CHAPTER 7

EVIDENTIARY ASSESSMENT AND PSYCHOLOGICAL DIFFICULTIES

Jane Herlihy[1]

7.1. INTRODUCTION

This chapter will outline some of the effects that psychological and psychiatric difficulties can have on individuals' abilities to present their case for asylum.

It will briefly outline a number of aspects of the asylum seeker's experience in the host country from a psychological perspective, considering the issues of migration into a new culture and some of the ways in which the legal process of seeking asylum can impact on the individual. However, the main focus of this chapter is on asylum seekers with mental health problems.

As will be shown many asylum seekers and refugees have no significant mental health problems and do not seek or require professional psychological or psychiatric help. However, a significant number do, and it is crucial that the judicial system take this into account. Given the nature of the mental health problems that do occur, to ignore this group would be to systematically discriminate against them.[2]

There is a large body of evidence that suggests that memories of traumatic events are initially held in a significantly different form from our normal memories of past events. Most refugees are by definition likely to have had experiences that would be defined as traumatic. This has serious implications for asylum seekers whose ability to accurately and consistently recall autobiographical memories is seminal to the outcome of their case. These problems are most likely to appear in individuals diagnosed with Post Traumatic Stress Disorder (PTSD), but may not be exclusive to them and this issue will be discussed first.

The two most common diagnoses noted in refugees and asylum seekers are Post Traumatic Stress Disorder (PTSD) and Depression. These two diagnoses will be briefly discussed – outlining what is meant by them and how common they are amongst asylum seeker populations. Most importantly, the effects that the symptoms of PTSD and depression can have on the individual's ability to present a case for asylum will be examined. It will be argued that, in the search for valid methods of

---

[1] Chartered Clinical Psychologist at the Refugee Service, Traumatic Stress Clinic, London.
The author is grateful for detailed input from Dr. Stuart Turner, Honorary Senior Lecturer, University College London.

[2] Asylum procedures which put persons with a mental health condition into a disadvantageous position when presenting their claim may bring about violations of international law. Typically, issues might be raised under article 3 (freedom from torture and other forms of ill-treatment), article 13 ECHR (right to a remedy) and article 14 ECHR (non-discrimination with regard to rights guaranteed by the ECHR).

assessing asylum claims, PTSD has been pressed into service as an indicator of the truth of a claim, as it includes an assumption that the origin of the disorder lies in a traumatic event, whereas the symptoms of PTSD also have wide-ranging implications for judgements of credibility.

A further possible effect of extremely traumatic experiences is dissociation, which will be described.

The chapter will also briefly mention a number of other issues that always need to be considered when interviewing and assessing individuals who may have a history of torture or violence. This is not intended to be a comprehensive list, but rather to give an indication of the main groups of people who may not be receiving equitable justice due to unidentified or misunderstood psychological or mental difficulties.

7.2. THE EXPERIENCE OF SEEKING ASYLUM

7.2.1. Systems and Officials

For the majority of asylum seekers, their arrival in a host country means entering a culture about which they may know a little, but are likely to understand less. Upon arrival they enter into legal and bureaucratic systems which are likely to not only work differently but that are underpinned by different attitudes and assumptions from those with which they are familiar. A recent example emerged from a discussion with a group of Kosovan Albanians who explained that for them, the correct response to not getting what one needs from an official is to show that one is angry: shouting and behaving aggressively means that you are serious, and are more likely to be taken seriously and attended to, whereas if you remain quiet and meek you will be ignored. In the UK, where politeness with calm persistence are more the cultural norm, it is easy to see where this group of people might alienate themselves from the officials with whom they are interacting. This example may or may not rest on a valid generalisation – so often generalisations are misleading – but it does give a glimpse of some of the more subtle learning that asylum seekers are faced with if they are to make their way successfully into host cultures. This learning is of course particularly crucial in interacting with the judicial system.

Refugees, by definition, have a well-founded fear of persecution, persecution that has been allowed, if not sanctioned by the state in which they lived. Whether such tolerance is by weakness or intent on the part of the state, a degree of mistrust of, or at least a marked ambivalence of feeling towards state officials of whatever origin would be entirely understandable. Guidelines for immigration interviews in the UK recommend that assurance is given that all material disclosed is confidential. Nonetheless, for many people, and understandably, given their experience, this is hard to believe completely. This would lead to a reluctance to give a complete disclosure and may lead some people to gloss over parts of their story. It is often the experience of clinicians that one meeting is insufficient time for an individual to be able to consider whether s/he can take the risk of trusting his/her interviewer. Where

an individual has been submitted to torture, which directly or indirectly targets the breaking down of trust in others, this effect can be significantly stronger.

