VULNERABILITY

IN THE CANADIAN REFUGEE DETERMINATION ARENA:

AN INTERPRETIVE DESCRIPTION STUDY

by

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Abstract

This exploratory study utilized Interpretive Description, an applied qualitative methodology, to investigate the manner in which the concept of vulnerability is currently understood and intervened upon within the refugee determination arena in Canada. Consistent with Interpretive Description, this study generated qualitative data from multiple sources, which were theoretically and purposively selected. Four distinct source groups provided data at different levels of analysis: government documents and qualitative interviews with officials offered insight into the systemic level, key professional informants provided access to the organizational level, recent refugee claimants provided information on the individual level, and the collected documentation of a small number of refugee claims provided examples of particular instances, while providing insight into the refugee determination arena as a whole.

In the context of Canadian refugee determination, 'vulnerability' refers to factors that impede access to a fair hearing and the risk of retraumatization. This study provides a rich and timely description of aspects of identity and experience that give rise to vulnerability for refugee claimants and the institutional and community-based practices that can exacerbate or mitigate risks for harm. Three key findings can be distilled from this study: vulnerability is conceptualized according to essentialized characteristics of refugee claimants, there is variation between professional conceptualizations of vulnerability, and there are barriers to implementation across the refugee determination arena. I argue that a mis-attribution of harm to the individual/intrapsychic rather than to the systemic domain, a lack of integration of the psychological knowledge base that underpins the concept of vulnerability, and systemic barriers to implementation result in less than optimal protection for refugee claimants.

Preface

This dissertation is original, unpublished, independent work by the author, Kirby Huminuik. The research was approved by the University of British Columbia's Behavioural Research Ethics Board (Certificate # H13-02636).

Table of Contents

List of Tables

Acknowledgements

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Dedication

Dedicated to those who are forced to leave their homes to seek protection.

No one leaves home unless home is the mouth of a shark.

Warsan Shire

The earth was born yearning to be a home for everyone.

Eduardo Galeano

Chapter 1: Introduction to the Study

The words ‘refugee’ and vulnerable’ both capture a conceptual sense of risk, fear, and potential harm. In the context of refugee determination, the concept of vulnerability has particular mental health and policy implications. With this study, I investigate the concept of ‘vulnerability’ and how it used within the in-country refugee claim process in Canada. I seek to understand how vulnerability is understood and intervened upon throughout the refugee determination ‘arena’ -- which includes the policies and procedures of the Immigration and Refugee Board (IRB) at the governmental level; professionals who provide services for refugee claimants such as refugee lawyers, health care professionals, and agents of non-governmental organizations at the community level; and at the individual level with the experiences of refugee claimants themselves. This is an exploratory qualitative study, using data from multiple sources to generate applied knowledge for an interdisciplinary audience of scholars and practitioners that is concerned with the well-being of refugees.

This study focuses on refugee determination process, which is an emergent focus of research within the refugee mental health field. As the study is grounded in a counselling psychology perspective and uses an applied health research approach to inquiry, there are areas of knowledge that are relevant to the understanding of the concept of vulnerability that may be less familiar to applied psychology or health research audiences. This introductory chapter, therefore, situates the research problem and the research questions in the context of the Canadian refugee determination process. In the following chapter, the literature review provides an integrated overview of the interdisciplinary knowledge base that is relevant to the research problem.

Background

As this document was being written, the world was experiencing the most severe refugee crisis since World War II, with more than 60 million forcibly displaced people in need of protection as a result of armed conflict or the deterioration of security and human rights protections in numerous countries (United Nations High Comissioner for Refugees [UNHCR], 2015). As one of 148 United Nations member states to have ratified the 1951 Geneva Convention relating to the Status of Refugees, Canada is obligated under international law to provide asylum for persecuted and stateless people (UN General Assembly, 1951). Section 96 of the Canadian Immigration and Refugee Protection Act sets out this definition of a Convention Refugee:

> 96. A Convention refugee is a person who by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion,
>
> (a) is outside each of their countries of nationality and is unable or, by reason of that fear, is unwilling to avail themselves of the protection of each of those countries, or
>
> (b) not having a country of nationality, is outside their country of former habitual residence and is unable or, by reason of that fear, unwilling to return to that country. (Immigration & Refugee Protection Act, 2001)

There are different ways that people fearing persecution can obtain Canada's protection. People who have fled their country and who meet the definition above may be referred for resettlement to Canada by the United Nations or they may be sponsored by a group within Canada (Government of Canada, 2017). People who fear persecution may also arrive directly at a Canadian border and apply for refugee protection inside the country (Government of Canada, 2017). These individuals, who are called 'refugee claimants,' are the focus of this study. They comprise a very small proportion of the world's displaced people; for example, in 2014-15

Canada registered 13,216 new refugee claim applications (Immigration and Refugee Board of Canada [IRB], 2016).

According to the definition above, refugee claimants must demonstrate that they would be subject to persecution should they be returned to their country of origin (UHCR, 2011). Persecution is understood as serious physical or mental harm, including acts of physical violence, torture, assault, beatings and deprivation of liberty resulting from unlawful arrest or imprisonment (UHCR, 2011). The agent of persecution must be the government or a non-governmental actor that the state cannot, or will not, protect against. A refugee claimant must also demonstrate that he or she cannot relocate safely to another part of his or her country, and has no right to claim refugee status in another safe country (UHCR, 2011).

When someone applies for refugee protection within Canada, they must submit evidence and appear before the Immigration and Refugee Board (IRB). The IRB was created in response to Canada's international obligations as a signatory to the UN Convention on refugees and because of its own constitutional obligations to protect the right to life and security of the person, and to protect against torture or other cruel, inhuman or degrading treatment (Dauvergne, 2012). The IRB administrates a quasi-judicial process whereby individuals who arrive in the country to make a refugee claim are provided a full oral hearing and must prove that they meet the legal definition of "Convention Refugee." Under the *Protecting Canada's Immigration System Act*, which was implemented on December 15, 2012, most refugee claimants must prepare written narratives in10-15 days after arrival in Canada, submit evidence within 30-45 days, and testify in hearings within 60 days (Canadian Council for Refugees [CCR], 2012).

The definition of a Convention refugee is forward-looking, which means that it does not rely on persecution in the past and claimants must demonstrate that they have objective reasons

to fear persecution in the future. However, evidence relating to past persecution may be considered as the foundation of present fear (Immigration and Refugee Board of Canada [IRB], 2010). Research demonstrates that traumatic events in a refugee claimant's past (which are likely among the central motivations for fleeing his or her homeland and seeking refugee protection) can have lasting mental health consequences (Fazel, Wheeler, & Danesh, 2005; Kirmayer, 2016; Kirmayer et al., 2011; Mollica et al., 2014; Rousseau & Drapeau, 2004; Rousseau, Pottie, Thombs, Munoz, & Jurcik, 2011; D. Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Steel, Chey, Silove, & Marnane, 2009). Clinicians advocating for refugee claimants in Canada have long been concerned that trauma-related mental health sequelae may impact a claimant's ability to provide evidence of past persecution (Cleveland, 2006). Refugee advocates and mental health professionals in Canada appealed to Canadian immigration authorities prior to 2006 to adopt policies to meet the needs of psychologically vulnerable asylum seekers (Cleveland, 2006).

It is incumbent on a nation that has ratified the UN Convention on refugees to uphold its international commitment to provide protection for persecuted people, and this includes protecting their right to a fair and just hearing of their claim by appropriately addressing vulnerability. Accordingly, the IRB implemented a set of guidelines, entitled "Guideline 8: Guideline on Procedures with Respect to Vulnerable Claimants Appearing Before the IRB," (hereafter referred to as 'Guideline 8' or 'the guidelines'). These are intended to ensure a fair hearing and protect vulnerable claimants from further mental and emotional harms (IRB, 2006).

Guideline 8 provides special accommodations for claimants who are identified as vulnerable and is intended to ensure the consistency, coherence and fairness of the refugee determination process (IRB, 2006). The guideline defines "vulnerable persons" as those whose

ability to present their claim is “severely impaired” and who may be experiencing “mental illness,” or be minors, elderly, victims of torture, survivors of genocide and crimes against humanity, women facing gender-based persecution, and people fearing persecution on the basis of the sexual orientation and gender identity. The objectives of Guideline 8 are to 1) recognize that certain individuals face particular difficulties when they appear for their hearings or other IRB processes because their ability to present their cases is severely impaired, 2) ensure that vulnerable persons are identified and accommodated appropriately, 3) prevent vulnerable persons from becoming traumatized or re-traumatized by the hearing process or another IRB process, and 4) ensure the ongoing sensitization of members and other hearing room participants to the impact of severe vulnerability (IRB, 2006). The guidelines set out a number of procedural accommodations to meet these objectives.

These guidelines only apply officially to the divisions of the Immigration and Refugee Board; however, a broad multi-disciplinary network of professionals (including refugee lawyers, mental health professionals, settlement workers, physicians, housing providers, and advocates) have the potential to address the concept of vulnerability in the context of supporting refugee claimants on arrival in Canada and throughout the refugee determination process. These various professionals can also contribute directly to the application of the Guidelines by identifying potentially vulnerable claimants, alerting authorities about vulnerability concerns, applying for formal vulnerability status, recommending appropriate accommodations, and providing material assistance and psycho-social support to reduce vulnerabilities. Given that an expert report is one of the ways to establish vulnerability, members of the mental health professions have a particularly relevant knowledge base from which to highlight issues related to vulnerability and to ensure respect for claimants’ rights to a fair hearing.

While professionals of varying disciplines may engage with the concept of vulnerability, there is very little information to help them understand what makes claimants vulnerable, how to identify vulnerable claimants, how to support them, and how to determine what accommodations are likely to be most effective. Other than the guidelines themselves, and Cleveland's (2006) critical overview released shortly after Guideline 8 was implemented, there no consolidated knowledge base for professional decision-making in this area. Furthermore, with significant changes to the Canadian refugee determination system that were introduced on December 15, 2012 with the coming into force of the 'Protecting Canada's Refugee System Act' (Statutes of Canada, 2012), no new research has been conducted to investigate how the concept of vulnerability is currently being understood and intervened upon. The aim of this study is thus to understand how this interdisciplinary concept is understood and intervened upon throughout the refugee determination arena, and to what effect.

Research Problem

Given concerns about the high prevalence of trauma-related mental health sequelae among refugee populations (Fazel et al., 2005; Kirmayer, 2016; Kirmayer et al., 2011; Mollica et al., 2014; Rousseau & Drapeau, 2004; Rousseau et al., 2011; D. Silove et al., 1997; Steel et al., 2009), the potential impact of these on testimony (Herlihy & Turner, 2007a, 2007b; Derrick Silove, McIntosh, & Becker, 1993; Steel, Frommer, & Silove, 2004), and the duty of a signatory to the UN Convention on Refugees to provide a fair and just hearing of a claim (Dauvergne, 2012), the government of Canada has implemented a set of guidelines to address 'vulnerability'. A wide range of professionals, including mental health professionals, may utilize this concept in their work of supporting refugee claimants and may contribute directly to the implementation of the guidelines; however, other than these policy guidelines there is no consolidated body of

knowledge to inform such activity. Mental health professionals, in particular, may be called upon to offer professional opinions in vulnerability designations or make recommendations regarding accommodations and there is no current Canadian literature to guide such specialized clinical decision-making.

Purpose of the Study

This study proposed to:

1. Produce descriptive knowledge about one aspect of the refugee determination experience that can be used by an interdisciplinary community of practitioners to promote the well-being of a marginalized and highly diverse population. For counsellors and psychologists who work with refugee claimants in particular, this study will fill a critical gap in the knowledge base. Consistent with the mandate of counselling psychology, which is characterized by a focus on mental health concerns, the distress and difficulties associated with life events and transitions, multicultural and sociocultural dimensions of psychology, as well as prevention, psycho-education, and advocacy (Canadian Psychological Association, 2009), this study proposes to provide applied information that can guide mental health professionals who are working in the context of the refugee claim process.

2. Contribute to scholarship in counselling psychology and the interdisciplinary areas of refugee mental health and migration studies. In describing the mental health implications of a particular policy context that impacts a distinct and important population that is not well represented within counselling psychology research, this study will make a unique contribution to counselling psychology scholarship. This study will also contribute to scholarship in the interdisciplinary areas of refugee

trauma and migration studies by describing how vulnerability is defined, recognized, and addressed by claimants, adjudicators, and other actors in the newly streamlined Canadian refugee system.

Research Questions

The Research Questions are:

1. How is "vulnerability" conceptualized within Canada's refugee determination arena?

2. How are systemic practices enacted with respect to vulnerability?

Assumptions

Two assumptions underlying the study's purpose, questions and design were: (1) the construct of vulnerability is conceptualized and intervened upon within a complex systemic arena comprised of a legal framework, policy guidelines, the knowledge and practices of officials, professionals, and advocates, and the experiences of claimants, and (2) data from these multiple sources are necessary to define, describe and interpret how practices related to vulnerability are enacted within the refugee determination arena. The philosophical assumptions fundamental to the study's design are discussed in Chapter 3.

Organization of the Dissertation

In this chapter I have provided an introduction to the context from which the research problem emerges. Chapter 1 has also defined the problem, the purpose, the questions and the assumptions underlying the research. Consistent with the Interpretive Description approach to inquiry, Chapter 2 departs somewhat from the traditional literature review in its presentation of what is termed the 'theoretical scaffolding' (Thorne, 2008; Thorne, Kirkham, & O'Flynn-Magee, 2004). The theoretical scaffolding is comprised of two parts: first, the review of the literature, which situates the study within its empirical and theoretical context, and second, an explication

of the theoretical fore-structure, which is conceptualized as comprising the main intellectual, disciplinary and personal influences perceived as relevant to the researcher as the study commenced. Chapter 3 addresses methodological issues pertinent to this study. In this chapter, the Interpretive Description method is explained, the study is located within a constructivist-interpretivist paradigm of scientific inquiry, the design of the study is described, ethical issues are discussed, and the criteria for evaluating the trustworthiness of the study's findings are presented. In Chapter 4, findings are presented that answer the research question at a descriptive level. In Chapter 5, these findings are interpreted with attention to practice and policy implications. The limitations of the study and a concluding summary are also provided in the final chapter.

Chapter 2: Theoretical Scaffolding

A defining characteristic of Interpretive Description is the manner in which a researcher 'scaffolds' the study and establishes her intellectual position prior to beginning (Thorne, 2008). With this 'theoretical scaffolding,' a researcher with practical experience within the context in which a problem of inquiry is embedded considers what is known and not known in relation to the problem, as well as the disciplinary and theoretical assumptions and values that shapes the researcher's initial understanding of the problem. Thus there are two elements to the theoretical scaffolding: a review of the literature and a self-reflexive piece, termed the 'theoretical fore-structure.'

The first element of the theoretical scaffolding is a review of relevant bodies of literature with the objective of establishing the merit of the study and presenting the 'state of the science' in relation to the clinical problem of concern. According to Thorne, the kind of literature review that best supports an Interpretive Description "grounds the study in existing knowledge, offers critical reflection on what exists and what does not, and offers commentary on the strengths and weaknesses of the overall body of knowledge" (Thorne, 2008; p. 61).

In Interpretive Description the second element of the theoretical scaffolding functions very differently than the review of the literature. It is termed the 'theoretical fore-structure' and it is not meant to directly address literature on the research problem or form the foundation for later discussion of the findings. Rather it is the product of a preliminary self-reflexive process wherein the researcher elucidates the intellectual and experiential knowledge base that she herself brought to the study at its inception. This comprises the theoretical influences and conceptual perspectives that informed one's thinking about the research problem at the time the study was being developed, as well as an examination of one's location as a researcher, the disciplinary

foundations and personal values that had a part in shaping the direction of the project (Thorne, 2008). Consistent with a social constructivist approach, this self-reflexive exercise complements the literature review by offering the reader some insight into theoretical influences and personal values that inspire and motivate the researcher to address the particular problem and anticipates how this may influence design decisions. These influences are not to be "bracketed" in Interpretive Description and it is important that they be explored and declared in advance so that they are transparent to the researcher and the reader (Thorne, 2008).

Review of Consequential Literature

Because there is no body of literature that directly addresses the current research question, a study focusing on the concept of vulnerability and an understanding of the systemic practices related to this concept requires a broad interdisciplinary overview of the current state of research. The primary thematic areas of literature and documentary information that will be reviewed for this study are 1) the mental health impact of traumatic events, 2) trauma-focused psychiatric epidemiology in refugee populations 3) critique of trauma-focused psychiatric epidemiology, and 4) the interaction between trauma and testimony in the refugee determination system.

Given that refugee populations experience a high prevalence of PTSD and this concept is implicit in the way the Guideline on vulnerability (IRB, 2006) defines vulnerability, an overview of PTSD research was indicated. The review narrows to focus on the research in refugee mental health, which is demonstrably dominated by trauma-focused psychiatric epidemiology. One section of this area of review is devoted to critiques of PTSD research in refugee populations that demonstrate the need for exploratory research of other facets of refugee mental health. The review moves from this summary and critique of the general state of the science toward a

focused examination of the small number of studies that address the research problem in the context of refugee determination in Canada and internationally. This small body of research establishes the existence of an on-going scientific dialogue, within which there is more to be known, and to which this study will contribute. The review explicates the current state of knowledge in this field and concludes with a rationale for the conceptualization of the problem and research questions of this study.

The Mental Health Impact of Traumatic Events

The construct of Post Traumatic Stress Disorder assumes a central focus in research related to refugee mental health. It is also a concept that is implicitly foundational to 'Guideline 8: Guideline on Procedures with Respect to Vulnerable Claimants Appearing Before the IRB' (Cleveland, 2006; IRB, 2006). Accordingly, a study on the concept of vulnerability and an understanding of the systemic practices related to this concept, requires a broad overview of the current state of research in the area of Post Traumatic Stress Disorder. In this section I will situate PTSD in socio-historical context, provide the diagnostic criteria for PTSD as defined in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2013), and discuss the epidemiology and etiology of PTSD. This section is not meant to provide an exhaustive review, but presents highlights of some foundational sources in the literature on PTSD that will begin to situate the current study within a socio-historical context and the current state of the science.

Trauma in socio-historic context. Traumatic events happen in the normal course of human life and most people recover without becoming distressed or dysfunctional over the long-term (Frazier, 2011; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). While there is a long history of literary and scientific observations on the effects of exposure to overwhelming danger,

the construct of Post Traumatic Stress Disorder has emerged and been formally recognized as a mental disorder only relatively recently (Friedman, Keane, & Resick, 2014; Pennington, 2002; van der Kolk, Weisæth, & van der Hart, 1996). One of the earliest associations between trauma and hysteria was noted by Briquet in 1859 (van der Kolk et al., 1996). And while clinicians in both World Wars described "shell shock" and "battle fatigue," attention to these experiences diminished significantly after the wars were over (Pennington, 2002). Formal recognition of PTSD as a mental disorder did not occur until it was included in the DSM-III in 1980, prompted in large part by the return of American soldiers from the Vietnam War (Herman, 1997; Nemeroff et al., 2006; Pennington, 2002). Throughout its history, research on trauma has focused primarily on combat experiences, however sizable bodies of research related to sexual and domestic violence and natural disasters, have allowed researchers to identify common features of symptoms and recovery processes across different populations and events (Herman, 1997). What distinguishes PTSD from other psychiatric disorders is the causal attribution and the central role of memory in the symptomology (Kirmayer, Lemelson, & Barad, 2007). Nevertheless, psychological reactions to traumatic exposure are highly heterogeneous, vary according to the idioms of distress within a given culture, and are expressed along a wide spectrum of severity and complexity (Briere & Spinazzola, 2005). Least severe/complex are adult-onset, single-incident traumatic events that occur to individuals who have experienced adequate childhood development, have a non-reactive nervous system, and no comorbid psychological disorders (Briere & Spinazzola, 2005). Most severe/complex expressions of the disorder occur in individuals who have experienced early onset, multiple, highly invasive traumatic events of an interpersonal nature, involving a significant amount of stigma or shame, and to those who are more susceptible to the effects of stress (Briere & Spinazzola, 2005). There

is a strong relationship between adverse childhood events such as exposure to abuse and family dysfunction and the illnesses which are the leading causes of death in adults (Felitti et al., 1998).

Definition of Post Traumatic Stress Disorder. PTSD (in adults, adolescents and children over 6) is defined in the DSM-V as the development of four types (or clusters) of symptoms, in response to exposure to an extreme traumatic stressor such as actual or threatened death, serious injury, or sexual violence (APA, 2013). Exposure can occur either as a direct victim, as a witness or a closely related person, or to extreme or repeated exposure to aversive details of a traumatic event. The first symptom cluster relates to intrusion symptoms such as recurrent, distressing memories or dreams with traumatic content, dissociative reactions, intense distress or physiological reactions to exposure to traumatic material. The second symptom cluster refers to persistent avoidance of stimuli, such as memories, thoughts, feelings, people, places, conversations, activities, objects or situations related to the traumatic event. The third symptom cluster refers to negative alterations in cognitions and mood associated with traumatic events, such as the inability to remember important aspects of the traumatic event, persistent negative beliefs about the self, others or the world, persistent, distorted cognitions about the cause or consequences of the traumatic events, persistently negative emotional state, markedly diminished interest or participation in significant activities, feelings of detachment or estrangement from others, and persistent inability to experience positive emotions. The fourth symptom cluster deals with alterations in arousal and reactivity, including angry or irritable behaviour, reckless or self-destructive behaviour, hypervigilance, exaggerated startle response, problems with concentration, and sleep disturbance. This disorder can occur with dissociative symptoms such as depersonalization in which a person feels detached from his or her own mental processes or body (for example, feeling as though in a dream), or derealization in which a person experiences

the world around as unreal or distorted. Symptoms of the disorder usually begin within the first three months after the traumatic event but their expression can be delayed months or even years (APA, 2013).

The criteria for posttraumatic stress disorder have been updated as of the fifth edition of the DSM, which was published in May 2013. There are some important differences from the DSM-IV. For example, the stressor criterion (Criterion A) is more explicit regarding how an individual experienced traumatic events, while Criterion A2 (subjective reaction) has been eliminated. There are now four symptom clusters, instead of three, as the avoidance/numbing cluster has been divided into two distinct clusters: avoidance and persistent negative alterations in cognitions and mood. The latter category retains most of the DSM-IV numbing symptoms, but also includes new symptoms, such as persistent negative emotional states. The final cluster—alterations in arousal and reactivity—retains most of the DSM-IV arousal symptoms but also includes irritable or aggressive behavior and reckless or self-destructive behavior (APA, 2013).

Epidemiology. Lifetime prevalence rates for individuals exposed to traumatic events ranges from 7-18% in large-scale epidemiological studies (Frazier, 2011). A frequently cited nationally representative study of adults in the United States, the National Comorbidity Study (NCS), found lifetime prevalence for PTSD in the United States of 7.8% (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Compared with U.S. whites, higher rates of PTSD have been reported among U.S. Latinos, African Americans, and American Indians, and lower rates among Asian Americans, after adjustment for traumatic exposure and demographic variables (APA, 2013). Lower estimates of around 0.5%- 1.0% are seen in Europe and most Asian, African, and Latin American countries (Hinton & Lewis-Fernández, 2011). Given the central importance of the issue of culture to the present study, a more thorough review on socio-cultural differences in

PTSD epidemiology will be provided in the subsequent section on culture and PTSD. The NCS found that women (10.4%) are affected about twice as often as men (5%). Numerous explanations have been offered for this discrepancy, including the nature of trauma that women and men are subjected to, with intimate partner abuse and rape leading to higher risk of PTSD (Nemeroff et al., 2006; Pennington, 2002). Social support and stigma are also likely to influence gender differences (Nemeroff et al., 2006). However, it has been suggested that gender differences may be negligible under conditions of extreme trauma exposure (Nemeroff et al., 2006). Data on socioeconomic status differences consistently show that people of lower socioeconomic status experience more frequent and more stressful traumatic life events than people of higher socioeconomic groups (Breslau et al., 1998; Frazier, 2011). Children and adolescents, including preschool children, have lower prevalence rates, which may either indicate that the prevalence of PTSD varies across development or that previous criteria were insufficiently developmentally informed (Scheeringa, Zeanah, & Cohen, 2011). The prevalence of full-threshold PTSD also appears to be lower among older adults, however there is evidence that sub-threshold presentations are more common in later life and that these symptoms are still associated with substantial impairment (Thorp, Sones, & Cook, 2011). Finally, PTSD is comorbid with alcohol abuse, depression, generalized anxiety disorder and/or panic disorder in 80% of adults who have the disorder (Pennington, 2002).

Etiology. While it was long assumed that traumatic exposure was the single causal factor in the development of PTSD, it is now clear that there are individual, including genetic, responses to trauma (Friedman et al., 2014; Pennington, 2002). Modest heritability has been found, leading researchers to conclude that PTSD fits the general diathesis-stress model (Pennington, 2002; True et al., 1993). Other risk factors include previous trauma exposure, lower

socio-economic status, lower social support, a pre-existing mood or anxiety disorder, a family history of such disorders, lower IQ, and the occurrence of dissociation at the time the traumatic event occurred (Briere & Spinazzola, 2005; Friedman et al., 2014; Pennington, 2002). Exposure to childhood trauma, in particular, is associated with more complex and more severe presentations of PTSD on exposure to trauma in later life (Briere & Spinazzola, 2005; Felitti, 2009; Herman, 1997; van der Kolk et al., 1996). Variables leading to the development of distress and disorder are interactive, cumulative and affected by environmental factors, with more severe and complex outcomes associated with a life history of multiple experiences of victimization in impoverished circumstances (Briere & Spinazzola, 2005).

Summary. Given that traumatic exposure and memory dysfunction are referenced in the guideline on vulnerability (IRB, 2006), a broad overview of the history and current state of research in the area of Post Traumatic Stress Disorder provides an initial foundation of knowledge for this study. Throughout history there is documentation of high rates of traumatic exposure associated with psychological morbidities but it was not until 1980 that PTSD was formally recognized in the DSM-III. This provided a unified description of symptoms across a wide range of traumatic events and has stimulated copious research investigating the impact of extreme stress on the brain and behaviour. PTSD is characterized by exposure to an extreme stressor, followed by intrusion and avoidance symptoms, negative alterations in cognition and mood, and alterations in reactivity, that persist from 6 months to a lifetime. Lifetime prevalence rates for individuals exposed to traumatic events ranges from 7-18% in large-scale studies. The foundational body of research raises questions, such as whether the current knowledge of psychopathology that is reflected in the DSM formulations are culturally valid or if there are unique effects of different types of traumatic exposure that are common among refugee

populations. These questions are addressed to in the literature reviewed in the section and the critique below.

Trauma-focused Epidemiology in Refugee Populations

In order to provide a foundation for understanding vulnerability as it relates to mental health concerns in refugee claimants, the following section examines selected literature on the psychological impact of traumatic events on both refugee and in-situ populations of survivors, highlighting core findings and current debates in the field. Research articles were selected after an electronic search of the psycINFO database was conducted using the date parameters 1980-2016 and the terms PTSD, prevalence, refugee, war, and torture returned over 1,500 articles. A manual search of the bibliographies of key review articles was also conducted. Key articles were selected for review on the basis of their impact, as well as the lead author's prominent research agenda and often lengthy clinical practice in this field.

The study of torture, political violence & refugees. The research questions for this study focus on the concept of vulnerability in the refugee determination arena and thus invite a review of literature on refugee mental health. Research in this area has steadily accumulated beginning in the 1980's. Early research was predominantly undertaken through centers for survivors of torture which were newly being established in the United States of America, Western Europe and Canada in response to large numbers of refugees fleeing the war in Vietnam and the Cambodian genocide, and the 'dirty wars' in Central and South America. Thus a large body of research is focused on treatment seeking refugees who have relocated to major urban centers in high-income countries and who have a history of exposure to torture. Subsequent researchers have looked at the prevalence rates of PTSD within populations exposed to war both in refugee camps and in their countries of origin. Researchers have attempted to categorize subjects based on their

exposure to what are presumed to be different categories of traumatic events, differentiating between, for example, civilian and combatant survivors of war, survivors of torture and rape, and forced migrants with various categories of legal immigration status. All of these categories of refugee status and types of trauma exposure are reviewed for their potential relevance to an understanding of vulnerability in the experience of newly arrived refugee claimants.

The Research Findings on the Prevalence of Psychiatric Diagnoses. The following section consists of brief reviews of selected studies, including a description of the study design, setting, sample size and characteristics, measurement tools and highlighted findings.

Refugees. A number of large studies have focused on the effects of traumatic events among populations of refugees in high-income countries or living in camps in countries near the region of conflict.

A household survey was undertaken of 993 randomly selected adult Cambodians who had lived in a Thai refugee camp for at least five years (Mollica et al., 1993). The trauma history and mental health status was obtained using the Indochinese version of the Hopkins Symptom Checklist- 25 and the Harvard Trauma Questionnaire while health status, disability and social functioning items were drawn from the short form of the Medical Outcomes Study General Health Survey and were modified in consultation with Cambodian and Western health professionals who had worked at the site. Respondents reported having been subjected to a wide-range of traumatic experiences from combat situations, bombing, torture, indoctrination, forced labor, sexual abuse, and the murder of intimates, as well as deprivations during the refugee period including lack of food, water, shelter and medical care. Fifty-five percent met full diagnostic criteria for depression and 15% for PTSD, while 15% reported functional impairments and 20% moderate to severe bodily pain.

A major study of 418 tortured Bhutanese refugees living in Nepal used structured interviews and an age and sex-matched control group (392 non-tortured) using modules of the Composite International Diagnostic Interview (CIDI) and found torture to be the most significant predictor of PTSD, anxiety and depression (Van Ommeren et al., 2001). Four out of Five tortured refugees had a lifetime disorder, including PTSD, pain disorders, affective disorders, dissociative disorders, and generalized anxiety. Women were more likely than men to report lifetime generalized anxiety disorder, persistent somatoform pain disorder, affective disorder and dissociative disorder.

Silove et al. examined the effect of torture and other conflict-related traumas, using the Harvard Trauma Questionnaire translated into Tamil, on a sample of 107 Tamil refugees living in Australia (Silove, Steel, McGorry, Miles, & Drobny, 2002). The sample comprised refugees and asylum seekers (who were considered to be at higher risk) and immigrants who had endorsed at least one trauma category on the HTQ including torture, imprisonment, near-death, kidnapping, murder of family of friend, and combat. The authors noted that the mean post-traumatic stress score for the whole trauma affected group (1.72) fell within the cut-off scores previously obtained by Mollica et al. in their studies of Cambodian refugees (2.5) and Vietnamese refugees (1.22). Findings of this study also confirmed that, after controlling for other types of trauma exposure, torture was the event most predictive of PTSD.

The correlates of torture and other wartime trauma to psychological and social problems were examined in a community sample of 1,134 Somali and Oromo refugees living in Minnesota (Jaranson et al., 2004). As no existing, previously validated measures of war-time trauma was available for use with East African refugee populations, the researchers developed a questionnaire consisting of 188 questions adapted from published studies and their own clinical

experience and translated from English into the Somali and Oromo languages. All but 6 participants reported exposure to traumatic events while 44% of the sample met the criteria for torture exposure. 25% of torture survivors had PTSD compared to 4% of the non-tortured participants, while for both groups a higher number of traumatic events correlated to more social and functional problems.

A random sample of 342 Ethiopian immigrants and refugees conducted in Toronto used the Composite International Diagnostic Interview questionnaire to measure depression (Fenta, Hyman, & Noh, 2004). This study found that the lifetime prevalence of depression was 9.8%, higher than prevalence rates in both Ontario (7.3%) and Southern Ethiopia (3.2%). The authors stated that their data confirmed the significance of known risk factors for depression in immigrants, including pre-migration trauma, refugee camp internment and the stressors of migration and resettlement.

638 immigrants from Mexico, Central and South America, currently living in Los Angeles, were surveyed in community-based primary care clinics to determine the rates of exposure to political violence and the impact of violence on mental health (Eisenman, Gelberg, Liu, & Shapiro, 2003). A 154-item interview was adapted from the Exposure to Community Violence Scale and an additional newly developed event-specific checklist, as well as the Medical Outcomes Study Short Form 36, the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire, and the PTSD Checklist-Civilian Version. An interview was also conducted with socio-economic, service utilization and immigration-related questions. The authors reported 54% of respondents had experiences of political violence, while 8% of those experienced torture. Of those exposed to political violence, 36% had symptoms of depression and 18% had PTSD, compared to 20% and 8% respectively for those with no exposure to

political violence. Those with a history of political violence also had higher rates of chronic pain and functional limitations, as well as lower perceptions of general health.

In-situ populations. A classic controlled study of non-refugee survivors of torture was carried out in Istanbul, and compared 55 Turkish political activists who had experienced torture with a closely matched sample of 55 activists who had not been tortured (Başoğlu et al., 1994). The study used the Structured Clinical Interview for DSM-III- R, the Semi-structured Interview for Survivors of Torture, and additional unspecified self-report and assessor-rated measures. The study found a lifetime prevalence of 33% and 18% of respondents currently met the diagnostic criteria for PTSD, suggesting that PTSD occurs in a substantial proportion of cases and is often chronic. The authors also noted that while the survivors of torture had significantly higher rates of PTSD than the non-tortured comparisons, the symptoms were only moderately severe and in general their mood was normal. The authors concluded that long-term effects of torture exist independently of the effects of migration, and they speculate that while a referral bias may have existed (with healthier, more resilient participants volunteering for the study), prior knowledge and preparedness for torture, a strong commitment to a cause and strong social support may be protective factors against the disabling potential of PTSD.

An epidemiological survey of survivors of mass violence randomly selected among post conflict populations in Algeria, Cambodia, Gaza and Ethiopia, found rates of PTSD ranging from 16-37% (de Jong et al., 2001). Prevalence rates were measured using the PTSD module of the Composite International Diagnostic Interview version 2.1 and evaluated in relation to traumatic events assessed using an adapted version of the Life Events and Social History Questionnaire. Rather than assessing only the consequences from one focal event, the authors took complete histories of traumatic experiences over time. Thus they identified specific risk patterns in each

country, and suggested that PTSD could result from different determinants and pointed to the importance of attending to contextual differences in post conflict environments.

A three-year follow-up study was conducted among a random sample of 534 adult Bosnian refugees who had remained in the conflict region and were living in a refugee camp in Croatia (Mollica et al., 1999). The researchers used the Hopkins Symptom Checklist-25, the Harvard Trauma Questionnaire and the Medical Outcomes Study Short-Form to investigate whether previously observed associations between war-related trauma exposure and psychiatric diagnoses and physical disability persist over time. 45% of the original respondents who met the criteria for depression, PTSD or both continued to have these disorders, while 16% who had originally been asymptomatic developed one or both of the disorders. 46% of those who originally met disability criteria remained physically disabled.

Review articles. Fazel et al. reviewed 20 interview-based studies, providing results for 6743 adult refugees who had resettled in high-income countries (Fazel et al., 2005). Studies were not included if the diagnoses were solely based on self-report questionnaires or were focused only clinical populations of refugees accessing treatment services. Only prevalence rates of current diagnoses were recorded, not the lifetime prevalence rates. The authors found 9% were diagnosed with current post-traumatic stress disorder, suggesting that refugees could be at least ten times more likely to suffer PTSD than the general population in these countries. They also found 5% of refugees were diagnosed with major depression, as well as evidence of significant psychiatric co-morbidity. The authors commented that larger (>200) and more rigorous studies reported lower prevalence rates. Their meta-analysis suggests that approximately 1 in 10 adult refugees in Western Countries has PTSD, 1 in 20 has major depression, 1 in 25 has generalized anxiety disorder, and suggested that these disorders are likely

co-morbid in many people. They also noted that prevalence rates in this study are lower than other frequently cited statistics, especially major depression, which are similar to the prevalence rates in general western populations; nevertheless, the prevalence of PTSD among refugees found in this study is still approximately ten-times the general US population.

Johnson and Thompson reviewed the literature on the development and maintenance of PTSD in survivors of civilian war trauma and torture (Johnson & Thompson, 2008). They reviewed articles focused on PTSD prevalence in tortured refugee populations (reported prevalence of 14-92%), tortured community samples (18-82%), refugee and displaced populations (4- 71%), community samples affected by war (11%- 75%). The authors of this study (and authors of the studies they reviewed) attempted to account for the high variability of the findings with a number of explanations, both thematic and methodological; such as, the types of traumas encountered in different settings may not be easily comparable, variability in the length of time from the traumatic exposure to the point of study, sampling biases either from relying on a clinical sample or a highly resilient referral group, the impact of current living conditions and stressors, psychological preparedness or lack thereof, diversity of sample size, reliance on self-report measures, and issues in translation and cultural validity. Several factors that appear to impact the prevalence of PTSD, such as gender (women seem more likely to develop PTSD, potentially due to the consequences of rape, violent loss of spouse and children and the hardships inherent with being a single parent or widow in wartime conditions), age (three studies supported the finding that those over the age of 65 were at increased risk of developing PTSD), and particular conditions of being a refugee (increased risk was related to poor quality of life in refugee camps, less than one year in a resettlement country, delays in processing refugee status applications, lack of status, obstacles to employment, racial discrimination, and

loneliness). Several protective factors were highlighted such as preparedness for torture, social support, camaraderie, religious beliefs and family reunification. Finally the authors comment on cross-cultural issues given that psychiatric constructs and measurement instruments emerging from in western countries are generally being applied to non-western populations.

The Journal on Rehabilitation of Torture Victims and Prevention of Torture published a desk study review of the literature and reported that PTSD appears to occur in a minority of those exposed to war and political violence, with prevalence rates varying between 4 and 37% (Quiroga & Jaranson, 2005). The authors of this study find that whether in populations in resettlement countries, refugee camps or countries of origin, PTSD and depression are the most common diagnoses. Sleep disturbances (insomnia and nightmares, trauma-related anxiety dreams) are among the most common and distressing symptoms reported by survivors of torture. Traumatic brain injury, secondary to beatings, is suggested as a factor associated with co-morbidity. Given the high rates of depression, suicidal ideation and attempts have been reported with a prevalence of 19% and, in at least one study, the choice of method was found to be related to the method of torture experienced. PTSD and depression co-morbid with abuse of alcohol and other drugs is relatively uncommon, especially in certain populations – though when it is present substance abuse is seen more often in men than in women. In general, symptom levels tend to be higher among refugees than those who remain in their country of origin, and also in refugee camps rather than in resettled populations. Coping and resilience factors were addressed including a strong belief system and psychological preparedness. While the social and economic consequences on the family have received scant systematic attention the authors highlight loss of trust, damaged relational and sexual capacity, and decline in occupational functioning. Finally,

the authors report studies that discuss the impact of torture on the social and political life of an affected community, wherein political opposition is stifled and people live in fear.

Summary. A study on vulnerability as it relates to the potential impact of mental health concerns on refugee claims processes must be grounded in the literature in refugee mental health. Research on refugee mental health began in the mid-1980's as clinicians in North America and Western Europe were responding to large populations of migrants fleeing war and political violence. Thus a large body of research is focused on treatment seeking refugees who have relocated to major urban centers in high-income countries and who have a history of exposure to torture. Subsequent researchers have looked at the prevalence rates of PTSD within populations exposed to war both in refugee camps and in their countries of origin. Whether in populations in resettlement countries, refugee camps or countries of origin, studies find that PTSD and depression are the most common diagnoses. In their meta-analysis, Fazel et al suggest that refugees resettled in Western nations have a current PTSD prevalence rate of 9%. The lifetime prevalence rates in studies that I reviewed here range from 15-33% and this wide variation, and critiques of the prevailing mode of research, will be discussed further in the following section.

Critiques of Trauma-focused Psychiatric Epidemiology

Cultural Psychology of Trauma. Trauma-focused psychiatric epidemiology has, to date, been the prevailing model of mental health research with war-affected populations, yet the wide variation in prevalence rates between groups has raised questions about the validity of the PTSD construct across cultures and how this body of knowledge is situated within a larger socio-political discourse (Kleinman, Das, & Lock, 1997; K. E. Miller, Kulkarni, & Kushner, 2006). As the focus of this study lies within a particular developmental and cultural context (i.e. the period of time in a person's life when he or she has just migrated to a foreign culture, under stressful

circumstances, and is making a refugee claim), it is important to understand how different social positions and cultural models and the ways in which these are embedded in political and historical moments that change over time, shape clinical symptomatology and give meaning to experience (Kirmayer et al., 2007). In this section, I will review select literature pertaining to trauma from cultural psychology perspectives in order to strengthen the foundation for exploring the concept of vulnerability in the arena of refugee determination.

