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Post-Traumatic Stress Disorder and the Refugee Determination Process in Canada: Starting the discourse

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Abstract

The relationship between mental illness and the refugee determination process involves dynamic and static issues. Through a social constructionist perspective and secondary research methods, this paper touches on legal, political, cultural and psychological factors which can influence the outcome of refugee claims. Asylum Seekers who face pre-migratory traumatic events may be at increased risk of receiving a negative refugee decision due to lack of knowledge, training and experience among board members, lawyers and immigration officials. Furthermore, limited understanding of mental health variables and its impact on testimony during the refugee determination process, over reliance on psychiatric categories like PTSD along with cultural and communication barriers can have serious consequences in the process of ascertaining claimant credibility in asylum cases.

Introduction

In recent years Post-Traumatic Stress Disorder (PTSD) has become a significant diagnostic tool in criminal and civil litigation to obtain more favourable legal outcomes. In Canada, individuals suffering from PTSD during the commission of a crime may receive lenient sentences or be found Not Criminally Responsible (NCR). In the United States similar trends are noted**.** For example, in a recent case involving an Iraq war veteran accused of murder, lawyers successfully argued that he suffered from PTSD during the criminal event and was subsequently found 'not guilty by reason of insanity'. Although there is a significant amount of research regarding the use of PTSD as a legal defense, little is known about the impact of mental health on refugee/asylum cases. This paper seeks to understand how mental health impacts on refugee determination cases in Canada. We will argue that, asylum seekers who have experienced pre-migratory traumatic events may be at increased risk of receiving a negative refugee decision due to lack of knowledge, training and experience among board members, lawyers and immigration officials. Further, limited understanding of mental health variables and its impact on testimony during the refugee determination process, over reliance on psychiatric categories such as PTSD along with cultural and communication barriers can have serious consequences in the process of ascertaining claimant credibility in asylum cases.

According to Herlihy and Turner (2007) refugee determination is one of the most complex and difficult processes relegated to refugee decision-makers. This stems from a variety of contexts which include arbitrary refugee policy, the lack of objective evidence available to boards, and inconsistencies in the application of justice amongst refugee decision-makers. The Immigration and Refugee Board (IRB) is currently relying on expert witness testimony and formal psychiatric diagnosis to verify the credibility of mentally ill asylum seekers who disclose pre-migratory traumatic events and trauma-related mental health issues.

We suggest that, although the IRB provides guidelines relating to vulnerable populations (i.e. mentally ill asylum seekers), decision-makers appear to face significant difficulties in addressing mental health within the refugee evaluative process. To compensate for the lack of resources and tools available to decision makers in assessing trauma related evidence, IRB board members, immigration officials (i.e. Refugee Protection Officers) and lawyers are inadvertently using the language and ideology of PTSD as a measuring stick to determine the credibility of asylum seekers. However, as we will discuss later, the IRB's inability to identify and accommodate other hidden or diminished mental health symptoms can result in problematic/distorted evidence which may lead to erroneous hearing outcomes. Specifically, individuals who are unable to access lawyers and/or expert witnesses that can translate their trauma stories into medico-legal language that the board deems valid may be at an increased risk of negative decisions, deportation and continued mental health deterioration in their country of origin. We suggest that the refugee evaluative process has become a two tier system where only a small portion of mentally ill asylum seekers are able to access meaningful supports (e.g. lawyers/psychiatrists) that assist them in navigating the complexities of the refugee determination system in Canada.

Although a full discussion of the legal, political, psychological and cultural aspects of the refugee determination process are beyond this paper and deserve ongoing research; we hope to develop a constructive narrative which challenges the current refugee evaluative system, while

also highlighting the difficulties that vulnerable groups face in developing a 'credible' refugee claim in Canada.

Definitions and Legal Framework

Today, refugee claims, specifically applications from asylum seekers are being challenged through complex legal and medical criteria. In the Canadian context, the Immigration and Refugee Board-a quasi-judicial tribunal-has jurisdiction relating to the adjudication of refugee cases. In the current refugee determination process, asylum seekers must prove that they meet the standard of proof for refugee status, which is outlined in the 1951 Refugee Convention and 1967 Protocol Relating to the Status of Refugees (Rousseau, Crepeau, Foxen and Houle, 2002). The UNHCR indicates that an asylum seeker is an inland refugee applicant whose claim has yet to be determined.

According to the 1951 Convention a refugee is defined as a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group (e.g. Mentally Ill) or political opinion, is outside the country of his nationality and is unable or, owing to such a fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it (Parsons, 2005). Further, according to the Immigration and Refugee Board of Canada a person in need of protection may also make an application for refugee status. "A person in need of protection" is defined as person(s) whose removal to their country of origin would subject them personally to a danger of torture; a risk to life, or; a risk of cruel and unusual treatment or punishment. More specifically, to meet the requirements of Convention refugee or "person in need of protection" the IRB's decision-makers must assess the veracity of an applicant's credibility through legislative provisions and principles which are grounded in jurisprudence (e.g. Balance of Probabilities).

Although the 1951 Convention does not require a refugee to be 'credible' in order to receive protection, the literature highlights that many refugee decision-makers weigh evidence based on an individual's ability to produce clear and 'consistent' testimony which the board deems valid. However, as we will discuss, asylum seekers who are suffering from pre-migratory trauma or other related mental health issues are less likely to provide consistent and reliable testimony, thus creating significant challenges for board members to make well-founded refugee decisions. Bailliet (2009) points out that "the majority of asylum cases are actually rejected on the basis of an adverse credibility assessment" (p.1). Despite the well documented prevalence of mental health, including trauma based illnesses among refugees, there continues to be inadequate resources to assist decision-makers in assessing the effects of trauma in asylum cases. Although Canada has taken the lead in recognizing the impact of mental health on the refugee determination process, through the development of guidelines and protocols (e.g. Chairpersons Guidelines for Vulnerable Groups/Victims of Torture/Gender-Related Persecution), these continue to be applied in an inconsistent and arbitrary manner. For example, refugee applicants who are experiencing mental health issues may be supported in the following ways: a) asylum seekers may disclose any general mental health issues or experiences of trauma at the port of entry through the Basis of Claim form which is provided by the Canadian Border Services Agency and is later forwarded to the IRB as documentary evidence; b) asylum seekers who

present in front of the IRB and who are presenting with serious mental health difficulties may be provided a Designated Representative (DR) to assist them with the tribunal process; DR's are available to persons who are unable to understand what the refugee protection process is about; and c) asylum seekers who are viewed to have a significant mental health issue which may impair the tribunal proceeding can receive special procedural accommodation which is outlined in the Immigration and Refugee Board's *Guideline 8: Procedures with Respect to Vulnerable Persons Appearing before the IRB* (2006).