7.2.2. Contexts

We also need to take into serious consideration the context in which asylum seekers disclose details of their experiences. Clients report immigration interviews which have been conducted in a small, bare room sometimes with the same number of people in attendance as were in the small, bare room in which they were tortured. Highly vivid memories of traumatic experiences can very easily be evoked by such a context. As will be shown later, such memories can be experienced as the event happening again in the present. Clearly this would impede one's ability to give accurate and coherent responses to questions.

One women, when asked to describe her immigration interview could describe only the shoes of the three men in the room with her. Sexual torture (the use of sexual assaults, rape, violence to the genital area, as methods of torture) is typically associated with high levels of shame, making disclosure extremely difficult.[3] Despite UNHCR guidelines, women are still interviewed by male immigration officers, sometimes with the assistance of male interpreters, and are expected to disclose having been raped. Men also have to disclose being raped.

7.2.3. Interviewing Skills

In order to arrive at information that is both accurate and complete, it is important to understand and implement the principles of interviewing. In the medical field, as one example, an initial open question will be followed up by focused and then closed questions to go into more details. However, the clinician will then return to another open question to ask if there is any other problem. We see examples of immigration interviews where details have been elicited about one period of detention, but the individual was not then asked if there were any other detentions. Consequently later interviews would appear to be uncovering further material – thus producing discrepancies or new disclosures – whereas the interviewee may be giving details of a different period of detention to the one first described.

The above considerations will be true for many asylum seekers arriving in a host country – they arise largely from the situation of the individual interacting with a foreign culture, bringing with her/him, as everyone must, the assumptions of their own experience. These issues are discussed more comprehensively in Chapters 5 and 6 above. However, for some people, there will be more particular psychological and emotional difficulties that will need special attention.

[3] C. Van-Velsen, C. Gorst-Unsworth & S. Turner, 'survivors of Torture and Organized Violence: Demography and Diagnosis' [1996] *Journal of Traumatic Stress*, 9(2).

7.3. TRAUMATIC MEMORY

The process of presenting a case for asylum rests heavily on each individual claimant's memory. Autobiographical memory is, as the name suggests, the recall of events in one's personal history. We know that the recall of normal memory involves the relatively easy construction of a verbal narrative – we can produce a story of what happened to us yesterday, or last year on holiday; a story with a beginning, a middle and an end. There is now a substantial body of evidence showing that when we experience something traumatic (threatening to our life or our physical integrity, or that of someone close to us) the memories of that experience are of a very different nature.

The characteristic of traumatic memories is that they are fragments, usually sensory impressions; they may be images, sensations, smells or emotional states.[4] Importantly, probably because of the nature of the memory store in which they are held, they do not seem to carry a 'time-stamp' so they are often experienced as if they were not memories of the past at all, but current experiences. These types of memories are usually not evoked at will, as a normal memory can be searched for and produced, but they are provoked by triggers, or reminders of the event.[5]

This means that when someone is interviewed and asked about an experience that was traumatic, and has only, or largely memories of this fragmentary type, they are unlikely to be able to produce a coherent verbal narrative, quite simply because no complete verbal narrative of their experience exists. S/he will have only fragments and impressions, which are likely, incidentally, to evoke the feelings that were felt at the time of the original experience – which may be fear, distress, shame, humiliation, guilt or anger.

This distinction between traumatic and non-traumatic memory is a highly significant factor to be taken into account when making judgements regarding discrepancies in asylum claims.

Another area of memory research, which is particularly pertinent to asylum law, is work examining the testimony of eye-witnesses. A classic experiment demonstrated how the type of details recalled of an event can depend on how distressing the event is to the witness. Loftus and Burns[6] asked participants in their study to watch one of two video recordings of a simulated armed bank robbery, at the end of which the robbers run away past a young boy with a rugby shirt with a number on the back. The recordings were identical except that in one version one of the robbers turns and shoots the boy in the face. In the other the robbers merely run away. The experimenters found that the participants who watched the video with the

[4] B. van der Kolk, 'Trauma and Memory' in B.v.d. Kolk, A.C. MacFarlane and L. Weisaeth (eds.), *Traumatic Stress : The Effects of Overwhelming Experiences on Mind, Body and Society* (Guilford Press, New York, 1996).

