Susanna M. Francies, Psy.D

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Psychological Evaluation

Subject: [redacted]
Date of Birth: [redacted]
Interpreter: [redacted]
Date Evaluation: 5/21/2015
Date of Report: 6/3/2015

Diagnosis: **Posttraumatic Stress Disorder, 309.81; Major Depressive Disorder, Recurrent, Severe Without Psychotic Features, 296.23**

Credentials of Evaluator

I, Susanna Francies, Psy.D., certify that I am a Licensed Psychologist in the Commonwealth of Pennsylvania (license PS017175). I have provided diagnostic evaluations and psychological treatment to adults and children since 2002. In my academic and clinical work, I have specialized in the psychological impact of trauma, particularly for refugees and immigrants. I have conducted research on the experiences and coping strategies of refugees living in the United States. I have completed advanced study of trauma through Columbia University's International Trauma Studies Program. In addition, I have traveled internationally to Africa for specialized training in international disaster response, and the impact of trauma on vulnerable populations worldwide.

I completed training by Health Right International and Physicians for Human Rights on documenting the effects of torture. I am a member of the University of Pennsylvania Center for Public Health Initiatives Asylum Evaluator's group. I have completed over thirty immigration-related psychological evaluations, and have been qualified as an expert in immigration court in York, Pennsylvania.

I provided diagnostic assessment and treatment to children suffering from the sequelae of abuse and trauma at the Children's Crisis Treatment Center. I also provided testimony and advocated for the best interests of these children in Philadelphia Family Court.

Assessment Procedures

Diagnostic Interview of Ms. [redacted] 5/21/2015
Psychosocial/Educational/Physical Health history of Ms. [redacted]
Beck Depression Inventory-II (BDI-II-Spanish Translation)
Trauma Symptom Inventory-2 (TSI-2 Spanish Translation)
Montreal Cognitive Assessment (MoCA- Spanish Translation)

Collateral Sources

Sworn Statement of [redacted]
Review of medical files from Berks Family Detention Center of Ms. [redacted] and her daughter, [redacted]

Referral

This 35-year-old, single mother of three children, from Guatemala, was referred for evaluation by her attorney. The purposes of this evaluation were to determine: 1) What is Ms. [redacted] current psychological functioning, including the impact of her extended detention? 2) What, if any, was the psychological impact of the abuse and trauma that Ms. [redacted] experienced in Guatemala? 3) Are there any psychological factors which impact Ms. [redacted] ability to recount her history of abuse? 4) What would be the psychological impact if Ms. [redacted] were forced to return to Guatemala?

Conditions of Interview and Informed Consent

Prior to this psychological evaluation, Ms. [redacted] agreed to the condition that I approach this assessment with no particular results in mind and that I would exercise independent professional judgment on all aspects of this evaluation.

Before beginning the interview, I informed Ms. [redacted] that with her consent I would discuss my findings with her attorney and write a report that her attorney could submit as evidence, if she so chooses.

Behavioral Observations and Mental Status Examination

The assessment was conducted in a private interview room at the Berks Family Detention Center. The interview was conducted in Spanish, Ms. [redacted] native language, with the assistance of an interpreter, [redacted]z. The interview lasted approximately 3 hours and 30 minutes, including 45 minutes of assessment administration.

Ms. [redacted] asked that the written assessment measures be read aloud to her. Throughout the administration of the standardized assessments, she asked questions to clarify her understanding and provided additional details about her responses.

Ms. [redacted] was very emotional throughout the interview. At times, she was sobbing so hard that she had difficulty speaking. She cried, wrung her hands and rubbed her forehead and neck repetitively during the interview.

Ms. [redacted] was cooperative and engaged. Eye contact was good. There was no evidence of a thought disorder.

At times during the interview, Ms. [redacted] responses to questions were tangential. She answered a part of the question posed, but seemed more driven by emotion in terms of what she focused on. Her memories about her past were reported in a way that was fragmented and disjointed. With repeated, direct questions, she was able to clarify her responses and stay on task. This type of response style is not unusual in survivors of trauma, as traumatic memories are highly emotional, and can be disorganized and disjointed.