As a result of an increasing critique of the cultural and ethnic biases in psychiatric practice, the study of the relationship between culture and psychopathology emerged as a topic of significant research interest and led to a widespread consensus that cultural factors are critical in shaping the onset, course and expression of psychopathology (Marsella & Yamada, 2007). Publications by Kleinman (1980), Leighton (1959), Marsella and White (1982), Triandis and Draguns (1980) have been highlighted as especially influential in precipitating this shift towards socially constructed and contextualized understandings of psychopathology in the field (Marsella & Yamada, 2007). A social constructivist epistemology would assert that it is not, of course, just our understanding of pathology that is socially constructed, but our entire view of reality. According to Marsella and Yamada,

> Our worldviews – our cultural templates for negotiating reality – emerge from our inborn efforts after meaning... The brain not only responds to stimuli, it organizes, connects, and symbolizes them, and in this process generates patterns of explicit and implicit meanings and purposes that promote survival, growth, and development. This process occurs through socialization and often leads us to accept the idea that our 'constructed' realities are in fact realities. The relativity of the process and product is ignored in favour of the certainty provided by the assumption that our way of life is correct, righteous and indisputable (e.g. ethnocentricity) (Marsella & Yamada, 2007; (2007, p. 801).

These authors go on to say that the current knowledge of psychopathology that is reflected in the DSM formulations are based in ethnocentric assumptions about the nature of mental health, and that these culturally dominant ideas have tended to marginalize other ways of making sense of

experience. Such a universalizing characterization of mental health does not adequately address a number of cultural factors that have been demonstrated to influence mental health, including types of stressors, coping mechanisms and available resources, personality patterns, the language system, standards of normalcy and deviance, and attitudes toward health (Marsella & Yamada, 2007).

Critics of the previous PTSD category debated its both its cross-cultural validity and its clinical utility (for a prominent example, see Summerfield, 2001). In order to make recommendations for changes to the PTSD definition for the DSM-V that reflected newer conceptualizations of cultural psychology, Hinton and Lewis-Fernández (2011) review the evidence for the validity of the previous DSM-IV-R PTSD definition to understand whether the construct applies equally well across cultures. While recognizing the considerable within-group variation and dynamism that exists, they define culture in a broad sense and explore, in particular whether "culturally related cognitive/affective/somatic/behavioral elements (e.g., interpretations of illness and patterned reactions to stressors) common to a certain group affect the development or expression of PTSD" (Hinton & Lewis-Fernández, 2011, p. 785).

Hinton and Lewis-Fernández (2011) found that while there was evidence of substantial cross-cultural variation, PTSD criteria demonstrates biomarker validity, general and trauma-specific causal validity, structural validity, and content validity. In regards to biomarker validity, Hinton and Lewis-Fernández cite the Kinzie et al. (1998) study that demonstrated physiological reactivity in Cambodian refugees, consistent with findings in Western populations. Causal validity exists in PTSD to the extent that traumatic events have been demonstrated to give rise to PTSD symptoms across cultures. The severity of traumatic events has been shown to be predictive of the severity of PTSD symptoms in numerous studies, however most studies do not

distinguish among the variety of types of traumatic events, their frequency, duration or severity which might reveal a greater cross-cultural variance (Hinton & Lewis-Fernández, 2011). While PTSD has been diagnosed in cultures internationally, a high rate of variability in prevalence rates has yet to be satisfactorily explained. Hinton and Lewis-Fernández hypothesize that it is possible that prevalence rates vary more on the basis of contextual parameters, such as gender, urban-rural status, socioeconomic status and due to methodological issues, than on the basis of individual experience. They note, however, that several studies also find a non-specific relationship between past events and symptomology, when PTSD severity is studied in relationship to non-traumatic events (such as current poverty and lack of security). This may relate, in part, to a cross-cultural variance in what is considered or experienced as traumatic. In terms of structural validity, the factor structure across cultural settings differed little from Western samples, however PTSD clusters did differ; for example, negative symptoms were less frequently endorsed, had low coherence and did not correlate well to trauma severity among people from non-Western cultures. This issue of over-inclusion of avoidance/numbing symptoms also relates to content validity – which is the extent to which the symptoms capture the most salient experiences of trauma-related disorder. Somatic complaints have been frequently noted as under-included items, thus decreasing the content validity of PTSD among certain cultures. The review concludes that PTSD is a valid cross-cultural category, such that a cohering group of symptoms arise in response to traumatic events in diverse cultural settings. Nevertheless, there remain areas that require further study to explain significant areas of cross-cultural variation. These include:

> The relative salience of the avoidance/numbing cluster and of somatic symptoms; the importance of distressing dreams and the need to broaden the description of this item; the specific characteristics of the negative expectations as a result of trauma; the impact of the meaning of the trauma on PTSD severity and symptom expression; and the role in patterning PTSD phenomenology of cultural syndromes and of sociocultural variation in exposure to types of trauma events (Hinton & Lewis-Fernández, 2011, p. 796).

The most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) acknowledges that there may be differences across cultures for the risk and severity of PTSD as a result of variation in traumatic exposure, differences in the meanings attributed to traumatic events, and on-going stressors in the socio-cultural environment (APA, 2013). Furthermore, there may be cultural idioms of distress that influence the way symptoms are expressed and the range of comorbid disorders that are frequently seen (APA, 2013).

While noting significant ethnocultural differences in the types and rates of traumatic exposure, prominent mental health researchers and practitioners concur that traumatic events affect individuals' psychological well-being, independent of ethnicity, race, or cultural affiliation and conclude that PTSD occurs in a considerable range of non-Western cultures (Beiser, 2010; Marsella, Friedman, Gerrity, & Scurfield, 1996; Norris et al., 2003). Marsella and White (1982) also hypothesized that with increasingly severe psychological disturbance, cross-cultural variability in symptoms is likely to diminish. Nevertheless, research on racial and ethnic group differences is "surprisingly sparse and inconsistent" (Frazier, 2011, p. 815). At the most foundational level, PTSD research has generally utilized only the most rudimentary descriptive indices about race, culture and ethnicity, and also usually fails to control for other sources of variance such as differences in trauma exposure, social class, education (Marsella et al., 1996). This does not allow for more than the most tentative conclusions about the connection between trauma and cultural diversity (Marsella et al., 1996). Rather than culture or ethnicity, per se, related risk factors such as poverty, refugee status, substance abuse and education, predict a greater likelihood to exposure to more frequent and severe forms of traumatic events and to be less protected by social or material resources (Kleinman et al., 1997). Conversely, attention to ethnocultural affiliations, communal living and social embeddedness might reveal a reduced risk

for exposure to traumatic events and distress (Koch, Douglas, Nicholls, & O'Neill, 2006).

Ultimately, PTSD, like any mental health disorder, has complex biological, psychological, cultural, sociological, spiritual and environmental determinants. Even while attempting to understand such problems as trauma-related vulnerability in context, relying on diagnostic categories is ultimately essentializing such that we situate the problems in the brain or psychology of an individual, and attend to symptoms as entities decontextualized from the particulars of a person's life and social environment (Kirmayer, 1996). The transcultural literature directs our attention to the social practices inherent in defining and addressing distress, disorder and vulnerability.

The complexity of political violence. In addition to the conceptual challenges raised above, another issue when researching the impact of traumatic events on survivors of war and other forms of political violence is how to define and delimit the population. This is important for the purpose of this study because refugees experience political violence in many forms, not limited to torture. Research on the impact of political violence has been criticized for over-simplifying what are in fact highly complex experiences and consequences (K. E. Miller et al., 2006; Montgomery & Patel, 2011; Stanciu & Rogers, 2011). This complexity introduces a large number of methodological challenges.

A large body of the research cited above concentrates on survivors of torture, which is defined by the U.N. Convention Against Torture, as severe pain or suffering intentionally inflicted or instigated by a person acting in an official capacity for the purpose of punishing, obtaining information, or intimidating the victim or a third person[1] (UN General Assembly,

[1] Article 1 of the Convention Against Torture states: "For the purposes of this Convention, the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person committed or is suspected of having committed, or intimidating or coercing him or a third person,

1984). And while there is evidence to suggest that torture is a strong risk factor for the development and maintenance of PTSD there are debates surrounding the salience and potentially reductive nature of the construct.

While the categorization and attempt to standardize the traumatic events encountered by individuals in contexts of political violence is done so that researchers may adhere to the research methodologies that traditionally offer the most authoritative findings, the narrowness of these findings may render them less meaningful outside of the academic or legal discourse (K. E. Miller, Kulkarni, & Kushner, 2006). Quantifying categories of war experience might imply that they are equivalent in their potency -- even torture, which conclusively leads to higher rates of diagnosis, is by no means a standardized experience (Johnson & Thompson, 2008). The category includes many variations of method, severity, and context (Başoğlu, 2009). Furthermore, one person may be a survivor of war, torture *and* rape; he or she may have also at times been a combatant or civilian perpetrator; after fleeing his or her country, the whole range of post-migration stressors including social and cultural alienation, loss of networks of support and poverty that can trigger or exacerbate a mental health crisis. Finally, the reductive focus on singular trauma events rather than on the systemic environment in which torture is practiced depoliticizes the meaning and intent of the act.

Methodological Challenges. It is the very complexity of the subject that gives rise to the methodological challenges seen in the body of literature under review. Several authors highlight methodological weaknesses such as insufficient description of interview procedures, assessment instruments, diagnostic criteria, small sample sizes, imprecise diagnosis, self-selection bias, length of time between the traumatic event and the diagnosis, length of time in resettlement

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or for any reason based on discrimination of any kind, when the pain or suffering is inflicted by or at the instigation

environment (Johnson & Thompson, 2008). Questions about whether instruments are adequately translated and deeper conceptual matters related to the salience and meaning of the diagnostic categories, local expressions of disorder and idioms of distress have been given insufficient attention in this body of research (Fazel et al., 2005; Johnson & Thompson, 2008). These issues give rise to the wide variation of reported findings and make it difficult to make comparisons among studies.

Summary. The pioneering phase of research in this field has occurred over twenty-five years and has primarily arisen from a trauma-focused psychiatric epidemiology paradigm. Critiques have been raised regarding the cultural and socio-political validity of the PTSD construct and the methodological issues inherent to this body of research. Yet, in spite of the variability of the research findings, the consensus of an international community of researchers who have been looking at the impact of political violence on survivors is that war, political violence and forced migration generate traumatic events that can precipitate wide-ranging post-traumatic psychological dysfunction. This body of research has significantly informed public health policy focused on survivors of torture and political violence and is a highly relevant and appropriate foundation for the study of mental health vulnerability in refugee determination processes.

Trauma and Testimony

Literature supports the assertion that mental health symptoms and disorders that result from traumatic experiences have the potential to impact the refugee determination process, and that this occurs in two distinct ways. The first is that mental health symptoms or disorders may impede a claimant's ability to provide a complete, consistent, credible narrative testimony as the

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of or with the consent or acquiescence of a public official or other person acting in an official capacity."

basis of his or her claim for refugee protection. The second is that refugee determination processes may exacerbate a pre-existing mental health condition or may trigger the onset of symptoms or conditions for which there was a pre-existing vulnerability. In order to demonstrate the potential interaction between mental health and the refugee determination process, the following section will review bodies of literature related to 1) the impact of trauma on memory and 2) re-traumatization during testimony.

The Impact of Trauma on Memory. Several of the diagnostic criteria for Post Traumatic Stress Disorder (PTSD) are related to memory impairments (for example, recurrent and distressing recollections, acting or feeling as if the event were recurring, and inability to recall an important aspect of the trauma) and a considerable body of research demonstrates the prevalence of memory impairment in trauma survivors with PTSD. Since Canadian refugee determination places a heavy weight on the credibility of the claimant, memory disorders, especially as they impact autobiographical memory, would be expected to have a significant impact on the outcome (Cleveland, 2006; Showler, 2007). This section will review the evidence related to autobiographical memory dysfunction in individuals with PTSD and describe their potential impact on refugee proceedings.

Evidence for memory impairments in individuals with PTSD. In a recent meta-analysis of the literature that examined the relationship between verbal memory functioning and PTSD, 32 studies published between 1993 and 2007 were reviewed (Johnsen & Asbjørnsen, 2008). As part of the inclusion criteria, each study had to report data on verbal memory. Several free recall tests were used in the studies under review, but the California Verbal Learning Test, Wechsler Memory Scale Logical verbal memory, and Rey Auditory Verbal Learning Test were used most frequently. Across studies, verbal memory was found to be significantly impaired in individuals with PTSD

compared to healthy controls (*d*=0.82), and there was a modest effect size in comparison with trauma-exposed individuals without a PTSD diagnosis (*d*=0.60). The findings also suggested that the extent of memory impairment is related to the type of trauma that was experienced. The greatest impairment was found in traumatized war-veterans, compared to sexual abuse survivors; and while sampling issues and comorbidity may be implicated in these differences, subsequent research on survivors of political violence corroborate the traumatogenic effect of war on cognitive processes (Johnsen & Asbjørnsen, 2008).

Mechanisms of memory impairment in PTSD. Post Traumatic Stress Disorder can be conceptualized as a disorder of memory, given that three of the symptom clusters (re-experiencing, avoidance and hyper-arousal) represent direct or indirect alterations of memory (Layton & Krikorian, 2002; Qureshi et al., 2011; Verfaellie & Vasterling, 2009). While knowledge of neurobiology is becoming increasingly precise regarding the neurophysiological mechanisms implicated in autobiographical memory, the nature of traumatic memory and the underlying neuroanatomical basis of memory dysfunction are still subject to on-going research and some debate (Brewin, 2007; Layton & Krikorian, 2002). Because the recall of traumatic events and related peripheral information are the aspects of memory most relevant to legal testimony, a brief description of the current theories of autobiographical memory (that is, memories for facts and events concerning the self) will follow.

It is widely argued that traumatic experiences are encoded, processed and accessed differently than ‘normal’ memory (Brewin, 2001, 2005; Ehlers & Clark, 2000; Foa & Riggs, 1993; van der Kolk, 1997, 1998). Given the frequency as well as the complexity with which impairments in autobiographical memory are seen in trauma survivors with PTSD, a theory of autobiographical impairment has been postulated which includes qualitative changes in memory

as well as differential disturbances in the retrieval of memories for aspects of trauma but also of unrelated memories (Verfaellie & Vasterling, 2009). In studies using the Autobiographical Memory Test (AMT), a cued recall task, trauma survivors tended to produce more over-general autobiographical memories to negative cues but also, and particularly, to positive cues (Verfaellie & Vasterling, 2009). Verfaellie and Vasterling theoretically attribute this dysfunction to rumination (in which negative self-representations are highly activated and elaborated), avoidance as an affect-regulation strategy, and a reduction in executive resources - especially working memory and inhibition of unwanted memories (Verfaellie & Vasterling, 2009). Given the prevalence of depression and dysphoric mood symptoms in PTSD, when depressive symptoms are controlled, over-general memory is still associated with symptoms of PTSD, suggesting that mood disorders are not the sole cause of over-general memory (Verfaellie & Vasterling, 2009).

With regard to the qualitative characteristics of memories of traumatic events in comparison to other autobiographical memories, there is evidence to suggest that over-general recall may not extend to trauma-related memories (Verfaellie & Vasterling, 2009). Studies indicate that individuals with PTSD have more vivid and detailed sensory and emotional memories of traumatic events than trauma-exposed individuals without PTSD (Verfaellie & Vasterling, 2009). This trauma-induced intensification along with peri-traumatic memory diminution can be understood as a brain-based disorder of episodic memory triggered by excessive emotional arousal (Layton & Krikorian, 2002). Laboratory evidence tends to suggest that even in healthy individuals, memory for central aspects of witnessed traumatic scenes is generally enhanced by stress, whereas memory for peripheral or unrelated material is often diminished – though it has been pointed out that such experimental conditions do not reproduce

an actual stress response which, in real-life traumatic situations may be protracted and complex (Brewin, 2011). Individuals with PTSD often report 'flashback' or 'flashbulb' memories, which are involuntary, intrusive, emotionally intense memories consisting of detailed multisensory images, somatic sensations and intense emotions and feel as though the traumatic event is occurring in the present moment (Brewin, 2011). These can range from relatively mild occurrences to extremely intense experiences in which a person loses all connection to his or her current autobiographical self and present surroundings (Brewin, 2011). These types of memories cannot be retrieved voluntarily, though individuals may attempt to assert control by avoiding the types of internal and external stimuli that tend to trigger them (Brewin, 2011).

The literature on 'flashbulb' memories suggests that events that are extremely unanticipated and/or salient to the individual are remembered in a more durable and fixed form because they do not require a hierarchical search of the autobiographical memory but are accessed directly through event-specific cues (Verfaellie & Vasterling, 2009). The process of 'memory fragmentation,' which refers to the lack of coherence within a memory sequence, is thought to occur as a result of disorganized initial encoding in a state of extreme anxiety and has been used to explain the uniqueness of traumatic memory (Brewin, Dalgleish, & Joseph, 1996; Foa, Molnar, & Cashman, 1995; Foa & Riggs, 1993; Verfaellie & Vasterling, 2009). Psychological processes of avoidance, which are conditioned by fear, are also thought to be mechanisms that impede encoding and retrieval (Ehlers & Clark, 2000; Foa & Riggs, 1993). Altered perceptions of time, distorted time sequencing, and memory blocks and complete or partial amnesia for events are also common consequences of fragmentation (Kirmayer, 1996; Koutstaal & Schacter, 1997; McNally, Clancy, Schacter, & Pitman, 2000). The intensification of memory and these types of amnesias appear to be contradictory phenomena that nevertheless

interact to produce the range of symptoms that constitute PTSD. Experiments suggest the existence of a general neurobiological mechanism in which memory intensification and diminution are coupled in normally functioning memory and to an intensified pathological degree in PTSD (Layton & Krikorian, 2002).

In the dual representation model, proffered by Brewin et al., trauma memories are thought to be stored as hypocampally mediated, verbally accessible narratives that can be retrieved either automatically or strategically *and* in image-based forms mediated by the amygdala that do not interact with the autobiographical memory and are only situationally accessible via trauma cues (Brewin et al., 1996). The two systems are thought to be differentially impacted by neuro-hormonal responses to stress, such that during traumatic events and in post-traumatic stress, situationally accessible trauma memories will be encoded with more potency than verbally accessible memories (Brewin, Kleiner, Vasterling, & Field, 2007). In retrieval, the conceptual and sensory memory for an event may dominate a person's mental life, while the specific facts of the event are excluded from consciousness and remain fragmented and disconnected (Brewin, 2011). Thus in the process of healthy adaptation to trauma, image-based memories can be re-encoded into verbally accessible memories, whereas in PTSD this process does not spontaneously occur.

A subject of considerable investigation, and significant concern for refugee determination processes, is the stability of trauma-related memory over time. Verfaellie and Vasterling (2009) emphasize the malleability of memory, in general, stating that memories are continually susceptible to change over time, as with each instance of retrieval the memory trace can be updated with new information obtained during the retrieval situation, new memories can be formed that link with previous ones, and by virtue of retrieval some forms of memory may

become modifiable and subject to reconsolidation. Thus, and especially given the fragmented and disorganized nature of trauma memories in individuals with PTSD, it is unsurprising that instability has been demonstrated in certain aspects of voluntary recall of events (Brewin, 2011). Two studies in which survivors were questioned very shortly after a traumatic incident, victims displayed significant gaps in memory at two weeks which had improved significantly three to four months later, though their emotional intensity remained high (Brewin, 2011). A much larger body of literature examines recall of events from which a considerable time has elapsed and, in general, have found that recall of traumatic events tends to increase slightly over time – and, this likely reflects a tendency for memory to improve with repeated recall attempts as would occur in re-experiencing processes (Brewin, 2011). The severity of current symptoms can also have an impact on the way traumatic material is remembered. The more severe an individual's current PTSD symptoms, the greater their tendency to report more exposure, more intense reactions and more dissociation at the time of trauma; however, it is unclear whether the severity of symptoms is associated with more or less accurate recall of events over time (Brewin, 2011). The observations that the nature of voluntary and involuntary memories can change over time and that these changes may in part be due to symptom-dependent appraisals of events are strengthened by the existence of a substantial percentage of cases in which PTSD onset is delayed. In such cases, individuals tend to experience a gradual accumulation of symptoms until full-blown PTSD is triggered by a subsequent (though not necessarily traumatic) life event (Brewin, 2011).

While the majority of studies addressed memories of singular events, in individuals who have suffered prolonged exposure to trauma, such as often experienced by survivors of political violence or childhood sexual abuse, it has been suggested that the multiplicity of traumatic

events will inevitably lead to a higher degree of inconsistency (Brewin, 2011). In contrast, the studies that showed a gradual improvement of recall over time were focused on particular instances of episodic, voluntarily and verbally retrievable autobiographical memory, so it is unknown whether narrative memory for prolonged or complex traumatic exposure should similarly be expected to improve over time. In the very few studies that have addressed the consistency of involuntary, non-narrative, sensory memories, such as flashbacks, a gradual decline in frequency, vividness, sense of being relived in the present, and associated distress suggests gradual extinguishment of these memories over time (Brewin, 2011). Thus, while traumatic memory as a whole shows significant malleability, different memory mechanisms undergo distinctly different processes of change over time, and these changes reflect the potential for adaptive alteration of distressing memory processes.

*Consequences of Traumatic Impairment on Refugee Determination***.** Trauma-induced psychological impairment is a point where the disciplines of psychology and administrative law intersect, and the issue has important consequences for refugee determination (Steel et al., 2004). Peter Showler, a leading expert in Canadian refugee law and former Chair of the Canadian Immigration and Refugee Board, explains that deciding who meets the international criteria to be granted refugee status is "the single most complex adjudication function in contemporary Western societies" and yet one which most frequently turns upon the perceived credibility of the testimony of the individual refugee (Showler, 2007). Consequently, Immigration and Refugee Board members must not only have accurate and specific information about international political conditions, they must also have the ability to evaluate the psychological aspects of each case (Rousseau, Crépeau, Foxen, & Houle, 2002). In assessing credibility, decision makers examine the reasonableness of the allegations, the consistency and coherence of the testimony,

omissions of significant evidence, corroborating evidence, consistency with generally known facts and what is known about the conditions of the country of origin (Crépeau & Nakache, 2008). Inconsistencies between statements made earlier in the process (i.e. eligibility interview, Basis of Claim form, detention) and statements made during the oral hearing seem to be weighted heavily, the assumption being that any discrepancies in testimony are an indication of lying (Herlihy & Turner, 2007b; Showler, 2007). Showler asserts that refugees are the most exceptionally disadvantaged group of applicants in any process in Canadian law, and numerous characteristics and circumstances may detract from a claimant's ability to present their testimony in a credible way including language, cultural difference, personal history, and trauma, fear and anxiety (Showler, 2007). The complexity of these inter-related factors can make it very difficult for a non-mental health specialist to distinguish between psychological and credibility issues (Rousseau et al., 2002).

With their reliance on consistency and full-disclosure, refugee status decision makers have been criticized for having an unrealistic expectation of memory functioning, even in the absence of trauma or extreme stress (Cameron, 2010). Decades of psychological research has established that memory for time, common objects, repeated events, peripheral information, names, and verbatim memory are all subject to common distortions and that memory alterations over time are to be expected even in healthy people (Cameron, 2010). Consequently, Cameron argues that regardless of the mental health status of a claimant, credibility determinations that hinge on accurate recall under highly stressful conditions are scientifically unsound and fundamentally unjust.

An investigation into the consistency of refugee testimony compared narratives relating to traumatic and non-traumatic material provided by refugees with PTSD symptoms and those

without (Herlihy, Scragg, & Turner, 2002). Refugees who had already been granted refugee status and were living securely in the U.K. -- are were thus without the often presumed incentive of gaining immigration status as motivation to alter their testimony-- were interviewed about the same event on two separate occasions. Inconsistencies were found in their accounts of both non-traumatic and traumatic material. The inconsistent details were most often of peripheral rather than central material. A relationship was found between the rate of discrepancies and the nature of the questioning. Individuals with symptoms of PTSD presented greater inconsistencies over time.

A multidisciplinary analysis of the decision-making process of the Canadian Immigration and Refugee Board, in which the research team reviewed 40 problematic cases, revealed, among other concerns, significant problems related to the assessment of credibility (Rousseau et al., 2002). While many negative findings of credibility reflected a lack of understanding of the social and political conditions refugees were fleeing, other examples reflected a clear lack of awareness of the psychological factors that may impact a claimant's ability to provide testimony. For example, Board members commonly ruled against claimants when they found discrepancies between the notes taken by immigration officers at the point of entry, the Personal Information Form (PIF) filed by the claimant, and the oral hearing. Cases were also frequently dismissed on the basis that the claimant's testimony was vague, lacked sufficient detail or was imprecise. Contradictory statements or errors concerning factual details, such as dates and time sequences, were often cited as the basis for the negative assessment of credibility. Omission of significant traumatic events in point-of-entry statements was also taken as evidence that such events did not occur. The authors found that post-traumatic symptoms were frequently misinterpreted as

evidence to disprove credibility, and concluded that adjudicators lacked the ability to understand and evaluate the psychological aspects related to cases.

Many parallel experiences were described in a study using Australian case studies, in which complex psychological conditions had an adverse effect on refugee proceedings (Steel et al., 2004). In the cases presented, disclosure of traumatic events was delayed or incomplete, and narrative details were inconsistent, vague or forgotten. Significantly, in several cases, full disclosure of traumatic events only occurred in the context of a clinical interview with a mental health professional. This was especially true when traumatic experiences were experienced as humiliating. In all case studies, claimants displayed symptoms consistent with depression and post-traumatic stress disorder, and yet in all but one case the decision makers overlooked or misinterpreted symptoms and the testimony was deemed not credible. Decision-makers received psychological reports with attitudes ranging from appreciative to incredulous.

Re-traumatization During the Refugee Claim Process. A small body of literature describes the potential for re-traumatization for victims of traumatic events who testify in legal proceedings. A small but growing body of literature suggests that refugee claim processes can similarly be associated with risk of re-traumatization (Steel et al., 2004). While the section above details the potential impact that mental health symptoms can have on the refugee claim process, the following section will describe the potential for the refugee determination processes to exacerbate a pre-existing mental health condition or trigger the onset of symptoms or conditions for which there was a pre-existing vulnerability.

Re-traumatization generally refers to the cumulative impact of exposure to traumatic stress over a period of time (Ford, 2009; Leshner, Kelly, Schutz, & Foy, 2012). Conceptually, the term is somewhat confounded, as it used to describe both a complex process that is not well

delineated, as well as a variety of outcomes (Ford, 2009). As it refers to a process, 'retraumatization' is commonly used in two distinct ways: 1) to describe an event of re-victimization in which a person is exposed to a subsequent traumatic event or events after the exposure to an initial, 'index' traumatic event in the past and 2) to describe a situation in which trauma-related distress is reactivated in response to a current stressor that may not be traumatic in nature, such as reminders of the original trauma or an increase in stress due to adverse life experiences (Ford, 2009; Leshner et al., 2012). As it refers to outcomes, 'retraumatization' denotes either the onset or marked increase in posttraumatic stress reactions, which may include symptoms of PTSD or depression, physical complaints, grief reactions or general anxiety (Leshner et al., 2012). The more numerous events and different types of traumatic events a person experiences, the greater the psychological impact is found (Leshner et al., 2012).

Retraumatization of victims who participate in legal proceedings. There is both clinical and research evidence to suggest that interaction with the criminal justice system can exacerbate the trauma-rated mental health symptoms of crime victims (Parsons & Bergin, 2010). According to Judith Herman, a psychiatrist and one of the preeminent researchers in the area of psychological trauma, while involvement in legal processes can be difficult even for "psychologically robust" individuals, however "for victims of violent crime, who may suffer trauma as a result of their victimization, involvement in the justice system may compound their original injury" (Herman, 2003, p. 159). Herman asserts that the imperatives of legal proceedings are in conflict with the mental health needs of victims. Victims need to be physically safe and psychologically secure in the knowledge that their trauma is behind them, they need to tell their stories in a manner that supports personal meaning-making and integration, they need to be believed and supported, and they need to regain a sense of power and control

over their exposure to traumatic memories and events (Herman, 2003). By contrast, court proceedings hold victims' credibility up to scrutiny, deny the opportunity to construct a meaningful personal narrative, require them to confront traumatic material in a manner over which they have no control and may even expose victims to further violence through retribution by perpetrators (Freedy, Resnick, Kilpatrick, Dansky, & Tidwell, 1994; Herman, 2003). While clinical documentation exists attesting to the detrimental effect of crime victims' participation in the criminal justice system, systematic data on the mental health impact is somewhat sparse (Herman, 2003; L. Miller, 2008; Parsons & Bergin, 2010). Several common features of the criminal justice system, such as the adversarial nature of trials and the availability of information for victims, are posited to affect victims' mental status and have been highlighted in research studies (Parsons & Bergin, 2010). A number of studies suggest that involvement with the criminal justice system can lead survivors of rape and domestic violence to experience re-victimization and exacerbated trauma-related symptoms (Campbell & Raja, 1999; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Herman, 2003; Koss, 2000; Uli Orth, 2002). Two published studies, however, did not find a similar effect (Frazier & Haney, 1996; Ulrich Orth & Maercker, 2004). In their review of the literature on victims' experiences of the criminal justice system, Parsons and Bergin (2010) conclude that much of the literature is out of date, and methodological inconsistencies make comparisons between studies challenging. Further difficulties with generalizations about court involvement and harm to victims are not only due to the diversity of traumatic events and their particular impacts on victims, but also the immense variability in the nature victims' interaction with the legal system (Herman, 2003; Parsons & Bergin, 2010). For example there are those who never report the violence against them, those who report the crime but whose cases are not forwarded for prosecution, those who offer victim

impact statements and those who testify and stand for cross examination (Parsons & Bergin, 2010). This is an area in which insights generated through clinical experience across traumatized populations could be reinforced by new research that uses structured clinical interviews to document short- and long-term mental health impacts.

Post-migration Retraumatization. There may be certain common elements between crime victims' experiences of the criminal justice system and refugee claimants' experiences with the refugee determination process, that make some extrapolation possible.

Through the lens of retraumatization theory, pre-migration experiences of violent persecution would be considered index traumatic events (unless there was previous trauma, such as childhood abuse), which would likely be compounded by post-migration stressors and the refugee claim process itself. Indeed, there is a large body of literature describing the complex, cumulative interaction between pre- and post- migration traumas that are attributed to high rates of PTSD in resettled refugee populations. Beiser (2009) asserts that in any individual migrant, the nature of their traumatic experiences, the personal coping strategies they use, and their particular phase of resettlement determines "the degree to which risk is translated into morbidity" (p. 554). In a review of the literature on refugee mental health, Porter and Haslam (2005, p. 611) concluded that

> The psychological after-effects of displacement by war cannot be understood simply as the product of an acute and discrete stressor, but depend crucially on the economic, social, and cultural conditions from which refugees are displaced and in which refugees are placed.

There are very few studies that focus specifically on mental health within the refugee claim phase, as compared to later phases after individuals have been accepted as refugees and/or have been living in a host country for a longer period of time. Refugee claimants inhabit a distinct economic, social, cultural and emotional context that is often characterized by detention,

precarious socioeconomic status, homelessness, separation from family, social isolation, difficulties communicating, and limited access to medical or psychological services, all the while living in fear of being repatriated to face persecution (Beiser, 2009, 2010; Leshner et al., 2012; Silove, Steel, Susljik, Frommer, Loneragan, et al., 2006; Silove et al., 1993; Silove, Steel, & Mollica, 2001; Steel et al., 2004). The compounded and highly stressful experiences common among refugee claimants during this uniquely critical time have the potential to be 'retraumatizing,' by triggering, reactivating or exacerbating negative mental health states (Silove, Steel, Susljik, Frommer, Loneragan, et al., 2006; Steel et al., 2004).

Added to the particular constellation of pre- and post-migration stressors that create risk of traumatization and re-traumatization, the refugee determination process has distinct characteristics that are also potentially re-traumatizing (Steel et al., 2004). In general, researchers and clinicians have highlighted interaction with the legal system as a potentially triggering life event for those with previous trauma history (Ford, 2009; Leshner et al., 2012). While engaging with the legal system is not seen to be traumatic per se, it is the elevated stress and exposure to traumatic memories during preparation and testimony that is posited to account for experiences of re-traumatization in victims of past trauma (Ford, 2009). Within the legal context of refugee determination, refugee claimants must narrate their traumatic histories on numerous occasions (e.g. during their eligibility interview, while preparing their basis of claim form, at the hearing, in order to receive material resources and services, for a mental health assessment), to different kinds of agents (e.g. border guards, immigration officials, lawyers, social service providers, and mental health professionals), and with varying degrees of stress (e.g. in detention, in a high-stakes hearing) (Herlihy & Turner, 2007b). The frequent exposure to

traumatic material under such conditions of elevated stress would indicate a high potential for re-traumatization.

*Summary***.** Given the centrality of credibility on refugee determination procedures, and the significant prevalence of PTSD among refugees, it is important to ground this study in an understanding of the ways in which Post Traumatic Stress Disorder can impact memory functioning. Traumatic memory of an autobiographical nature is characteristically fragmentary and disorganized, and functions in a dual process of over-generalized and vivid, sensory, non-verbal recall – both of which are malleable over time and by the effects of current symptoms. A refugee claimant, therefore, may have a clear conceptual awareness that traumatic events have occurred which have had a profound impact on their lives, as well as persistent, involuntary and distressing intrusions of memory, while simultaneously being unable to voluntarily access detailed, sequential and consistent episodic memory for testimony. A small but growing body of literature suggests that refugee claim processes can be associated with risk of re-traumatization. The compounded and highly stressful experiences common among refugee claimants during this uniquely critical time have the potential to trigger, reactivate or exacerbate negative mental health states. Researchers and clinicians have asserted that the imperatives of legal proceedings, including refugee claims, are in not in synchrony with the mental health needs of victims of trauma.

Conclusions Derived from the Theoretical Scaffolding

Notwithstanding the methodological and conceptual problems characterizing psychopathology-focused research with migrant survivors of political violence that have been outlined in this chapter, the available research evidence suggests that more severe and complex mental health outcomes are associated with a life history of multiple experiences of victimization

in impoverished circumstances. Furthermore, the consensus of an international community of researchers who have been looking at the impact of political violence on survivors for over twenty-five years is that war and political violence generate traumatic events that can precipitate wide-ranging post-traumatic psychological dysfunction.

While the Post Traumatic Stress Disorder construct has generated criticism based on its perceived lack of sensitivity to cultural determinants, PTSD has been shown to be a valid cross-cultural category. Though significant differences in cultural expressions of PTSD remain unexplained, prominent researchers assert that with increasingly severe psychological disturbance, cross-cultural variability in symptoms is likely to diminish.

Given the general research consensus that traumatic events do produce predicable outcomes across cultures, it is reasonable to anticipate that trauma-related distress and disorder in refugee claimant populations would play a role in claimants' experience of vulnerability. While the symptoms of PTSD may not be the most salient concerns for refugee claimants *per se* (compared to grief and loss, poverty, homelessness, and precarious immigration status, for example), PTSD is a serious mental disorder that could have immediate and serious consequences in the lives of refugee claimants, and could also result in lasting dysfunction and distress. Autobiographical memory dysfunction, one of the central defining characteristics of PTSD, is likely to impact a refugee claimant's ability to testify in a coherent and credible manner, thus diminishing their chances at obtaining a fair hearing and raising the odds that they will be declared not credible. This examination of how vulnerability is conceptualized and intervened upon within the refugee determination arena is therefore grounded in the DSM conceptualizations of trauma-related distress and disorder that characterize the literature on refugee mental health.

While there is ample literature to suggest that refugee claimants may be vulnerable as a result of exposure to traumatic events, there is little research that describes whether or how this knowledge is integrated into the conceptualization of vulnerability. Additionally, given the narrow focus on PTSD in the psychological research on refugee populations, there is not much information that would allow clinicians and other professionals to consider whether and how other kinds of issues might contribute to vulnerability. The singular focus on PTSD in refugee populations is challenged by the transcultural literature, which directs our attention to the social practices inherent in defining and addressing distress. This body of literature offers a justification for investigating the conceptualization of vulnerability from a social constructivist perspective, to consider how a wide range of professionals in the refugee determination arena understand, identify, and engage with the concept. Finally, no literature to-date examines these issues in the Canadian context of the newly revised refugee determination system, therefore an investigation of these issues is timely and will add to the body of literature on refugee mental health.

Theoretical Fore-structure

Rather than attempt to neutralize the influence that a researcher may bring to the process, Interpretive Description recognizes the "researcher as instrument" and encourages researchers to reflect critically on issues of subjectivity in knowledge production. The "theoretical fore-structure" is the second part of the scaffolding process and it complements the literature review with a self-reflexive elucidation of the intellectual and experiential knowledge base that the researcher brings into the study (Thorne, 2008). In this section, I describe my disciplinary orientation and the theoretical influences that informed my thinking about the research problem at the time the study was being developed. I also examine my location as a researcher, the

clinical experience through which the research problem became evident to me, and the personal values that had a part in shaping the direction of this project. Finally, I will explain how these theoretical and personal influences led me to consider the appropriateness of Interpretive Description as a method.

Locating Myself as a Researcher

The primary identity that shapes my way-of-being as a researcher is that of a practitioner and researcher within the discipline of counselling psychology. According to the Canadian Psychological Association definition (2009), "Counselling psychology is a broad specialization within professional psychology that is concerned with using psychological principles to enhance and promote the positive growth, well-being, and mental health of individuals, families, groups, and the broader community. Counselling psychologists bring a collaborative, developmental, multicultural, and wellness perspective to their research and practice." My research stance is influenced by counselling psychology values that emphasize a holistic, person-centred conceptualization of problems, attending to social and cultural context, and an orientation towards prevention, psycho-education and advocacy. I am inspired by the theory and practice of social justice in counselling psychology that is aimed at changing social values, policies, structures and practices, to ensure a more equitable distribution of social opportunities and resources, to challenge systems that perpetuate injustice, and to advocate for fair and just social policy (Fouad & Prince, 2011). Counselling psychologists are encouraged to expand beyond individual counselling competencies, and to embrace a broader scope of practice that includes functioning as advocates and social change agents to make societal conditions more equitable and fair (Toporek & Reza, 2001; Vera & Speight, 2003). This project falls into the research mandate highlighted by Toporek and Reza (2001), of seeking to identify and understand how

social conditions interact with mental health concerns to facilitate or block fair access to justice.

A particular theoretical influence in my own orientation as a researcher and practitioner in psychology is the work of Ignacio Martín-Baró. Martín-Baró was a Jesuit priest and psychologist in El Salvador, and an esteemed member of the American Psychological Association. Martín-Baró took a critical, social constructivist approach, arguing that identity is historically constructed, contextually situated, deeply conditioned by power relations, and that individual psychological health or pathology cannot be separated from historical and societal conditions. He believed that for psychology to serve the needs of diverse people it must generate knowledge that allows for a better understanding of social structures and their impact on human development and functioning. The Liberation Psychology perspective influenced the development of this research project, insofar as I seek a pragmatic understanding of the psychosocial interface between social policy and individual experience that is sensitive to the dynamics of political power and trauma. In the initial stages of development, Martín-Baró's work helped me to clarify my research objectives in order to ask what vulnerability means in the context of social policy, how the concept of mental health vulnerability is enacted in day-to-day practice, and what might be done to improve conditions for a segment of society comprised of people seeking refuge from violence and persecution.

Cultivating the Research Question

My interest in refugee mental health is rooted in over a decade of community and therapeutic work with survivors of torture and political violence. In my review of the literature, I found that much of the research in the psychological literature on survivors of political violence is focused on the trauma history and subsequent symptomology and that the clinical research focus is often directed toward healing the damage caused far away under repressive political

conditions. However, in my clinical work, as I grew increasingly aware of the difficulties survivors faced to rebuild their lives here in Canada, I became interested in how psychological research could affect social policy and address the barriers to well-being in post-migration environments. My master's thesis explored the livelihood rebuilding strategies of refugees in Vancouver (Huminuik, 2006). This current research project is similarly located in the Canadian policy context.

