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AUTHOR	Westermeyer, Joseph; And Others
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ABSTRACT

This paper, the second in a series, focuses on the content of the diagnostic interview, in a clinical context, with refugee patients who have been victimized by physical violence. It is organized around a list of 11 introductory questions that will facilitate discussion of traumatic events in the patient's past. The questions focus on: (1) physical assessment; (2) adjustment to host country; (3) problems encountered in host country; (4) problems in country of first refuge; (5) flight from home country; (6) decision to leave home country; (7) life in home country; (8) experiences of purposeful mistreatment or torture; (9) subjection to threats or coercion; (10) wartime or combat experiences as civilian; and (11) wartime or combat exposure in military. In the discussion that accompanies each interview question, case histories are cited of common traumatic experiences that are unfamiliar to those who have never been refugees or war victims, and information is provided which may have clinical relevance either from a somatic perspective (e.g., central nervous system damage) or a psychosocial perspective (e.g., survival-oriented behavior inconsistent with previous personality). References are included. (TE)

Violence and Victimization in the Refugee Patient
II. Content of the Refugee Interview

Joseph Westermeyer, M.D., Ph.D.

Chanbo Keo, B.S. Candidate

Karen Wahmenholm, M.D. Candidate

Technical Assistance Center/Refugee Mental Health
Assistance Program, NIMH-ORR

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CONTENT OF THE REFUGEE INTERVIEW

This paper has been organized with the following purposes in mind:

-- To provide a list of several introductory questions that will facilitate discussion of traumatic events, if present;

-- To list examples of common traumatic experiences, so that the clinician will have been alerted to events which are generally unfamiliar to those who have never been refugees or war victims;

-- To orient the clinician to the kind of information which may have clinical relevance either from a somatic perspective (e.g., central nervous system damage) or a psychosocial perspective (e.g., survival-oriented behaviors inconsistent with previous personality).

This is not an exhaustive list. Further discussion of the relevant events and personal responses to them depend upon possessing basic clinical skills. The interviewer must be familiar with the following:

-- Interview and therapy techniques: facilitation, clarification, ventilation, support, reassurance, education, use of silence, confrontation, interpretation (Bates 1972, Enelow & Swisher 1972);

-- Interviewing patients with certain personality types, clinical conditions and psychiatric diagnoses (MacKinnon & Michaels 1971, Bird 1973);

-- Phasing this type of interview, or parts of it, at an appropriate point in the assessment and/or treatment.

1. Physical assessment is essential in evaluating the refugee patient. Somatic disorders may precipitate or masquerade as psychosocial problems. Examples which we have encountered include the following:

-- brain damage from war injuries, beatings, torture, malnourishment, or untreated infections;

-- parasitic or fungal diseases, such as tuberculosis, lung flukes, amebic abscess, intestinal parasites;

-- occult neoplasms, such as hepatoma, cranio-pharyngioma, lung cancer;

-- genetic disorders, such as certain hemoglobinopathies;

-- development of new "diseases of civilization" formerly unfamiliar in the country-of-origin, such as obesity, diabetes, hypertension, coronary artery disease;

-- maladies related to new climate, such as ichthyosis, rheumatic pains in colder climates, frostbite, sinusitis.

Complete psychiatric assessment must also be undertaken, much as with any other patients. Since emotional, mental, and behavior symptoms may not be volunteered, they must be inquired after. Refugee patients frequently present with somatic symptoms,but do endorse psychobehavioral if these are present. Use of one or more of the routine interview schedules can help with this process (e.g., Hamilton Depression and Anxiety Scales).

2. "Tell me about your adjustment so far to this country." An in-depth social, cultural, linguistic and religious history should be taken so as to assoss the patient's social adjustment and acculturation. Recreational activities in the expatriate community and the mainstream society should be listed. Efforts at learning the local language should be compared against actual language acquisition. Does the patient have any American friends? The Mini-Mental State exam can be used to assess spelling, identification of objects in English, enunciation, reading skill, and the ability to understand simple directions in English (although the Mini-Mental Scale has poor validity with those having eight or fewer years of education and those over age 65 years). Orientation to time and place in local terminology can also be informative, but the clinical value of these is poor with illiterate patients.

3. "What problems have you encountered in this country?" Refugees are frequently placed in neighborhoods or communities that have high crime rates. It requires time to learn "survival skills" and so avoid victimization in the new resettlement culture. Cases are encountered in which people have traumatic, stressful, or negative experiences in the U.S. Some causes of stress are due to physical violence: beatings, muggings, assault, rape, homicide. Vandalism or theft can precipitate feelings of vulnerability, insecurity, PTSD and major psychiatric disorde . Refugees may experience prejudice against their culture and religion, including attempts at isolation from their cultural peers and religious "brain washing". As acculturation proceeds at different rates within the community and the family, conflict with one's own cultural peers can appear. Psychopathology within the family can lead to victimization.