[5] C. Brewin, T. Dalgleish, and S. Joseph, 'A Dual Representation Theory of Posttraumatic Stress Disorder' [1996] *Psychological Review*, 103(4).

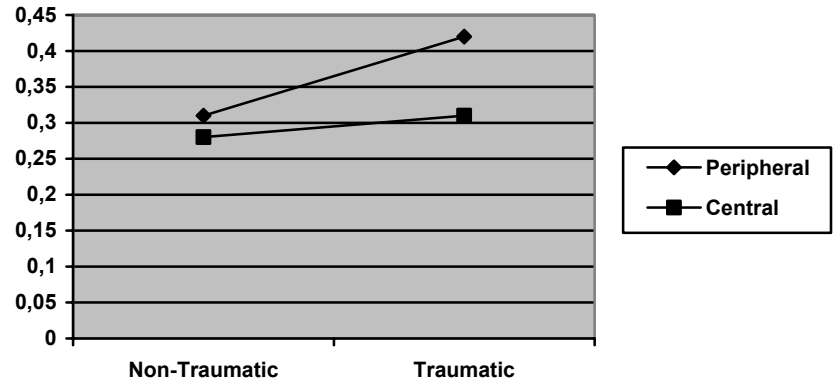
[6] E. Loftus, & T. Burns, 'Mental shock can produce retrograde amnesia' [1982] *Memory and Cognition*, 10.

shooting were less likely to be able to recall the number on the boy's back, compared to those who had watched the 'non-traumatic' video. Note that the participants were not people with PTSD, and it is arguable as to whether viewing a distressing video of such an event would necessarily be 'traumatic' by the definition used for the diagnosis of PTSD (see below). Nonetheless, this effect has been replicated and a distinction is now made when talking about disturbing or distressing memories, between 'central' details of a story – that is what is important to the gist of the narrative or the emotional content of the account – and 'peripheral' details, such as the number on a boy's rugby shirt.

This distinction was investigated in the particular context of asylum seekers' accounts of their experience in the study examining discrepancies in asylum claims. Herlihy, Scragg and Turner performed repeated interviews with refugees from Bosnia and Kosovo who had permission to stay in the UK.[7] The interviews were from four to thirty weeks apart. Interviewees were asked to recall one incident where they felt that their life was in danger and one neutral, or happy event. They were then asked, for each event, a set of fifteen pre-defined questions (*e.g.* who was with you?, what was the weather? what was the date?). They were asked to rate each question as to whether it was central to the story, or peripheral.

Up to 65 per cent of the details provided by the refugees changed between interviews. For the traumatic events, the details rated as peripheral were more likely to change than the details rated as central. For many interviewees the date, and the day of the week, for example, were not central details. (Although note that for some stories these details were rated as central). See figure 1.

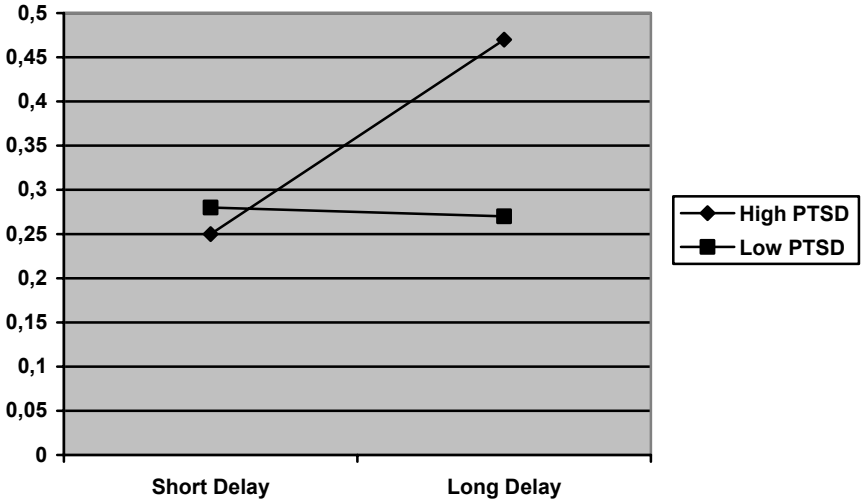
Figure 1 Discrepancies in peripheral and central rated details of traumatic and non-traumatic events



[7] J. Herlihy, P. Scragg and S. Turner, 'Discrepancies in Autobiographical Memories: Implications for the Assessment of Asylum Seekers: repeated interviews study' [2002] *British Medical Journal*, 324.