Vulnerable Persons are defined as individuals whose ability to present their cases before the IRB is severely impaired. Such persons may include, but would not be limited to, the mentally ill, minors, the elderly, victims of torture, survivors of genocide and crimes against humanity, and women who have suffered gender-related persecution (Cleveland, 2008). Although not a main theme in this paper, it should be noted that recent changes to refugee policy in Canada (e.g. Balanced Refugee Reform Act/Protecting Canada's Immigration System Act), specifically the introduction of faster processing times, is impacting the ability of vulnerable groups (e.g. mentally ill) to receive procedural accommodation. For example, the enhanced timelines for refugee determination cases are also creating significant challenges for asylum seekers and their representatives to obtain supportive documentation such as medical reports which is often conducive to a positive hearing outcome (Sandrehasemi, 2013).

Building on the information provided above we will argue that although the IRB has taken steps to identify and accommodate mentally ill asylum seekers, these legal pathways are not accessible to all and continue to be applied inconsistently. Although the Canadian government has developed 'soft' guidelines relating to vulnerable persons before the IRB, we will demonstrate that board members, immigration officials and lawyers continue to face challenges in assessing evidence provided by individuals who are experiencing complex and intersecting mental health issues. Specifically, our concerns are rooted in the emergence of a two-tier refugee evaluative system where a disproportionate amount of refugee applicants are unable to access expert witnesses/lawyers who are able to validate their trauma related testimony through psychiatric diagnosis/reports. As a result, we posit that mentally ill asylum seekers are subsequently relegated to the normal refugee determination process where their distorted/incomplete evidence may be viewed as 'untrustworthy', thus resulting in negative hearing outcomes. We will demonstrate that expert witnesses play a pivotal role in identifying serious mental health issues and transforming the trauma experiences of refugees into medico-legal language which is viewed by IRB decision-makers to be credible.

Frequency of PTSD among Refugee Applicants and other Comorbid Issues

Globally, of the 42.5 million people displaced last year, approximately 25, 000-30, 000 refugee/asylum applications were processed in Canada (UNHCR, 2011; Castles and Miller, 2009; CIC, 2013). However, in recent years Canada's commitment to refugee protection has been called into question as notable declines in refugee acceptance rates are being reported. Although the research literature highlights difficulties in quantifying refugee data, a recent report by the AMSAA entitled *Refugees-Statistics and Trends in Canada* indicates that the 2013 acceptance rate for asylum claims is approximately 38%. Beaudoin (2011) and Black, (2012) report that there has been a general decline in refugee acceptance rates which may be correlated

with shifts in the focus of refugee policy/reform (i.e. The Balanced Refugee Reform Act), including increased attention on combating 'bogus' refugee claims; increased demands on refugees to prove credibility; stricter timelines to provide medical/legal evidence; lack of satisfactory translation services; a decrease in the number of board members from two to one; increased workloads for immigration officials; and the influence of psychiatrists on the tribunal process. Research demonstrates that refugee boards in Canada are struggling to keep up with the current stream of refugee applications while pressures from a previous backlog are also contributing to a bottle neck in the refugee determination system. As the general refugee population struggles to meet the strict medical/legal threshold of refugee status in Canada, we are concerned that more vulnerable populations are being subjected to an arbitrary and punitive decision making process where they are less likely to receive a fair and equitable hearing.

It is well documented that refugees and asylum seekers in Canada and around the globe have experienced significant pre-migratory traumatic events which include war, torture, violence, targeted persecution, forced labour, forced migration and family separation (Rousseau, Pottie, Thombs, Munoz, and Jurcik, 2011; Parsons, 2005). Research suggests that these traumatic experiences may contribute to refugees developing a constellation of mental health issues such as depression/anxiety, adjustment disorders and trauma based illnesses including Post Traumatic Stress Disorder (PTSD) (Wilson, Murtaza and Shakya, 2010). Robjant, Hassan and Katona (2009) highlight that "refugees worldwide report high rates of pre-migration trauma, and therefore of trauma-related mental health problems" (p.2).

PTSD can be understood as experiencing/reliving a psychologically traumatic event and has been identified in large numbers of refugees who have experienced pre-migratory trauma (DSM-V, 2013). According to the United Nations High Commissioner for Refugees (UNHCR) *Resettlement Handbook* (2002), PTSD among refugees ranges from 39 to 100 percent, compared to 1 percent for the general population (p.236). In a recent article in the *Psychiatric News* Moran, (2013) also highlights that refugees experience extraordinary rates of mental illness including PTSD (84%), depression (61%), demetia/traumatic brain injury (0.5%) and cognitive limitations (9%). Furthermore, other studies demonstrate that the frequency and intensity of PTSD fluctuates based on the type of traumatic exposure. Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) report that contexts such as rape, combat exposure, childhood neglect/physical abuse, sexual molestation, physical attack, torture, war and being threatened with a weapon, kidnapped or held hostage are associated with a high rates of PTSD. Moreover, PTSD related symptoms may not manifest until sometime after the traumatic event, thus assessment of trauma induced mental health symptoms are also time sensitive and may be difficult to assess within the confines of medical/legal environments.

The authors also indicate that although PTSD is high amongst refugees/asylum seekers worldwide it is also reported that it is more likely that individuals who have experienced pre-migratory trauma will suffer from more than one mental health disorder. What is ignored or not recognized is a larger complex interaction of many comorbid mental illnesses like depression, anxiety, somatization problems, to name a few. For instance, Rousseau et al. (2011) highlights that "44% of individuals who develop PTSD are likely to simultaneously have other mental health related symptoms including depression" (p.7). We argue that this hidden comorbidity also can impact on claimant's testimony and hearing outcomes. The understanding of comorbidity in asylum seekers is important to our discussion, because many individuals may not receive a fair

hearing as their diminished or hidden mental health may cause them serious difficulties in providing medical/legal evidence which the board deems valid. This, we contend, can impede asylum seekers from receiving a full PTSD diagnosis and thus result in refugee decision-makers questioning the validity and intensity of their trauma experience. We suggest that in current refugee determination systems there may be a tendency among decision makers to utilize expert witness testimony and a diagnosis of PTSD to affirm an individual's disclosure of trauma. However, as we will discuss, PTSD is not a biological disease that can be assessed universally; instead, PTSD is a narrowly defined socially constructed psychiatric category that fails to capture a holistic view of people's trauma and should not be utilized as a tool to measure the credibility of refugee trauma.

