher attempted to relate the identified categories to each other and emphasized possible relationships. This was done to recognize and understand patterns that may be present within the data. The researcher also created a generic framework that emphasized the main phenomena, causal conditions, moderating contexts, mediating conditions, activities, and consequences. In selective coding, categories and relationships identified through open coding and axial coding were used to identify core categories. These core categories related to other categories and acted as the foundation of the “grounded” theoretical model. Through each step, the researcher attempted to refine connections between previously identified categories in an iterative manner.

Chapter IV

Results

Eleven major categories of experiences arose in participants' answers during the Semi-Structured Interview (Appendix D). These categories involved a) the location of assessment experiences, b) experiences working with interpreters, c) assessing for trauma and PTSD, d) the use of psychological measures, e) writing the assessments, f) experiences with the asylum system and process, g) adapting to cultural differences, h) personal and professional impact of this work, i) professional dilemmas, j) methods of self-care and coping, and k) training experiences.

Locations of Assessment Experiences

The participants provided psychological assessments for asylum seekers in several locations. Four out of six (67%) participants worked in only one setting, and two out of six (33%) participants had experience with multiple settings. Four out of six (67%) participants conducted their assessments in private practice offices. Three out of six (50%) participants provided assessments in an agency setting, such as a treatment clinic. One out of six (17%) participants worked within the offices of the clients' attorneys. One out of six (17%) participants conducted assessments at a detention center.

The participants often noted how the setting of the assessment seemed to affect the assessment experience. All participants who worked in private practice offices noted that they could offer a high level of client confidentiality and comfort. In regard to working in attorney offices, that participant expressed a similar benefit and said,

I think that there was increased comfort because they had already had positive experiences in these offices. If their lawyers are introducing them to me, they're kind of getting the implicit message that this is a safe guy, somebody who you can talk to who is working on your side.

In regard to agency settings, participants noted the administrative and peer support that came with working in an agency. One participant stated, "I had a small community of colleagues." This community was available to help clients with basic needs and possible treatment. This setting also supported this participant's clinical growth; "We didn't have training in doing asylum evals when I got there. I learned it from my colleagues." The agency setting also introduced challenges such as limited office availability, possible client discomfort, and increased client needs. One participant noted, "There are lots of reasons asylum seekers came to our clinic, and most of them were in some desperate need, either help with legal status or very basic needs, so the assessment takes on that much more pressure."

The participant who conducted assessments at a detention center identified many practical and psychological challenges to working in such a setting. The participant stated,

You really have to clear your schedule for the day because it can take me hours to talk my way into the detention center. It's always the same. We go thru all this rigmarole a week ahead of time to fax my credentials to get security clearance for me to go in. I go there, they've never heard of me, they've never gotten any of the pieces of paper, they have no idea what's happening, and so it takes hours back and forth between the attorney, me, the human rights clinic.

In addition to the time spent entering the center, the participant often experienced insufficient blocks of time for assessments to occur, which necessitated return visits. Finally, the participant noted the psychological impact of the detention center location and said,

I guess I feel the oppression. You know, which in some ways, I guess . . . was an interesting thing because you sort of, it's not anymore the scene, but you sort of have a more visceral empathy for the oppression that they go through, both not just in the prison but what they've gone thru as a torture survivor, that kind of oppression. So oppression becomes a much more visceral and open thematic issue in the evaluation.

Experiences Working with Interpreters

Five out of six (83%) participants discussed their experiences using interpreters during assessments for asylum seekers. Regarding the identities of interpreters, three out of six (50%) participants said that their clients already had a relationship with the interpreters, such as friendship, family connection, or a previously known advocate. One out of six (17%) participants discussed using only professional interpreters. One out of six (17%) participants preferred working with interpreters even when clients were proficient in English, as this participant believed that clients could express emotion better in their native language.

Three out of six (50%) participants said that interpreters sometimes did not translate clients' words exactly. Interpreters noticeably said either more or less than what the client spoke. One participant said,

Some people add their own commentary in there, and I have to ask them to not do that. It's a typical translation experience that I've had in settings where, say, the client will talk for 30 seconds, and the translator will use like 2 words, and I'm like, "Is that really what they said or not?" It's hard to tell.

One participant had the experience of assessing clients who spoke a language in which the participant had some proficiency. In that situation, this participant readily noticed interpreters not translating directly. The participant said

I still always use an interpreter because I don't want to miss anything because I'm not fluent in conversing, but that's interesting because a lot of times you know, an interpreter will feed something back to me, and I thought I understood it a little differently.

Two out of six (33%) participants said that interpreters often played a larger role than just translating client's words. One participant had experienced interpreters being an emotional support for clients, helping them through the assessment. Another participant stated that interpreters often educated them about the client's cultural background, such as providing contextual information to a client's statements. This participant also described a tendency for interpreters to embody familiar cultural roles with clients. This participant said,

Maybe the client is expressing something relevant and important, and then the interpreter kind of takes on a role, a familiar role of like, that's not okay, and I have to try to notice when that's happening, but also understand it a bit because it'll shut down the client.

Another participant identified how cultural gender norms became particularly relevant when the interpreter and client were different genders. This participant said,

Say for instance, a woman is the client, and a man is the translator. Some of the questions, for instance, on the TSI-2 [Trauma Symptom Inventory-2] are about peoples' sexual experiences and so forth, and I just eliminate them because really it's clear it's a violation or a taboo or just going to create way too much discomfort.

