ARTICLE

Mental Health in LGBT Refugee Populations

Mark Messih, M.D., M.Sc.

Within the United States and globally, there has been a shift toward acceptance of lesbian, gay, bisexual, and transgender (LGBT) individuals. Despite these advances, many nations continue to stigmatize, criminalize, and legitimize abuse of these communities (1). Global statistics reflect high levels of violence targeting individuals based on sexual orientation and/or gender identity (2). Concurrently, the number of refugees seeking asylum within the United States is rising. In 2013, 69,909 refugees applied for asylum, an increase from 58,159 in 2012 (3). A total of 3.8%–10.0% of refugees entering the United States identify as LGBT (4), translating to approximately between 2,656 and 6,991 LGBT refugees. Studies have examined mental illness and service provision in refugees and on mental health in LGBT populations. Increasingly, researchers are looking at the intersection of these areas (5), focusing on mental illness in LGBT refugee communities. In the present article, the most commonly cited psychiatric conditions facing LGBT asylum seekers are presented. Next, the role of psychiatrists in the asylum-seeking process is reviewed. Finally, guidelines informed by existing literature are put forward to inform clinical care. Researchers working in psychiatry, psychology traumatology, social justice, and ethics have explored this topic in recent years. The present article examines mental illness grouped according to the "phases of exile" (6), that is, pre-flight, migration, and postmigration.

Literature on LGBT refugees has focused on the reported trauma experienced by this community and examined how this correlates with posttraumatic stress disorder (PTSD), anxiety, and depression. More broadly, literature on refugee mental illness has focused in a similar area but is growing to look at other illnesses with which patients may present. Refugees show increased rates of schizophrenia, autism, and generalized anxiety disorder (7). According to the Centers for Disease Control and Prevention, refugees have an increased prevalence of depression, somatization, traumatic brain injuries, and panic attacks (8). Furthermore, refugee stressors can be organized into four categories: traumatic stress, resettlement stress, acculturation stress, and isolation stress (see Table 1).

PRE-FLIGHT

Pre-flight experiences are the traumas that occur in one's country of origin (see Table 2). LGBT refugees may have lived through years of persecution within their family or broader community. Documented violence includes corrective rape, honor killings, beatings, and imprisonment (9). This abuse can be longstanding, starting in early childhood, or more recent in adulthood. Adults who have suffered childhood sexual abuse, often from family or community members, are at increased risk of depression and anxiety (10). In some cases, individuals abruptly flee their homes due to changes in safety, including threat of exposure and fear of torture or death (11). The threat of violence, having witnessed a partner or friend murdered or tortured, can also trigger the individual to flee. Often, the spontaneous decision to leave means that individuals are not prepared for the journey or do not know where to go next. Patients may present with PTSD (12). In DSM-5, the diagnosis of PTSD incorporates depersonalization, derealization, and negative alterations in cognition (guilt, shame, fear). Presentations can include re-experiencing traumatic events, avoidance of reflecting on trauma hypervigilance, and anxiety. Previous literature has discussed LGBT refugee mental health in relation to disorders of extreme stress not otherwise specified or complex PTSD (13). Originally proposed within the DSM-IV Work Group (14), this was a cluster of symptoms encompassing three non-PTSD posttraumatic disorders: dissociative identity disorder, borderline personality disorder,

TABLE 1. Four Core Refugee Stressor Type

Type	Stressor	
Traumatic stress	War Torture Rape Forced displacement from home	Family/community violence Flight and migration Poverty Starvation
Resettlement stress	Financial stressors Housing Employment Loss of community support	Lack of access to resources Transportation difficulties Loss of pre-migration status
Acculturation stress	Problems fitting in at school Struggle to form an integrated identity including elements of the new culture and the culture of origin Conflicts related to cultural misunderstandings	The necessity to translate for family members who are not fluent in English Intergenerational conflicts over new and old cultural values Concern of children "losing" their culture
Isolation stress	Feelings of loneliness and loss of social support networks Discrimination Feelings of not "fitting in" with others	Harassment from peers or law enforcement Experiences with others who do not trust refugees

TABLE 2. Risk Factors That may Predispose Refugees and Asylum Seekers to Psychiatric Symptoms and Disorders

Pre-Flight/Migration	Post-Flight
Exposure to war	Loss of family members
State-sponsored violence	Prolonged separation
Oppression	Stress of adapting to a new culture
Torture	Low socioeconomic status and underemployment
Internment in refugee camps	Physical displacement outside one's home country
Human trafficking	

and somatization disorder. Proponents of complex PTSD suggested that it may better fit with prolonged, interpersonal, and repeated trauma (15). This is included to show that patients may present with a range of conditions that need to be addressed (16). In the long-term, repeated pre-flight trauma may erode a patient's resilience capacities, that is, how they adapt to future stressors (17).

