# Weill Cornell Center for Human Rights


Weill Cornell Medical College

# Asylum Evaluation Training Manual

## 2nd Edition

Compiled and Edited by the Weill Cornell Center for Human Rights

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# General Information

## Introduction

The *WCCHR Handbook* is the official manual of the Weill Cornell Center for Human Rights, a student-run organization that trains students and faculty to provide forensic evaluations for survivors of torture seeking asylum in the United States. The *Handbook* is aimed at students participating in a forensic evaluation with WCCHR for the first time, but can also be used by experienced students or faculty as a refresher.

This manual gives an overview of asylum law, outlines the structure and purpose of the forensic evaluation in the framework of the asylee's case, gives background information on WCCHR, and arms the student with the tools necessary to craft a forensic evaluation based on information gathered during medical, gynecological and psychological interviews with asylees by evaluators of WCCHR.

## Asylum Law – A Brief Introduction

In the United States, an asylum seeker must meet the definition of a "refugee," that is:

> *Any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of that country, because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group or political opinion. (*from the Immigration and Nationality Act).

In short, any asylum seeker must either have been persecuted or have credible fear that he or she will be persecuted due to one of the following factors:

- Race
- Religion
- Nationality
- Political Opinion
- Membership in a Particular Social Group

The last, membership in a particular social group, is the most elastic, and, in 1990 was widened to include "women" as a group. This has allowed women to seek asylum on the basis of FGM and domestic abuse if it has been shown that authorities in their home country will not intervene. Individuals identifying as LGBT also fall under this category.

If the asylum seeker meets these terms, he or she must provide a valid case for his or her asylum or withholding of removal. He or she can include a spouse and children on the application for asylum. However, it is applicant's responsibility to provide the burden of proof. There are three particular factors that may impact the asylum seeker's case:

1. Fraud during the refugee procedure
2. Criminal activity – not a bar to asylum but can be a negative factor.
3. And other general humanitarian considerations (age, health, and severity of past persecution)

Finally, US law requires asylees to file for asylum within one year of arriving in the US. This is known as the one year bar.

## Asylum Evaluations and WCCHR

Forensic evaluations

Clinical evaluations of asylum seekers are performed to establish the facts surrounding an asylee's abuse and torture. Having a physician or a medical expert produce a written document or oral testimony provides a level of validity to an asylum seeker's case that often cannot be attained in other ways. The use of medical testimony can also be a way to educate society on the sequeale of torture.

Licensed clinicians provide the level of expertise needed for a valid evaluation. Physicians of any background, including psychiatrists, gynecologists, and primary care physicians, as well as other clinicians such as licensed psychologists and social workers, can conduct evaluations depending on the needs of the client. In some cases, asylum seekers may have multiple evaluations; a client may need a medical examination to document scars and a psychological examination to document PTSD and depression.

In an evaluation, the evaluator will ask a client for a thorough history of his or her torture and other traumatic events, will assess the client for possible abuse sequelae, will document the psychological and physical evidence of torture, and then will state the degree of consistency between the narrative that the client has given and the evidence of torture that is found.

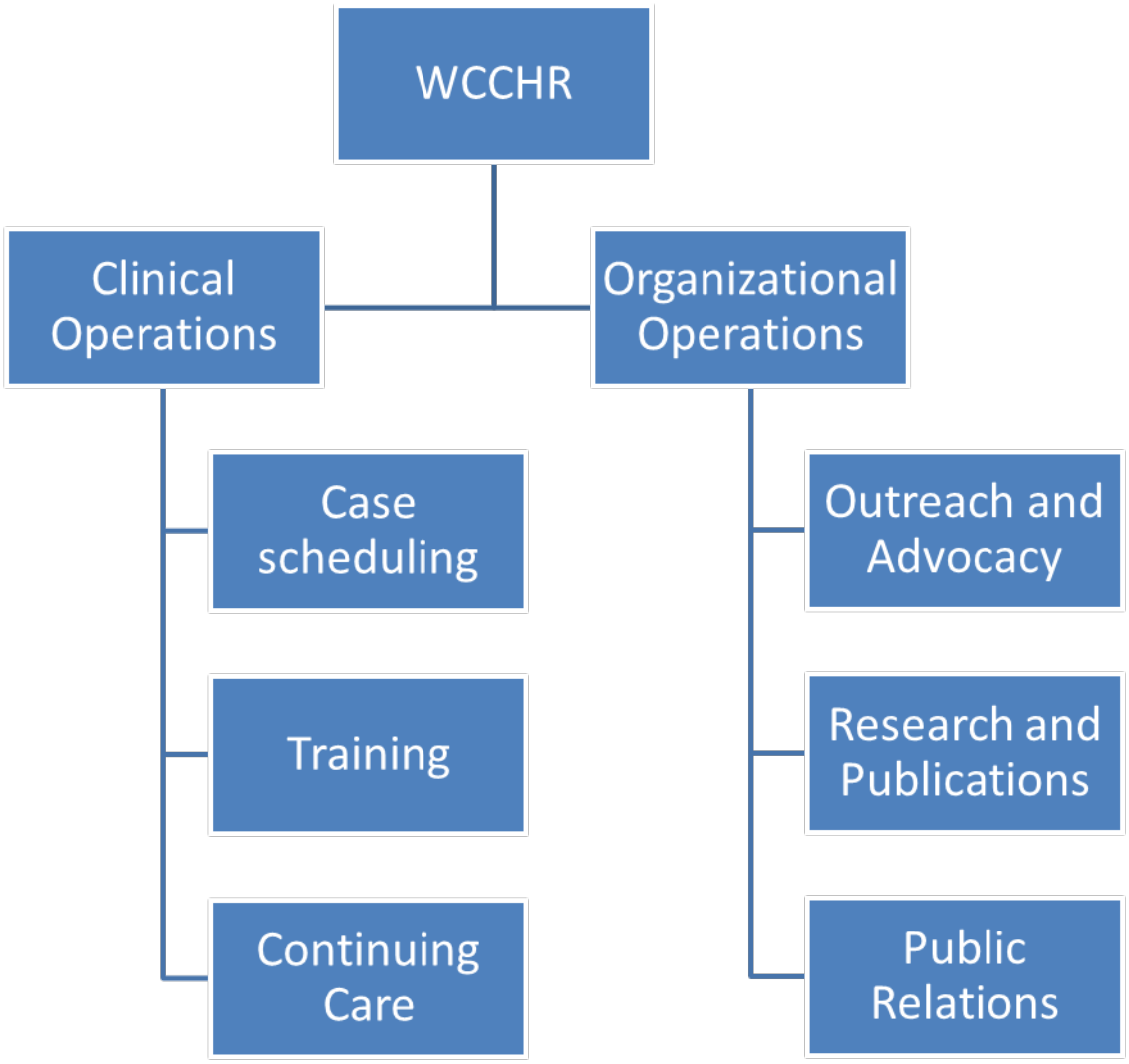
WCCHR

The Weill Cornell Center for Human Rights (WCCHR) is a medical student-run human rights clinic dedicated to providing forensic medical evaluations to survivors of persecution seeking asylum in the United States. Founded in 2010 through a partnership with Physicians for Human Rights, WCCHR is the first student-run asylum clinic at a U.S. medical school and has been heralded as a model for future asylum evaluation programs. The organization is comprised of a diverse and growing team of volunteer clinicians and medical students committed to serving asylum seekers and educating health professionals and the general public about the asylum process.

WCCHR was founded on the twin pillars of service and education. Service is provided to victims of torture from countries across the globe seeking asylum on multiple grounds, including persecution due to race, gender, religion, sexual orientation, and political affiliation. WCCHR is also committed to educating medical students, residents and practicing physicians about human rights violations and ways in which they can utilize the unique skills of their profession to defend victims of torture. The Center provides training sessions and educational seminars to teach physicians and students how to evaluate torture survivors, identify the physical and psychological sequelae of torture and abuse, and write medical affidavits documenting their findings.

## Clinic Structure

*For more information regarding the start-up, development, and operations of the clinic please contact us at wcchr@med.cornell.edu.*



## Practicalities of Evaluations for Students

Most evaluations will take place on the WCMC campus at the Margaret and Ian Smith Clinical Skills Center, but occasionally, evaluations take place at providers' offices or at detention centers. Regardless of location, it is important to prepare prior to the evaluation.

Before the Evaluation:

- Familiarize yourself with the client's statement but do not expect to get the exact same story during the evaluation.
- Review the training manual, including the sample affidavits, interview outlines, and appropriate additional readings or resources.
- Be on time. Cancel only when absolutely necessary and do it with enough time to find a replacement.
- Wear white coat attire but do not wear your white coat. It has been known to make clients uncomfortable.
- Bring the proper tools to take notes – it is best to take direct quotations when possible.

Prior to the client's arrival, the evaluator and the students will usually spend time discussing the client's previously provided narrative. The evaluator's role includes answering any general questions about asylum evaluations that students may have and ensuring the students are comfortable in their roles. The evaluator then invites the client into the room and conducts the evaluation in its entirety, inviting students to ask questions at the end of the evaluation.

Most evaluations begin with introductions and an explanation of the clinician's role: to evaluate the client, not to provide medical care to the client. Basic demographic data is then elicited. This is followed by a thorough history of torture or traumatic events. Interview time is spent focusing on medically relevant events in the client's history. Depending on the type of evaluation, the history may then be followed by a physical assessment and documentation of injuries or abuses. The evaluator looks to correlate the degree of consistency between examination findings and the narrative the applicant gave during the evaluation. Finally, the evaluator concludes the session, allowing for any questions, and the client is shown out. The students and the evaluator will then take a short period of time to debrief.

Students are asked to draft a complete affidavit within two weeks of the evaluation, or a shorter period of time if requested by the evaluating physician. If multiple students attend an evaluation, they can divide the workload.

The evaluator will utilize the draft affidavit as appropriate when completing the document that will ultimately be submitted to court. Evaluators are asked to provide students with feedback on the draft affidavit so students can improve.

## Medical Affidavit Writing - The Student's Role

The goal of a medical affidavit is to record evidence of physical and psychological trauma as an objective medical professional. Students drafting affidavits are not yet qualified to draw medical conclusions about clients- however, students can still make a significant contribution by preparing a draft of the narrative portion of the affidavit that can then be incorporated into the final document prepared by the evaluating physician.

Tips for student affidavit writing:

- Include only information that the client has told you.
    - Though a client affidavit will be provided to you before the evaluation, it should not be used as a source of information for the medical affidavit. Only information given by the client on the day of the evaluation should be included in your affidavit.
    - Any discrepancies should be discussed by the physician and lawyer, as there may be a medical explanation for inconsistencies.
- Students should read sample affidavits before preparing their own.
    - The client's account should include information about the client's life prior to abuse, episodes of traumatic events, and information about the client's present life.
    - Throughout the narrative portion of the affidavit, be careful not to report information as proven facts. Always state that the client "states" or "reports" events or incidents.
    - Direct quotes are very helpful; they can vividly illustrate the client's experiences and personality.
    - Do not include information that may hurt the client's case. This includes adding nonessential details such a colors, numbers, and dates - even small discrepancies can have serious consequences.
    - Avoid using legal terminology: for example, "persecution" is a more legally specific term than "torture" and therefore should not be used in a medical affidavit.
- Students should collaborate with physician evaluators to improve their affidavit writing skills
    - Seek feedback and tips for improvement from the physicians with whom you work; offer to make edits as a way to continue improving your skills.

Reference: Physicians for Human Rights, Spring 2012 Training

www.physiciansforhumanrights.com

# Medical Asylum Evaluations

## Medical Asylum Interview Outline

*The standard introduction paragraph of the affidavit should include the following:*

### Evaluation Information

1. Date of interview
2. Place of interview
3. Names of all present at the interview
4. Interpreter information (include country of origin, relationship to client, if applicable)
5. Length of interview

### Client Information

1. Full name of applicant
2. Place of birth
3. Current address
4. Roommates or housemates
5. Telephone
6. Email address
7. Other notable demographic data

*A transition paragraph of the affidavit, which follows the introduction, should include:*

> *A statement by the clinician that the following is his or her understanding of the client's account as reported during the evaluation. The clinician attests here that he or she did not see these events firsthand, but rather is reporting the information elicited from the client. Additionally, a statement that the evaluation was conducted in accordance with the Istanbul Protocol should be included:*
>
> "This evaluation was conducted in accordance with the standards described in the U.N. document known as the "Istanbul Protocol," *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations, New York and Geneva, 1999."

*The remainder of the affidavit should include the information outlined below:*

> *Note that clinicians and students should proceed gently throughout the interview, particularly when eliciting trauma history.*

### Social History

1. Family background
2. Early life circumstances
3. Ethnicity, race, religion, socioeconomic factors
4. Education and employment background
5. Marriage, relationships, children
6. Sexual orientation
7. How applicant spends his/her days

8. Where and with whom applicant lives
9. If applicant is employed
10. Hobbies, activities, likes and dislikes

## Torture-related History

1. Events that lead the client to seek asylum in US (in chronological order)
2. Prior injury/trauma
3. Relevant events that require elaboration:
    a. Death threats/accusations/slurs/claims:
        - What words were used?
        - By phone, in person, email?
        - Direct (to applicant) or indirect (to family or friends)?
    b. Beatings/hitting/attacks:
        - The type of object used to injury the client?
        - What position was he/she in? Was he/she held?
        - What parts of the body were injured in the attack?
        - How many times?
        - How many people?
        - What was said at the same time?
        - What were the immediate and long-term sequelae of the abuse
        - Did he/she receive any medical treatment (i.e. medication, sutures)?

## Additional Medical History

1. Current medications (include medicines used from home country)

## Physical Examination

*<u>Physical exam findings</u> should be explained in laymen's terms, as the report will be submitted to a non-medical audience:*

1. Scars
   Describe the scar:
        - Size (to the closest 0.5cm or 0.25 in).
        - Color (light, dark)
        - Texture (flat vs. raised, textured)
        - Borders
        - Location of the scar in relation to other body parts/landmarks
        - Single or multiple

   If taking pictures, a ruler should be visible in each photo
   Ask the client how it happened. Make sure that with each scar description, the history of injury is noted.
2. Dentition
3. Skeletal and soft tissue deformations

## Psychiatric Sequelae (when applicable)

1. Depression
    a. Change in mood, weight, sleep, anhedonia, agitation, fatigue, feelings of worthlessness or guilt, diminished concentration, suicidal ideation
    b. When did these feelings begin?

2. PTSD
    a. Recurrent recollections or nightmares, traumatic triggers, flashbacks, distress at re-exposure, physiological reactivity
    b. Avoidance of distressing thoughts, feelings or reminders
    c. Inability to recall
    d. Persistent negative emotion state (i.e. fear, anger, guilt)
    e. Irritability, sleep disturbance, difficulty concentrating, hypervigilance, hyperactive startle

3. Other symptoms
    a. Anxiety, panic attacks, prolonged grief, alcohol/substance use
    b. Cognitive difficulties, dissociative symptoms, obsessions, compulsions

4. Mental status exam

## General considerations

1. Client's attire
2. Describe interview behavior

## Sample Medical Affidavit

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
IMMIGRATION COURT
NEW YORK, NEW YORK

| | | |
|---|---|---|
| In the matter of | : | |
| | : | client application number |
| (Name of client) | : | |
| | : | |
| RESPONDENT | : | |

STATE OF NEW YORK

COUNTY OF NEW YORK

## AFFIDAVIT OF NICOLE SIROTIN, M.D.

I, Dr. Nicole Sirotin, pursuant to 28 U.S.C. 1746, declare:

### Introduction

1. I am a physician in the state of New York. I am currently working as an Assistant Professor and Attending Physician at Weill Cornell School of Medicine and New York Presbyterian Hospital in New York, NY. I have American Board Certification in Internal Medicine. My attached curriculum vitae details my education and professional experience.

2. I am a volunteer for Physicians for Human Rights and HealthRight International (formerly Doctors of the World-USA) and have served as a voluntary provider since January 2008. I have received specialized training at seminars sponsored by HealthRight International, Physicians for Human Rights and Survivors of Torture International in the use of medical skills for the documentation and treatment of survivors of torture. I serve as medical director of the Weill Cornell Center for Human Rights, and I teach and train medical students and physicians in providing medical evaluation of asylum applicants.

