

Asylum claims and memory of trauma: sharing our knowledge

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Summary Decisions about asylum are extremely difficult because of the absence of a body of objective evidence. Psychiatrists and psychologists have a breadth of knowledge relating to the memory of trauma which could help to inform the asylum process, but we need to investigate how to apply this knowledge and how to make it accessible to decision makers.

Declaration of interest None.

In the UK, 25 710 applications for asylum were made in 2005 by people who claimed they were forced to leave their countries because of a fear of persecution. There were 33 940 appeals determined by the appeal court, the Asylum and Immigration Tribunal (Home Office, 2005). In order to make a claim, the asylum seeker usually has to relate a coherent account of events that they have experienced and which they claim led them to fear a return to their country. Of course, some will not have had the experiences that they allege – they will be presenting a false story in order to gain entry to the UK. The legal process for identifying valid claims involves written statements, interviews and court hearings, and is intended to identify those with a well-founded fear of persecution as defined in the 1951 Geneva Convention Relating to the Status of Refugees. One of the challenges with this jurisdiction is that decisions often have to be based on little more than the story that the claimant presents. The decision maker usually has to determine whether or not this is credible, in the absence of independent corroborating evidence about the applicant's personal experience.

BREADTH OF EVIDENCE

The Working Party for Medical Evidence of the International Association of Refugee Law Judges (<http://www.iarlj.nl>) has as its

remit to consider whether, and if so what, general principles apply to the form, reception and evaluation of expert evidence. Currently in the UK, expert reports are rarely requested by the authorities for asylum cases, and never by the courts; solicitors acting for the asylum seeker have discretion to request expert reports in individual cases. John Barnes, one of the founding members of the working party, has argued that, because medical evidence is usually written in the form of a report for one specific claimant, there is 'no . . . breadth of evidence to assist in the evaluation of medical expert evidence' (Barnes, 2004: p. 354). We propose, using the example of memory functioning, that there is a body of general evidence, but that more research is required into its application in this context.

MEMORY

One of the key factors when presenting a case for asylum is the ability of the asylum seeker to remember past experiences, usually traumatic, and give a coherent account of these to officials. A common assumption is that an experience of severe violence or torture will be so important that it will be remembered very clearly over the long term. If applicants for asylum change their account of their experiences (give discrepant accounts), this is therefore taken to suggest fabrication. This is an understandable view but one which is challenged by scientific evidence.

Memory and trauma

When people witness accidents or crimes, some details are more likely to be remembered than others. Eyewitnesses to highly emotive events, such as violent crimes, tend to have a good memory for central details (moments central to the narrative or emotional gist of the event). However, these central details will be remembered at the expense of details peripheral to the overall

unfolding of the event (Christianson & Safer, 1996).

We also know that when people are interviewed about what they have seen, it is possible to influence their answers. Questioning techniques used by the police and the courts have been modified following work on 'suggestibility' which shows that the wording of a question can influence the answer given, even by well-meaning witnesses (Gudjonsson, 1997).

When it comes to memories of personal experiences, we also know that emotion plays a big part both in what is encoded at the time and what is recalled later. The Yerkes–Dodson inverted-U model of performance and emotional arousal (Yerkes & Dodson, 1908; see Deffenbacher, 1983) reminds us that high levels of emotion may impair encoding of any memory, not just traumatic memories.

Many psychiatric disorders are known to be associated with aspects of memory. People who are depressed tend to have a memory bias for events which reflect negatively on themselves and the world, more easily forgetting situations in which they performed well. Anxiety is also associated with an attentional bias towards threatening situations or facts (Williams *et al*, 1997). Both depression and post-traumatic stress disorder (PTSD) have been shown to be associated with a pattern of overgeneral memory, in which individuals have difficulty retrieving memories of specific events (McNally *et al*, 1995; Williams, 1995).

Some memories of traumatic experiences are probably qualitatively different from normal autobiographical memories. An autobiographical memory for a normal event is verbal, sequenced (having a beginning, middle and end), recognised as being in the past, and may be recalled voluntarily. Traumatic memories often include incomplete autobiographical accounts. However, they often also include perceptual 'snapshots' (a smell, the sound of screaming, the image of a face), which are experienced in the present (reliving experiences) and are often triggered by external or internal cues (the sound of a firework, a feeling of guilt) rather than being subject to conscious recall (Hellowell & Brewin, 2004).

It is understandable that people faced with painful memories like these will adopt strategies to avoid situations likely to trigger them, for example meeting others from their country of origin. They may also adopt less conscious strategies such as 'numbed' emotions or dissociative amnesias.

Memory and the asylum process

Despite the long-established body of knowledge about memory, a review of the literature shows a dearth of articles by psychiatrists and psychologists for lawyers involved in decisions about those seeking asylum. Perhaps Barnes (2004) can be forgiven for his assertion about the lack of a breadth of evidence.

We searched PsycINFO, Medline and PILOTS (the database of the National Center for Post-Traumatic Stress Disorder; <http://www.ncptsd.va.gov/ncmain/index.jsp>) with the terms *memory* AND *trauma* AND *law* AND (*refugees* OR *asylum*). Only three papers were identified that explicitly linked memory functioning to asylum decision-making.

Masinda (2004) analysed a series of seven negative asylum decisions on refugees exhibiting PTSD, comparing judicial determinations with clinical and research findings on memory. Herlihy *et al* (2002) interviewed on two occasions refugees granted asylum as a group by the United Nations and found inconsistency between their accounts on the two occasions. They found a relationship between the rate of discrepancies and the nature of the questions asked. Furthermore, individuals with higher levels of PTSD were more inconsistent the longer they had to wait between interviews. Morgan *et al* (2004) studied over 500 soldiers undergoing 'high-stress' interrogation, 'modelled from the experience of actual military personnel who have been prisoners of war'. These young, fit, trained individuals managed only a 66% recognition rate when presented with photographs (in identical clothes to improve performance) of their interrogators.

Other issues are probably also important in this context. For example, from clinical experience and the research literature, we know that when people feel shame they find it difficult to disclose personal information. In an interview with the authorities, however, there are often opposing forces at work. Shame regarding a brutal rape, for example, is likely to inhibit disclosure of the event to an official (Van Velsen *et al*, 1996), yet disclosure may be essential to gain protection from the possibility of further brutality.

Claimants' discrepant accounts of their experiences may also be related to the different triggering of traumatic memories depending on the situation. We do not know enough about the impact of this on

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the variability of presentation in the high-emotion contexts of the court room, the official interview and clinical assessment.

Some of these questions are being addressed. Steel *et al* (2004) used case examples to illustrate their arguments that mental health issues have an impact on the fairness of refugee status decisions. A recent study explored the experiences of 27 asylum seekers of interviews at the UK Home Office and identified the importance of the behaviour of interviewers as well as the impact of claimants' feelings of shame and efforts to avoid their memories (Bögner *et al*, 2007, this issue).

FUTURE DIRECTIONS

Psychiatrists and psychologists practising in this field hold a wealth of clinical knowledge which may be relevant to the legal process of deciding asylum claims. Legal advisors and immigration judges sometimes look to medical experts to help them to make these very difficult decisions. We need to find ways of developing the broader evidence base concerning not only memory and the asylum process, but also the impact of traumatic experiences, cross-cultural assessments, depression, forced migration, stressful environments and suicide risk assessments. We then need to make this evidence more accessible to decision makers. If we achieve this, we will have helped to produce a more robust system (with fewer false positives as well as false negatives), one better able to achieve fair decisions for all.

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