It is not unusual for survivors of trauma to present with memory impairment related to the trauma[1]. Posttraumatic Stress Disorder (PTSD) arises out of an effort to block out unwanted memories of a traumatic event, and a common symptom of PTSD is the inability to recall some aspect of the event. Memory problems can arise due to various aspects of trauma, including: failure to adequately encode the information due to extreme stress; efforts to block out painful memories; and difficulty retrieving memories when under distress.

Current Functioning

Ms. [redacted] has been detained with her 11-year-old daughter, [redacted] at the Berks Family Detention Center for approximately 10 months. She has two younger daughters who remain in Guatemala and are staying with a family friend.

Ms. [redacted] currently reports symptoms of anxiety and depression. She also endorses stomach pains and chronic headaches. She is currently prescribed 15 milligrams of Mirtazapine (an antidepressant medication) daily.

During April of 2015, Ms. [redacted] learned that her daughter, [redacted] was sexually abused by her ex-paramour, [redacted]. This news was devastating to Ms. [redacted] and she felt extremely guilty for not being able to protect her daughter. Overwhelmed, and feeling hopeless, Ms. [redacted] believed that her daughter might be better off without her. She thought that, if she died, her daughter would be able to stay in the United States. Ms. [redacted] starting thinking about killing herself. She considered trying to hang herself in the bathroom of the detention facility. Ms. [redacted] reportedly disclosed suicidal thoughts to her counselor and a psychiatrist. As a result, she was placed in solitary confinement. She was separated from her daughter for three days. Ms. [redacted] reported that those days were very hard for her. She felt extremely guilty for having thoughts of ending her life and the impact it would have had on her daughters. Though she missed [redacted] she was reluctant to have her

[1] Jenkins, M.A., Langlais, P.J., Delis, D. & Cohen, R. (1998). Learning and memory in rape victims with posttraumatic stress disorder. *American Journal of Psychiatry*, 155: 278-279.

visit, as she did not want her daughter to see her in that situation.

Ms. [redacted] no longer endorses suicidal intent. She does have passive thoughts about wishing she were dead, or believing things would be easier if she were dead. However, she feels strongly that she needs to be there for all three of her daughters, particularly those who remain in Guatemala.

Relevant Background
(Based on interview with Ms. [redacted]

Early Childhood

Ms. [redacted] was born in a rural village in Guatemala on [redacted] She is the third of her parents' eight children, and the oldest daughter. Her father worked as a farm laborer. Ms. [redacted] described her childhood has difficult. As the oldest daughter, she was often responsible for caring for her siblings. She attended school, sporadically. At about age eight, Ms. [redacted] was sexually abused by her father's cousin, who lived in their home. The abuse continued for many years. When Ms. [redacted] told her mother about the abuse, her mother did not believe her. Her abuser consistently threatened her, saying that if she told anyone he would hurt her siblings or her mother.

At about age 16, Ms. [redacted] left her parents home in order to escape the abuse. She found work as a housecleaner and stayed with the customers whose homes she cleaned.

Relationship with [redacted]

When Ms. [redacted] was about 22, she started dating [redacted] They met through classmates at the secretarial training program she was attending. [redacted] was a teacher who was about ten years older than Ms. [redacted] and because of this she "thought things would be different." She became pregnant after four months of dating. As her pregnancy progressed, she moved back to her parents' home. Her mother was not kind to her and seemed to resent having her there, but Ms. [redacted] father allowed her to stay.

During her pregnancy, [redacted] was not supportive. After their daughter, [redacted] was born, Ms. [redacted] returned to work. One day, [redacted] came to find her after work. He told her he wanted to introduce the baby to his parents. Ms. [redacted] told him the baby was at home, with her mother. He informed her that he had already picked up their daughter and brought her to his parent's home. After that, [redacted] convinced her to move in with him.

During the time that they lived together, [redacted] was physically abusive. He was very controlling of their daughter and often tried to take her from Ms. [redacted] He drank alcohol and, when he was intoxicated, he would become more aggressive. He forced Ms. [redacted] to have sex with him. Ms. [redacted] eventually moved out, but she continues to have conflict with [redacted] in regards to custody of their daughter.

Relationship with [redacted]

Ms. [redacted] later became involved with [redacted] the father of her younger two daughters. [redacted] was physically abusive and had problems with alcohol. During her pregnancy with her younger daughter, [redacted] attempted to choke her. She called the police and [redacted] was arrested. She thought the only reason that the police intervened was because she had visible injuries from the attack. After his arrest, he blamed Ms. [redacted] that he could not get a job, saying that she made his record "dirty."