3. On (date), I conducted a detailed clinical interview and physical examination of Ms. A at the Clinical Skills Center at the Weill Cornell Medical College. The interview and exam lasted approximately 1 hour and 30 minutes. Medical students, Ms. X and Ms. Z, were present for training purposes, and Ms. A consented to their presence. I communicated with

Ms. A during my evaluation through a Spanish interpreter, Ms. G, a professional interpreter who is fluent in both Spanish and English. Prior to the interview, I had read Ms. A's intake form. The following delineates my understanding of the events that led to Ms. A's arrival in the United States and my observations and clinical and diagnostic impressions. I have limited the narrative to those aspects of her history that are pertinent to the medical and psychological evaluation that I am providing.

4. This evaluation was conducted in accordance with the standards described in the U.N. document known as the "Istanbul Protocol," *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations, New York and Geneva, 1999.

## Ms. A's Account

5. Ms. A is a male to female transgender and will thus be referred to in the female gender in this declaration.

6. Ms. A grew up in a family that did not accept her because from a very young age, she appeared effeminate. When she was young, an uncle of hers took her and her cousins to a river to swim, which was a regular event for the family. Her cousins had always mistreated her and made fun of her. On this occasion, while her uncle was away from the children, Ms. A's cousins started pushing her into the river. The current was very strong, and they pushed her in so far that she could not stand. As the river current began to take her downstream, she was trapped underwater and felt as if she were drowning. Ms. A's right leg became caught in barbed wire that was tangled in the river and prevented her from going further downstream. Her cousins saw that she was not coming up to the surface and ran to her uncle. He pulled her out of the water and off of the barbed wire.

7. Ms. A had multiple cuts on her right leg from this incident. These took many months to heal. Her family did not take her to the doctor. Ms. A was tearful when recalling this event and said, "Every time I see it, it takes a lot from me."

8. Throughout her childhood, Ms. A was beaten by her cousins and uncles. Her uncles would tell her cousins to "make her a man." Ms. A's family was angered by her and often called her a "maricon," or faggot. Her uncle would say that in their family they did not accept "maricones". They told her she did not belong. They repeatedly pushed, pulled, pinched and insulted her. Ms. A wanted to die at many times and thought about suicide often. She wondered when the abuse was going to end.

9. Ms. A's cousins would play a game in which they would surround her, trapping her in the middle of a circle, and hit her with their fists. They told her she would become a man this way.

10. When they were working on the farm, her uncles would hit her with tree branches and say things such as, "Do it with balls. Where is your man strength?" One uncle once hit her many times with a tree branch, leaving a small scar on her hand.

11. One of Ms. A's uncles would force her to fight physically with her cousin, at one point until her cousin hit her so hard that her nose bled. Similar incidents occurred multiple times.

12. Ms. A's uncles tried to hide their abuse from Ms. A's mother, but even when she learned what was happening, she would not say anything against the men in the family.

13. Ms. A's family was very religious and forced her to attend religious ceremonies. If Ms. A made an effeminate gesture during the ceremony, her parents would yell at her and hit her when they returned home.

14. In (date), Ms. A was selling fireworks for her uncle in an arcade hall. She was wearing pants with deep pockets and kept the fireworks in her left pants pocket while holding a display in her hands of the fireworks she was selling. Her pocket was so full of fireworks that it was open at the top. Ms. A's cousin approached her, and she heard the light of a match. Her cousin threw the lit match into her left pants pocket, and the fireworks exploded, severely wounding her leg. Other persons picked her up off the ground and took her to her parents' house. When Ms. A arrived at home, her parents were very angry with her and told her that she was not obedient and that she had the devil over her. She was punished for this event.

15. The wound on the left leg took almost a year to heal. It was extremely painful, but Ms. A did not receive any pain medication during that time. Ms. A's parents told her that they were going to cut off her leg because it is what happens to those who do not listen. At one point after the wound had begun healing, her older brother took her to the doctor because the skin had started to turn green. A nurse at the clinic poured some type of liquid on it to clean the wound.

16. Ms. A felt that this was the most horrible experience of her life because it was so painful both physically and emotionally. She wanted to die at that time. She does not understand why she did not attempt to kill herself because the desire was present.

17. In (date), Ms. A decided to start a new life and went to (city X in home country) with a cousin and her cousin's husband. Her cousin's husband

kicked her out soon after they arrived. He called her a faggot, told her that faggots could not live in his house and slapped her. Ms. A lived on the street for some time.

18. Ms. A decided that her only choice was to go to (country B). She moved back to live with her parents and started working to save money.

19. Ms. A had one older cousin who had always been nice to her. She spoke to him about going to (country B), as he had a family member in (city B in country B). Ms. A felt she would have died if she had stayed in (city X in home country). Either someone would have killed her, or she would have taken her own life.

20. The trip to (country B) was "a torment." On (date), Ms. A traveled to (city Y in home country) and then to (city Z in home country). During the first three days of walking, the men in the group insulted Ms. A by calling her a faggot, pushing her, and telling each other not to get close to the "maricon". They told her she was going to die. One man pushed her over the edge of the road into a ditch.

21. Ms. A first stayed in (city W in home country) for one month while waiting for her family to pay the coyote who helped her get to (country B). During that time, the men in the house verbally harassed her. Finally, the money was paid, and she was free.

22. Ms. A came to (city B in country B) to be with her cousin's family. After a short time, her cousin's family started insulting her and harassing her, just as her own family did back in (home country). As a result, Ms. A tried to hide gestures that were not "manly". She started working in a salon, where she met her first transgender woman named Ms. K. This was the first time Ms. A felt completely comfortable with someone.

23. Because of the harassment she was experiencing at her cousin's house, Ms. A moved in with Ms. K. This arrangement, however, turned out to be an abusive situation as well. Ms. K began treating Ms. A like a servant. She took Ms. A's money and controlled what she did when she was not working at the salon. Ms. A finally moved in with another woman who worked at the salon in order to get away from Ms. K's abuse.

24. Ms. A then met a man, Mr. N, and began a relationship with him. He, too, quickly became abusive. Around this time, Ms. A went home one day to the apartment where she was staying and discovered that the woman with whom she had been living had sold all of her belongings. This forced her to move in with the man she was seeing because she had nowhere else to go.

25. Mr. N was very manipulative. He hit her many times and threatened her. He put a knife to her neck and forced her into prostitution. He would repeatedly hit her with a cable cord and drag her across the floor by her hair. This abuse continued for approximately 3 years. Although Ms. A was scared to call the police, she finally did so. They told her they needed 3 reports before she could get to a shelter.

26. One night when Mr. N forced her to prostitute herself, in (date), Ms. A was in a car accident with a man who she did not realize was driving drunk. She was putting on her seatbelt when she looked up just in time to see that the car was about to crash. The airbag did not inflate on her side of the car. She remembers feeling the seatbelt hold her down very tightly. Ms. A was taken to hospital, X. She had pain at the left side of her head, middle of her chest and left arm. She received an MRI as part of her management for the head injury. She was also sent to physical therapy to treat the pain. She took medications, such as Tylenol, and applied creams to help ease the pain. She was unable to work because of her arm injuries. During this time, Ms. A became very depressed. She felt her life was a failure.

27. A lawyer contacted her soon after the accident and told her he and his colleagues were going to take on her case. They gathered a lot of information on the case and told her everything was in order. Ms. A signed papers in English that she could not read because the lawyers instructed her to do so. One day the lawyers moved offices, and when Ms. A went to find them, they told her that the case was closed.

28. Ms. A was very upset by this incident. She had persistent pain in her left arm that made work difficult because her salon job required her to blow dry hair.

29. After the accident, Ms. A left Mr. N and stayed with some friends. She started going to a clinic, X, in (city B in country B). There, she began but could not sustain courses of hormone therapy, due to financial difficulty. There was a support group, but it was conducted in English.

30. Ms. A had also sporadically taken female hormones that were bought on the street.

31. Around (date), she was staying with friends because she was unable to work with her arm injury from the accident. She saw a friend of hers who told her about a support group of Latina transgender individuals run by a woman named Ms. H. Ms. A finally found a group that really helped her.

32. Ms. A started receiving supervised hormonal therapy at clinic X in order to transition into becoming a woman. She has not had any surgeries at this time to change her sex. Ms. A feels very positive about her life now, after

meeting Ms. H and the Latina transgender support group. She wants to help others in similar situations.

33. During my evaluation, Ms. A was tearful and emotional. Ms. A fears returning to (home country) for multiple reasons. She fears being psychologically and physically harmed by her family or others if she were forced to return. She said of returning to (home country), "it would collapse my life." Ms. A mentioned a recent incident in (home country) where a female transgender was killed for being transgender because she wanted her college diploma to display her chosen female name. Ms. A feels that (home country) is still very homophobic and fears that she would be killed if she returned.

## Clinical Examination of Ms. A

34. Physical examination of Ms. A demonstrates the following scars and injuries (measurement of scars has been rounded to the nearest 1/4 inch):
    a. Left thigh: 6 inch long x 2 inch thick, textured, raised, light and dark in color, with one are of star like shape that was white in the middle of the scar. Devoid of hair, shaped in a rectangle with rough borders
    b. Right thigh: 6 ¼ inch long, ½ inch wide, white, textured, linear scar stretching from the middle of the thigh to the outer thigh horizontally. This scar is thicker in the middle of the scar and tapers off to a thin line on the outer edge
    c. Right thigh: 2 ¼ inch long, ¼ inch thick irregularly shaped linear scar. Immediately above the kneecap, the scar is thin and as it moves to the outside of the right kneecap, it thickens into a teardrop shape. Laterally from the teardrop shape is a very thin, white line (approximately ½ inch) that ends with a faint, irregularly shaped round white scar
    d. Right thigh: 3 ½ inch long, <1/4 inch wide, white, linear scar that is positioned diagonally starting above the thickest part of the scar in (c) and stretching 3 ½ inches laterally to the outside of the knee
    e. Right lower leg: 6 ¼ inches long, < ¼ inch thick curvilinear, white scar stretching from approximately 5 inches from the bottom of the knee cap to the top of the ankle
    f. Right lower leg: 4 ¼ inches long, with varying thickness, starting midway down the front of the R shin, white curvilinear scar that thickens to ~ ¼ inch midway down the scar
    g. Chest wall: tenderness to palpation along the midline of the chest at the bottom of the breast bone
    h. Right arm: ½ inch rounded area of pale scar without discrete borders on the right outer arm below the elbow joint
    i. Left index finger: ¼ inch thin, linear white scar over the knuckle closest to the finger tip
    j. Neck: ~1/2 inch circular, textured, indented scar on the front of the neck, to the left of the midline.

k. Right index finger tip: index finger tip shortened compared to other fingers, thickened, short white nail growing under a nail prosthesis.
l. Right shoulder: ½ inch round, light, textured with a raised center

35. The physical exam revealed numerous findings:
    a. The large, textured scar with areas of light and dark on the left thigh are highly consistent with a scar from a burn. The position and shape of the scar are consistent with an injury from a burn that was started inside a rectangular pants pocket, consistent with Ms. A's account. The textured nature of the scar is highly consistent with a scar that became infected, also consistent with Ms. A's account.
    b-f. These scars are highly consistent with injury from cuts from a cluster of sharp, thin metal objects, such as barbed wire. The change in the shape of the scars from linear on one end to thicker on the other is consistent with an injury that involved the sharp object impaling the limb and then moving with force across the leg with different pressure. This is highly consistent with Ms. A's account of being trapped in a cluster of barbed wire while in the strong current of a river.
    g. The tenderness over the sternum is consistent with a forceful impact while wearing a seatbelt. This tenderness commonly persists many months after this type of injury and usually does not leave any external changes in the skin. This is consistent with Ms. A's account of being in a motor vehicle accident with frontal impact while she was wearing her seatbelt.
    h. This scar is consistent with a scrape of the skin on a rough surface. Ms. A attributes this scar to an injury she sustained in school where kids were pushing her and closed a door quickly on her arm. This scar is consistent with this account.
    i. This scar is consistent with an injury caused by a thin, sharp object, such as a tree branch, consistent with Ms. A's account.
    j. This circular, depressed, round scar is highly consistent with a scar left from chicken pox as a child, consistent with Ms. A's description when asked.
    k. The shortened finger with grossly abnormal underlying nail is a typical appearance when the tip of the finger is traumatically removed. Ms. A attributes this scar to a childhood accident unrelated to her abuse and it is consistent with that account.
    l. This scar is highly consistent with a childhood vaccination scar, consistent with Ms. A's account.

## Summary

36. In closing, it is my assessment that Ms. A demonstrates the physical and emotional sequelae of severe trauma. The scars on her body are highly consistent with the manner in which she describes being abused. Her descriptions of her abuse and the maltreatment she sustained are

anatomically and medically consistent. Ms. A offers the type of details about her experiences (mechanism of injury, treatments, hospitalization, and time to heal) that would not be likely for one who had not experienced them. I am positively impressed that she readily attributed several significant scars to childhood injuries and medical treatments not related to her maltreatment, namely her shortened right fingertip. Her emotional reactions and demeanor while retelling her story are consistent with someone who has survived significant traumatic experiences. Furthermore, it is my assessment that forcing Ms. A to return to (home country) could severely impact her emotional health. I would be willing to answer any questions or further explain my findings.

I, Nicole Sirotin, M.D., declare under penalty of perjury, that the foregoing is true and correct.

Nicole Sirotin, M.D._____

Dated:_____

## Examples of Objects Used to Inflict Trauma and Types of Injury that Might Result

*A great reference for additional examples of scars is "Atlas of Torture: Use of Medical and Diagnostic Examination Results in Medical Assessment of Torture," available at the WCMC library*

Cigarettes

- Hypopigmented, textured scars
- May have different shapes depending upon the angle at which the cigarette touched the skin (i.e. circular for a direct burn, oblong if burned at a slant)

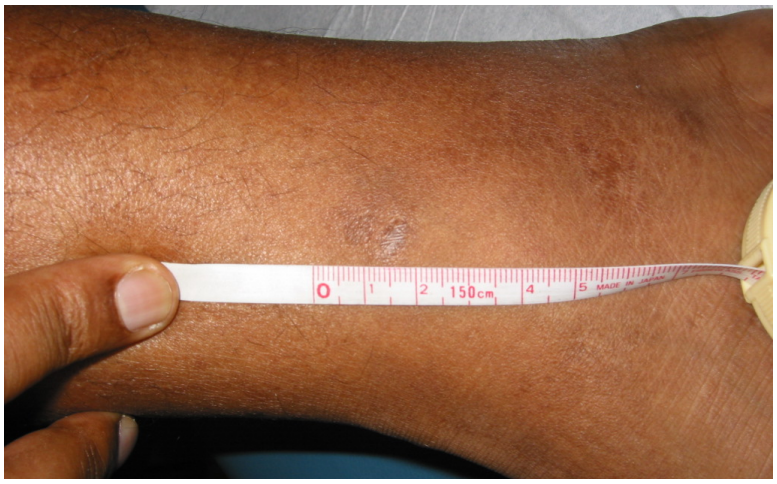


Fig. 1: Cigarette burns

Rope

- Repeating pattern of impressions left on the body parts that were touched by the rope

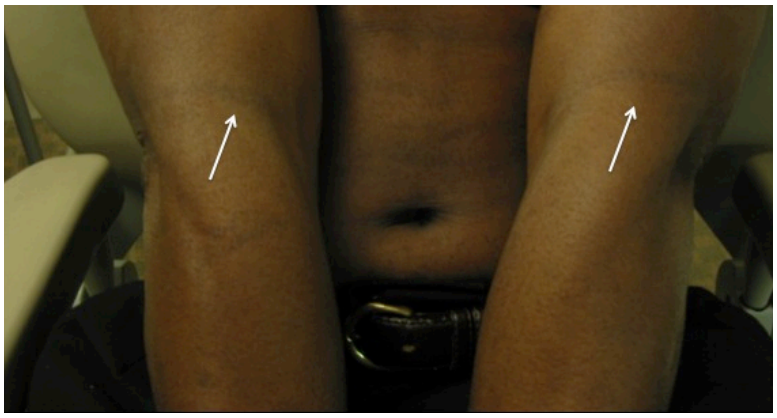


Fig. 2: Rope burns

Acid

- Irregular pigment and texture to the skin
- Thickening of skin is usually observed