Two out of six (33%) participants described challenges that interpreters often face when translating for asylum seekers. One participant believed that interpreters were often caught between two cultures. This participant described an assessment in which an asylum seeker's claim involved persecution for sexual orientation. This subject matter was reportedly difficult for the interpreter, who did not know the client well, to discuss. The other participant identified the interpreter's trauma history as a particular difficulty that can arise in asylum assessments. This participant said,

Most of the interpreters I've worked with have trauma histories, and many of them are refugees and asylum seekers themselves. And so it's a clinical triad. I would spend quite a lot of time with the interpreter before and a lot of time after.

Assessing for Trauma and PTSD

Six out of six (100%) participants discussed their experiences assessing asylum seekers for mental health issues related to traumatic experiences, mostly notably PTSD. Five out of six (83%) participants commented on the difficulty of diagnosing PTSD in asylum seekers. Three out of six (50%) participants noted that asylum seekers often have

complex, multi-faceted traumatic experiences, and they provided examples. Some clients had been threatened by gangs in their country of origin. Others faced persecution for their sexual orientation. One participant noted working with a client who had been a child soldier in Africa. In addition to these experiences, participants discussed the difficult journeys that their clients took to reach the United States. Participants also highlighted their clients' loss of culture and the stress of being in an unfamiliar environment. Finally, participants discussed how the asylum process and court hearings can re-traumatize people. They can be adversarial, unsupportive contexts in which people must recount their claims.

In addition to the complex traumatic experiences that asylum seekers can experience, participants noted that other factors complicated formulating a clear diagnosis. One participant reported having to learn more about cultural variations in emotional presentation, especially with clients from non-Western cultures. This participant typically used affect as a diagnostic indicator. Related to this, one participant noted that clients frequently told their stories multiple times before the assessment occurred. This participant believed that this repetition resulted in clients discussing their stories in a rote and unemotional manner. Finally, one participant described the paradoxical objectivity (e.g., set criteria) and subjectivity (e.g., use of clinical judgment) of diagnoses as a complication. This participant rhetorically asked, "Is mild PTSD just as valid as horrifyingly full blown and awful PTSD? Because the criteria is objective, but it's also subjective. They do have nightmares once a week, but this person has them 5 times a week."

In contrast to this difficulty with diagnosing asylum seekers, three out of six (50%) participants commented on the ease by which they can sometimes diagnose PTSD with their clients. One participant noted that most clients' experiences have "face validity" for being traumatic, meaning one could easily assume that they met criterion A for PTSD in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR) (American Psychiatric Association, 2000). A second participant believed that some symptoms and sequelae of trauma were mostly universal, despite cultural variations. A third participant openly wondered if it was "too easy" to diagnose PTSD. This participant said, "I can always find a degree of PTSD, generally, and it's sometimes . . . I question like if I'm really doing an honest job or a good job or if I need more training." Interestingly, two out of six (33%) participants expressed both the challenges and ease with diagnosing, indicating a degree of ambivalence about the act of diagnosing clients with PTSD.

In discussing these themes, one out of six (17%) participants commented on the demand characteristics of the asylum assessment. Namely, a diagnosis of PTSD was important for a client's case, and lawyers and clients applied subtle pressure to find it in an assessment. Additionally, clients were often in desperate need of asylum, treatment, and other resources, so this participant felt the pull to help them with a diagnosis. This participant said,

The commission [psychologist] who is doing this... taking some time, doing this for little money, if any, or a lot less money than they usually get paid. So has a real investment in doing good...those two demand characteristics together really make it difficult to be really as objective about the assessment as one can be.

The Use of Psychological Measures

Five out of six (83%) participants said that they rarely used measures or a structured interview protocol as part of their assessments. Three participants felt like the psychometric properties of the available measures would not apply to people from non-Western cultures. One participant said, “You’re dealing with people from completely different cultures where we just don’t know what the norms are, for instance.” Furthermore, one participant highlighted that many measures assess along DSM criteria that may be inappropriate for people from other cultures and for their distinct traumatic experiences. This participant said, “Most of the people we see are torture survivors who don’t have a typical, oftentimes don’t have a typical, DSM-IV PTSD profile, or depression profile, anxiety profile.” One participant was concerned about the possible legal implications of translating an English-language measurement into another language. That participant said, “I don’t want to bring in validation questions into the courtroom by translating those things.” Two participants stated that they trusted their interview questions, which were informed by previous work with traumatized clients, to be sufficient for diagnosing PTSD and other other clinical diagnoses. One out of six (17%) participants administered psychological measures as a regular practice with clients. This participant described using them to generally screen for symptoms but not directly diagnose any disorder.

Writing the Assessments

Four out of six (67%) participants discussed writing the assessment as a challenge. One participant succinctly said, “I find it difficult to write them. I find it... I

feel stupid saying it because think of what the patients have gone through. They're difficult to write." On a practical level, some of this difficulty involved the format of the assessments. As opposed to standard psychological reports, these participants discussed using a format that resembled a legal affidavit, in order to present evidence in a clear fashion. One participant said,

You write it up in a way that looks like an affidavit, so you may have 20 or 50 paragraphs, and each paragraph has a thesis point and then supporting details, so it looks, and also reads, differently than a psychological evaluation you might do in another setting.

Two participants discussed how this change in style took practice to learn. One participant said,

Over time, I did a move of the assessments I was doing, along into the sort of numbered forensic assessment legal brief type things, which I feel much more comfortable doing. But that was something I really had to learn over time and with consultation from a number of people around assessment.