Theoretical Perspective: Social Construct vs. Medical Model

Post-Traumatic Stress Disorder (PTSD) was first introduced into the Diagnostic and Statistical Manual in 1980. According to Friel, White and Hull (2007) the Vietnam War and the socio-political context in which it took place "allowed an examination of the psychological effects of trauma in general and combat in particular...this led to the classification of PTSD (p. 65). Today the category of PTSD is being utilized in a variety of legal contexts including criminal and civil litigation. However, what is less well known is how PTSD and other mental disorders are impacting on refugee determination cases. We will argue two points in this regard. First, in place of often missing documentary evidence, and the complexity of supporting mentally ill asylum seekers, board members and immigration officials are relying on expert witness testimony to substantiate asylum claims of vulnerable persons (e.g. mentally ill) through the subjective diagnostic category of PTSD. Second, we will demonstrate that lawyers and asylum seekers are also drawing on PTSD as a vehicle toward credibility and access to Canada. To explore the impact of PTSD on the refugee determination process we have chosen to utilize the theoretical concept of social constructionism in order to deconstruct and locate the subversive power inequalities which exist within the psychological, legal and medical discourse of trauma. Specifically, we are concerned with the social construction of psychiatric categories such as PTSD and the utilization of its discourse by so-called experts as a form of universalized truth knowledge to evaluate the reliability and consistency of people's trauma narrative.

Investigating the tool of social constructionism and its application to mental illness, Barker and Conrad (2010) examines through the theoretical concept of social constructionism how individuals and groups contribute to producing perceived social reality and knowledge. The author's state that the social constructionist approach to illness is "rooted in the widely recognized conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition)…. In contrast to the medical model, which assumes that diseases are universal and invariant to time or place, social constructionists emphasize how the meaning and experience of illness is shaped by cultural and social systems (p.2). Summerfield (2001) draws on social constructionism to challenge the positivist-essentialized notions of PTSD. The author notes that "the psychiatric sciences have sought to convert human misery and pain into technical problems that can be understood in standardized ways and are amenable to technical interventions by experts. But human pain is a slippery thing, if it is a thing at all: how it is registered and measured depends on philosophical and socio-moral considerations that evolve over time and cannot simply be reduced to a technical matter" (p.4). Furthermore, the author

indicates that PTSD has been constructed out of a neo-trauma industry which includes experts, lawyers and decision-makers who utilize PTSD as an access point to alter the outcomes of criminal/civil cases or in our case refugee decisions.

Building on social constructionist thought, it can be argued that individuals in refugee determination cases undergo an arbitrary decision making process which relies on socially constructed diagnostic categories such as PTSD to validate and legitimize claimant testimony. For example, asylum seekers who are able to construct a consistent and reliable trauma narrative are labelled with a mental health diagnosis (e.g. PTSD), thus resulting in their testimony being viewed as reliable and credible (Cleveland, 2009). In her study of refugee determination systems in Norway and Australian, Bailliet (2009) reports that, evidence of PTSD in refugee determination hearings may be "interpreted as grounding a finding of past persecution or torture" (p.2). However, research seems to point out that PTSD is a diagnostic category which is defined by westernized concepts that may have less applicability to refugees from non-western origins (Marsella, 2010; Jobson, 2009; and Wilson, 2007). It appears that positivist approaches essentialize individual trauma and fail to consider the fluidity and complexity of the person's experiences and rely on labels for credibility. Further, 'trauma' as a language has become universalized and normalized by the psychiatric community. In essence, mental health experts have become claims makers reproducing the knowledge and experiences of 'trauma' into defined and compartmentalized diagnostic categories which have become legitimized through the language of mental health and the Diagnostic and Statistical Manual (DSM-V). Trauma has become disenfranchised from the individual where their experiences are measured against a universal western discourse of mental health which clearly fails to include the larger socio-political contexts which have contributed to the traumatic event but also negates the cultural lens of mental health and recovery (e.g. spiritual/religion) (Waldron and McKenzie, 2008; Foucault, 1965).

The social construction of PTSD allows dominant groups, such as expert witnesses to validate what a traumatic experience is and who can access this label. We argue that in legal environments such as criminal courts and refugee tribunals this access to PTSD and other diagnosis can skew legal outcomes. Thus, PTSD as a psychiatric category is not a biologically predetermined disorder which the medical model compartmentalizes as a 'disease' with an explicit treatment regime. Instead, PTSD must be viewed through the broader perspective of social constructionism which highlights that this diagnostic category was created by scientists and is flawed by the self-serving hegemony of psychiatry and psychology. PTSD and its relationship with the law must be deconstructed and its label as a form of 'truth' knowledge needs to be disputed. In other words PTSD as a label can survive but not in its narrow medicalized state but in a broader and inclusive understanding that changes the power inequalities which are hinged within its discourse (Friedson, 1970). In legal environments such as criminal courts and refugee tribunals the individual experience of trauma will be trumped by the need to define and categorize the traumatic event in order to justify its relevance to the decision making process. More specifically, it is the language of PTSD that is being utilized as an access point to credibility and a positive refugee decision. Asylum Seekers are drawn into the medico-legal trauma industry where the privileged text of 'expert witnesses' mark individuals with medical labels such a PTSD; however, without this often costly exercise, the individuals trauma narrative is lost and their refugee claims are viewed as less favourable by decision makers (Smith, 2011; Mendelson, 1995).

Assessing Credibility: Adjudicator Knowledge

As we have discussed thus far, PTSD and other related mental health disorders play a significant role in refugee determination cases. Specifically we highlight that the evaluative process utilized by decision-makers, the guidelines that are accessible to them and the subjective evidence which is presented, contributes to serious difficulties in the assessment of refugee credibility. For example, according to Houle (2009) "when one examines these cases, the general impression that emerges is that Board members view the task of weighing the evidence as something mechanical or mathematical. After Board members believe that they have accumulated sufficient implausibilities, exaggerations, inconsistencies or contradictions they feel confident they can find the testimony not credible or trustworthy and reject the claim. These types of examinations aim more at finding a flaw in the testimony than to genuinely understand the relevancy (or lack of) of the information provided by the asylum seekers" (p.13).