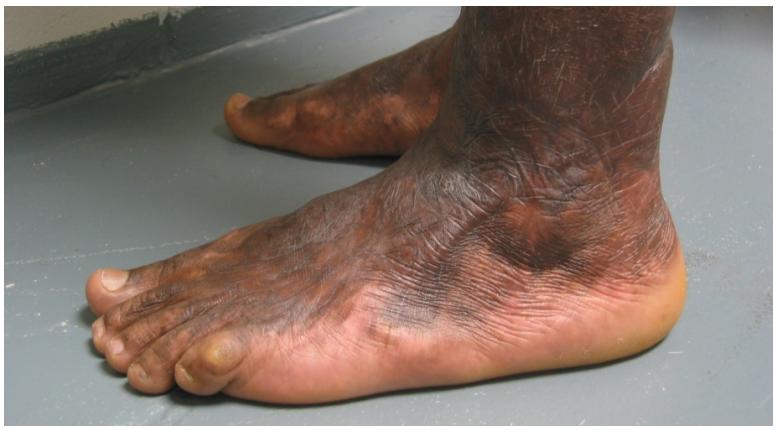


Fig. 3: Acid burns

Knives

- Slashing can produce long linear lacerations, while the tip of a knife may produce a small, deep impression
- Multiple scars are usually found to be asymmetrical on the body
- Border may be irregular or jagged jagged or very clean, depending on the knife used

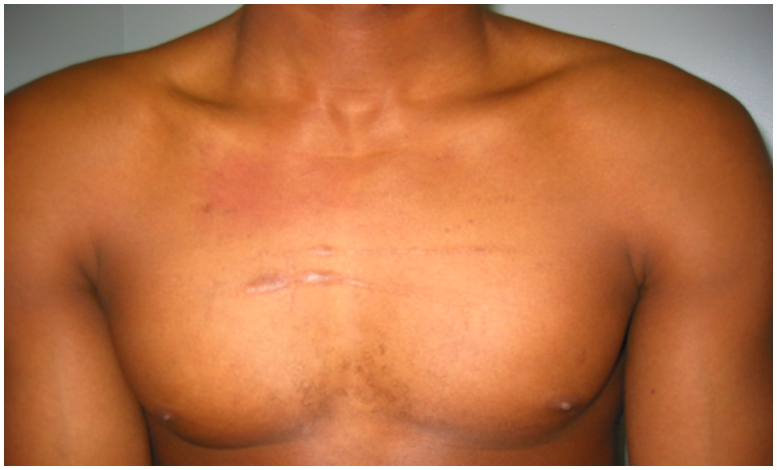


Fig. 4: Knife wounds

Whips

- May produce a long scar with a very thin end and a hypertrophic end that is thickest at the point of impact

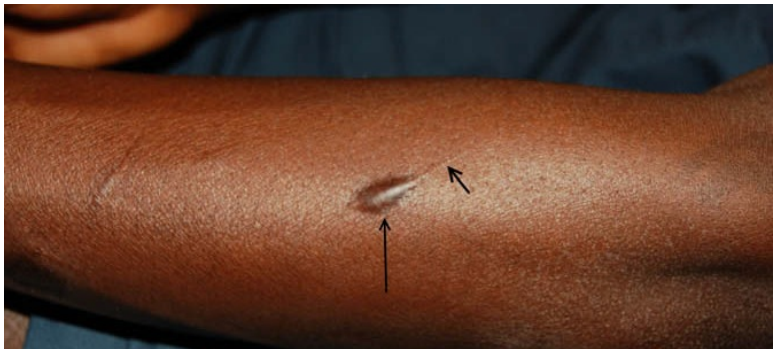


Fig. 5: Whipping injury

Heated metal objects (used for branding)

- Produce scars with shapes that reflect the angle of contact (i.e. linear if applied lengthwise)

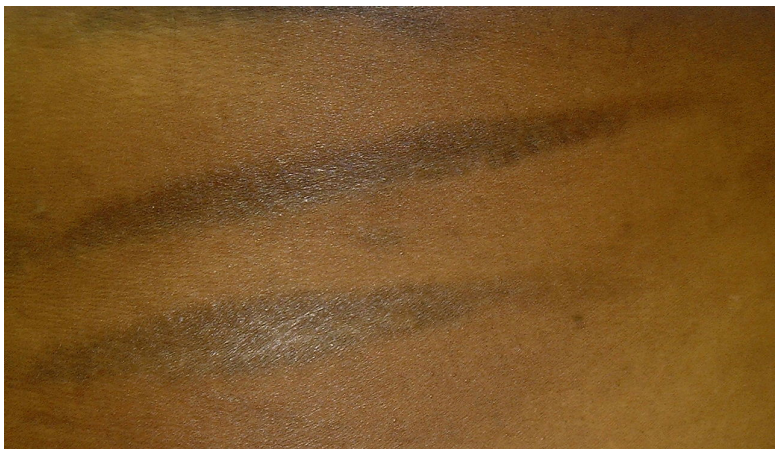
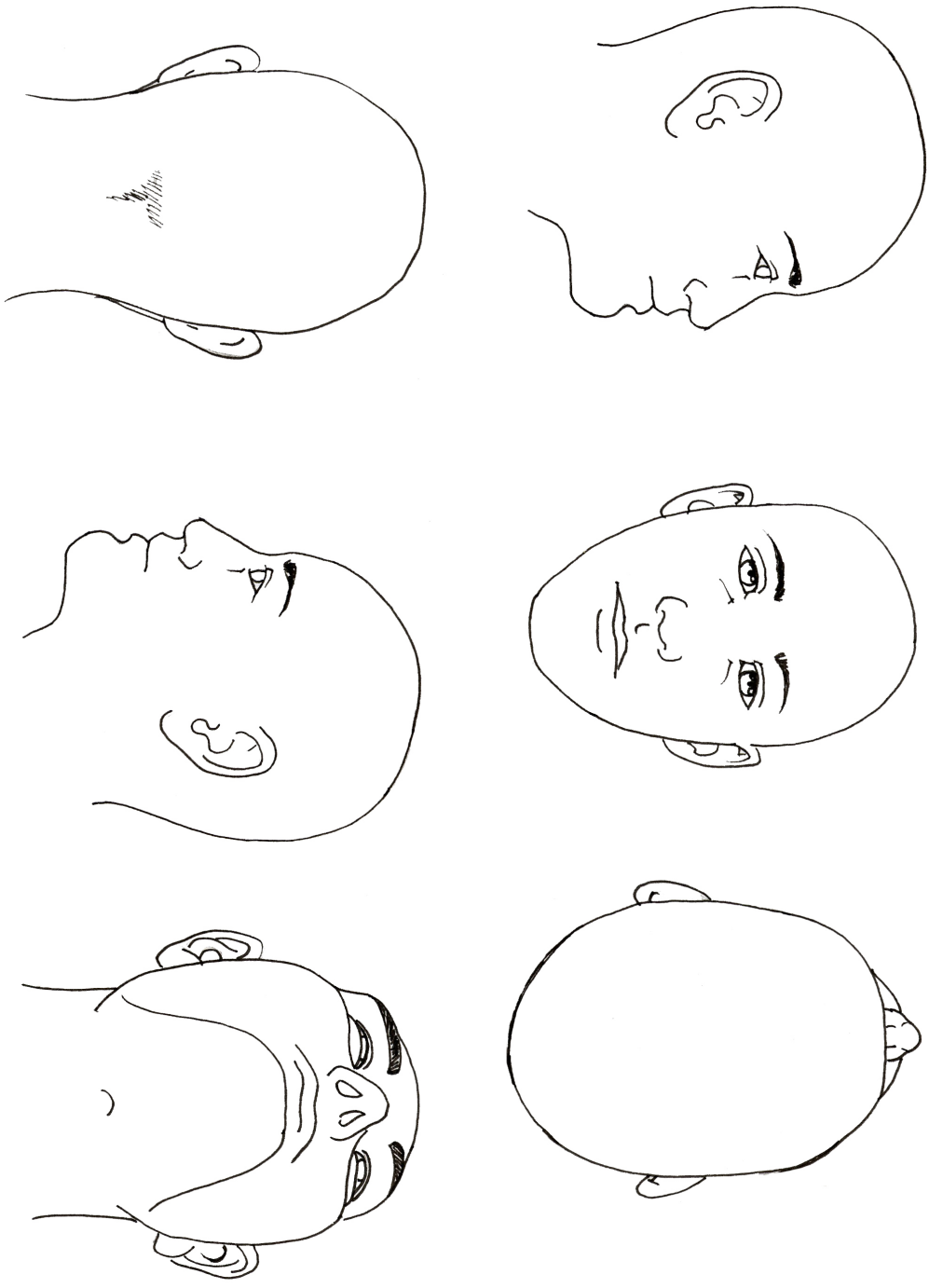
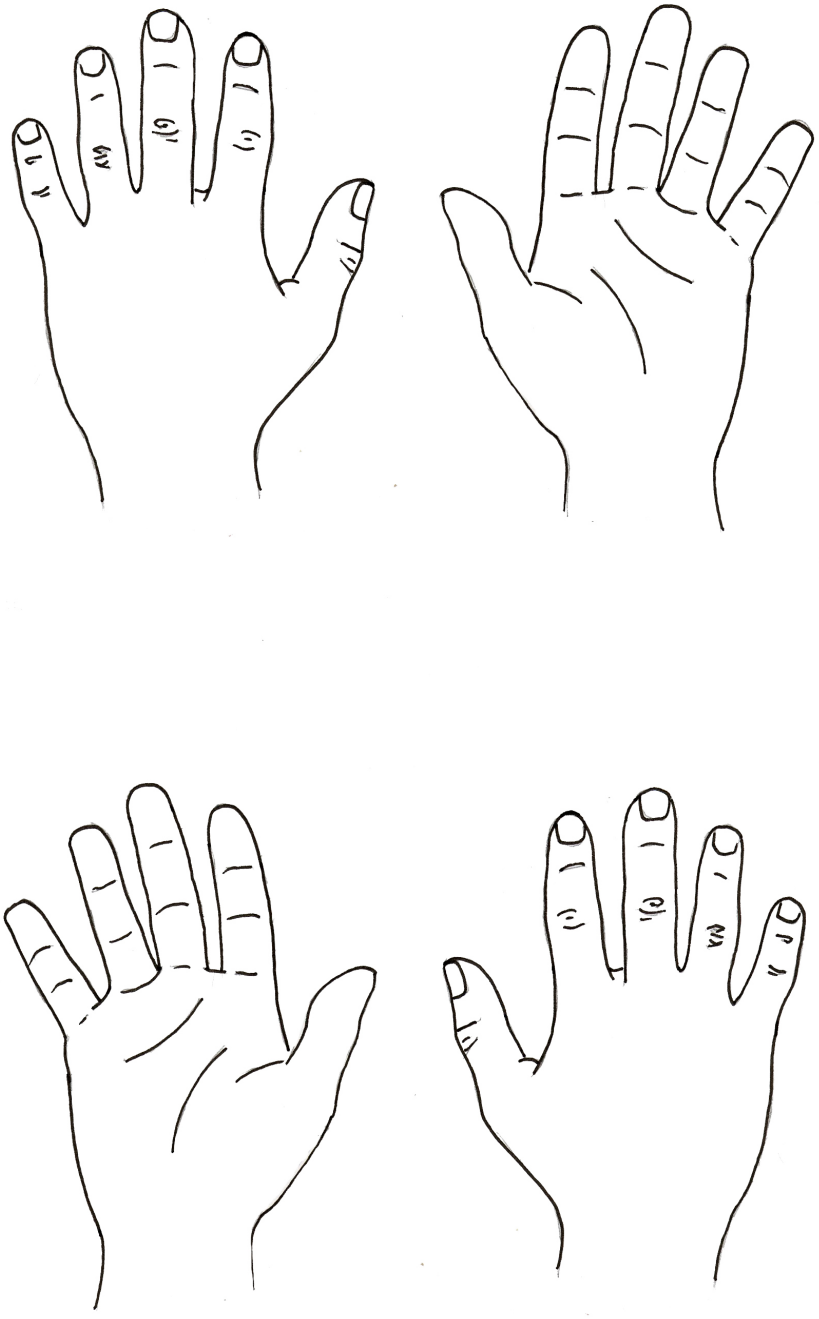
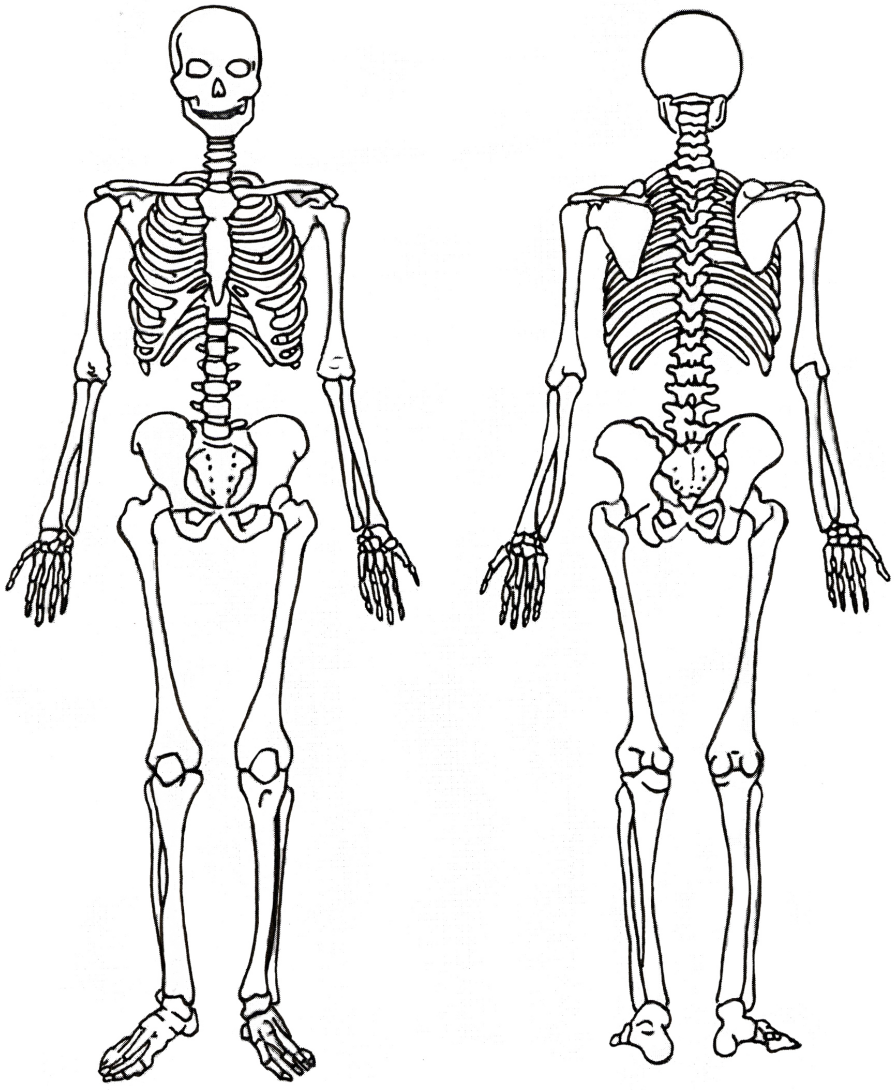