JOURNEY INTO EXILE

After leaving one's country of origin, there are dangers in transit, especially if one must travel through nations with discriminatory laws. Refugees report abuse, imprisonment, and torture after leaving their homes. Additionally, in the initial stages of a humanitarian crisis, LGBT people are more at risk of being excluded from basic protections (18). Beyond access to care and increased likelihood of harm, alienation from government and NGO organizations can affect long-term coping and resilience ability in LGBT individuals. When promises of safety are made and then broken, clinicians have noted lasting effects on the patient's ability to form relationships and seek help. This is especially troubling given that patients who access community resources and group activity have better outcomes than patients in isolation (19). LGBT refugees may be more marginalized during the process of registration, including scrutinizing documents, detention in gender-segregated facilities, and public reporting of private information. LGBT refugees in detention are at increased risk of violence and sexual assault compared with other detainees (20). Security during asylum seeking is precarious with reports of attacks, as well as harassment by family members and other refugees.

POST-FLIGHT TRAUMA

Once a refugee has obtained status or is awaiting a court date, there are mental health challenges that can emerge in his or her new country. One such issue is the concept of "cultural bereavement" (21). This refers to the loss of familiar social structures, values, and even language. Some grieving for this loss can be expected, but symptoms may progress, causing depression. Patients may lose ties to their families and become isolated from communities because of their LGBT identity (Table 2). They may report hypervigilance and anxiety about having their identity being revealed. If they seek support within their cultural community, they risk being ostracized. While considering these factors, clinicians should remember that pre-flight trauma is connected to post-flight trauma. Pre-flight trauma has lasting effects on how the patient views him- or herself and adapts to a new life. In patients who have reported childhood abuse, for example, patients may feel shame, invisible, and "wrong," having internalized negative perceptions of family and community (22). This affects how the patient approaches therapy and informs how they approach the asylum-seeking process. For example, some individuals may not have considered filing for asylum based on being LGBT or may be resistant to doing so all together.

TABLE 3. Recommendations for Working With LGBT Refugees

Item
Establishing a sense of safety
Engendering tolerance of multiple self-identities
Preparing clients for trauma disclosure in the asylum-seeking process
Mitigating the risk of retraumatization inherent in the asylum-seeking process
Addressing cultural challenges to the utilization of psychotherapy
Empowering patients

THE CLAIMS PROCESS

In the United States, refugee claimants are asked to recount their experiences that led to leaving their country. Reviewers assess an applicant's story for plausibility, consistency, detail, country of origin information, and corroborating evidence (23). Preparing an application can force patients to revisit trauma and reflect on their identity. In transgender individuals, proof of identity is problematic (24), as some may have transitioned and/or no longer identify as the gender listed on accepted forms of identification. Not all individuals may identify outright as LGBT due to internalized shame or cultural understandings of their sexuality. As such, it is important to be sensitive to these variations when treating patients and assisting in the navigation of the asylum process. There is a one-year filing deadline from the time an individual enters the country, after which patients cannot file a claim. It is important to consider this timeline when preparing a case. When working with survivors of torture, the interviewer should make the purpose of the discussion clear, address cultural and language differences, and be aware of the impact of third parties on testimony. For example, is someone safe to identify as LGBT for asylum if he or she is with family or living within a broader community of refugees from the same area.

As clinicians, we must be aware of our own expectations and assumptions of how LGBT individuals should present. For example, a woman who identifies as lesbian may have been pressured to marry and have children (25). Reading and Rubin (19) highlighted the following priority areas for clinicians to incorporate when working with LGBT refugee applicants: cultural issues, culturally appropriate services related to language and

KEY POINTS/CLINICAL PEARLS

- There is a rising proportion of refugees that identify as LGBT who present with a range of mental health conditions from posttraumatic stress disorder, depression, and anxiety to substance abuse.
- Patients face multiple stressors due to their LGBT identity and their refugee status, stressors that may hinder access to care and inhibit patients from accessing social and medical supports.
- When working with patients, establishing safety, preparing clients for the asylum-seeking process, and empowering them are important considerations in the treatment plan.

other needs of immigrants, meeting the needs of children, the elderly, and other special groups (see Table 3). The World Psychiatric Association has established similar recommendations (26). In working with patients, it is important to acknowledge cultural differences in understanding identity. The World Psychiatric Association (26) recommends that clinicians access information of specific cultural issues, provide culturally appropriate services related to language and other needs of immigrants, and meet the needs of children, the elderly, and other special. In working with patients, it is important to acknowledge cultural differences in understanding identity.

CONCLUSIONS

Understanding the trauma experienced by LGBT refugees allows clinicians to empathize and provide appropriate care. Patients will present with complex histories comprising trauma at home, in transit, and while acclimatizing to their new lives. In working with this community, broader social, cultural, and legal aspects of mental illness should be considered by the psychiatrist to understand the patient's experience. The role of therapy is two-fold: to navigate the past and prepare the client for the future. Opportunities exist for residents and clinicians looking to assess asylum seekers. For example, the Weill Cornell Center for Human Rights (27) provides resources and training for medical students, residents, and clinicians interested in conducting asylum evaluations. Organizations such as Physicians for Human Rights and HealthRight International provide trainings as well. Finally, psychiatrists have the opportunity to act as advocates for their patients by empowering refugees to navigate the asylum process and make sense of their experiences.