-- After a decade in the U.S., a highly acculturated refugee developed paranoid delusions about his wife's

sexuality. He accused her publicly of having sex with strangers, their friends and family members. Several times a day he insisted on examining her underwear, pudendum and vaginal secretions for "evidence" of having intercourse with other men. Several of his male relatives were enlisted to spy on her while at work or shopping trips. Despite lack of any evidence of infidelity, he beat her severely on several occasions "to force a confession". She submitted to these beatings and spying in the hope that her psychotic husband would eventually become convinced of her morality. When he did not become so convinced, and the accusations and behaviors became more bizarre and dangerous, she developed a major depression requiring treatment. Once separated from her husband, she responded rapidly to treatment for depression.

-- A 68 year old Vietnamese widow presented with confusion and depression. Both of her adult sons were drinking and abusing drugs heavily. They abused their mother verbally and physically, stole her meager income, and brought drug-using friends into the home. Social services were alerted about her being a vulnerable adult. One son left the home, and the other entered treatment. The woman then responded well to treatment.

-- A 38 year old Lao widow presented with major depression. The eldest of her eight children, a 17 year old boy, was stealing from her in order to purchase alcohol and cannabis for himself and a 15 year old brother. The two sons threatened her with physical violence on several occasions, and were terrorizing the household. Placement of the sons in two foster homes, followed by treatment of mother and the two

sons, resulted in recovery and eventual reuniting of the family.

-- A 62 year old Hmong man was admitted to urology with a severe hematoma on the testicle, following a beating by his wife (who was a decade younger and considerably larger). Both partners were found to have melancholic depressions. Although they had gotten along well in Laos for over three decades, constant togetherness at home resulted in severe conflicts. Following treatment for depression, each was able to become involved in separate activities outside the home on a regular basis (i.e., gardening, fishing, babysitting, church activities, light wage work).

Stresses may also be imposed by the host culture, as in this case:

> A 34 year old married Hmong man was brought in from an outstate rural hospital for assessment following a recent serious suicide attempt. His family had been placed in a small farming village under the sponsorship of a fundamentalist church. The family, animistic in their belief, had been told that they were "pagans" and "heathers". They were told that they should not listen to music on the radio or own a television. Their mail was opened and read before they received it. Although the man's cousin arrived later from Asia, he was told not to have contact with "pagans". During orientation the patient had been instructed about English language and vocational training; but his sponsors told him that he

was "too old" for training. The sponsoring pastor, who accompanied the patient to the interview, told the treatment team that the man was "possessed by the devil" and should be exorcised. The patient responded well to initiation of tricyclics in his local hospital, later outpatient care at our facility, and milieu change to a larger Hmong expatriate community in which his cousins resided.

4. "Were there any problems in the country of first refuge?" Once refugees leave their own country, their fear and threat of attack or arrest usually abate. Ordinarily they are welcomed, registered, and brought to a relocation center, where nutrition and shelter are provided. This is not always the case, however. In some situations, local citizens, border guards, or the police may prey on refugees. Reports of robbery and rape are frequently encountered among patients fleeing into certain countries or along certain ocean routes. Once refugee camps are well established, nutrition, shelter, immunizations and medical care range from adequate to exceptional. In early crisis stages, however, this is often not the case. Infants and young children can sustain permanent brain damage from malnutrition, poor sanitation, exposure, epidemics, malaria, untreated fevers and other adverse conditions. Grief, loss, depression and sociocultural isolation may not receive attention, with consequent family discord, divorce and suicide. If security is not provided for in the camp, corrupt guards and refugee gangs can perpetrate theft, rape and even homicide. The following exemplify such problems:

-- An 11 year old Hmong orphan had been placed out of his home because his grandparents had been beating him on the soles of his feet with a piece of bamboo. The boy had been oppositional and disobedient to his grandparents and eldest sibling, inattentive at school,

borderline-to-failing grades, mean to a younger sibling, had poor self image, preferred to play with girls and younger children, and was 40% overweight. He had been fourteen months old (the youngest of four children at the time) during flight. Nutrition during flight and in the refugee camp remained poor for several months, with much rice but few fruits, vegetables or meat. He sustained a prolonged high fever for over a week, during which time he had several episodes of prolonged and repeated convulsions. Exam and testing demonstrated attention deficit disorder with hyperactivity; I.Q. was 119. The older three siblings (all exposed to the same nutritional problems, but at an older age) and a later-born sibling did not manifest these difficulties.