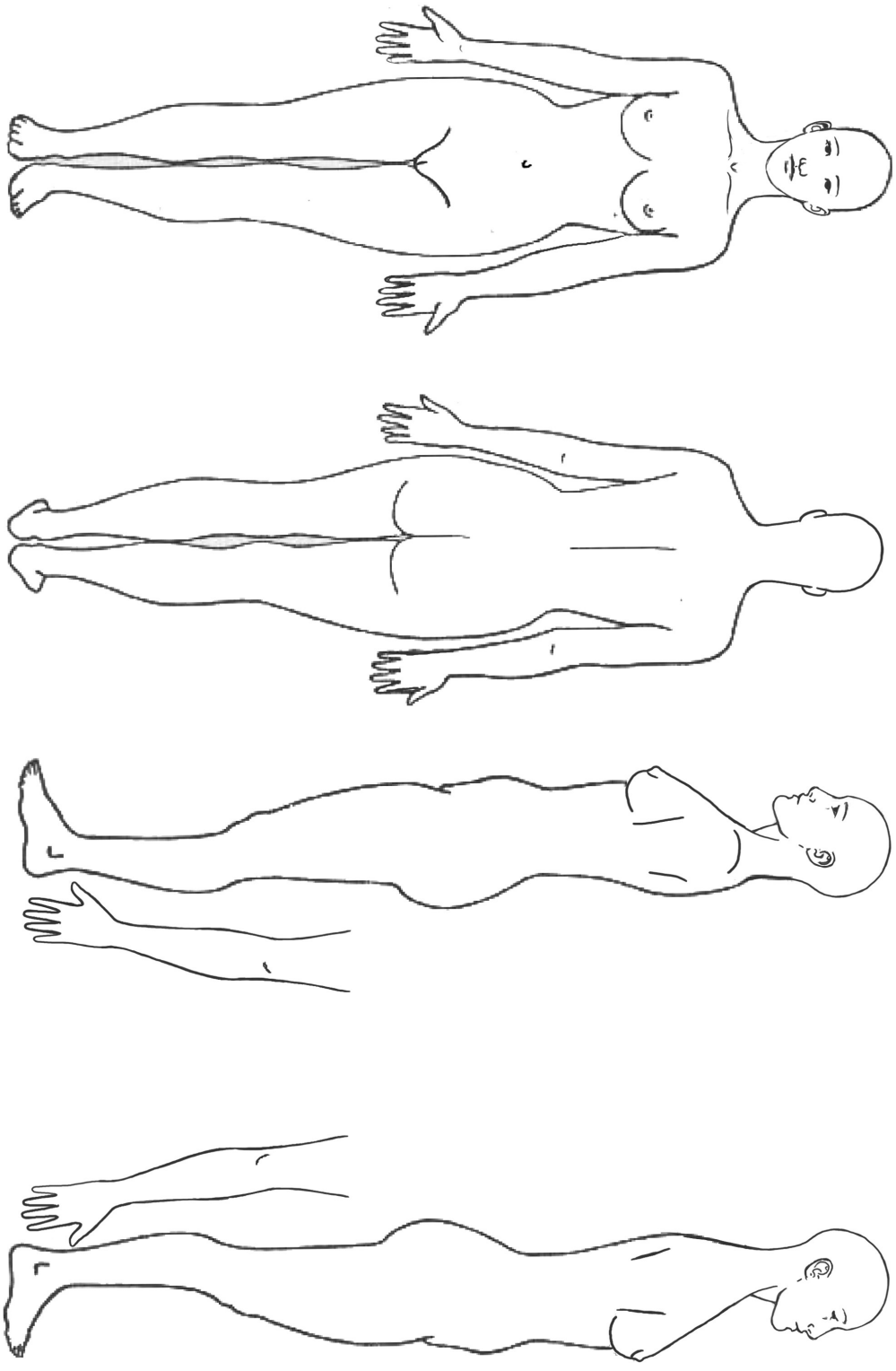
Fig. 6: Branding

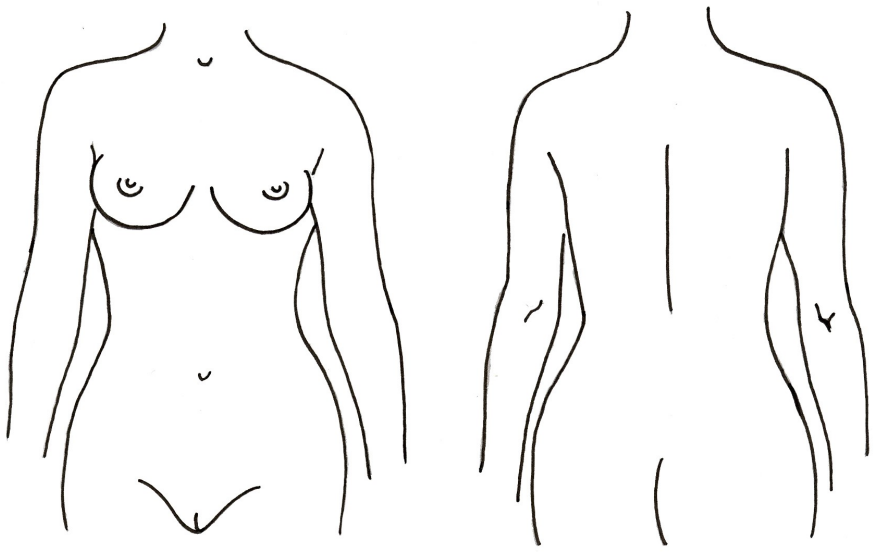
## Representative Scales and Diagrams

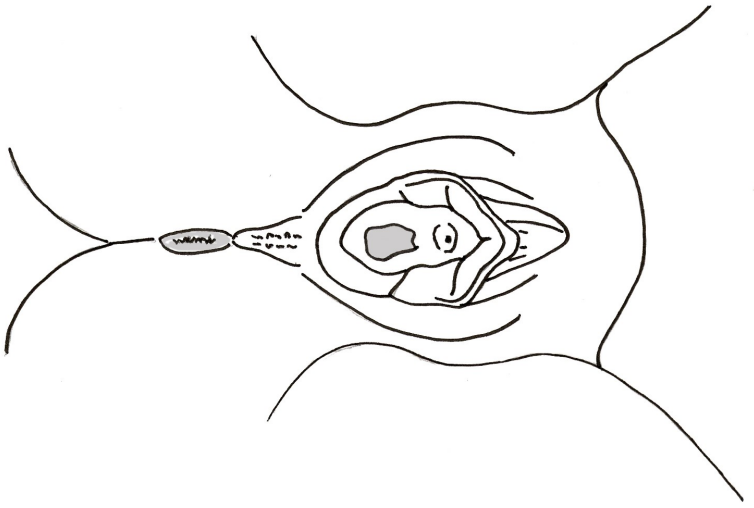


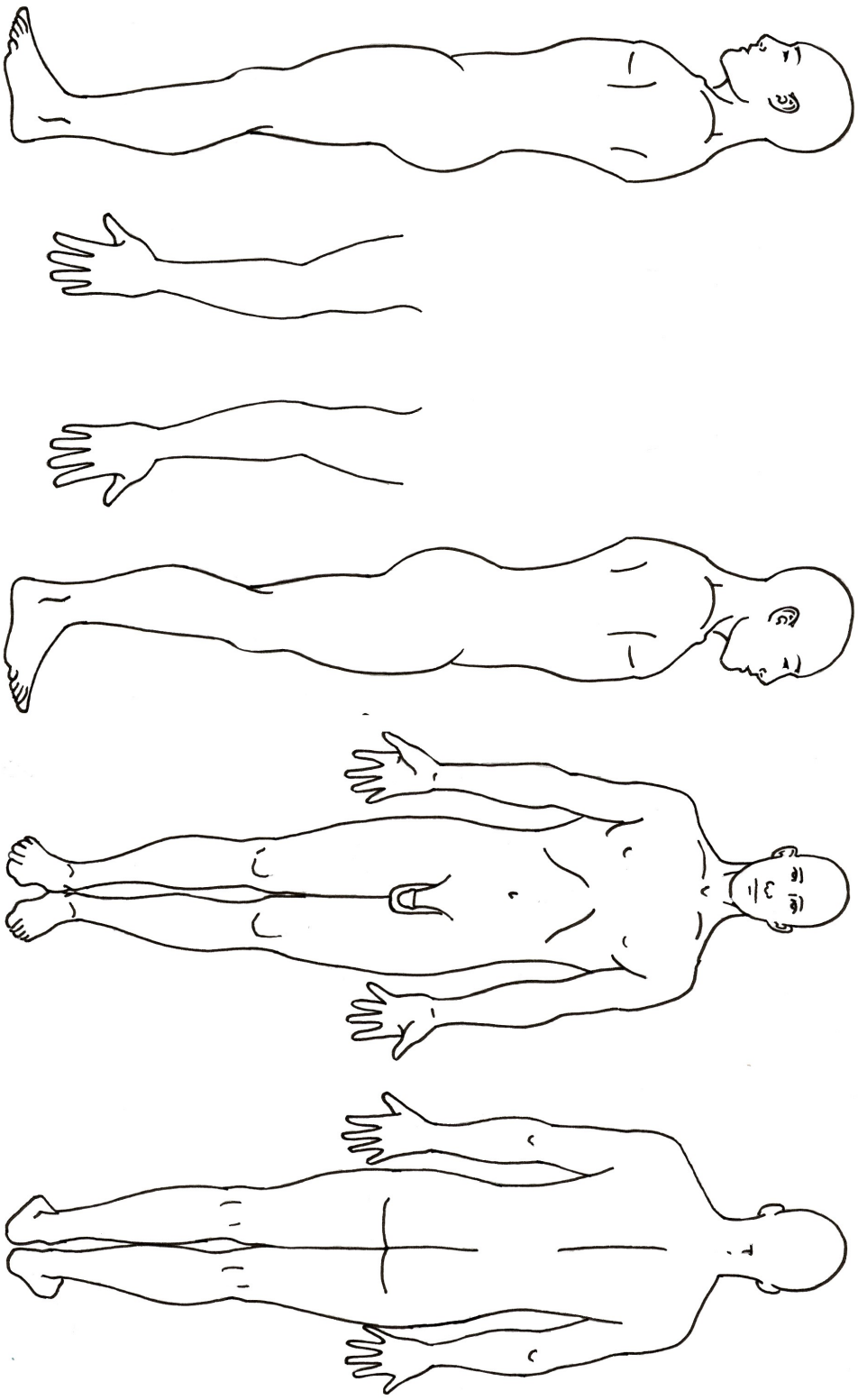


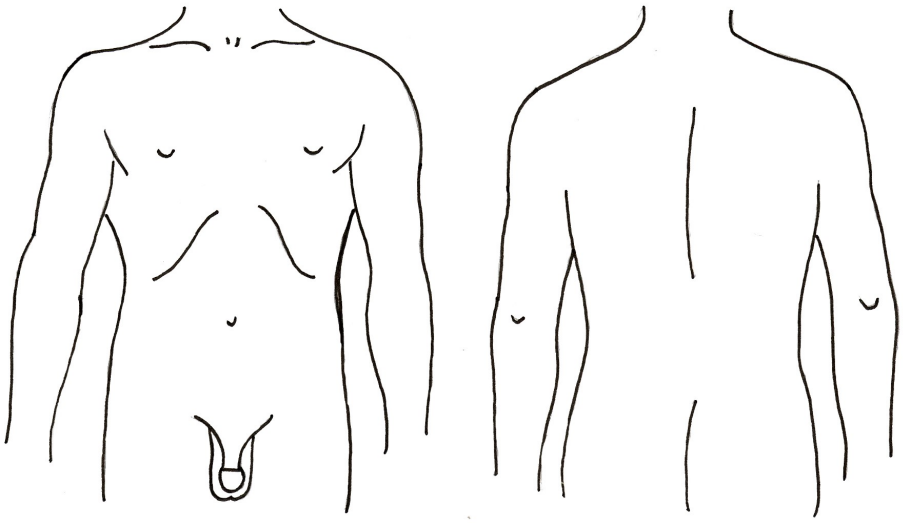


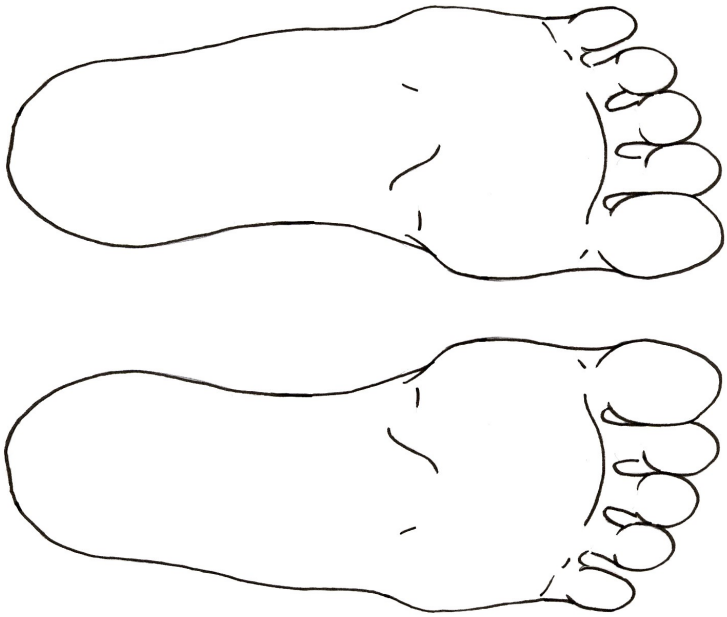












# Gynecological Asylum Evaluations

## Gynecologic Asylum Interview Outline

*The standard introduction paragraph of the affidavit should include the following:*

### Evaluation Information

1. Date of interview
2. Place of interview
3. Names of all present at the interview
4. Interpreter information (include country of origin, relationship to client, if applicable)
5. Length of interview

### Client Information

1. Full name of applicant
2. Place of birth
3. Current address
4. Roommates or housemates
5. Telephone
6. Email address
7. Other notable demographic data

*A transition paragraph of the affidavit, which follows the introduction, should include:*

> *A statement by the clinician that the following is his or her understanding of the client's account as reported during the evaluation. The clinician attests here that he or she did not see these events firsthand, but rather is reporting the information elicited from the client. Additionally, a statement that the evaluation was conducted in accordance with the Istanbul Protocol should be included:*
>
> "This evaluation was conducted in accordance with the standards described in the U.N. document known as the "Istanbul Protocol," *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations, New York and Geneva, 1999."

*The remainder of the affidavit should include the information outlined below:*

> *Note that clinicians and students should proceed gently throughout the interview, particularly when eliciting trauma history.*

### Social History

1. Family background
2. Early life circumstances
3. Ethnicity, race, religion, socioeconomic factors
4. Marriage, relationships, children
5. Sexual orientation
6. How applicant spends his/her days
7. Where and with whom applicant lives

8. If applicant is employed
9. Hobbies, activities, likes and dislikes

## Family Structure with Reference to Women

1. With whom did she live?
2. What was her normal daily life like?
3. Did she go outside alone?
4. Education? To what level?
5. Work outside the home?
6. Was her marriage arranged? By whom? Did she have any input?
7. Does she know of any family conflicts surrounding marriage choice?
8. Cultural norms for women in her society

## FGM(C)

1. Did the patient undergo female genital mutilation?
2. At what age did it occur?
3. Does she remember the circumstances?
4. Who brought her to the place to be cut?
5. How many other girls were there?
6. What did she see or hear?
7. What did she know in advance about what was going to happen?
8. What procedure or events followed the FGM and where did they occur?
9. How did FGM affect her functioning, urination, menstrual periods, intercourse, or childbirth?

## Sexual Experiences

1. Listen to the description of first intercourse carefully.
2. Has she experienced rape? What were the circumstances? (Keep in mind that rape can occur within a marriage)

## Childbirth

1. Gravity (number of pregnancies)
2. Parity (number of deliveries after 20 weeks)
3. Pregnancy losses
4. Number of living children

    Include place and date of birth, where they are, who cares for them, if they have undergone FGM(C)

    *Important*: Part of the evaluation of the client includes evaluating the genital status of any female child with her in the US. The court will want to know if the female child has or has not undergone FGM(C)

## Additional Medical History

1. Current medications (include medicines used that are from home country)

## Gynecological Examination

1. Scars
    a. Describe where each scar is on her body
    b. Indicate if it is hypopigmented or hyperpigmented
    c. Describe if the scar is single or multiple
    d. Measure its size (a ruler should be visible in each photograph)
    e. Discuss the client's account of how it happened
2. FGM(C)
    a. Use the diagrams that were published in the WHO 2008 report on FGM to illustrate findings. See Figure 1.

    Note: Do not take photos of the client's genitals.