Furthermore, the longer the time between interviews, the more the details changed for those who had high levels of PTSD symptoms suggesting perversely that the group with high trauma scores may be more likely to be refused asylum on the basis of discrepancies. See figure 2.

Figure 2 Discrepancies in high and low levels of PTSD, by length of delay between interviews



More recent research has examined the effect of highly stressful conditions – interrogation – on individuals' ability to later recognise the face of their interrogator. Forty-eight hours after a stressful interrogation, Morgan III and his colleagues asked U.S. army personnel to look at pictures of 10 interrogators, one of which had interrogated them as part of their training.[8] Thirty-eight per cent of these healthy highly trained military subjects could not identify their interrogator. The researchers' findings showed that general ability to remember faces may be the important factor, but a related study showed that the confidence of the subject in their identification of the interrogators was a poor indication of whether or not they were accurate.[9] It is perhaps worth noting that memory by recognition is generally considered to be an easier task than the more effortful recall of information, as is generally required by the asylum process.

[8] G. Hazlett, C. Morgan III and S. Southwick, 'Predicting Accuracy of Eyewitness Memory' Paper presented at the 19th Annual Meeting: Fragmentation and Integration in the Wake of Psychological Trauma, Chicago, Illinois USA, 2003.

[9] C. Morgan-III, S. Southwick and G. Hazlett, 'Accuracy of Eyewitness Memory During Acute Stress'. Paper presented at the 19th Annual Meeting: Fragmentation and Integration in the Wake of Psychological Trauma, Chicago, Illinois USA, 2003.

7.4. EPIDEMIOLOGY – COMMON MENTAL HEALTH DIAGNOSES IN ASYLUM SEEKERS AND REFUGEES

In a review of the refugee literature, Silove *et al.*[10] found a range of reported prevalence of 42–89 per cent for depressive disorders and over 50 per cent for PTSD across studies of people seeking clinical help. In community based studies lower rates were found in some samples, but the higher levels found were very similar to the clinical samples – between 15 per cent and 80 per cent prevalence of depression and between 3.5 per cent and 86 per cent of PTSD.

A recent study explored a concern that the methodology used in epidemiological studies was causing an over-estimation of prevalence.[11] In particular they were concerned with the use of self-report measures (standardised questionnaires filled in by each participant). Turner, Bowie *et al.* surveyed a sample of 842 Kosovan Albanian programme refugees in the UK, using self-report measures, and then interviewed a subset of the participants (120) to validate the results. They did indeed find that the percentage of cases of PTSD found was lower in the group who were interviewed and they adjusted the results for the whole sample on this basis. Their adjusted figures showed that the proportion of people with a diagnosis of PTSD in the whole sample (842) was just under 50 per cent. The researchers also measured the incidence of depression in the same group, using the same methodology and found that approximately 16 per cent of the sample met diagnostic criteria for Depression.

Only one study has been identified that specifically focuses on long term adjustment in refugees. This study compared the levels of psychopathology of 34 Bosnian refugees upon resettlement in the USA and twelve months later.[12] Weine *et al.* found that twenty-five individuals reported a decrease in severity of PTSD symptoms, eight an increase and one remained stable. Of the 25 cases of PTSD at the time of resettlement, fourteen still met the diagnostic criteria and one new case arose.

It is important to note that not everyone who experiences a traumatic incident will go on to develop PTSD. In the non-asylum seeking British population up to 20 per cent of those who have a traumatic experience later receive a diagnosis of PTSD. The implication of this is that not having a diagnosis of PTSD does not mean that there was no trauma. If PTSD continues to be an important factor in asylum claims, then there is a danger that the 50 per cent of asylum seekers with traumatic

[10] D. Silove, I. Sinnerbrink, A. Field, V.Manicavasagar and Z.Steel, 'Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors' [1997] *British Journal of Psychiatry*, 170.

