



Overgeneral memory in asylum seekers and refugees



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ABSTRACT

Background and objectives: Studies in western samples have shown that post-traumatic stress disorder (PTSD) and depression are associated with overgeneral autobiographical memory retrieval. This study assesses whether this association extends to asylum seekers and refugees from diverse cultural backgrounds. We discuss implications for those providing testimony of their experiences when seeking asylum.

Method: 38 asylum seekers and refugees were recruited through clinics and community groups. Clinical interviews assessed PTSD and depression and participants completed a test of autobiographical memory specificity.

Results: When accounting for omissions, participants with PTSD and depression recalled a lower proportion of specific memories. Those with PTSD also failed more frequently to report any memory.

Limitations: The sample did not permit separate evaluation of the effects of PTSD and depression on specificity.

Conclusions: Lower memory specificity observed in people experiencing PTSD and depression in western populations extends to asylum seekers and refugees from diverse cultural backgrounds. This study adds to the literature suggesting that being recognised as a refugee fleeing persecution is more difficult for those with post-traumatic symptoms and depression.

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This study compares the ability of asylum seekers and refugees with and without post-traumatic stress disorder (PTSD) and depression to recall specific memories of their personal past. Current legal guidance specifies that the inclusion of specific details in personal testimony is a marker of credibility ([Asylum Policy Instructions, 2012](#)) and decision-makers frequently rely on their own assumptions about human behaviour when making such judgements ([Herlihy, Gleeson, & Turner, 2010](#)). An association between overgenerality and psychopathology in this population may have important implications for the success of asylum applications.

Introduction

Refugees and asylum seekers

The term refugee was defined in the Convention and Protocol Relating to the Status of Refugees ([UNHCR, 1951](#)) as 'someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion'. Refugee status is contingent upon fear of future persecution, but for many this is based on experiences of past persecution, including traumatic events. Prevalence of mental health problems is high among refugees. Of refugees resettled in western countries, a systematic review ([Fazel, Wheeler, & Danesh, 2005](#)) found that almost one in ten were experiencing symptoms consistent with PTSD and one in twenty with depression. Among Kosovan refugees in the UK, prevalence was even higher: 39% had symptoms consistent with PTSD and 16% with depression ([Turner, Bowie, Dunn, Shapo, & Yule, 2003](#)).

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Particularly in refugees, the sequelae of trauma may not be fully captured by quantitative psychological assessment tools (Hollifield et al., 2002) and clinician assessments are recommended to avoid overstating or misrepresenting symptoms (Turner et al., 2003). Survivors of torture often have high levels of hyperarousal and intrusions but score below the PTSD diagnostic threshold on avoidance (Ramsay, Gorst-Unsworth, & Turner, 1993) and survivors of sexual violence have much higher levels of avoidance (Bögner, Herlihy, & Brewin, 2007). However, clinician assessed PTSD diagnosis is commonly employed in clinical and legal contexts with refugees and there is clear utility in terms of intergroup comparison.

Autobiographical memory overgenerality

Autobiographical memory refers to the recollection of events that were personally experienced in the past. Autobiographical memory specificity (AMS) refers to the ability to recall specific memories, commonly defined as lasting less than one day, and overgeneral memory (OGM) refers to the tendency to recall general memories, either categories of events that happened repeatedly or events that lasted a long time. The term overgenerality has been used to describe both phenomena (e.g. Moore & Zoellner, 2007).

The Self-Memory System model of autobiographical memory (Conway & Pleydell-Pearce, 2000) proposes that memory representations are stored within a hierarchy that ranges from broad themes of the life story (e.g. relationships) to lifetime periods (e.g. 'when I was a student') to general events (e.g. 'going to psychology lectures') and specific events (e.g. 'my graduation ceremony'). It also proposes that autobiographical knowledge is stored and retrieved in the context of an abstract conceptual self which is socially and culturally constructed. This self-concept defines schemas for knowledge about the self and interactions with others. Memories of specific events can be retrieved either via a top-down generative search process through the hierarchy or triggered directly by cues in the environment. The model suggests that general representations are accessed first in an effortful generative search, with specific sensory and affect-laden representations accessed subsequently via linked associations.