After her second daughter was born, Ms. [redacted] did not want to have any more children. She started taking birth control pills. When [redacted] found out, he was furious. He wanted more children. He accused her of being a "prostitute" because she was taking birth control. He forced her to have sex against her will. She later became pregnant and [redacted] denied that the child was his.

[redacted] humiliated her in public. When he would see her in the street he yelled at her and accused her, saying that one of his daughters was not really his. Ms. [redacted] tried to avoid [redacted] but he continued to pursue her.

Educational and Employment History

Ms. [redacted] reports that she attended public school through high school. After that, she enrolled in a secretarial school. She noted that her peers at school were a source of support and encouragement. They urged Ms. [redacted] to continue her schooling after the birth of her daughter. Ms. [redacted] attended the secretarial training program for three years.

Although Ms. [redacted] has training beyond high school, she has always held low-skill jobs like house cleaning or as a home aid for an elderly person. She has never worked as a secretary.

Ms. [redacted] spent approximately ten years working for a dentist. She cleaned his home and took care of his elderly mother, who suffered from diabetes. This man was always kind and supportive to her. She considered telling him about the problems she was having with [redacted], but she worried that this could put her job in jeopardy. She felt it was too much of a risk, and did not want him to think of her in a negative light. When the dentist's mother died, he eventually closed his practice and Mr. [redacted] lost her job. Following that job loss, she was unable to provide for her children.

Medical History

Ms. [redacted] has a scar on the right side of her forehead. She explained that this was the result of a head injury she sustained at age 16. She reported that several men were trying to steal her brother's car and attacked him. She and her sister attempted to defend their brother and were also attacked. They were all hospitalized with various injuries. Ms. [redacted] was hit in the head. She is not sure exactly how the injury occurred. She believes she was hit with

the door of the car, or a rock. She was hospitalized for two weeks before she was transferred to another medical facility for reconstructive surgery. Following the operation, she was given prescription lenses to help with damage to her right eye. These lenses also shielded her eyes from bright lights. As a result of the injury, she experienced numbness on the right side of her head for many years. More recently, she has begun to regain some feeling.

Diagnostic Findings

Trauma Symptom Inventory- 2

The Trauma Symptom Inventory is a widely used standardized test that measures "...a wide range of potentially complex symptomatology, ranging from posttraumatic stress, dissociation, and somatization to insecure attachment styles, impaired self-capacities, and dysfunctional behaviors. Normed and standardized on a representative sample of the United States general population, it consists of two validity scales, 12 clinical scales, 12 subscales, and four factors."[2]

Ms. [redacted] responses on the Validity scales of the Trauma Symptom Inventory-2 were in the valid range, suggesting that she answered the questions openly and honestly.

Most of Ms. [redacted] scores on the clinical scales fell in the "clinically significant" range. Her highest scores were on the following scales:

Anxious Arousal: This scale reflects the extent to which the respondent is experiencing general symptoms of anxiety, such as fear, panic, tension, and jumpiness.

Intrusive Experiences: This scale measures nightmares, flashbacks, and unwanted thoughts and memories of an upsetting past event. These symptoms represent "Criterion B" events in Posttraumatic Stress Disorder.

Dissociation: This scale assesses "largely unconscious, defensive alteration in awareness, developed as an avoidance response to overwhelming – often posttraumatic- psychological distress."[3] This includes such symptoms as "spacing out," feeling like things aren't real, people saying you don't pay attention, and difficulty remembering details

Somatic Preoccupations: This scale measures a preoccupation with somatic dysfunction, which is sometimes found in traumatized individuals. Examples include: aches, pains, indigestion, nausea, and muscle spasms.

Suicidality: This scale assesses self-reported suicidal thoughts and behaviors. "Suicidal ideation is not uncommon among those suffering from posttraumatic distress, but can also be

[2] Briere, J., 2011, *Trauma Symptom Inventory-2 Manual*, p.1; Briere, J., Elliott, D.M., Harris, K., & Cotman, A. (1995). Trauma Symptom Inventory: Psychometrics and association with childhood and adult trauma in clinical samples. *Journal of Interpersonal Violence,* 10, 387-401

[3] TSI-2 Manual, page 16

found among those suffering from non-trauma-related depression or inescapable, highly adverse circumstances."[4] Items on this scale include: wishing you were dead, fantasies about dying, feeling so hopeless you wanted to die, and trying to kill yourself but then changing your mind.