Beyond the issue of a different format than other psychological assessments, three out of six participants (50%) discussed feeling that their assessment would highly influence a judge's decision. One participant said, "These are very much weighed in the asylum decision." Participants felt the emotional burden of putting clients' experiences into words that would help their claims. One participant explained, "I personally really struggle with writing it up. It's agonizing because I feel like a lot is riding on the report." Another participant said,

I never lose sight of the fact that it seems like a tremendously sobering task to put someone's life on the page and know that that life will go to a court of law and that their future... our document is not the only thing, but it's a big thing. I had many, many, many immigration people say to me it's the psychological affidavit that things hang on. So you feel the weight of that.

Experiences with the Asylum System and Process

In regard to the asylum system, four out of six (67%) participants described testifying in a courtroom as a stressful experience. Three out of six (50%) participants noted that testifying required a large time investment in preparation, such as reviewing their final report for the court and waiting to be called as a witness. Three out of six (50%) participants said opposing attorneys challenged them professionally by either questioning their credentials or questioning the validity of PTSD as a diagnosis in general or for specific clients. One out of six (17%) participants thought that asylum courts wanted clinical judgments to be too concrete. This participant often wanted to present a more nuanced clinical judgment. One out of six (17%) participants reported frequently worrying about performance in court, due to the weight it held for determining clients' claims.

Two out of six (33%) participants described the asylum process and being in court as traumatic experiences for their clients. One participant noted, " [Asylum seekers are] thrown into this very traumatic process of revealing their trauma when they may have had no preparation or even any kind of education about trauma." Another participant added,

I had one woman say to me, you know I feel like I'm naked in court, you know I feel like I have no clothes because here are things that had been done to me that I can't you know bring myself to even speak about, and they're being read out loud to people who don't know me.

Finally, two out of six (33%) participants expressed frustration that it was uncommon to hear if their clients ultimately received asylum. One participant said, "It really varies because it's a long, slow process. That's one of the bones of contention . . . trying to get the lawyers to give us feedback. I probably have officially heard about maybe 30%." Additionally, feedback may not be positive. One participant stated, "I've only had the results of one of them, and it wasn't ideal. It was withholding from removal, as opposed to asylum, and I was disappointed."

Adapting to Working with Cultural Differences

Most participants did not discuss explicitly how culture impacted their work providing psychological assessments. Two out of six (33%) participants said they research the country and culture of clients before the assessment. While conducting the assessments, two out of six (33%) participants discussed the need to explicitly consider cultural context in order to communicate a concept. One participant said,

One challenge that's certainly come up is for cultures where psychotherapy is not part of the culture... even my language and my questions and my observations and my musing and my whatever are rooted in a context that people don't know. We have to kind of find a way to find the words or to illustrate what exactly it is, I guess, I'm talking about.

The other participant referred to this process as “cultural interpretations,” trying to translate a culturally laden concept into a different culture. It often required the need to simplify language, but this held the unfortunate prospect of losing some original meaning.

One out of six (17%) participants discussed realizing that their views of mental health and psychology were imbued with American values and beliefs. In general, this participant realized that many parts of the world had ideas of mental health and trauma that differed from American views. This participant said,

One of the first people told me just a really incredible story of what they went through and I said, “oh my gosh, you’re so brave” or “you must have been so brave.” And they look at me like “uh, no? Its just what you have to do.” The words coming to mind are touchy-feely aspects of the way an American has of doing things. I think it pulls on your own desire to comfort or to make it okay or to cheerlead, and I think that’s probably the thing that’s a little different with some of the clients coming in because often I think more of our typical clients expect some of that kind of response, and the asylum seekers, it’s foreign to them, its inappropriate, or it’s just not... they don’t respond as well.

Personal and Professional Impact of This Work

Participants were asked for examples of the personal and professional impact this work has had on them. Many of their answers overlapped domains and showed a blurring of the personal and professional in their experiences. Six out of six (100%) participants felt like assessing asylum seekers had enhanced them professionally. They cited such

benefits as gaining new clinical skills, retaining a valued connection with direct clinical service, becoming a “tougher” clinician, growing into a political advocate, and having a significant focus for their career. One participant said,

I don’t baby people, because I’ve seen how people survive an awful lot. People survive a lot of heavy-duty shit in life, and so I have empathy, but I tend to be kind of a tough love sort of person.

Five out of six (83%) participants said that this work was personally meaningful and gratifying. One participant said, “I always start off saying it’s the most gratifying work I’ve ever done. I’m not just trying to sell them. It’s very true.” Four out of six (67%) participants said that they possessed a broader knowledge of culture due to assessing asylum seekers. One participant said, “You realize you don’t know anything about the people who are around you. There’s such diversity and such an amazing amount of life experiences.” After doing this work, one participant reported having a sense of gratitude and good fortune about life. This participant said, “I think that it certainly makes me aware of the good fortune that I have and the amount of luck that is involved in life. Good luck, bad luck, the sort of happenstance of life.”

Participants also focused on some of the personal and professional challenges experienced while doing this work. Five out of six (83%) participants expressed that these assessments could be emotionally intense and exhausting. One participant said, “There’s [often] new information that comes your way, and it’s horrifying in many ways.” Another participant said, “You know, it’s a challenge sometimes to listen to some really painful, painful memories and try and stay together emotionally myself.” Another

participant expressed how this emotional challenge exacerbated the regular professional challenges of doing an assessment. This participant said,

You're hearing terrible things, and there's always a drama in these stories too, which just sucks you in. And that can be exhausting as well, so you're dealing with a lot of emotions, and you're trying to keep track of: I gotta remember to ask these other questions and rule out this and make a clinical diagnosis and sort of get some corroborating evidence. So it's exhausting, you're trying to track a lot of things. Clinical interviews can be very exhausting, particularly if you're dealing with a trauma-affected population.