Overgenerality may result from interruptions to the generative retrieval process which truncate the search at the general level before specific memories are accessed. Possible mechanisms behind this process include rumination and deficits in the way the memory is encoded, functional avoidance of negative affect associated with certain specific events, or impaired executive control (CaRFAX; Williams, 2006).

Psychopathology and overgenerality

Following the functional avoidance hypothesis, overgenerality may protect against negative affect in the short term (Williams, Eelen, Raes, & Hermans, 2006) but also contributes to the onset and maintenance of emotional disorders (for a review, see Williams et al., 2007). Several studies have assessed overgenerality in survivors of trauma and found it to be linked with negative post-traumatic reactions (Brennen et al., 2010; Moore & Zoellner, 2007). For veterans (Brown et al., 2013; McNally, Lasko, Macklin, & Pitman, 1995), motor-vehicle accident survivors (Harvey & Bryant, 1998) and people who have been assaulted (Schönfeld, Ehlers, Böllinghaus, & Rief, 2007) higher post-traumatic symptoms are associated with greater overgenerality (for a review, see Brewin, 2011).

Few studies exist of overgenerality in asylum seekers and refugees despite the prevalence of trauma and psychopathology in this population. One study undertaken with refugees in the UK

(Moradi et al., 2008) found that specificity was associated with fewer traumatic intrusions and higher avoidance but not with overall symptom severity. Of note, all participants in this sample met criteria for diagnosis of PTSD so interpretation of this finding should be cautious.

The present study extends current research by assessing overgenerality in asylum seekers and refugees with and without PTSD and depression. Following previous research, we hypothesised that those who met criteria for these disorders would have lower autobiographical memory specificity.

Method

Participants

38 adult asylum seekers and refugees in the UK who had suffered at least one traumatic event participated in the study. Potential participants were excluded if they were currently suicidal or experiencing psychotic symptoms that they were finding hard to tolerate. They were recruited via specialist traumatic stress treatment clinics and community organisations providing services to immigrants.

From the community group, four potential participants who had been referred to the study declined to arrange a meeting, stating that they feared it would be too stressful to think about traumatic experiences. One research session was discontinued when the participant stated that he was not an asylum seeker or refugee. Two participants who had consented to participate became distressed and agitated in the room and requested to end the session before completing any measures.

Administration of measures

Data were collected in one-off interviews lasting 60–120 min. Written informed consent was sought at the start and an extended debrief was offered at the end. Interviews were carried out in settings familiar to the participants. UK National Health Service Research Ethics Committee approval was granted before the study began. Care was taken to ensure that the potential participants understood the limits of confidentiality. English is commonly not a first language in this population and literacy varies considerably so all measures were administered orally, via an interpreter as necessary. English literacy was not formally assessed.

Following previous research in clinical and non-clinical groups (see Moore & Zoellner, 2007; Williams et al., 2007) overgenerality was assessed using the Autobiographical Memory Test (AMT; Williams & Broadbent, 1986). Emotion-related cue-words were presented on cards one by one and simultaneously read aloud. Participants were given 60 s to recall a specific memory. They were told that memories could be recent or distant, important or trivial. If the first response was not a specific memory, a standard prompt was given – "can you think of a specific time?" An example of a specific and general response to the cue-word 'good' was suggested by the researcher. The task began when specific memories had been generated in response to two practice words (bread, expert).

Sixteen cue words (ugly, failure, bored, upset, tired, sad, blame, helpless, eager, happy, friendly, excited, lively, joy, calm, hopeful) were selected from an established list of words used in AMT research (Brittlebank, Scott, Williams, & Ferrier, 1993). The high number of cues was chosen to allow for errors and exclusions due to potential language difficulties. Kucera Francis Frequency ratings were within limits suggested for the AMT (positive words: $M = 37.6$, suggested range 18.8–39.8; negative words: $M = 34.37$, suggested range 18.8–37.7). Emotionality was within the suggested range for negative words ($M = 4.81$, suggested range 4.81–4.98) and slightly above the suggested range for positive words ($M = 5.31$,

suggested range 4.73–5.04). It is possible that there is inherent variation in frequency and emotionality cross-culturally and following translation.