Unfortunately, the 'cat and mouse' game that Houle describes above has become normalized and embedded within the IRB adjudication sub-culture. The author stresses the importance of consistency and clarity in the delivery of trauma narratives to decision-makers. In cases involving refugee trauma where mental health can seriously impact the testimony of asylum seekers, the rigid/mathematical process of weighing evidence can create serious inconsistencies in the ability of Board members to step back from the evidence and to identify other reasons for distorted testimony, including trauma related mental health symptoms. Moreover, without a strong PTSD diagnosis via expert witnesses, we contend that decision-makers fail to adequately identify and assess other hidden or diminished mental health issues (e.g. adjustment disorder/depression) which can have a significant impact on the outcome of refugee cases.

For instance, current research literature demonstrates that although asylum seekers may have a well-founded fear of persecution, which has caused them psychological distress, their stories are being evaluated through 'expert witness' testimony and interrogated by decision makers who are in pursuit of the subjective legal test of 'credibility' (Saphir and Molina, 2011). A recent article by the Canadian Council for Refugees (2006) provides an example of the severe trauma some asylum seekers have experienced and the challenges they face in translating their experiences into medico-legal language that is viewed by board members to be authentic and 'credible'. This article refers to the case of Mr. Rios who fled to Canada from Mexico in order to escape ongoing physical and psychological torture/persecution. In Canada, Mr. Rios made a refugee claim where he provided substantial medical and psychological evidence. Subsequently the case was later rejected on the grounds that his testimony was not credible due to inconsistencies in his testimony and a lack of medical and documentary evidence. Although Mr. Rios had access to expert witnesses who confirmed that his pre-migratory traumatic experiences have led to serious mental health issues, the board member did not recognize his mental health as a mitigating factor in his case. We highlight that the board members decision to not accept the testimony of the expert witness is clearly in opposition with the Immigration and Refugee Boards own policies and procedures relating to vulnerable persons and expert witness testimony. Specifically, the IRB's *Training Manual on Victims of Torture* highlights that although members are not bound to accept and give full weight to an expert's testimony, they are expected to take into consideration all evidence including expert reports. However, as Bailliet (2009) notes, refugee decision-makers are hesitant, at times, to accept expert witness testimony as they are skeptical in regards to the objectivity of psychiatric/psychological reports. Also due to the lack of knowledge and training

among decision-makers regarding mental health, a complex medical report that fails to correlate the asylum seeker's mental health with the traumatic event (e.g. PTSD) may push adjudicators to refute the evidence. Thus, it appears that a lack of training and experience among board members and immigration officials can have a negative impact on the refugee evaluative process, as was in this case.

Cases such as Mr. Rios highlight that ascertaining credibility among asylum seekers, specifically those with mental health challenges, is a problematic and salient issue in the refugee determination process. For example, not only is the refugee determination process subjective, but many board members and immigration officials are not experienced with or trained to analyze and understand: a) the complex experiences of refugees and asylum seekers; b) their own bias within their decision making process; c) the mental health challenges of asylum seekers; c) the importance of adequate translation and cultural competency and d) their position of 'power' and the impact this may have on the decision making process. Pieters (2004) suggests that "in refugee claims credibility is always an issue….the majority of claims are determined on the basis of a subjective analysis, whether or not the panel believes the claimant's story" (p.1). Although the refugee system employs guidelines, policies and safeguards which are constructed to protect the rights of individuals throughout the refugee determination process (e.g. *Guidelines on Vulnerable Persons*, 2006); these policies and practices are not always followed and can impact the outcome of hearings. Rousseau et al. (2002) reports that the Federal Court of Canada has exclusive jurisdiction to set the legal parameters which are to be followed by the IRB when it makes decisions, however due to the "the lack of competence of Board Members, these legal guidelines appear, at times, not to be followed resulting in negative decisions which are not well founded" (p.4). The Schizophrenia Society of Ontario (2010) also highlights that IRB board members face significant challenges in regards to weighing and assessing evidence provided by mentally ill asylum seekers. Specifically, the authors note that "the formal training they receive in the area of mental health is minimal. IRB Members cannot be expected to be able to ascertain the extent of a mentally ill individual's ability and/or vulnerability, and subsequently the special accommodations they require, unless they receive proper training to do so" (p.25).

The case of Mr. Rios, and many others like it (e.g. *Elezi v. Canada,* 2007; IRB, 2008; and *Somakandhan v. Canada*, 2002), are in stark contrast to Canada's commitment to protect refugees as outlined in the Immigration and Refugee Protection Act, and the 1951 Geneva Convention relating to the Status of Refugees, including the principle of non-refoulement which forbids the return of victims of persecution to their country of origin (UNHCR, 1997). Furthermore, the policies and guidelines that are developed by the Federal Government of Canada to support decision-makers throughout the refugee determination process are, at times, being ignored by IRB members, thus increasing the risk of negative decisions, deportation and continued persecution in the asylum seekers country of origin (Pieters, 2004; Rousseau et al. 2002; and Mackey and Barnes, 2013). In discussing the competency of board members Roussea et al. (2002) indicates that "some board members fail to carry out their duties effectively…they do not always know how to treat expert evidence, or they use it in ways which are clearly inappropriate" (p.57). The lack of training and knowledge among board members and immigration officials relating to mental health correlated with the subjective nature of the refugee determination process creates significant challenges in evaluating testimony. Such difficulties which are rooted in misstated, misunderstood and misconstrued evidence (*Bouguettaya v Canada,* 2000) can lead to negative refugee decisions.

We argue that many vulnerable persons who have experienced pre-migratory trauma may not meet strict diagnostic criteria (e.g. PTSD) or lack the ability due to other forms of psychiatric disability, to provide decision makers and medical experts with a consistent and reliable trauma narrative, thus raising questions of credibility and increasing the risk of a negative decision. This coupled with the lack of experience and knowledge among board members/lawyers and immigration officials regarding mental health issues, and the impact this has on testimony, can also create an environment where the asylum seeker's story is viewed as problematic and/or not credible.

Impact of Mental Health on Testimony

Veterans of war and who subsequently engage in criminal activity or women who commit violent crimes to flee abusive situations (*R v Lavallee*, 1990) have utilized the PTSD defense to receive more lenient sentences (Gold, 2005). A review of the literature raises more questions than answers as to whether asylum seekers are more successful if they can prove PTSD or other serious mental health disorders through their own disclosure of trauma or via expert witness testimony. At this time we also do not know if other trauma-linked psychiatric disorders are being recognized by immigration officials and are these diagnosis impacting refugee and asylum case decisions.