5. "Tell me about the flight out of your country." As with pre-flight life history and rationales to flee, information about the flight itself is often not sought by clinicians who see it as "too private" or "irrelevant" or "I assume it was stressful". Unresolved or delayed grief, guilt, shame, post-traumatic stress syndromes, organic brain damage and other conditions may be related to the flight experience. For some, the flight itself may be relatively brief and safe (even when motivated by fear and accompanied by a sense of great loss). For others, flight is long, dangerous and replete with violence and loss. Sources of violence include military units, border guards, police, bandits, pirates, and land mines. Dehydration, starvation, illness and injury during flight may also cause death, or disability in survivors. Examples of flight-related problems are as follows:

-- A 15 year old unaccompanied Hmong male was brought for evaluation of cannabis abuse. Two years previously, his father, mother and three siblings had entered the Mekong River together (along with fellow

villagers), with border guards in pursuit. During the long swim across the river, he had seen both of his parents and all of his siblings shot. He merged as the only surviving family member, and was taken in by relatives of another clan. There was no funereal ritual, and the patient manifested no grieving at the time. His cannabis smoking began at that time in the camp and continued after his arrival in the U.S.

-- A 40 year old Hmong woman and her 12 year old son presented with "family discord" between them, and "school failure" in the son. They had been evaluated at a primary care clinic and found to be "in good health". Flight history revealed that the entire family of five people had been intercepted at the border and beaten into unconsciousness by border guards, using rifle butts. Local Lao villagers observed the beatings and later rescued these two survivors (the father and two older siblings were dead). According to what they were told, both patients were unconscious for days and were not able to resume their flight into Thailand for several weeks. Skull x-rays in both patients revealed old skull fractures, and both patients had abnormal EEG's. On psychological testing, the boy indicated a normal I.Q. but scattered neuropsychological deficits. Further evaluation and testing demonstrated attention deficit disorder, without hyperactivity. The mother had a major depression, along with memory deficit, disinhibition and frontal lobe release signs consistent with frontal lobe syndrome.

6."Your decision to leave your country may be important to an understanding of your problem. How did you come to the decision to leave your country and go elsewhere?" Those

unfamiliar with refugees often assume that all or most refugees have left their country because of threat to life or freedom, that this decision has been made carefully and independently, and that the individual has consciously chosen to live in a society such as the U.S. Such assumptions may fall widely askew of the mark. Understanding the factors which led to flight is often important to understanding the patient's clinical problem. Many people have left their country for reasons which lead to subsequent disappointments (i.e., reasons such as higher education, economic advancement, or "an easy life"). The decision to flee may be made by others (e.g., village chief, clan elder, family matriarch or patriarch), so that the compliant but uncommitted follower later resents the uprooting. Flight decisions with lifelong implications may be made literally in minutes or even seconds, with subsequent regrets. Unlike many other types of migrants, refugees are typically leaving an undesirable situation in crisis rather than knowingly choosing to live in another country. Disappointment in the resettlement country commonly ensues. Examples of these are as follows:

-- A 34 year old Hmong man presented with a psychotic depression; mild mental retardation was also present. Accustomed to lifelong dependence on others, he had fled Laos with his wife and four children because his entire village was going to Thailand. He personally would have preferred to remain in Laos, but had no confidence in his ability to exist independently. Relocated as a nuclear family in a remote rural community, his condition rapidly deteriorated. He developed auditory hallucinations, nihilistic delusions and attempted to hang himself.

-- A 30 year old Lao man had fled a Soviet bloc European country where he was attending graduate school under the auspices of the communist government in Laos.

His plan was to join relatives in the U.S., who had sent glowing reports of their material acquisitions. Upon arriving in the western Europe, he learned that his educational certificates would not be recognized in the U.S. and that he would have to perform manual labor. He began to rue his decision to flee, as he would have occupied a high-status position had he returned to Laos. In addition, he learned that there was no opportunity for him and his wife and family to reunite with him in the foreseeable future. (This individual was interviewed in Austria, where he was an asylum seeker.)

-- A 19 year old unaccompanied Vietnamese man was seen for major depression, associated with angry outbursts and threats which had occurred at school and in his foster family. The patient had been sent out of Vietnam by his family to avoid the draft there. As the eldest and only son, he was expected to guide the future family fortunes. His parents feared that, in the army, he might die as had several male relatives. Without involving their son (at that time 17 years old) in the decision making, they had arranged for him to leave Vietnam by boat for Thailand.