Responses were coded as specific (referring to an event that happened in a particular instance and lasted a day or less, e.g. 'when I went to my friend's party'), categoric (referring to a category of events, e.g. 'watching football on TV', or a series of repeated events, e.g. 'I used to play football every weekend'), extended (referring to a period of life that lasted for longer periods of time, e.g. 'when I was at college', or an event that lasted longer than a day, e.g. 'during summer when I spent time at the river'), omission (failure to report a memory within the time limit) or error (problem with translation, or the response was not a memory).

The total number of each type of memory was calculated. Proportions were calculated for each memory type as follows, including and excluding omissions. Proportion Specific including omissions = # Specific/# (Specific + Categoric + Extended + Omissions). Proportion Specific excluding omissions = # Specific/# (Specific + Categoric + Extended).

When not administered in English, cue words were translated and their meaning verified via back-translation between the interpreter and the researcher. This process was repeated with different interpreters when possible to improve reliability. Words were written clearly on cue cards in the relevant language and spoken aloud by the interpreter when instructed by the researcher. The interpreter gave an immediate verbatim translation of each response which was transcribed in English on the record form. Any ambiguity was discussed and reconciled directly after the session. Coding and analysis of responses was based on the English transcriptions made at the time of the session. Farsi and French translations are available from the authors if required.

Structured clinical interviews (SCID: First, Spitzer, Gibbon, & Williams, 1995) assessing symptoms over the previous month enabled DSM-IV diagnostic categorisation of PTSD and depression. Participants were not required to disclose details of traumatic incident(s).

Primary coding was carried out by the first author and secondary coding of 20% of clinical interviews and all AMT answers was completed by a psychology graduate trained in the coding systems and blind to clinical diagnosis. Inter-rater reliability was very high. For specific, categoric and extended memories in the AMT, Kappa = .941, $p < .001$, for presence of PTSD, Kappa = .912, $p < .001$, and depression, Kappa = .883, $p < .001$.

Using G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007) it was estimated that a sample of 22–40 participants would be required to detect between group differences. This was based on effect sizes from Kangas, Henry, and Bryant (2005) and Harvey and Bryant (1998), additionally specifying alpha = 5% and desired power = 80%, and assuming equal group sizes.

Results

Analyses were carried out with Statistical Package for the Social Sciences (SPSS 17.0). Normality in the data was assessed by evaluating statistics for kurtosis and skewness and examining histograms. Parametric t -tests were used to assess between group differences when conditions were satisfied. Otherwise non-parametric methods were used. Homogeneity of variance was assessed for each test and where assumptions were violated the alternative test statistic is reported. No significant outliers were detected so all relevant cases were included in each analysis. Directional hypotheses were tested with one-tailed tests. There were no meaningful differences in the direction or significance of results when the five cases that were conducted via an interpreter

Table 1
Participant demographics and trauma characteristics.

	PTSD (<i>n</i> = 22)	No-PTSD (<i>n</i> = 16)	Statistic <i>t</i> (36)	<i>p</i> -value (two-tailed)
<i>Demographics</i>				
Age in years <i>M</i> (<i>SD</i>)	41.73 (11.18)	39.56 (8.96)	−0.64	.52
Gender <i>N</i> (%)				
Female	5 (22.73)	6 (37.50)		.47 ^a
Legal status in UK <i>N</i> (%)				
Asylum seeker	3 (13.64)	8 (50)		.03 ^a
Occupation type <i>N</i> (%)				
Skilled	14 (63.6)	10 (62.5)		.69 ^a
Unskilled	0 (0)	1 (6.3)		
Student	6 (27.3)	4 (25)		
Other	2 (9.1)	1 (6.3)		
Years spent in the UK <i>M</i> (<i>SD</i>)	9.05 (4.77)	9.94 (5.38)	.54	.59
Language <i>N</i> (%)				
English speaking	17 (77.3)	16 (100)		.06 ^a
<i>Trauma characteristics</i>				
Index trauma type <i>N</i> (%)				
Torture	13 (59.1)	4 (25.0)		.05 ^a
Other (including war, political violence, natural disaster)	9 (40.9)	12 (75.0)		
Years since index trauma <i>M</i> (<i>SD</i>)	13.68 (7.24)	12.88 (9.51)	−0.30	.77