Two out of six (33%) participants said that they sometimes felt demoralized, humbled, or powerless during the work. One participant, discussing how clients often do not have a sense of what psychologists do, said, "you're like, wow, there are parts of the world where people don't necessarily express themselves or talk about things or do all the things that I value and think are critical to a healthy development." One out of six (17%) participants described feeling a sense of moral responsibility with asylum seekers, which sometimes felt like a burden. This participant said, "I really do feel that there are instances where someone's life is on the line, that deportation can equal death for some people, so there's a lot riding on it, and there's a tremendous sense of moral responsibility."

Professional Dilemmas

Four out of six (67%) participants discussed feeling a tension between being an objective assessor and helping someone in need. One participant said,

I really feel for these people that I'm sitting with. I know that the immigration system is screwed up. I know that it is kind of unjust and folks have suffered and my evaluation, statistically, can make or break their application for asylum.

Another participant said,

In my heart I might feel like I am an activist for them, an advocate for them, but I also realize that in the technical execution of my work I have been commissioned to be an independent evaluator, and that's what I'll do.

In regard to political beliefs and clinical work, one participant said,

Clinical experience [is] somehow supposed to be devoid of politics, right? But what if you're a feminist? What if you believe in liberation psychology? I don't always know how you can look at the client's trauma and suffering and separate it from these crazy injustices that they experienced at more systemic levels.

Five out of six (83%) participants discussed the difficulty of assessing the veracity of asylum claims. Two participants believed that a client may have lied or exaggerated an asylum claim. One participant said, "Many people will be honest about a lot of things but feel like they need to exaggerate something else." Two participants believed that communities sometimes shared stories of trauma. One participant noted that other cultures have different behaviors around telling the truth, and in recognizing this, the participant found it difficult to evaluate malingering.

Three out of six (50%) participants noted that the process of asylum and even the assessment encourages people to delve into trauma without a guarantee of follow-up treatment. One participant said, "The process of the evaluation kind of forces them, or encourages them to, kind of, go delve into their psychological trauma and pain, but

there's no guarantee that there is treatment available." Another participant noted, "I have had people who are psychotic or appear to be psychotic or whose histories, to me, seemed like they need, do need mental health services ASAP."

Three out of six (50%) participants felt uncomfortable with the low level of confidentiality that clients have during the asylum process. One participant said, "Nothing is confidential . . . and so you have to . . . really explain that to the client. It's forensic work so nothing's confidential, and at the same time you're really trying to protect peoples dignity." One participant said,

People do tell you things about how debased they've been in certain actual acts of torture, and so its kind of a dilemma about how much detail you go into because they're going to hear that spoken out loud. So it's hard.

One participant commented that other professionals working with the client sometimes push to know more information than is necessary. This participant said, "There's that line between the information that needs to be known and the information that is really a little bit further."

Methods of Self-Care and Coping

In response to the professional dilemmas that participants encountered, they discussed a variety of ways in which they responded to them. Two out of six (33%) participants discussed how they cope with the difficulty of assessing a client's honesty. One participant accepted this difficulty and thought there were likely more "false negatives than false positives" in the asylum system, meaning more clients are denied asylum who likely deserve it than the converse. The other participant echoed this

sentiment and reported, “I generally air on the side of caution, and I’m not going to call them out or minimize something.” This participant added, “You spend a lot of time trying to chase down the truth, you know, but that’s not my job. I’m not the truth and reconciliation team.”

In regard to the expressed dilemma between being an objective assessor and helping someone in need, four out of six (67%) participants reported the ways in which they managed it, sometimes describing multiple methods. One participant reported being mindful of the competing demands and trying to maintain an attitude of “truthful but also just.” One participant tried to be administratively distant from clients’ attorneys in order to maintain a professional boundary and minimize any pressure. Another participant tried to leave the burden of advocacy to the attorneys. One participant mentioned peer support as a preferred way to cope with this tension. One participant described trying to resolve the issue by writing “conservative yet thorough” assessments. Finally, one participant discussed accepting the tension and said,

It doesn’t necessarily ever get resolved in a way that you no longer have the duty to quote-unquote objectivity or the duty to social justice, but you’ve got to find your way through them, being as faithful as possible to both of those ideals.

In regard to coping with other professional dilemmas or their reported professional and personal challenges, participants discussed several strategies. Two out of six (33%) participants felt the practice of doing these assessments became easier for them over time, so they coped by naturally growing in expertise. One participant out of six (17%) discussed focusing on the positive in clients’ situations, such as basic safety. This participant said, “When somebody’s in front of me telling me this stuff, they’re in a much

safer place than they were.” One participant out of six (17%) tended to downplay the difficulty of asylum cases by comparing it favorably to other difficult clinical situations, such as dealing with child abuse. Finally, one participant out of six (17%) discussed trying to maintain a balance between empathy and emotional distance with clients.

While discussing the personal impact of this work and dilemmas they faced, participants often talked self-care strategies. Three out of six (30%) participants reported seeking support from other psychologists who do this work. One out of six (17%) participants described scheduling the assessments on Fridays, and this allowed ample time for physical activity and writing in a journal over the following days.