## General Considerations

1. Client's attire
2. Describe interview behavior

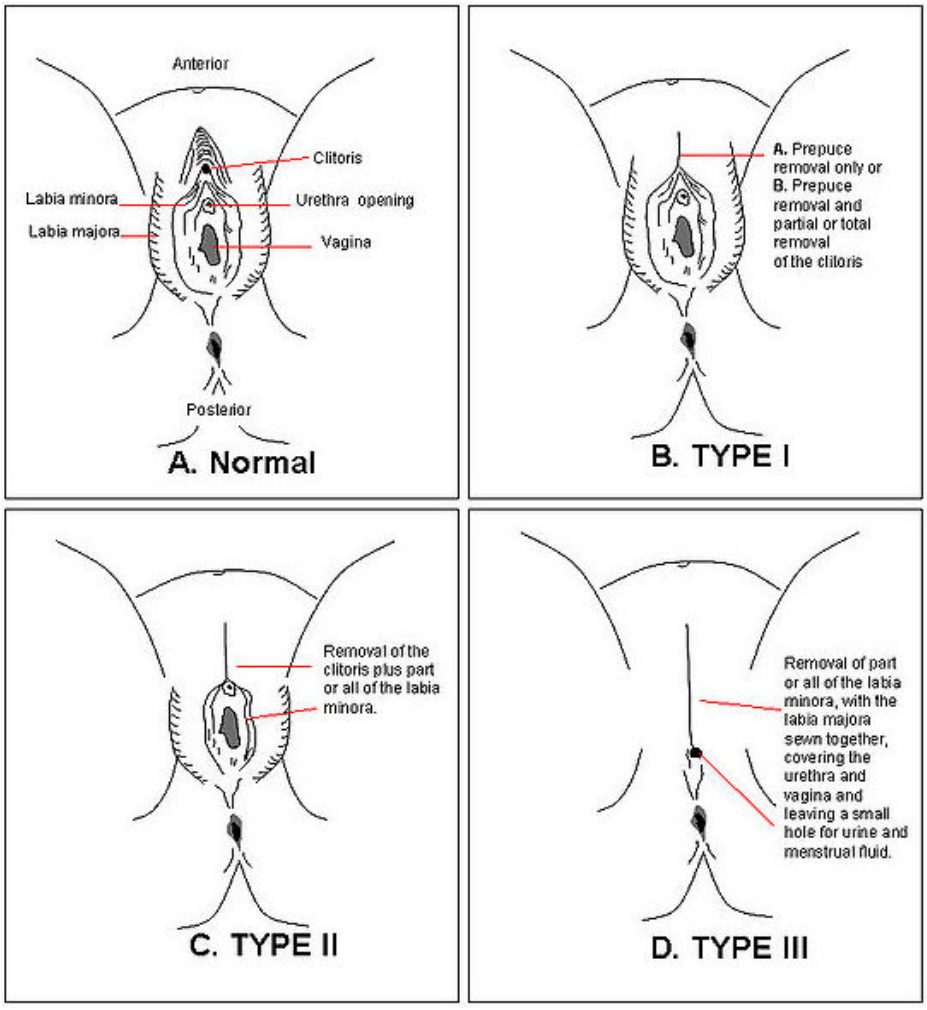



Figure 1. Image copyright World Health Organization, *Eliminating Female Genital Mutilation, An Interagency Statement* (2008), reproduced under the 'fair use' clause of section 107 of US Copyright Law.

## Guidelines and Formatting for Gynecologic Affidavits

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
IMMIGRATION COURT
NEW YORK, NEW YORK

| | | |
|---|---|---|
| ---------- | X | |
| In the matter of | : | |
| | : | client application number |
| (Name of client) | : | |
| | : | |
| RESPONDENT | : | |
| ---------- | X | |

STATE OF NEW YORK

COUNTY OF NEW YORK

AFFIDAVIT OF Your Name, M.D.

I_____, M.D., being duly sworn deposes and says,

### Introduction

Here, give a review of you and your credentials, how you got to see the client, when and where she was seen, who was there when you interviewed her, who was the translator and what documents you reviewed in advance in paragraph form.

### Ms. X's Account

Making it clear this is her report of what happened in a non-rambling historical format.

### Clinical Findings

This should be a numbered list of important findings and physical scars. In gyn affidavits, I usually start by describing genital status regarding female genital mutilation. For other scars, they should be described as length in centimeters or inches, color and texture.

## Summary of Clinical Findings and Conclusions

Here, address each point of the physical exam and whether they are or are not consistent, diagnostic of the facets of her history.

I close with a place for my signature to be notarized and the following statement: I am willing to answer any additional questions or explain my findings further.

_____
Your Name, credentials

## Special circumstances

Describing rape in the conclusion:

Since there are few chronically visible changes on physical examination, I use a statement such as the following:

*"Examination in this time course would not expect to reveal physical evidence of rape 3 years after the rape. Ms.X exhibits fear, shame and guilt about both rapes, hiding it even from her husband who knew how badly both of them had been beaten. Ms. X told me she is always afraid and in dread that somebody might find out what happened to her. She speaks of tremendous fear and guilt."*

When evaluating the genital status of children:

Sometimes the judge in a case will want proof that female children have not already had FGM if the mother's application is in part based on not going back to her country of origin to avoid GFM for those children. I do not write a separate evaluation for the children but rather make an addendum to the application of the mother, right after her clinical examination segment:

*Examination of Name of Child (age z)*
*Child's name appears her stated age. Upon inspection her genitalia appeared intact. There is no evidence of FGM.*

## Sample Gynecologic Affidavit

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
IMMIGRATION COURT
NEW YORK, NEW YORK

| | | |
|---|---|---|
| In the matter of | : | |
| | : | client application number |
| (Name of client) | : | |
| | : | |
| RESPONDENT | : | |

STATE OF NEW YORK
COUNTY OF NEW YORK

### AFFIDAVIT OF TERRI GALLEN EDERSHEIM, M.D.

I, Terri Gallen Edersheim, M.D., being duly sworn, depose and state,

### Introduction

1. I am a licensed physician in the State of New York. I am board certified in the specialty of Obstetrics and Gynecology and subspecialty certified in Maternal-Fetal Medicine. I am currently a physician at the New York Presbyterian Hospital, where I serve on the voluntary attending staff. Since 1984, I have also served as a Clinical Assistant Professor at the Weill Cornell University Medical College, where I am responsible for teaching medical students, interns and residents. I was on the full time faculty in Maternal-Fetal Medicine and Obstetrics and Gynecology from 1985 until 1990. In 1990, I joined the voluntary faculty where I had an active clinical practice in Obstetrics and Gynecology and Maternal-Fetal Medicine until 2008. In 2006, I served as a consulting Visiting Professor at the Bugando University College of Health Sciences in Mwanza, Tanzania. During my time there, I gained extensive experience with patients who had undergone female genital mutilation.

2. I received my medical degree from the Albert Einstein College of Medicine in 1980 and was named a member of the National Alpha Omega Alpha honors society. I received my clinical training as an intern and resident in Obstetrics and Gynecology at The New York Hospital-Cornell University Medical College from 1980 through 1983 and then in 1984 served as chief

resident. I became an attending there in Obstetrics and Gynecology and did subspecialty training in Maternal Fetal Medicine from June 1984 through June 1986. I practiced medicine at the Weill Cornell Medical College campus of New York Presbyterian Hospital on the full time faculty of Weill Cornell Medical College from 1985 through 1990 and then on the voluntary faculty from 1990 through 2008.

3. I serve as a member of the admissions committee of Weill Cornell Medical College, the voluntary physicians committee of the New York Presbyterian Hospital, and am a member of The Greater New York Pre-Eclampsia Study Group. From 2006 through 2009, I served as a member of the American College of Obstetrics and Gynecology's Clinical Practice Bulletin Committee, which was charged with providing recommendations for clinical care to U.S. obstetricians.

4. I work with Physicians for Human Rights through the Weill Cornell Center for Human Rights and with HealthRight International. I am an attending in the Weill Cornell Center for Human Rights, where I participate and supervise the medical evaluation of asylum seekers with Weill Cornell medical students. I have served as a voluntary provider at the HealthRights Human Rights Clinic since 2009. I have received specialized training sponsored by HealthRight in the use of medical evidence for the documentation of torture.

5. On (date), I conducted a detailed interview and examination of Ms. A (client's name) at the Obstetrics and Gynecology clinic at the New York Presbyterian Hospital. The interview and exam lasted approximately 2 hour and 30 minutes. Ms. Z, a medical student at the Weill Cornell Medical College, was present for the duration of the evaluation. Ms. A consented to Ms. Z's presence. Prior to her evaluation, I read Ms. A's intake application and her statement. The following is my understanding of the events surrounding Ms. A's female genital mutilation and circumstances entering the United States, which is based on the above documents, my own interview and the physical exam. I have limited the narrative to the aspects of her history that are pertinent to the medical report I am providing. Ms. A speaks French, Mandingo and some English. I conducted the interview in Mandingo through Pacific interpreters (interpreter phone number), and during the examination, we spoke French together.

## Ms. A's Account

6. Ms. A was born on May 25, 1991 in (city and country). Her parents (names) belong to the Y tribal affiliation. She has (number) siblings. She was brought up in (city X) with her parents, siblings and her extended family. She attended school through age 14.

7. Ms. A recalls some of the details of her female genital mutilation (FGM) as a young girl. She reported that her mother woke her early, and she left with her grandmother, who said they were going to visit a friend in (village Y), a small village in (home country). Ms. A said there were other young girls, and they were told to change into different garments. Ms. A waited with the other girls, and they were taken out one at a time by their families. She said she had no idea what was about to happen. Ms. A said that when it was her turn, her grandmother came to get her and brought her to a room where other older women were waiting. She became frightened; she saw the knife and blood on the ground. She asked her grandmother what was happening, and her grandmother told her she was going to be cut and that this was a responsibility of all young women in their ethnic group. Ms. A was grabbed, blindfolded, and held tightly on the ground by several women. She described a searing and burning pain followed by lots of what she thought was warm fluid running down her legs. When the blindfold was removed, she saw that the fluid was blood. The excisor put a traditional black salve on her genitals. She thinks the salve was used to stop the bleeding.

8. Ms. A was then expected to walk into the other room, but she was so dizzy that she could not. She was thus carried and dragged into the other room. She stayed with the other girls, all of whom had been through FGM that day, for a few weeks. The excisor would come around and check the wound and reapply a dressing. During the time they were together in the healing hut, the girls were all told what was expected of them as wives. After several weeks, she was returned home by her grandmother.

9. Ms. A told me that because of the FGM, she now has severe lower abdominal pain, especially with her menstrual periods. She also told me that she has no sexual feelings at all and that intercourse is very painful.

10. At the age of 15, Ms. A was told by her father that she was promised to marry a wealthy man, Mr. Y. Mr. Y was in his 50's and had two other wives and children who were Ms. A's age. He was a friend of her father's. Ms. A refused to marry him. She reported that her father beat her severely with a

stick and insisted that she would dishonor the family if she did not. Her father told her that she would marry Mr. Y or he would make her leave the house. She still refused to marry Mr. Y and went to live with a relative in another area of town. When Ms. A's mother came to visit her, she told Ms. A that her father was beating her also and was going to kick her mother out of the house as well. She and her mother thought it was not safe for her to live in (home country). Ms. A was sent by her mother to live with an "Auntie" in the United States. She found out after she left that her mother had been thrown out of their home. Her mother returned to Ms. A's grandparents' home for several years.

11. Ms. A came to the U.S.A. through (name of) airport in N.Y.C. on (date).

## Clinical Findings

12. Ms. A's examination is significant for absence of the prepuce, clitoris, and upper labia minora (see Figure 1).

13. Clinical examination of the client's skin reveals the following information:
    a) Right thigh: hypopigmented, hypertrophic 4 cm by 1.5 cm scar (Photo 1)
    b) Inner aspect of right knee & calf: 2 scars, irregular in shape, hypopigmented (Photo 2)
    c) Upper and lower right side of her back: 2 small irregularly shaped scars, one hypopigmented and relatively linear, measuring approximately 2 cm by .5 cm, one roughly circular, measuring 2 cm by 2 cm (Photos 3 & 4)

## Summary of Clinical Findings and Conclusions

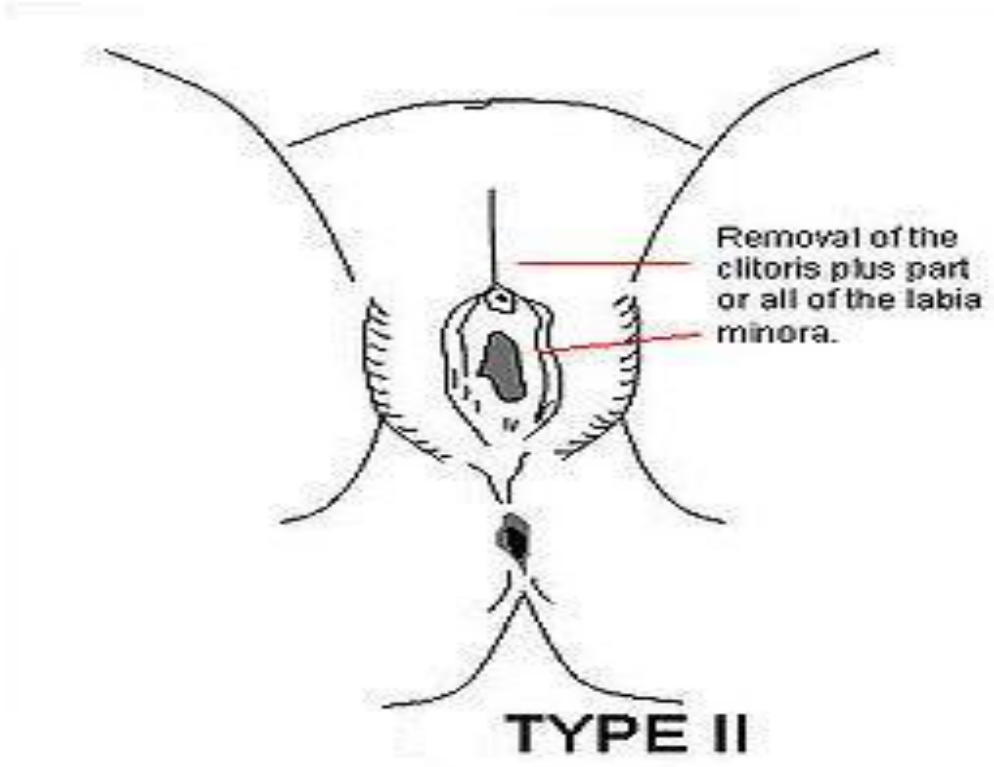
14. Examination of Ms. A's genitalia confirmed that she has experienced FGM Type II. According to the World Health Organization, "Female genital mutilation comprises all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons" (WHO, UNICEF, UNFPA, 1997). There are three major types in the classification of Female Genital Mutilation and many variants. (See Figure 1 from WHO classification 2008).

15. Ms. A has several other skin scars (described in para. 13) that are consistent with her report of having been beaten.

I am willing to answer any additional questions or explain my findings further.

_____
Terri Gallen Edersheim, M.D.
Sworn to me this_____day of _____(year)

**Figure 1**
World Health Organization FGM type IIb



## Additional Information on Female Genital Mutilation

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. However, more than 18% of all FGM is performed by health care providers, and this trend is increasing.