When I began conceiving of this project, my purpose was to find answers to questions that arose out of my own clinical experience as a counsellor. While working with refugee claimants, I frequently encountered people who were traumatized and overwhelmed by the demands of the refugee claim process. I had seen that if such people faltered in their refugee claim, they risked being found not credible and having their claim denied. My clinical observations were congruent with the literature on the impact of mental health problems in the refugee claim process. As a counsellor, I was also called upon to provide psycho-social support to claimants as well as expert opinion on the likely impact of their symptoms on their ability to present their claim. This required detailed knowledge of the legal and settlement landscape, which I acquired through immersion in the field, in consultation with various professionals, and through a self-directed program of interdisciplinary study. This was necessary because beyond official government guidelines, there was no one source that compiled all the relevant information that would help me, or another worker like me, understand what makes refugees vulnerable in the claims process or how to intervene appropriately. I was no longer working on the 'front line' in 2012, when significant changes were made to the Immigration and Refugee Protection Act and the time period for refugee determination was significantly shortened, and I wanted to understand how vulnerability was being understood and used in the new policy

landscape.

Arriving at a Method

The fact that the research problem became apparent to me through clinical experience, that I wanted to observe the interaction between individuals and systems, and that I was seeking pragmatic knowledge that could be applied within a specific arena of practice led me to consider Interpretive Description as a research method. I was also interested in the socially constructed nature of the concept and suspected that multiple sources of data would be useful. These considerations were also highly consistent with Interpretive Description. I will describe the methodological rationale and provide further justification for my research design choices in greater detail in the following chapter.

Working with Subjectivity

Consistent with the stance of the researcher in Interpretive Description, I do not claim to eliminate, or 'bracket,' my personal, professional and disciplinary understandings, as these represent the foundations of my knowledge and situate me within the research arena. Nevertheless, it is in keeping with Interpretive Description to maintain an awareness of one's own positionality and values, while remaining open to the new and different knowledge that emerges as one collects and analyzes data from multiple sources and vantage points. In this study, I formed research relationships with people and sites that required my continuous awareness of positions and identities and in which I aspired to adopt an attitude of cultural humility. I tried to understand how my social conditioning and the way I would be perceived as a Canadian-born, English-speaking, white, middle class, highly-educated, heterosexual, able-bodied woman could impact my access to information and my interpretations. I also navigated the boundaries between professional and student, and practitioner and researcher, which

introduced productive tensions into the research process. An on-going note taking process provided the space to reflect on my decision-making process and I frequently brought insights and questions that emerged for discussion with supervisors and experienced people in the field in order to challenge the assumptions and biases that inevitably arose out of my own subjectivity. I also took several opportunities to present my work, in various stages of development, at community meetings and conferences in order to elicit feedback from multiple perspectives.

Concluding Summary of the Theoretical Scaffolding

The purpose of the theoretical scaffolding is to ground the study in existing knowledge. This includes the 'state of the science' as well as the disciplinary and experiential knowledge that the researcher brings to the project. The theoretical scaffolding is also intended to provide a justification for the study and its design.

In this chapter, I reviewed the literature pertaining to the mental health impact of traumatic events, trauma-focused psychiatric epidemiology in refugee populations, critiques of trauma-focused psychiatric epidemiology, and the interaction between trauma and testimony in the refugee determination system. I found that the research on refugee populations has largely been focused on the prevalence of posttraumatic stress disorder and understanding how this is mediated by exposure to particular kinds of traumatic events, by migration, and by culture. Within this field of study, there is a very small body of literature that considers the impact of posttraumatic stress disorder on the refugee determination process. It is to this body of research that the current study refers.

The processes of traumatic memory and their potential impact on testimony have been well documented, and this knowledge base is reflected in government policy on 'vulnerability;' however, there is little research that describes how this knowledge is integrated into

governmental and professional practice. In addition to exposure to traumatic events, the policy suggests that there are other facets of vulnerability, which are not reflected in the psychological literature. The transcultural literature directs our attention to the social practices inherent in defining and addressing distress. Yet while the policy invites expert opinion and requests for accommodations, and a variety of professionals engage with the concept, neither the literature nor the official documents provide clinically relevant, detailed information on what makes a person vulnerable and how best to intervene. Finally, no current research examines these issues in the context of the newly revised Canadian refugee determination system. In order to arrive at a holistic understanding of vulnerability that could inform practice recommendations in this context, additional information was required.

My ability to identify this important gap in the literature, and my recognition of a problem in need of research, arose in the context of clinical experience. I understood that the concept of vulnerability was anchored in government policy but enacted by a wide variety of professionals in government and civil society. My experience in the field suggested that those with experience in identifying and supporting vulnerable claimants and recommending appropriate accommodations were likely to have important insights as to what makes claimants vulnerable. I also knew that recent refugee claimants have an important experiential perspective on vulnerability.

The literature and my clinical experience highlighted the research problem and demonstrated the need for a rich, qualitative exploration of the concept of vulnerability as perhaps a precursor to further evaluative resesearch. The fact that I was seeking pragmatic knowledge and was also interested in the socially constructed nature of the concept is highly

congruent with Interpretive Description. The following chapter describes the methodological rationale in greater detail and provides further justification for my research design choices.

Chapter 3: Research Method

In this chapter, I describe the Interpretive Description approach to inquiry and locate it within the constructivist-interpretivist paradigm of scientific research. Next, I provide a rationale for this choice of methods. I then discuss the methodological and ethical considerations relevant to the study's design, detail the research procedures and participants, describe the process of data analysis, and discuss the ethical issues that arose over the course of the study. Finally, I explain the strategies that were utilized for optimizing rigour and trustworthiness.

Introduction to the Methodology

In order to answer research questions related to 1) how "vulnerability" conceptualized within Canada's refugee determination arena and 2) how systemic practices are enacted with respect to vulnerability, I have used Interpretive Description (Thorne, 2008) as a research method. My choice of Interpretive Description (Thorne, 2008; Thorne, Kirkham, & MacDonald-Emes, 1997; Thorne et al., 2004) was guided by the contextual and pragmatic nature of the research problem, as this is an appropriate framework to explore clinically relevant issues in context. Interpretive Description encourages the use of multiple data sources to generate descriptive information about 'what is happening' in a particular context and then brings together all available sources of knowledge (from the literature and from clinical experience) to interpret what that descriptive information means in order to make actionable practice recommendations. I have also integrated a case study approach (Stake, 2006) to provide individual examples of how problems are handled in context. I will situate and describe this methodological approach below.

Interpretive Description

Philosophy of science paradigms -- positivism/post-positivism, contructivism-

interpretivism, and critical-ideological -- differ in their perspective towards reality (ontology), knowledge (epistemology), and the role of researcher values (axiology) (Ponterotto, 2005). Qualitative research is most often conducted from within the constructivist-interpretivist and critical-ideological paradigms (Ponterotto, 2002; Ponterotto & Grieger, 2007). Interpretive Description is situated within the constructivist-interpretivist paradigm of science and draws on qualitative traditions of evaluation research and naturalistic enquiry (Thorne, 2008). As part of the interpretative lineage, Interpretive Description has roots that can be traced to hermeneutics (e.g., Gadamer, 1989, Heidegger, 1982, as cited in Thorne, 2008), which sees the art of interpretation as fundamental to understanding phenomena and the construction of meaning as an intersubjective experience. However Interpretive Description holds this heritage lightly, integrating pragmatism as another significant philosophical strand. Pragmatism is concerned with the practical outcomes of knowledge and its purpose is not to represent reality but to increase human understanding of their practical circumstances in order to facilitate action (Thorne, 2008; 2014). This methodology assumes the existence of multiple subjective realities, and explicitly attends to subjective and experiential knowledge (Thorne, 2014). Interpretive Description studies acknowledge, however, that subjective and experiential knowledge can only be partially accessed, and thus generates tentatively claimed “constructed truths” that will be adjusted in new contexts, and as new concepts, new understandings, and new meanings emerge (Thorne et al., 1997; Thorne, 2008).

With its origins in nursing, Interpretive Description is a method that seeks to articulate the kind of human experiential knowledge that is of critical importance to applied disciplines such as counseling psychology (Thorne, 2008). This is a method that “ arose from a need for an applied qualitative research approach that would generate better understandings of complex experiential clinical phenomena within nursing and other professional disciplines concerned with applied health knowledge or questions from the field” (Thorne, 2008; p. 27).

Interpretive Description requires that a research project be grounded in an “integrity of purpose” that derives from actual practice goal and the delineation of all that is known about the problem on the basis of available empirical evidence from all available sources. This knowledge base is combined with a rigorous process of self-reflexivity about the disciplinary, theoretical and personal influences and locations which the researcher brings to the field of inquiry (Thorne, 2008). From this “integrity of purpose,” a researcher seeks to describe a whole phenomenon by accessing a wide variety of data sources, using sampling techniques that are purposive and theoretical in order to locate data that provides emerging themes and their variations, and examining the relationships among the themes (Thorne, 2008; Thorne et al., 1997, 2004). Still guided by her integrity of purpose, the researcher will then interpret why the current state of empirical knowledge is the way it is and what it might mean when applied to the subjective, experiential and patterned aspects of experience that have been observed and described, in order to arrive at a sufficient contextual understanding that can guide decision-making in real world settings (Thorne, 2008). The researcher brings her experiential knowledge and that which is already established into “the field” to engage with the data, beyond the self-evident, to “see what else might be there” and in so doing, potentially deconstruct the current angle of vision and generate new insights that can be applied to practice or to shape new inquiries (Thorne, 2008; p. 35). Findings are presented in the form of “careful and rigorous description, expanding or extending upon what is already ‘known,’ [to] enhance our ability to engage with a particular phenomenon of some clinical interest” (Thorne, 2008; p. 43). Interpretive Description does not seek to test a theory or prove a relationship, but rather to report what is observed when a phenomenon is examined in an open and exploratory manner. The ‘interpretive’ aspect of the method occurs upon analysis, as meaning is constructed within inter-subjective experience.

Multiple Case Study Analysis

For one key data source – the interviews and documentary data related to refugee claims processes of three individual refugee claimants --, this study also draws on multiple case study techniques (Stake, 2006) in an effort to present in detail a small number of exemplary cases that will allow a better understanding of the functioning and impact that policies and practices have. According to Stake (2006), whole systems are often best understood by attending to the way problems are handled in context. As an approach to data collection and analysis, Multiple Case Study Analysis techniques are compatible with an Interpretive Description framework, as both are constructivist in orientation, and share the expectation that the people connected to cases have a perception of reality that is social, cultural, and contextually situated. Both also aim to produce actionable knowledge by describing the behaviours and contexts that are encountered as thoroughly as possible.

Research Design

Consistent with Interpretive Description, in order to arrive at a holistic understanding of how the concept of vulnerability is being understood and intervened upon, this study generated qualitative data from multiple sources, which were theoretically and purposively selected. Four distinct source groups provide perspectives at different levels of analysis (Prilleltensky, 2008a). These data sources, which will be described in more detail below, were comprised of: 1) government documents and qualitative interviews with officials, which offered insight into the systemic level; 2) key professional informants who provided access to the organizational level; 3) recent refugee claimants who provided information on the individual level; and 4) the collected documentation of a small number of refugee claims, as examples of particular instances of how systems and individuals respond to vulnerable people throughout the refugee

determination arena. I selected these various data sources on the assumption that the construct of vulnerability is conceptualized and intervened upon within a complex systemic arena comprised of a legal framework, policy guidelines, the knowledge and practices of officials, professionals, and advocates, and the experiences of claimants. A further assumption is that data from these multiple sources are necessary to define, describe and interpret how practices related to vulnerability are enacted within the refugee determination arena.

In the section that follows, I provide a basic description of each data source and explain how each one is relevant to the research questions. I explain how specific documentary materials were selected. For the interview participants, I also explain the procedures that I used for recruitment and the inclusion/exclusion criteria. A table follows these detailed descriptions, which provides a visual summary of the characteristics of the interview participants and documentary material for each of the four data sources.

Description and Selection of Data Sources

Source group 1 (Official documents). As part of my efforts to answer the first research question, on how vulnerability is conceptualized, I analyzed a number Canadian government and United Nations policy documents. These documents were analyzed to understand how the concept of vulnerability is defined and operationalized at the official level. I accessed the following official government documents:

- Chairperson Guideline 3: Child Refugee Claimants: Procedural and Evidentiary Issues (Immigration and Refugee Board of Canada, 1996)
- Chairperson Guideline 4 - *Women Refugee Claimants Fearing Gender-Related Persecution* (Immigration and Refugee Board of Canada [IRB], 1996b)

- Chairperson Guideline 8: Guideline on Vulnerable Persons before the IRB (Immigration and Refugee Board of Canada, 2006)
- The *Training Manual on Victims of Torture* developed by the Learning and Professional Development directorate (LPDD) of the IRB (Immigration and Refugee Board of Canada, 2004)
- New RPD Member Training: Module 12, Chairperson's Guideline on Vulnerable Persons (Immigration and Refugee Board of Canada, 2013).
- UNHCR Executive Committee Guidelines on the Protection of Refugee Women (UNHCR, 1991)
- The UNHCR Guideline in International Protection number 9: Claims to Refugee Status Based on Sexual Orientation and/or Gender Identity (United Nations High Commissioner for Refugees [UNHCR], 2012)

I used a 'snowball sampling' selection process, focusing initially on Chairperson's Guidelines. In Canadian refugee policy, these offer guidance to IRB decision-makers and on adjudicating and managing cases. I began with Chairperson's Guideline 8, as it provides the official definition and delineation of the concept of vulnerability. I also accessed Chairperson Guideline 3, on child refugee claimants, and Chairperson Guideline 4, which focuses on women and gender-related persecution, as these both had relevance to the concept of vulnerability. IRB training materials also pertain to issues of vulnerability. Certain UNHCR guidelines were also accessed, as they provide information on aspects of vulnerability that are not fully developed in the Canadian guidelines. All of these documents were available on-line, except the "New RPD Member Training: Module 12, Chairperson's Guideline on Vulnerable Persons (Immigration and Refugee

Board of Canada, 2013)," which was obtained through an access to information request. While there may be information relevant to the concept of vulnerability in other Canadian legal settings, such as criminal justice policies, I excluded material that was not specifically about refugee determination.

Source group 2 (Qualitative interviews with professional informants). Twenty-five professionals comprising past or current IRB employees, refugee lawyers, mental health counselors, primary healthcare providers, and other service providers were interviewed on the basis of their experience in the refugee determination arena. The rational for interviewing this wide range of actors was to generate a variety of perspectives on the concept of vulnerability and intervention practices across the field.

I was aware from my prior employment experience in this field that various professionals engage with the issue of vulnerability as they support claimants. I assumed that individuals from each of these groups would have valuable perspectives on what vulnerability means and how the field responds. For example, lawyers specializing in refugee law have expertise advising claimants about their rights and how to navigate the refugee determination process, they assist with gathering evidence, they represent the claimant at their hearing, and, according to Guideline 8, they are well-positioned to identify issues of vulnerability. There are also a few small non-profit organizations in which mental health counsellors work to support refugee claimants. In the course of their work, such counsellors provide expert opinion reports to the IRB documenting mental health symptoms and highlighting any vulnerability issues that impact the determination process. Settlement service organizations work with refugee claimants to help them access social services and supports to meet their basic needs. In Vancouver there are also small, specialized housing organizations where refugee claimants can live for a short period of time. They employ

workers who sometimes live closely with claimants in a supportive role and thus have intimate knowledge of refugee claimants' experiences.

Professional participants (source group 2) were included if they were known to have, or were referred on the basis of, lengthy experience in the refugee determination field in British Columbia/Vancouver, in a professional role such as refugee lawyer, clinical counsellor or primary health care provider, or service provider within the refugee services sector, or past or present IRB employee. Individuals with long-term professional experience were expected to be able to insight into the concept of vulnerability, to describe their own intervention practices, to share observations on how the concept is used by various actors across the refugee determination arena, reflect on how this impact claimants, and provide informed recommendations for improvements.

Sampling was theoretical, purposeful and drew from members of a Multi-Agency Partnership (MAP) network of organizations in Vancouver, on snowball recommendations from experts with long experience in the refugee determination arena, as well as on the basis of my experience in the field. Desired participant groups were identified prior to recruitment, and included representatives from all of the professional groups and agencies that serve refugee claimants in Vancouver and who were active participants in the MAP network at the time of data collection. There may be other professionals who work with refugees independently or as part of non-refugee focused organizations, and while these were not explicitly excluded, they were not accessible.

In accordance with inclusion criteria, twenty-five professional informants participated in interviews. One official within the Immigration and Refugee Board consented to participate and this person referred a former official who also agreed to be interviewed. Six Refugee Lawyers,

with ten to thirty years of experience representing refugees participated in interviews. I interviewed four directors of non-governmental organizations (NGO) and they, along with one additional NGO director who served as a consultant throughout the project, each referred the most experienced front-line members of their staff and networks. These comprised two clinical counselors, one medical doctor, six settlement workers, two supportive-housing providers, and two interpreters.

One limitation of this participant group is the dearth of government officials who consented to participate. One current and one past Immigration and Refugee Board Official participated, though no sitting decision makers consented to participate. And though requests were sent to Canadian Borders Services Agency and Immigration, Refugees and Citizenship Canada, these requests were declined.

Source Group 3 (Recent Refugee Claimants). Recent refugee claimants were included as a vital source of experiential knowledge on the subject of vulnerability. Eight recent claimants volunteered to participate in interviews. These claimants had been referred by key professional informants who were familiar with particular issues of vulnerability that were represented in the cases. In my communications with professional, I explained that the aim was to include a diversity of manifestations of and experiences with vulnerability during the claim process.

Recent refugee claimants (source group 3) were included if they were over the age of 18, had made an inland refugee claim after December 15, 2012, and met the following criteria to be considered vulnerable for the purpose of this study: first, they were identified as vulnerable and referred by community service providers, legal professionals or community allies on the basis of their knowledge of vulnerability issues involved in the case, and second, they scored medium or

high on the PROTECT questionnaire. Exclusion criteria included not meeting the inclusion criteria and, in the case of recent refugee claimant participants, being perceived as at risk of re-traumatization through the interview process. Recent refugee claimants were not excluded on the basis of speaking languages other than English, as independent interpreters were contracted as needed.

The PROTECT Questionnaire, which is included in Appendix A, was used as a screening tool for potential refugee claimant participants (source group 3). It was designed by the International Rehabilitation Council for Victims of Torture (IRCT) to identify refugee claimants in need of specialized referral and support through the refugee claim process. It is a brief (10 items, typically taking less than 10 minutes, available in 15 languages including English), standardized screening tool intended to quickly identify claimants with trauma-related mental health symptoms. Used widely in the European Union, it is minimally invasive and inter-culturally robust. While the questionnaire is based on the DSM-IV criteria for PTSD, there are no psychometric data available for this screening instrument. The PROTECT score classifies cases as high, medium or low vulnerability, based on endorsement of common post-traumatic and depressive symptoms and functional impairments. The questionnaire also served the function of orienting interviewees to the kinds of difficulties that I would be asking them to reflect on throughout the interview.

All of the recent claimants who were referred by key informants volunteered to participate in this study. Professionals with an understanding of the study's aims referred clients that they considered vulnerable as a result of their knowledge of the refugee claim history. Six of the recent claimant participants obtained a PROTECT score of high. Two claimants scored medium for current symptoms and both stated that during their claim process they would likely

have produced high scores. In total, seven recent refugee claimants were interviewed. One claimant consented to participate without engaging in an interview, by releasing documents and allowing key informants to be interviewed about his case. Four of the recent claimants were women and four were men. One man self-identified as bi-sexual, as this was the salient identity characteristic in his refugee claim. Three of the recent claimants originated from Middle Eastern countries, three were Latin American, one was from an African nation, and one was from a country in Asia.

Source Group 4 (Exemplary Case Documentation). My intention in including a small sample of exemplary cases was to create as complete a picture as possible of how vulnerability is experienced and intervened upon in particular instances. I interviewed claimants about their own particular experience of making a refugee claim and I reviewed their complete case submissions as well as the decision to understand whether it was possible to detect issues that might leave the claimant vulnerable and how these were addressed. I also interviewed the professionals connected to the case, to access their observations about the process. In this way, I attempted to generate a comprehensive narrative, from multiple perspectives.

Of the eight recent claimants who participated in the interviews described above, I selected three to form the basis of exemplary cases. I made these selections on the basis of their completeness, relevance, diversity, and complexity (Stake, 2006). Of the eight interview participants, six consented to provide documentary material pertaining to their refugee claim and allowed me to speak to professional informants who were familiar with their case. Of these participants, I chose a group of three who together would provide a range of experience. My exemplary case sample is thus comprised of two women and one man from three different geographical regions, who each had a distinct basis to make a refugee claim and experienced

diverse aspects of vulnerability. It should be noted that the three cases were not chosen as particularly extreme examples, as those who were not included faced circumstances that were equally severe. In my professional experience all of the claimants who were referred for this study were fairly typical of the type of client who would be referred to a community organization for additional social or psychological support through their claim process.

The documentary material that was accessed in each case included:

- Hearing Disposition Record, which provides a summary of the file and information on the hearing such as whether the person was designated vulnerable, what accommodations may have been granted, if it was a gender-related claim, and the final decision that was rendered.
- Basis of Claim form (BOC) including the Narrative Addendum**,** which is a written narrative outlining the facts of a refugee claim that is (usually) prepared by a lawyer.
- Country Conditions Documentation, which is the collection of research on the human rights and political conditions in the claimants geographical region included in the submissions.
- Psycho-legal Report from a mental health professional and/or medico-legal report from a medical doctor (if one was submitted)
- Applications for vulnerability designation (if an application was made)
- Audio recorded or written transcription of the Refugee Hearing session (if available)

- Notice of Decision, which is the written copy of the decision made by the Refugee Board Member about whether or not a claimant has been granted refugee status, and the reasons for the decision.

These documents and observations provided evidence of potential vulnerability (for example, that a person fits within a category of potentially vulnerable people as outlined in guideline 8), contained information about whether vulnerability was identified and accommodated, and offered insights into how it may have impacted the claim.

The three exemplary cases are presented as rich, descriptive accounts of what can happen as claimants who fit the official definition of 'vulnerable' navigate the refugee determination process. These specific cases were drawn from refugee claimants who volunteered access to their personal case material, which is not publicly available. As a small sample, they are presented as illustrative, rather than as representative, of how the concept of vulnerability is being implemented.

Community Engagement and Recruitment Strategies

After the UBC Behavioral Ethics Review Board (BREB) granted approval, I offered three presentations to community and legal organizations, to introduce the project. I invited attendees to consider participating as informants, and to refer claimants as participants. Those in attendance included refugee lawyers and members of refugee-serving community organizations in Vancouver. Professional informants were also contacted directly by email with invitations to participate. Recent claimants were contacted and provided information by a professional informant who was familiar to them.

Informed Consent

Consent forms were provided to the participants prior to the initial meeting, to allow time to read and process information prior to offering consent (see Appendix C and note that issues of voluntary consent pertaining to this specific population will be discussed further in the Ethics section). Interpretation was provided as needed for the informed consent process and for interviews with refugee claimants who spoke languages other than English. The consent process emphasized that research participation has no impact on access to community services, nor would it impact the decision of the Refugee Board proceedings. Each recent refugee claimant participant was provided a twenty-dollar grocery card in appreciation for their time and travel as well as a list with counselling resources and relevant contact information, in case they were needed.

Participant Characteristics

Interviews were conducted with thirty-three individuals (twenty-five professional informants and eight recent refugee claimants), who I described above to demonstrate their depth of expertise and range of perspectives, while preserving their anonymity. The following table provides a simplified visual display of the data sources. The first column lists the four distinct groupings: official documents, professional informants, recent refugee claimants and exemplary cases. In the second column, the different documents, participant groups or particular individuals that are included in each group are named. The third column lists or provides a brief description of the salient characteristics of each data source.

Table 1. Participant Characteristics

Source Group	**Title, Type or Name**	**Salient Characteristics**
1) Official documents		
	Chairperson Guideline 8 – Guideline on Vulnerable Persons before the IRB (IRB, 2006)	Primary government source in which vulnerability is defined
	The *Training Manual on Victims of Torture* developed by the Learning and Professional Development directorate of the IRB. (IRB, 2004)	Government produced training materials related to hearing claimants who allege to have survived torture and mental health implications
	Guideline 4 - *Women Refugee Claimants Fearing Gender-Related Persecution.* (IRB, 1996)	Discusses issues pertinent to female claimants
	New RPD Member Training, Module 12: Chairperson's Guideline on Vulnerable Persons" manual (IRB, 2003)	Training materials related to applications of Guideline 8
	UNHCR Executive Committee Guidelines on the Protection of Refugee Women (UNHCR, 1991)	Discusses issues pertinent to female claimants, referred to in Guideline 4
	The UNHCR Guideline in International Protection number 9: Claims to Refugee Status Based on Sexual Orientation and/or Gender Identity (United Nations High Commissioner for Refugees [UNHCR], 2012)	Discusses issues pertinent to claims based on gender identity, and sexual orientation
	Chairperson Guideline 3: Child Refugee Claimants: Procedural and Evidentiary Issues (IRB, 1996)	Discusses issues pertinent to child claimants
2) Professional Informants		
	Immigration and Refugee Board Officials (2)	1 senior official 1 former official

Source Group (continued)	Title, Type or Name	Salient Characteristics
	Refugee Lawyers (6)	All senior lawyers with significant experience (10-30 years)
	Health Care Providers (3)	2 Mental Health Counsellors working in refugee serving NGOs 1 Physician with lengthy experience working in a refugee health clinic
	Refugee Service Providers (14)	4 Program Directors 6 Settlement Workers 2 Housing Providers 2 Interpreters
3) Refugee Participants		
	Recent refugee claimants (8)	Gender identity: 4 Women 4 Men Sexual Orientation: 1 self-identified Bisexual 7 Heterosexual Region of Origin: 3 Middle East 3 Latin America 1 Africa 1 Asia PROTECT Score: 6 high scores 2 medium scores
4) Exemplary Cases		
"Ms. Flores"	• Interview w claimant • Interview w lawyer • Interview w clinical counsellor • Case submissions: Basis of	Female Early 30's Central American Accompanying children Sexual violence

	claim form, Narrative Addendum, Country Conditions Documentation Package, Psycho-legal Report from clinical counsellor, Notice of Decision	
Source Group (continued)	**Title, Type or Name**	**Salient Characteristics**
"Mr. Naji"	• Interview w lawyer • Case submissions: Basis of claim form, Narrative Addendum, Country Conditions Documentation Package, Psycho-legal Report from clinical counsellor, Notice of Decision, complete written transcript of hearing	Male Mid-30's Middle Eastern Survivor of Torture
"Mrs. Sun"	• Interview w claimant • Interview w lawyer • Case submissions: Basis of claim form, Narrative Addendum, Country Conditions Documentation Package, Psycho-legal Report from clinical counsellor, Notice of Decision	Female Early 40's Asian Accompanying family Gender violence

Interview Procedure

The interviews with all participants from each data source were conducted in the form of a "conversation with a purpose" (Morrow, 2005). As such, I used a semi-structured, open-ended questioning format in order to explore and understand participants' perspectives on the ways in which vulnerability is experienced, recognized, intervened upon, exacerbated or mitigated. At the beginning of each interview I explained the purpose of the study, obtained consent and, in the

case of refugee claimant interviews, I also administered the initial screening questionnaire. If an interpreter was present, as in three interviews with recent refugee claimants, I explained the importance of confidentiality to her. All the interviews were audio recorded, and an independent transcriber transcribed all but the first two, which I transcribed myself to develop a deep immersion in the data. To maintain this immersion, I read and copyedited each transcription as soon as I received it. Throughout the interviews I utilized active listening skills such as reflecting, summarizing, paraphrasing and probing in order to clarify and understand what I was hearing from participants (Morrow, 2005). I responded with empathy to aspects of participants' stories and, at the process level, I was continually monitoring participants for signs of discomfort or distress. I attempted to engage with participants from the stance of a curious learner (Thorne, 2008), such that, though I had previous experience as a counsellor in the field and was on collegial terms with some of the professional participants, I explicitly put them in an expert role. The complete interview protocols are contained in Appendix E.

Data Analysis

Interpretive Description aims to generate a 'conceptual/thematic' descriptive product, in which patterns and meaning in the data are identified through analytic and interpretive processes (Hunt, 2009; Thorne, 2008). However, because Interpretive Description is not prescriptive regarding design choices nor does it provide explicit analytical instruction, analytic strategies were drawn from various qualitative research traditions to answer the research question and fulfill the purposes of the investigation (Thorne, 2008; Thorne et al., 2004). The process of data analysis was inductive, iterative, and occurred concurrently with a multi-stage data collection process.

From the early stages of conceptualization through the later analysis and interpretation

stages, I drew on an ecological model that considered multiple levels of analysis (Prilleltensky, 2008b). At the systemic level, I began asking how policies, as represented in the seven Canadian government and United Nations documents, define the concept of vulnerability and establish parameters for implementation. At the organizational level, I wanted to understand how professionals interpret vulnerability and intervene on behalf of claimants. At the relational level, I considered how interactions between claimants and professionals within the system influence vulnerability. Finally at the individual level, I considered how vulnerability is manifested and experienced by claimants.

In the first stage, I collected and began initial analysis of government documents (source group 1). In analyzing the government documents, I was attending to the first level of conceptualization: how the concept of vulnerability is defined, what are its constituent parts, how are these defined, what are the stipulations for implementation, and what might be missing in each of these.

Next I began collection and initial concurrent analysis of the interviews conducted with professional informants (source group 2), and the eight recent refugee claimants (source group 3). Exemplary refugee case material was analyzed separately. I worked with interview data using five main analytical approaches, as recommended by Kvale (1996): condensation, categorization, narrative structuring, interpretation and ad hoc methods. The first stage of analysis occurred during the interviews themselves, as the interview-participants described their thoughts, observations, and experiences, and, through reflecting and speaking, they reported new meanings and connections (Kvale, 1996). Within the interview encounter new meanings and connections were often made by the participant as I, as the interviewer, reflected or summarized my understanding and the participant clarified or expanded on what she or he had said (Kvale,

1996). The next stage of analysis was concurrent with collecting interview data, as I read transcriptions and listened to audio-recordings with the initial objective of trying to broadly understanding the issue of vulnerability within the refugee determination arena. The questions I asked at this time of the data were, 'what does this mean?' and, 'why is this here and not something else?' and, 'what might be missing?' (Thorne, 2008). As I attended to the interview data, I began to fracture the data into provisional categories, roughly corresponding to interview questions about the ways participants understand and recognize vulnerability, interventions that are made with vulnerable persons (or not), consequences of vulnerability, criticisms and recommendations for improvement. A categorizing system developed, and was revised, as broad categories were broken into smaller and more refined subcategories. As the main dimensions and subcategories became more and more refined, I frequently shared and discussed new iterations with advisors and community-based consultants. After the data collection and initial categorization was complete, I began to condense the material, trying to distinguish essential from non-essential information. In generating the narrative structure, I used 'ad hoc' tactics such as noting patterns, seeing plausibility, clustering, making metaphors, comparing and contrasting, subsuming particulars under the general, noting relationships among variables, and creating conceptual coherence (Miles & Huberman, 1994).

In seeking to answer the first research question, how is vulnerability conceptualized, I compared the official definition of the concept and its constituent parts with the way the interview participants described their observations and experiences of vulnerability. I tried to identify distinctions between the official definition and the way this conceptualization was amplified or challenged by participant knowledge, and if there were any patterns that emerged in these distinctions. Eventually, I began to develop a narrative structure that began with official

definitions of the concept and its constituent parts, and then enriching or contesting this with thick descriptions drawn from the integration of participant observations and experiences.

The next stage of data analysis focused on specific cases. Drawing from case study techniques (Stake, 2006), I began by carefully reviewing refugee claimant and related key informant interviews and the collected documentation on each case. At the descriptive level of analysis, I first explored whether and how various actors throughout the refugee determination process identified vulnerability, and how the claimant experienced vulnerability. Triangulating the claimants' own perceptions, with the observations of the professionals involved in the case, with whatever information was available in the case submissions, and the scores of the PROTECT questionnaire, I tried to understand what psychological factors were present and how these may have impacted the claim. I then examined whether and how vulnerability was addressed and whether the accommodations and protections were provided, as reported by informants and claimants and by looking in the documentation. At the next level of analysis, I considered whether these appeared to offer adequate protection or to cause harm, and if they facilitated or hindered the narrative testimony. Case reports were written as a narrative, according to the template I created (see Appendix D for the Case Study Template). They were constructed one at a time, after singular immersion in the material of each case (Stake, 2006). The descriptive account of each case will be presented in section 2 of the findings. The case studies will be discussed according to the categories that are presented in the findings and will situate the general descriptions and interpretations in particular, illustrative examples.

The final, interpretive stages of analysis included a return to the literature to understand how the concept of vulnerability relates to the body of psychological research. The results of this analysis form the substance of the discussion. At this level of analysis I also attended to how

socio-cultural discourses related to trauma, vulnerability and credibility surfaced throughout the data. The discussion at the end of the study interprets what the current state of empirical knowledge might mean when applied to the aspects of experience that have been described, in order to arrive at a sufficient contextual understanding that can inform decision-making (Thorne, 2008).

Ethical Considerations

In this section, I discuss the manner in which ethical considerations related to informed consent, trustworthiness, confidentiality, representation and stereotyping, traumatized populations, and ethical decision-making, influenced the design of the research.

Informed Consent

The concept of informed consent is intended to ensure that research participants fully understand the design and the expected outcomes of the study, and accept, without coercion, the potential risks they may be exposed to (Haverkamp, 2005). I anticipated that the two groups of research participants (the professional informant group and the recent claimant group) would have different requirements for informed consent. The professional respondents were not considered a high-risk group and were not expected to feel coerced or induced to participate. I exercised more caution with the refugee claimant group. Claimants were introduced to the project in advance by a referral source known to them and assured that their consent was in no way contingent on the services they were entitled to. They were offered an opportunity to contribute to a study that aims to add to knowledge about what makes refugee claimants vulnerable, which could potentially lead to recommendations that would create better conditions for claimants in the future. Refugee claimant participants were also offered a copy of their screening questionnaire results.

Trustworthiness

The construct of trustworthiness, as an element of rigour in qualitative research, generally refers to the expectations a reader has of the researcher (Morrow, 2005). Haverkamp (2005), however, describes an ethical dimension of trustworthiness that refers to the researcher's responsibilities to protect the participant from harm and to promote their wellbeing. While the issue of trust raises concerns about the level of access to information available to outsiders, I recognize that research participants have the rightful agency to control the way they present themselves and their narratives and that a good research relationship is characterized by just enough trust, without becoming intrusive. This quality of 'just enough trust' is one I aspired to capture throughout this project.

Confidentiality and Data Storage

Any form of qualitative research poses inherent risks to confidentiality, due to the depth and richness of personal information that can be accessed and which may be recognizable to others (Haverkamp, 2005). The level of protection of confidentiality necessary, particularly to protect refugee claimant participants in this particular project, was carefully assessed in the project design stage, in consultation with supervisors, potential participants and other community members. Refugee claimant participants were asked about sensitive experiences and those who were chosen as exemplary cases were also asked to provide research access to documents concerning their cases, and to allow for information to be released through key informant interviews. I was keenly aware that this is a high degree of access to sensitive information. I recognized that professional key informants may also have a particular need for confidentiality, as they were asked to comment on practices that occur within their field of professional practice. Therefore, no one other than myself had access to documentary data, names and demographic

information were not audio recorded at the time of the interviews, interviews were transcribed by a known and trusted colleague and then cleaned of identifying information, and all raw data files were password protected. Finally, the exemplary cases are presented anonymously with recognizable elements and personal information altered or omitted, with care taken to maintain the particularity and meaning of the data, in this and all subsequent versions.

Representation and Stereotyping

While focusing my attention on vulnerability in the refugee claim process, I wish to avoid the potential harm of negatively stereotyping refugee populations as a whole. I am aware that traumatic events and the refugee claim process are critical points in the life history of the people who experience them, but they need not be seen as the defining features of their identity. By focusing on how practices within the policy environment address issues of vulnerability, I wish to maintain clarity about the responsibility of the refugee determination system to provide a fair and safe process. I do not wish to contribute to a discourse that constructs refugees themselves as perpetually damaged victims, or potential threats to Canadian systems. Nor, by investigating an issue of refugee mental health, do I wish to individualize or medicalize the trauma that is the consequence of social and political problems, caused by state violence. I hope that by maintaining a critical, self-reflexive stance and consulting regularly with people who could challenge any assumptions that might lie beneath my representations of the data, I was able to avoid reproducing such negative stereotypes.

Special Considerations for Traumatized Populations

As a researcher with a focus on traumatic re-experiencing, I am keenly aware of the potential for psychological harm if dormant post-traumatic symptoms are re-triggered. I am sensitive to the fact that refugee claimants are likely to have been exposed to high levels of

violence and abuse, so my highest ethical priority is to protect vulnerable people from being re-traumatized by the research process. This consideration influenced decisions in every stage of the research cycle, making me alert to possible triggers in the environment, the research questions and activities, as well as in the relationships.

In conceptualizing this study, I deliberately precluded any research topics requiring participants to discuss their trauma histories, as I could not personally justify the potential risks of exposing participants to their trauma narratives in a non-therapeutic setting. Additionally, I believe that a focus on social policy invites participants to engage in a process that shifts attention away from the traumatic past and towards a shared knowledge creation process that could allow them to provide benefits to future claimants. Nevertheless, Haverkamp (2005) examines the implicit and legitimate expectation a research participant may have that a counselling psychologist, whether in a practitioner or researcher role, has the clinical skills to anticipate and protect them from potential risks and also to provide assistance. Haverkamp cautions us to be mindful of the limits of consent within a qualitative research relationship, in which participants have agreed to engage in a research process but not to an emotionally intense or transformative experience.

As an experienced counsellor with this population, I anticipated that my clinical experience had prepared me to exercise extreme caution to avoid harm in the research process, as well as to recognize and respond to signs of psychological distress in face-to-face encounters. I was also prepared to liaise with counsellor-colleagues to ensure that psychological care will be made available in the event that participants does experience distressing emotions as a result of participating in an interview or meeting. I provided brief psychological education to all the refugee claimant participants, while explaining the their scores on the PROTECT questionnaire,

and I offered information and referrals to counselling agency with a specialization in refugee mental health as a matter of protocol. I was mindful of the limits of the researcher-participant contract, not to veer into therapeutic role, and sought consultation whenever necessary to ensure that these boundaries are respectfully maintained.

Rigour and Credibility

As a professional discipline associated with the health sciences, Counselling psychology research has a social mandate "that entails a moral obligation toward benefitting individuals and the collective" (Thorne, 2008, p. 223). As a result, the criteria used to evaluate the quality of counselling psychology research extends beyond the limits of theoretical qualitative research evaluation, into an assessment of how research findings might be interpreted and used (Thorne, 2008). The following set of evaluation criteria, described by Thorne (2008), were used for assessing the rigour and credibility of this qualitative interpretive description study: epistemological integrity, representative credibility, analytic logic, interpretive authority, moral defensibility, disciplinary relevance, pragmatic obligation, contextual awareness, and probable truth.

To demonstrate epistemological integrity, there must be "a defensible line of reasoning from the assumptions made about the nature of knowledge to the methodological rules by which decisions about research processes are explained" (Thorne, 2008, pp. 223–4). The first three chapters of this document serve as the foundation for epistemological integrity, through which readers should be able to trace a logical progression from a contextualization of the research problems, to the research questions, to the review of the literature and explication of the location of the researcher, through the methodological design. For findings and interpretations to be credible, they must extend from this same logic. To convey the substantive completeness of what

is a constructed perception of the refugee policy and practice arena, this study was designed to incorporate numerous 'angles of vision' via adequate variation, non-superficial engagement, and multiple sources of data (Morrow, 2005). It is my intent that the logic behind my inductive reasoning and decision-making processes is apparent throughout the report, from the theoretical forestructure, presentation of findings, through to the interpretations and knowledge claims that are being advanced.