Dr. Messih is a first-year resident in the Department of Psychiatry, Drexel University, Philadelphia.

REFERENCES

1. Human Rights Watch: Together, Apart: Organizing Around Sexual Orientation and Gender Identity Worldwide. New York, Humans Rights Watch, 2009. http://www.hrw.org/node/83162
2. International Lesbian, Gay, Bisexual, Trans and Intersex Association: State Sponsored Homophobia: A World Survey of Laws: Criminalization, Protection and Recognition of Same-Sex Love Association. http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2015.pdf
3. US Department of Homeland Security: Annual Flow Report: Refugees and Asylees–2013. http://www.dhs.gov/publication/refugees-and-asylees-2013
4. Heartland Alliance: Rainbow Welcome Initiative: An Assessment and Recommendations Report on LGBT Refugee Resettlement in the United States. Washington, DC, US Department of Health and Human Services, Office of Refugee Resettlement, 2012
5. Shidlo A, Ahola J: Mental health challenges of LGBT forced migrants. Forced Migrat Rev 2013; 42:9–11
6. Higgins S, Butler C: Refugees and asylum seekers, in Intersectionality, Sexuality and Psychological Therapies: Working with Lesbian, Gay and Bisexual Diversity. Edited by Nair R, Butler C. Oxford, United Kingdom, Blackwell, 2012, pp, 113–136
7. Parekh R: The Massachusetts General Hospital Textbook on Diversity and Cultural Sensitivity in Mental Health. New York, Humana Press, 2014
8. Centers for Disease Control and Prevention: Guidelines for Mental Health Screening During the Domestic Medical Examination for Newly Arrived Refugees. Atlanta, CDC, 2015
9. United Nations High Commissioner for Refugees: Working with Lesbian, Gay, Bisexual, Transgender and Intersex Persons in Forced Displacement. Geneva, Switzerland, UNHCR, 2011
10. Lindert J, Ehrenstein S, Priebe S, et al: Depression and anxiety in labor migrants and refugees: a systematic review and meta-analysis. Soc Sci Med 2009; 69:246–257
11. Kinzie JD, Jaranson JM: Refugees and asylum-seekers, in the Mental Health Consequences of Torture. Edited by Gerrity E, Keane TM, Tuma F. New York, Springer, 2001, pp 111–120
12. McDonnell M, Robjant K, Katona C: Complex posttraumatic stress disorder and survivors of human rights violations. Curr Opin Psychiatry 2013; 26:1–6
13. de Jong JTVM, Komproe IH, Spinazzola J, et al: DESNOS in three postconflict settings assessing cross-cultural construct equivalence. J Trauma Stress 2005; 18:13–21
14. Herman JL: Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. J Trauma Stress 1992; 5:377–391
15. Sochting I, Corrado R, Cohen IM, et al: Traumatic pasts in Canadian aboriginal people: further support for a complex trauma conceptualization? BC Med J 2007; 49:320–326
16. Cloitre M, Stolbach BC, Her man JL, et al: A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity. J Trauma Stress 2009; 22:339–408
17. Herman JL: Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. J Trauma Stress 1992; 5:377–391
18. Rumbach J, Knight K: Sexual and gender minorities in humanitarian emergencies, in Issues of Gender and Sexual Orientation in Humanitarian Emergencies. Edited by Roeder LW, Jr. New York, Springer, 2014, pp 33–74
19. Reading R, Rubin LR: Advocacy and empowerment: group therapy for LGBT asylum seekers. Traumatology 2011; 17:86–98
20. Tabak S, Levitan R: LGBTI migrants in immigration detention. Forced Migrat Rev 2013; 42:47–49
21. Kirmayer L, Young A, Hayton BC: The cultural context of anxiety disorders. Psychiatr Clin North Am 1995; 13:503–521
22. Pepper C: Gay men tortured on the basis of homosexuality. Contemp Psychoanal 2005; 41:35–54
23. www.uscis.gov/USCIS/Humanitarian/Refugees%20&%20Asylum/Asylum/Asylum%20Native%20Documents%20and%20Static%20Files/RAIO-Training-March-2012.pdf
24. Berg L, Millbank J: Constructing the personal narratives of lesbian, gay and bisexual asylum claimants. J Refugee Studies 2009; 22:195–223
25. Pope KS: Psychological assessment of torture survivors: essential steps, avoidable errors and helpful resources. Int J Law Psychiatry 2012; 35:418–426
26. Bhugra D, Gupta S, Bhui K, et al: WPA guidance on mental health and mental health care in migrants. World Psychiatry 2011; 10:2–10
27. http://www.wcchr.com/get-involved/clinicians