FGM is recognized internationally as a violation of the human rights of girls and women, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security, and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

### Procedures

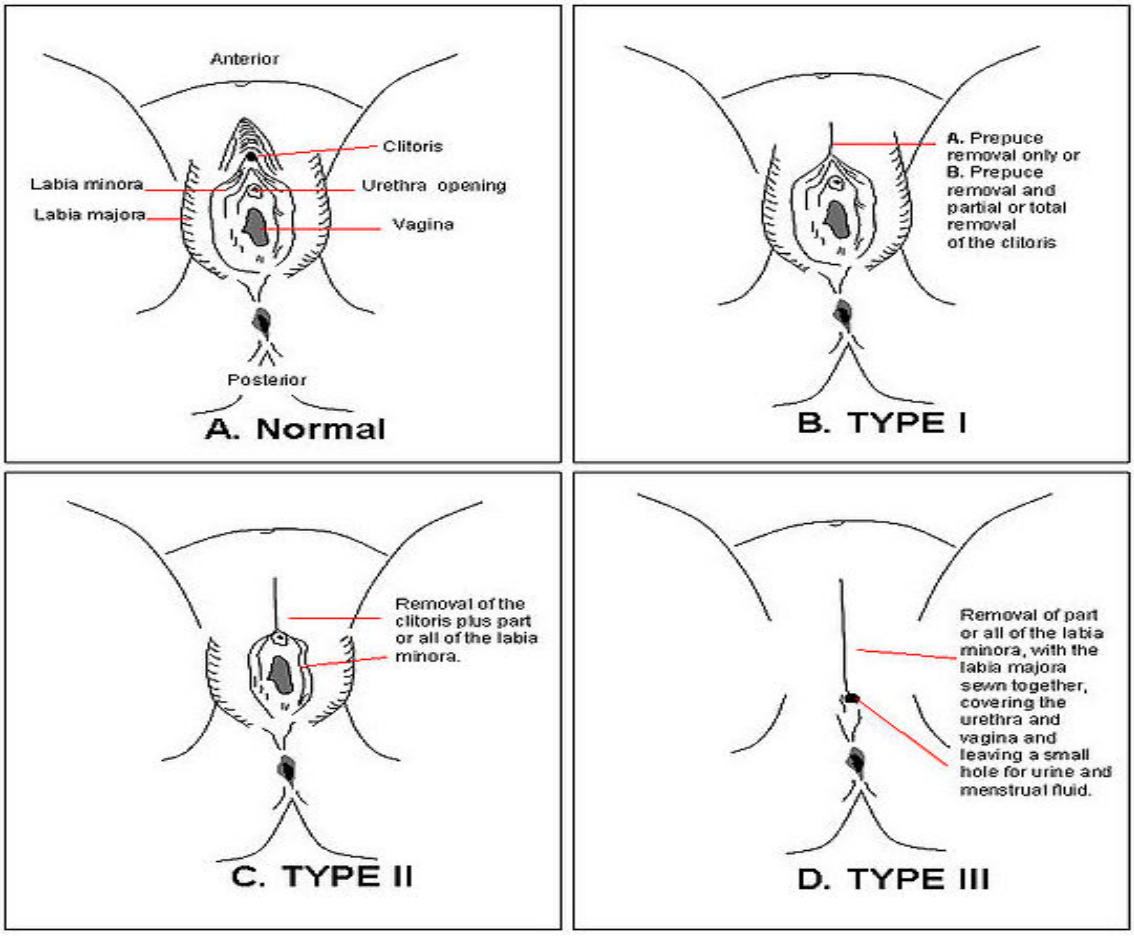
Female genital mutilation is classified into four major types.

**Clitoridectomy**: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

**Excision**: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

**Infibulation**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

**Other**: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.






## References

1. WHO | Female genital mutilation - World Health Organization www.who.int/topics/female_genital_mutilation/en/

2. The Tahirih Justice Center " Precarious Protection" http://www.tahirih.org/site/wp-content/uploads/2009/10/tahirihreport_precariousprotection.pdf

3. An update on WHO's work on female genital mutilation (FGM) progress report http://www.who.int/reproductivehealth/publications/fgm/rhr_11_18/en/index.html

4. Women Stats.org http://womanstats.org/mapEntrez.htm

# Psychiatric Asylum Evaluation

## Psychiatric Asylum Interview Outline

*The standard introduction paragraph of the affidavit should include the following:*

### Evaluation Information

1. Date of interview
2. Place of interview
3. Names of all present at the interview
4. Interpreter information (include country of origin, relationship to client, if applicable)
5. Length of interview

### Client Information

1. Full name of applicant
2. Place of birth
3. Current address
4. Roommates or housemates
5. Telephone
6. Email address
7. Other notable demographic data

*A transition paragraph of the affidavit, which follows the introduction, should include:*

> *A statement by the clinician that the following is his or her understanding of the client's account as reported during the evaluation. The clinician attests here that he or she did not see these events firsthand, but rather is reporting the information elicited from the client. Additionally, a statement that the evaluation was conducted in accordance with the Istanbul Protocol should be included:*
>
> "This evaluation was conducted in accordance with the standards described in the U.N. document known as the "Istanbul Protocol," *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations, New York and Geneva, 1999."

*The remainder of the affidavit should include the information outlined below:*

> *Note that clinicians and students should proceed gently throughout the interview, particularly when eliciting trauma history.*

### Social History

1. Family background
2. Early life circumstances
3. Ethnicity, race, religion, socioeconomic factors
4. Education and employment background
5. Marriage, relationships, children
6. Sexual orientation (include follow-up questions on LGBT identity, if appropriate)

7. How applicant spends his/her days
8. Where and with whom applicant lives
9. If applicant is employed
10. Hobbies, activities, likes and dislikes

## Medical History

1. Medical problems, symptoms and medications
2. Scars (examine, measure and describe in notes)

## Psychiatric Sequelae

1. Any psychiatric treatment, past or present?
2. Depression*
    a. Change in mood, weight, sleep, anhedonia, agitation, fatigue, feelings of worthlessness or guilt, diminished concentration, suicidal ideation
3. PTSD*
    a. Recurrent recollections or nightmares, traumatic triggers, flashbacks, distress at re-exposure, physiological reactivity
    b. Avoidance of distressing thoughts, feelings or reminders
    c. Inability to recall
    d. Persistent negative emotion state (i.e. fear, anger, guilt)
    e. Irritability, sleep disturbance, difficulty concentrating, hypervigilance, hyperactive startle

**See full DSM-V diagnostic criteria below.*

## General considerations

1. Client's attire
2. Describe interview behavior

## Additional questions

1. What does the client think would happen if he or she were forced to return to his or her country of origin?

## Important Diagnostic Criteria (DSM-V)

Major Depressive Disorder

- Duration
  - Depressive episodes include **five (or more) of the following symptoms** present during the same **2 week period**
- Symptoms
  - Depressed mood most of the day
  - Diminished interest or pleasure in all or most activities
  - Significant unintentional weight loss or gain
  - Insomnia or hypersomnia
  - Agitation or psychomotor retardation
  - Fatigue or loss of energy
  - Feelings of worthlessness or excessive or inappropriate guilt
  - Diminished ability to think or concentrate, or indecisiveness
  - Recurrent thoughts of death or suicide

Post-Traumatic Stress Disorder (PTSD)

- Duration
  - Symptoms present for **more than 1 month**
- Functional significance
  - Causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- Symptoms
  - Intrusive symptoms (**one or more**)
    - Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.
    - Recurrent distressing dreams of the event
    - Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring
    - Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
    - Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
  - Avoidant symptoms (**one or both**)
    - Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
    - Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)

- Negative alterations in cognitions and mood (**two or more**)
  - Inability to recall an important aspect of the traumatic event(s)
  - Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world
  - Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others
  - Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)
  - Markedly diminished interest or participation in significant activities
  - Feeling of detachment or estrangement from others
  - Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings)
- Hyperarousal symptoms (**two or more**)
  - Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects
  - Reckless or self-destructive behavior
  - Hypervigilance
  - Exaggerated startle response
  - Problems with concentration
  - Sleep disturbance

## Sample Psychiatric Affidavit

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
IMMIGRATION COURT
NEW YORK, NEW YORK

| | | |
|---|---|---|
| In the matter of | : | |
| | : | client application number |
| (Name of client) | : | |
| | : | |
| RESPONDENT | : | |

STATE OF NEW YORK

COUNTY OF NEW YORK

### AFFIDAVIT OF THOMAS KALMAN, M.D.

I, Thomas P. Kalman, MS, MD, do hereby affirm the following:

### Introduction

1. I am submitting this affidavit in support of the asylum application of Mr. A, reporting my examination of him on (date).

2. I have been a licensed physician in New York State since 1976 and Board-Certified in Psychiatry by the American Board of Psychiatry and Neurology since 1980. I have been in private practice since 1979.

3. I graduated from The New York Medical College in 1975, completed a medical internship at The Lenox Hill Hospital in 1976, and psychiatric training at The New York Hospital (1979). I have also completed psychoanalytic training at The New York Medical College (1982) and a Master's Degree in Health Care Policy and Management at The New York University (1996).

4. I am engaged full-time in the private practice of psychiatry and teach voluntarily at the Weill Medical College of Cornell University (WCMC), where I am Clinical Professor of Psychiatry. I am also Adjunct Associate Professor of Psychiatry at New York Medical College.

5. I have been a member of Physicians for Human Rights (PHR) and a volunteer with the Weill Cornell Center for Human Rights (WCCHR) since 2011. The WCCHR functions in partnership with PHR to provide pro bono

medical and psychiatric/psychological evaluations of asylum applicants from various countries. This work is on behalf of individuals who have been traumatized by war, violence, torture, persecution, and other issues.

6. On (date), I examined Mr. A at the WCMC facilities. Two Cornell medical students, Ms. X and Ms. Z, attended the interview, which lasted slightly more than two hours. I have also reviewed Mr. A's affidavit, the content of which will not be restated below except as is relevant to my examination. The following delineates my understanding of the events that led to Mr. A's arrival in the United States and my observations and clinical and diagnostic impressions. I have limited the narrative to those aspects of his history that are pertinent to the psychiatric evaluation that I am providing.

7. This evaluation was conducted in accordance with the standards described in the U.N. document known as the "Istanbul Protocol," *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, United Nations, New York and Geneva, 1999.

## Narrative of Mr. A

8. Mr. A was born in (city, country). He reports that he arrived in the United States on (date) and presently lives in (city, state) with his wife and his two sons. Neither he nor his wife is employed, and his sons, ages 8 and 3, attend local schools. Mr. A reports that this interview is his first psychiatric evaluation.

9. Mr. A is the 5$^{th}$ of 6 children born to Brahmin caste Hindu parents. He reports that both his father and grandfather were educated and valued studies. Two older brothers have died, one older brother now lives in the United Kingdom, and another older brother and younger sister remain in (home country).

10. Mr. A reports that his father had a transportation-related business and that he and his siblings were always well cared for, clothed and fed. Mr. A described the area where he was born as predominantly Muslim and characterized by militancy and hostility towards the minority Hindu population. In (year), when (country B) came into existence (formerly country A), the A family land was seized under provisions of the Enemy Property Act (which allowed legal seizure of minority-held land), and their home was lost and their father's business burned.

11. As a result, Mr. A reports that the family was forced to relocate to (region), a region that was felt to be safer for Hindus. But here, too, there was still significant anti-Hindu sentiment and Islamic militancy. Hindus were viewed as the enemy.

12. Mr. A has few childhood memories: “I was a small boy.” He does recall wanting to be a Hindu priest. Although Mr. A’s father was a pragmatic businessman who tried to avoid political and religious conflicts, his children were less able to ignore the injustices and mounting religious persecution to which they were subjected. Both of his parents are now deceased (father in year and mother in year). After Islamist organizations persecuted him for his Hindu practices, Mr. A’s oldest living brother left (country B) for Qatar in (year). Another brother, (name 2), has often been threatened and survives in (country B) by moving frequently and concealing his identity.

13. Mr. A notes that he generally managed to avoid direct problems with hostile Muslims until he became involved with various Hindu and youth organizations.

14. As an idealistic young college student at a university founded by a Hindu philanthropist, Mr. A was troubled that the open observance of Hindu religious practices was not permitted. Thus, in (year) he established an activist organization to address this inequity. During (year) and (year), he reports that he “started to speak up” in college. He recalls a specific instance in (year) when he decided to hold a religious event, a Puja. Despite having obtained permission from the college, a leader of (organization, student wing of the Islamist extremist organization, Jamat-e-Islam) told Mr. A not to proceed with the observance.

15. Mr. A chose not to submit to the warning, and the militant Islamic students attacked the Hindu group, destroying their altars and Hindu artifacts while also beating many of the students, including Mr. A. He reports that they “beat with sticks” (sic), leading to loss of consciousness, heavy bleeding, and hospitalization. He was taken to a small, more private clinic/hospital instead of the main hospital so that his attackers would not be aware of his survival or whereabouts. Mr. A identified a scar (visible beneath his hair) on the left side of his head as being from this beating.

16. After this incident, Mr. A attempted to publicize the unfair activities of the (organization) with a protest march/procession. He also approached college authorities and the police. He remains very proud that unlike “most people…[who] ran away, go to India, become Muslim,” Mr. A remained

dedicated to what seemed right and was “still talking”(sic) – i.e., that he would not be silenced.

17. On the occasion of this protest, violence again erupted against the Hindus. Many were beaten and injured, although on this occasion Mr. A himself was not and was able to escape.

18. Mr. A remained politically active and passionate about fighting the Islamist oppression of the Hindu minority students. In February and March (year), there were more violent incidents in response to Mr. A’s activism, culminating in a confrontation at his home, where he had planned a religious observance (having moved his religious observances off-campus).

19. On this occasion, a mob of Islamists using Molotov cocktails and other weapons partially burned Mr. A’s home and destroyed property. They beat the students and neighbors attending the celebration, and Mr. A’s brother sustained a serious knife wound. Mr. A himself was punched in the head with a brass-knuckle-like instrument, causing a puncture wound of his forehead and again rendering him unconscious. (Mr. A identifies the visible scar on his forehead as the result of this attack). He reports that after this attack on his family’s home, his mother was afraid to leave the house or speak to friends.

20. In this melee, one of the attackers was injured by a fragment of an incendiary bomb, causing him to lose one eye. This individual, who has remained powerful in militant Islamist organizations within (country B), blames Mr. A personally for his injury and has repeatedly sworn revenge.

21. In October (year), police arrested Mr. A after he made and handed out leaflets regarding Islamic extremists and minority rights. He reported that “they beat me” and “inserted hot needles under my toe fingers.” The police warned him to stop passing out leaflets and to stop causing trouble in the neighborhood. Additionally, Mr. A says that the police “showed me the light,” which meant that they forced him to watch others enduring torture in order to intimidate him. Mr. A’s associate, a Hindu woman who had helped him with the leaflets, had also been tortured and had identified Mr. A to the police. Threatened with further torture, he agreed to sign a document (he has no recall of what he signed). They released Mr. A after many days of incarceration, when his father had paid a bribe to officials. He has significant “blank spots” in his memory for the details of this episode.

22. In (year), Mr. A left (country B) to work in Qatar. At home, he was terrified for his own safety as well as that of his parents and siblings. Mr. A's father, while he "might have liked what [I] did, but he can't show his support," asked his son to leave (country B) for his own safety and for the safety of his family.

23. In Qatar, Mr. A obtained stable employment with a florist and learned all aspects of this business. He thrived in this occupation for over two decades, receiving many accolades for his floral arrangements and creativity from numerous clients, including the U.S. Embassy. He is very proud of his work ethic and accomplishments.

24. Mr. A's employer sold the florist business in (year) to a devout, intolerant Muslim who disliked Mr. A because he was Hindu. This marked the beginning of the end of his work in Qatar as he was ultimately dismissed from this job in (year).

25. Between (year), when he first went to Qatar, and (year), when his employment formally ended, Mr. A made trips home to (country B) only for significant family reasons – his sister's marriage (year), his own marriage (year, an arranged marriage to a woman from country B), his older son's 1st birthday visit to his in-laws (year), and visits to his ailing mother (year).

26. On these visits, because of his "notoriety" among the Muslim militants, Mr. A (and then his new family) always experienced harassment and threats. He always had to pay extortion to both extremists and government officials to try to assure his safety, but even this did not ensure safe passage.

27. In (year), on the visit to attend his younger sister's wedding, Mr. A refused to pay for "protection" (extortion). Muslim fundamentalists came to the wedding celebration and threatened Mr. A and others before leaving. A few days later, he was attacked and was injured trying to defend himself (he showed a long scar on his right forearm). Urged again to flee for his safety by his father, Mr. A fled immediately via (country C), as he was unable to get immediate transportation to Qatar.

28. From Qatar Mr. A regularly sent money to his family to pay extortion demands by extremists and political officials for "protection" of his family in (country B). His father, too, regularly paid extortion in return for safety. On some of his visits to (country B) from Qatar, Mr. A had to try to remain hidden and move to different locations for fear of being noticed by the extremists.

29. After his own wedding (year) (for which he had paid considerable extortion for safety), Mr. A was stopped at the airport as he was leaving the country. In effect, this was a "shakedown" for a bribe to be allowed passage. Mr. A describes this as a common practice against Hindus, who are identifiable by their names.

30. In (year), Mr. A returned to (country B) with his wife and his son to celebrate his son's first birthday at his wife's parents' home. While Mr. A was out running an errand, people came to the house looking for him; they asked for money, destroyed things, and held a gun to his son's head. Mr. A and his wife attempted to get some help from the police after this event, but were not successful. They could not even have a report taken because they are Hindu and the police themselves were afraid of the extremists. The As returned to Qatar as quickly as possible, frightened for their safety.

31. On the (year) visit to his ill mother, extremists again confronted Mr. A and not only demanded money but also made death threats to him and his family.