Training Experiences

Participants were trained to provide assessments for asylum seekers in a variety of ways. Six out of six (100%) participants said that an experienced colleague mentored them either formally or informally. Formal mentorship was arranged through a their training and referral agency. Moreover, two out of six (33%) participants described consultation with peer colleagues as an important learning opportunity. Four out of six (67%) participants attended a formal training event through an agency that taught them about the asylum process and assessments for asylum seekers. Three out of six (50%) participants said that reading academic or professional literature about asylum seekers and assessments was an important part of their training. Three out of six (50%) participants believed that their previous training and experiences with psychological assessments, either through graduate school, internship, or afterward, helped prepare them for this work. Finally, three out of six (50%) participants mentioned the role of

practice as highly important. One participant said, “There’s no substitute for just doing these over and over and over again. It’s like joint replacement surgery. The surgeons who are the best at it have done 2,000 of them.”

For continuing education and training, four out of six (67%) participants discussed peer consultation as their primary method. This happened either through an ongoing peer supervision group or individual discussions with colleagues about distinct clients. One participant out of six (17%) participants described using a variety of continuing training activities that went above and beyond consultation. This participant attended formal training events, became involved with social advocacy networks, and travelled internationally.

In regard to their sense of preparation, five out of six (83%) participants generally felt like their training prepared them to assess asylum seekers. One participant, who had prior forensic assessment training, said, “I think it prepared me pretty well. It felt very familiar to be sitting with a client and doing an interview and to working with a translator... to working with lawyers.” Two participants expressed feeling prepared but also described feeling a level of uncertainty. One participant said, “I guess I must have obviously felt like it prepared me enough to do it, and so I did. But . . . I wasn’t 100% sure that I was doing it as well as I could or should.” Another participant said,

In the beginning you think it’s pretty good preparation, but then 10 years into it you realize you’re prepared for nothing, and so I think it was good preparation. I do. I think it was as good of preparation you can give somebody for this because its on the job training. It’s just the kind of work where it’s hard to be trained and be prepared, but I think this is as excellent as it’s going to be.

One out of six (17%) participants felt that training did not adequately prepare for the work. This participant said, “I think that... in terms of forensic assessment training, I think it was pretty bad. But in terms of an assessment experience that meets the demands of immigration court, probably adequate.” As opposed to the others, this participant did not receive many of the formalized aspects of training, such as a training event. This participant relied heavily on informal mentoring and consultation with peers.

When asked how they thought future psychologists should be trained to provide assessments for asylum seekers, the participants gave a variety of recommendations. Three out of six (50%) participants suggested that psychologists consult with peers or attorneys. Two out of six (33%) participants stressed the importance of referencing academic and professional literature. Two out of six (33%) participants recommended training that involved the intersection of the clinical and legal realms, such as forensic psychology and knowledge about the asylum process. One out of six (17%) participants recommended that people be trained to assess asylum seekers as part of their graduate training. One out of six (17%) participants recommended further training on translated and validated psychological measurements. One out of six (17%) participants recommended trainings that cover multicultural competency. One out of six (17%) participants recommended that experiential opportunities, such as roleplaying, be a part of formal training events. One out of six (17%) participants recommended additional training in differential diagnosis, which hopefully would lead to diagnosis options beyond PTSD. One out of six (17%) participants thought that there was no substitute for experiential growth through providing assessments.

While those recommendations involved active steps that psychologists or agencies could take, some participants' recommendations involved more passive or implicit aspects of training. Two out of six (33%) participants thought that prospective psychologists must have the appropriate perspective or attitude for this work. One participant said,

A lot of it is attitude, you know? I think the best human rights clinics kind of are careful who they select. You really talk about this position ... two positions you have to internalize. One is this position of bearing witness, and so to approach the evaluation with an open heart for suffering and that you're bearing witness, which is essential. It's not the cold heart evaluation. That's that piece. And then the other piece is the forensic piece, which is you have to really balance being an independent evaluator, with the fact that most of us are acting as activists and advocates. And you have to figure out how you're going to balance that in yourself.

Both participants thought that organizations likely screen for psychologists who can embody this attitude. They also thought people who become interested in this work likely self-select from this attitude.

Chapter V

Discussion

The current study explored the experiences of psychologists who provide assessments to asylum seekers to the United States. Participants were asked about their experiences conducting assessments with asylum seekers and their professional training to conduct these assessments. Also, a general, open-ended question was asked to close the interview and elicit unprompted data. This chapter will explore the central themes that ran through the general categories of experiences, which were reported in the Results section. These central themes included a) the tension between social advocacy and clinical integrity and b) cultural challenges to usual professional praxis. Limitations and implications of the current study will also be addressed.

Central Themes

The Tension between Social Advocacy and Clinical Integrity. Several participants noted feeling a tension between being an advocate for their clients and producing an objective and credible psychological assessment. These goals were not necessarily incongruent, and participants discussed the ways in which they worked with this dilemma. For some, they created boundaries with attorneys in order to avoid any potential for pressure. For others, they accepted that they wanted a certain outcome for their clients. However it was addressed, this tension did not seem to dissipate or resolve in a final manner, and it continually shaped multiple aspects of the participants' experiences in explicit and implicit ways.