This imperative relates to the requirement that qualitative studies produce a knowledge product that is independent of the researcher's own bias or experience. In keeping with qualitative principles, descriptive findings remain close to the source material, with thick descriptions and verbatim accounts, and include contrasting as well as confirmatory information drawn from interview material, to ensure that subsequent interpretive claims are well-grounded in the data (Miles & Huberman, 1994). Furthermore, consistent with a constructivist stance to knowledge production, I also utilized consultative and self-reflexive practices throughout the research process in order to reduce biases from unduly influencing my decision-making and interpretive processes.

Because applied qualitative research within health disciplines aims to alleviate suffering and promote "as much well-being as is possible under the circumstances," moral defensibility is a criterion by which all such research must be evaluated (Thorne, 2008, p. 226). Thus we need to justify why the knowledge we hope to generate is necessary and what purpose it will serve once we obtain it -- especially when we do research with vulnerable populations (Thorne, 2008). In the case of this project, the explicit objective is to understand a situation in the context of a particular time and place, in order to provide pragmatic recommendations, grounded in data, to increase protections and mitigate harms for vulnerable people. It will be morally defensible

insofar as it makes actionable knowledge accessible to those situated to use it. Accordingly I will endeavor not only to present my findings in interdisciplinary academic settings and journals where it may be accessed by a wide range of researchers, but also in formats and settings that may be more readily accessed by practitioners.

Interpretive Description seeks to produce knowledge that is situated within and relevant to distinct practice communities and disciplines. To date, applied psychology perspectives in migration studies research have primarily addressed treatment-related concerns (Nickerson, Bryant, Silove, & Steel, 2011). This current study is a departure from that body of literature, as it does not focus on treatment, per se. It does, however, seek to describe a contextual moment in the lives of vulnerable people that is not well-studied, especially under the current policy constraints. Such knowledge will be of relevance to practitioners of various disciplines who practice within this arena.

Concluding Summary of the Methodological Approach

In order to arrive at a holistic understanding of vulnerability that could inform practice recommendations, an exploratory, qualitative, multiple-data source method was needed. I have used Interpretive Description as a primary research method, to which I have integrated case study techniques.

In this chapter, I described how Interpretive Description is situated within the constructivist-interpretivist paradigm of science and draws on qualitative traditions of evaluation research and naturalistic enquiry. I designed and implemented my research in a manner that was highly congruent with this method, from framing an amenable question that is grounded in actual practice goals, to delineating all that is known about the problem on the basis of available empirical evidence from all available sources including self-reflexivity, to accessing a wide

variety of data sources in order to describe and interpret a whole phenomena in its applied context.

I explained in this chapter that in order to answer the research questions on how the concept of vulnerability is conceptualized, I first needed to understand how the concept is defined, what are its constituent parts and how are they described, and how it is intended to be implemented. To understand how vulnerability is officially defined and how implementation is stipulated at the governmental level, I analyzed numerous government documents. To access detailed, clinically relevant, experiential information on what makes a person vulnerable and how intervention occurs in practice, I interviewed professionals from disciplines that engage with the issue of vulnerability as they support claimants. I also interviewed recent refugee claimants and the collected documentation of a select number of refugee cases in order to provide direct, first-person examples of how vulnerability is understood experientially. I used purposive and theoretical sampling techniques in order to locate data that provided emerging patterns and their variations, and examined the relationships among themes or categories.

In this chapter, I also described the principles that I followed to ensure the quality of this interpretive description. In order to convey substantive completeness, beyond a single angle of vision, I have attempted a triangulation of data from multiple sources and presented a thick description, grounded in verbatim material. I also accessed consultative feedback from a variety of sources to check my decision-making process and interpretations. In so doing, my qualitative research practice endeavors to generate knowledge claims that are informed by the social contexts into which the final research product will be directed.

In the following chapter I will describe what I found about how vulnerability is being conceptualized and addressed in this particular context. This will be presented first in the form

of a descriptive account of the whole phenomena. This descriptive account is followed by three case studies presented in their entirety to provide individual examples of how problems of vulnerability are handled in context. In the final chapter I will bring together available sources of knowledge (from the literature and from clinical experience) to interpret what the descriptive information means in order to make actionable practice recommendations.

Chapter 4: Descriptive Findings

In this chapter, I present a series of descriptive accounts in answer to the research questions: how is "vulnerability" conceptualized within Canada's refugee determination arena, and how are systemic practices enacted with respect to vulnerability? As noted in Chapter three, in research conducted using Interpretive Description, findings are presented in the form of "careful and rigorous description, expanding or extending upon what is already 'known,' [to] enhance our ability to engage with a particular phenomenon of some clinical interest" (Thorne, 2008; p. 43). The descriptive accounts presented here will serve as the basis for the interpretations and conclusions that are presented in Chapter five.

I present the findings, or descriptive accounts, in two major sections. The first section comprises a descriptive account of how vulnerability is conceptualized; that is, how it is officially defined, how it is understood by the people engaged with these systems, and how it is implemented in the field. Analysis revealed that while vulnerability is defined in official documents, information from diverse data sources would allow for a much more detailed and nuanced understanding of the concept and how it is implemented throughout the refugee determination arena. Nevertheless, while the concept is presented first as an integrated description, it was evident that in practice, professional groups across the refugee determination arena engage with the concept in distinct ways. Thus this section also describes the considerable variation in the way each discipline conceptualized vulnerability and how intervention practices differ correspondingly. These findings were derived through an analysis of three data sources: government documents, qualitative interviews with key professional informants, and interviews with recent refugee claimants.

In section two of this chapter, three exemplary refugee claimant cases are presented in detail. These are descriptions of individual cases in which vulnerability was identified, and function as illustrations of how vulnerability can be experienced by claimants and addressed across the refugee determination arena. As such, they provide a further "thick description" relevant to the project's research questions. Drawing from documentary material and qualitative interviews with multiple sources, the exemplary cases are offered as a source of triangulation to connect research findings to lived experience and to illustrate how the process of refugee determination can unfold in individual experience.

Three key findings can be distilled from the descriptive accounts presented in this chapter. The first is that vulnerability is described in official documents and by respondents according to essentialized characteristics of refugee claimants, which overlooks the multiple intersecting characteristics and experiences reflected in the case studies. The second is that there is considerable variation between disciplinary conceptualizations of vulnerability. The third key finding is that there are identifiable systemic barriers that limit the scope and utility of the concept of vulnerability to afford protections for claimants across the refugee determination arena. These key findings will be interpreted and discussed in light of existing literature in chapter five.

Section One: The Concept of Vulnerability

In section one of this chapter, I present a descriptive account of how vulnerability is conceptualized across the refugee determination arena. To begin this section, I present a definition of vulnerability which is drawn from "Chairperson's Guideline 8: Guideline on Vulnerable Persons before the IRB" (Guideline 8). Following this definition, this section is

organized into three main subsections: an integrated description of the concept of vulnerability, disciplinary descriptions of the concept of vulnerability, and implementation strategies for the concept of vulnerability.

I have organized the findings in this way because, firstly, a comprehensive description of the concept of vulnerability in this context is not available in a single source. It is defined and its various aspects are described at the explicit level across a number of government documents; however, these sources alone do not provide for a substantive understanding of the concept to facilitate professional decision-making. Professionals throughout the arena engage with the concept of vulnerability and contribute important knowledge to its construction. The first main subsection following the definition thus provides an integrative description of each aspect of vulnerability that emerged through analysis, beginning with information drawn from the documents and moving to information from various perspectives (government officials, professionals in the field, and recent refugee claimants). This allows for a richly detailed understanding of the concept of vulnerability, not only how it is defined, but also how it is understood to function, and how it is experienced.

Second, while this integrated description of the concept and its various aspects provides a framework for understanding the concept in its entirety, in practice, respondents described engaging with the concept in a more circumscribed way, based on their professional or disciplinary mandates. Thus the second subsection also draws from interview data to present the finding that the concept is understood in distinctly disciplinary ways at the governmental level, as well as at the community level by lawyers, service providers, and primary and mental health professionals.

Third, in answer to the second research question, I provide a descriptive account of the way the concept of vulnerability is implemented across the refugee determination arena. As each professional group articulated a distinct conceptualization of vulnerability, so too did each group describe unique intervention strategies that reflected these conceptualizations. How each professional discipline conceptualizes vulnerability, and the perceived impact it has on the outcomes they are trying to achieve, determines the kinds of interventions they make to address it in their practice. Because the responsibility for identifying and mitigating vulnerability ultimately rests with the Immigration and Refugee Board, I begin with a description of how the IRB applies the concept of vulnerability. Next, I describe ways in which professionals at the community level also engage with the concept of vulnerability by offering supports and services to help claimants navigate the refugee determination process. In answering the research questions, this chapter collects and integrates government definitions and directives, and then provides elaboration on the governmental description of vulnerability by incorporating the perspectives and reports of professionals and refugees. Thus this text moves from official government policy statements to an expanded description of how vulnerability is understood and enacted "on the ground."

The Concept of Vulnerability Defined

In Canadian refugee policy, "Chairperson's Guideline 8: Guideline on Vulnerable Persons before the IRB" (Guideline 8) is the primary source by which the concept of "vulnerability" is defined (IRB, 2006). Guideline 8 establishes that unless claimants can adequately present their claim without becoming re-traumatized, the principles of fairness and natural justice are not upheld. Thus, while in colloquial terms "vulnerability" implies frailty, or refers to personal characteristics that render one helpless or defenseless, within this context, the concept of

vulnerability is narrowly defined as being *vulnerable to,* or at risk of, not receiving a fair hearing, which carries the subsequent risk of refoulement – the act of returning a person to a country where they may face persecution – which is prohibited by international law.

Guideline 8 defines "Vulnerable Persons" as those whose ability to present their claim is "severely impaired" as a result of some particular aspect of their identity or experience; specifically those who are,

> Mentally ill, minors, the elderly, victims of torture, survivors of genocide and crimes against humanity, women who have suffered gender-related persecution, and individuals who have been victims of persecution based on sexual orientation and gender identity (IRB, 2006; p. 2).

Furthermore, by stating that the guidelines refer to, "but [are] not limited to" (IRB, 2006; pg. 2) the categories of claimants listed, the guidelines leave space for emergent characteristics or experiences that are not explicitly included in the definition.

Guideline 8 is intended to apply to claimants who are most vulnerable, relative to the population of claimants as a whole. The guidelines state,

> Persons who appear before the IRB frequently find the process difficult for various reasons, including language and cultural barriers and because they may have suffered traumatic experiences that resulted in some degree of vulnerability. IRB proceedings have been designed to recognize the very nature of the IRB's mandate, which inherently involves persons who may have some vulnerabilities. In all cases, the IRB takes steps to ensure the fairness of the proceedings. This guideline addresses difficulties that go beyond those that are common to most persons appearing before the IRB. It is intended to apply to individuals who face particular difficulty and who require special consideration in the procedural handling of their cases. It applies to the more severe cases of vulnerability (IRB, 2006; p. 2).

This passage attempts to clarify that while there are "difficulties" which may be common to all or most claimants, the guidelines refer to those whose ability to present their claim is the most severely impaired, or whose potential for re-traumatization is greatest, relative to the population of claimants as a whole.

Guideline 8 asserts that certain experiences and identities may convey vulnerability by 1) affecting memory, behaviour and ability to recount events; 2) causing symptoms that impact the consistency and coherence of testimony; 3) causing people to fear authority; and/or 4) causing people to be reluctant or unable to disclose their experiences, which can severely impair their ability to present their case (IRB, 2006). Therefore, the guideline provides procedural accommodations that are intended to ameliorate these issues "so that the person is not disadvantaged in the presentation of their case " and "to the extent possible, to prevent vulnerable persons from becoming traumatized or re-traumatized by the hearing process or another IRB process" (IRB, 2006; p. 3).

Integrated Description of the Aspects of Vulnerability

As noted above, Guideline 8 provides a list of experiences and "innate or acquired personal characteristics," (IRB, 2006; pg. 2) that may render some claimants more vulnerable than others; however it does not explicate the mechanism by which these confer vulnerability. Guideline 8 refers Immigration and Refugee Board members to other government and United Nations documents for further guidance on some particular aspects.

In the following section, I describe each of these aspects of vulnerability in detail. Each subsection begins with a brief, integrative description of the particular aspect, drawn from the official document data sources. This is followed by a detailed, integrative description, derived from qualitative interviews with professional and refugee claimants respondents, of how the particular aspect is understood to confer vulnerability. I begin with those aspects that are derived from Guideline 8: mental health concerns and then history of torture, genocide and crimes against humanity, followed by gender, then sexual orientation, and then age. I then briefly explore emergent characteristics and experiences that informants identified but which are not

addressed in official guidelines. In each subsection, I present the conceptual parameters of each of the characteristics as they are explicated in the policy documents. I then draw from key informant and recent claimant reports to describe how each characteristic is understood to confer vulnerability.

Table 2 is included below to provide a visual summary of the aspects of vulnerability that are the focus of this section. In the first column of the table, I list the various aspects of vulnerability that are specified in Guideline 8 as well as those which emerged from interviews. In the second column, I provide a brief summary of the definitions that are found in various official documents. In the third column, I list the sources from which the definitions are derived. One section was not derived from official documents but from qualitative interviews and is included as an emergent aspect. It is labeled “emergent aspects” and includes migration trauma, class and literacy, detention on arrival, significant unmet settlement needs.

Table 2 Concept of Vulnerability

Concept of Vulnerability		
Claimant Characteristics	**Definitions** *A vulnerable person has:*	**Sources**
1) Severe Impairment due to: a) Mental Health Concerns	Symptoms that may affect memory, behaviour and ability to recount events, thus impacting testimony	Chairperson's Guideline 8: Guideline on Vulnerable Persons before the IRB (IRB, 2006)
b) Identity: Age, gender, gender identity, and sexual orientation	Identity characteristics that may cause people to be reluctant or unable to disclose experience, thus impacting testimony	Guideline 8 **AND** Chairperson Guideline 3: Child Refugee Claimants: Procedural and Evidentiary Issues Chairperson's Guideline 4: Women Refugee Claimants Fearing Gender-Related Persecution (IRB, 1996) UNHCR Executive Committee Guidelines on the Protection of Refugee Women (UNHCR, 1991) The UNHCR Guideline in International Protection number 9: Claims to Refugee Status Based on Sexual Orientation and/or Gender Identity (United Nations High Commissioner for Refugees [UNHCR], 2012)
c) Traumatic experiences:	Experiences that may cause people to fear authority or	Guideline 8 **AND**

Torture, genocide, crimes against humanity	be reluctant or unable to disclose experience, thus impacting testimony	The Training Manual on Victims of Torture (IRB, 2004)
Concept of Vulnerability (Continued)		
Claimant Characteristics	**Definitions** *A vulnerable person has:*	**Sources**
d) Emergent aspects: Migration trauma, class and literacy, detention on arrival, significant unmet settlement needs	Current experiences and living conditions that may limit the ability to meet the demands of the claims process and impact testimony	Emergent aspects, not included in Canadian policy guidelines, derived from interviews
2) Potential for re-traumatization	The potential to suffer onset or exacerbation of symptoms	Guideline 8 **AND** IRB Training Manual on Victims of Torture (IRB, 2004)

Mental Health Concerns. Guideline 8 simply lists "mental illness" as a "personal characteristic" that can confer vulnerability when symptoms affect memory, behaviour and ability to recount events, and thus impacts testimony (IRB, 2006; p. 3). Review of government documents revealed that official sources do not provide guidance beyond this basic description, with the result that persons applying the guideline will need to draw on other sources or professional experience to develop a substantive understanding of how 'mental illness' is understood to confer vulnerability.

In qualitative interviews, respondents elaborated their own understanding of how mental health impacts claimants throughout the refugee claim process and their descriptions provide an expanded understanding of how mental health concerns may create vulnerability. While Guideline 8 merely mentions "symptoms," respondents reported on a wide range of specific

symptoms that they have encountered in refugee claimants. Many of the symptoms reported were consistent with post-traumatic stress disorder (PTSD), as well as with anxiety disorders, sleep and somatic disorders, depression and suicidality. In particular, the respondents who were medical and mental health clinicians provided detailed observations on such symptoms and disorders and also stated that they occasionally observed psychosis symptoms in refugee claimants.

In describing the impact that such symptoms have on the claimant's narrative capacities respondents noted, for example, that cognitive deficits, such as memory impairments, information processing and attention, affect the coherence and consistency of communication over time. In this regard, one clinician asserted,

> The most traumatized people are in many ways the least likely to succeed because they aren't going to be able to put a story together. Or at least not a story that is consistent in detail from point of entry, through detention, and all the way through the claim.

Given that consistency was cited as a major requirement of the refugee process, these symptoms were regarded as a major contributing factor to vulnerability.

Clinicians also reported that other constellations of symptoms, such as disorientation, lack of energy, inattentiveness, and generalized anxiety can impede functional capacities, such as organization and attention to detail that are required, for example, to compile evidence, attend appointments, and meet deadlines. Professional and refugee respondents provided numerous examples of how claimants struggled to meet the demands of the refugee claim process that demonstrated the interaction between psychological symptoms, cognitive dysfunction, functional deficits, and stress. For example, a recent refugee claimant described ruminating continuously on "all the reasons that made [her] come here" and stated,

> [My mental health] has been especially bad the whole time we've been here. I'm

> not sleeping, not eating, I always feel like crying, I am scared all the time, so worried, I can't concentrate, I can't think of all the things I have to do. I don't do anything right. I have so much pain in my body. This is happening all the time…. I feel so angry, I want to cry, I want to scream, all the things I went through, all the suffering we had, and then the process here, I just want to explode. I feel like I am crazy. Life has no flavour. There is nothing.

She explained that she found it hard to remember appointments and directions, it was difficult to recall details such as dates and times in her narrative, she could not self-regulate her emotions and became easily overwhelmed, panicky, confused, disoriented or "blanked out". She stated that this happened throughout the pre-hearing phase and resulted in her being poorly organized, missing appointments with lawyers, forgetting to go to the Immigration, Refugees and Citizenship Canada (IRCC) office for mandatory weekly reporting, and feeling highly anxious throughout. One of the clinical counsellors noted that depressive, hypervigilance and dissociative symptoms can be so severe that some refugee claimants avoid leaving their accommodation in the pre-hearing phase. She stated,

> I've worked with several people who had difficulties going out –like no place felt safe— and that was something that would spike at various times in their process. You know, they have one week where they are feeling OK and could get out and do the things they needed to do and then something would come up and they'll have a whole week where they can barely leave their apartment.

In another example, a recent refugee claimant shared his experience, stating

> I was not going outside. I just want to stay at home. I was just thinking, just like a robot, like a fool…. just like a catatonic [person]… I would just sit there thinking. I swear to God, I remember myself. I look out the window. Then I check my watch. Then it was already evening, six or something. Seven hours. Just looking out the window because it was—it's not easy things. No, it's human—I'm human, right? I'm not Superman or something. I cannot handle everything, right?

He stated that given his mental state, he did not access any support or information services, and found it very difficult to prepare submissions for his hearing, which in turn strained his relationship with his lawyer.

Several respondents provided examples of claimants who functioned adequately in the pre-hearing phase, only to decompensate in the hearing room itself. As one recent claimant reported,

> For me the hearing was very difficult, even though I was prepared... But in my mind I forget some things, get it wrong or get confused. Because when they ask you questions, then after the question they have another question, and more questions, so you feel tired, you begin to feel you are not safe… sometimes you will just stay quiet there for 3 or 5 minutes [*Enacts staring blankly into space*]. I say [to myself], "Just stay there." And sometimes, they ask me a question and I begin to speak, but it is like a movie, I continue to speak, to speak, to speak, but you don't realize that you are speaking. Do you understand? Like a movie is playing […] sometimes they can ask you some questions and you begin to answer, and you begin to feel like you go back again to your country, the situation is right there in front of you, and you don't feel ok. And all these things are coming out of your mouth, but it doesn't feel like you are the one. It was like someone else was speaking. […] Like your body was there, but someone else was talking.

With this example, the claimant describes a chain of events that were echoed by several other respondents. As the hearing progressed he began to feel pressured by the questioning, and this increased his anxiety until he became exhausted and overwhelmed. He eventually experienced dissociation, such that he was no longer aware of what was going on around him, and no longer able to respond consciously to questioning. He continued speaking, automatically, without being fully aware of what he was saying, while he re-experienced traumatic memories as if they were happening in the present. He stated that he got through the hearing, but that it was "very difficult" and he was unsure how coherent his testimony had been. One of the clinical counsellors reported that this is a common occurrence for vulnerable claimants, and explained,

> People can easily escalate when faced with questions, when faced with their trauma history and having to report on it… By 'escalate,' I mean being triggered, and experiencing symptoms such as flashbacks or dissociation.

With these examples, informants suggest that claimants' ability to cope in the pre-hearing phase may mask the severity of their symptoms and their vulnerability can be manifested acutely when

they decompensate during the high-stakes context of the hearing.

As in the previous examples, most key informants spoke of symptoms subsequent to traumatic experiences, but several also highlighted the fact that a small number of claimants have severe mental disorders, such as psychotic illness, which are independent of or in addition to a trauma history, and which can also impede functioning in different ways. They explained that one way in which psychotic illness may contribute to a claimant's vulnerability is by limiting his or her ability to understand the nature of the proceedings. One lawyer shared the example of a claimant with severe but undiagnosed and untreated mental illness who became disoriented and was unable to communicate the facts of the case. He stated,

> During the hearing he was way worse than he was even in my office. He was just almost zoning out from the questions and giving these really perfunctory one-word answers. Just out of it, quite frankly. Just completely not even addressing what he was being asked[…] He curled up into a fetal position at times, it was so bad.

Yet another vulnerability risk for someone who is experiencing psychosis may be that delusional beliefs distort their understanding of reality, such that they make a manifestly unfounded claim. A medical doctor explained,

> I never saw a refugee claimant from a Western developed country that wasn't psychotic. American, German, Australian, [for example]. They are often quite intelligent, but they are psychotic. They say they worked for a newspaper, or for the government, and they are being persecuted, but they are just quite obviously not well… And then they are just lost here, living with no status and with terrible, untreated mental illness.

He suggested while such claimants may not be at risk for persecution in their countries of origin, their experience within the refugee system leaves them vulnerable to deteriorating mental health, as a result of not having access to mental health treatment. He claimed that some such people eventually end up without immigration status, spend long periods of time in detention, or live precarious lives as undocumented people in Canada.

While Guideline 8 lists ‘mental illness’ as an aspect of vulnerability, information from a variety of respondents allows for a far more nuanced understanding of what this means. Respondents described types of symptoms and common disorders, and shared their observations of how these can impede the refugee claim process. They described the impact on narrative consistency, reduced capacity to meet the demands of the process, the potential to decompensate under the stress of the hearing, and the specific threats to the claim that psychotic illnesses can present.

Torture, Genocide, Crimes against Humanity. Guideline 8 states, “A person’s vulnerability may be due to having experienced or witnessed torture or genocide or other forms of severe mistreatment” (IRB, 2006; p. 2) and refers its members to “The Training Manual on Victims of Torture” for additional guidance (IRB, 2004). The Training Manual on Victims of Torture does not address the issue of “vulnerability” directly, as this concept was integrated into IRB practices, via Guideline 8, after the manual came into effect. However, the manual does describe the impact of torture on individuals and explains how subsequent symptoms can impede the information gathering process, suggesting that victims of torture will likely “feel stressed, vulnerable, powerless, and, even fearful in the setting of a refugee hearing” (IRB 2004; p. 11), even though there may be no obvious signs. The manual explains that difficulties in obtaining testimony about torture and other similarly traumatic experiences may be due to processes of avoidance, problems with memory, concentration, stress and anxiety, experiences of fear or mistrust, and “emotionally unpredictable” behaviour (IRB 2004; p. 11).

Key informant statements deepened the understanding of how vulnerability is conferred on survivors of massive trauma. For example, one respondent, who works in a supportive housing organization, offered an explanation that was echoed by many of the other professionals,

that claimants who have been directly exposed to politically motivated violence are likely to be particularly vulnerable. She said,

> Many [refugee claimants] have lived in chaotic, violent, hostile environments, but they don't experience a direct attack on themselves. Sometimes they are lucky or decisive enough to leave immediately after the first threat, and so they are not exposed, personally, to violence. But when women are raped, or someone survives genocide, or someone is tortured, these people seem to be impacted much more seriously. […] Even then, many people present really well. They appear very resilient, and they are. They do what they need to do to survive and they don't show too much of their pain. But then we see more what is going on under the surface, because we live closely with people. We hear them up all night, pacing, we hear them wailing and crying in their rooms, we see how easily overwhelmed and disoriented they can get, when they talk about themselves and their story is all a jumble.

The respondent suggests that, in her experience, those with a lived experience of violence are more likely to experience post-traumatic symptoms –compared to claimants who fear persecution but who have not suffered direct violence. She ascribes vulnerability to a resulting inability to narrate a coherent "story" for the refugee claim, but also to the propensity for becoming "overwhelmed" and "disoriented" which can create functional problems, as was described above. She also highlights the idea of resilience, which was raised as an issue by many of the professionals across disciplines. She explained that resilience is not incompatible with vulnerability. In her experience, while many such claimants demonstrate a remarkable ability to persevere and overcome extreme challenges, they may nevertheless experience severe distress and have a propensity to decompensate.

Many respondents echoed Guideline 8 when asserting that survivors of political violence are, in the words of one clinician, "often intensely triggered by any contact with officials," and emphasizing that this can also have a serious impact on their performance throughout the refugee claim process. One recent refugee claimant shared his experience,

> When I got here I don't trust in anybody. It was hard for me. Because, first with my lawyer it was hard to explain… in my country the government, the system is corrupt, you don't know anybody, even the lawyer, you never know. And CBSA, it was hard to trust, hard, hard, hard. And when people say 'don't worry everything is ok, its different here, you have rights'… you don't trust that. People say nobody is going to hurt you, all the bad things are gone. But that's so hard [to believe]. It was difficult because it all [i.e. the refugee claim process] starts at the moment of arrival, and you know nothing about the system, you know nothing about the government, you know nothing about CBSA, you know nothing, nothing, nothing!

As someone who had suffered at the hands of officials in his country, he was wary of the officials he encountered on arrival in Canada. He described being unsure of how refugee lawyers, CBSA, IRCC and the IRB interfaced, and not knowing who was advocating for his rights. Indeed, one of the refugee lawyers suggested that because the system is very complex, it is hard for claimants to know which officials play which roles. He asserted, however, that it would be reasonable for someone with a history of torture at the hands of state actors to approach all officials with caution or suspicion. A settlement worker, who himself had once been a refugee, echoed this sentiment and explained that for people who had been politically active in their countries of origin, this deep distrust is both involuntary – meaning a product of physiological hyperarousal – and also a long-ingrained habit of survival, of being observant, analytical and alert to danger. He called this "the clandestine way of surviving" and explained,

> After hiding to survive all your life, and now you come to claim refugee [protection] and within one month you have to transform from a person who has lived like a turtle, protecting themselves, and now suddenly you must open everything. How is that possible?

Respondents also stated that survivors of state violence often live in fear that, if they disclose information about what happened to them, family and community members remaining in the country of origin may be put at risk. The lawyer of one recent claimant stated, for example,

> I think he knew about the torture all along. I don't really know why he wasn't able to disclose it. Part of it was fear. He said, "They told me I couldn't tell anyone." So, I don't know to what extent that created a block, that he would like to have told me but he was unable to or if he was truly living in fear that the authorities would find out and they would kill his family.

This lawyer highlighted the difficulty in distinguishing between a 'well-founded fear' and trauma-related intra-psychic processes that create "blocks," or cognitive impairments, or that fuel hyper-vigilance.

Key informants emphasized the need for individuals throughout the refugee determination arena to develop trust with claimants, and enough time to do so. Respondents unanimously asserted that, for claimants traumatized by severe violence, the reduced timeframe is a major element that increases vulnerability. They explained that without sufficient time to build genuine rapport, claimants will remain hyper-vigilant and distrustful, and this will impede their effectiveness in navigating institutions, and block information gathering and questioning processes.

Guideline 8 lists exposure to 'torture, genocide and crimes against humanity' as an aspect of vulnerability, and directs IRB members to the Training Manual on Victims of Torture for more information on how to understand vulnerabilities posed by these experiences. Respondents confirmed and added to this conceptualization, by describing how traumatic sequelae of political violence, the way claimants can be triggered by officials, and the fear for remaining family members can impede or block disclosure, especially given the reduced time to develop trust.

Gender, Gender Identity, and Sexual Orientation. Guideline 8 specifies that "women who have suffered gender-related persecution, and individuals who have been victims of persecution based on sexual orientation and gender identity" may be vulnerable (IRB, 2006; p.

2). It refers decision-makers to Chairperson's Guideline 4: Women Refugee Claimants Fearing Gender-Related Persecution (IRB, 1996b) for guidance "in all cases in which female claimants allege persecution based on gender" (IRB, 2006; p. 6). While Guideline 4 does not formally address the concept of vulnerability, it nevertheless highlights "special problems" that may arise in claims involving women, including that women may experience "rape trauma syndrome," and they may be ashamed and reluctant to disclose experiences of sexual violence (IRB, 1996; p.7). The guideline also states that given the cultural dynamics of the family, women may not be in possession of all of the facts of the case or may not be empowered to communicate on their own behalf. Guideline 4 also refers members to the UNHCR Executive Committee Guidelines on the Protection of Refugee Women (United Nations High Commissioner for Refugees [UNHCR], 1991). The UNHCR document highlights similar concerns and also states that women can be made vulnerable if a male relative is treated as the primary claimant but is not aware of issues pertinent to the woman's need for protection. It further suggests that women may face greater difficulties obtaining evidence to support their claim, as there are many potential barriers to reporting to authorities. It also states that women will likely have problems with disclosing sexual violation in hearing settings with other family members present (United Nations High Commissioner for Refugees [UNHCR], 1991). While Guideline 4 addresses only women claimants, Guideline 8 addresses gender identity and sexual orientation somewhat more broadly in a 2012 addendum that states,

> Lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals may have suffered negative experiences due to homophobia in their respective countries of origin, most specifically discrimination, bullying, ostracism, violence, sexual assault, and so on. The IRB has been sensitive and will continue to be sensitive and alert to the impact that these particular circumstances may have on some LGBTI individuals; it will also ensure that when identified as vulnerable, those individuals, like other persons identified as vulnerable, are not disadvantaged in presenting their cases to the IRB (IRB, 2006; p. 7)

The UNHCR Guideline in International Protection number 9: Claims to Refugee Status Based on Sexual Orientation and/or Gender Identity provides comprehensive guidance on procedural concerns that may confer vulnerability for this population (United Nations High Commissioner for Refugees [UNHCR], 2012). Though the word "vulnerability" is not used in this document, it describes the factors that can impact a LGTBI claimant's capacity to present their claim, listing previous experiences of discrimination, hatred and all forms of violence, and noting that,

> Some may be deeply affected by feelings of shame, internalized homophobia and trauma, and their capacity to present their case may be greatly diminished as a consequence. Where the applicant is in the process of coming to terms with his or her identity or fears openly expressing his or her sexual orientation and gender identity, he or she may be reluctant to identify the true extent of the persecution suffered or feared (UNHCR, 2012; p. 14).

The UNHCR guideline also specifies precautions to ensure that LGBTI claimants "can present their claims fully and without fear," which suggest that the environment in which the claim is heard can also be a factor of vulnerability for this population if interviewers and decision-makers do not receive specialized training and demonstrate a positive appreciation of sexual diversity, if interviews focus on a claimant's sexual practices, and if conclusions are drawn on the basis of "stereotypical, inaccurate or inappropriate perceptions of LGBTI individuals" (UNHCR, 2012; p. 15).

In line with the guidelines referred to above, key informants reported that in claims related to gender or sexual orientation, vulnerability is conferred by the expectation for claimants to fully disclose information that is deeply private, concerning sexual violence, relationship history, abuse by intimate partners or authority figures, as well as gender or sexual orientation identity development, and discrimination. One of the clinicians explained that claimants are vulnerable because the internalized shame that is intertwined in much of this experience impedes

disclosure. Numerous informants provided examples of survivors of sexual violations who struggled to disclose their history for their refugee claim; such as this doctor, who reported,

> This one fellow, he was an intelligent, articulate, young man, and he came in to see me [days before his hearing] because he'd had a huge panic attack on the weekend and he'd ended up in the emergency room being worked up for heart disease, and there was a concern that maybe he had an adrenal secreting tumor [….] Essentially he had been raped by the police[…] and it was only one minute to midnight that he actually disclosed.

Several respondents noted that though decision-makers may not address questions about a claimant's sexual history, lawyers cannot be sure of this in advance and will often press for full disclosure themselves. One lawyer explained,

> Many years ago I had a client that was questioned in depth. Really, really hard questioning, in detail about the rapes she had experienced and there was so much pain in her eyes. I never saw anything like that. But they questioned her because it was not disclosed fully. It was just awful. I learned from that experience and I never wanted that to happen again. So I really push to get the whole story beforehand.

Respondents also stated that even when the history is contained in the submissions, claimants may still be asked to respond to questions about sexual violations during the hearing, and if there are inconsistencies in their oral testimony this can have serious consequences. Furthermore, informants explained that claimants can be rendered additionally vulnerable when asked such questions when family members are present during the hearing, as they may not have shared their aspects of their sexual history, and can be reluctant to disclose information that they have kept private.

Similarly, in line with the UNHCR guidelines, informants noted lesbian, gay, bisexual and transgender people face challenges in presenting their claim that extend beyond the narration of traumatic experiences of sexual violence. As one clinician noted, such claimants will fall on a spectrum in terms of their identity development, and there is significant cultural diversity in the

ways in which sexual and gender identities are constructed and expressed. She explained that an additional element of vulnerability for such claimants is that there can be an expectation that the development of gender identity and sexual orientation occurs in the same manner and with the same expression across cultures. She explained,

> They can't demonstrate in a way that satisfies the board member that they actually are lesbian, gay, bisexual or transgender without having made some contact with the broader [LGBT] community here. I've heard members say that, "If I had been persecuted because of my sexuality or gender and I arrived in a place like Canada, the first thing I'd want to do is find somebody else like me. So, if they haven't done that, I think they're lying." But there are so many things that constrain people's willingness and ability and sense of safety around engaging with a local queer or LGBT community. Pursuing sexual and relationship needs may not be the highest priority when you're in the middle of a refugee claim.

She asserted that, "the sequelae of trauma, the shame and stigma that are at work in their experience, and then the intercultural differences around how sexuality and gender are organized" are three levels of vulnerability that the LGBT claimants experience.

Several respondents noted that the member's gender role expectations can make culturally diverse women vulnerable in the refugee claim process, as well. One of the exemplary cases describes a claim that failed because the member asked a male family member without full possession of the facts to stand as the primary claimant, ostensibly to protect the vulnerable female claimant from testifying about sexual violations. In another example, a recent claimant explained that her husband concealed information from her about the threats to the family and discouraged her from performing the public role that was demanded of her in the hearing. The family expected the 17-year old son to play the role of the primary claimant, but since he was a minor, he was not allowed to provide testimony and, when she was called, she was expected to answer questions about matters that her husband had not disclosed to her. She stated,

> The judge called them, and asked their names and then they went out. I asked the judge for my son to stay. But he was not allowed to say anything, he couldn't help

> me, because he is underage. My children are 17, 15, 12, 10 and 7. It's enough for me. My children's work is enough for me. 17 years I am at home. Even shopping, grocery shopping I never did it.

She explained that before arriving in Canada, her role had been to stay in the home and care for children. She had not been expected to function independently outside the home and thus the demands of making a refugee claim was entirely out of her range of experience and quite anxiety provoking. She emphasizes this by saying that she was unaccustomed even to go out for grocery shopping on her own. She went on to say that after they lost their claim, her son blamed her and in so doing articulated the gendered dimensions of her vulnerability, stating,

> He thinks I am weak, I am not able to do it…. and he is not patient and so when he would see me being nervous or making mistakes he would get really mad. When we got rejected, he told me we got rejected because of me, [saying], "Because you forgot, you got scared, you don't tell the details."

In addition, some women may be exposed to on-going violence at the hands of family members. One of the supportive housing providers stated that given her close proximity to claimants, she is aware of cases in which women are living in situations of on-going violence, stating,

> Domestic violence is another issue. Women may still be in violent circumstances, and the claim process is so stressful that things just get worse. Sometimes they don't talk about that and we would never hear about it except that we are all living together.

She asserted that on-going interpersonal violence would likely decrease a woman's capacity to meet the demands of the refugee claim process and present testimony.

Finally, respondents suggested that the claim process might disproportionately burden women with primary childcare responsibilities, and can also exacerbate existing vulnerabilities for both women and children. Post-partum depression was an issue flagged by one clinician, who shared this example,

> So, now this woman's really in crisis with this new baby and she's got a hearing coming up and she's not coping well at all and the question is, "To what extent is

> this sense of being overwhelmed a reflection of the years of abuse?" that was a domestic violence case, and to what extent is it just being an exhausted new mom, who's isolated in this country, doesn't have any [people from her cultural community] who can help her?

Furthermore, without childcare or a social network, women have no alternative than to bring their children to legal appointments and the hearing, where exposure to traumatic narratives can harm the children's mental health.

Following from the earlier Chairperson's Guideline 4: Women Refugee Claimants Fearing Gender-Related Persecution, gender, gender identity and sexual orientation was flagged as an aspect of vulnerability in Guideline 8. This aspect of vulnerability is also elaborated in the UNHCR Executive Committee Guidelines on the Protection of Refugee Women. Respondents shared observations that confirmed these official conceptualizations. They also cited pressured expectations of full disclosure and internalized shame as impediments to narrative testimony, as well as risks for re-traumatization. They added disruption in family dynamics, increased risk of domestic violence, cultural diversity in expressions of identity and sexuality, and responsibilities of childcare as factors that added complexity to this aspect of vulnerability.

Age. Guideline 8 includes "minors" and "the elderly" in its list of potential categories of vulnerable people (IRB, 2006; p. 2). While there is no special guideline that refers to vulnerability with regard to elderly people, for cases involving minors, Guideline 8 refers members to Guideline 3: Child Refugee Claimants - Procedural and Evidentiary Issues (IRB, 1996a). Guideline 3 does not formally address the concept of "vulnerability," however it does highlight factors that may impede a child's ability to present their case if they are called upon to do so, stating that,

> Children are not able to present evidence with the same degree of precision as adults with respect to context, timing, importance and details. They may be unable, for example, to provide evidence about the circumstances surrounding

> their past experiences or their fear of future persecution. In addition, children may manifest their fears differently from adults (IRB, 1996a; p. 4).

Guideline 8 also specifies that,

> In certain circumstances, close family members of the vulnerable person who are also presenting their cases before the IRB may qualify as vulnerable persons because of the way in which they have been affected by their loved one's condition (IRB, 2006; p. 2).

While this statement does not refer specifically to age, very young or very old people who are physically and/or emotionally dependent would be at greater risk of being affected by a caregiver's condition.

Consistent with these guidelines, some respondents highlighted the vulnerability that may be conferred with age, stating that minors and elderly claimants require special consideration. When children, minors or elderly people are the primary claimants, there were concerns raised about cognitive development or decline, level of education or literacy, and the impact these might have on claimants' ability to understand the proceedings and to narrate a credible testimony. They also suggested that physical stamina can be an issue in the hearings, especially for elderly claimants with physical illness or pain. As one recent claimant stated,

> I was very concerned about my mother, because she is an older person. In the hearing[…] I thought she needed special treatment as an elderly person. I thought it was very strenuous for her. We didn't ask for any special consideration, because I didn't know you could ask for that, but during the hearing I was so preoccupied with worrying about my mother. It was so long, my mom was sitting there the whole day. And even though it was mostly me being interrogated, my mother is very involved in the situation, and so I knew it would be very stressful for her. At many points I was thinking she should have a break, but then I didn't know how long it would take and I felt, maybe its better if we just get it over with.