32. In Qatar, while generally safer than in (country B), Mr. A also could not openly practice the Hindu religion. He states that he cannot speak openly in Qatar, is not eligible for citizenship, and does not enjoy the same rights as citizens. Although his sons were born in Qatar, they were not eligible for Qatari passports and are citizens of (country B).

33. Mr. A reports that in (year) he came to the United States and eventually learned of the possibility of seeking asylum and initiated the process. If able to remain in the U.S., he and his wife hope to work and educate their children.

## Psychiatric Assessment of Mr. A

34. Mr. A arrived early for his appointment. He is a dark-skinned, (ethnicity) man, neatly dressed and groomed, approximately five and one-half feet tall and of medium build. He has a full head of black hair, is clean-shaven, and uses eyeglasses to read. There is a small visible scar on his forehead, a scar on the left side of his head beneath the hair, and a scar on his right forearm. Mr. A was notably anxious at the start of the interview and remained only slightly less so for the entire two hours while trying throughout to be cooperative and answer all of my questions. He had worn several layers of clothing under his overcoat on this cold winter's day, but in the warm examination room, he never removed any garments despite

being invited to make himself more comfortable. Soft-spoken, Mr. A was cooperative, made good eye contact with the interviewer, and was responsive to all questions. He speaks faintly, has a very thick accent, and at times speaks so rapidly that it was necessary to ask him to repeat or re-phrase himself. On occasion, the volume of his voice would trail off, contributing to difficulty understanding him.

35. Mr. A is alert and oriented in all spheres, and has grossly intact short and long-term memory function, although there are gaps in his recall of some events (for example, details about his [year] arrest and being subjected to torture). He demonstrates normal thought processes, with logical connections between expressed ideas. There is no evidence of delusions, hallucinations, obsessions or other disturbances of process. Thought content is appropriate to the questions asked and he remained focused on his history, experiences, and current circumstances. His responses to questions are consistent throughout the interview and with the material contained in his affidavit.

36. Mr. A clearly indicated that he does not feel well. His vocabulary for describing emotions or his inner mental state is limited and he does not think in abstract, psychological terms. However, he was able to say that he is “not well” and that “inside something is not right” (while motioning with his hand over his chest). He also described that he worries all the time (about his future, his children, and his circumstances) and is unable to sleep. He has two sleep patterns – either he goes to bed and cannot fall asleep, or he falls asleep from sheer exhaustion only to awaken after a few hours and be unable to fall back asleep. During the interview, Mr. A appeared uncomfortable, anxious, and emotionally vulnerable – very sad at times, even plaintive. At several times he became overwhelmed with emotion and openly cried when recalling his torture and persecution, when talking about his children and a terrorist holding a gun to his then 1-year-old son’s head, and when recalling with pride his work as a florist in Qatar and how much his artistry was appreciated by clients (including the American Embassy). The breakthroughs of emotions caused him some discomfort and led him to apologize profusely, saying that he feared he was giving us a hard time. When asked if he ever feared for his life, Mr. A became flustered and began to cry. He says that he cries when he feels angry, and he is upset that these things happened to him. He feels that he follows rules well and should be left alone.

## Psychiatric Diagnoses

37. Mr. A's history, symptoms, and clinical presentation are consistent with the following diagnoses:

    a. Post Traumatic Stress Disorder, severe and chronic with nightmares, intrusive thoughts and flashbacks, gaps in recall, emotional dyscontrol, chronic anxiety, insomnia, and intense feelings of fear, helplessness, and severe depression.

    b. Major Depressive Disorder, severe and chronic, without psychotic features. Relevant findings include severely depressed mood, insomnia, social isolation, and diminished interests and energy.

## Psychological Profile

38. Mr. A is a man characterized by an abiding dedication to spirituality, fairness, and respect for the law, tradition, and family. As a young, idealistic student he fought vainly for the rights of his Hindu community. Perhaps unable to perceive the insidious power of the militant Islamists in his homeland or the cultural bigotry in Qatar, he has fled and his spirit is damaged. A proud man, Mr. A remains dedicated to that which is correct and fair.

## Summary and Conclusions

39. I find Mr. A to be entirely credible. His description of persecution on the basis of his religious background is consistent with the known history of relations between Muslims and Hindus in (country B). It is highly likely that his life experiences, particularly those of persecution, beatings, torture, and forced exile contributed to the development of the psychiatric conditions described above, and it is my professional opinion that forcing Mr. A to return to (country B) would pose a serious threat to his mental health and his safety. Currently depressed, it is possible that his condition could worsen, including the emergence of suicidal thinking.

I declare under penalty of perjury that the foregoing is true and correct.

Thomas P. Kalman, MS, MD

## Vicarious Trauma and Self-Care

*"The professional work centered on the relief of the emotional suffering of clients automatically includes absorbing information that is about suffering. Often it includes absorbing that suffering as well." Dr. Charles Figley*

Figley, Charles R. (ed). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. Brunner/Mazel. 1995.

### Vicarious Trauma

Vicarious trauma is the process of change that happens because you care about other people who have been hurt, and feel committed or responsible to help them. Over time this process can lead to changes in your psychological, physical, and spiritual well-being.

Vicarious trauma is a process of change. It is the ***cumulative*** effect of contact with survivors of violence or disaster or people who are struggling. This process of change is ongoing.

Vicarious trauma happens because you care about people who have been hurt. Vicarious trauma happens because you care – because you empathize with people who are hurting. And when you care about and identify with the pain of people who have endured terrible things, you bring their grief, fear, anger, and despair into your own awareness and experience and feel it along with them in some way.

What sort of problems or people do you find it especially easy to empathize with? What are some ways that caring about people who have been hurt affects you?

Vicarious trauma happens not only because you care about people who have been hurt, but because you feel committed or responsible to help.

Your commitment and sense of responsibility can lead to high expectations and eventually contribute to your feeling burdened, overwhelmed, and perhaps hopeless.

How does your sense of commitment and responsibility to your work help you? Are there ways in which your sense of commitment and responsibility to your work might hurt you? How?

Over time, vicarious trauma leads to changes in your own psychological and spiritual well-being.

A key component of vicarious trauma is changes in spirituality. Vicarious trauma, like experiencing trauma directly, can deeply impact the way you see the world and your deepest sense of meaning and hope.

## Definitions of related effects

Secondary traumatic stress (STS) is the constellation of emotional and behavioral responses that can result from "knowledge about a traumatizing event experience[d] by a significant other." It is the stress resulting from helping or wanting to help a traumatized or suffering person.

Compassion fatigue is a term that refers to a gradual lessening of compassion over time. It is common among victims of trauma and individuals that work directly with victims of trauma.

## Symptoms

The manifestations of STS can mirror the psychological symptoms experienced by the victim. For instance, STS may include feelings of depression, irritability, intrusive recollections ("I can't get it out of my head"), sleep disturbances, nightmares, emotional numbing, or intolerance of others' experiences – especially the stresses of daily life.

Contemporary writers on STS focus on the imbalance between the survivors' compelling needs and traumatic story on the one hand and, on the other hand, the workers' ultimately limited resources for help and capacity to absorb the story.

Burnout: Subtle, over time, & leads one to believe he/she is not meant for this type of work.

Feelings of being ineffective, callous, negative, emotional absence, sarcastic, & "stuck"…"My tank is empty!"

Compassion Fatigue: Preoccupation with absorbing trauma and emotional stresses of others.

Symptoms similar to burnout, but onset is faster with better opportunity to recover. It may lead to burnout.

## Vicarious Joy

Vicarious joy is the inspiration and empowerment a provider may experience through exposure to the coping capacities and resilience of torture survivors. Vicarious joy might be felt in defining problems differently, becoming more resourceful, less fearful, and more resolute. It stems from conscious recognition and celebration of successes and satisfactions of our work. It allows us to draw strength from the human capacity for healing and develop a more realistic view on our own problems AND our capacity for interventions in others' problems!

We enhance our appreciation for the spiritual dimensions of life, we reaffirm the value of our work and we strengthen the commitment to remain engaged with our profession and clients.

## Recognizing Vicarious Trauma and Self-Care Tips

Self care strategies involve the **A, B C's.**

- **Awareness:** be reflective of your own reactions either through thought or writing, be self-aware of how different cases might be affecting you, check in with yourself at the end of a session
- **Balance:** maintaining balance in work and life, vary the types of cases, when starting to feel the beginning of burnout, take a break from the work
- **Connection:** avoid isolation, maintain positive connections with family and friends, develop relationships with peer and other evaluators who might have had similar experiences, share your thoughts and feelings at WCCHR debriefing sessions.

If you do find yourself starting to feel symptoms of vicarious trauma, please let your evaluator and/or the student coordinator at WCCHR know. It is important to address early and there are many ways for us to help, but we need to know what is happening!

## Debrief Sessions

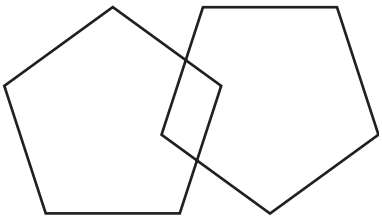
WCCHR holds biannual debrief sessions in the fall and spring that are open to all students. Participating in evaluations can be challenging, and a chance to discuss the impact volunteering has had on students is important. The overall purpose of the student debrief is to facilitate opportunities for communication between the student volunteers, the WCCHR Student Board and the Medical Directors and specifically to deal with the issue of vicarious trauma.

The session is informal and gives students a chance to talk about their experiences and provide feedback to the clinic administration. A short presentation on vicarious trauma and self-care is followed by an open forum. This provides an opportunity for students to speak about both the positives and negative aspects of their experiences. Resources are made available throughout the year to students dealing with vicarious trauma and are re-addressed at this session.

# The Mini-Mental State Exam

Patient_____ Examiner _____ Date_____

| Maximum | Score | |
|---|---|---|
| | | **Orientation** |
| 5 | ( ) | What is the (year) (season) (date) (day) (month)? |
| 5 | ( ) | Where are we (state) (country) (town) (hospital) (floor)? |
| | | **Registration** |
| 3 | ( ) | Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____ |
| | | **Attention and Calculation** |
| 5 | ( ) | Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively spell "world" backward. |
| | | **Recall** |
| 3 | ( ) | Ask for the 3 objects repeated above. Give 1 point for each correct answer. |
| | | **Language** |
| 2 | ( ) | Name a pencil and watch. |
| 1 | ( ) | Repeat the following "No ifs, ands, or buts" |
| 3 | ( ) | Follow a 3-stage command: "Take a paper in your hand, fold it in half, and put it on the floor." |
| 1 | ( ) | Read and obey the following: CLOSE YOUR EYES |
| 1 | ( ) | Write a sentence. |
| 1 | ( ) | Copy the design shown. |



_____ Total Score

ASSESS level of consciousness along a continuum _____

Alert Drowsy Stupor Coma

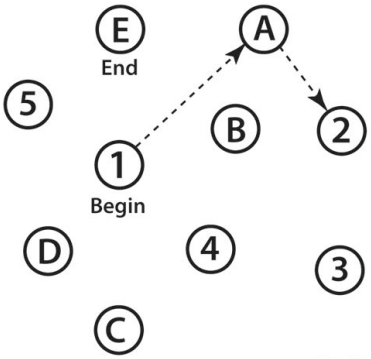
"MINI-MENTAL STATE." A PRACTICAL METHOD FOR GRADING THE COGNITIVE STATE OF PATIENTS FOR THE CLINICIAN. *Journal of Psychiatric Research*, 12(3): 189-198, 1975. Used by permission.

## MONTREAL COGNITIVE ASSESSMENT (MOCA)

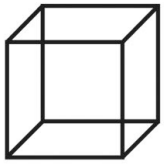
Version 7.1 Original Version

NAME :
Education : Date of birth :
Sex : DATE :

### VISUOSPATIAL / EXECUTIVE




Copy cube



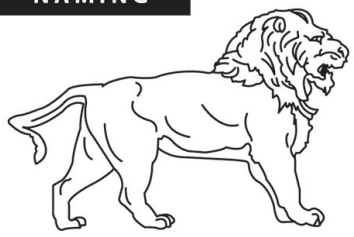
[ ] [ ]

Draw CLOCK (Ten past eleven)
( 3 points )

[ ] Contour [ ] Numbers [ ] Hands

POINTS ___/5

### NAMING



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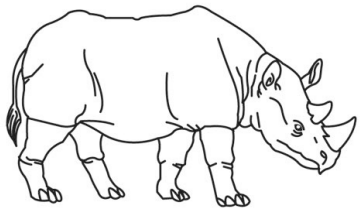

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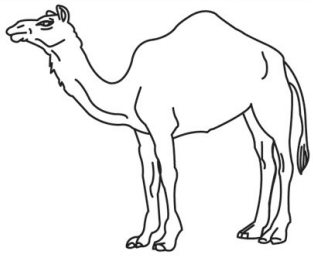

[ ]

___/3

### MEMORY

Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.

| | FACE | VELVET | CHURCH | DAISY | RED |
|---|---|---|---|---|---|
| 1st trial | | | | | |
| 2nd trial | | | | | |

No points

### ATTENTION

Read list of digits (1 digit/ sec.).
Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2

___/2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

___/1

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

___/3

### LANGUAGE

Repeat : I only know that John is the one to help today. [ ]
The cat always hid under the couch when dogs were in the room. [ ]

___/2

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words)

___/1

### ABSTRACTION

Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler

___/2

### DELAYED RECALL

| | Has to recall words WITH NO CUE | FACE | VELVET | CHURCH | DAISY | RED | Points for UNCUED recall only |
|---|---|---|---|---|---|---|---|
| | | [ ] | [ ] | [ ] | [ ] | [ ] | |
| **Optional** | Category cue | | | | | | |
| | Multiple choice cue | | | | | | |

___/5

### ORIENTATION

[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City

___/6



www.mocatest.org

Normal ≥ 26 / 30

TOTAL ___/30

Add 1 point if ≤ 12 yr edu

Administered by: _____

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:** _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| | **add columns:** | | + | + |
| *(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)* | **TOTAL:** | | | |

**10.** If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all** _____
- **Somewhat difficult** _____
- **Very difficult** _____
- **Extremely difficult** _____



ZT274388

Generalized Anxiety Disorder 7-item (GAD-7) scale

| Over the last 2 weeks, how often have you been bothered by the following problems? | Not at all sure | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it's hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
| *Add the score for each column* | + | + | + | |
| Total Score *(add your column scores)* = | | | | |

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

# PCL-5

**Instructions**: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

| *In the past month, how much were you bothered by:* | *Not at all* | *A little bit* | *Moderately* | *Quite a bit* | *Extremely* |
|---|---|---|---|---|---|
| 1. Repeated, disturbing, and unwanted memories of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 2. Repeated, disturbing dreams of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*? | 0 | 1 | 2 | 3 | 4 |
| 4. Feeling very upset when something reminded you of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*? | 0 | 1 | 2 | 3 | 4 |
| 6. Avoiding memories, thoughts, or feelings related to the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*? | 0 | 1 | 2 | 3 | 4 |
| 8. Trouble remembering important parts of the stressful experience? | 0 | 1 | 2 | 3 | 4 |
| 9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*? | 0 | 1 | 2 | 3 | 4 |
| 10. Blaming yourself or someone else for the stressful experience or what happened after it? | 0 | 1 | 2 | 3 | 4 |
| 11. Having strong negative feelings such as fear, horror, anger, guilt, or shame? | 0 | 1 | 2 | 3 | 4 |
| 12. Loss of interest in activities that you used to enjoy? | 0 | 1 | 2 | 3 | 4 |
| 13. Feeling distant or cut off from other people? | 0 | 1 | 2 | 3 | 4 |
| 14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*? | 0 | 1 | 2 | 3 | 4 |
| 15. Irritable behavior, angry outbursts, or acting aggressively? | 0 | 1 | 2 | 3 | 4 |
| 16. Taking too many risks or doing things that could cause you harm? | 0 | 1 | 2 | 3 | 4 |
| 17. Being "superalert" or watchful or on guard? | 0 | 1 | 2 | 3 | 4 |
| 18. Feeling jumpy or easily startled? | 0 | 1 | 2 | 3 | 4 |
| 19. Having difficulty concentrating? | 0 | 1 | 2 | 3 | 4 |
| 20. Trouble falling or staying asleep? | 0 | 1 | 2 | 3 | 4 |