From their descriptions, this tension appeared to be present at the onset of a psychological assessment with an asylum seeker. The nature of the work's commission was inherently ambivalent, as assessments could serve dual purposes. Participants were commissioned to make a clinical judgment about the credibility of an asylum seeker's claim, and they had a legal and professional obligation to do so in an unbiased fashion. In the execution of this, participants could play a slightly adversarial role with clients in their need to judge the credibility of their claims. Also, the legal purpose of these assessments and low level of client confidentiality in the court process required psychologists to work with traumatized clients beyond a purely clinical and therapeutic manner. However, participants sought this line of work due to a desire to help those whom they saw as vulnerable, and they were motivated to protect their clients. They needed to have a positive rapport with their clients in order to gather a detailed narrative of a client's traumatic life history and subsequent psychological distress. Participants entered this work with an identified set of values and contended with the legal system's structure and processes, which did not always reflect those original values.

This tension also complicated the customary process of writing the assessments. Participants readily discussed the writing process as emotionally charged, and it appeared to be a reification of the tension between social advocacy and clinical integrity. Participants grappled with the challenge of presenting the clients' stories as thoroughly as possible. They knew that they needed to accurately reflect reported experiences in order to support asylum claims. The use of the affidavit format, which is non-clinical in appearance and legalistic in tone, also reified the participants' dual role within the asylum process.

The tension between social advocacy and clinical integrity meant that these assessments could not be emotionally neutral for participants. They discussed the emotional impact as a mixture of positive and negative experiences. Most participants strongly valued social advocacy and the welfare of their clients, and they cited this as the most positive component of work with asylum seekers. Their assessments held the possibility of safety for clients in a very clear way. Conversely, they also held the possibility of removal if a client's claim was not granted, which could mean life-threatening danger. To complicate matters, participants could not behave as advocates in an outright and uncomplicated fashion. They had to hew closely to their role as an independent and objective assessor, so their professional judgment would be respected in court. They resided within an emotionally taxing and sometimes unsatisfying middle position.

Cultural Challenges to Usual Professional Praxis. A second central theme in participants' experiences involved how they worked with people from other cultures. Assessing clients from non-Western cultural backgrounds profoundly challenged many taken for granted aspects of psychological work. Few participants explicitly discussed this central theme. However, it appeared to be an implicit factor across the participants' experiences, and it constituted a central way in which work with asylum seekers differed from the participants' other clinical experiences.

Culture complicated the participants' usual diagnostic practices. The use of psychological measures was questionably useful in asylum assessments due to reliability and validity concerns. Participants felt they could not use them in a customary fashion,

such as supporting a diagnosis through a conceivably objective method. Participants also expressed a great deal of ambivalence about conceptualizing a client's distress into a Western diagnostic category, and it led them to critically evaluate the purpose of diagnoses. This ambivalence revolved mainly around PTSD. They paradoxically saw diagnosing PTSD as both easy and difficult with asylum seekers. It could be easy in that clients' experiences had strong face validity for being traumatic. Also, the commission for providing an assessment created a strong demand to diagnose PTSD. As PTSD includes etiology in its formulation, it could support the credibility of a reported event by default. Conversely, they acknowledged that the Western conceptualization of PTSD often did not match a client's cultural idiom of distress or adequately reflect their experiences. For instance, cultural variations in emotional expression meant that participants could not reliably use it as a diagnostic indicator of PTSD. Participants were also keenly aware that the absence of symptoms of PTSD or trauma did not prove the incredulity of a reported claim. However, participants had very little choice in using Western diagnostic systems. The commission for the assessment required it, and a diagnosis could have an undeniably positive effect for someone's asylum claim.

Additionally, working with clients from non-Western countries made participants keenly aware of their profession's cultural context. On a practical level, participants had to routinely attend to language on both a literal level (i.e., simply translating an English word into another language) and a conceptual level (i.e., translating networks of concepts from one culture to another). This often resulted in participants having to express things in a more basic, less nuanced fashion. The converse was likely true, as clients had to express their thoughts and emotions in a more basic and less nuanced fashion. This

challenged participants' and their clients' ability to communicate and understand each other and likely impacted crucial elements of the therapeutic relationship.

Beyond the practical level, this process of linguistic and conceptual translation challenged participants' assumptions of experiential safety and the universality of clinical phenomena. Participants realized that they lived lives of relative safety and privilege in relation to their clients, and they reported having an expanded awareness of conflict and difficulties in many parts of the world. Participants realized that the knowledge base and usefulness of clinical psychology has been intimately rooted in Western, especially American, epistemological traditions and cultural values. As one participant noted, clients often had different cultural norms around things such as the value of emotional expression, and they may not necessarily subscribe to Western notions of mental health. For the current study's participants, these realizations resulted in feelings of uncertainty and powerlessness about their ability to help.

Limitations of the Current Study

The primary limitation of this study was the low number of participants. The original proposal sought eight to 10 participants. Recruitment for the study was slow, and the researcher expanded the inclusion criteria twice in order to gain qualified potential participants. First, originally only licensed, doctoral-level psychologists were eligible. This was changed so pre-licensed psychologists, who completed asylum assessments under the supervision of a licensed psychologist, could participate. Second, originally only participants who had completed at least one assessment in the last two years were eligible. The rationale for this was to ensure their experiences would reflect current

conditions in the asylum process. This time frame was expanded to encompass completing at least one assessment since 2003. In 2003, the United States created the Department of Homeland Security and incorporated Immigration and Customs Enforcement as a branch (Department of Homeland Security, 2012). Assessments since that time would reflect the current structure and processes of asylum determination.