Tension Reduction Behavior: This scale refers to "external activities engaged in by an individual as a way to modulate, interrupt, avoid, or soothe negative internal states and may reflect underdeveloped affect regulation and tolerance skills."[5] Items on this scale include: calming yourself down by eating more than you should, punishing yourself so you would feel less guilty, and doing something self-destructive during or after an argument.

Beck Depression Inventory-II (BDI-II) [6]

The Beck Depression Inventory-II is a revised form of a very widely used questionnaire, designed to assess the intensity of depression in clinical and normal populations.

Ms. [redacted] responses on the Beck Depression Inventory were consistent with clinical interview findings and indicative of severe depression. Her most severe symptoms were: sadness, hopelessness, self-blame, self-dislike, anhedonia (lack of interest or pleasure) difficulty concentrating and lack of sexual feelings.

Montreal Cognitive Assessment (MoCA- Spanish Version)

"The MoCA was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations and orientation."[7]

Ms. [redacted] score fell in the range of mild cognitive impairment. She had particular difficulty with visuospatial and memory skills (delayed recall). There are a number of factors that could be contributing to Ms. [redacted] impairment, including the impact of her head injury as a teenager. In addition, given that English is not her first language, this may have presented a barrier and contributed to a lower score. Although the test was administered in Spanish, language interpretation can be challenging in administering a test of this sort. Ms. [redacted] appeared slightly anxious about her performance and anxiety can contribute to impaired comprehension and diminished

[4] TSI-2 Manual, page 17
[5] TSI-2 Manual, pages 18-19
[6] Beck A.T., Steer R.A., Ball R., and Ranieri, W. (December 1996). Comparison of Beck Depression Inventories -IA and -II in psychiatric outpatients". *Journal of personality assessment* 67 (3), 588–97
[7] Nasreddine ZSI, Phillips NA, Bédirian V, Charbonneau S, Whitehead V, Collin I, Cummings JL, Chertkow H. (2005) The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. *Journal of American Geriatric Society.* 53(4) 695-9

performance on cognitive tasks. Depressive symptoms can also confound performance on cognitive assessments. Further testing would be needed to assess the extent of Ms. [redacted] cognitive functioning.

The results of the various forms of assessment were consistent with the findings of the clinical interview and indicate the presence of Posttraumatic Stress Disorder and Major Depressive Disorder. Ms. [redacted] current psychological condition is consistent with the following diagnoses:

DSM-5 Diagnosis

Posttraumatic Stress Disorder, 309.81,
Major Depressive Disorder, Recurrent, Severe Without Psychotic Features, 296.23

Diagnostic Criteria

Posttraumatic Stress Disorder

A diagnosis of Posttraumatic Stress disorder is dependent on four different categories of symptomatology. These include: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. Ms. [redacted] responses to this multimodal assessment confirm the diagnosis, based on her history of sexual abuse as a child and as a victim of domestic violence by two of her paramours.

Intrusion: Ms. [redacted] reports difficulty with intrusive memories from the past. She experiences nightmares, unexpected memories from the past, and emotional distress when she thinks about what happened to her.

Avoidance: Ms. [redacted] tries not to think about what she has been through. She avoids things that remind her of the past and avoids talking about what happened to her. When painful memories pop up, she tries to push them away.

Negative Alterations in Cognitions or Mood: Ms. [redacted] endorses very low mood and feelings of distress. She tends to engage in negative thinking, such as blaming herself for the abuse that her daughter experienced, or believing that her children would be better off without her.

Negative Alterations in Arousal and Reactivity: Ms. [redacted] reports symptoms consistent with prolonged, heightened arousal, common to people who have endured trauma. She reports feeling jumpy, difficulty sleeping, tension, and irritability.