[11] S. Turner, C. Bowie, L. Shapo and W. Yule, 'Mental health of Kosovan Albanian refugees in the UK' [2003] *British Journal of Psychiatry*, 182.

[12] S.M. Weine, D.F. Becker, D. Vojvoda, E. Hodzic, M. Sawyer, L. Hyman, D. Laub and T.H. McGlashan, 'Individual Change After Genocide in Bosnian Survivors of "Ethnic Cleansing": Assessing Personality Dysfunction' [1998] *Journal of Traumatic Stress*, 11(1).

experiences but who do not meet the full criteria for a diagnosis of PTSD have a lower chance of their story being believed.

It is also important to note that individuals are diagnosed by meeting cut-off criteria for a particular disorder. It is possible to have many of the symptoms of a disorder without meeting those cut-off levels. Diagnosis is a categorical assessment, but this should not be allowed to mask the effects that may be seen in individuals with different patterns of presentation.

7.5. POST TRAUMATIC STRESS DISORDER (PTSD)

Before discussing the effects of Post Traumatic Stress Disorder, we should be clear what is meant by this psychiatric diagnosis. It consists of six sets of criteria. The first is a definition of a traumatic event; the next three are groups of symptoms – intrusions, avoidance and hyperarousal; the final two relate to duration and disability. Italics are used to indicate extracts from the Diagnostic and Statistical Manual of Mental Disorders.[13] To be diagnosed with PTSD, the individual must meet the first criterion and have at least two intrusion symptoms, at least one avoidance symptom and at least three hyperarousal symptoms.

The first criterion is that the individual has been subject to a traumatic event, which is defined as an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. This criterion also stipulates that the person's response involved intense fear, helplessness or horror.

7.5.1. Intrusions

Someone diagnosed with PTSD will have at least some form of uncontrollable, recurrent and intrusive memories – in the form of *recollections . . . images, thoughts, or perceptions, nightmares, acting or feeling as if the traumatic event were recurring (flashbacks).* They are likely to experience *intense psychological distress* and/or *physiological reactivity at cues that symbolise or resemble an aspect of the traumatic event* – also known as triggers.

7.5.2. Avoidance

They will also make strenuous efforts to avoid having to revisit memories of the trauma – whether by *avoiding thoughts or conversations* to do with the events, or by *avoiding places, people or activities* which remind them. They may be unable to recall important aspects of the traumatic event.

[13] American Psychiatric Association (1994) *Diagnostic and Statistical Manual of mental disorders.* (Washington DC, American Psychiatric Association).

7.5.3. Hyperarousal

Finally, someone with a diagnosis of PTSD is likely to have difficulties sleeping, outbursts of anger, difficulty concentrating and fearful reactions, such as being hypervigilant and very easily startled.

These symptoms will have lasted more than one month (a duration of more than three months is defined as Chronic PTSD), and be severe enough to be causing *significant impairment in social, occupational, or other important areas of functioning*, such as interpersonal relationships.

7.5.4. What is PTSD?

Briefly, the latest understanding of PTSD is that these symptoms are a result of the way in which memories of a traumatic event are processed. Unlike a normal event, as has been seen, a traumatic event is often held in memory in fragments, and these fragments of the experience are 're-experienced' in an unpredictable way, causing extreme distress to the individual. The individual's response, quite reasonably, is to make strenuous efforts to put it out of their mind and 'forget all about it'. This fails, and the continued repetition of these memories keeps alive a sense for the individual that they are still in danger. This can also re-evoke any emotions that they may have felt at the time of the trauma, such as fear, shame, humiliation, anger or guilt.

7.5.5. PTSD Symptoms and Giving Evidence

Where PTSD has been diagnosed, it is likely to be significantly more difficult for individuals to talk about their experiences. One of the diagnostic features of PTSD is that the individual makes efforts not to have conversations associated with the trauma. Factors in the interview or hearing that increase the triggering of memories and feelings will make it more likely that the individual will switche into an avoidance response. Many people find that talking about the situation in their country causes them extreme distress and they will consequently avoid talking to compatriots, including interpreters. Adopting an approach in an immigration interview or in an oral hearing that does not take account of this phenomenon stands to make it less likely that justice will be served.