^a significance of Fisher's Exact Test reported if fewer than five cases per cell in χ^2 comparison.

(Farsi, $n = 4$; French, $n = 1$) were excluded so reported results include those cases. (Table 1).

Demographic characteristics

The groups did not differ in terms of age, gender, years spent in the UK, or years since the index traumatic event reported. Torture was more frequently reported as index trauma in the PTSD group. In terms of legal status, significantly more participants from the community group were currently seeking asylum at the time of testing, reflecting the nature of the population in the recruitment sites for each group. There were 19 different first languages reported by participants from 17 countries in Africa, South America, Middle East and Eastern Europe reflecting some of the diversity of backgrounds of asylum seekers and refugees in the UK. (Tables 2 and 3).

PTSD, depression and overgenerality

PTSD and depression are highly co-morbid (Blanchard, Buckley, Hickling, & Taylor, 1998) particularly in the refugee population (Fazel et al., 2005) and Fisher's Exact Test confirmed that diagnoses of PTSD and depression were strongly associated in this sample, $p < .001$. Specific memories were retrieved most commonly compared to other types of memories, although on average slightly fewer specific than non-specific memories were retrieved by

Table 2
Mean (*SD*) number of memories generated by participants with and without PTSD.

Memory type	Number per participant <i>M</i> (<i>SD</i>)	
	PTSD (<i>n</i> = 22)	No-PTSD (<i>n</i> = 16)
Specific	5.64 (2.77)	8.19 (3.75)
Categoric	4.00 (3.28)	4.25 (2.89)
Extended	2.55 (1.60)	1.88 (1.20)
Omission	2.50 (2.32)	1.00 (1.26)
Error	1.32 (1.13)	.69 (.87)
Total excl. omissions & errors	12.18 (2.32)	14.31 (1.74)
Total excl. errors	14.68 (1.13)	15.31 (.87)

Table 3
Proportional memory scores for participants with and without PTSD and depression.

Memory type	Proportion of memories M (SD)		Statistic t (36)	p value (one-tailed)	Effect size (Cohen's d)
	PTSD (n = 22)	No-PTSD (n = 16)			
<i>Excl. omissions</i>					
Specific	.46 (.22)	.56 (.23)	1.30	.10	.44
Categoric	.30 (.22)	.31 (.22)	.09	.47	.05
Extended	.23 (.17)	.13 (.09)	-2.36*	.01	.73
<i>Incl. omissions</i>					
Specific	.39 (.18)	.53 (.24)	2.10*	.02	.68
Categoric	.27 (.21)	.28 (.19)	.13	.45	.04
Extended	.17 (.11)	.12 (.08)	-1.75*	.05 ^a	.56
Memory type	Proportion of memories M (SD)		Statistic t (36)	p value (one-tailed)	Effect size (Cohen's d)
	Depressed (n = 19)	Non-Depressed (n = 19)			
<i>Excl. omissions</i>					
Specific	.43 (.22)	.57 (.21)	1.95*	.03	.65
Categoric	.35 (.22)	.26 (.21)	-1.26	.11	.42
Extended	.21 (.18)	.17 (.11)	-0.98 ^a	.17	.27
<i>Incl. omissions</i>					
Specific	.38 (.20)	.52 (.22)	2.02*	.03	.67
Categoric	.31 (.21)	.23 (.19)	-1.24	.11	.40
Extended	.16 (.12)	.14 (.08)	-0.71 ^a	.24	.20

Note. Errors were excluded.