This statement also highlights the interactional quality of vulnerability between minor or elder claimants and their care-providing family members. Like this claimant, several respondents were concerned about the potential mental health impact on dependent family members, especially

children, who are exposed to trauma narratives throughout the refugee claim process. Informants described how, for a primary claimant who is a caregiver, the fear of harming a dependent family member with their testimony can impede full disclosure. One lawyer also described the converse situation, wherein the desire to protect a minor or elder from having to testify can lead an adult family member, with a potentially weaker case, to be declared the primary claimant. Extending the idea that the risk to mental health is one of the factors of vulnerability, several of the respondents highlighted complex disruptions in family dynamics that can occur as part of the refugee determination process. They noted that while family relationships can be a source of tremendous resilience, caregiving claimants face additional logistical and emotional challenges, as they attempt to protect the wellbeing of their dependents. The lack of childcare or eldercare throughout the claim process was highlighted as a related source of difficulty for many claimants.

Guideline 8 and Guideline 3 provide the official conceptualization of ‘age’ as an aspect of vulnerability. To these documents, respondents added nuanced observations on the consequences of stages of cognitive development or decline, limited stamina for proceedings, and the risks that arise from dependence.

Emergent Sources of Vulnerability. Guideline 8 states that considerations of vulnerability “would not be limited to” the categories of identity or experiences that are explicitly included in the definition (IRB, 2006; p.2). In considering what makes refugee claimants vulnerable, professional and refugee claimant respondents spoke of migration trauma, class and literacy, experiences at ports of entry and in detention, and precarious living conditions as other experiences and identity markers that they suggest can also confer vulnerability, but which are not described in the guidelines. Thus it emerged through analysis that while respondents

frequently described aspects of vulnerability that corresponded to the categories listed in Guideline 8, a number of important aspects were not included in government guidelines.

Migration trauma, which for many people includes exploitation, sexual assault and violence that is experienced en route, was mentioned as a vulnerability factor. Though migration trauma may often be overlooked because it does not provide grounds for refugee protection, respondents described these kinds of traumatic experiences in ways that suggest they would confer vulnerability in ways similar to torture and political violence.

Class and literacy were also seen as potentially giving rise to vulnerability as a consequence of current IRB policy and procedures. Respondents described situations that suggested, for example, that less educated and illiterate claimants have been disproportionately disadvantaged by the move from in-person to on-line services, and that claimants from the least developed countries will not necessarily have access to the types of supporting documentation that is expected.

Numerous respondents voiced concerns about the impact of Canadian Border Services Agency (CBSA) practices. Refugee claimant and professional respondents described situations that suggest that CBSA agents at the border interview refugee claimants immediately on arrival in Canada in a manner that is often experienced as intense or even harsh, and without legal representation. Respondents also provided descriptions of experiences that they or their clients experienced as humiliating, such as claimants being shackled as they walk through the airport and being made to remove clothing in ways that they find culturally inappropriate. A service provider shared her observations, stating,

> Well, right from the start, the intensity of the experience with CBSA is just brutal. People are just arriving, they are exhausted, and then they just get hammered with questions. I have been there, and the questions are just one after another, relentless, I have seen people just shut down – they are so confused. They get

> here and there are all these big guys in black uniforms and they don't know who they are and if they are supposed to trust them, they don't know anything about the refugee law and they don't have anyone to help them.

Another service provider echoed these observations, stating,

> One of their first encounters here in Canada, [at the] ports of entry, is that they're sort of very quickly pinned against the wall and basically have information drawn out of them in what I would call interrogation techniques.

One recent claimant described his experience at the border in detail, stating

> When I arrived to the border… all these police and all the staff at immigration, they are very serious, they don't talk to you like people. [I was thinking], "what exactly are these people?" I don't understand what is happening. Before I came here I thought Canada is a good country, people are very open, well-educated, but then I wondered, "Am I even in Canada?" because here [at the border] they are very closed, aggressive…. For me it was a kind of intimidation, I am new, I don't know anything, I do not want go into this place with the police…They can be two or three persons, asking questions at the same time, I can't even listen. Like we are suspected. It was very frightening.

He went on to explain,

> They give you some paper and they ask you to write. They say "right here, you can write your story, you can say what happened in your country" and in your mind you say, "what kind of story?"… It was very hard [in that environment] because of how they treat you when you come. Because, when you want to write this story, what happened to you, you must have a place that you feel safe, but if you are not safe, you can't even think. You know what I mean? And they continue to ask the question, another question, and another question. At that moment you don't feel ok. You say No. You don't even want to talk to anyone.

This claimant reported that he was asked for specific details on the forms that he found very difficult to remember under those circumstances. He stated that he just made his best guess, assuming that he could look things up and correct any mistakes later on. He explained,

> And like in Africa we move all the time, and you can't remember some address, or where you used to work, and birthdays of children and so many things. I even said, yes I'm married, and they say what date where you married, and honestly, I can't even be sure what year it was…. So there are some questions they ask you, and maybe it should be easy, but your brain is not ok, because you are not safe. It is very difficult. I was there already for 3 hours. I was afraid! I was afraid!

Respondents suggested that refugee claimants are made vulnerable as a result of their experiences at the border in large part because inconsistencies are commonly introduced under these circumstances, which can cause serious problems at later stages in the claim. As one lawyer indicated, “If a person isn’t able to tell the same story over and over again, then they’re going to fail their claim,” and “what’s maddening, generally speaking, with a lot of credibility [determinations] is that, you know, you’ll often get members looking at minutia rather than at the big picture.”

Respondents also highlighted the practice of detaining refugee claimants on arrival in Canada as another factor contributing to vulnerability. Several respondents were concerned that the conditions in which claimants are being held and the treatment they receive in detention could exacerbate mental health conditions. They reported that because there are not enough immigration detention facilities, claimants are often held in the general prison population and treated like criminals. They also stated that claimants have minimal mental health care or social support while in detention. They described refugee claimants being shocked and afraid to find themselves in detention after reaching a place they hoped would be safer for them. As one service provider stated,

> And then detention – many people have fled to escape this, and here they are in detention. They are wearing orange uniforms, and in with the general population. It is humiliating, degrading for them. But also it is very frightening. Because they are not criminals, and they don’t know how to survive in this place, they are just looking over their shoulder all the time.

A recent claimant described his experience in detention, stating

> My detention took twelve days. I’m destroyed [by that experience]…. Because firstly, I had no problem in my life like that before. I haven’t been any [conflict] with any police officer in my life but then I went—I changed three different prisons in twelve days! It slaps you. It was a shock, a super shock. It was the worst place I have ever seen. My roommate was an addict. He was shaking all day… He asked me to have sex... I’m not that kind of person. It’s terrible, terrible

> things. I could die. I could be raped, right? Everything was possible.

He continued, explaining how hard it was to disclose the basis for his claim under these conditions, stating,

> Officers are coming asking questions, all the time asking questions. I don't know. What am I supposed to do? What am I supposed to say?

Another service provider provided an example of a family who was detained for so long and experienced such duress that they withdrew their claim and were at risk of being deported, stating

> They have lost all hope that Canada is going to provide them safety. They have abandoned their claim. They've decided they would rather go home, live underground and take their chances, than live in this place that has been so terribly traumatic for them. And these are people who are legally entitled under international law to be here, and make a claim for refugee protection.

Respondents described situations which suggested that the experience of detention can undermine claimants' mental health and damage their sense of trust that the Canadian refugee system will offer them protection, and this also creates conditions of vulnerability that persist throughout the refugee claim process.

Several professional respondents were also concerned that the conditions under which claimants are questioned while in detention could promote vulnerability. They reported that while in detention, CBSA agents interview them frequently and claimants are completing their BOCs in stressful circumstances and without access to adequate legal information or support. As one service provider stated,

> I feel like there is no accountability at CBSA about how they are interrogating people in detention, or what they record and pass on to the IRB about the case. We do not know what gets used as evidence... The questioning is direct and intense, and I think that interrogational style is the norm there. It scares people, especially people who have been exposed to political violence. People start giving irrelevant information, or they start getting defensive and nervous, or start to argue with them…What if they say something just to get an officer off their back,

> for example, and then that could be used against them?

These respondents asserted that these experiences in CBSA custody can feel psychologically intrusive and frightening and can introduce inconsistencies that may not be corrected at later stages in the process.

Lawyers also reported that, in addition to CBSA's role at ports of entry and detention, CBSA officers can intervene at any time throughout the refugee claim process, including at the hearing. As one lawyer stated,

> In fact, it's getting a lot worse because they're interviewing far more frequently, doing so in a more invasive way, in a more catch-all way and in all kinds of instances where there's nothing to attract enforcement action or more intervention to begin with. [And when they are present in the hearing room] it just heightens the stress… It brings another person into the hearing room who is hostile towards them. And the amount of claims that they intervene in has increased by—I don't know—a hundred and fifty percent. It's particularly bad in this region, for some reason, in Vancouver.

Several professional respondents stated they consider interactions with CBSA a significant source of vulnerability, especially as they are not bound by a mandate to protect refugees or to observe the vulnerability guidelines. They raised concerns that the conditions of detention, style of questioning, and adversarial presence in hearings, tends to significantly increase claimants level of anxiety, which can impact mental health functioning and impede the ability to narrate in a clear and consistent manner.

Finally, recent claimants and professional respondents identified the precarious living conditions that many refugees find themselves in throughout the time of the refugee claim process as a significant potential source of vulnerability. One service provider described the material circumstances most claimants face on arrival, stating,

> People often arrive with next to nothing. And I feel like the income assistance process drags on, and leaves people in a very desperate place. Usually the first thing people need is housing, but if you have no income, you don't have housing

> and you also don't have food. And it's humiliating. People just don't understand how much you have to push to get what you are entitled to. But if you don't have the knowledge, the confidence or just the strength, emotionally, to push, things can get drawn out. And all this is happening alongside the refugee claim process and it's another thing that is wearing away at them…

She continued, stating,

> Actually, to be honest, since the changes to the refugee system, it seems like on balance everything is has gotten worse, much more extreme. CBSA, detention, the lack of health care with the IFH cuts, the new income assistance process – it was always really difficult, and now I think it is worse. Its not just the short time – though obviously that is a problem – it just seems like the policies are designed to make it harder for people, and it is certainly much harder for us [as service providers] to navigate all these complex processes. How bad does it have to get before there is a change?

Refugee claimants and professional respondents described circumstances that suggest refugees are impacted by numerous changes across the policy landscape that result in extreme poverty, food insecurity, homelessness or inadequate housing, and lack of access to mental and medical healthcare treatment. These conditions appear likely to jeopardize the refugee claim process, because claimants are so preoccupied with meeting their basic survival needs that they cannot properly attend to the tasks associated with the claim.

Though they are not described in the guidelines, migration trauma, class and literacy, experiences at ports of entry and in detention, and precarious living conditions emerged from interviews as additional aspects vulnerability. Respondents were especially alert to current environmental and systemic factors that surround the refugee determination process and suggested that these can considerably impact claimant's mental wellbeing and ability to fulfill the requirements of the refugee claim process.

Varied Professional Perspectives on Vulnerability

While the integrated description of vulnerability and its constituent aspects was derived from multiple sources, the interview data suggested that, in practice, professional respondents

across the refugee determination arena -- government officials, lawyers, service providers and health professionals – tended to conceptualize vulnerability in distinctly different ways. My analysis suggests that these various ways in which the concept of vulnerability is understood and applied across the refugee determination arena generally reflects each group's professional mandate, such that while government officials tended to emphasize fair access to the system, refugee lawyers focused on legal strategy and barriers to disclosure, settlement workers emphasized the challenges of migration and socio-economic deprivation, and clinicians prioritized mental and physical health. The following subsection provides a descriptive account of how the concept of vulnerability is conceptualized by different respondent groups, which was constructed from analysis of qualitative interviews with professional respondents.

Government officials. In interviews, IRB officials framed the concept of vulnerability within their larger objective of ensuring fair access to the refugee determination system. These officials stated that the primary intention of the guidelines is to "level the playing field" so that vulnerable claimants are not disadvantaged compared to other claimants. The IRB officials noted during their interviews, however, that within the IRB there tends to be an emphasis on establishing vulnerability based on a claimant's ability to "understand the nature of the proceedings". The RPD Training Manual indicates that the definition of vulnerable persons should not be narrowly restricted to those who are so functionally impaired as to require a Designated Representative, but indicated that,

> The Guideline can pose challenges for Members in its practical application. Where the line falls exactly – between a person who ought to be identified and a person who will not be identified as vulnerable – will not always be clear and a case-by-case approach is necessary (IRB, 2013; p. 4).

One official provided an example of a "clear cut" case, in which a claimant with a developmental disorder, severe cognitive impairment, or untreated psychotic disorder, grossly does not

understand the significance of the proceedings to the extent that they are not oriented to time and place. Another official conceded, however, “That’s a fairly high bar, to not understand the nature of the proceedings.” He pointed out that the guidelines make explicit reference to factors of identity, or particular types of traumatic events, which are likely to make a person vulnerable regardless of whether they still understand the nature of the proceedings. This official stated, “This is a question of accessibility. Can they tell their story and make themselves understood? Because if not, they need help to do that” and asserted that if vulnerability is not considered appropriately, this can leave a decision open to appeal. Lawyers in the field suggested that there are significant differences between IRB members in where the line is drawn in determining vulnerability.

Refugee Lawyers. The refugee lawyers primarily conceptualized vulnerability primarily in terms of legal strategy, and described vulnerable persons as those who have difficulty in making disclosures or narrating their testimony completely and coherently. Numerous barriers to communication were identified. Lawyers cited claimants’ difficulty in disclosing traumatic experiences, as well as the challenges posed by the psychological symptoms of trauma.

First, the refugee lawyers recognized vulnerability primarily as the risks to the claim that could arise as a result of incomplete disclosure or inconsistent testimony. The lawyers that I spoke to acknowledged that it is uncomfortable for claimants to discuss traumatic experiences and voiced concern for the emotional suffering and psychological dysfunction of many of their clients. They often shared concerns that they did not know enough about these issues to make fully informed decisions about vulnerability related to mental health. They emphasized the importance of full disclosure, stating that since the claim depends on the claimant’s subjective fear of persecution, even though refugee protection is forward looking, in practice decision

makers tend to rely heavily on narrative testimony of past abuse to corroborate the supposition of future risk. Several lawyers explained that the IRB emphasizes the importance of detail, linearity, and consistency, vulnerability stems from incomplete disclosure and the inability to present the narrative in a linear, detailed manner. They indicated that they want to know as much as possible about the claimant's history, so that they could anticipate and prepare for any challenges that might arise in the hearing. They described the discomfort they experienced of having to, as one lawyer put it, "Get the claimant to speak." Some lawyers stated they felt compelled to "push" claimants to disclose traumatic material and stated, "it is safer for them to disclose here in this office than in the hearing room." Another lawyer explained, "You have to develop a sense of when to try to push through and when to let it go and just try to give the person time." They explained that the concern for what they perceived as a claimants psychological discomfort was outweighed by the risk that their claim would not be successful and their life could be endangered.

Secondly, lawyers described various difficulties that give rise to claimants' inability to fully understand the nature of the proceedings, explaining that given the legal and procedural complexity of the refugee determination system, this was a far more complex issue than simply the cognitive deficits or problems with reality testing which IRB officials described above. According to one refugee lawyer, "Claimants have to understand the tests to be met. Refugee law incorporates principles that are not necessarily easy to understand." Several lawyers explained that claimants require significant preparation prior to the hearing in order to understand the imperatives of the refugee claim process, and if they are not well-represented and adequately prepared, this will increase their vulnerability.

Finally, a few lawyers described cross-cultural differences that result in inadequate communication and implied that, in the interaction between a claimant and a decision-maker, cultural assumptions and biases may create a condition of vulnerability for the claimant. One lawyer explained that much of the Basis of Claim – the concepts of 'subjective fear' and 'internal flight alternative,' for example – depend on a claimant's personal, social and cultural understandings which may not be readily open to introspection and explanation, nor easily accessible to an IRB member who is culturally and socially different. As one lawyer stated,

> Credibility is such a function of where the board member's coming from, right? Which is usually this very white, middle class, privileged person. So, they judge the way somebody appears, their comportment, they way they answer questions in terms of being specific and direct and not confused…You know, it's just this very strict, very western perspective on credibility and what's considered reasonable and possible is clearly an identity issue, right? It's coming from where you are and what you have at your disposal.

An IRB official provided an example of when cultural difference is an issue in decision-making, stating,

> For example, looking at a case of elderly claimants from rural areas, with a low level of education —so, their reality was the sun rose and then the sun set, and the sun rose, and the sun set, and then there were seasons. So, the Board Member says, "What year did the police come?" "It was 1923." "Are you sure?" "Yes, it was 1923." OK. "So, what year did the police come the second time?" "Well, that was in 1968." "Are you sure it was 1968?" So, how much time passed in between? "Oh, that was five seasons." So, this can happen… and if board members had used that as evidence against the claimant, it would not have held.

While she asserted that IRB members are sensitive to cultural diversity in narrative style and do not make negative credibility determinations as a result, lawyers suggested that there is significant discrepancy among members. Lawyers explained that what they perceived as an ethno-centric decision-making style in some IRB members made newly arrived claimants particularly vulnerable because, with the current timelines, they would not have had time to

develop any measure of dual-cultural awareness, which would enable them to respond to the member in the expected manner.

With all of these additional complexities, lawyers acknowledged that working with vulnerable claimants to prepare for the hearing is very challenging. The limited time available to prepare the claim was cited as a major exacerbating factor of vulnerability in the new system. One lawyer summarized the central concern, stating, “The irony is that those who are most in need of protection are often the least able to articulate it.”

Service providers. In their conceptualization of vulnerability, service providers – including settlement workers, information and referral providers, community-based housing support workers, and interpreters – generally emphasized the stressors for claimants of being in extreme poverty in a highly precarious new environment. They explained that this can jeopardize the refugee claim process, and that this ought to be considered as part of the criterion for vulnerability. Service providers understood that claimants with significant settlement needs, when their energy and attention is focused on meeting basic survival needs on a day-to-day basis, are at risk of being unable to meet the demands of the claim process or perform adequately in the hearing. They highlighted the fact that, in the current policy environment, refugee claims take place at the moment of peak post-migration stress, without the benefit of time and sufficient supports to reduce their impact. One settlement professional succinctly articulated the concerns of many,

> Mental health is integrated with socio-economic precarity. You could even take totally healthy people and put them in an extreme situation like this and they will react. The system here can push and push and push. Because when you’re worrying about basic needs, and then you don’t have the ability to focus your attention where you need to be in these 45-60 days. And then how are you going to perform, coherently, consistently, in this extremely high stakes situation at the hearing?

This service provider explained that claimants typically arrive in Canada with limited money, little or no social connections, no knowledge of the social support systems available, and little to no knowledge of the refugee system, and that they are arriving at a time in which there are severe service cutbacks and a high-pressure timeline. She asserted that the state of socio-economic precariousness in which they exist throughout the time they are preparing their claim puts claimants at high risk for missing important deadlines, being unable to produce the necessary evidence, and ultimately abandoning their claims. One housing support worker characterized the current process and settlement context as "incredibly grueling" and stated that mental health concerns are frequently exacerbated well before the claimant reaches the hearing room. He shared an example of a family he recently worked with, saying,

> We've had a situation here recently with a family, where everything was going wrong in terms of their welfare, housing, legal aid, it was all a problem with their documents—and all you need is a very small trigger in any one of those departments for things to unravel– and the anxiety reached such a pitch that the mother couldn't even talk. Which was just scary! […] She just seized up and couldn't talk. It's not a medical thing, I think; it's a trauma thing. Just severe, severe anxiety.

Another housing support worker concluded that in the current context, "One of the biggest risks is that people just give up." She went on to explain,

> There's a really high level of suicidality. […] This is what "vulnerability" really looks like. We want to be able to protect people from being pushed to that extreme, and we can't because the systems are what they are.

These service providers and others described an exacerbation of mental health symptoms prior to the hearing that ranged from being despondent, disoriented and disorganized, to actively suicidal, and which threaten claimants' ability to complete the refugee claim process.

Clinicians. The clinical counsellors and physician who participated in interviews defined vulnerability as the interaction between mental health and the refugee claims process. These

health professionals explained that while, in general, symptom presentations can range from very mild to severe, the most vulnerable claimants tend to be "very symptomatic" and the symptoms "very severe." In addition to the impacts on claimants functioning throughout the refugee claim that were presented in the 'mental health concerns' section above, these clinicians recounted how for claimants with severe symptomology, no matter what the trigger is during preparation or in the hearing room, once anxiety levels exceed an individual's threshold of tolerance, they can no longer think clearly or respond appropriately and this can have profound implications for the outcome of a hearing. For example, one clinician explained that once a person is emotionally disregulated it can derail the hearing, as he or she may become defensive, suspicious, withdrawn, hyper- or hypo-aroused or cognitively impaired, which can then be misinterpreted by decision-makers as being untrustworthy. She went on to report that trauma and anxiety symptoms can impact the way in which claimants interpret the decision-maker's attitude toward them, saying,

> The member asked a question about the person's motivation, like 'Why didn't you do that?' and, even if it's not asked from a place of skepticism, […] it sounds like you've done something wrong. It instantly creates this sense of defensiveness and anxiety. […] And sometimes, I think, also mentally takes them to the fear. […] It just throws people into a very scared defensive place.

The pathway of vulnerability, as understood by the health care professionals, is that stress exacerbates symptoms, claimants become overwhelmed, and communication breaks down. Clinicians explained that if decision makers do not understand this pathway of vulnerability, this leads to a negative decision on credibility grounds.

All of the health care professionals emphasized their conviction that the severely curtailed access to mental heath supports in the current environment is a significant contributing factor to vulnerability for refugee claimants. As one clinician explained,

> I know that refugee claimants were 65% of [a specialized public health clinic] visits when I was there and now they are negligible. The [mental health] program

> is gone. Claimants don't have the opportunity to seek care because there is no [Health] coverage, but even if they did, they don't have time to find us.

He went on to say that the most severely symptomatic people have no other recourse than to access "treatment through the ambulance or at the emergency room." One of the clinicians explained that, in the past,

> [Counselling] allowed them to 'be here' in all senses of the word. To be resilient enough [to face] the day-to-day struggles that are huge and are ever increasing these days. To provide orientation, understanding [...] and the feeling of being more grounded. Even being able to tell the story enough so that it becomes coherent, to be able to rehearse it a bit, so that they are not so raw. All that is background that people would have already developed by the time they got to their hearing. Now that's almost non-existent and people have to face that brutally fresh.

She explained that prior to the changes to the refugee determination policy, when there was more time and more mental health treatment available in the community, a brief course of therapy could help a claimant prepare for their hearing and thus reduce vulnerability.

The health professionals also reflected on the kinds of reactions different mental health presentations can elicit in other service providers. One counsellor explained that the diverse range of trauma-related symptoms described above are not always recognized as such by non-mental health professionals. She explained that when claimants expressed sadness, grief or a depressed mood, especially by crying, they elicited the strongest empathy, concern and support. In her experience, non-mental health professionals in the community most frequently identified these claimants as vulnerable. In contrast, she stated that flat-affect, anger, irritability, thought disturbance, hyper-arousal, and anxiety presentations did not have the same help-attracting effect. In her words, these are "more misunderstood," and she explained,

> A client that remains silent, or digresses into tangents, or becomes irritable, or whose speech is pressured, when being interrogated tends to turn the interviewer off more than the one that gets more emotional. Emotionality draws people in, compels people to take care.

As these respondents suggest, mental health symptoms can elicit different kinds of responses from non-mental health professionals, and claimants can be vulnerable to the extent that their symptoms provoke disbelief, rather than empathy.

This descriptive account of the diverse perspectives held by the various professional groups across the refugee determination arena demonstrates that it is not a unified concept, and that a working understanding of 'what vulnerability looks like' is informed by a person's professional experience and context, and reflect tensions and contradictions in the way the concept is understood 'on the ground.' Government officials shared their observation that the concept of vulnerability is about unfair access to the system that could be mitigated with accommodations, but they indicated that there is some debate within the system about whether this is to be seen strictly as a consequence of claimants not "understanding the nature of the proceedings" or if the spirit of the guidelines allows for a more generous interpretation. Refugee lawyers challenged this narrow conceptualization and described ways in which vulnerability is an interactive process in which lawyer's past experiences with incomplete disclosure or variances in decision-makers interviewing styles can lead them to "push" claimants for full disclosure in advance of the hearing even at the expense of mental health concerns. Service providers emphasized social determinants of vulnerability, citing extreme poverty, precarious housing, and the physical and material demands of the early phase as factors that contribute to vulnerability. They reported that the refugee hearing takes place in the period of peak migration stress, which impedes claimants' performance in a very demanding process. Primary and mental health clinicians also focused on the interaction between the claimants and the system. They described a pathway of vulnerability along which pre-existing mental health issues are

exacerbated by stress, causing a breakdown in communications and the risk of claimants being disbelieved and found not credible.

Taken as a whole, this collection of diverse professional perspectives allows even greater insight into the concept of vulnerability than the subsection above – which provided the official definition and integrated descriptions of the aspects of vulnerability – could offer alone. For example, in contrast to the official definition, professionals who engage with this concept articulate their understanding of it in a way that highlights its interactive and systemic qualities. The section that follows describes the implementation strategies that are undertaken at the governmental and community levels.

Implementation Strategies

As each professional group articulated a distinct conceptualization of vulnerability, so too did each group describe unique implementation strategies that reflected these conceptualizations. Furthermore, in my analysis of interview data it was evident that individual respondents within the different professional groups demonstrated varying degrees of familiarity with the concept and its aspects and this reportedly impacted their ability to engage with the concept of vulnerability in practice. The identification and implementation strategies described below reflect the finding that emerged through analysis of interview data, that individuals and groups tended to emphasize certain elements and were less focused on others.

Identification of Vulnerability. Interviews with respondents across professional disciplines indicated that there was a wide variation in the ways individuals and groups identified vulnerable claimants in their practice. This subsection describes how respondents identify claimants based on their awareness of the different aspects of vulnerability.

At the time of the data collection for this research, there were no reports of measures either at the IRB or the community level being employed to systematically assess for vulnerability subsequent to mental health concerns, traumatic experience, or identity variables. A few respondents described using standardized measures or questionnaires in their workplace to assess for mental health and psychosocial concerns, but without a clear focus on identifying vulnerability in the refugee determination process.

Respondents at the IRB and in the community stated that they often relied on claimant disclosures and their own empathy or intuition to identify vulnerability. One respondent acknowledged that she is much less confident about relying on empathy under the current time constraints, stating, "You understand it by being with people. There used to be more time for that." Other service providers stated that though they worked with large numbers of refugee claimants, they did not think they interacted with many vulnerable claimants. Some stated that they did not have the training, mandate or comfort to consider vulnerability in their professional role. Some expressed the hope that if a claimant were vulnerable, their lawyer or another service provider would identify this.

While there was a high degree of general awareness of mental health concerns as an aspect of vulnerability, there were varying reports of competency in recognizing issues related to mental health and subsequent vulnerabilities in practice. Several respondents explained that their training and their roles do not include a mental health focus; such as this service provider who explained,

> It would be hard for me to recognize if somebody needed further support in terms of a mental health disability because, how do you know the difference between [being] nervous about something […] as opposed to actually having some deep suffering? […] I don't know the difference […] To me, that's very complicated and to be able to deal with it in such a short period of time and not have somebody who knows what they're doing be able to recognize it [and to consult],

> is a really difficult thing.

Conversely, several non-mental health professionals asserted that they could easily identify people who were vulnerable as a consequence of mental illness because it was "just obvious." From their description, however, it appeared that they were only referring to cases in which florid psychosis was present. For example, an IRB official stated,

> If you get an incoherent BOC [Basis of Claim narrative], if it's, you know, "I was forced to put aluminum on my ears," and so on and so forth, there's a tip off there that this person may not have the capacity to understand the nature of the proceedings. They may be suffering from schizophrenia or some other kind of mental illness and they are going to need some assistance.

While severe untreated psychosis would likely be identifiable to non-mental health specialists such as this official, and would certainly confer vulnerability, this was described as if it were the only form of mental health-related vulnerability. This suggests that such individuals would not likely identify the wide range of mental health presentations described above. Indeed, mental health clinicians stated that they were aware of many cases in which severe mental distress and dysfunction was not identified, or was misinterpreted to the detriment of the claimant. Among the respondents who demonstrated a nuanced understanding of mental health-related vulnerability, a few noted that claimants' symptoms often have a fluctuating, inconsistent presentation which can make it difficult to determine the severity of the mental health challenges present and to anticipate how they might confer vulnerability in the hearing. As described above, when claimants are functioning at their worst, they often withdraw socially; and while this behaviour increases their vulnerability within the claims process, it also makes the severity of their dysfunction less visible to service providers. In short, while mental health was clearly a topic of interest and concern among members of all respondent groups, there was significant variation in the depth and nuance of understanding of how mental health interacts with

vulnerability across the refugee determination arena.

In contrast to the variable of 'mental health concerns' respondents stated that they identified vulnerability on the basis of claimants' traumatic experiences more consistently. Some respondents indicated that while they did not have the expertise to identify mental health symptoms, they would immediately consider vulnerability if they became aware that claimants had experiences of torture, genocide, crimes against humanity or sexual violence. However, while none of the respondents described using standardized procedures such as a traumatic events checklist to access this information, some informants stated that they relied on their knowledge of country conditions to probe this issue. A number of respondents highlighted the idea of resilience, explaining that while many claimants who suffer traumatic events demonstrate a remarkable ability to persevere, their resilience can mask the severity of their distress, with the result that their vulnerability is unrecognized or minimized. Respondents also cautioned that vulnerability can also be overlooked, even in cases of where violent trauma is disclosed, because it is so common among claimants that it begins to be seen as normative and thus unremarkable. In the words of one service provider,

> It becomes normal. We just kind of expect that that's the way it's going to be. I think that's one of my challenges personally and then probably as a team, is that we've lost track of our baseline.

So while respondents stated that they are alert to trauma histories in refugee claimant narratives, they indicated that these would not always lead them to consider vulnerability.

There was a high level of recognition among respondents that women facing gender-based persecution and persons fearing persecution on the basis of sexual orientation and gender identity are to be considered vulnerable persons. Respondents were most alert to the risks attendant to sexual violence. As with the political violence variable described above, none of the

key informants indicated that they used a standardized tool such as a traumatic events inventory to elicit disclosure of this type of trauma history. Some stated they relied on their intuition that a claimant is withholding something, as one lawyer put it, "You just go partly on instinct and, in my own professional experience, having an ability to observe people." Less frequently mentioned were cross-cultural differences in the development and expression of gender- and sexual identity, on-going exposure to interpersonal violence, primary childcare responsibilities, or post-partum depression. Furthermore, while most respondents were attuned to sexual violence, some acknowledged their own discomfort in asking about such history or considering the consequent vulnerabilities. One clinician suggested that discomfort and shame can limit the effectiveness of service providers and officials as they engage with claimants on this theme. One lawyer, for example, shared his discomfort with and tendency to avoid themes of sexual trauma,

> But, um, it's something that I personally, usually will talk about to a very limited extent in some kind of claims, like sexual assault. I don't really want to go there, or child abuse, you know. Issues like that I don't probe too much into, that unless the claimant is initiating that openness and then I sort of just respond to that but I don't willingly go there if it's clear to me, you know, that they don't want to talk about it that much. And usually the members are OK with that; they don't want to talk too much about the actual sexual assault or something.

Thus while respondents demonstrated their alertness to the vulnerabilities associated with gender and sexual orientation, there was significant variability in how comfortable they were in addressing it.

While respondents discussed an ability to identify vulnerable claimants based on their signs of psychological distress or dysfunction and reports of traumatic exposure, other indicators of vulnerability were not mentioned. Specifically, age-related vulnerability and emergent aspects of vulnerability, such as poverty and detention were not mentioned as indicators. This omission may be an artifact of the interviewing process, however it is possible that these other aspects of vulnerability are likely to be more familiar to professionals who encounter claimants in a

community-based setting where a wider range of their needs and experiences are visible and may be missed by those who interact only in official settings. In general, however, respondents reported variable familiarity with the categories of identity and experience that are listed in Guideline 8. It was evident that across the refugee determination arena there was a diverse array of approaches to identifying vulnerability and limited use of standardized measurement. Some spoke of experiencing difficulties identifying vulnerable claimants and not everyone was comfortable with even addressing the construct. Respondents suggested improvements such as more consistent direction from the IRB in this area, a standardized process, further training, or access to mental health or other professionals for consultation.

Application of the Vulnerability Concept at the Immigration and Refugee Board. In this next subsection, I describe how the concept of vulnerability is applied within the Immigration and Refugee Board of Canada. I constructed this description after examining Guideline 8, the application form for the Vulnerable Person designation, two completed applications contained in the case submissions package of two recent claimants, the "New RPD Member Training, Module 12: Chairperson's Guideline on Vulnerable Persons" manual ("RPD Training Manual") dated February 2013 that was obtained through an Freedom of Information request, interviews with two IRB officials, and interviews with key informants.

Given the existence of Guideline 8 and the RPD Training Manual, the IRB clearly acknowledges vulnerability as an important issue. It was nevertheless difficult to determine how frequently and to what extent the guidelines are applied in practice. IRB officials stated the IRB does not maintain statistics on the numbers of vulnerability applications submitted or designations granted. However, one official conceded that there are "very few" applications relative to the caseload. This official asserted that a formal application and designation should

not generally be required because all members are trained to treat every claimant with respect and with sensitivity to the fact that, “Everybody’s in a difficult situation.” The official explained that members work hard to integrate the testimony with what is documented in the submissions and contained in the country reports, so that the decision does not rest exclusively on the claimant’s testimony. This official also maintained that questions are addressed appropriately for a claimant’s culture and level of education, and that members are advised to avoid asking questions about traumatic history, saying, “We’ll take that very seriously. We won’t re-traumatize them.” Thus the official suggested that special measures are not generally warranted.

Nevertheless, according to Guideline 8, any person with knowledge of a potentially vulnerable claimant can make an application for the vulnerability designation at any stage in the process. The guidelines suggest that applications are preferred at the earliest stages of the process, and that refugee lawyers are considered “best placed” to make an application for vulnerability (IRB, 2006; p 4). The RPD Training Manual also states that members can identify vulnerability on the basis of the file review or in person at the hearing, and that members should exercise special care to ensure they consider vulnerability issues when claimants are not represented by counsel (IRB, 2013). The vulnerability application form provides an option for counsel, the IRB or the Minister to identify vulnerability; however, while according to the guidelines, unrepresented claimants, service providers, and community members may also apply, there is no check box on the form to indicate this, suggesting that this option is not anticipated in practice.

Guideline 8 suggests that the following accommodations are available to support vulnerable claimants:

> a. Allowing the vulnerable person to provide evidence by videoconference or other means; b. allowing a support person to participate in a hearing; c.

> creating a more informal setting for a hearing; d. varying the order of questioning; e. excluding non-parties from the hearing room; f. providing a panel and interpreter of a particular gender; g. explaining IRB processes to the vulnerable person; and h. allowing any other procedural accommodations that may be reasonable in the circumstances (IRB, 2006; p. 3)

The guidelines also stipulate that whoever makes the application can recommend accommodations or accommodations can be made at the IRB member's discretion.

According to the RPD Training Manual, and re-affirmed by an IRB official, members enjoy significant discretion to make procedural changes in the way they conduct a hearing, so that they are able to meet a claimant's needs whether they have been officially designated a Vulnerable Person, or not. In addition to the accommodations listed in Guideline 8, one of the IRB officials described a possible range of accommodations that a member might make, stating, "sometimes it can be something so simple, like the member says, 'Would you like some water?'…or "asking a child to do a drawing" or "just let[ting] the person talk without interrupting them at all." She stated that it may also be enough to simply verify a claimant's identity and accept the submissions as fact, without requiring oral testimony. Both she and the RPD Training Manual suggested that the first scheduled hearing could be used as a pre-hearing conference at which to request accommodations, such as a postponement to allow time for the claimant to access medication and counselling, and to stabilize psychologically. The IRB official also stated that if there are any discrepancies in the submissions, the decision maker has the discretion to interpret these in light of vulnerability, especially if there are recognized mental health concerns. Finally, the official and RPD Training Manual both stated that members are encouraged to render their decision orally, from the bench, or as soon as possible after the hearing to protect vulnerable claimants from the additional stress of uncertainty about their case.

IRB officials acknowledged, however, that there are some obstacles in the new system to implementing the guidelines, and suggested that the greatest of these are the new timelines, which stipulate that, in general, refugee claims are heard within 60 days. As one official stated, "it's an extraordinarily short period of time to get all of this together." In recognition of the time pressure all actors in the system face, the RPD Training Manual suggests that while applications are preferred, this procedural formality should not interfere with a member's duty to assess vulnerability needs and make necessary accommodations even if no formal application is made in advance of the hearing.

Another obstacle to consistent implementation, according to one of the IRB officials, is the fact that adherence to the guidelines is purely voluntary. The RPD Training Manual states,

> Chairperson's guidelines are intended to promote consistency, coherence and fairness in the treatment of cases at the IRB. Guidelines are not binding on members, but members are expected to follow them, unless compelling or exceptional reasons exists to depart from them. Failure to adequately consider the Guideline, in appropriate cases, may constitute a basis for appeal to RAD or to judicial review.

Thus while IRB members are expected to adhere to Guideline 8, since they are not binding an IRB official conceded that in practice there "may be variations among members as to how it is applied." This official went on to compare Guideline 8 with the gender guidelines, which are mandatory, saying,

> There's no legal framework to require them to do that [i.e. implement Guideline 8]. And I think this is probably the most important thing I may say today: all the sensitivity training in the world isn't going to help that. [In the case of the Gender Guidelines] what was required was a directive from the IRB that said you *must* do this and if you're not going to do this then you must distinguish the case and say why.

Furthermore, this IRB official suggested that in order for the vulnerability guidelines to be implemented in a more rigorous and consistent manner, more training resources would need to

be allocated to this issue. He suggested that this would likely only occur if the Federal Court highlighted a systemic problem by overturning a number of decisions on the grounds that vulnerability was not considered.

Key informants throughout the service community acknowledged the work of the IRB to address the needs of vulnerable claimants. A number of respondents asserted that Guideline 8 is "a good start." Several of the refugee lawyers noted that some members are "very sensitive" to issues of vulnerability, and stated that in best-case scenarios, claimants are supported to present their testimony, and decisions are made in consideration of vulnerability. This was echoed in the words of a recent claimant, who stated,

> The member was a great person. In that moment she helped me to feel safe, and she really listened to me, and I can say what I need to say. […] I feel like I was treated with respect, like a human being for once in my life, and that thing made me comfortable.

Like the IRB official above, however, some lawyers observed that there is no imperative on members to implement the guidelines and, as a result, there is considerable variability among members. Several lawyers stated that they rarely make formal vulnerability applications because it is a "very onerous process," especially if separate corroborating documentation is needed. The Guidelines indicate that applications must be supported "whenever reasonably possible" by "independent credible evidence" such as a detailed expert assessment report (IRB, 2006; p 4); however lawyers pointed out that vulnerability applications and supporting assessments are not compensated and so this step takes time and resources away from preparing the refugee claim.

Refugee lawyers also suggested that obtaining the designation did not substantially alter the course of the proceedings; with one asserting, "I'm reluctant, quite frankly, to do it because I don't think it makes a whit of difference to some members, or even to most members." Another lawyer stated "the accommodations are procedure without substance," and yet another said,

"You may recognize vulnerability but then just not have much to ask for, and so then what's the point in bringing it up?"

Some respondents suggested, however, that the formal vulnerability designation had grown in importance under the new legislation. Indeed the RPD Training Manual makes reference to the fact that more applications are anticipated, given that this is one of the only justifications for postponement. A number of lawyers acknowledged the strategic importance of the vulnerability application, as one of the only ways to request more time to compile the necessary documentation and prepare the claimant to testify. Yet as one lawyer stated,

> Vulnerability status is probably more important under the new timelines. The first disclosure is generally happening without representation, claimants have limited adjustment, very little psychological preparation. However the accommodations are insufficient. They don't necessarily help.

Additionally, as one lawyer stated, "When we do apply for vulnerability and request an extension, they only give 10 days. It is an extraordinary amount of work with very little return."