The avoidance response in people with PTSD has been shown to be even stronger with respect to certain types of trauma experienced. Van-Velsen, Gorst-Unsworth and Turner analysed the symptoms of 60 survivors of torture referred to the Medical Foundation for the Care of Victims of Torture in London.[14] They found that there were significant differences in the number of avoidance symptoms between people who had been sexually tortured and those who hadn't: People who had been subject to sexual torture were significantly more likely to make efforts to avoid any reminders of their experiences.

[14] Van Velsen *et al.*, *supra* note 3.

The hyperarousal symptoms of PTSD are also particularly pertinent to the ability of the individual to engage in the legal process. S/he is likely to have extremely impaired concentration and very likely, also due to hyperarousal, to be getting insufficient sleep. We find clinically that people with PTSD have sleep problems due to three inter-related factors: a/ they have nightmares which wake them up in an extremely distressed state and it may take a considerable time before they feel calm enough to sleep again; b/ many people try to avoid sleeping, due to the distress that their nightmares cause them; c/ high levels of anxiety and worry keeps them from being able to fall asleep. The effects of even moderate sleep deprivation may include fatigue, confusion, loss of motivation and loss of concentration, amongst others.

7.6. DEPRESSION SYMPTOMS AND GIVING EVIDENCE

Depression is another diagnosis that is found relatively commonly in asylum seekers. It is linked with post-migration factors, notably isolation from family or friends, poor accommodation and other social difficulties.[1516] It is very often co-morbid with PTSD.

A diagnosis of Depression means that the individual has persistent feelings of low mood and/or an inability to enjoy previously pleasurable activities. Other symptoms include feelings of guilt, worthlessness, weight change, sleep disruption, suicidality and a '*diminished ability to think or concentrate, or indecisiveness'*.[17] This last item is emphasised, as it is clearly likely to have an impact on the quality of an individual's legal evidence.

A further effect that has been robustly associated with Depression is the inability to recall specific autobiographical memories. Experimenters have found that, when asked to provide a specific memory in response to a cue word – for example 'happy', people with depression tend to give a general response – such as 'I used to be happy when my Dad was alive', whereas people without depression would recall a specific event, such as 'when I went to the seaside with my Dad last year'.[18] There is also some evidence that this effect is found in people with PTSD.[19]

Again, as with PTSD, it should not be assumed that only the people with a full diagnosis of Depression might be subject to some of the symptoms or

---

[15] C. Gorst-Unsworth and E. Goldenberg, 'Psychological sequelae of torture and organised violence suffered by refugees from Iraq: trauma related factors compared with social factors in exile' [1998] *British Journal of Psychiatry*, 172.

[16] Van Velsen *et al*., *supra* note 3.

[17] American Psychiatric Association, *supra* note 13.

[18] J.M.G. Williams, 'Autobiographical Memory and Emotional Disorders' in S.A. Christianson (ed.), *The Handbook of Emotion and Memory* (Lawrence Erlbaum Associates Inc., Hillsdale, New Jersey.1992).

[19] R.J. McNally, N.B. Lasko, M.L. Macklin and R.K. Pitman, 'Autobiographical memory disturbance in combat-related posttraumatic stress disorder' [1995] *Behaviour Research and Therapy,* 33(6).

effects of chronic low mood. Low concentration is associated with both PTSD and Depression, but may be present despite the individual not meeting full diagnostic criteria for either diagnosis.

Suicidal thoughts, plans and, in severe cases, attempts to commit suicide, are often associated with Depression. The beliefs that the future is hopeless and the self is worthless, characteristic of Depression, combine to make suicide more likely. There is also evidence that for people with Depression and PTSD, there is an increased risk of suicide.[20]

Some people awaiting asylum decisions describe plans that they perceive as a rational response to deportation – they will kill themselves rather than return to the situations in their home country.

7.7. DISSOCIATION AND GIVING EVIDENCE

Dissociation is described in the Diagnostic and Statistical Manual of Mental Disorders as a 'disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment'.[21]

This disturbance of awareness is a common effect of past trauma experience.[22] It is sometimes experienced by the individual as a 'spacing out'. They may look like someone who is deep in thought or day-dreaming. Entering this state is not under the individual's control. It is often triggered by memories of the traumatic event – which may be unpredicted, sudden and intrusive memories.