7. "Tell me about your life in your home country." Frequently clinicians only ask about the refugee's life in the U.S., as though their life began upon reaching this country. This problem usually stems from two common but erroneous assumptions: the person's former life and pattern of adjustment has no relevance to their current condition; in any event, the interviewer will not be able to understand the data obtained. Neither assumption is necessarily correct. In order to assess refugees seeking mental health care, it is important to understand the person's life prior to migration. This

includes their family background, early adjustment, rural or urban residence, occupation, marriage, avocational interests, special clan and social roles.

Victims of psychological and/or physical mistreatment must not be viewed solely as "victims". That is only a part of their identity, and may not even be related to their current clinical condition. A thorough understanding of the individual is necessary to complete a clinical assessment, to set a realistic prognosis and expectation, and to plan an effective course of treatment. Vague responses should alert the clinician to the need for other sources of data, such as collateral sources of information, psychological tests, or neurological evaluation, as in the following case:

-- A 28 year old "Hmong" man working as a translator for a local social service agency presented with symptoms of anxiety and depression. He was vague about his background, did not appear to be Hmong, and did not speak English with a Hmong accent. Interview with Hmong elders revealed him to be a Thai man who had illegally entered a Hmong refugee camp in order to emigrate illegally to the U.S. for economic advancement. Interview with the patient confirmed this deception and led to further awareness regarding his problem. He was desperately unhappy in the U.S. and wanted to return to Thailand, but feared legal consequences by American and Thai authorities.

-- A 30 year old Lao man with major depression was vague about his pre-migration life. Interview with his wife and other relatives indicated that he had been a soldier in the communist army in Laos and had collaborated with the communist regime. Subsequently he fled Laos because he had antagonized

the authorities due to his numerous extramarital adventures and was facing legal censure. In the U.S. other Lao expatriates knew about his past history and shunned him. He had thus been unable to resume his "Don Juan" role, an activity and role highly valued by him.

8. "Have you ever undergone purposeful physical mistreatment or torture?" Rage, shame, loss of self valuation can be resurrected when recalling any adverse refugee experience, but may be especially severe if the individual has harbored their experience from others. It is not unusual to find that such victims have tried to tell their story to others, but have been rejected or abandoned or disbelieved. Inadequately managed, victims may develop a morbid identity with their own victimization, obstructing their eventual recovery and the redevelopment of a healthy self image. In undertaking such an interview, the clinician must be prepared to listen through to the end and not to abandon the patient in the midst of an emotional catharsis or abreaction.

Since more than one type of physical mistreatment has often occurred in such cases, it can be valuable to inquire specifically about other forms of mistreatment. Patients may report their worst subjective experiences, while ignoring or minimizing experiences more apt to leave permanent damage, especially to the central nervous system, the organ of psychosocial adaptation. As with all other areas, it is important to ascertain the repetitiveness or duration of these events, along with the patient's psychological response at the time, and currently. Examples of physical mistreatment employed against refugees during recent years have included the following:

-- humiliations (deprived of clothes, head shaven, public shaming);

-- beatings (hand, fist, foot, gun, club, rubber hose, bamboo cane,
metal pipe);

-- cutting or piercing (knife, blade, nail, ice pick, needles, wood or bamboo splinters);

--electrical current (to produce pain, spasms, burns, disfigurement);

-- burning (cigarettes, matches, coals, firebrands, iron pokers, petroleum products);

-- hanging (inverted, by arms or legs, dropping, joint dislocations);

-- oxygen deprivation (immersion of head in water or petroleum products, plastic over head, obstruction of mouth or nose by cloth or other object);

-- bondage (in ropes, irons, stocks, wire, sack, box, container; tying to others or tree or ground);

-- physical mutilation (dislocations of joints; amputation of digits, extremities ,tongue, teeth, lips,ear ,nose, eye, or genitalia; scarring, tattooing, scalping);

-- sexual abuse (pain or blows to sexual organs, sexual touching, rape, cutting or removing sexual organs);

-- contamination of wounds (dirt, grass, salty water, sputum, feces);

-- exposure to elements, temperature extremes (dehydration and hyperthermia in sun, immersion dermatitis and hypothermia in water or rain);

-- exposure to harmful animals (red ants, mosquitoes, leeches, mice, rats, dogs);

-- nutritional deprivation (restriction of fluids, calories, protein, minerals, vitamins; e.g., pellagra, anemia, maramus, corneal ulcer from hypocarotenemia, Wernicke syndrome, beri-beri);

-- forced overexertion (prolonged work, forced marches, inadequate rest, exertion inappropriate for age or physical condition -- such as pregnant, postpartum, ill, young or elderly);

-- exposure to unhygienic conditions (dirty clothes, no bathing, or bathing in dirty water, inadequate sanitation, clothing, housing, medical care).