Refugee lawyers reported that some of their most significant concerns, regarding the way claims are adjudicated, are not addressed in the way Guideline 8 is applied. Several lawyers reported that even when claimants are declared vulnerable, and the decision-maker behaves in a compassionate and respectful manner, claimants are often asked detailed questions about peripheral details to traumatic events. Refugee lawyers were very concerned that decision makers rely heavily on the consistency of claimant's narratives in making credibility determinations, and that inconsistencies generally occurred in peripheral details. One lawyer stated,

> It's hard [for decision makers] to get out of the mindset of how they normally conduct a hearing. But if the questions they ask and how they ask them are kind of the same, I don't see a difference… I find it confusing, meaningless actually, to have someone talk about it in a light way, like 'relax, its going to be ok, we're just

> here to have a conversation' and then launch into lots of really detailed, specific questions where they are totally calling into question [the claimants] statements.

Refugee lawyers stated that inconsistencies were rarely, if ever, interpreted in light of vulnerability. They also reported that decision makers did not tend to consider psychological evidence that anticipated or contextualized a claimant's difficulties in consistently narrating testimony. One lawyer stated, "Psychological evidence is handled in an arbitrary and random way." Another lawyer elaborated, stating,

> The fact that you have strong psychological evidence that somebody can be expected to have a difficult time recalling traumatic events, especially the chronology or the details etcetera. You know, members don't grant much leeway and they generally don't hold off on asking questions in precisely the area that's expected to give [the claimants] trouble.

Another refugee lawyer stated that decision-makers increasingly dismiss psychological reports, especially those that do not rely on standardized testing. He stated that refugee lawyers frequently rely on clinicians' reports because there is very little funding to cover comprehensive psychological assessments by independent evaluators.

All of the refugee lawyers who were interviewed asserted the need, at the IRB level, for greater nuance and precision in recognition of the special needs of vulnerable claimants, with one lawyer stating, "The accommodations that are given are not directed in any kind of justifiable way towards what actually makes people vulnerable." While the RPD Training Manual states that the IRB encourages counsel to be very focused in their requests for accommodations and to justify in writing why they are needed, several lawyers stated that they would benefit from more direction in terms of what additional 'reasonable accommodations' they could request, and how to tailor their requests to the specific needs of the claimants.

The primary source for the conceptualization of vulnerability is the Immigration and Refugee Board. The concept and stipulations for its internal implementation originate within

Guideline 8, which only officially applies to the IRB. Nevertheless, professionals in various capacities are engaged with the concept as they support claimants to navigate the refugee determination system. The ways in which the concept of vulnerability is applied in the community is described in the subsection below.

Community-Level Application of the Vulnerability Concept. The following section provides a description of the community-level interventions in which the concept of vulnerability is engaged. This description was constructed from analysis of qualitative interview responses of professional and refugee claimant respondents. My analysis of these responses suggests that how each professional discipline conceptualizes vulnerability, and the perceived impact vulnerability has on the outcomes they are trying to achieve, determines the kinds of interventions they make to address vulnerability in their practice. While Guideline 8 only officially applies to the Immigration and Refugee Board, professional respondents, including IRB officials, were unanimous in asserting that vulnerability cannot be addressed solely the IRB level because, as one service provider stated, “Once they get to the IRB, it’s too late in the game.” Service providers at the community level, often engage in interventions to address vulnerability either directly, as a means to support the refugee claim process, or indirectly, to reduce the stressors that impact a claimant’s performance.

Respondents asserted that while community-level interventions are necessary to reduce vulnerability and ensure that claimants have access to a fair hearing, they could only be effective if services were accessible, timely, and highly specialized to assist claimants to meet the exacting requirements of the refugee claim process. They also stated that effective interventions depend on accurate identification, appropriate referrals and adequately resourced services. Respondents described scenarios that illustrated that when all goes well, a refugee claimant travels a well

coordinated pathway, characterized by a high degree of communication and collaboration among professionals with strong working relationships, in which claimants are identified early and concerns about their vulnerability were communicated across the arena in order to generate personalized accommodations and supports.

As described by several respondents, in such a best-case scenario, a vulnerable claimant would receive specialized orientation information at the point of entry, obtain shelter with a supportive housing organization, meet with a settlement worker who could assist the claimant to access necessary material supports, and be approved by legal aid. Ideally a service provider would flag vulnerability by this point, so that the claimant could be referred to a lawyer who is experienced in working with vulnerable claimants, and who could prepare the claimant appropriately, refer him or her to a specialized counselling program designed for pre-hearing psychological preparation, and obtain a psychological assessment. Refugee lawyers described using practices with vulnerable claimants that they believe facilitate disclosure and protect against harm, such as taking the time to explain the process and the expectations, working to build trust, emphasizing confidentiality, listening without interrupting to the complete history, conveying a non-judgmental attitude, to be attentive to claimants' emotional reactions, and to provide empathy and breaks as necessary. Refugee lawyers also emphasized the importance of working collaboratively with mental health professionals who can provide support to claimants and psychological reports for the IRB. As one housing provider stated, "this is the best kind of outcome that you can hope for from the whole system when everything works properly."

Respondents acknowledged, however, that vulnerable claimants do fall through the cracks, as can be observed in the case studies presented in the next section of this chapter. Respondents asserted that, with the current time restrictions and severely curtailed services for

refugee claimants, there is a greater risk to claimants and a need for a consistent application of the provisions of Guideline 8 across the refugee determination arena. One service provider echoed the sentiments of many, when she stated,

> There are the changes to the claims process and then also all the federal government funding cuts [to services] at the same time, so there is just such a limit on what we can do as a community. It's a bleak time, that's for sure. For all of us who work in this sector, it is really hard to keep hearing of so much need and to know the whole range of challenges that claimants have ahead of them, and to know that there is only so much we can do.

Several respondents suggested that in an environment defined by scarcity and the intense pressure of time, it is imperative that vulnerable claimants are accurately identified, appropriately referred and prioritized for services.

Additionally, while many respondents stated that good medical and psychological reports and consultations by health and counselling professionals with expertise in refugee mental health are very helpful and assist them, as well as the IRB member, to understand how a claimant's identity, trauma history and symptoms have the potential to impact their claim, these are not frequently utilized. Those who recognized this value asserted the need for increased access to specialized mental health services within the refugee determination arena. As one lawyer stated,

> Sometimes we need help getting to understand this person, and their behaviours and how they might be typical of post traumatic stress… That would be great to have in a report. Because sometimes you get to the hearing and the decision maker is totally frustrated – why aren't they just answering the question directly… If you have evidence and can justify it, to state a professional opinion, *that* is helpful. Because just picture it, a person in the hearing room avoiding, very bad on date recollection, vacant, vague details, gaps in memory – we need help interpreting that. And even though they've been told in a training that it's post-traumatic stress disorder, when they are in the hearing room and a person has a blank in memory, they may not attribute it to the training that they had.

Several respondents noted that a more active and visible presence of mental health professionals within the sector could contribute to a greater degree of trauma-informed practice at all points of

contact with government agents, legal professionals and community services**.** Respondents cautioned, however, that highly specialized knowledge of the refugee claim process is necessary for such assessment and consultative services to be effective.

Primary health and mental health clinicians highlighted the need for their organizations to formalize their response to vulnerability within the context of the refugee claim, at the community-level. For example, one clinician explained that while highly symptomatic claimants are frequently referred for treatment, clinicians may limit their practice to the provision of treatment but may not initiate communication with lawyers or the IRB, and as a result highly pertinent information regarding vulnerability is lost to the refugee determination process. He emphasized the importance of these inter-professional communications, stating,

> There have been several times [in my experience] that the case was made because of a medical examination, and the documentation of scars. I have to say that many times lawyers don't ask for a letter or an exam…. I always examine people… and I can write to the adjudicator and say this person [has] these nasty scars.

This clinician stated that it took many years and significant consultation with refugee lawyers for him to develop the expertise to produce medical reports that address issues of vulnerability, and that in his opinion there are not very many clinicians in the field with this specialized knowledge and experience. He explained,

> I would say it was often just luck that a person connected with a health professional with knowledge of the refugee system. I did a lot to try to broaden that skill base [within my organization] and I had some success, but [my supervisor] called that activism.

He highlighted the need for organizations that provide health and counselling services to refugee claimants to address vulnerability within their own mandates so that, in addition to providing treatment, clinicians are trained and empowered to advocate for their clients throughout the refugee determination arena.

Finally, in such a time-limited and resource-strapped environment, respondents emphasized the increased importance of communication between the diverse actors. While strong mechanisms of communication exist within groups, many respondents voiced the desire for more communication between groups. As one service provider suggested,

> We need to focus more attention on not being such siloes, […] We need to come together and talk about what vulnerability means, we all have different lenses that we come at that with, and maybe we need to develop a kind of standard that we are all measuring or thinking about the same thing. That seems like an important first step. There is so much willingness to enhance practices and collaboration in this region.

Respondents like this one were interested in developing collaborative partnerships, with the aim of developing a more uniform understanding of vulnerability across the refugee determination arena. They suggested that when government officials, lawyers, service providers and health professionals are able to discuss both sector-wide and case specific concerns it serves the best interests of vulnerable claimants.

Concluding Summary of Section One

The preceding section answers the question of how vulnerability is conceptualized in the refugee determination arena; that is, how it is defined officially and understood by the people engaged with these systems. Vulnerability is defined and detailed descriptions are provided of its constituent aspects -- the characteristics and experiences that are listed in Guideline 8, as well as a number of aspects that emerged from interviews. Analysis revealed that, for participants across groups, vulnerability relates to the potential for re-traumatization as well as severe impairment of a refugee claimant's ability to present his or her case as a result of mental health, aspects of identity, traumatic experience, and current environmental conditions, such as precarious living conditions and detention in Canada. Reports from diverse data sources provided elaboration on the core categories cited in government guidelines and offer a more detailed description of how

vulnerability is understood in the field.

Though the description of vulnerability was constructed using information from all data sources, in practice, professional groups across the refugee determination arena engage with the concept in distinct ways. There was considerable variation in the way each professional group conceptualized vulnerability and the intervention practices differed correspondingly. Government sources emphasize fair access to the system, refugee lawyers tended to focus on barriers to disclosure, service providers concentrated on social determinants of vulnerability, and primary and mental health professionals described a pathway of vulnerability that highlighted the interaction between stress, mental health functioning, and communicative capacity. While the ultimate responsibility for identifying and mitigating vulnerability rests with the IRB, respondents highlighted the role that various civil society groups can play in helping vulnerable claimants navigate the system.

In the following section, three exemplary cases are presented to offer readers insight into the experiences of particular people, as illustrative grounding for the preceding section's description of vulnerability across the refugee determination arena. There are no claims being made that the cases are "representative" in a quantitative sense; instead, the case descriptions are intended to connect research findings to lived experience as a source of triangulation. Drawing from documentary material and qualitative interviews with multiple sources, the exemplary cases are offered to illustrate how the process of refugee determination can unfold in individual experience.

Section Two: Exemplary Cases

This section presents three exemplary cases in order to ground the previous section's description of vulnerability in the experiences of particular people. As detailed previously in the

methods chapter, all of the recent refugee claimants who participated in this study were referred by key informants in the community, on the basis of their knowledge of the claimants' experiences of vulnerability throughout the claims process. Out of the eight claimants who participated, three cases were chosen for their diversity and availability of complete submissions packages. The cases are not meant to be representative, but are offered as illustrative examples to give readers insight into the particular experiences of people in the process of refugee determination.

In each case study, the refugee claimant is briefly introduced with general demographic information and the basis of their refugee claim, with all identifying information removed or obscured. This is followed by a description of the interview conditions and the researcher's observations at the time of the interview, as well as list of the documents that were reviewed. The exemplary cases proceed with a description of the refugee claim process and outcomes, drawing from interviews with the claimant and key professional informants familiar with their case, and the documentation on the case, to answer the questions: What was the claimant's experience of vulnerability throughout the refugee process? How was vulnerability identified and addressed? And, what were the consequences of vulnerability on a claimant's ability to present his or her case and on his or her mental health, throughout the claim process? The cases are presented at this point in this research report because they serve to illustrate many of elements of vulnerability described previously, which were distilled from the government documents, key professional informants and multiple refugee claimants.

Exemplary Case #1: Central American Target of Gang Violence

> "Many times we cannot talk for fear and for shame and pain. And they need to consider that these are the reasons why we cannot talk clearly. It is very painful, very hard for the people."
>
> -Ms. Flores

Background. Ms. Flores is a woman in her early 30's from Central America, who came to Canada to seek protection from a criminal gang that had targeted her and her children in her country of origin. In her application she described how she and members of her immediate family had experienced a gradually escalating campaign of extortion and attempts at forced recruitment, during which time they endured extreme financial hardship, threats, harassment, beatings, kidnapping, and sexual assault. Her submissions also describe how she fled her country with her two young children, and survived a terrifying and violent journey through Mexico and the United States, before reaching Canada.

Research Process. A clinical counsellor with lengthy experience working with refugee claimants referred Ms. Flores to participate in this research project, on the basis that her symptomology was severe and likely contributed to difficulties narrating her testimony. Ms. Flores participated in a sixty-minute interview, in conjunction with her counsellor who provided translation from Spanish to English and was available for emotional support if necessary. During the interview, Ms. Flores' affect was flat and occasionally tearful, and she appeared severely depressed. With her consent, I also discussed her case with her counsellor and her lawyer, and reviewed the entire submission package for the refugee claim, including: the Basis of Claim Form, the Narrative Addendum, Country Conditions Documentation, Psycho-legal report from Registered Clinical Counsellor and the Notice of Decision.

Description of the Refugee Claim Process. Ms. Flores was never officially designated as

a Vulnerable Person, though various people throughout the refugee determination arena recognized vulnerability factors. At one of the earliest points of contact, the intake worker at an organization that provides legal assistance, responded to the history of sexual violence that was included in her Basis of Claim form, as well as to her emotional presentation during the interview, and made a referral to a non-profit organization specializing in refugee mental health. Because Ms. Flores was referred early and was assessed as in urgent need, she was able to access five sessions of counselling prior to the hearing. According to the counsellor, the sessions were primarily focused on emotional regulation and helping her prepare to testify in the hearing. Ms. Flores explained,

> [The counselor] helped me with my nightmares and taught me many techniques to manage my emotions. But I was still nervous because I knew I would have to talk about [the experiences that were the basis for her refugee claim].

The counsellor also provided a letter, which was included in the submissions to the IRB, detailing generalized anxiety, sleep disturbances, frequent nightmares, hyper-arousal, fear to be alone on the street or at home, inability to be around many people, constant fear that someone might hurt her, feeling exhausted, afraid, overwhelmed, and constantly on alert. The letter concluded that Ms. Flores had symptoms consistent with PTSD but did not explicitly identify vulnerability as per Guideline 8, and did not discuss the possible impact of symptoms on testimony nor suggest specific accommodations.

Ms. Flores retained a refugee lawyer with considerable experience with vulnerable claimants from her region. While the lawyer stated that a full psychological assessment was warranted, she did not believe there was sufficient time or financial resources to make this possible. The lawyer identified the vulnerability factors in this case, including that Ms. Flores had experienced gender-based persecution and had current mental health symptoms that might

impact her capacity to narrate the basis for her claim. She also recognized that the children were vulnerable, by virtue of their age and the fact that they had also been threatened with and witness to violence. However, the lawyer explained that she declined to make a formal application because she believed the case was strong enough to succeed without drawing special attention to vulnerability. She also stated that in her opinion, "It makes no difference. At the IRB, nothing changes. It all depends on the particular member and also, on how well the client performs at the hearing." She stated that whenever she has a vulnerable client she works intensively to obtain full disclosure and prepare them to testify.

Ms. Flores described how her lawyer helped her to prepare for her hearing, saying, "she would call me and ask me how I was feeling, and she helped me feel better. And she told me to take my time. She told me that everything was going to be alright, not to worry." Nevertheless, she explained that though she trusted her lawyer, there were many things she couldn't disclose. "I didn't say everything," she said, "Even with her there were things that were too difficult. Even though she was my lawyer, and she was a woman, I couldn't do it." When I asked what made it difficult for her to communicate, she replied, "I don't know. I would feel like crying…"

Ms. Flores described her experience of the hearing, saying,

> That day it was like I didn't know where I was. I forgot everything. It was like it was all erased. It was like I couldn't remember. Everything came to me very fast, very fast, all the memories would come all at once, and I was very nervous. I felt so sensitive, like I would only cry and cry and cry *(voice shaking slightly).* I felt like… like… like everything that happened in that time was happening again right in that moment.

In addition to feeling blocked and overwhelmed, as she described above, she also stated that there were things she could not disclose in the hearing, "for fear and for shame."

I asked how the Board Member and her lawyer responded when she cried and she replied, "I don't know, they told me if I wanted to go [for a break], they gave me 15 minutes, but it didn't

really help." She explained that her mental health was not specifically addressed in the hearing. She had worked with her therapist to tell the most painful parts of her story, explaining,

> I was so nervous, but I was ready to talk, some things I could tell [the counsellor] in therapy, but then they didn't ask… [The lawyer] never mentioned that I was coming [for counselling] and I thought she was going to.

The Immigration and Refugee Board Member delivered a negative decision at the conclusion of the hearing, explaining that she rejected the claim on the basis of credibility, due to inconsistencies and omissions in the testimony. She described two specific discrepancies between information included in the written submissions and answers given at the hearing, which were related to Ms. Flores' memory of details embedded in traumatic events. The member determined that the narrative lacked credibility due to Ms. Flores' inability to comprehensively describe information of a deeply intimate nature. In her decision, however, the Board member appeared to disregard the expert opinion of the counsellor and, rather than interpreting the omissions and inconsistencies with regard to vulnerability, the decision maker used them as the justification for finding the claimant not credible. Subsequently, in what appears to be an instance of circular logic, as a consequence of finding that the claimant was not credible, she then explicitly declined to apply Guideline 4 on Women Refugee Claimants fearing Gender-related persecution. Though the basis of Ms. Flores' claim was related to sexual violence and there was evidence to suggest she was experiencing traumatic sequelae, the decision maker stated,

> As my decision in your case rests primarily on discrepancies within your evidence I do not find any application for the [gender] guidelines in assessing your evidence.

Furthermore, the decision maker made no reference to The Guideline on Vulnerable Persons at any point in her decision.

Ms. Flores' lawyer reflected on the case, saying

> In this case I don't know what happened. I was very confident about this case. She was very well prepared, but it all fell apart in the hearing. What happened? What happened? She was very frightened. But there were inconsistencies. And [there were issues] she just simply wouldn't talk about. I don't know why.

I inquired about whether Ms. Flores observed changes in her mental health symptoms before and after the hearing. She responded, "Yes, since the hearing I feel more depressed, my nightmares are more, even now when I am alone I don't feel safe, when I think about going back to my country I feel so afraid." The counsellor also confirmed that while Ms. Flores displayed symptoms consistent with Post Traumatic Stress Disorder before the hearing, after the hearing she also showed signs of severe depression and anxiety that persisted at the time of the research interview.

In sum, in this case, various actors in the determination arena recognized vulnerability factors, the claimant accessed community-based mental health supports and her lawyer worked under the assumption that she was vulnerable and prepared her accordingly. There was evidence contained in the submissions to suggest that the claimant had experienced traumatic events, including gender-based human rights abuses, and the letter from the counsellor stated that she was suffering mental health sequelae that could impact her ability to present her case, and which could be exacerbated by the hearing process. There was no indication in the documentation that vulnerability was flagged by Immigration, Refugees and Citizenship Canada (IRCC) at the eligibility interview or by the IRB member in preparation for the hearing. Nevertheless, certain informal provisions may have been made to address vulnerability in the hearing, given the fact that a female member was assigned to the case possibly in deference to the sexual nature of alleged assault, and that a break was granted in response to the claimant's emotional breakdown. However, both Ms. Flores and her lawyer stated that neither the pre-hearing preparation nor the

accommodations were sufficient, as she was not able to fully disclose her history nor present her testimony without experiencing emotional and cognitive difficulties consistent with a severe post-traumatic anxiety response. She recalls having become overwhelmed, flooded with intrusive memories, unable to concentrate or articulate responses in a clear and coherent manner. No attempt appears to have been made by the decision-maker to understand inconsistencies in her testimony in light of the mental health sequelae using either Guideline 4 or 8, and her case was dismissed on credibility grounds.

Exemplary Case #2: Middle Eastern Survivor of Torture

> "When he was here telling me about the torture, he was screaming. He was standing up and he was screaming, and it was really hard for me to follow exactly what happened. He'd get more and more agitated. I mean it's just the rage, the despair, the horror."
>
> -Lawyer for Mr. Naji

Background. Mr. Naji is a man in his mid-thirties from a Middle Eastern country. The basis of his claim was governmental persecution, due to his political opinions and as a result of his whistle-blowing activities. In his application he alleged that he had been arrested, detained and tortured on several occasions and that family members had also been threatened on his account. He was detained on arrival in Canada and at the time of the interview he was still being required to report weekly to Canadian authorities.

Research Process. A lawyer with over thirty years experience working with refugees referred Mr. Naji to participate in this research project. She stated that this claimant was experiencing an unusually severe level of psychological distress and that it had been impossible to obtain a coherent narrative. During my initial meeting with him, Mr. Naji enthusiastically stated that he wished to participate in the study and hoped his experience might benefit others. Nevertheless, he appeared very anxious and, given the severity of psychological distress

described by his lawyer, I decided that there was a potential for harm and that it would have been unethical for me to proceed with an interview. Therefore, with his permission, I interviewed his lawyer and reviewed the following documents: the Basis of Claim (BOC) form, the Narrative Addendum, country conditions documentation, psycho-legal report from a medical doctor, Application for Vulnerability Designation, Designation of Vulnerability, and the Notice of Decision. Mr. Naji also provided the full transcript of his refugee protection hearing.

Description of the Refugee Claim Process. Mr. Naji's lawyer stated that by the time she identified vulnerability, it might have already been too late. She explained that Mr. Naji had been detained on arrival and his original lawyer, "only made one trip out to the prison in the Fraser Valley, so he prepared the BOC, by and large, on his own." According to this lawyer the BOC was superficial, full of errors, and did not include any medical or psychological evidence related to physical and psychological injury secondary to torture. When she took over his file, and read that he had been detained in a country that routinely used torture, the lawyer sent him for a medical evaluation. She also filed a vulnerability application.

In her application for Vulnerability Designation Mr. Naji's lawyer wrote,

> I have noticed a marked deterioration in his mental health. He has told me that he is experiencing severe insomnia and anxiety, and is having trouble recalling even the most basic information [....]. His distress and agitation is palpable as he struggles to relay what has happened to him. When I met with him today, the interpreter and I spent considerable time trying to reduce his anxiety and distress. However, his anxiety would quickly re-escalate when trying to narrate traumatic events related to his refugee claim.

In the application, the lawyer requested the following accommodations: 1) the assignment of an experienced member with "particular sensitivity and skill in communicating with persons suffering from PTSD, [who] can create a safe atmosphere in the hearing room," 2) frequent breaks to be permitted throughout the hearing, "including during the course of his testimony,

should the need arise," and 3) reverse order questioning (that is, for the lawyer to begin the questioning process, followed by the IRB member).

A medical report, prepared by a senior physician with significant experience treating refugees, was also submitted with the Vulnerable Person application. In it, the physician described significant physical evidence of scarring on Mr. Naji's body and determined that these were consistent with a history of torture. She diagnosed Post Traumatic Stress Disorder and described his presenting psychological symptoms in detail. These included flashbacks, which reportedly occurred several times per day and left him "fearful, confused and disoriented." Mr. Naji was reportedly so hyper-vigilant that he was preoccupied with scanning the environment for danger and found it difficult to sustain a conversation. The physician wrote that Mr. Naji would likely have difficulty presenting himself at his refugee hearing, saying, "his current mental state is extremely fragile and he is expected to have significant intrusive recall and psychological re-experiencing of his trauma at the refugee hearing." She also cautioned that his medication would likely have a sedative effect and could exacerbate the cognitive difficulties he was already experiencing, explaining that as a result "he may not be able to present time sequences, dates and chronologies accurately." She suggested that a "gentle, informal environment and appearance of support people at his refugee hearing would be beneficial to him."

The IRB granted the vulnerable person designation and scheduled the hearing for a full day, to allow for extra breaks. The tribunal officer who completed the form noted that the case was to be assigned to "an experienced member." The officer also noted that the presiding member would determine whether to grant the request for reverse order questioning.

Though, by his lawyer's account, he was intensely distressed throughout the hearing preparation phase, Mr. Naji does not appear to have accessed any of the social services available

to refugee claimants. He received medical treatment for his psychological symptoms but did not access psychological therapy, though the lawyer noted that during his claim preparation period, mental health counselling for refugee claimants was particularly difficult to access due to funding cuts and the closure of pre-existing therapy programs.

According to the lawyer, the refugee hearing was a harrowing experience for Mr. Naji. It is evident from the transcript that the IRB member used a friendly and somewhat informal demeanor to try to put the claimant at ease at the beginning of the hearing. She also took time to explain the issues that she would be raising in the course of the hearing, provided breaks, and allowed for reverse order questioning. Nevertheless, the lawyer stated that the claimant was visibly distressed and had considerable difficulty responding to questioning. She explained that she began the hearing with questions about Mr. Naji's mental health, the medications he was currently taking, and the symptoms and side effects he was feeling, because she had wanted to emphasize the claimant's vulnerability in the hopes that this would set the tone for the hearing. The lawyer recalled, however, that when the member began her questioning, she focused on small details in his submissions, including some that required him to make conversions and calculations, and she noticed that he quickly became disoriented. She also recalled that as he was testifying, and as he became increasingly agitated, he began to speak more quickly than the interpreter could accommodate. After being asked to pause for the interpreter to catch up, he lost his train of thought, and this increased his sense of disorientation and agitation. She also stated that he "blanked out" on simple information, of which he had previously demonstrated fluent knowledge. According to documents filed in the appeal, Mr. Naji "broke down frequently during questioning." When the lawyer intervened to remind the member that vulnerability was an issue and she stated for the record that she was observing the claimant's "anxiety going way up," the

member responded that she was aware of the issue and she did not understand why the lawyer was interjecting in this regard. The member is quoted from the transcript of the hearing, saying,

> I understand you are nervous today and I also understand that you are anxious, but it's very important for us to understand each other. And I have to – I can't just sit here and not ask you these questions and then make a fair decision. I want you to relax. I don't want you to be anxious. I don't want you to be nervous. I just want you to speak what you know and what information you can provide me.

The transcript records Mr. Naji explaining how he felt "helpless, sometimes my brain freezes. I can't think of anything to say… I am totally blank." Furthermore, in response to a question from his lawyer to read part of a letter in which traumatic incidents are disclosed, Mr. Naji demonstrates typical avoidant behaviour, and states, "I don't dare to read it. I don't want to face the truth. I have made everyone I love to suffer…" After he does disclose the traumatic incidents, the member asks, "how come you can remember this, but not [logistical details related to dates and mundane events]?" and Mr. Naji responds, "every night I have nightmares about these things. These are not things I can forget." The lawyer stated that throughout the very lengthy hearing, Mr. Naji was able to speak about his work and his political activism with "remarkable clarity" but frequently became disorientated when asked to provide detailed information about dates or to justify decisions he made under duress.

The member denied Mr. Naji's claim for protection on the basis of credibility, stating that he was inconsistent in certain details, such as the number of days he spent on a layover while in transit. She also stated that she did not find his allegations of torture credible and believed he was merely harassed by authorities. In her decision, she found "the claimant was able to testify and explain his story in a coherent manner, although emotional at times" and stated that she did not believe that "the claimant's psychological condition impaired his ability to testify in a clear and coherent manner during his hearing." She acknowledged that the lawyer stated that the claimant

was frightened in the hearing room, but noted “the claimant was given procedural accommodations in order to make the hearing room comfortable for him.” She stated that though Mr. Naji stated that his “psychological problems and forgetfulness” were due to traumatic exposure, she found that there is no evidence “that he is incapable of thinking for himself due to previous problems with the authorities.”

In preparing his appeal, the lawyer observed that Mr. Naji’s mental state had deteriorated even further. She stated that he disclosed far more information about torture than he had done previously, but that it would erupt from him “like he was vomiting out his story.” She also stated that he began to describe speaking to imaginary people. Most alarmingly, she stated that rather than face the possibility of being deported, he had begun to ruminate about suicide.

In sum, this case raises the issue of the adequacy of legal representation and mental health support in pre-hearing detention; given that Mr. Naji’s original BOC was largely written without counsel and while he had no mental health treatment, and may have introduced errors that were a threat to credibility. Furthermore, though Mr. Naji was designated as a vulnerable person and granted procedural accommodations, these did not facilitate clear and coherent testimony, prevent symptom exacerbation, nor inform the decision-maker’s interpretation of his credibility. Though the lawyer was acutely aware of his dysfunction and distress, and the member appeared responsive and sympathetic, he displayed signs of distress and dysfunction throughout the hearing that were significant enough to cause severe cognitive disruptions. According to the lawyer’s recollection and hearing transcripts, he became overwhelmed, flooded, distressed, and disoriented. In the transcripts he described being “frozen” and having his “mind go blank.” Though the member assigned was experienced in hearing refugee claims, the lawyer remarked that she did not appear to have “the expertise to manage someone who is highly

traumatized." While she accepted that Mr. Naji was a vulnerable person, and appears to have attempted to make feel him comfortable in the hearing room, she did not recognize that her accommodations were not having their intended effect. Furthermore, in stating that she could not understand how Mr. Naji could remember traumatic experiences but not small and seemingly un-emotionally charged details, the member displayed a lack of understanding of how trauma impacts cognitive functioning. She also misconstrued the definition of vulnerability as the inability to "think for oneself." On the contrary, though Mr. Naji appears to have experienced a severe exacerbation of symptoms, consistent with re-traumatization, the transcript shows that he was insightful enough to attempt to explain what he was experiencing to the member during the hearing. Finally, Mr. Naji's mental health deteriorated precipitously subsequent to the hearing, such that he began describing auditory and visual hallucinations and became acutely suicidal.

Exemplary Case #3: Asian Survivor of Reproductive Rights Violations

> "I tried to open my own mind, to think about my children and why it was important for me to be brave and face these terrible things, and also to feel powerful in myself, to think that this is my chance, finally, to solve my own problems."
>
> -Mrs. Sun

Background. Mrs. Sun is a woman in her late-30's, who fled her country in Asia, with her husband and two children. In her application for refugee protection, she reports having experienced coerced gynecological exams, forced contraception, pressure to abort "out of quota" pregnancies, fines for having an additional child, and social marginalization for more than a decade. She also alleged having experienced sexual assault at the hands of a government official. On arrival in Canada she and her family lived in hiding, in isolation and precarious economic conditions, without obtaining information about the refugee process or the support services that they were entitled to for over a year.

Research Process. Mrs. Sun was referred to this research project by an experienced refugee lawyer, who recognized her vulnerability and the impact it had on her refugee claim process. I conducted a sixty-minute interview with Mrs. Sun, with the assistance of an interpreter who had worked with her throughout the claim process. While it was clearly painful for her to discuss her experience of the refugee hearing, Mrs. Sun stated that she was determined to share her story as she hoped it might benefit other women in her situation in the future. With her consent, I also discussed her case with her lawyer and reviewed the following documents: the Basis of Claim form, the Narrative Addendum, a medico-legal report from a registered psychologist, and the Notice of Decision.

Description of the Refugee Claim Process. Mrs. Sun stated that she arrived in Canada with her husband and two children, and that they lived in hiding for a year before initiating her refugee claim. She explained, "After one year of my arrival I made a refugee claim. I didn't want to face anyone, I was wandering around and worried and I didn't know what to do. So when I started to make the claim, I step up to my next step and my worry was a bit relieved." She was referred to a lawyer, with whom she felt very comfortable, and described the process of preparing for her hearing,

> He is a very nice person, he helped me to tell him little bit by little bit. He let me take my time. He would encourage me. If I couldn't talk any more, then he would stop. I try not to remember [my traumatic experiences], so I didn't know how to answer him. I didn't want to think about it. After I met my lawyer, in the beginning, it was very painful for me to talk about my experience. Every time I would go there, the night before I couldn't sleep. I would feel so bad. Until the late stage, he would comfort me and encourage me, and we had enough time before the hearing, so I was ready to talk.

She stated that though she was hopeful and determined prior to her hearing, she acknowledged that her traumatic experiences had impacted her significantly and she was "not coping very well."

Indeed, Mrs. Sun's lawyer explained that though he does not tend to use the vulnerability designation, as he finds it provides negligible benefits, he did make a vulnerability application in this case because he believed that the vulnerability issues were exceptionally salient. He confirmed that Mrs. Sun experienced great difficulty in discussing the details of her case, and that she would become highly distressed, agitated, and sob uncontrollably. He reported that he referred her for a thorough psychological assessment, and then applied for vulnerability status on the basis of the psychologist's conclusion that Mrs. Sun was suffering from "extremely high levels of anxiety and depression, while displaying all the major symptoms of PTSD."

The psychological report corroborated the lawyer's observations of how difficult it was for Mrs. Sun to narrate the basis of her claim. The psychologist wrote that during the assessment Mrs. Sun showed,

> Intense and dramatic reactions to having to speak about her traumatic past; she was easily triggered by reminders of her past and showed marked signs of physiological activation such as accelerated heartbeat, sweating, as well as hyperventilation.

The assessment also lists the symptoms that Mrs. Sun was experiencing prior to the hearing, stating,

> Frequent panic attacks, dissociative episodes in which the claimant feels disconnected from her body and as though she is floating, frequent flashbacks and intrusive memories, frequent nightmares, and hyper-active autonomic nervous system.

The psychologist also suggested that Mrs. Sun's mental health would likely deteriorate further if she were removed from Canada, however the assessment does not indicate how her current symptoms might impact her testimony, how the conditions of the hearing might impact her symptoms, or what accommodations might be protective.

In his application for vulnerability designation, the lawyer requested specific accommodations to allow her to "feel as comfortable as possible at her hearing so that she can answer questions about a topic that she finds challenging to discuss." He requested reverse order questioning on the basis that he had "been able to develop a level of rapport and trust" and believed that the claimant would be "better able to provide her evidence if [he was] permitted to question her first." He also requested a female interpreter, a more informal hearing setting, and the possibility of being granted breaks as needed.

Mrs. Sun explained that, though it was very difficult, in the time before the hearing she did disclose her full trauma history to the lawyer and that they worked together to ensure that she was ready to respond to questioning on the day of the hearing. She also stated,

> At that time I was ready to answer any questions, I was prepared for my hearing. I knew that this was the moment to decide my family's future. I knew that our fate depended on my ability to control myself and speak on our behalf. I knew what was important and I knew that I would be able to explain myself at my hearing. I tried my best to hold myself together.

Unfortunately, however, the hearing did not go as planned. When the hearing began, the lawyer reported being "blindsided" by the IRB member's decision to address all of his questions to Mrs. Sun's husband. Mrs. Sun explained what happened,

> [The Lawyer] requested vulnerability status, and he had asked that he could ask the questions first. But in my case the member was very different, very contrary to our expectations, it came as a surprise to [the lawyer], the member said 'ok so she is vulnerable, but the husband is not vulnerable so let me ask him instead.' That was very surprising. My husband does not have a refugee claim actually, he and the children are here because of me.

The lawyer explained that his request to question the claimant first was granted, and asked a few simple questions to put the claimant at ease, before turning the proceedings over to the IRB member. He explained that in the current system, lawyers are not provided a list of the issues that the member will be covering, and so he used caution in reverse order questioning to avoid raising

any issues that the member might not have flagged and to avoid asking trauma-related questions that the member might anyway repeat. In this case, the lawyer explained that after he finished questioning the claimant, the member directed all of his questions to the husband, "under the guise of trying to make it easier on the claimant" and as a result, Mrs. Sun was never thoroughly questioned. Mrs. Sun stated, "[the member] said that I was a vulnerable person and I need protection, and he said I should sit behind and my husband should sit in front with the lawyer." She also stated that

> At first I was a little bit relieved of my anxiety. At first I felt that this would let me take a rest. He asked my husband some questions and I was calm to listen to the questions, but gradually I find out that it was not just brief questions to let me have time to feel at ease, gradually the questions became more detailed… I was waiting and waiting and listening. He never asked me! I was even thinking of interrupting and asking the lawyer to tell him to ask me.

She reported that she was not called to speak again throughout the hearing, even when discrepancies arose that she wanted to correct. She said,

> Actually it hurt me much more at the hearing. I was there when the member was asking my husband, I knew the situation, I heard the questions, I felt the situation, but I could not speak out. I recalled the situation but I could not speak. If you hear the question and you are thinking and recalling everything and you could speak you could get it out, but then I was silent. It hurt me more.

She explained that being exposed to her traumatic experiences, and all the memories that this triggered, without being able to speak for herself or clarify points of misunderstanding, was damaging rather than protective. The lawyer explained, furthermore, that given the that the case was based on Mrs. Sun's reproductive health and sexual assault history, Mrs. Sun's husband did not know all of the facts and was in no position to testify on her behalf.

In the member's decision, provided from the bench, he stated that Mrs. Sun was designated a vulnerable person, and that accordingly, counsel was granted reverse order questioning, and Mrs. Sun was offered breaks as necessary throughout the hearing. Additionally,

he stated that he took the guidelines on "Women Refugee Claimants Fearing Gender Related Persecution" into consideration, though he does not mention how the guidelines were used to inform his decision. He also stated that Mrs. Sun had "the full opportunity to provide her evidence." The IRB member concluded that he found the husband "was unable to articulate in his testimony what plans [they had made to prevent further abuses]" and that he was "not aware of the details" of the case. The decision-maker thus found that the husband was "not a credible witness" and then dismissed the case on credibility grounds without referring to the fact that he had not heard Mrs. Sun's testimony. The lawyer explained that,

> We had a great psych report, just a fantastic one and the board member virtually ignored it, other than to circumvent the evidence. Just one brief, two or three-word mention of [the report] in the decision in a totally different context than credibility, nothing to do with credibility.

He stated his opinion that the way in which the vulnerability designation had been handled by the decision-maker displayed a lack of awareness of psychological factors, severely undermined the claimant's ability to present her case, and likely exacerbated her mental health condition.

Mrs. Sun initially stated that she did not access mental health supports while preparing for her hearing, because she did not feel comfortable going to a community-based counselling service. She explained that she had never been to a counsellor before and it did not feel particularly relevant to her during the time that she was working towards her hearing as she had so many pressing tasks to do in preparation. She explained that after she received her negative decision, she was utterly devastated, and at this time she accepted the referral and found the counselling to be very helpful. She stated that the counsellor was knowledgeable about the refugee claim process and could help her understand her experience and process her feelings, which has helped her in her appeal process.

In sum, in this case the lawyer submitted a detailed psychological assessment and

requested specific accommodations in his application for the vulnerability designation; however, at the member's discretion, the claimant was not questioned in the hearing, ostensibly in order to protect her from exposure to traumatic material. The claimant's husband was questioned instead, though he was not in possession of the facts of the case. This unusual accommodation did not meet the objectives of Guideline 8, in that the claimant asserts that she was prepared to testify on her own behalf and that her husband was not an adequate substitute, and that by being passively present in the hearing and listening to the questions and the testimony, she was not protected from traumatic exposure.

Integrative Summary of Descriptive Findings

In seeking to answer the question of how 'vulnerability' is conceptualized within Canada's refugee determination arena, I investigated the characteristics and experiences that are defined in Guideline 8 and further elaborated in other policy documents and by practitioners in various disciplines. According to Guideline 8, vulnerability relates to the potential for re-traumatization as well as severe impairment of a refugee claimant's ability to present his or her case as a result of mental health factors, identity factors, or traumatic experience factors. Current environmental conditions, such as precarious living conditions and detention in Canada, emerged through analysis as additional factors that can also contribute to vulnerability.

As described in the first section of this chapter, mental health concerns confer vulnerability when mental health symptoms cause impaired functioning in the tasks associated with the refugee claim process, especially in situations of intensified stress such as during the hearing itself. The symptoms most frequently described by respondents are associated with post-traumatic stress, depression and anxiety; however, key informants also highlighted particular vulnerabilities associated with psychotic disorders. Mental health related vulnerability

was often, but not exclusively, understood as being subsequent to traumatic exposure.