Board members and immigration officials in asylum cases are challenging the validity of trauma-related testimony through the utilization of 'expert witnesses' who draw on psychiatric/psychological diagnosis to indirectly establish credibility (IRB, 2003; Cleveland, 2009). We are concerned that board members and immigration officials have created a subculture of decision making which is rooted in the medicalization of trauma where a strict diagnosis (e.g. PTSD) has been used as a threshold to substantiate testimony. However, this one size fits all model fails to take into consideration the different experiences and symptoms of trauma that may fall short of a psychiatric diagnosis such as PTSD. Specifically, those experiencing PTSD symptoms may not meet the DSM criteria; however their stories and symptoms should not be minimized and de-legitimized by board members, legal counsel, expert witnesses or immigration officials. Furthermore, we will demonstrate that asylum seekers who have experienced pre-migratory traumatic events and who are presenting with complex mental health symptoms may fail to provide reliable testimony that can be utilized by board members and medical experts in their medico-legal test of credibility. This we argue, can impact the asylum seeker's overall refugee claim and may lead to negative decisions which are based on erroneous and incomplete evidence.

Recent studies have demonstrated that mental health, including PTSD, can have an adverse effect on asylum seeker testimony and their ability to develop and produce 'credible' legal/medical evidence (Steel, Frommer and Silove, 2004; Cohen, 2001). For example, the research literature draws attention to how asylum seekers understand and cope with their trauma during the refugee determination process and how post-traumatic symptoms can hinder oral testimony. According to Rousseau et al. (2002) pre-migratory traumatic events "can engender post-traumatic psychological reactions in the claimants, which often affect both their ability to testify and the content of their testimony" (p.6). The authors argue that revisiting traumatic

events can trigger avoidance reactions; while also overwhelming them with powerful emotions of anxiety, depression, and anger leading to loss of control or dissociation.

Herlihy and Turner (2009) also posit that recalling traumatic memories can have an explicit impact on refugee testimony. The authors contend that people make sense of life events through autobiographical memories which link experiences through structured narratives that can be recalled at will. In contrast when people experience traumatic events they retain a very different and at times distorted-fragmented picture of the events. Instead of recalling memory as a fluid narrative, those who have experienced a traumatic event will only recall vivid pieces of their experience, including external and internal stimuli (e.g. a smell, a loud shout or a face). When the individual is triggered by such stimuli they will re-live the experience as if it was happening again (e.g. 'flashbacks'). To compensate for re-visiting these stressful events individuals may draw on protective mechanisms such as avoidance and dissociation to manage painful and uncontrollable memories. As a result, these protective mechanisms may impede an individual's ability to formulate a consistent and accurate narrative of their traumatic events, thus leading decision makers to speculate about their credibility. Sarkar (2009) notes that "the problem of recall is particularly great when the trauma survivor is exposed to further stress such as an asylum interview or an immigration hearing. In such situations, survivors of torture or trauma are forced to recall frightening or painful, even humiliating, experiences" (p.4). Thus, individuals participating in refugee hearings may be unable to recall exact experiences, including times and dates, while also experiencing memory blocks which may compromise the coherence/consistency of trauma evidence and can negatively impact the validity of the individual's testimony.

The Immigration and Refugee Board's *Training Manual on Victims of Torture* (2004) describes the difficulties in assessing credibility/evidence:

> "Our assumptions and beliefs about memory can be a key element in assessing the credibility of alleged victims of torture. While some claims are legitimately rejected on the basis that the claimants cannot provide sufficient details about their torture experiences, or omitted important details in earlier statements, there is also a risk that genuine victims of torture may be rejected when decision-makers draw wrong conclusions about their memory difficulties" (p.1).

As a result of the difficulties in assessing trauma-related testimony/evidence, the Immigration and Refugee Board is currently relying on expert witnesses to guide the refugee determination process. However, concerns arise when decision-makers fail to move beyond the threshold of a PTSD diagnosis in their investigation of credibility; thus, undermining the importance of other related diminished/hidden mental health disorders which can significantly impact the testimony of asylum seekers. Although there is limited research regarding the frequency at which this occurs, researchers such as Bailliet (2009) have identified that diminished traumatic symptoms such as "psychological harm (depression/feelings of hopelessness) linked to the forced migration process is usually not identified or considered relevant to the asylum claim" (p.3).

As described earlier, board members and immigration officials face multiple challenges in determining legitimate claims of persecution which are rooted in pre-migratory traumatic events.

Specifically, without expert psychiatric support there appears to be considerable issues and barriers in an asylum seeker's ability to receive a positive decision based on pre-migratory trauma/mental health issues. These include: a) the consistency of board members and immigration officials to follow guidelines (e.g. *Guideline 8: Procedures with Respect to Vulnerable Persons Appearing Before the IRB,* 2006*)* in determining the credibility of vulnerable populations; b) board members and immigration official's knowledge and understanding of mental health issues and the impact on the tribunal process; and c) how the tribunal process itself re-traumatizes asylum seekers and can proliferate mental health symptoms which can lead to questions of malingering.

Meffert, Musalo and McNiel et al. (2010) indicate that attaining credibility can pose a challenge for refugees and asylum seekers "because the hallmarks of credibility in the legal system do not take into consideration the way in which the trauma many asylum seekers have suffered affects their ability to provide believable testimony" (p.481). The authors argue that one of the main focal points for board members and immigration officials in their investigation of credibility is the 'consistency' of evidence. Specifically, board members and immigration officials are relying heavily on the 'consistency' of narratives as a measure of claimant testimony; however, this is problematic as many asylum seekers who have traumatic experiences and post-traumatic stress related symptoms will have serious difficulties in cultivating a consistent written/oral narrative due to their mental health symptoms. For example, Suzuki (2007) claims that many board members and immigration officials continue to "assume that consistency in the recall of details is evidence of credibility, and that someone who has accurate recall of details is more credible. This assertion, however, is not supported by research on trauma survivors" (p.24). Cameron (2010) also notes that "even when decision makers can accept gaps in a claimants' memory, most boards still expect a high degree of consistency in their testimony" (p.21). Specifically, the authors point out that that memories of traumatic events are often difficult to recall and can be suppressed through dissociation and other protective mechanisms which may lead to questions of validity and malingering, thus contributing to negative refugee decisions.