9. "Were you ever subjected to threats, political imprisonment terror or the harming of others? Did you have to do things that you did not want to do in order to survive?" Refugees have often been enjoined from participating in family gatherings or rituals, religious ceremonies, and cultural celebrations. Removal from one's intimate social network from being sent away by authorities, becoming lost in the midst of chaos, or being rejected by peers (and sometimes even by family). Exposure to violence being meted out to others (i.e., beatings, rape, execution) can be especially intimidating, leading to armed opposition or flight (and sometimes both, flight occurring when armed opposition has proven fruitless). Other direct intimidations include mock executions, and threats to harm oneself, one's family, or friends. Incarceration may ensue due to religious belief,

political preference, occupation, education, race, ethnicity or family affiliation. Prisoners may be arrested without warrant, held without charges or a preliminary hearing, tried without expert defense or even attendance at the court proceedings, sentenced without a trial, and deprived of communication with family or friends. Imprisonment may involve unhygienic, crowded or isolated conditions.

The individual may have been forced to engage in morally odious behaviors. Examples include lying, stealing implicating others, deciding on one's own survival versus that of a valued other person, and aiding oppressors in their abuse of others. The duration or repetitiveness of these events, together with the person's emotional response at the time and now, should be pursued.

10. "Were you ever affected by wartime or combat experiences as a civilian noncombatant?" Loss of home, occupation, social network, and material possessions occurs to virtually all refugees, albeit with differing emotional impact and accommodation. Other experiences are more variable. In some cases an attack or occupation was threatened or imminent; others have been exposed to attack or enemy occupation. Injuries and loss of friends or family may have occurred. Refugees may have had to abandon family or friends during flight, leaving them ill, wounded, or (if deceased) unburied or without funereal rituals, as in this case:

> A 29 year old Hmong refugee presented with opium addiction, major depression, and nightmares regarding his nephew. He and his nephew (as former soldiers) had alternated as the point for a column of villagers leaving Laos for Thailand. In a remote mountainous area, the nephew set off a land mine while

walking point, blowing off his foot and lower leg. They decided that it would not be feasible to carry him out of the mountains to a hospital. Accordingly he was left with a small supply of water, food, and a weapon, anticipating that he would die of his injury within some days.

Burying loved ones at sea, leaving deceased family members unburied during urgent flight, watching helplessly while a beloved relative starves, leaving dying parents or children along a forest pathway: such themes are frequent among today's refugees.

11. "Were you ever affected by wartime or combat exposure as a member of the military, militia, partisans, or guerilla fighters?" Latter PTSD is often related to deaths of comrades- in-arms, injuries to self, assignment to burial details, identifying corpses of dead comrades; or killing the enemy (especially in personalized or isolated face-to-face conflicts). Group experiences may also be important, especially when these involve abandonment or unnecessary loss: i.e., losses due to poor leadership, being overrun or defeated, being abandoned by elders or other military units, as in this case:

A 45 year old Hmong developed a major depression in the U.S., accompanied by PTSD. Early in the war with the Vietnamese his militia unit (successful in home defense) had been activated as a military unit. During a deep penetration into enemy territory, they stopped to bivouac in an area without setting up outposts or a defensive perimeter. Within hours they were surrounded, attacked, and

about half the unit was killed immediately. Shot in two places, he survived and was able to return to safety. In association with onset of his depression, he began to have nightmares about the battle along with ghost fear focused on dead comrades. He also developed uninvited homicidal ideas towards the officer who led them into the ambush; this officer was a member of his current expatriate community.

Prolonged assignment to combat or to remote isolated outposts can result in unsoldierly conduct, later giving rise to shame or guilt. Death of personnel under one's command can also result in later PTSD, as in this case:

A 29 year old Hmong developed a major depression following his being laid off from a job which he had held for three years. In association with his depression, he also began to experience (1) ghost dreams of specific dead soldiers formerly in his small unit (as a sergeant, he had led a squad of ten men), and (2) pain in about a third of his 50-some shrapnel injuries (with no pain in the others). He had sustained the painful shrapnel injuries at age 19, at the first battle in which he had a command position. While not life- threatening, his injuries led to his removal from the scene of the battle. During the subsequent fight, half of his men (all young teenagers, aged 14 to 17) were killed and half were severely injured. He felt personally responsible for their deaths since he had been unable to remain with and lead them through the battle. He also experienced

some "survivor guilt" in that he had survived the battle and so many others had not.

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