An individual may have frequent dissociative episodes – every few minutes. When spoken to directly, using her/his name, s/he will look slightly startled and try to re-engage in the conversations. This phenomenon clearly will have a very detrimental effect on her/his ability to concentrate or follow the line of a conversation. S/he may not be able to understand questions, and s/he may lose track of the answer s/he is trying to give. Because s/he is not always attending, s/he does not learn new information well, which manifests as very poor memory.

---

[20] M. Oquendo, J. Friend, B. Halberstam, B. Brodsky, A. Burke, M. Grunebaum, F. Michael, K. Malone and J. Mann, 'Association of Comorbid Posttraumatic Stress Disorder and Major Depression With Greater Risk for Suicidal Behavior' [2003] *American Journal of Psychiatry*, 160(3).

[21] American Psychiatric Association, *supra* note 13.

[22] B. van der Kolk, O. van der Hart and C.R. Marmar, 'Dissociation and Information Processing in Posttraumatic Stress Disorder' in B.v.d. Kolk, A.C. MacFarlane and L. Weisaeth (eds.), *Traumatic Stress: The Effects of Overwhelming Experiences on Mind, Body and Society* (Guilford Press, New York, 1996).

7.8. OTHER CONSIDERATIONS

7.8.1. Head injury

A common phenomenon experienced in torture is repeated blows to the head.[23] In extreme cases, recurrent blows to the head may cause a dementia such as is seen in boxers. However, there may also be other forms of less severe organic brain damage. This possibility needs to be taken into account and questions should be asked about head injury particularly where there has been either a significant duration of loss of consciousness, or there is a loss of memory for events immediately surrounding the time of a serious head injury, or where blows to the head have been frequent and might have had a cumulative effect.

7.8.2. Psychosis

Where there is a psychotic disorder, it may be necessary to undertake assessments differently or to advise that they should be delayed until an active psychosis has been treated. Here clinicians should be asked to advise on standard treatment approaches and timescales for recovery.

Difficulties may arise where there are delusions of persecution. Of course, an individual may have both genuine and delusional beliefs about persecution. There is the aphorism, 'Just because you are paranoid, it does not mean that they are out to get you'. Indeed, the fact is that some people who are deluded are more likely than others to be persecuted. They are more likely to have difficulties appraising threat appropriately and may lay themselves at increased risk of persecution. Delusions may lead them to challenge people in authority or to pester security forces, both potentially dangerous actions in some settings.

It is possible that some have been given refugee status on the basis of entirely delusional persecution histories. However, equally, some may have been rejected on the grounds that they had some delusions – when the experience of persecution was, in fact, accurate. Great care is needed in this setting and experienced clinical input into the legal process is essential.

Delusions may not only be relevant to understanding past experiences. They may represent a risk factor for future persecution. Probably the most obvious example of this is in people who have manic episodes. Grandiose delusions of a political or religious nature may, in some countries, lay the individual open to some of the most serious consequences. A common grandiose delusion would involve a belief that the individual was destined to be a religious leader – the next Pope, Ayatollah *etc*. Their behaviour is often disinhibited and risk-taking. To express such ideas or to behave in this way in some countries would be to court persecution, especially if there was limited knowledge of mental health issues.

---

[23] A.E. Goldfeld, R.F. Mollica, B.V. Pesavento *et al.* 'The physical and psychological sequelae of torture' [1988] *Journal of the American Medical Association,* 259.

7.8.3. Learning disabilities

People with learning difficulties may also present special issues in assessment. In safe countries, there are often special mechanisms to protect vulnerable adults who are being interviewed in connection with criminal allegations. They may be more vulnerable to pressure to conform or agree with the interviewer. There may be an over-reliance on factual material – going beyond what is safe in the context of their intellectual ability. It is seldom that people are even asked about basic literacy and yet this may be crucial to understanding their appraisal of factual evidence.

7.8.4. Chronic pain

Pain is likely to be highly common in survivors of torture, where the infliction of pain and damage to the body has been used as a means of coercion, often over a prolonged period.[2425] Chronic pain is recognised to have a considerable impact on the individual in terms of concentration, fatigue, and irritability.