Another context that streams from the discourse on mental health and credibility assessments is the impact of 'stigma' on testimony. For example, asylum seekers who have experienced pre-migratory trauma and who are presenting with post-traumatic symptoms may not fully disclose the details of their experience due to the fear of stigmatization which can significantly compromise the refugee evaluative process, including legal and medical evidence. Kirmayer, Narasiah, Ryder, Burgos, Zelkowitz, Pottie and Kutcher (2011) inform that "many cultures strongly stigmatize mental health problems, which can limit disclosure of behavioural or emotional difficulties (p.7). More specifically, research has demonstrated that immigrants and refugees may have conflicting values and norms which make it difficult for them to discuss traumatic experiences and possible mental health symptoms. For instance, Amri and Bemak (2013) discuss the barriers immigrants and refugees face in identifying/disclosing mental health symptoms contending that in many cultures, there is a strong stigma that is attached to mental health and treatment of psychological conditions thereby resulting in families and individuals failing to seek help for their psychological problems for fear that they will shame their family or that they are revealed as being weak.

As indicated in the above narrative ethno-racial groups may not conform to Western notions of mental health out of fear of stigmatization. The fear of stigmatization can have a serious impact

on the refugee determination process, including the disclosure of medical and legal evidence. Asylum seekers may not have had to confront their mental health issues in the past; however, through the refugee determination process they are coerced to confront past trauma and subsequently are subjected to the labeling/diagnostic process of Western medicine which seeks to interrogate their traumatic experiences. Furthermore, many refugees have fled their country of origins due to fear of persecution where they have had negative experiences with international/domestic state agents (e.g. police/immigration officials/army) and medical professionals. This may also invoke strong feelings of mistrust which can further impact the disclosure of mental health issues and other related evidence pertaining to the asylum seekers refugee case.

Thus, mental health can severely impact the refugee determination process as individuals may not be able to provide consistent evidence, resulting in decision makers questioning the validity of the trauma testimony and leading to increased risk of negative decisions. Specifically, we argue that asylum seekers complex and often hidden mental health issues may complicate the hearing process if: a) board members and lawyers are unable to identify the asylum seekers mental health issues and subsequently fail to make submissions for vulnerable accommodation and/or special legal counsel; b) expert witnesses are not involved to articulate the trauma narrative and the reasons for distorted and incomplete evidence; and c) board members, immigration officials and lawyers fall short in recognizing other general and diminished mental health disorders, thus failing to understand how these may impact claimant testimony and their ability to articulate a consistent and credible trauma narrative. As a result, mentally ill asylum seekers may be stratified into the regular refugee determination process where they are more likely to provide distorted and incomplete evidence which can impact hearing outcomes. Moreover, the fear of stigmatization can also make it difficult for individuals to disclose their mental health issues to the Board, thus resulting in distorted testimony that is viewed as unreliable by decision-makers.

As we have discussed, trauma induced mental health is complex and must be understood through a broader view of mental illness which incorporates a holistic approach to assessing individual trauma stories on a case by case basis. The problems that arise in legal environments such as the IRB, is that decision-makers, lawyers and immigration officials fail, at times, to take the proper steps in unpacking the trauma that individuals have experienced. Decision-makers/immigration officials need to receive better training in assessing trauma related testimony against a continuum of mental health diagnosis which moves beyond the compartmentalized discourse of PTSD, thus broadening its scope to embody other contexts such as cultural, social and political factors.

PTSD as a Social Construct: A Mechanism for Credibility or Not?

PTSD, Trauma and stress related conditions was originally classified under anxiety disorders, but with the recent publication of the DSM V (2013), a new category, Trauma-and Stressor Related Disorders have been elevated to an independent category. Under this heading, the following disorders find their place:

- Reactive Attachment Disorder

- Disinhibited Social Engagement Disorder
- PTSD
- Acute Stress Disorder
- Adjustment Disorders
- Other Specified Trauma and Stressor Related Disorder
- Unspecified Trauma and Stressor Related Disorder

Reactive Attachment disorders and Disinhibited Social Engagement Disorders are trauma based disorders seen in children who have had problems with attaching to caregivers. It is unclear to what extent, pre-migratory adverse life experiences impact on bonding, attachment and caregiving in families who find themselves displaced from their origins, separated from loved ones, and existing for lengthy periods of time in refugee camps (Kirmayer et al., 2010). These disorders have been paid scant attention in various refugee reports/studies reviewed by the authors of this paper.

When defined behavioral or emotional symptoms of a clinically significant nature occur in response to an identified stress occurring within 3 months of the onset of a stressor, an Adjustment Disorder label is used. The symptoms are expected to remit within 6 months of the termination of the stressor. It is clear that adjustment disorders are different from PTSD quantitatively and qualitatively. However, adjustment disorders are associated with significant emotional distress and impacts on the individuals psychosocial functioning. They are also associated with an increased risk of suicide attempts and completed suicide. The relocation process, uncertainty as to what the future holds in store, and fear of being sent back to the place of origin are obvious psychological stressors that refugees experience, in addition to the traumatic experiences they had in the country they came from. Disentangling the origin of symptoms and attribution of cause and effect is likely to tax the skills of seasoned clinicians, leave alone members of the IRB and lawyers. Often Adjustment disorders are associated with prominent anxiety and depressive symptoms and can evolve into other psychiatric disorders. It is our experience that sometimes Adjustment Disorders are not given the same importance as other formal diagnostic categories like Anxiety Disorders and Major Mood disorders but can be as debilitating.

The category of Post-Traumatic Stress Disorder may be better understood as being conceptualized as a response to specified stressful events with characteristic symptoms that are intrusive, behaviors of avoidance, negative alterations in cognitions, and mood and autonomic impairments. The DSM V addresses the importance of understanding variations in expression of trauma and distress in different cultures and unique ways they are expressed (idioms of expression). Marsella (2010) has pointed out that in addition to conventional pattern of responding, culture shapes various psychological aspects of response to traumatic events including meaning and implications of phenomena such as nightmares and visions, role of beliefs in destiny or fate, perception of personal responsibility for the event and response, and other vulnerabilities to trauma like genetic make-up, social network, status and structure, patterns of coping, and religious and related belief systems.