After the above changes, sixteen individuals responded to recruitment efforts, but only six met the inclusion criteria and completed interviews. Four factors may be responsible for this low recruitment rate. First, qualified psychologists may have been reluctant to participate due to confidentiality concerns. One participant expressed concern that an opposing attorney could identify participants and use their comments in a court hearing. One potential participant would not consent to recording. This concern may have led some qualified individuals to not participate. Second, the advertisement and oral consent form estimated interviews would take 90 minutes each, which was ultimately an overestimate. Many interested participants may have elected to not participate due to the perception of a large time commitment. Third, advertisement efforts may not have reached the small number of people who do this specialized type of work. Fourth, participants who have had negative experiences in this work might be reluctant to discuss them in a research study.

A second limitation involved the exploratory nature of this study. In the interest of outlining the breadth of participants' experiences and avoiding presumptive questions, the researcher did not explore deeply some significant aspects of participants' experiences. For instance, two participants expressed the opinion that psychologists who work with asylum seekers start with an existing ability to embody social advocacy values

while maintaining clinical integrity. From this theme, the topics of motivation to enter this work and how psychologists enact value systems through clinical practice could have been explored further. Also, some participants described their assessments with asylum seekers as emotionally intense. This topic could have been explored further to see if it related to vicarious traumatization or professional burnout. These topics and others would bear further research, and a future study about the experience of assessing asylum seekers could be more focused on any specific category identified in the current study.

Implications of the Current Study

The current study has several implications for future research, practice, and training.

Implications for Research. Two participants identified that a certain “attitude” was an important professional trait for psychologists to do this work. They believed that psychologists self-selected for this work based on it and that agencies select people from this. One participant described it as balancing “bearing witness” to a client’s narrative and completing a forensic assessment, which fit within the central theme of a tension between social advocacy and clinical integrity. Since it was not explored further within this study, these comments raised the issue of what might characterize and define this attitude. It also raised the question of initial motivation for this work and possibly other psychological work that involves components of social advocacy. Researching this issue may provide more information about whether this attitude is dispositional or a set of learned knowledge, skills, and abilities.

Implications for Practice. Peer support and consultation were discussed as common experiences among the participants. It was a formative element of initial and ongoing training. Participants also described talking with peers, especially those who did similar work, as an important way to cope with professional and personal stress. Participants also sought the advice and support of peers to help address clinical or ethical dilemmas that arose in the midst of clinical work. If they do not do this already, psychologists who provide assessments to asylum seekers should consider joining or forming an ongoing peer supervision group. If possible, agencies that refer asylum seekers to psychologists can help act as a central hub for networking.

Implications for Training. Most participants thought that the diversity of their training experiences prepared them for conducting assessments with asylum seekers. The participant responses indicated three implications for how agencies should select candidates for training. First, the participants highlighted prior assessment, especially forensic, training and experience as a valuable foundation. Agencies that refer asylum seekers to psychologists should consider assessment proficiency as an important pre-condition for this work. Second, two study participants identified an attitude that balances issues of social advocacy with clinical integrity as an important factor in psychologist selection, and they believed that agencies already screen prospective psychologists for this, either explicitly or implicitly. Although this bears further research, agencies should evaluate how they screen prospective psychologists for entry into training in light of this quality. Third, agency training curricula should consider identifying the tension between

clinical advocacy and clinical integrity and the challenges of working with people from different cultures as potential ethical and professional issues that psychologists can expect.

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Appendix A

Advertisement

Email subject/headline: Seeking psychologists who have conducted psychological assessments with asylum seekers to the United States.

Are you a psychologist who has done a psychological assessment with an asylum seeker to the United States since 2003? If so, please consider participating in a new study on psychologists' experiences providing these assessments. Doctoral-level, licensed or supervised psychologists who do these assessments are being recruited for a doctoral dissertation study at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University.

Participants will be interviewed about training to provide these assessments, aspects of their assessment experiences, professional and personal challenges raised by doing these assessments, and how these assessments may be of benefit to asylum seekers.

If you are interested in participating or learning more about the study please contact Patrick Cheatham, M.A., Psy.M. at 206.947.5158 or at pjcheatham@gmail.com for more information.

Interviews will last approximately 90 minutes and be conducted in person or via Skype or Google Chat. All interviews will be recorded to ensure accuracy in transcription. All interviews will be held confidential and no identifying information will be attached to interview responses. Participants will not be compensated for this study.

Study on Psychologists Who Assess Asylum Seekers
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Appendix B

Oral Consent Agreement

The Assessment of Asylum Seeking Immigrants to the United States: An Exploratory Study of Psychologists' Experiences

You are invited to participate in a research study. Before you agree to participate it is important that you know enough about the study in order to make an informed decision. If you have any questions about the nature of this study, please ask the principal investigator (PI). You should be satisfied with the answers you received from the PI before you agree to participate in this study.

Purpose of the Study: This study examines the experiences of psychologists who provide psychological assessments to asylum seekers to the United States. The study seeks to understand the psychologists' training to provide these assessments, several aspects of the psychologists' assessment experiences, professional and personal challenges raised by doing these assessments, and how these assessments may be of benefit to asylum seekers.

The principal investigator (PI) is a doctoral student at the Graduate School of Applied and Professional Psychology at Rutgers University and is conducting this study as a fulfillment of dissertation and doctoral requirements. It is anticipated that 8-10 individuals will participate in this study. If you wish to be provided with the general results of this study, you should notify the PI, and this information will be shared with you at the completion of the study.

Study Procedures: You will be interviewed about your training to provide psychological assessments to asylum seekers, experiences doing these assessments, challenges you have faced, and your thoughts on how their benefits. The interview will take about 90 minutes.