Major Depressive Disorder, Recurrent, Severe Without Psychotic Features

According to the DSM-5, the diagnostic criteria for Major Depressive Disorder are:

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
4) insomnia or hypersomnia nearly every day
5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6) fatigue or loss of energy nearly every day
7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8) diminished ability to think or concentrate, or indecisiveness, nearly every day
9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Ms. [redacted] signs and symptoms of depression include: sadness, hopelessness, self-blame, self-dislike, feelings of failure, difficulty making decisions, irritability, lack of energy, anhedonia, difficulty concentrating, and lack of sexual feelings. She also endorses recent suicidal ideation.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Ms. [redacted] reports significant distress, dating back many years. Recently, she was so overwhelmed that she contemplated suicide.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Ms. [redacted] symptoms are not likely due to the use of substances. She denies any significant health problems.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorders.

There was no evidence of hallucinations, delusions or psychotic thinking.

E. There has never been a manic episode or a hypomanic episode.

There was no evidence of prior manic or hypomanic symptoms.

Clinical Impressions

Ms. [redacted] presentation during the interview was consistent with someone who is experiencing significant distress. Her style of responding to questions was tangential. At times, repeated questions were necessary to redirect Ms. [redacted] back to the topic. There are several factors that may contribute to this style of responding, including: significant distress, trauma history, dissociation, and cognitive impairment.

Ms. [redacted] eported that her prolonged detention has contributed to her distress. It has been difficult for her to live with the uncertainty of whether or not she will be forced to return to Guatemala. She also worries about the impact of detention on her daughter. Feelings of hopelessness and helplessness are linked to depression; her detention likely exacerbates her mental health problems.

Ms. [redacted] reports that she suffered from a significant head injury in her late teens. This resulted in loss of consciousness and she required reconstructive surgery. Cognitive screening in this evaluation revealed some impairment. Despite completing further training after high school, Ms. [redacted] has never held a job in her field, which could be related to her impairment. It is also possible that Ms. [redacted] response style is related to her cognitive impairment.

Ms. [redacted] presents with a history of repeated trauma dating back to childhood, when she was the victim of sexual abuse by a family member. She went on to experience intimate partner violence by both of the fathers of her children. The cycle of abused described by Ms. [redacted] is, unfortunately, quite prevalent in victims of child sexual abuse. In fact, two out of three sexual abuse victims will be re-victimized.[8] Specifically, child sexual abuse is also associated with rape and sexual victimization by a partner in adulthood.[9] The experience of repeated trauma and re-victimization increases feelings of shame and hopelessness, as endorsed by Ms. [redacted]. This can also interfere with a victim's ability to disclose their abuse.

Impact of Removal to Guatemala

If Ms. [redacted] were forced to return to Guatemala, it is highly likely her psychological symptoms would worsen. Ms. [redacted] is at extremely elevated risk for suicide, due to multiple factors, including her recent suicidal ideation and intent. She is also very vulnerable to repeated abuse by men. She said "I don't understand why so many bad things happen."

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[8] Classen, C.C., Palesh, O.G., and Aggarwal, R (2005). Sexual revictimization: a review of the empirical literature. *Trauma Violence Abuse,* 6 (2) 103-29.

[9] Parillo, K.M., Freeman, R.C., and Young, P. (2003). Association between child sex abuse and sexual revictimization in adulthood among women sex partners of injection drug users. *Violence and Victims*, 18, 473-484.

Ms. [redacted] is suffering from serious and chronic mental health problems that impact her quality of life and her ability to care for herself and her children. Ms. [redacted] is in need of mental health treatment to help her process her history of abuse and learn skills to protect herself in the future. Given that her daughter may also be a victim of abuse, it is essential that Ms. [redacted] receive the support she needs to heal, and to support her daughter's recovery as well. If psychotherapy is to be effective for Ms. [redacted] it is essential that she establish a sense of physical safety. It is extremely unlikely, given Ms. [redacted] history of abuse by multiple perpetrators, that she could achieve this sense of safety in Guatemala.

Recommendations

Given Ms. [redacted] significant mental health problems and likely cognitive impairment, it may be difficult for her to testify on her own behalf. Talking about the traumatic events she has experienced is stressful and painful. Ms. [redacted] is quickly overwhelmed by emotions when she thinks about her past, and she struggles to focus and respond to questions in a concise manner.

Ms. [redacted] would benefit from further neuropsychological assessment to determine the extent of her cognitive impairment and identify any interventions that may help her to improve her functioning and overcome deficits.

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

Susanna Francies, Psy.D.
Licensed Psychologist

6-4-2015
Date