As will be discussed later, the presence of PTSD in psychiatric parlance and the use of this concept by psychiatry tends to legitimize a specific trauma response to exceptional stressful events. The danger that one runs into is several fold. One is dependent on accuracy of reporting by the client, the accuracy of the collateral information, and expertise in equating signs and symptoms as representative of the disorder. When an IRB is sitting, the diagnosis may have the effect of deciding for the board that the trauma is genuine and this could impact on credibility assessments. Secondly, by its presence in the DSM V, the use of criteria, and using an expert to endorse a label may auger well for a particular case, but it creates a misperception that absence of PTSD, is indicative of lack of serious distress and creates an atmosphere of disbelief about the seriousness of the trauma experienced. It creates a myth that lack of characteristic post-traumatic stress symptoms equates with less serious symptomatology overall, less serious impact the trauma had on the person, and a bias against the asylum seeker. It is therefore important to look beyond diagnostic labels and broaden policy and decisions, including refugee determination processes. (Conrad and Barker, 2010)

Although there is very little research which focuses on mental health and the refugee determination process in Canada, we can draw on knowledge relating to criminal and civil litigation to develop a window into which we are able to view how PTSD operates within a variety of legal environments, including the refugee system. For example, in speaking in regards to criminal and civil law Smith (2011) posits that "PTSD has been subjected to particular scrutiny within the behavioral sciences in part because of the use of the diagnosis, or at least the term, in the courts and the broader culture" (p.52). The author contends that the use of PTSD in criminal and civil matters has become the hallmark and at times over utilized to draw conclusions about specific and traumatic events (Friel et al, 2007; Gold, 2005; Samra and Connolly, 2004; *Mustapha v Cullignan*, 2006; Berger et al, 2012). Furthermore, Smith (2011) suggests that the "specific conceptualization of PTSD as a stand-alone diagnosis with a defined set of symptoms has brought widespread attention and scrutiny within psychiatry. Two key questions linger that have direct implications for the legal uses….the validity of the A Criterion and the extent to which PTSD is a construct rather than a "scientific discovery." (p.52). Subsequently, we will argue that Smith's discussion and questions relating to the diagnosis of mental illness can also be applied to the refugee determination process where a substantial amount of weight is placed on expert witness testimony and the reliance on diagnostic categories to prove whether an asylum seeker's story is genuine.

Immigration officials (e.g. Refugee Protection Officer), including board members have become rooted in the medicalization of trauma and that any diversion from their perception of this pathologized norm would raise suspicions of malingering and thus have adverse effects on their decision making process (Davis 1999; Summerfield, 2001; Briere and Scott, 2006). Although research by Smith and others have demonstrated significant problems with the diagnostic category of PTSD among the behavioral science community; one can only imagine the challenges which exist in a complex arena such as the IRB where few have the training and knowledge to truly draw objective decisions from such a subjective vacuum of evidence. Researchers drawing on trauma theory, postmodernism and social constructionist approaches argue that trauma cannot and should not be compartmentalized into a single diagnostic criterion as this suppresses other traumatic experiences which do not fall into the PTSD category. Briere and Scott (2006) challenge the medicalization of trauma by arguing that the requirement that trauma be limited to "threatened death or serious injury, or other threat to one's physical

integrity" (p.4) fails to take into consideration other traumatic events which do not involve threat to life or injury. Specifically, the DSM falls short in capturing the trauma that individuals experience in areas such as extreme emotional abuse, major losses or separation, degradation and humiliation, and coerced sexual experiences. Similar arguments are seen in Burstow (2003) who notes that "a related but more general criticism raised about PTSD is that it does not describe the effects of repetitive violence and victimization. What is more fundamental, PTSD is a grab bag of symptoms with no context, divorced from the complexities of people's lives and the social structures that give rise to them. As such, the diagnosis individualizes social problems and pathologizes traumatized people" (p.4). The above noted data relating to the discourse of trauma and PTSD highlights serious issues with the diagnostic category of PTSD. Utilizing this information we are able to develop a view into the complexities of refugee determination and the challenges which may exist in understanding and articulating traumatic experiences in the rigid confines of legal environments. We argue that in an environment such as the IRB the inability of decision makers to identify and understand other traumatic symptoms which fall short of a PTSD diagnosis may leave asylum seekers at an increased risk of a negative hearing outcome, deportation, continued persecution and subsequent mental health deterioration.

After understanding the problematic nature of PTSD as a diagnostic category we must examine who has access to the PTSD diagnosis and who is privileged to apply this label? How is PTSD being utilized in the IRB to determine credibility? Burstow (2003) also questions the privilege and power rooted in psychiatry and the ability of medical and psychiatric institutions to not only construct labels of abnormality but also apply these labels to individuals through the tools of diagnosis. The author posits that "mental disorders, whether they are called PTSD or anything else, in other words, are a function of the power of psychiatry mediated by the psychiatric text" (p.8). This is important to our conversation of mental health and the refugee determination process because board members at the IRB have constructed a culture of decision making which relies on western-medicalized notions of trauma that are rooted in 'power' inequalities and privileged text. Specifically, we question whose knowledge is privileged in the context of immigration hearings? Whose norms and values are being used as a measuring stick to 'the others' trauma?

Summerfield's (2001) investigation of PTSD and the law explores how western medicalized notions of trauma are being used in legal environments and how psychiatric evidence can play a pivotal role in the outcome of litigation. The author notes that "in western societies, people can receive compensation for psychic discomfort in some contexts although not in others. Although the basis of many compensation cases for post-traumatic stress disorder is moral—that is, embracing the sense of having been wronged—rather than psychological, the psychiatric category is the instrument by which a moral charge is fashioned into a medico-legal one…The diagnosis of post-traumatic stress disorder is the certificate of impairment" (p.96). Bringing the above noted discussion into the arena of refugee determination we can also see how Summerfield's research relating to the medicalization of trauma is significant in the IRB environment. Specifically, the authors infer that the social construction of PTSD has become normalized by Western society and this normalcy has rooted itself in our daily lives and institutions. As a society we are reliant on so called experts and medical categories to make sense of 'traumatic' events. However, one must question the validity of PTSD and its applicability across cultures. Subsequently, this hyper-reliance on a medical perspective alone, fails to take into consideration the fluidity and complexity of trauma, thus creating a subculture of

refugee/immigration decision makers who erroneously draw on medical evidence (i.e. PTSD diagnosis) to discern between the credible-good refugee and the malingering-bad refugee. We suggest that in the legal environment PTSD is less about the recovery of actual human suffering and the symptoms which develop as a result of traumatic events; instead PTSD as a construct, within a burgeoning trauma industry, has become a mechanism where lawyers, decision makers and other interested parties draw on its category to develop a privileged position for their clients who may receive reduced sentences or favourable hearing outcomes.