7.9. CONCLUSIONS AND RECOMMENDATIONS

One of the conclusions of this article is that some individuals may be either too afraid or unable to reveal a coherent or complete history of persecution when they first present. It has been shown that autobiographical memory is susceptible to distortion, most particularly when the events to be recalled were traumatic. This may affect the ability of the individual to present a coherent narrative, and it may mean that details, which are not core to the experience of the event (peripheral details), are forgotten or confused. If the experience has had a serious psychological impact (and van Velsen *et al*.[26] argue that torture always targets psychological effects) or includes significant sexual assault, this is more likely to be the case. If a successful application for asylum is to rest on the individual disclosing a *coherent* history of torture, then those individuals who are suffering some of the more disruptive psychological sequelae of their torture are being discriminated against.

7.9.1. Research

More research is needed to explore the issue of discrepancies and other assumptions made in the course of asylum decision-making. Decisions on refugee status are made based on assumptions about how individuals present themselves and their histories. We must be sure that these assumptions are valid in order to ensure that the system is making the right decisions.

---

[24] J. Cohen, 'Errors of Recall and Credibility: Can Omissions and Discrepancies in Successive Statements Reasonably Be Said to Undermine Credibility of Testimony' [2001] *Medico-Legal Journal*, 69(1).
[25] M. Peel, G. Hinshelwood and D. Forrest, 'The Physical and Psychological Findings Following the Late Examination of Victims of Torture' [2000] *Torture*, 10(1).
[26] Van Velsen *et al*., *supra* note 3.

Research investigations could establish whether there are other reasons for discrepancies between accounts. We know for example that people select different details of memory according to their mood at the time of asking. In the study into discrepancies one participant answered the same question with 'we were badly beaten' on one occasion and 'we were slapped around a bit' on another occasion.[27] Was he in a different mood state on each occasion?

7.9.2. Support in Interviews and Oral Hearings

Some of the psychological difficulties described may manifest in quite subtle ways in oral hearings. Furthermore, it has been shown how such difficulties can impact on the claimant's ability to perform in these settings. Having support in these unfamiliar, stressful situations, which may be triggering memories or otherwise impeding the claimant could be crucial in obtaining a fair hearing. One way to improve such a situation would be for the individual to be accompanied by someone who knows them closely enough to recognise the incipient signs of anxiety, panic attacks or dissociation and be able to say the person's name, or use pre-arranged strategies for gently bringing them back to their present surroundings. When someone dissociates, for example, it is often not noticeable – or s/he may appear to be day-dreaming. Someone who did not know such a claimant might conclude that s/he was not paying attention, by choice.

Of course such an individual would have to be able to stay close by the claimant, and have the permission to speak up whenever s/he felt that the claimant needed them. S/he would need to be given sufficient permission by the court to play this role, and be sufficiently assertive to carry it out.

A better solution might be possible if claimants' legal representatives had sufficient time to get to know their client and to understand any such difficulties, and thus to be able to recognise when s/he is distressed or dissociated.

7.9.3. Mental health

An assessment of the mental health of asylum claimants can be crucial in understanding their presentation and hence in making judgements of credibility.

This paper has argued that a categorical diagnosis of PTSD has been increasingly relied upon in recent years as an indicator of the truth of asylum claims, or at least to add weight to a history of trauma, as it includes an assumption that the origin of the disorder lies in a traumatic event. Similarly, psychiatrists and clinical psychologists have been turned to as experts to declare whether an individual 'has' or 'doesn't have' PTSD, in order that conclusions may be drawn about the reliability of their statement. This paper has suggested that, even falling below the diagnostic criteria, people who have witnessed or experienced traumatic events may bear psychological difficulties as a result. Indeed, Byrne describes international legal

[27] Herlihy *et al*., *supra* note 7.

arenas where an assumption of suffering is made without recourse to diagnosis.[28] The importance of our understanding of PTSD and Depression and other mental difficulties goes beyond factual evidence to raise important factors in the individual's ability to present themselves in a way that is seen by decision makers as credible.

Mental health problems do not by any means affect all asylum seekers or refugees. However, for those who are affected, there are a number of important ways in which their difficulties interact with the needs of the legal process, in such a way that they may be less likely to receive fair and valid treatment and judgements. This chapter has begun to suggest some of the ways in which psychological and psychiatric factors – whether giving rise to psychiatric diagnosis or not – can impede asylum seekers' access to justice in the legal systems of host countries.

[28] *See infra* Chapter 10, text accompanying note 29.