A history of traumatic exposure to events such as torture, genocide, and crimes against humanity is another aspect of vulnerability, such that experiences of state violence and exposure to massive trauma can induce symptoms, behaviours and beliefs that can impact testimony. Somewhat intertwined with the potential to develop post-traumatic symptomology, the issues most frequently highlighted by respondents are associated with being "triggered" by officials, leading to autonomic hyperarousal and/or reluctance to disclose sensitive information.

Though sexual violence can also occur as part of torture, genocide and crimes against humanity, it was most often subsumed in policy documents and by respondents under the category of 'gender.' Sexual violence was identified as a factor conferring vulnerability again by its propensity to induce symptoms, behaviours, and beliefs that can impact testimony. Respondents emphasized the inhibitory effect of shame on disclosures of sexual violence. However, in addition to the sexual violence frequently suffered by women and people with marginalized gender identities and sexual orientations, it was recognized that these groups of people may also be disproportionately burdened by biases in the refugee determination arena.

Age was recognized as a final identity-based variable, conferring vulnerability by way of cognitive immaturity or impairment, the burdens of physical health, and the potential to be adversely effected by the traumatic sequelae of caregivers. Finally, respondents assert that refugee claimants can also be vulnerable to the extent that they have significant unmet settlement needs, and if they have been detained on arrival in Canada.

The exemplary cases demonstrate a diversity and multiplicity of experiences, with vulnerability stemming from intersecting facets of the claimants' identity and traumatic past experiences, as well as their current mental health symptoms. In two cases, there were issues

related to gender persecution, and one claimant reported being a survivor of torture. All three disclosed violent trauma histories in their submissions, and all were experiencing severe post-traumatic symptoms. Two of the claimants also had children who could be considered vulnerable. The case studies demonstrate that the aspects of experience and identity that are described in section one are not experienced as discrete, singular categories in the lives of individual claimants. Rather, multiple aspects of vulnerability can intersect in unique and compounding ways. This will have implications for the kinds of interventions and accommodations that are needed.

In answer to the second research question, whether systemic practices with respect to vulnerable people are enacted in a manner consistent with their stated intent, section one describes the way vulnerability is conceptualized and the corresponding identification and intervention practices that were reported across professional disciplines. There was considerable variation in the way each discipline conceptualized and responded to vulnerability. Government sources emphasized fair access to the system, refugee lawyers tended to focus on barriers to disclosure, service providers highlighted social determinants of vulnerability, and primary and mental health professionals described the interaction between systemic stressors and symptoms which led to a break down in communication. Respondents reported that in the best-case scenarios, vulnerable claimants are identified in early stages of the claims process and receive a complementary range of services and supports. However, as reported by key informants and demonstrated by the exemplary cases, the disjuncture between disciplines can also result in vulnerabilities going unrecognized, services not offered, and accommodations not made. The very tight timelines, variation among IRB decision-makers, limited use of a wider possible range of accommodations, and the capacity of legal counsel and community service providers to

identity vulnerable claimants were seen as some of the contributing factors to these less than ideal outcomes for vulnerable claimants.

In the individual exemplary cases, legal professionals and service providers in the refugee determination arena identified each claimant as vulnerable, and two of three claimants were officially designated as Vulnerable Persons at the IRB. Though all three claimants disclosed identity features and trauma histories that fit Guideline 8 criteria, they were not flagged for Vulnerable Person status internally by the IRB, IRCC or CBSA. All three claimants obtained some accommodations in the hearing. All three also accessed some, but not all, of the range of community-based supports available to minimize the impact of external stressors on the refugee claim. In all three cases the claimants had refugee lawyers with considerable experience and sensitivity to vulnerability issues to represented them. They had each obtained some form of psychological report attesting to the consistency between alleged trauma history and current symptoms. All had been referred and two of the three had accessed mental health treatment prior to the hearing. And while all were living in impoverished and precarious circumstances, only one had accessed orientation and settlement services prior to the hearing.

While the claimants stated that the pre-hearing preparation and support that they received was beneficial, and all were afforded accommodations in their hearing, they all nevertheless exhibited cognitive and emotional symptoms characteristic of post-traumatic stress disorder during the hearing, and these symptoms persisted after the hearing in a manner consistent with re-traumatization. In two cases, the claimants' were severely impaired in their ability to testify. In the third case the quality and completeness of testimony was impacted by the IRB member's decision to protect the vulnerable claimant by directing his questions to a family member who

was not in possession of the complete set of facts. In all three cases, the accommodations did not achieve the intended effect of reducing vulnerability and ensuring a fair hearing.

While the descriptive accounts are presented above in response to the research questions, three key, integrative findings can be distilled from this chapter. The first is that vulnerability is described in official documents and by respondents according to essentialized characteristics of refugee claimants, however this obscures the experience of multiple intersecting characteristics and experiences which are highlighted in the exemplary cases. The second is that there is considerable variation between professional conceptualizations of vulnerability. While this variation could be a fertile ground for a diverse array of complementary services and supports, the third key finding is that systemic barriers combined with a lack of consistency or guidance from the IRB results in idiosyncratic practices and less than optimal protections for vulnerable claimants across the refugee determination arena. These distilled findings will be discussed in the following chapter.

Chapter 5: Interpretive Discussion

In this final chapter, I discuss the three key integrative findings that were distilled from the previous chapter. I also situate them within the interdisciplinary body of literature that I drew from in the theoretical fore-structure and my analysis.

In the first section, I return to an examination of the concept of vulnerability as a whole. I discuss the first key finding, that vulnerability is described in official documents and by respondents according to essentialized characteristics of refugee claimants, and this has the effect of obscuring the multiple intersecting characteristics and experiences highlighted in the exemplary cases. I also suggest that this conceptualization fails to acknowledge the settings in which vulnerability is generated and the interactional quality of the concept.

The second key finding is that there is considerable variation between professional conceptualizations of vulnerability. The discussion on this point begins with a consideration of the tension that exists between legal and psychological systems of thought that is expressed in the concept of vulnerability. I suggest that this essential tension between legal and psychological conceptualizations of protection contributes to systemic problems in the way that vulnerability is conceptualized and enacted.

Finally, I discuss the third key finding, which is related to systemic barriers. I consider how systemic problems in the implementation of Guideline 8, combined with a lack of consistency or guidance from the IRB, result in idiosyncratic practices and less than optimal protections for vulnerable claimants across the refugee determination arena.

In the section that follows, I describe the implications of this study for practitioners within refugee determination field. I also suggest how a trauma- and violence-informed approach could address problems in the conceptualization and implementation of Guideline 8, in practices

that are fairer and more protective of refugee claimants. Subsequently, I describe the implications of this study for research and draw out from these my recommendations for further research in refugee mental health and the field of counselling psychology. I then close with a discussion of the limitations of this study and a concluding summary.

The Concept of Vulnerability

While vulnerability is described in official documents and by respondents according to essentialized characteristics of refugee claimants, the exemplary cases provide examples of refugee claimants who embody multiple intersecting characteristics and experiences that give rise to vulnerability in the context of particular systemic interactions. In my analysis, therefore, the concept of vulnerability, as it is defined in Guideline 8, mistakenly attributes the location of risk to the individual/intrapsychic rather than to the systemic domain. As Rousseau and Kirmayer (2010) point out, "The refugee population is not so much intrinsically vulnerable (though the factors that force people to flee for their lives do confer vulnerability) as they are made vulnerable by the hostile or violent reception they encounter in their efforts to find safe haven (p.66)." In the following section, I return to an examination of the concept of vulnerability, first by considering the salience of identity through a lens of intersectionality and then by examining the settings and interactions in which vulnerability is generated.

The Salience of Identity. In Guideline 8, vulnerability is said to emanate from "innate or acquired personal characteristics," (IRB, 2006; pg. 2) of refugee claimants. However, my analysis of the qualitative data and the exemplary case material revealed that "vulnerability" is not a static condition resulting from essentialized characteristics of individual claimants; rather it is a potential for negative outcomes related to fairness, natural justice, and ultimately the risk of refoulement, which is realized at particular points throughout the refugee claim process.

The concept of vulnerability can be enriched by the theory of intersectionality, which suggests that individuals' experiences of social life are profoundly shaped by the intersection of multiple dimensions of identity (Crenshaw, 1991; Hankivsky, 2012; Ratts et al., 2016). In my analysis, the "innate or acquired personal characteristics" (IRB, 2006; pg. 2), which I have referred to in the findings as 'categories or aspects of vulnerability' (related to mental health, trauma exposure, gender, sexual orientation, age and current living conditions), cannot be seen as singular, discrete conditions that confer vulnerability in a direct, linear manner.

Each of the exemplary cases that were presented in the findings chapter demonstrates different intersecting constellations of identity and unique outcomes of vulnerability within the refugee claim process. The case studies demonstrate how each category of identity can leave claimants open to risk along numerous pathways in their interactions with the system, and, that claimants may embody or experience several identity factors that expose them to risk simultaneously. For example, while all three claimants had histories of violence and significant post-traumatic symptoms, the two women had also experienced gender-related persecution, and described struggling to overcome feelings of intense shame in order to disclose pertinent details of their claim. The male claimant had attained significantly higher education, had a high status professional occupation, and had a conversational level of English Language proficiency which could have allowed him to navigate the system more efficiently, however it appears that the vulnerability he experienced as a result of his status as a survivor of torture was compounded by his experience of being detained in Canada on arrival. This resulted in preparing early submissions without sufficient legal support and reportedly exacerbated symptoms of anxiety, which generated significant difficulties in the hearing. While all three claimants received some procedural accommodations, these were not tailored to address the particular constellation of

vulnerability that each experienced, and as a result did not mitigate vulnerability by enabling them to clearly or consistently present their case or protect them from suffering exacerbated mental health symptoms consistent with re-traumatization. As the exemplary cases suggest, a categorical approach to vulnerability obscures the diversity and complexity of experiences and needs of claimants within and across social categories, and increases the risk that vulnerability will not be appropriately identified or accommodated.

The Location of Vulnerability. A categorical approach to vulnerability also fails to acknowledge the settings in which vulnerability is generated. My findings demonstrate that claimants who embody particular characteristics or prior experiences (related to mental health, trauma exposure, gender, gender identity, sexual orientation, age, and current socio-economic conditions) are more likely to be disadvantaged by challenges inherent to the system, putting them at risk of not being heard fairly and of being psychologically harmed in the process. This observation is in line with findings in the literature. For example, a complex, fast-paced, legal process disadvantages children and claimants with less education or developmental or mental health conditions (American Psychological Association, 2010; Steel et al., 2004; United Nations High Commissioner for Refugees [UNHCR], 2013). People in authority are more likely to be experienced as threatening by claimants who have experienced torture and political violence (Derrick Silove, Steel, Susljik, Frommer, Brooks, et al., 2006). Confrontational interviewing styles and stressful interpersonal interactions lead to an intensification of trauma and anxiety symptoms and cause cognitive dysfunction in traumatized individuals (Silove et al., 2006; UNHCR, 2004). Similarly, the requirement to fully disclose prior traumatic experiences will not be easily met by claimants who are blocked by feelings of shame or distrust as a consequence of prior discrimination or trauma (Jordan & Morrissey, 2013; IRB, 2004; UNHCR, 2004; 2013).

Furthermore, complex bureaucratic requirements will be harder to satisfy for claimants who are coping with current socio-economic stressors, such as poverty, homelessness and poor housing conditions, difficulty accessing welfare assistance, unemployment or bad working conditions, lack of healthcare, lack of childcare, separation from family, social isolation, and linguistic barriers. Under these conditions, claimants have their energy, attention and resources diverted from the refugee claim process towards basic survival needs (Beiser, 2009, 2010; Leshner et al., 2012; Morantz, Rousseau, Banerji, Martin, & Heymann, 2013; Rousseau et al., 2008; Silove, Steel, McGorry, & Mohan, 1998). Finally, literature also supports the finding that the practice of detaining claimants during the pre-hearing phase impacts their mental health, which likely reduces their effectiveness in narrating their claim (Cleveland & Rousseau, 2012; Kronick & Rousseau, 2015; Derrick Silove et al., 2001; Derrick Silove, Steel, & Watters, 2000). These examples demonstrate that vulnerability is not an intra-psychic condition that resides in individual claimants but a risk potential that is located in points of interaction between claimants and the system.

The Interactional Quality of Vulnerability. In Guideline 8, vulnerability is said to emanate from "innate or acquired personal characteristics," (IRB, 2006; pg. 2) of refugee claimants. However, in my analysis, there is an important interactional quality to the concept of identity that has implications for the conceptualization of vulnerability.

In the context of the refugee claim process, claimant's identities are dynamic as a result of dramatic geographical and social change, and because the psychological and political understanding of who individuals and groups are, and what social resources they are entitled to, is being interrogated and contested. To narrate the basis of a refugee claim, a claimant must often explain the essence of who they are and what they have experienced in a way that can be

comprehended and believed by people who do not share their cultural and political history. In the cross-cultural encounters that occur throughout the refugee determination process, the sum of a claimant's identity dimensions, as others perceive them, will have varying psychological and political implications.

For example, the findings describe the difficulty many LGBTQ individuals have in articulating their culturally contextualized experience of gender identity and sexual orientation to a decision-maker who expects behavioural markers of identity and orientation that are particular to their own socio-historical context, such as "coming out," or attending gay night clubs (Jordan & Morrissey, 2013a). As a result, claimants are at an even greater disadvantage in presenting their claims in the current policy environment, because in the 30-60 days from when they arrive, to when they attend their hearing, they will not have developed the bi-cultural awareness that would help them navigate this complex intercultural communication. Thus they are more dependent on interlocutors, such as lawyers, NGO advocates, and mental health assessors, to frame their stories within the legal and cultural context of the Canadian refugee determination system.

I have conceptualized vulnerability as a multifaceted risk for harm that is contingent on institutional contexts, and open to interpretation by multiple actors with varying levels of power. My critique of Guideline 8 here is that it locates vulnerability as an intra-psychic harm residing in generic individuals ("vulnerable persons"), as opposed to a potential for harm that is generated in the interactions between culturally diverse groups and systems, across significant disparities of power. This conceptualization is resonant with literature on the cultural idioms of distress (Kirmayer, 2005; Kirmayer et al., 2011; Kleinman et al., 1997), and ways in which multicultural counselling literature has theorized the socially constructed nature of harm, concluding that

considerations of harm are not self-evident or culturally neutral (Altmaier & Hansen, 2012; Arredondo & Perez, 2003; Brown, 2008; Fouad & Prince, 2011; L. Miller, 2008; Moane, 2008; Neville & Mobley, 2001; Ratts et al., 2016; Speight & Vera, 2004; Toporek & Reza, 2001 Vera & Speight, 2003; Sue, 2015; Wendt, 2015). Alternatively, if the locus of vulnerability shifts from the individual to the system, then the system can be held accountable for changes that will enable it to better fulfill its mandate.

Professional Variability in the Conceptualization of Vulnerability

The second key finding is that there is considerable variation between professional conceptualizations of vulnerability. The discussion on this point begins with a consideration of the tension that exists between legal and psychological systems of thought that is expressed in the concept of vulnerability. Then I suggest that psychological knowledge is not integrated adequately in the conceptualization and implementation of the concept.

The Tension between Legal and Psychological Imperatives. The concept of vulnerability reflects an inherent, unreconciled tension between legal and psychological systems of thought. While Guideline 8 defines vulnerability as a risk to fairness and natural justice, the claimant characteristics that are described as giving rise to vulnerability are related to psychological concepts such as traumatic memory impairment, identity, and the risk of re-traumatization.

The central legal issue at stake in the refugee determination process is the obligation to non-refoulement, which means preventing claimants from being returned to situations where they would face persecution (Lauterpacht & Bethlehem, 2003). To ensure that Canada is meeting this obligation, the Immigration and Refugee Board (IRB) needs to be able to accurately identify refugees who are at risk of refoulement. While refugee determination is a forward-looking process based on a well-founded fear of persecution that has objective grounds,

participants in this study reported that in the absence of factual evidence there tends to be significant interrogation into experiences of past persecution. In order to build a case for present fear, refugee claimants are called upon to provide credible evidence of past persecution. Claimants have a better chance of doing this if the process is fair and enables them to tell their story as fully as possible at all stages: port of entry, completion of the Basis of Claim form, while preparing submissions for the claim, and during the hearing. At every stage, claimants need to be able to speak about potentially traumatic events and respond to probing questions in order to establish a strong basis for their claim. By adopting Guideline 8, the Immigration and Refugee Board (IRB) acknowledges that certain "vulnerable people" face particular difficulties associated with narrative testimony, and that such people can be identified and accommodated in order to "level the playing field" and ensure the fairness of the system.

The claimant characteristics that are described as giving rise to vulnerability are related to psychological concepts such as traumatic memory impairment, identity, and the risk of re-traumatization. In the findings chapter, I described how claimants can experience impairments in cognitive, emotional or interpersonal functioning that block disclosure, or limit their capacity to complete the tasks associated with the refugee claim. The guidelines and many respondents recognize these problems primarily as impediments to a decision maker's ability to assess the legally relevant facts of a claim in order to determine whether human rights protections are warranted, rather than as psychological processes that interact with barriers and biases in the system to put claimants at risk of not receiving a fair hearing. Thus while legal and psychological perspectives on the concept of 'protection' are divergent at a very fundamental level, the concept of vulnerability draws both sources together in an uneasy convergence.

The vulnerability guidelines attempt to bridge these divergent priorities of law and psychology, by suggesting that claimants run the risk of failing the tests of the determination process as a result of their own essential characteristics and experiences. However, as I suggest above, this is an inadequate conceptualization. Rather than an essential weakness embodied by an individual claimant, vulnerability is an outcome of systemic imperatives that give rise to potentially damaging interpersonal interactions. Numerous examples highlight this tension, such as the lawyers who stated their discomfort with the need to "push" their clients for disclosure, or the decision maker in exemplary case #2 who stated, "I understand you are [vulnerable]… but I can't just sit here and not ask you these questions and then make a fair decision." These are examples in which respondents across the refugee determination field recognized the risks described in Guideline 8 and described their own human desire to spare claimants from further suffering, while struggling to varying degrees with reconciling these with performing tests of credibility and encouraging full and consistent disclosure of traumatic past events.

Integration of Psychological Knowledge. My analysis suggests that there are aspects of psychological science and psychological practice that are not well-integrated currently in how vulnerability is conceptualized and intervened upon and few participants/decision makers reported familiarity with this information. For example, a psychological science perspective on vulnerability offers knowledge about how past trauma can manifest in multiple ways (i.e., trauma can produce flat affect, or cognitive dysfunction), and that contextual factors interact with personal characteristics to increase vulnerability (Cameron, 2010; Herlihy & Turner, 2009). Psychological practice emphasizes the importance of physical and emotional safety, for claimants to be able to tell their stories without dysfunction or harm, plus the ethical imperative

to assess, treat, and prevent retraumatization (Ekblad, Prochazka, & Roth, 2002; Furtmayr & Frewer, 2010; Herman, 2003; Mollica, 2011; van Willigen, 2008).

Guideline 8 and the Training Manual on Victims of Torture recognize the centrality of cognitive dysfunction and failures of memory, as a consequence of trauma, in the construct of vulnerability. In the descriptive accounts provided in the findings chapter, and especially in the case studies, I provide descriptions of failures of memory that occur in the refugee determination process; for example, memory for time, repeated events, peripheral information, and consistency. Nevertheless, respondents reported that an approach to questioning that IRB decision makers typically use is to narrow in on small details that are unrelated or peripheral to traumatic events. Case studies and key informant responses provided examples of decision makers who do not recognize or understand complex psychological processes and instead rely on simplistic explanatory models in their application of the guidelines and in their decision-making process. My findings are resonant with Herlihy and Turner (2009), who observed that decision makers seem to expect claimants to be able recall events as if the human memory operates like a recording device. This model, however, has long been supplanted by the understanding that human memory is a dynamic process (Kapardis, 2003). Even in normal memory of non-traumatic events, studies show that people rely on a combination of complex memory strategies, often involving guesses and inferences, when attempting to reconstruct and narrate memory of past events (Cameron, 2010). Perhaps this style of questioning has been adopted at the IRB in order to avoid re-traumatizing claimants by not asking them to remember and discuss painful and distressing content. However, research casts doubt on this as an effective strategy to test the credibility of the claimant, as such details are often poorly remembered (Cameron, 2010; Herlihy, Scragg, & Turner, 2002; Herlihy & Turner, 2006, 2007).

My findings also suggest that IRB members place significant weight on the consistency of testimony gathered at different points in the process. However, the literature on refugee claimants and traumatic memory does not provide support for credibility determinations based on inconsistencies in peripheral detail, as central elements of a traumatic event are likely to be remembered at the expense of details that are not attributed centrality by the subject (Herlihy et al., 2002; Herlihy & Turner, 2006, 2007b). Peripheral memory around traumatic events is often lost in the initial coding process, with the more intense, sensory stimuli becoming more strongly encoded (Cameron, 2010). Peripheral memory can also be inaccurately recalled when cognitive and emotional energies are directed towards managing the strong emotions and intense sensory experiences that occur when claimants are exposed to traumatic memories (Cameron, 2010; Herlihy et al., 2002; Herlihy & Turner, 2006, 2007). Numerous respondents stated that when such details in a claimants' testimony are different from one version to the next, decision makers often take this as proof that the person is lying in all aspects of their claim, and the claim is dismissed. Eye witness research suggests, however, that consistency is not a strong predictor of the factual accuracy of testimony (Brewer, Potter, Fisher, Bond, & Luszcz, 1999; Gilbert & Fisher, 2006; Wells & Olson, 2003).

Furthermore, the descriptive findings, and the exemplary cases in particular, demonstrate the interaction between psychological symptoms, cognitive dysfunction, and functional deficits, which can be triggered during conditions of intensified environmental and interpersonal stress. Informants reported that at times of relatively less stress, claimants are able to use coping strategies to contain or mask the severity of their symptoms, while at times of more intense stress they can decompensate rapidly. My descriptive findings highlight a range of common emotions, cognitive processes, symptoms, and disorders, including post-traumatic stress disorder (PTSD),

anxiety disorders, sleep and somatic disorders, depression, suicidality and psychosis, and describe the fluctuating nature of these mental health concerns in response to the interpersonal and environmental stressors that are commonly encountered throughout the refugee determination process.

Theories of psychological trauma explain how exposure to traumatic material, perceived threats to safety, and interpersonal stressors elevate physiological arousal, and cause cognitive disruptions, such as memory dysfunction, information processing problems, and attention deficits, and dissociation, as well as processes of avoidance such as emotional numbing and amnesia (Bremner & Brett, 1997; Ehlers & Clark, 2000; Golier & Yehuda, 2002; Nemeroff et al., 2006; Qureshi et al., 2011; van der Kolk, 1998; Vasterling & Brewin, 2005). Experiencing significant or chronic emotional and physiological dysregulation can result in more pervasive and lasting symptoms, which is what is meant by re-traumatization (Ford, 2009; Leshner et al., 2012). Thus the trauma literature supports the observation of several interview participants that when claimants' affective reactions surpass their capacity for emotional and physiological self-regulation, the coherence and consistency of communication declines.

I reported in the findings that decision makers are not always aware of or responsive to emotional distress or psychological dysfunction. Respondents stated that decision makers, as well as community service providers, do tend to accommodate claimants when they are in obvious emotional distress, for example if they cry, but that they are not as effective at recognizing vulnerability when claimants display a wide range of other emotional and psychological responses such as anger, irritability, blankness, numbness, disorientation, pressured speech, or muteness. If decision makers are not able to interpret intense or conspicuously absent emotional responses as expressions of post-traumatic sequelae, this failure

of empathy can have serious consequences (Rousseau & Foxen, 2010). Such mis-attunement will increase a claimant's stress in the communications that follow and have the potential to generate a vicious cycle of emotional dysregulation and cognitive dysfunction. Expert evidence, in the form of psychological reports or consultation, can help decision makers understand how memory and psychological symptoms impact on individual cases (Prabhu & Baranoski, 2012). Unfortunately, however, my findings echo Cleveland (2006) and indicate that psychological evidence is not being utilized to its fullest potential at the IRB.

The conceptual and systemic problems in the way that vulnerability is defined, understood and intervened upon could exist in part because the tension between the legal and psychological conceptualizations of protection is not reconciled and, as a result, the issue of vulnerability is not prioritized in the refugee determination process. A way to integrate these contributions of psychology into the concept of vulnerability will be discussed further in the recommendations below.

Systemic Barriers to the Implementation of Guideline 8

The third main finding is that numerous systemic barriers at the IRB level limit protection for vulnerable claimants. In addition to problems with the conceptualization of vulnerability that I have outlined above, my findings suggest that the systemic environment of the refugee determination process is characterized by fragmented and inconsistently applied knowledge of the concept, a result, in part, of the tension between the legal and psychological imperatives underpinning the concept and also from a lack of consistent application and guidance at the IRB level. To the extent that this level of variability can be attributed to a lack of specificity in official documents, gaps in knowledge, and inconsistent implementation, this constitutes a systemic barrier to adequate application of intended protections. These findings resonate with

recent research examining the issue of ‘fitness to stand trial’ and the assignment of a designated representative in relation to the Canadian refugee determination system, in which researchers found that the Canadian refugee determination system does not have clearly defined standards for assessing fitness and that there is no requirement to integrate mental health considerations into decision-making processes (Ramos-gonzález, Weiss, Schweizer, & Rosinski, 2016).

My findings suggest that professionals across all disciplines have difficulties identifying vulnerable claimants and that the guidelines are applied in a discretionary and inconsistent manner in a system that currently places significant importance on the speedy resolution of claims. While the professional participants in this study acknowledged the importance of the concept of vulnerability, I found that knowledge about the concept and its constituent parts is fragmented across individuals and disciplines, and implementation is inconsistent. First, there was an acknowledged limitation in familiarity with aspects of vulnerability that were not central to the scope of practice of each discipline.

This problem originates with the fact that Guideline 8 and other relevant guidelines are lacking specificity and thus do not provide adequate information on how to identify vulnerability and intervene appropriately. Added to this, there is a reported lack of knowledgeable guidance and consistent implementation from the IRB, and at the governmental level proactive identification processes are non-existent. There is also a concern that at the IRB level, vulnerability designations may be conflated with ideas of ‘fitness to stand trial,’ as revealed in statements by IRB officials that considerations of vulnerability should be limited to those who do not understand the nature of the proceedings. Thus while Guideline 8 is supposed to apply to only the most severely disadvantaged refugee claimants, because the document does not delineate severity it is difficult for guideline users to determine which refugee claimants should

be considered vulnerable and which should not. In fact, the research literature suggests that torture, identity-based persecution, and psychological impairment, all aspects of vulnerability that are defined in Guideline 8, are quite common among refugee populations (Beiser, 2005; Goldfeld, Mollica, Pesavento, & Faraone, 1988; Jordan & Morrissey, 2013b; Kirmayer, 2016; Derrick Silove, 1999; Derrick Silove, Steel, McGorry, & Mohan, 1998; Steel et al., 2009). Therefore, while it may be that not all refugee claimants are vulnerable, it is unlikely that serious vulnerability is exceptional among people who are in need of refugee protection (Cleveland, 2006).

Bureaucratic requirements for implementation of the guidelines also appear to limit their effectiveness. Many key informants stated that the application for vulnerability designation is exceedingly onerous, especially since the provisions for procedural accommodations that are listed in the guidelines are not seen to justify the unremunerated, labour-intensive process. Furthermore, as there is a requirement for corroborating information, content that is relevant to vulnerability determination can be conflated with content that is pertinent to the basis of the claim in expert reports. For example, one psychological report for the case submissions must address how trauma symptoms lend credibility to the claim, while a separate report for the vulnerability application must report on how these symptoms are anticipated to impact a claimant's ability to testify and risk for re-traumatization. The heavily bureaucratized application of the vulnerability guidelines could also contribute to stigmatizing refugee claimants, by creating processes that make those who are seen to be more vulnerable also more burdensome to the system.

Refugee lawyers and community-based service providers expressed their dissatisfaction with what they perceive as generally insubstantial accommodations. Respondents indicated that

the most frequently requested accommodations are related to procedural aspects of the hearing such as reverse order questioning, an all-female panel, breaks on request, and scheduling. The findings do suggest that a wider range of accommodation practices is permitted under the scope of Guideline 8 than is generally enacted. According to the Refugee Protection Division (RPD) training manual, members are also empowered to take a proactive approach toward identifying the most severely impacted claimants during the initial file review, have the discretion to facilitate collaborative planning meetings, and can make uniquely tailored accommodations. IRB officials stated that claimants can be allowed to tell their story at their own pace and without interruption, testimony can be provided in an informal setting or submitted by video, postponements can be requested for claimants to access appropriate treatment, and members can consider the evidence in light of vulnerability issues. However, these provisions did not appear to be frequently encountered and were not well-known in the legal and support communities. Therefore, in the absence of explicitly detailed guidance by the IRB about the wider range of accommodations that are available, legal, medical, mental health, and support service professionals require a nuanced understanding of the aspects and mechanisms of vulnerability in order to advocate on a case-by-case basis for more specifically relevant and effective accommodations.

The impact of Guideline 8 is ultimately constrained by the fact that it is discretionary and not mandatory for members of the IRB. According to IRB officials, all members receive orientation and in-service training on vulnerability issues and the potential impacts on individual claims processes and the RPD Training Manual on Vulnerability states that members are expected to refer regularly to all Chairperson's guidelines and the Training Manual on Torture. However, the participants in this study reported that there is a high degree of variability among

decision-makers at the IRB in their interpretation and implementation (or lack thereof) of Guideline 8.

IRB officials conceded that they are under significant pressure to process claims quickly and this appears to limit the IRB's capacity to engage with the concept of vulnerability in a meaningful way. Legal and community service providers also reported that in the past, they had time to form strong, trusting working relationships with refugee claimant clients, and this allowed them to prepare claimants for their hearing, using techniques that would facilitate disclosure, protect against re-traumatization, and engender empathy. The findings of this study suggest that time factors magnify all of the sources of vulnerability, while decreasing the likelihood that vulnerability will be detected and appropriately addressed within the current refugee determination system, and also limiting refugee claimants' opportunity to develop the skills and capacities to navigate the system effectively.

Finally, the impact of Guideline 8 is undermined by the fact that it does not apply to all government agencies, like Canadian Border Services Agency (CBSA) and Immigration, Refugees and Citizenship Canada (IRCC), which routinely interact with refugee claimants prior to their hearing. If, as is indicated in the findings, narrative testimony is gathered prior to the hearing under intensely stressful conditions with limited legal or psychosocial support, and compared for consistency with testimony provided under different conditions such as at the hearing, then no procedural accommodation during the hearing itself will have the power to mitigate vulnerability. My findings suggest that CBSA interviewing practices and the conditions of detention, especially, have the potential to generate and exacerbate vulnerability. This latter finding is supported by a systematic review which demonstrated that detained claimants tend to have higher rates of anxiety, depression, PTSD, suicidal ideation and self-harm than those who

have not been detained, and that symptoms worsen over time (Robjant, Hassan, & Katona, 2009). Furthermore, scholars examining the effects of detention in the Canadian refugee determination context have argued that, for the reasons cited, vulnerable claimants should not be detained (Cleveland & Rousseau, 2012; Kronick & Rousseau, 2015). In the absence of mandatory and consistent application of Guideline 8 across all government agencies, refugee claimants experience inconsistent treatment with regard to vulnerability.

Findings of this study suggest that the concept of vulnerability, as it is currently defined in policy documents and interpreted and implemented throughout the refugee determination arena, does not offer maximal protection for refugee claimants. I argue that this is due to a mis-attribution of harm to the individual/intrapsychic rather than to the systemic domain, a lack of integration of the psychological knowledge base that underpins the concept of vulnerability, and systemic barriers to implementation.

Implications and Recommendations

In the following section, I outline the implications of this study and make recommendations for practice and research. Consistent with the epistemological scope of Interpretive Description, the knowledge claims that emerge from this study are presented tentatively, in recognition that credibility and probable truth, not generalizability or absolute truth, is the objective. With the goal of producing actionable knowledge for applied practice, Interpretive Description studies invite an applied audience to "consider shifts in direction and guide them in determining the nature and scope of knowledge development that might make them feel justified in defending those shifts (Thorne, 2014; p. 111)." With this in mind, I begin this section by making an over-arching recommendation for the refugee determination field that addresses the findings in an integrative way. Next, I make a number of achievable practice

recommendations that arise from the findings of this study. I then describe the implications of the study for research and make recommendations for further research.

Implications for Practice

With this study, I offer a timely description and an interpretive analysis of the systemic ways in which vulnerabilities are generated and exacerbated within a particular policy context in Canada. I provide a rich description of the factors that give rise to vulnerability for refugee claimants, and the institutional and community-based practices that can exacerbate or mitigate these harms. Specifically, the findings draw attention to the interactive quality of vulnerability, emphasizing that multiple, intersecting aspects of refugee claimants' experience and identities may leave them open to particular disadvantages and forms of discrimination in their interactions with the refugee determination system.

This is a newly consolidated and specialized knowledge base about an aspect of the refugee determination experience and the early settlement context. This is pragmatic knowledge that can be used by an interdisciplinary community of practitioners to promote the well being of a marginalized and highly diverse population. For counsellors and psychologists in particular, the findings of this study fill a critical gap in the knowledge base. The tasks of assessing vulnerability, providing mental health supports and recommending appropriate accommodations fall within the scope of practice of mental health professionals; however, clinicians must develop a specialized knowledge base about vulnerability within the legal and social context of the refugee claim. Prior to this study there were only the IRB guidelines and one published article to draw on for guidance (Cleveland, 2006).

In the section that follows, I make an overarching recommendation for practice, followed by a number of specific recommendations for the various groups of professionals who are

engaged with the concept of vulnerability. In so doing, I acknowledge that some of the systemic barriers that I identified in the findings will likely continue to function as barriers to the implementation of my over-arching recommendation. For example, the fact that it is not mandatory for IRB decision-makers to integrate vulnerability considerations into decision-making practices, means that any changes that are made at the institutional level will not necessarily result in improvements in practice or lead to consistent guidance for professionals across the arena. There are also political, economic and structural factors involved in whether changes at the policy level become salient. Thus there are shifts in practice that professionals can begin to make immediately, without waiting for changes to IRB guidelines to be made or for systems to adopt the approach recommended below.

Over-arching Recommendations for Practice

The adoption of a trauma- and violence-informed approach throughout the refugee determination arena has the potential to address some of the problems that the findings of this study make apparent. Trauma-informed policy is that which reflects a comprehensive understanding of the wide-ranging effects of trauma and incorporates the needs of traumatized people into all facets of service delivery (Fallot, R. D.; Harris, 2008; Poole, Nancy; Greaves, 2012; Urquhart & Jasiura, 2013). Recently, scholars have been referring to a broadly conceptualized practice as 'trauma- and violence-informed,' reflecting a shift in language that foregrounds the traumatic effects of violence on survivors, and avoids seeing the problem as residing only in an individual's psychological state (Ponic, Varcoe, & Smutylo, 2016). In the context of refugee determination, this would imply an awareness of state violence and the ways in which exposure to experiences of political violence and chronic persecution can compromise individual development and functioning. This view emphasizes the need to make practices and

policies safe for traumatized people by acknowledging that while institutions and service providers cannot influence past events, they can endeavor to prevent exposure to ongoing violence, including structural violence, and reduce the risk of retraumatization (Farmer, Nizeye, Stulac, & Keshavjee, 2006; Ponic et al., 2016).

Adopting such an approach would entail something of a paradigm shift throughout the refugee determination arena, moving away from an essentialized conceptualization of "vulnerability," and making the awareness of trauma and violence an organizing principle of professional practice. While this may be an unaccustomed perspective, a trauma- and violence-informed approach is not incompatible with the human rights and refugee protection mandates that are the legal foundations for work in this field. This framework allows us to ask, what would be different if the entire arena functioned from the understanding that people who are in need of state protection are likely to be vulnerable in their interactions with the refugee determination process?

Given that there is a high incidence of traumatic exposure and post-traumatic sequelae in refugee populations and numerous intersecting ways in which claimants may encounter inequalities and barriers throughout the system, and given the difficulty of quickly and accurately determining who meets these criteria and who does not within the constraints of the refugee determination system, it is reasonable for the refugee protection field to assume that any claimant may be vulnerable and, therefore, to utilize trauma- and violence-informed policies and practices universally.

A trauma-informed approach could also bridge the legal/psychological tension that exists within the concept of vulnerability. While trauma-informed practices are gaining recognition in health care settings, this concept is quite new in the field of law in Canada (Elliott, Bjelajac,

Fallot, Markoff, & Reed, 2005; Randall & Haskell, 2013; Urquhart & Jasiura, 2013). Its implementation across the refugee determination arena would provide a common conceptual framework that would enhance efforts to develop an integrated interdisciplinary response to the concept of vulnerability. Such a conceptual framework would incorporate the knowledge that was consolidated in this study in an understanding of the bio-psycho-social impacts of trauma on refugee populations, an awareness of post-migration stressors and the current policy environment for claimants, and an awareness of how all of these create conditions of vulnerability within the refugee claim process. Such an approach would also recognize how social determinants such as culture, gender, class, sexuality, disability, age, poverty, housing, employment, education and literacy, and relational supports and responsibilities, intersect to shape refugee claimants' experience of making a refugee claim.

When these principles are integrated into systems as 'universal precautions,' the resulting policies and practices will reduce barriers and provide supports for all people (Ponic et al., 2016). Ponic et al (2016) describe a continuum of responses to trauma and violence. In the context of refugee determination process, a focus on minimizing the potential for vulnerability-induced risks to the claim and prevention of re-traumatization would exist at one end of the continuum, community supports, such as trauma-informed legal and social services, would exist in the middle, and on the other end of the continuum, there would be trauma-specific treatment through specific healthcare modalities, such as psychotherapy and chronic-pain interventions (Ponic et al., 2016). Such a continuum of trauma-informed approaches could be implemented within the current multi-sectoral service arena if a proactive approach to vulnerability at the IRB resulted in referrals to and highly coordinated delivery of specialized healthcare, housing, settlement and social services.

Specific Recommendations for Practice

Numerous achievable practice recommendations arise from the findings of this study, which have the potential to address some of the shortcomings in the way in which vulnerability is understood and intervened upon in the refugee determination arena.

At the governmental level. Canada does not have a clearly defined standard for determining vulnerability and ensuring that all claimants have access to a fair hearing. The shortcomings of Guideline 8 that were highlighted by Cleveland (2006) and in my findings could be addressed if Guideline 8 was made a compulsory, rather than a discretionary tool and with a shift towards a more explicitly trauma-informed practice. By recognizing that vulnerability factors are not exceptional among refugee claimants, and that most of the available accommodations are not particularly demanding of the system(Cleveland, 2006), the IRB could create a trauma- and violence-informed institutional setting.

If a trauma- and violence-informed approach to the use of Guideline 8 were mandated, this would allow the IRB to build on the wide range of accommodations that reportedly are permitted but not generally enacted under the scope of Guideline 8, such as proactive identification of potentially vulnerable claimants during the initial file review, collaborative planning meetings, uniquely tailored accommodations, testimony provided at claimants own pace and without interruption or in an informal setting or submitted by video, postponements for claimants to access appropriate treatment, and for decision-makers to consider the evidence in light of vulnerability issues.

It appears, however, that one challenge is to make more effective and consistent use of the provisions of the guidelines, without increasing their bureaucratized and mechanical implementation, or adding more burdens to an already highly constrained system. For example,

one consistent finding that emerged was that refugee lawyers experience the system as highly bureaucratic and time consuming, and that this creates a barrier to filing applications for vulnerability status. This could be improved by building an organizational culture that is attuned to the impacts of trauma and violence, for example through employing 'universal precautions,' assuming that any claimant could be traumatized and experience aspects of vulnerability, and adjusting the setting and procedures to ensure protections exist for every claimant. Then, the IRB could take a very proactive approach to identifying vulnerable claimants by reducing the 'vulnerable person' application requirements and by accepting all substantiated request for vulnerability status, consistently communicating with refugee lawyers and community members on cases involving vulnerability issues, and compiling data on the numbers of applications and their outcomes.