Returning to the discussion of criminal and civil law Gold, (2005) asserts that in recent year's lawyers and claimants have accessed the PTSD diagnosis to drastically change the outcome of legal cases. A significant amount of research suggests that lawyers, expert witnesses and decision-makers are drawing on the diagnosis of PTSD as an access point of privilege where clients can receive more lenient sentencing in criminal cases and more favourable financial outcomes in civil cases (e.g. car accidents). Stone (1993) indicates that:

> "No diagnosis in the history of American psychiatry has had a more dramatic and pervasive impact on law and social justice than post-traumatic stress disorder…accurate assessment of PTSD specific symptoms forms the basis for defining psychic injury in law, and for exculpating an individual from criminal responsibility. Lawyers have invoked PTSD in ingenious, if sometimes farfetched, attempts to obtain insanity and self-defense acquittals" (p.25).

More specifically, PTSD has become a socially constructed mechanism which allows privileged voices, such as lawyers and psychiatrists to drastically impact the outcome of legal cases (Mezey and Robbins, 2001). However, this point of privilege cannot be accessed by all. Those who are marginalized and vulnerable (e.g. mentally ill) may not have the financial key or legal knowledge to unlock the pass code to the PTSD label. Thus, the PTSD defense may only be accessible to specific groups who have access to and/or are able to employ 'experts' who can transform their stories of trauma into legal and medical text. This enables defendants to carry the PTSD label which can have a favorable impact on their legal outcomes. Drawing on the research which focuses on PTSD and the law one can argue that similar pathways to legal outcomes may also be seen in the refugee determination process (Gold, 2005; McGuire and Clark, 2011). We suggest that PTSD has also infiltrated the refugee determination process as it has in criminal and civil litigation. This infiltration has broadened the trauma industries reach where PTSD is now a tool for lawyers, expert witnesses and other parties to legitimize testimony and solidify credibility in refugee determination cases. According to Cleveland (2007) a thorough credibility assessment and a well written psychiatric report can strongly impact the chances of an individual receiving refugee status. Thus, instead of more lenient sentences in criminal matters or increased financial outcomes in civil cases, asylum seekers are alternatively compensated with access to Canada and a pathway to citizenship. However this pathway is not accessible to all and is marred with medico-legal barriers which make it very difficult to build a case based on mental health issues.

Decision makers in the refugee determination system continue to depend on expert witness testimony and subjective documentary evidence to ascertain credibility and trustworthiness (Cleveland, 2008). More specifically, in cases involving asylum seekers suffering from mental

health issues, decision makers appear to be dependent on a PTSD diagnosis to reward a positive decision as they are unable to understand the complexities of other hidden/diminished comorbid metal health symptoms (Bailliet, 2009). However this is highly problematic. As noted earlier, some asylum seekers are not able to create a consistent and reliable testimony due to their mental health symptoms which may affect their ability to provide 'experts' and decision makers with enough input to qualify them for a mental health diagnosis such as PTSD. Concerns arise when decision makers are unable to identify other traumatic symptoms which fall short of a PTSD diagnosis, thus stratifying individuals into the regular refugee determination process where their mental health can impact testimony and lead to negative hearing outcomes. We argue that many asylum seekers may be rejected as they cannot articulate or conflate their stories into the rigid confines of the western universalized silo of the PTSD category.

Research by Waldron and McKenzie (2008) suggest that asylum seekers who are moving through the refugee determination process may also be subjected to Western/Eurocentric notions of mental health (i.e. PTSD) which fail to consider the ethno-cultural contexts of trauma. Considering that many asylum seekers are racialized populations, measuring their 'trauma' and mental health from a Westernized/medicalized lens can be problematic. In Waldron and McKenzie's discussion of PTSD and racialized populations the authors note that "it is difficult to understand and treat non-Western and racialized peoples without an appreciation for how their individual and collective identities are shaped by these social, political, and historical forces. Positivist approaches, such as those often used in medicine and psychiatry, are typically concerned with using objective generalizations to define reality through a scientific lens" (p.15). In discussing the mental health of refugee populations Karachiwalla (2011) also indicates that "a range of mental health symptoms may manifest in refugee populations depending on cultural factors, and not all may be pathological. The focus should be shifted away from a purely biomedical model when trying to establish the meaning of mental health symptoms in this group" (p.21).

The author's discussion draws attention to the highly problematic utilization of scientific approaches to narrowly define the life events of refugees/asylum seekers and those who have been exposed to traumatic events. More specifically, we argue that although psychiatry has a place in giving victims of trauma a causal identity to their experience via diagnostic categories such as PTSD, this generalized and subjective approach can also undermine the complexity of the traumatic event itself. This is even more relevant in a discussion of racialized populations whose experiences are magnified and investigated under the lens of Western notions of trauma. This, as demonstrated by the research literature, can pose significant challenges for asylum seekers who are trying to contextualize their trauma into the narrowly defined parameters of Western medicine.

Conclusion

In short, we argue that the utilization of PTSD as a threshold for credibility whether formal or informal fails to adequately move beyond the medicalization of trauma and minimizes the more broad socio-political and cultural contexts of trauma. We suggest that a two tier refugee evaluative system has emerged, where PTSD is being utilized**,** at times, as a threshold to measure the validity of trauma, and that the buffer between a positive/negative refugee decision is hinged

on an individual's ability to access experts who are able to translate their trauma narratives into medico-legal language that the Board is able to qualify. More specifically, although asylum seekers experience trauma at different rates (e.g. frequency/intensity) and is strongly correlated with other comorbid mental health symptoms, we are concerned that decision-makers who focus on PTSD may inadvertently minimize and pass over other trauma related mental health issues which may lend weight to the evidence of persecution that claimants are presenting. As a result, we contend that asylum seekers with diminished or hidden mental health issues may be inadvertently pushed into the regular refugee determination stream where they are more likely to provide decision-makers with distorted/incomplete evidence, thus increasing the risk of a negative decision. A review of the research literature thus far, identifies a gap in regards to knowledge and data relating to the role of expert witnesses and their utilization of psychiatric categories such as PTSD to influence refugee cases. Moving forward we hope more research will focus on the intersections of mental health and refugee determination (e.g. detention/gender/children) thus informing refugee policy, guidelines, and practices which better support refugees who are suffering from trauma related mental health issues.

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