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

# SEXUAL ORIENTATION AND GENDER IDENTITY ASSESSMENT IN LGBT REFUGE AND ASYLEES

Ahola and Shidlo, 2011

| | Timeline | | | | Change in status between arrival in U.S. and today |
|---|---|---|---|---|---|
| | Today | 1 Year after arrival to U.S. | On arrival to U.S. | In country of origin | |
| **Attraction** | | | | | |
| To whom are you sexually attracted? | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Yes ☐ No<br>If yes, when did the change start? (mo/yr):_____<br>Has the change become stable?<br>☐ Yes ☐ No<br>If so, when?<br>(mo/yr):_____ |
| **Fantasies** | | | | | |
| About whom do you have sexual fantasies? | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Yes ☐ No<br>If yes, when did the change start? (mo/yr):_____<br>Has the change become stable?<br>☐ Yes ☐ No<br>If so, when?<br>(mo/yr):_____ |
| **Behavior** | | | | | |
| With whom have you had sex? | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Yes ☐ No<br>If yes, when did the change start? (mo/yr):_____<br>Has the change become stable?<br>☐ Yes ☐ No<br>If so, when?<br>(mo/yr):_____ |
| **Emotional Preference** | | | | | |
| Whom do you fall in love with or have crushes on? | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Women<br>☐ Men<br>☐ Transgender Persons | ☐ Yes ☐ No<br>If yes, when did the change start? (mo/yr):_____<br>Has the change become stable?<br>☐ Yes ☐ No<br>If so, when?<br>(mo/yr):_____ |
| **Community** | | | | | |
| With whom do you feel comfortable socializing?<br><br>Check all that apply. | ☐ Lesbian(s)<br>☐ Gay Men<br>☐ Bisexual(s)<br>☐ Heterosexual<br>☐ Transgender Persons | ☐ Lesbian(s)<br>☐ Gay Men<br>☐ Bisexual(s)<br>☐ Heterosexual<br>☐ Transgender Persons | ☐ Lesbian(s)<br>☐ Gay Men<br>☐ Bisexual(s)<br>☐ Heterosexual<br>☐ Transgender Persons | ☐ Lesbian(s)<br>☐ Gay Men<br>☐ Bisexual(s)<br>☐ Heterosexual<br>☐ Transgender Persons | ☐ Yes ☐ No<br>If yes, when did the change start? (mo/yr):_____<br>Has the change become stable?<br>☐ Yes ☐ No<br>If so, when?<br>(mo/yr):_____ |
| | | | | | |

| | Timeline | | | | Change in status between arrival in U.S. and today |
|---|---|---|---|---|---|
| | Today | 1 Year after arrival to U.S. | On arrival to U.S. | In country of origin | |
| **Self Identification (Private)** | | | | | |
| How do you identify yourself (to yourself)? | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Yes ☐ No<br>If yes, when did the change start? (mo/yr):_____<br>Has the change become stable?<br>☐ Yes ☐ No<br>If so, when?<br>(mo/yr):_____ |
| **Self Identification (To LGBT Persons)** | | | | | |
| How do you identify yourself to LGBT persons? | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Yes ☐ No<br>If yes, when did the change start? (mo/yr):_____<br>Has the change become stable?<br>☐ Yes ☐ No<br>If so, when?<br>(mo/yr):_____ |
| **Self Identification (To Heterosexual Persons)** | | | | | |
| How do you identify yourself to heterosexual persons? | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Lesbian<br>☐ Gay Man<br>☐ Bisexual<br>☐ Heterosexual<br>☐ Transgender Person | ☐ Yes ☐ No<br>If yes, when did the change start? (mo/yr):_____<br>Has the change become stable?<br>☐ Yes ☐ No<br>If so, when?<br>(mo/yr):_____ |
| **Additional Comments:** | | | | | |

## Personal Information

**Providing the following information is completely optional.**

First Name: _____ Last Name: _____

Email:_____ Phone Number:_____

**Would you be willing to have someone contact you regarding your responses on this survey?**

○ Yes ○ No

## Additional Scales

Beck Depression Inventory
Beck Anxiety Inventory
Harvard Trauma Questionnaire
Hopkins Symptom Checklist 25
Mini Mental Status Exam
PTSD Checklist (PCL)
PCL-Civilian
PCL-Military
Clinician-Administered PTSD Scale (CAPS)
CAPS for Children and Adolescents (CAPS-CA)
Combat Exposure Scale (CES)
Life Events Checklist
Life Events Checklist-Child
Life Stressor Checklist
Mississippi Scale for PTSD (M-PTSD) Civilian
M-PTSD Military
Traumatic Events Screening Inventory (TESI) Child
TESI-Parent

# Continuing Care

## About Continuing Care

Accessing medical care can be a daunting task, especially for the many WCCHR clients who do not speak English, lack access to computers, or have limited financial resources. The continuing care branch of WCCHR aims to help asylum seekers overcome these barriers by connecting them with medical and mental health treatment and non-medical services. At the end of their evaluation with our clinic, clinician evaluators and medical students help asylum seekers indicate which services they are interested in receiving by completing our needs assessment and client information form. These forms are sent to the Continuing Care Team, and the client is assigned to one of our medical student case managers. The case manager contacts the client and/or lawyer to review the client's needs assessment. The case manager then arranges care and other services for the client by connecting with outside organizations and clinics.

We have the capacity to make the following types of referrals:

- Medical and gynecologic: WCCHR typically refers to the Weill Cornell Community Clinic (WCCC), a student-run free clinic for the uninsured. If the client prefers to visit a clinic closer to home, we research local options and connect him or her with a free or low-cost clinic in that neighborhood.

- Mental health: Case managers are familiar with several well-established New York City treatment centers for survivors of torture and victims of domestic abuse. These centers provide free individual and group therapy and include Libertas, Bellevue PSOT, and Sauti Yetu. We also make referrals to the Cornell psychiatry resident clinic at NewYork-Presbyterian. If none of these resources are appropriate or conveniently located, we research other free or low-cost options.

- Health insurance: Asylum seekers who are NY State residents are eligible for Medicaid. We help asylum seekers enroll by referring them to our colleagues at the Legal Aid Society or another capable Medicaid navigator for assistance.

- ESL classes: Case managers are able to refer clients to one of the many free ESL classes available in the New York City area.

- Housing: Through our partnership with Seafarers International, we are able to assist clients with short-term (<1 month) housing needs. Clients with long-term housing needs can be referred to shelters or outside agencies.

- Other: If an asylum seeker has needs that do not fit into the categories above, we make every effort to assist him or her.

## PRUCOL: How Asylum Seekers Qualify for Medicaid

Permanent Residence Under Color of Law, or PRUCOL, is a public benefit eligibility status, as opposed to an immigration status, that allows certain groups of individuals, including those seeking asylum, to be eligible for full Medicaid coverage. Eligibility for Medicaid depends on a variety of other factors (income, state residence, etc.), which PRUCOL applicants for Medicaid must also meet to be found eligible.

### What does "Permanent Residence Under the Color of Law" really mean?

"Permanent" implies that the individual will be in the United States permanently. "Residence" indicates that the individual is a resident of New York State. "Under the Color of Law" means that the individual has some legal basis for being in the country. PRUCOL is more inclusive than the federal immigration requirements for Medicaid eligibility.

### When is an asylum seeker eligible for PRUCOL?

An asylum seeker is eligible for PRUCOL once he/she obtains confirmation that his/her formal application for asylum has been received by USCIS. Proof that USCIS has received the application includes a I-797 Notice of Action or a postal service return receipt stating "signature confirmation" or "delivery confirmation." Once individuals have been granted asylum status, they continue to be eligible for Medicaid under the status of Qualified Alien.

Prior to submitting their application for asylum, asylum seekers may be eligible for Emergency Medicaid, which is a more limited form of Medicaid for undocumented immigrants and other non-immigrants. Emergency Medicaid covers services needed to treat a condition that has acute, severe symptoms and which, if left untreated, could place the individual's health in jeopardy. Once their application for asylum is received, asylum seekers are classified as PRUCOL immigrants and are eligible for full Medicaid.
Contact wcchr-continuingcare@med.cornell.edu for more information.

Pregnant women are eligible for Medicaid regardless of immigration status, provided they meet the other eligibility requirements.

### How does an asylum seeker apply for Medicaid under PRUCOL?

First, determine whether the individual would be categorized as MAGI or non-MAGI ("MAGI" stands for "Modified Adjusted Gross Income"). The majority of asylum seekers will be budgeted under the MAGI income limits. Please see criteria at http://wcchr.com/sites/default/files/MAGI%20criteria.pdf. MAGI asylum seekers should apply through the New York Health Exchange website (https://nystateofhealth.ny.gov/). Non-MAGI asylum seekers should apply at their

Local Department of Social Services. Certified disabled, aged, or blind applicants who are not caretaker relatives of children under the age of 18 are subject to a resource limit.

Second, determine whether or not the applicant's household income falls below the limit for his or her household size. Income limits are different for MAGI and non-MAGI applicants.
Please see: http://wcchr.com/sites/default/files/Income%20level%20sheet.pdf

Applicants for Emergency Medicaid are not required to have a social security number (SSN). However, PRUCOL applicants for Medicaid must at least be in the process of applying for an SSN. If their application for an SSN is denied, they cannot be denied Medicaid based on lack of an SSN.

## Where can I get help applying for Medicaid?

Asylum seekers can receive free assistance with the Medicaid application. Visit https://nystateofhealth.ny.gov/agent/hx_brokerSearch to find a Navigator/Broker near you who will help you with your application and will guide you through the registration process. Navigators are available in dozens of different languages.

Specific questions about applying can also be directed to the Continuing Care team at WCCHR by emailing wcchr-continuingcare@med.cornell.edu.

## What services will Medicaid Managed Care cover?

Primary care physician (PCP), mental health, gynecological, and dental services are all covered. Transportation to medical appointments and translation services are also covered.

**Information and attachments courtesy of The Legal Aid Society.

# Additional Resources

## Library and Online Resources

Available at the WCMC Library

To access these resources, please see Caryn Davi in her office in the library.

*"Examining Asylum Seekers: A Clinician's Guide to Physical and Psychological Evaluations of Torture and Ill Treatment"*
By: Physicians for Human Rights
Published by Physicians for Human Rights, this manual describes the process by which a physician can evaluate an asylum seeker's history and document that evaluation in a legal affidavit.

*"Well-Founded Fear"* (DVD)
By: PBS
A film by PBS which explores the stories of several individuals in the New York City area seeking asylum, and examines the process by which INS officers render their decisions.
A longer description of the film can be found here:
http://www.pbs.org/pov/wellfoundedfear/film_description.php#.UXMKyIJAtrY

*"Atlas of Torture: Use of Medical and Diagnostic Examination Results in Medical Assessment of Torture"*
By: Human Rights Foundation of Turkey
An extremely informative reference with many excellent illustrations and photographs, this will be a great resource for students learning to corroborate patients' histories with physical manifestations of torture such as scars. This would be a great resource for students to use when preparing to observe physical examinations in particular.

Available Online

"*An Update on WHO's Work on Female Genital Mutilation*"
By: World Health Organization
This article done by the WHO looks at data on the practice of FGC and shows the prevalence of the practice declining.
http://www.who.int/reproductivehealth/publications/fgm/rhr_11_18/en/index.html

"*Asylum Grant Rate Following Medical Evaluations of Maltreatment among Political Asylum Applicants in the United States*"
By: Lustig, Stuart L., Kureshi, Sarah, Delucchi, Kevine L., Iacopino, Vincent, Morse, Samantha C. Journal of Immigrate and Minority Health.
This study evaluated the asylum grant rate among US asylum seekers who received medical evaluations from Physicians for Human rights in comparison to those who did not.
http://www.springerlink.com/content/r0g61557tn547086/

"*Brain Structural Abnormalities and Mental Health Sequelae in South Vietnamese Ex-Political Detainees Who Survived Traumatic Head Injury and Torture*"
By: Mollica MD, Richard F et. al., Archives General Psychiatry. 2009; 66(11): 1221-1232
A pilot study of South Vietnamese ex-political detainees show that structural defects in prefrontotemporal brain regions are linked to THI exposures.
http://archpsyc.jamanetwork.com/article.aspx?articleid=210410

"*Coercive US Interrogation Policies: A challenge to medical ethics*"
By Rubenstein JD, Leonard
This article looks into the DoD ethical guidelines of medicine and how it creates a loophole for physicians to facilitated and monitorabusice interrogation practices and subvert ethical duties to support health and human dignity.
http://jama.jamanetwork.com/article.aspx?articleid=201572

*"Country of Origin Information (COI) Experts"*
By: Fahamu Refugee Legal AID Programme
The Fahamu Refugee Legal AID Programme compiles the COI Experts by their country of expertise in alphabetical order by country name.
http://www.frlan.org/content/country-origin-information-experts

"*Detention of Immigrants: Enforcements, Non-Compliance, and Punishment"*
By: Dr. Dan Wilsher
Global Detention Project and the Programme for the Study of Global Migration presents Dr. Wilsher, author of Immigration Detention: Law, History, Politics, in a lecture on the perils of detention.
http://www.globaldetentionproject.org/de/publications/newsletter/public-event-8-march-2012.html

"*Eliminating Female Genital Mutilation: An interagency statement*"
By: OHCHR, UNAIDS, UNDP, UNECA, UNESCO,UNFPA, UNHCR, UNICEF, UNIFEM, WHO
As a call to States, organizations on the national and global level, and to societies as wholes to uphold the rights of females around the globe.
http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf

"*Guidance for adjudication Lesbian Gay, Bisexual, Transgender and Intersex (LGBTI) Refugee and Asylum Claims*"
By: Refugee, Asylum, and Internatinoal Operation Directoratate (RAIO). U.S. Citizenship and Immigration Services.
http://www.uscis.gov/USCIS/Humanitarian/Refugees%20&%20Asylum/Asylum/Asylum%20Native%20Documents%20and%20Static%20Files/RAIO-Training-March-2012.pdf

"*How Unsettled Policy and Current Laws Harm Women and Girls Fleeing Persecution*"
By Tahirih Justice Center
In conjunction with the organization's mission to promote justice for women and children seeking asylum in the US, the Tahirih Justice Center's work exposes the continual injustice done to women looking to find safety in America.
http://www.tahirih.org/site/wp-content/uploads/2009/10/tahirihreport_precariousprotection.pdf

"*Human Rights and Refugee Protection*"
By UNHCR
Developed by UNHCR, this is a self-study module that was created with the intent of use to provide protection and assistance to those who provide protection and assistance to refugees and other persons of consern to UNHCR.
http://www.unhcr.org/45a7acb72.html

"*Istanbul Protocol*"
By United Nations
The Istanbul Protocol is a manual developed by the United Nations on the effective investigation and documentation of Torture and other Cruel, Inhuman or degrading treatment or punishment.
http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf

"*Knowledge and quality of life in female torture survivors, building health-related knowledge and quality of life through health promotion and empowerment strategies among female expatriate torture survivors*"
By: Wendy Pabilonia, RN, WHNP, DNP, Sarah P. Combs, RN, MPH, PhD & Paul F. Cook, PhD
As a pilot study done to evaluate the effectiveness of an education and interactive women's health-based programme.
http://www.irct.org/Files/Filer/TortureJournal/20_01_2010/Knowledge%20and%20quality.pdf

"*Photographic documentation, a practical guide for nonprofessional forensic photography*"
By Önder Özkalipci, MD & Muriel Volpellier, MD.
Informational article on when and how to take pictures when documenting torture developed by the International Rehabilitation Council.
http://www.irct.org/Files/Filer/TortureJournal/20_01_2010/Photographic%20documentation.pdf

"Supporting Interventions after Exposure to Torture"
By: Brigitte Lueger-Schuster, PhD
This study looks to understand the coping mechanisms as a result of torture to provide supporting interventions that are productive for the survivor.
http://www.irct.org/Files/Filer/TortureJournal/20_01_2010/Supporting%20interventions.pdf

## Acknowledgements

Faculty Advisory Board:

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Elisa Mceachern: Continuing care case manager
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Pfizer, for Major Depressive Disorder and Generalized Anxiety Disorder Evaluation Scales

The National Institute of Health, for Post-Traumatic Stress Disorder Evaluation Scales

Dr Z. Nasreddine, for the Montreal Cognitive Assessment