* $p < .05$.

^a Equal variances not assumed.

participants in the PTSD group (Table 2). Overall there were 40 errors, representing 6.6% of all possible responses.

When omissions were included, participants with PTSD generated a significantly lower proportion of specific memories and higher proportion of extended memories compared with the no-PTSD group. When omissions were excluded, the difference in the proportion of specific memories retrieved was no longer significant but the proportion of extended memories generated remained significantly higher in the PTSD group. There was no significant difference in terms of categoric memories. The proportion of omissions was also significantly higher in the PTSD group, $U = 104.0$, $p = .03$ (two-tailed). Between-group differences in specific memories and omissions remained significant when controlling for torture survivor status, but differences in extended memories were no longer significant, including omissions, $F(1,35) = 1.57$, $p = .22$, and excluding omissions $F(1,35) = 2.83$, $p = .10$.

Participants with depression generated a significantly lower proportion of specific memories compared with the no-depression group both including and excluding omissions. There were no other significant differences between the groups. There was also no significant group difference in number of omissions, $U = 155.5$, $p = .47$ (two-tailed). There was no impact on significance of results when torture survivor status was included as a covariate.

Discussion

Psychopathology and overgenerality

High comorbidity limits interpretation of the independent associations of PTSD and depression with overgenerality. Following similar findings in other trauma exposed groups (e.g. Brown et al., 2013) when omissions were included in the analysis, those with PTSD retrieved a lower proportion of specific memories. Also, in common with previous studies with western samples (see Williams et al., 2007) depression was associated with lower specificity.

Previous studies have shown that participants with PTSD also retrieve more general memories in the AMT. Combat veterans with PTSD retrieved more general memories (McNally, Litz, Prassas, Shin, & Weathers, 1994) and in two studies with assault survivors, one found that those with PTSD retrieved more categoric memories overall (Schönfeld & Ehlers, 2006) and after trauma memories were excluded from the analysis (Schönfeld et al., 2007). The current study found no difference in retrieval of categoric memories even at a trend level.

Extended memories have been excluded from analyses in previous studies due to low incidence (e.g. Schönfeld & Ehlers, 2006) or conflated with categoric memories into an overall variable of overgeneral memory. In the current study, extended memories were the least common type of memory given but still constituted 15% of responses. Participants with PTSD produced a significantly higher proportion of extended memories overall. Much of the effect was statistically accounted for by those in that group who had experienced torture. In addition, reference to the content of responses given in the AMT supported the suggestion that many extended memories were accounts of extended trauma including torture. For example, "during the time I was in prison" and "when I was in detention".

The role of omissions has only recently been considered in some AMT studies (Griffith et al., 2009). Overall, significantly more omissions were recorded by refugees with PTSD in this study. Given the requirement for asylum seekers to disclose personal memories, this is a potentially important finding which merits further investigation. These omissions may reflect a memory problem or a reluctance to disclose trauma related memories. These possibilities cannot be further elucidated within the current study but should be investigated in future research.

Methodological limitations

Despite its utility for comparisons, we acknowledge that categorical diagnosis of PTSD may be criticized in this population (Ramsay et al., 1993) and that there are some challenges to its validity across cultures (Jobson, 2009). High comorbidity with depression also means that interpretation of our results concerning PTSD cannot be reliably disentangled from the influences of depression. Discrete measures of individual symptom clusters in this study would have enabled more sophisticated and symptom specific analysis of factors underlying overgenerality. Measures of traumatic brain injury and experiences of early trauma were also not assessed.

Administration of the AMT in this study followed best-practice in terms of visual presentation of cues, blind coding, reliability testing and maximum response time. However, imageability of positive cue words was slightly above the suggested range for use in the AMT (Brittlebank et al., 1993) which may have facilitated direct retrieval of specific memories to those cues. Cue words were translated carefully but the equivalent meaning of words across cultures cannot be guaranteed. Even when presented in English the cultural connotations of the words perceived by participants may have varied.