One concern that was voiced consistently by participants was the lack of clear criteria to determining vulnerability. There also appears to be a risk of conflating vulnerability with fitness to stand trial, as when IRB officials describe vulnerable people as those who do not understand the nature of the proceedings. The design and implementation of a standardized screening checklist would provide clearly demarcated inclusion criteria, and could allow for the development of more nuanced accommodations that are specifically designed to ameliorate particular vulnerability issues, which would provide members more explicit direction.

Such an institutional culture could be fostered through on-going training, hiring, and recognition of best practices. A mental health expert could also be employed at the IRB to provide in-service training and consultation, to recommend accommodations, to attend hearings and provide mental health first aid, and to review transcripts and decisions for evidence of effective trauma-informed practice. Supports and opportunities for self-reflection should also be

made available for decision makers and service providers who are at risk for vicarious traumatization. Performance evaluations could give weight to compliance with these procedures, evidence of successful implementation of trauma-informed services, and continuing education in the field of psychological trauma. Sufficient time and resources must be allocated to allow meaningful institutional engagement with the concept of vulnerability. These kinds of institutional changes would ensure that trauma- and violence-informed practices are consistently implemented and do not remain aspirational.

The findings indicated that interactions outside the hearing process can also increase vulnerability. This indicates that for Guideline 8 to be maximally effective, it must be extended to all government agencies that engage with refugee claimants, especially at the border and in detention. The findings of this study suggest that government timelines for refugee determination should be reassessed, given the report by numerous participants that pressure to resolve claims quickly can undermine safe and fair processes for all claimants.

At the community level. Building on the strong intention to support claimants through the refugee determination process, community-based organizations are recommended to provide initial and on-going training for their staff about vulnerability so that they have the knowledge base to identify the most acutely vulnerable and advocate for special accommodations that address their needs. In order to develop the knowledge base among professionals working in this area, information on aspects of vulnerability related to refugee mental health and social determinants of health should be integrated into professional training programs as well as continuing education for lawyers, primary and mental health professionals, and settlement workers.

The findings described how legal and community services can effectively address vulnerability, even if indirectly, through various methods that promote psychosocial stability. These include specialized orientation information on arrival, supportive housing opportunities, financial assistance and necessary material supports, specialized counselling programs designed to address emotional and physiological arousal in preparation for the hearing, and physician care that is attuned to the psychological needs of survivors of violence. These are all examples of supportive practices that have the potential to increase physical and psychological safety, and reduce emotional and physiological dysregulation, especially if they are characterized by a high degree of awareness of the exacting demands of the current refugee determination process. In addition to delivering these kinds of services, community-based settings can attend to the ways in which people who have histories of severe trauma experience the same environment differently than those who do not.

For Mental Health Professionals. Mental health professionals who wish to practice in this field require specialized knowledge that includes a comprehensive understanding of refugee determination policy and the process of refugee settlement, so that work with vulnerable refugee claimants is highly contextualized. Mental health intervention with refugee claimants must be embedded in the settlement and policy context and thus be trauma-informed without necessarily being trauma-specific. Of necessity, counselling work with refugee claimants is time-limited, and focused on emotional regulation, containment, and coping, with the goal of meeting the demands of the refugee determination process, including strengthening the capacity to testify. The findings suggest that mental health professionals must also have specialized competencies in assessment in order to provide high quality reports for the IRB that are able to address issues of vulnerability and recommend individualized accommodations

Implications for Research

This study resonates with the values of contemporary counselling psychology research, which often aspires to understand the complexities of diversity, the impact of systemic oppression, the social construction of identity and intersectionality, and the implications of these on mental health and for psychotherapy. Recent research on refugee populations within the counselling psychology literature has tended to focus on treatment and training related themes (Barrington & Shakespeare-Finch, 2013; Kuo & Arcuri, 2013; Lambert & Alhassoon, 2015; Nilsson, Schale, & Khamphakdy-Brown, 2011). However, the broader counselling psychology literature on multicultural counselling competencies suggests that counsellors need to be knowledgeable about the groups that they work with, to understand sociopolitical issues such as immigration and poverty that are salient to their clients, to understand institutional barriers and how discriminatory practices operate at the community level, to understand the cultural aspects of assessment, and exercise institutional interventions on their client's behalf (Arredondo & Perez, 2003; Sue, 2001; Vera & Speight, 2003).

My study fills gaps in knowledge and addresses these competency requirements by adding detailed, population specific knowledge on refugee claimants and their context. In defining the concept of vulnerability and providing detailed descriptions of it's various aspects, this study contributes rich qualitative information about symptoms, behaviour and cognitions that may occur as part of the refugee experience, due to exposure to extreme violence or other mental health concerns. This study also offers insight into the intersectionality of vulnerability, suggesting that various combinations of identity and experience can leave claimants open to specific harms that are not easily mitigated by available accommodations. This study also

explores the interaction between the individual and his or her socio-political context, and the findings suggest that the particular social and policy conditions that exist for refugee claimants in Canada have an impact on their mental health and wellbeing. In examining the symptoms, behaviours, and beliefs that can cause impaired functioning in the refugee claim process, and how these interact with the policy context and social conditions that have such power in the lives of refugee claimants, this study asserts that refugee claimants are a small but very distinct population that deserves particular attention within the much broader field of multicultural counselling. Not only do counsellors have to be knowledgeable about and attentive to their client's cultural heritage, but also to their migration history and the particular social and policy contexts that shape their lives.

A small and emerging body of psychological research has begun to address psychological implications of the refugee claim process (Graham, Herlihy, & Brewin, 2014; Herlihy, 2000; Herlihy et al., 2002; Meffert, Musalo, Mcniel, & Binder, 2010; Ramos-gonzález et al., 2016; Wilson-Shaw, Pistrang, & Herlihy, 2012). My study fits within this emergent body of research, and also contributes to scholarship in the interdisciplinary areas of refugee trauma and migration studies by describing how vulnerability related to trauma and identity is defined, recognized, and addressed by adjudicators, and other professionals in the newly streamlined Canadian refugee system. Exemplary cases and key informant responses provide examples of decision-makers who rely on simplistic explanatory models for complex psychological processes and my findings cast doubt on the common strategies that are used for testing credibility in refugee determination processes. This study also provides descriptive examples that demonstrate that the refugee claim process can create conditions of intensified environmental and interpersonal stress that trigger an exacerbating interaction between psychological symptoms, cognitive dysfunction and functional

deficits.

Recommendations for Research

The use of a multi-data source qualitative method to describe and interpret one facet of the current policy environment is a novel addition to the fields of counselling psychology and refugee trauma studies. This exploratory study provides a descriptive foundation that indicates a need for more empirical research on vulnerability in the context of refugee determination.

My findings suggest that there is no clear, consistent guidance on how to determine severity or how to ameliorate specific forms of vulnerability. Further research to support the development of a measure of vulnerability within the refugee determination process is indicated. A standardized measure would provide a more objective delineation of the cut-off between vulnerability and non-vulnerability, and its constituent factors, which could lead to specifically targeted accommodations and interventions. Thus a next step in operationalizing the concept of vulnerability could be to translate the aspects of vulnerability that are described in my findings into measurable variables, which could lead to the creation of a vulnerability screening tool and more precise recommendations for interventions.

In-line with prior research (Bogner, Brewin, & Herlihy, 2010; Herlihy, Jobson, & Turner, 2012; Rousseau & Foxen, 2010; Rousseau & Kirmayer, 2010), and building on this study's finding that vulnerability resides in systems, further research into the refugee determination process and its institutional settings and practices is also indicated. My findings echo the call for data to be collected within the IRB (Ramos-gonzález et al., 2016) so that researchers may examine the numbers and outcomes of vulnerability applications and produce further knowledge about how this concept is being utilized at the institutional level.

While there is an emergent body of research on clinical efficacy with refugee populations (Bunn, Goesel, Kinet, & Ray, 2016; Nakeyar & Frewen, 2016; Patel, Kellezi, & Williams, 2011; Patel, Williams, & Kellezi, 2016; Weiss et al., 2016), this literature does not yet integrate a nuanced developmental approach to refugee mental health. There are well-developed literatures on pre-migration trauma and post-migration settlement; however, the psychological dimensions of the inland refugee determination process have received less attention. A multi-stage model of refugee mental health that includes pre-migration, refugee determination, early and late settlement stages would allow for the development of stage-based clinical and community interventions that would address the mental health needs of refugees at particular points in the developmental process of forced migration and settlement. The rich description of the aspects of vulnerability that exist within the inland refugee determination process that I have provided could inform one stage of such a model.

This study presents a consolidated knowledge base regarding vulnerability in the area of refugee determination that can assist in professional decision-making; however the study also highlights the need for research on clinical competencies for counsellors and other mental health professionals who work with refugee claimants. As reflected in the findings, counsellors need to be knowledgeable about the refugee claim system and the impact that it can have on claimants so that they can provide appropriate interventions and supports, and so that they can assess for vulnerability and recommend effective accommodations. From a social justice perspective, counsellors need these competencies to ensure equitable access to high quality mental health care for all populations and so that they can advocate at the institutional level on their client's behalf

Finally, there is preliminary evidence in support of the enhanced effectiveness of trauma-informed services; however, more research is needed to investigate the effects of implementing

such services in diverse settings (Nova Scotia Health Authority, 2015; Fallot, R. D.; Harris, 2008; Poole, Nancy; Greaves, 2012; Urquhart & Jasiura, 2013). Given that trauma is experienced disproportionately in refugee communities, as a result of pre-migration exposure to political violence and persecution, as well as post-migration experiences of marginalization and inequality, research on trauma-informed practices with refugee populations could generate knowledge that could help to integrate this field of research with theories of intersectionality.

Limitations

The qualitative, exploratory design of this study determines the kinds of knowledge claims that can be made; thus, consistent with the constructivist and pragmatic research traditions from which Interpretive Description has emerged, I have endeavored to develop descriptive, contextual knowledge in response to an applied problem with the intent to inform and influence shifts in practice and stimulate new research (Thorne, 2008, 2014). Specifically, with this study, I attempted to understand how the concept of vulnerability is socially constructed and utilized within a local context. By using multiple data sources and engaging deeply with this material over a substantial period of time, I have been able to integrate numerous angles of vision into my descriptive findings and have provided interpretive claims that are firmly grounded in the data. I have situated myself in the theoretical scaffolding and will highlight some contextual and self-reflexive observations in this section so that readers are better able to evaluate the trustworthiness and limitations of my findings and recommendations (Thorne, 2008).

First, though the policies that I studied are national in scope, this is a dynamic and constantly evolving arena, in which there are likely to be regional differences in the range of practices occurring across the country. Thus the findings and the pragmatic recommendations that emerged from my analysis best reflect what was happening in Vancouver, British Columbia

at the time of data collection and will be of specific relevance to practitioners of various disciplines who practice in this region.

Second, my participant sample was limited in particular ways. One limitation is that I had very little access to government officials. A few high-level officers with past decision-making experience volunteered to participate, but no current decision-makers were interviewed. I thus had to try to understand government processes and practices through other means. I analyzed official documents, training materials obtained through access to information request, refugee claim submissions, hearing transcripts, and reports about government practices by outside professionals. The hearing transcripts are a verbatim account of what was said in a refugee hearing and offer a primary source perspective into how the various parties address, or fail to address, vulnerability in the hearing itself. Though they do not include non-verbal communication, which could provide additionally important information about the tone of interpersonal interactions and the emotional state of the claimant, they are nevertheless valuable sources of information that do not rely on self-report. While this triangulation of multiple data sources lends trustworthiness to my findings and interpretations, I do acknowledge that had I been able to access IRB decision-makers directly I would have gained primary source information about how they as individuals address vulnerability, and perhaps about the constraints and pressures they face in attempting to do so.

While the number of professionals who work to serve refugee claimants locally is relatively small and I managed to interview a sizable proportion, the sample of professionals is also limited in certain ways. The time during which I was collecting data was a time of unprecedented funding cuts, resulting in decreased services and outright closure of certain critical programs for refugee claimants. As a result, I interviewed the only two mental health

professionals and all of the settlement service and housing providers who were working with refugee claimants at this time. The refugee lawyers who volunteered their time to participate in this study were among the most highly experienced and were very knowledgeable about and interested in issues relating to vulnerability. If there are early career lawyers with less experience, or refugee lawyers with less awareness or concern for vulnerability issues, their views on vulnerability have not been included. Finally, all of the professionals who volunteered their time demonstrated care, dedication and commitment to supporting refugees and this may result in less variation of perspectives.

I did not interview immigration consultants, human rights activists and grassroots community support groups who may sometimes be involved in supporting claimants. Members of these groups could have added perspectives on vulnerability that may have altered the findings and interpretations.

My sample of refugee claimants is also limited. Consistent with my inclusion criteria, I only interviewed claimants who were considered vulnerable. Consequently, the findings do not provide insight into the experience of navigating the system without experiencing vulnerability. The claimants who volunteered to participate were referred by professionals who knew their case history and recognized that issues of vulnerability were present. In my professional experience, these were not extreme cases, but fairly typical of the types of claimants that would be seen in a refugee mental health service. Additionally, for ethical reasons I was not able to interview any claimants who were so vulnerable that it would not be safe to participate or who could not understand the nature of the research process. It was not logistically possible to include those claimants who are unrepresented or without connections to community supports. While these are likely to be the most vulnerable claimants of all, there was no way to access such claimants.

Nevertheless, some information about the existence and experiences of these more extreme cases are included in the descriptive account, derived from interviews with professional informants.

Third, the issue of trust is a salient methodological concern in research projects focusing on populations with less power in society (Miller, 2004). I acknowledge that my positionality as a researcher has consequences for my ability to build trust within this community and the sample of participants who were accessible to me. My prior professional experience in this field informed my assumption that the concept of vulnerability is a social construct, that there was a need for an integrated source of information to guide professional practice, and that experienced people throughout the arena – including recent refugee claimants – would have valuable insights into the concept and how it is used. Prior professional relationships with potential informants may have allowed me to enter the field as a researcher with a certain level credibility and trustworthiness already established, but may have also shaped an impression of shared values and concerns. Indeed, my prior experience has been with highly vulnerable claimants and while this experiential knowledge base allowed me to see patterns and meanings in the data, it was important to check the trustworthiness of my impressions and interpretations with research committee members and knowledgeable consultants in the field.

Finally, a different kind of study may have been possible if certain kinds of data were available. For example, there would be value in conducting an evaluation study focused on the implementation of Guideline 8 at the institutional level. Such a study could determine the proportion of vulnerable claimants who are identified and offered accommodation, and the impact of these interventions on the hearing process and outcomes. However, such a study would require agreement on an operational definition of who is vulnerable, a consistent means of identifying vulnerability, and available data on the numbers of designated claimants, types of

accommodations and hearing outcomes – none of which are currently available. Given the absence of data and evaluative research on the implementation of the guidelines at the governmental level nationally, an in-depth exploration of how vulnerability is operationalized at both the governmental and community levels is a necessary first step.

Concluding Summary

With the extensive changes to refugee protection policies that came into effect in Canada on December 15, 2012, there was no current research to show how the concept of vulnerability is understood and intervened upon. This study was designed to provide answers to the questions: 1) How is "vulnerability" conceptualized within Canada's refugee determination arena? And 2) How are systemic practices enacted with respect to vulnerability?

I reviewed literature in the areas of trauma-focused epidemiology in refugee populations, cultural psychology of trauma, trauma and testimony, and re-traumatization. I concluded that the available research evidence suggests that a life history of multiple traumatic experiences in impoverished circumstances predicts more severe and complex mental health outcomes. I anticipated, therefore, that trauma-related distress and disorder is likely to impact a refugee claimant's ability to testify in a coherent and credible manner, thus raising the odds that they will be declared not credible and diminishing their chances at obtaining a fair ruling. I reported that no literature to-date examines the construct of vulnerability within Canada's newly revised refugee determination system. This investigation is thus timely and unique, and will add to the body of literature on refugee mental health.

The contextual, pragmatic and interdisciplinary nature of the research problem determined my choice of Interpretive Description (Thorne, 2008, 2014) as a research

methodology, as this is an appropriate framework to explore clinically relevant issues in context. I also integrated a case study approach drawn from Stake (2006) to provide examples of how issues of vulnerability are handled in context.

Consistent with Interpretive Description, this study generated qualitative data from multiple sources, which were theoretically and purposively selected. Four distinct source groups provided information and perspectives at different levels of analysis. At the systemic level, I reviewed government documents and interviewed IRB officials. I accessed the organizational level through interviews with key professional informants. Refugee claimants themselves provided information on the individual level about how vulnerability is manifested and experienced. Finally, focused interviews and the collected documentation of a small number of refugee claims provided examples of particular instances, while offering insight into the functioning of the arena as a whole.

Descriptive findings provide detailed information on the characteristics and experiences that are defined in Guideline 8 and further elaborated in other policy documents and by practitioners in various disciplines. I found that mental health concerns confer vulnerability when mental health symptoms cause impaired functioning in the tasks associated with the refugee claim process, especially in situations of intensified stress such as during the hearing itself. A history of traumatic exposure to events such as torture, genocide, and crimes against humanity is another aspect of vulnerability, and I described how experiences of state violence and exposure to massive trauma can induce symptoms, behaviours and beliefs that can impact testimony. Sexual violence was identified as another factor that can confer vulnerability due to the onset of post-traumatic symptoms as well as the inhibitory effect of shame on disclosures. I also found that women and people with marginalized gender identities and sexual orientations may be

disproportionately burdened by biases in the refugee determination process. I described how very young or very old people may be vulnerable as a result of cognitive immaturity or impairment, the burdens of physical health, and the potential to be adversely effected by the traumatic sequelae of caregivers. Finally, I also highlighted the potential for vulnerability that accrues with significant unmet settlement needs, and experiences of detention on arrival in Canada.

I investigated the identification and intervention practices that were reported, as well as data derived from individual exemplary cases and found that in the best case scenarios, vulnerable claimants are identified in early stages of the claims process, are well-supported in the community throughout the hearing preparation phase, and are appropriately accommodated in the hearing so that they are able to present their case coherently and consistently. In practice, however, the findings revealed conceptual problems and systemic barriers that prevented full and effective intervention to mitigate vulnerability.

Finally, I discussed the main findings and situated them within the research literature. The findings illustrate the ways in which aspects of refugee claimants' identities, pre-existing conditions, and current circumstances leave them open to specific harms that may or may not occur, or may be amplified, as a result of policies and interactions with agents of the refugee determination system and broader arena. My analysis suggests that conceptualizing vulnerability according to essentialized categories of identity and experience is inadequate because, when vulnerability is understood as residing in the individual, the intersectional, interactive and systemic qualities of vulnerability are ignored. I observe that if the locus of vulnerability shifts in this way from the individual to the system, then the system can be held accountable for changes that will enable it to better fulfill its mandate.

In response to these findings, I describe the implications for practice and make an integrative recommendation for the field as a whole. I describe how a trauma- and violence-informed approach across the whole refugee determination arena might result in practices that are fairer and more protective of refugee claimants. I then describe implications for research and make recommendations. This includes a description of the next step in operationalizing the concept of vulnerability, which is to translate the aspects of vulnerability that are described in the findings into measurable variables, which could lead to the creation of a vulnerability screening tool and more precise recommendations for interventions.

In conclusion, the qualitative, exploratory design of this study was not intended to provide generalizable findings, but to offer a rich and timely description of what is currently happening with respect to vulnerability in the refugee determination arena located in Vancouver, Canada, which could be of use to practitioners in this region. It is my hope that people who are engaged with refugee claimants in other regions in Canada, or who are concerned with issues of vulnerability in other refugee determination processes internationally, may also find useful points of comparison and relevance, and that this work will catalyze shifts in practice, continued research and policy development.

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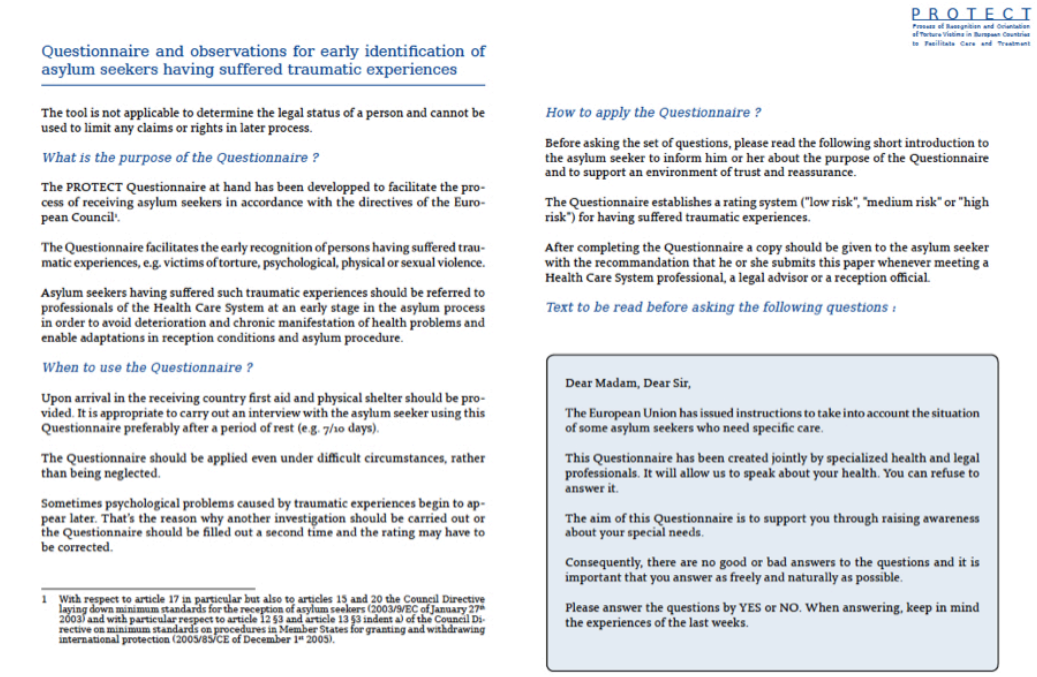
Appendices

Appendix A: PROTECT Questionnaire



PROTECT
Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment

Questionnaire and observations for early identification of asylum seekers having suffered traumatic experiences

The tool is not applicable to determine the legal status of a person and cannot be used to limit any claims or rights in later process.

What is the purpose of the Questionnaire ?

The PROTECT Questionnaire at hand has been developped to facilitate the process of receiving asylum seekers in accordance with the directives of the European Council[1].

The Questionnaire facilitates the early recognition of persons having suffered traumatic experiences, e.g. victims of torture, psychological, physical or sexual violence.

Asylum seekers having suffered such traumatic experiences should be referred to professionals of the Health Care System at an early stage in the asylum process in order to avoid deterioration and chronic manifestation of health problems and enable adaptations in reception conditions and asylum procedure.

When to use the Questionnaire ?

Upon arrival in the receiving country first aid and physical shelter should be provided. It is appropriate to carry out an interview with the asylum seeker using this Questionnaire preferably after a period of rest (e.g. 7/10 days).

The Questionnaire should be applied even under difficult circumstances, rather than being neglected.

Sometimes psychological problems caused by traumatic experiences begin to appear later. That's the reason why another investigation should be carried out or the Questionnaire should be filled out a second time and the rating may have to be corrected.

1 With respect to article 17 in particular but also to articles 15 and 20 the Council Directive laying down minimum standards for the reception of asylum seekers (2003/9/EC of January 27th 2003) and with particular respect to article 12 §3 and article 13 §3 indent a) of the Council Directive on minimum standards on procedures in Member States for granting and withdrawing international protection (2003/85/CE of December 1st 2005).

How to apply the Questionnaire ?

Before asking the set of questions, please read the following short introduction to the asylum seeker to inform him or her about the purpose of the Questionnaire and to support an environment of trust and reassurance.

The Questionnaire establishes a rating system ("low risk", "medium risk" or "high risk") for having suffered traumatic experiences.

After completing the Questionnaire a copy should be given to the asylum seeker with the recommandation that he or she submits this paper whenever meeting a Health Care System professional, a legal advisor or a reception official.

Text to be read before asking the following questions :

Dear Madam, Dear Sir,

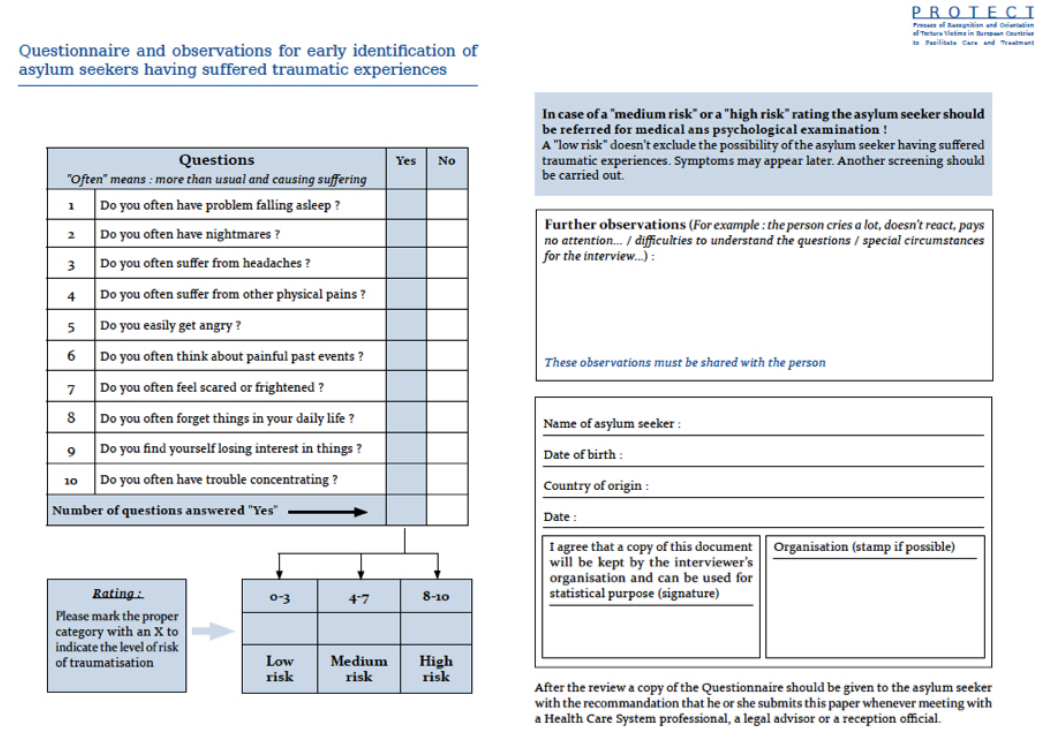
The European Union has issued instructions to take into account the situation of some asylum seekers who need specific care.

This Questionnaire has been created jointly by specialized health and legal professionals. It will allow us to speak about your health. You can refuse to answer it.

The aim of this Questionnaire is to support you through raising awareness about your special needs.

Consequently, there are no good or bad answers to the questions and it is important that you answer as freely and naturally as possible.

Please answer the questions by YES or NO. When answering, keep in mind the experiences of the last weeks.



PROTECT
Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment

Questionnaire and observations for early identification of asylum seekers having suffered traumatic experiences

	Questions *"Often" means : more than usual and causing suffering*	Yes	No
1	Do you often have problem falling asleep ?		
2	Do you often have nightmares ?		
3	Do you often suffer from headaches ?		
4	Do you often suffer from other physical pains ?		
5	Do you easily get angry ?		
6	Do you often think about painful past events ?		
7	Do you often feel scared or frightened ?		
8	Do you often forget things in your daily life ?		
9	Do you find yourself losing interest in things ?		
10	Do you often have trouble concentrating ?		
Number of questions answered "Yes" →			

Rating :
Please mark the proper category with an X to indicate the level of risk of traumatisation

0-3	4-7	8-10
Low risk	**Medium risk**	**High risk**

In case of a "medium risk" or a "high risk" rating the asylum seeker should be referred for medical ans psychological examination !
A "low risk" doesn't exclude the possibility of the asylum seeker having suffered traumatic experiences. Symptoms may appear later. Another screening should be carried out.

Further observations (*For example : the person cries a lot, doesn't react, pays no attention... / difficulties to understand the questions / special circumstances for the interview...*) :

These observations must be shared with the person

Name of asylum seeker :

Date of birth :

Country of origin :

Date :

I agree that a copy of this document will be kept by the interviewer's organisation and can be used for statistical purpose (signature)

Organisation (stamp if possible)

After the review a copy of the Questionnaire should be given to the asylum seeker with the recommandation that he or she submits this paper whenever meeting with a Health Care System professional, a legal advisor or a reception official.

Appendix B: Recruitment Letters

Advertisement to Recruit Participants: Community Participation Information

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

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Educational & Counselling Psychology,
And Special Education
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Kirby Huminuik is undertaking a case study project on the concept vulnerability in refugee determination processes since December 15, 2012. One of the aims of the project is to gather a small number of exemplary cases in which mental health vulnerability was a factor, whether or not the vulnerability was recognized at the IRB.

If you are aware of refugee claims in which vulnerability was a factor, we would appreciate it if you would contact Kirby Huminuik at this email address. She will contact you to discuss your role in the case (while maintaining the claimant's confidentiality), and why you believe the case to merit consideration. If the case is deemed appropriate, she will request you to forward information on the study to the claimant.

Refugee claimants will be asked to take a very short (10 item) screening questionnaire to determine their eligibility for the study. If eligible, they would be asked for consent to release their refugee claim documentation for a confidential review. They would also be invited to participate in a qualitative interview regarding their experience of the refugee claim process. The interview will address the factors that facilitated or hindered their communication with lawyers and officials, their recollection of their mental and emotional

states at various stages throughout the process, and their recommendations for procedural accommodations or policy changes that would have provided better mental health protection/support and assisted them to testify more completely/accurately.

While there may be risks for vulnerable claimants associated with participation, the researcher has significant clinical experience and a high degree of sensitivity to risks associated with working with traumatized people. Furthermore, she believes that a research focus on social policy invites participants to engage in a process that shifts attention away from the traumatic past and towards a shared knowledge creation process that could allow them to provide benefits to future claimants.

You may also be contacted with a request to participate in a 60-90 minute qualitative interview as an expert informant. Expert informants with significant experience in the Canadian refugee determination arena will be asked to reflect on how mental health vulnerability is currently being addressed. You will be asked for your assessment of what impact this has on the fairness of claims and on the mental health of claimants.

This research project is being undertaken as part of a doctoral degree in Counselling Psychology at UBC. It is supervised by Dr. Beth Haverkamp through the department of Educational Psychology, Counselling Psychology and Special Education. Committee members are Dr. Catherine Dauvergne, Dr. Susan James, and Dr. Victoria Smye.

If you are interested in participating, or for more information, please contact Kirby Huminuik at [contact information]

Invitation letter: Refugee Claimant Participants

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

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Refugee claimants have the right to a fair and safe hearing. With the recent changes to the refugee system, we want to learn if refugee claimants are being protected and treated fairly throughout the claim process.

We are inviting people who have made a refugee claim since December 15, 2012 to participate in a UBC study.

By taking part in this study, you have a chance to offer your knowledge and experience to help make things better for refugee claimants in the future. If you agree to participate, we will ask you to complete a short (10 item) screening questionnaire. You will receive a copy of your screening questionnaire. We may then review your refugee claim documents. We may also invite you to participate in an interview about what happened and how you felt during your refugee claim process. Your information will be **confidential**. You can withdraw at anytime.

This research project is being done by Kirby Huminuik, a doctoral student in Counselling Psychology. She is supervised by Dr. Haverkamp, Dr. Dauvergne, Dr. James and Dr. Smye.

If you are interested in participating, or for more information, please contact Kirby at [contact information]

Thank you.

Appendix C: Consent Forms

Consent form: Key Informant

a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Faculty of Education Vancouver Campus
Educational & Counselling Psychology,
And Special Education
2125 Main Mall
Vancouver, B.C. Canada V6T 1Z4
Phone 604-822-0242
Fax 604-822-3302
www.ecps.educ.ubc.ca

Vulnerability in the Canadian Refugee Determination Arena:

An Interpretive Description Study

Principal Investigator: Dr. Beth Haverkamp, UBC Department of Educational and Counselling Psychology and Special Education, Office of Graduate Programs and Research, [contact]

Co-Investigator: Kirby Huminuik, Doctoral Candidate in UBC Department of Educational and Counselling Psychology and Special Education, [contact]

Refugee claimants have the right to a fair and safe hearing. With the recent changes to the refugee system, we want to investigate how mental health vulnerability is being addressed in the refugee determination arena, to understand if vulnerable refugee claimants are being adequately protected throughout the claim process. We are inviting people in the community who have supported refugee claimants who have made a refugee claim since December 15, 2012 to participate in this study.

By taking part in this study, you have a chance to offer your knowledge and expertise to improve mental health policy and practice for vulnerable refugee claimants. If you agree to take part in this study, you will be asked to participate in a

60-90 minute qualitative interview related to your experience supporting vulnerable claimants through the new claims process.

There are no anticipated harms associated with your participation in this study.

All recordings and private documents will be stored safely for five years after the end of the study. This information will not be used for any purpose other than this research. No names or identifying information will be provided in the final report. Everything you share will be strictly confidential – all names and identifying information will be changed to protect your confidentiality unless you specifically request to be identified with the material you provide. Information that discloses your identity will not be released without your consent unless required by law. Researchers have a legal requirement to disclose information about criminal activity or intent to commit a crime. All documents will be identified only by code number and kept in a password protected computer file or in a locked filing cabinet.

The results of this study will be reported in a doctoral dissertation and may also be published in journal articles and books. A policy brief will also be shared with government and community members with recommendations on how to improve mental health policy and practice within the refugee determination system.

If you have any questions or concerns about what we are asking of you, please contact one of the researchers. The names and telephone numbers are listed at the top of the first page of this form.

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on you.

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

_____

Participant Signature Date

_____

Printed Name of the Participant signing above

Consent form: Refugee Claimant Participant

a place of mind
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Faculty of Education Vancouver Campus
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And Special Education
2125 Main Mall
Vancouver, B.C. Canada V6T 1Z4
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Participant Information

Vulnerability in the Canadian Refugee Determination Arena:

An Interpretive Description Study

Principal Investigator: Dr. Beth Haverkamp, UBC Department of Educational and Counselling Psychology and Special Education, Office of Graduate Programs and Research, [contact info]

Co-Investigator: Kirby Huminuik, Doctoral Candidate in UBC Department of Educational and Counselling Psychology and Special Education, [contact info]

Refugee claimants have the right to a fair and safe hearing. With the recent changes to the refugee system, we want to learn if refugee claimants are being protected and treated fairly throughout the claim process. We are inviting people who have made a refugee claim since December 15, 2012 to participate in this study.

If you agree to participate, we will meet you the first time to provide a brief health screening and review your refugee claim documents. You will receive a copy of your screening questionnaire. We may also invite you to participate in a 90-minute interview about what

happened and how you felt during your refugee claim process. The interview will be audio recorded.

By taking part in this study, you have a chance to offer your knowledge and experience to help make things better for refugee claimants in the future.

We do not think there is anything in this study that could harm you or be bad for you. **Your participation will not affect the outcome of your refugee claim in any way.** Some of the questions we ask may seem sensitive or personal, as they may remind you of difficult times in your refugee claim experience. You do not have to answer any question if you do not want to. Please let one of the study staff know if you have any concerns. We can arrange for you to meet a counsellor if you would like some additional assistance.

All recordings and private documents will be stored safely for five years after the end of the study. This information will not be used for any purpose other than this research. No names or identifying information will be provided in the final report. Everything you share will be strictly confidential – all names and identifying information will be changed to protect your safety. Your confidentiality will be respected. Information that discloses your identity will not be released without your consent unless required by law. Researchers have a legal requirement to disclose information about criminal activity or intent to commit a crime. All documents will be identified only by code number and kept in a password protected computer file or in a locked filing cabinet. Participants will not be identified by name in any reports of the completed study.

The results of this study will be reported in a doctoral dissertation and may also be published in journal articles and books. A policy brief will also be shared with government and community members with recommendations on how to improve the refugee determination system to make it more fair and safe for refugee claimants.

If you have any questions or concerns about what we are asking of you, please contact one of the researchers. The names and telephone numbers are listed at the top of the first page of this form.

If you have any concerns about your rights as a research subject and/or your experiences while participating in this study, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time until the dissertation is finalized, without giving a reason and without any negative impact on you. You will receive a gift card even if you decide to withdraw from the study after the interview.

If you needed an interpreter to assist you in reading this document, the interpreter will sign below attesting that they have interpreted the document faithfully.

_____

Interpreter Signature Date

_____

Printed Name of the Interpreter signing above

Appendix D: Case Study Template

Case Study: Pseudonym

Background

- Brief demographic description, obscuring identifying details
- Brief description of the basis of claim allegations

Inclusion criteria

- Referral source
- Grounds for referral
- PROTECT questionnaire score: self-report of current and past symptoms (throughout time of hearing preparation and at the hearing)

Qualitative Interview

- Interview conditions (eg. length, interpretation)
- Mental health status observations at time of interview

Documents Reviewed

List of documents that were reviewed (for example):

- Basis of Claim Form
- Narrative Addendum
- Country Conditions Documentation
- Medico-legal report from mental health professional or physician
- Application for Vulnerability Designation
- Designation of Vulnerability
- Transcript of Refugee Protection Hearing
- Notice of Decision
- Application for Appeal

Description of the refugee claim process

Drawing from interviews with the claimant, key informants and the documentation on the case to answer the following questions:

- What was the claimant's experience of the refugee claim process?
    - How did the claimant prepare for the hearing?
    - What supports were accessed?
    - What was helpful, what was particularly difficult?
- Any corroborating information about how the claimant experienced the refugee claim process from counsellors, lawyers, service providers or reports in the submissions?
- How was mental health addressed in the documentation? (Vulnerability application, letters, assessments)
- Was Vulnerability designated? Were accommodations made? Do claimants and others believe they were helpful?
- Was there any reference to mental health in decision?

Analysis of how vulnerability was conceptualized in the case

- When and how was vulnerability identified?
- What were the critical points of vulnerability in the claims process?
- How did identifying professionals/community members address vulnerability?
- How did government agencies address vulnerability? Were the guidelines enacted?
- Did the process meet the standards set out by Guideline 8? If they fell short, how, and what were the consequences? If they met the expectations, were these sufficient to ensure fairness and protection? If not, what would have been be needed?
- Does it appear the accommodations were effective in ensuring fairness and protection?
- Further accommodations that could have been beneficial?

Appendix E: Interview Protocols

Key Informants

Key informants (such as past or current IRB employees, lawyers, service providers, community members) will be invited on the basis of their experience in the refugee determination arena and their proximity to claimants throughout the process.

In 60-90 minute semi-structured interviews, key informants will be asked to discuss mental health vulnerability in the current refugee protection policy environment. They will be asked to discuss how vulnerability is being conceptualized, and their assessment of what impact this has on the fairness of claims and on the mental health of claimants.

Key questions will include:

- How is vulnerability defined in practice? For example, what is seen to constitute a claimant with 'particular difficulty' or determines whether a claimant is thought to be able (or not) to adequately present their claim?
- How are vulnerable claimants identified? Is there an established process? Who makes these judgments and on what basis?
- What accommodations are commonly requested? Are the accommodations that are granted commensurate with impairments? How is this determined?
- Are steps taken to prevent (re)traumatization? Are these adequate?
- What changes could improve the fairness and protections for vulnerable claimants?

Refugee Claimant Participants

In 60-90 minute semi-structured qualitative interviews, refugee claimants will be asked to recount and reflect on their experience of the claim process. The interview will probe the factors that facilitated or hindered their communication with lawyers and officials, their recollection of their mental and emotional states at various stages throughout the process, and their recommendations for procedural accommodations or policy changes that would have provided better mental health protection/support and assisted them to testify more completely/accurately.

- Key questions will include:
    - What was your experience of telling the story of your case?
    - Did you find yourself unable to remember certain details or feeling more upset when you had to talk about the things that happened to you?
    - Did [specific symptoms from PROTECT questionnaire or key informant observations, described in lay terms] affect your ability to present your case? Did they get worse at any time during the claim process?
    - Did anyone notice that you were having trouble presenting your case and needed additional help?
    - What help did you get? Was this useful?
    - Do you think your worries, fears, or emotions got in the way during your hearing?
    - What could have helped you tell your story more clearly and get through your hearing more easily?
    - Is there anyone else I could talk to, to help me understand your case?

- Interpretation will be provided, as needed, by mental health interpreters hired on contract.