Interviews will be recorded and transcribed in order to ensure accurate transcription and authenticity of the data obtained. The recorded interview will be transcribed within three weeks of the interview, and the recording will be destroyed after transcription. The PI will maintain transcripts of interviews and other materials in a locked file cabinet and password protected electronic files. These materials will be destroyed three years after completion of the study.

Risks: The interview focuses on your experiences providing psychological assessments to asylum seekers. It is the PI's belief that this will be a positive and thought-provoking experience for you. However, recalling difficult or unpleasant professional experiences might lead you to feel discomfort or distress. It is important that you notify the PI immediately so that he can discuss these feelings with you and provide you with referrals to local counseling services if necessary. Note that the study will not pay for any counseling services recommended following participation in this study. In this event, you would assume all financial responsibility for such services.

Also, the confidentiality parameters (see below) are designed to protect participant confidentiality and limit the recording of identifying information. However, your answers might contain information that could identify you. If you have concerns about the potential for harm to your professional reputation, please discuss these concerns with the PI immediately, so he can discuss these concerns with you and suggest ways to limit identifying information in interviews.

Benefits: Your experience and knowledge have tremendous value in helping the field of psychology better understand how to provide psychological assessments to asylum seekers. The

information shared has the potential to inform psychologists who conduct these assessments. Also, results obtained could inform the training and practice of future psychologists who are interested in this area. Finally, the opportunity to share your own clinical experiences on this topic may be valuable for your reflection and practice. There is no compensation for participating in this study.

Confidentiality: This research is confidential. Confidential means that the research records will include some information about you and this information will be stored in such a manner that there is some linkage between your identity and the response in the research exists. Some of the information collected about you includes age, gender, ethnicity, professional degree, years since licensure; number of assessments provided in career, and year of most recent assessment. This oral consent form will help protect participant confidentiality by limiting the storage of identifying information. The researcher will conduct all in-person interviews in settings that are private. For those interviews taking place by Skype or Google Chat, the researcher will ask you to find a setting that ensures privacy. Your interview will be assigned a non-sequential, three digit case number prior to the interview. All interviews will be recorded for later review and transcription. The recording of the interview will be transcribed within two months of the interview date. After transcription, the recording will be destroyed immediately. No identifying information, beyond the case number, will be attached to recordings, measures, or transcriptions. Your contact information will not be part of the research record, and the researcher will destroy any record of it. All records will be stored in a locked file cabinet, and electronic files will be password protected. Your responses will be grouped with other participants' responses and analyzed collectively. All potential identifying information, such as demographic and practice information (e.g., age, area of practice, etc.) will be reported as aggregates. Information that cannot be aggregated will be disguised to protect your confidentiality. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated. All study data will be kept for three years after completion of the study.

Research Standards and Rights of Participants: Your participation in this research is **VOLUNTARY**. If you decide not to participate, or if you decide later to stop participating at any time during the interview, you will not lose any benefits to which you are otherwise entitled. Also, if you refer other individuals for participation in this study, your name may be used as the referral source only with your permission.

You may contact the PI or the PI's dissertation chairperson at any time at the addresses, telephone numbers, or emails listed below if you have any questions, concerns, or comments regarding participation in this study.

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If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University, the State University of New Jersey
Institutional Review Board for the Protection of Human Subjects
Office of Research and Sponsored Programs
3 Rutgers Plaza
New Brunswick, NJ 08901-8559
Tel: 848.932.4058
Email: humansubjects@orsp.rutgers.edu

Statement of Oral Consent

1. **Please state that you have read and understood the contents of this consent form, have received a copy of it for your files, and consent to participate in this research project.**
2. **Please state that you consent for this interview to be recorded.**

Appendix C

<u>Demographic Questionnaire</u>

Age: _____

Gender: _____

Racial and Ethnic background: _____

Professional Degree(s): _____

Years in Practice Since Licensure: _____

Number of Psychological Assessments for Asylum Seekers Conducted in Career: _____

Year of Most Recent Assessment: _____

Participant Code: _____

Appendix D

Semi-Structured Interview

Participant Code: _____

I. Personal and Professional Experiences

1. Please describe what doing this work is like, as if you are talking to a psychologist who does not know much about it. (Below is a specific follow-up question if their response does not cover this area.)
 - a. What is distinct or different about doing these assessments compared to other work?
2. Please tell me about the assessment experiences you have had. (Below are specific follow-up questions if their response does not cover these areas.)
 - a. In what places have you conducted assessments?
 - b. How did the location of the assessment affect the experience?
 - c. How do you feel about the assessment methods available to you?
(Prompts: measures, interviews, translators, etc.)
 - d. How have you felt about the language barriers between you and your clients?
 - e. How do you feel about interacting with the immigration/legal system?
3. How has doing these assessments impacted you personally?
4. How do you cope with unpleasant experiences during or after these assessments?
5. What kinds of ethical or professional dilemmas have you faced while conducting assessments?
 - a. How have you addressed them?

6. How has your professional identity been affected by this work?

II. Professional Training for Asylum Assessments

1. Please tell me about your training for providing these assessments. (Below are specific follow-up questions if their response does not cover these areas.)
 - a. What kinds of professional training did you receive to provide these assessments? (Prompts: courses, programs, trainings, readings, etc.)
 - b. What legal training did you receive? (Prompts: courses, programs, trainings, readings, etc.)
 - c. What supervision have you received on these assessments?
2. How well did your training prepare you for this work?
3. How do you think psychologists should be trained to do assessments with asylum seekers?

III. Closing Question

1. What else would be important for me to know about your experiences conducting assessments with asylum-seekers?