There is tentative evidence in bilingual studies that language may influence dominant self-concept and cognitive style during recall (Marian & Kaushanskaya, 2004) but also reason to believe that immediate context is more important (Watkins & Gerong, 1999). Interviews were carried out individually and were standardised as much as possible but the context of the room varied between community and clinical settings and the presence of the researcher, who was not from the same cultural background as participants, as well as an interpreter in some cases, may have affected memory retrieval.

It is important to consider these limitations in light of the diversity of the group under study and in terms the ecological validity of this research to the process of seeking asylum. Testimony is usually provided in an oral interview format with an official from a different cultural background, so the manner of oral administration of measures in this study mirrors that experience.

Implications for future research

This study provided initial evidence that when asked to give examples of specific personal experiences, asylum seekers and refugees with PTSD and depression are less able to do so than those without PTSD. Those with PTSD also tend to produce more extended memories and more frequently fail to respond at all. Future research should extend these findings to evaluate ability to recall specific sensory and contextual detail around the events described through analysis of memory narratives (Lemogne et al., 2009). This approach would also replicate more closely the nature of information sought and provided within the asylum seeking process.

All participants in this sample had been exposed to trauma and many had experienced multiple or long term traumatic events. The distinctions in overgenerality between the those experiencing current psychopathology and those functioning better supports the suggestion that post-trauma coping rather than trauma exposure per se is important in explaining overgenerality (Moore & Zoellner, 2007). Unfortunately, in this population it may not be possible to identify a matched sample of participants who have not been exposed to trauma. However, comparison with immigrants who have moved under different circumstances may help to extend understanding of the mechanisms and characteristics of overgenerality in this culturally diverse population.

Retrieving fewer specific, or more general, memories may stem from a functional avoidance of negative affect associated with aversive past events (Sumner, 2012; Williams et al., 2006). This tendency may be activated more strongly in threatening situations (Debeer, Raes, Williams, & Hermans, 2011) so when describing personal events in a novel and potentially pressured environment, overgenerality effects may be exacerbated. Asylum seekers are likely to find interviews about their experiences stressful – and even more so in interviews pertaining to their asylum applications – so it will be important to consider these contextual factors further.

Implications for the asylum process

UK Border Agency guidance to decision makers advises that asylum seekers who do not give specific details of their experiences are more likely to be fabricating their story (item 4.3.1; Asylum Policy Instructions, 2012) and a recent review of refugee status decision making in the UK, the Netherlands and Belgium by the United Nations High Commission for Refugees (UNHCR) reported that “sufficiency of detail and specificity is used in practice as an indicator of the credibility of applicants’ statements.” (UNHCR, 2013). Assessment of credibility has been found to be central to decisions to refuse applications for asylum (Asylum Aid, 2011). The current study indicates that asylum seekers who are experiencing more symptoms of PTSD and depression are less specific when asked to bring to mind memories of personally experienced events, suggesting that their credibility may be consistently underestimated.

When asked to disclose personal memories, refugees with PTSD failed significantly more frequently to provide any memory at all within the time limit given. This could reflect a memory impairment or perhaps generation of a trauma memory which the person

was unwilling or unable to disclose. Asylum seekers have reported difficulties disclosing traumatic experiences in Home Office interviews in previous research (Bögner et al., 2007). It would be interesting and important to investigate how administration of the AMT in a written format or with more time might influence the ability of asylum seekers and refugees to be more specific when reporting personal memories.

Conclusion

This study found that asylum seekers and refugees with PTSD and depression are less able to retrieve specific memories of their personal past within a given time limit when prompted to do so. Despite its limitations, this is one of very few studies of clinical and community asylum seekers and refugees showing that low memory specificity is a significant problem. This adds to the literature suggesting that being recognised as a refugee fleeing persecution is more difficult for those with post-traumatic symptoms.

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